OF THE CALIFORNIA DENTAL ASSOCIATION

# Journal

MARCH 2007



## Psychology of the Dentist Patient Relationship

CRAIG D. WOODS, DDS, MA

OF THE CALIFORNIA DENTAL ASSOCIATION
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## DEPARTMENTS

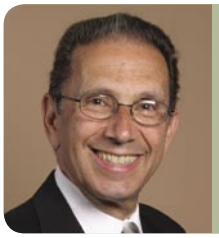


## FEATURES

CDA JOURNAL, VOL 35, Nº3

# Dental Association Diversity

ALAN L. FELSENFELD, DDS



**The California Dental Association, once again, is a bellwether state in dentistry.**

Diversity within the dental profession is not new. Much, some might argue too much, is written, debated, and legislated to ensure our dental association represents all of the profession regardless of who they are. This allows for inclusiveness — a core value of our association — for all without regard to age, race, gender, ethnicity, or any other personal attribute. This works well for our association; we are richer, better balanced, and can be proud of our efforts in this area.

Diversity has broader implications if one considers the definition to mean variety within an organization. For example, many of our members, and a surprisingly large proportion of our leadership in the House of Delegates and on the Board of Trustees, are specialists. This is a positive attribute that allows for variety in debate and conversation relative to the issues that confront the association.

The California Dental Association, once again, is a bellwether state in dentistry by becoming one of a handful, and certainly the largest, of states to expand its membership to include allied dental health professional members. The implementation of this category allows dental hygienists, assistants, administrative staff, and laboratory technicians to become full members of the association. Inherent in that membership is the right to participate in all of the activities as are afforded dentist members.

This was not an easy step for our organization. The Council on Membership was charged by the 2004 House of Delegates to develop a plan to include nondentist members. A task force was formed and a plan was brought to the 2005 house, but there were numerous questions and issues that did not sit comfortably with the delegates. It was returned for additional study. The areas of concern focused on representation on association committees, in the House of Delegates, and on the Board of Trustees; privacy of issues relative to apparent conflict of interests with our related professional organizations; and the pecuniary issues surrounding the dues structure for these members.

The concern for representation in the house is one that is of significance especially to our small society members. To seat any delegates from allied staff might disproportionately allow that group of members a voice in the house that dentist members do not have. As the program exists, the Allied Dental Health Professionals will have a committee to deal with issues that directly affect their membership. No voting representation is afforded at the house or the Board of Trustees, but there will be ADHP members present as guests with speaking privileges at each body and on committees. As the ADHP membership grows, there is a provision for additional guest positions for these members in the House of Delegates. This is an equitable solution to a significant problem.

Conflict of interest is a real issue in that, on occasion, the California Dental Association takes a disparate political position from related dental organizations. This is likely to be a continuing issue and several of our members expressed concern for the lack of privacy in our discussions if allied dental health professionals are allowed to participate in those debates. Considering the number of specialists within our organizational leadership, any issue that might conflict with the specialty groups, and there have been several in the past, would be looked at in a similar manner. For the general dentists, dual membership in the Academy of General Dentistry could pose similar political problems. If the house or board goes into a "closed session" then all the information in that session is privileged and members have an ethical responsibility to not share that information. All of our members need to be trusted to follow that rule and represent the best interests of the California Dental Association.

The question of who pays the dues for the allied professional members who join the CDA is one that must be left to the interrelationship of office staff with the employer dentist. The dues represent a small amount of money with a portion going to component dental societies that have similar membership provisions. For the small dental practice that might have one or two individuals who are interested in membership, this might not pose a problem. For the large dental practice with many allied dental health professionals, and perhaps a large demand for membership, the financial implications might be significant. Some of our members will see this as a benefit to the office staff and

pay the fees. Others might see this as an additional expense and not do so with the ADHP member responsible for their own dues. The CDA is wise to allow this issue to be settled in each practice.

The ADHP Task Force developed spreadsheets and pro forma analyses to project the costs to the organization for implementation of the plan and growth of membership. The ultimate goal of these projections would be that the allied dental health professional category would produce dues revenue to the organization as well as to the component societies, not unlike the dentist members.

After the category was approved this fall, there was a flurry of membership applications mostly from team members related to dentist members. At this time there is a list of potential members, albeit small, who want to belong. Whether or not this group becomes a significant portion of our membership or even reaches the financial breakeven point remains to be seen. Within the allied dental professional organizations in California membership varies but represents, at best, a small proportion of eligible individuals. It is unknown if CDA will attract a larger market share.

At issue is that we are the California Dental, not California Dentists, Association, and we should and do represent all aspects of dentistry in California. To understand this, all our members need to do is look at the programs and legislation that CDA sponsors that impact the dental profession as a whole and dental care in this state and not just dentists. Some of our members are uncomfortable with this membership category but for many of us, change is not always an easy thing. Dentists do not work in isolation. In order to deliver quality dental care, we need our team members. This is the right thing to do and this is the right time to do it. ■■■■

*Address comments, letters, and questions to the editor at alanfelsenfeld@cda.org.*

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# Praise for Article on Prions

Dear Editor:

I wanted to formally acknowledge the fact I have had the chance to carefully read the recent paper by Janyce Hamilton in relation to TSEs. I felt this was a very well-balanced and informative paper that is extremely up to date in content.

One of the most significant developments over the last few years without question is secondary transmission of the infectious agent(s) by iatrogenic methods. A sustained human-to-human epidemic is entirely plausible if nothing is done. The precautionary principle is completely relevant due to many current uncertainties. Variant Creutzfeldt-Jakob disease has only ever been studied in symptomatic patients (except for the one blood recipient who tested positive at postmortem biopsy and died of other causes). Therefore, we still do not know what happens early in the disease in humans who will become symptomatic later.

The CJD International Support Alliance fully recognizes, understands, and is engaged in the challenges that are before us. We have to accept the fact that due to the rarity of these diseases, we will never get the level of external support required to fully eradicate them. The level of understanding and passion of ordinary families affected by TSEs should not be underestimated.

Combined with the vigor and passion of key individuals and various research groups, the remaining uncertainties about these diseases I am certain will be understood and then acted upon.

Work on the diagnostic and treatment fronts are equally encouraging; they very much go hand in hand. The multidisciplinary approach is extremely important.

As with most situations, taking preventative measures is the first "firewall." I hope this paper goes some way to better educate many with regards to several key aspects of TSEs.

Kind regards,

**GRAHAM STEEL**
*Information Resource Manager*
*CJD International Support Alliance*

*Editor's note: As mentioned in the letter, variant Creutzfeldt-Jakob disease, rare as it is, has an overwhelming human cost to the few people and families affected directly by the incurable disease. The follow-up article, by Janyce Hamilton, author of the prions paper in the January issue, tells the story of one such family.*

## One American Family's Experience With Variant Creutzfeldt-Jakob Disease

Growing up with her dad, brother and sister in Miramar, Fla., where the family settled after moving from the United Kingdom when she was 12, Charlene Singh, being the oldest girl, took on the role of "mom" in the house and used "her loudest voice" to boss around her siblings. She taught her sister how to tie her laces and how to ride a bike. When she baked brownies, she gave strict orders of when they were and were not permitted to touch them.

Charlene was helpful and caring around the house and always set a good example for her sister and brother, especially when it came to studies. She graduated from high school fourth in her class, got scholarships to college, and organized the March of Dimes walk at work. She had the gorgeous skin tone of her Indian ancestry, and was proud of it — participating in a local Indian fashion show. Yet, she strove to exceed the expectations of a business world whose leaders often had lighter skin. And she did. She got straight-As in her courses.

Then, three months after proudly becoming the first in the family to graduate from university, there would be another first: an ominous invader that would make history.

Something silent started making its presence known inside her body. Charlene found herself becoming anxious and a bit forgetful, even teary at times, and this new moodiness dimmed the glow of her recent achievement. After uncharacteristically losing her temper, she told her little sister, "You know, Lisa, I think something is wrong with me."

She usually had her head in a book, but she barely read anymore. Her e-mails to her mother began not making much sense and then she totaled her car in a crash. Soon, she lost her job due to her forgetfulness. When she saw a doctor, he prescribed an antidepressant for anxiety.

But nothing changed, and her family noticed her hands began to shake. She even started to trip and stumble when

**CHARLENE SINGH** was the first U.S. victim of "mad cow" disease.

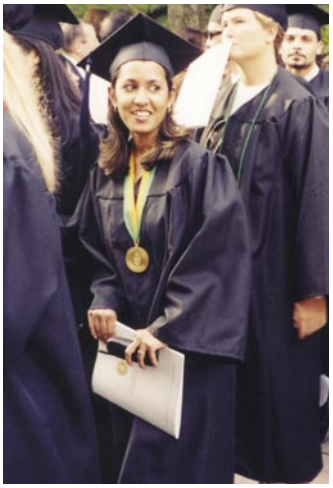
walking. Her eyes now had a permanent look of fright. Not trusting the doctors here, her family flew her to London, where she got worse. Meanwhile Christmas was upon them, and Charlene's dad bought her a black dress in just her favorite style as a gift. When her aunt asked her if she was happy with her dad's gift, Charlene said, "What gift? I didn't get a gift."

It wasn't long before London hospital doctors familiar with the symptoms took

a tonsil biopsy and delivered the worst news possible: Variant Creutzfeldt-Jakob disease — Charlene was the first such human "mad cow" victim in America.

While the family struggled with the shock, her mother flew with her back to the United States to die at home with her father, who raised her. Charlene's highly infectious and incurable disease would make the media, doctors, the Centers for Disease Control and Prevention, and even her dentist, appear to go a little mad themselves as they rushed to react to the news. The news had "implications."

Charlene's parents did not want any media coverage at that time. The CDC and the Florida Health Department advised the family to keep her identity out of the public when they first issued the public health statement. They did not want any unnecessary public alarm. Charlene's aunt, Sharon Singh-Passley of Pembroke Pines, Fla., said her niece's identity would have remained private, and did for a while, until she approached her parents about going public with Charlene's story. "I personally wanted her story to resonate at the USDA and hoped that it would encourage them to step up their screening and testing for bovine spongiform encephalopathy so that such a disaster would not happen here, and also to show the devastation that this disease does to a human life." Her parents' condition was that her last name not be used to protect her family, but one media outlet slipped and gave her full name, so that was that.



**CHARLENE SINGH** at her college graduation ceremony. She died three years later.

Charlene never underwent blood transfusions or tissue transplantations, nor had major surgeries or dental work. "As a child she liked hamburgers, sausages, and steak-and-kidney pie, growing up in the United Kingdom — all the usual foods children enjoy," Charlene's aunt explained, "but back then people didn't know beef cattle were widely infected with BSE, and the public was certainly not warned about the potential threat to human health. We don't even know if we ate the same food as her; if we will still come down with it. There's no test."

At Sunday dinner prayers, Charlene would mouth the words to her dad, "Am I going to die?" Her dad would say, "You are very sick, but we're doing everything we can to help you."

Bouts of madness knocked family members off guard as Charlene would kick, punch, and bite. A priest came with a blessing to tame the possessing illness. In the months ahead, she went down to about 70 pounds, stopped walking, and could no longer communicate. A feeding tube was fitted into her stomach because she also lost her gag reflex and ability to swallow. She was unrecognizable as the teenage girl who would get together with her girlfriends, dress up, and go out partying.

Charlene died on June 20, 2004, almost on the exact day she graduated from college, three years earlier. ■■■■

Polly Powell

## Young Smokers Run Higher Risk for Developing Asthma Later in Life

Nicotine-puffing youngsters are nearly four times as likely to develop asthma in their teens compared to their counterparts who do not smoke, according to new research from the University of Southern California.

"We've been studying this group of children long enough that now some of them have started smoking," said Frank Gilliland, MD, PhD, lead researcher and professor of preventive medicine at USC's Keck School of Medicine. "We found that teens who started smoking have a four times higher risk of developing asthma compared to teens who don't smoke. But if those same teenagers were also exposed to tobacco smoke before

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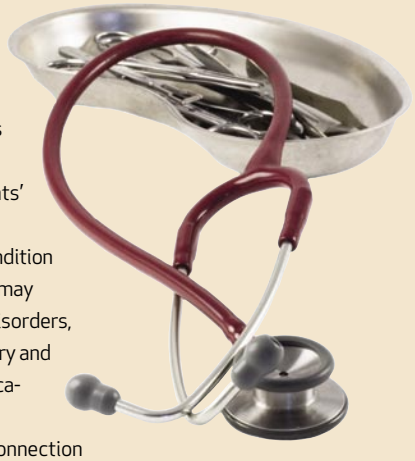
**Unotron WM10 ScrollSeal Washable Optical Mouse** ↑

Unotron introduces the international debut of the WM10 ScrollSeal Washable Optical Mouse, its patented SpillSeal protected, washable, 2.4GHz wireless, three-button mouse with removable Scroll Wheel. Unotron's patented SpillSeal keyboards and mice feature a sealed structure that allows for washing and sterilization, providing an easy solution to the problem of bacterial infection. They can be immersed in commercial-grade detergents or antibacterial solutions and rinsed under tap water, without damaging the product or impacting the functionality. The innovative technology works up to 26 feet away from the personal computer. Available in a standard finish, the new washable wireless mice can be purchased in gray or black to complement Unotron's SpillSeal corded and wireless computer keyboards and receivers. For more information about Unotron SpillSeal products, go to www.unotron.com or call (800) 469-7440.

## Medical Conditions May Affect Treatment Decisions

Because Americans are living longer and retaining their teeth, dentists are seeing an increasing number of patients with age-related chronic medical problems affecting the oral cavity.

Nelson Rhodus, DMD, MPH, recently wrote in an issue of *Northwest Dentistry* that because more patients come to the dental office with medically compromising conditions, the challenge for the dentist is managing them. When treating such patients, Rhodus, director of oral medicine at the University of Minnesota School of Dentistry, said several concerns must be addressed, including:



- The effect of patients' medical condition and therapy on their oral health;
- Specific oral and dental manifestations that arise from, or are exacerbated by, medical conditions or therapies; and
- Possible adverse interactions between patients' oral health and general systemic health.

Dentists should be aware of the current health condition of their patients since almost every medical condition may affect dental treatment and vice versa. Hematologic disorders, endocrine diseases, cardiovascular disease, and sensory and neural problems, among others, pose potential complications. Pregnancy also is a special consideration.

"The growing understanding we have about the connection between systemic and oral health makes it imperative that dentists obtain from their patients complete medical histories—including current drug use—as well as obtaining pre-visit vital signs," the article stated, adding "Abnormal or questionable results might indicate a referral to the patient's physician."

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*First, and most importantly, the office should have a plan that details what staff will do in response to an influenza emergency in their community.*

## How Can Dentists Prepare Themselves for an Influenza Pandemic?

During an influenza outbreak, the day-to-day operation of dental offices may likely be difficult. In fact, everyday life in the community may become disordered due to a number of individuals falling ill at the same time, and perhaps causing the collapse of basic services and a shortage of supplies.

But there are some things a dental office can do to prepare itself. First, and most importantly, the office should have a plan that details what staff will do in response to an influenza emergency in their community. The goals should be to protect office workers and their families from infection, protect patients, and generally help to prevent further spread of the virus. Part of the plan should include communication with patients and staff during this emergency.

The dental office staff should also be educated about influenza: symptoms, signs, infectious period, how it is spread, the value of vaccines and medication, individual protection, etc. Procedures for allowing staff who have been ill to return to work should be established to minimize the risk for spreading the disease. There should be no incentives or pressure on staff to return to work prematurely, even in the face of personnel shortages due to illness and the financial needs of employees.

Employees should be encouraged to receive influenza vaccines as they become available. The vaccination history of the staff and their families should be monitored as well as possible. Local dental societies should work with local health departments to make sure dentists, their families, and allied personnel are included on the locally determined priority list of individuals who will receive the vaccine specific to the virus causing the pandemic when it becomes available.

## New Name for Expanded Dental Organization

Special Care Dentistry's newly expanded organization, Special Care Dentistry Association, now offers its members full access to three of its component organizations: the American Association of Hospital Dentists, the American Society for Geriatric Dentistry, and the Academy of Dentistry for Persons with Disabilities.

"Our focus is on the patients who need special care, regardless of the particular practice setting," said SCDA President Roseann Mulligan, DDS, MS. "An SCDA member could easily be caring for a disabled, geriatric, hospitalized patient. This one patient incorporates three components. However, the key is the patient and his or her needs, which transcend particular practice setting."

By formally integrating these groups, SCDA benefits its patients and members by having a unified leadership and distinct mission, while giving members more occasion for knowledge sharing, networking, and open discussion.

Vincent Filanova, DDS, council chair and member of SCDA, said the ADA Council on Access, Prevention and Interprofessional Relations has a close working relationship with SCDA.

"During the last five years, the organization has really emphasized advocacy for all special needs patients, including its efforts to promote the Special Care Dentistry Act, which will strengthen federal support for children's oral services and extend Medicaid dental benefits to vulnerable adult populations (elderly, blind, and disabled) nationwide. Their work also goes hand in hand with the ADA's Elder Care Task Force and the adoption of Res. 5H in the 2006 ADA House of Delegates.

"The new name and mission also gives the profession one place to go for resources and information on all special needs patients," Filanova added. "CAPIR uses SCDA as a valuable resource and we applaud their strong efforts in advocacy."

SCDA's new Web site is www.scdaonline.org.

## UPCOMING MEETINGS

| 2007 | |
|---|---|
| April 15-21 | United States Dental Tennis Association, Sarasota, FL, www.dentaltennis.org. |
| April 17-21 | American Academy of Oral Medicine Annual Meeting, San Diego, www.aaom.com. |
| May 3-6 | CDA Spring Scientific Session, Anaheim, (866) CDA-MEMBER (232-6362). |
| June 13-17 | 21st Congress of International Association of Paediatric Dentistry, Hong Kong, www.iapd2007.com. |
| June 27-July 1 | Academy of General Dentistry Annual Session, San Diego Convention Center, (888) 243-3368. |
| Sept. 27-30 | American Dental Association 148th Annual Session, San Francisco, www.ada.org. |
| Nov. 16-19 | Second International Conference on Evidence-based Advanced Dentistry and Silver Jubilee Celebration of the Faculty of Dentistry, the University of Hong Kong Dent25 Congress, http://dent25.hku.hk. |
| Nov. 27-Dec. 1 | American Academy of Oral and Maxillofacial Radiology 58th Annual Session, Chicago, www.aaomr.org. |
| **2008** | |
| May 1-4 | CDA Spring Scientific Session, Anaheim, (866) CDA-MEMBER (232-6362). |
| Sept. 12-14 | CDA Fall Scientific Session, San Francisco, (866) CDA-MEMBER (232-6362). |
| Oct. 16-19 | American Dental Association 149th Annual Session, San Antonio, Texas, www.ada.org. |

*To have an event included on this list of nonprofit association meetings, please send the information to Upcoming Meetings, CDA Journal, 1201 K St., 16th Floor, Sacramento, CA 95814 or fax the information to 916-554-5962.*

## Steroid Misuse is Bad for Gums

Researchers have found that protracted use of anabolic androgenic steroids is strongly associated with substantial levels of gingival enlargement, according to a new study published in the *Journal of Periodontology*.

When gingival tissues become swollen and grow over teeth (gingival overgrowth), it is easier for bacteria found in plaque to build up and assault the supporting structures of the teeth, potentially leading to severe periodontal infection. It is therefore important for dentists and periodontists to be aware of the adverse effects of anabolic androgenic steroid on gingival tissues.

"It was found that AAS abusers had statistically significant levels of gingival enlargement compared to nonusers, requiring a gingivectomy for many cases," said Onur Ozcelik, DDS, PhD, faculty of Dentistry, Cukurova University, Department of Periodontology, Adana, Turkey. "Although it has been reported that many of the adverse effects of AAS abuse are fully reversible within several months after the cessation of the drug, it is not known if gingival enlargement would also regress after the withdrawal of AAS."

Researchers examined 24 athletes between the ages of 17 and 29 who had been using these steroids for more than 12 months. The athletes were examined for gingival inflammation, gingival enlargement, and plaque levels. Results then were compared with a control group of 20 bodybuilders who had never used anabolic androgenic steroids. The subjects in the control group were matched for age, educational level, and oral habits to their steroid-using counterparts.

*"It was found that AAS abusers had statistically significant levels of gingival enlargement compared to nonusers, requiring a gingivectomy for many cases."*

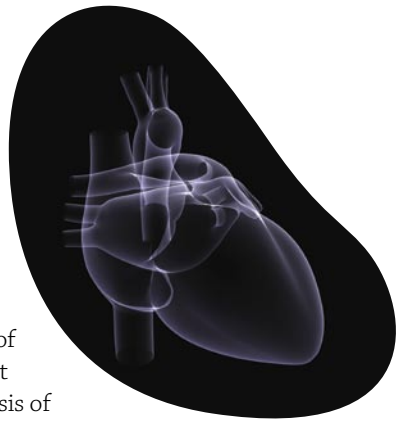
ONUR OZCELIK, DDS, PHD

## New Study: Periodontal Bacteria May Be Linked to Heart Disease

Researchers have found that the combinations of bacteria in periodontal pockets and the presence of specific bacteria might explain the relationship between acute coronary syndrome and periodontal disease, according to a study published in the *Journal of Periodontology*.

The amount of oral bacteria was twice as high in the acute coronary syndrome group for the combination of the bacteria streptococci spp, P. gingivalis, T. forsythia and T. denticola. The findings suggest that T. denticola, T. forsythia and streptococci spp are bacteria in a shared infectious etiology for periodontitis and acute coronary syndrome.

"This might be one of several explanations as to why elevated bacteria and the combination of specific pathogens in periodontal pockets can be linked to a history of ACS," said Stefan Renvert, DDS, PhD, Department of Health Sciences, Kristianstad University. "We also found that the amount of periodontal bacteria results in an inflammatory response that elevates the white blood cell counts and high sensitivity C-reactive protein levels, which has also been linked in past studies to heart disease."



Researchers evaluated 161 subjects diagnosed with acute coronary syndrome and a control group of 161 participants who did not have the syndrome. Diagnosis of the acute coronary syndrome group was based on chest pain associated with electrocardiogram changes that were combined with typical patterns of cardiac markers, such as creatine kinase. The control group included people without cardiovascular disease. This included the absence of elevated blood pressure, or the use of statins and beta-blockers.

Additionally, it was also found that the degree of alveolar bone loss was considerably greater among subjects with acute coronary syndrome. Seventy-seven percent of the participants in the acute coronary syndrome group and 42 percent in the control group demonstrated evidence of periodontitis.

*"This might be one of several explanations as to why elevated bacteria and the combination of specific pathogens in periodontal pockets can be linked to a history of ACS."*

STEFAN RENVERT, DDS, PHD

## Imagery Exercises Support Cancer Patients' Recovery

Cancer patients who fear their caregivers and physicians overlook the long-term impact of their battle, particularly after they've been "cured," may find the therapeutic use of imagery exercises to be helpful.

After analyzing the results from a National Cancer Institute-funded clinical trial, Lyn Freeman, PhD, and Lisa Dirks noted that collecting the breast cancer patients' daily records of "imagery practice experience," healing stories, and poetry as part of post-treatment "imagery classes" showed that these particular mental exercises helped patients reduce stress and stress-related symptoms associated in their recovery.

Quiet time meditating and focusing on mental pictures related to nature or other subjects helped patients relax. Physical traits associated with stress, i.e., high blood pressure, have been shown to improve through these types of exercises, the authors wrote in a recent issue of *Alaska Medicine*.

Helping patients tackle the emotional shock of having fought cancer is a vital part of the healing process, Freeman and Dirks said.

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*"These findings suggest that the harmful effects of cigarette smoking are not limited to those who are long-term heavy smokers."*

DAVID A. SCHWARTZ, MD

**SMOKING,** CONTINUED FROM 171

they were born, they get more than a double whammy: nine times the risk of getting asthma."

The research drew on data from the Children's Health Study, a longitudinal study of respiratory health among children in 12 Southern California communities. During annual school visits the researchers collected data on medical histories, demographic factors, household exposures, cigarette smoking, and newly diagnosed asthma. A group of 2,609 children and adolescents between the ages of 8 and 15 at the start of the study were followed. The subjects had no prior history of asthma or wheezing.

An estimated 28 percent of children reported smoking during their life; 13.8 percent reported smoking weekly; and 6.9 percent reported smoking regularly (at least seven cigarettes a week). The teens, researchers found, who became frequent, regular smokers had a fourfold greater risk of developing asthma compared to those who did not smoke.

The increased risk for newly diagnosed asthma was prevalent among youngsters exposed to maternal smoking during gestation. Among these children who became recurrent, habitual smokers, asthma risk was nearly nine times greater than for unexposed nonsmokers.

"These findings suggest that the harmful effects of cigarette smoking are not limited to those who are long-term heavy smokers," said David A. Schwartz, MD, director, National Institute of Environmental Health Sciences, which provided support for the study. "The study results provide clear evidence of a link between short-term smoking and respiratory illness in adolescents and young adults."

Results from the University of Southern California study were published Nov. 15, 2006, in the *American Journal of Respiratory and Critical Care Medicine*.

**Sani-Hands for Kids Instant Hand Sanitizing Wipe**

Nice-Pak Products Inc. introduces Sani-Hands for Kids Instant Hand Sanitizing Wipes. Sani-Hands for Kids pre-moistened wipes kill 99.99 percent of germs — more than gels or rub-in alcohol hand washes. Now available to schools, childcare facilities, children's hospitals and pediatric and dental offices, Sani-Hands for Kids contain emollients such as aloe, glycerin, and vitamin E to minimize the drying effects of alcohol and to moisturize the skin. Easy and fun to use, Sani-Hands for Kids wipes are available in 220-count and 135-count canisters, as well as individual on-the-go packets. For more information, visit www.pdipdi.com.

## Honors

Douglas Young, DDS, MBA, MS

Nader Nadershahi, DDS, MBA

A. Jeffrey Wood, DDS

**Douglas Young, DDS, MBA, MS,** of San Francisco, associate professor of the Department of Diagnosis and Emergency Services at University of the Pacific, Arthur A. Dugoni School of Dentistry, received the Lifetime Achievement Award from the World Congress of Minimally Invasive Dentistry.

**Nader Nadershahi, DDS, MBA,** chair of the Department of Dental Practice at University of the Pacific, Arthur A. Dugoni School of Dentistry, received the American College of Dentists Northern California Section 2006 Distinguished Faculty Member Award and the Pierre Fauchard Academy Northern California Section Citation for Excellence in Dental Education. He has also been named chairperson of the California Dental Association Leadership Development Committee.

**A. Jeffrey Wood, DDS,** San Francisco, professor and chair of the Department of Pediatric Dentistry at University of the Pacific, Arthur A. Dugoni School of Dentistry, completed the American Academy of Pediatric Dentistry Leadership Institute at the Kellogg School of Management, Northwestern University, earning a certificate in leadership management.

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# Listening to Patients

HAROLD L. PRUETT, PHD

**ABSTRACT** Being able to listen to patients is a basic and necessary tool in any helping profession. While dentistry's primary job is evaluating and carrying out procedures, taking the time to learn effective listening can help establish better working relationships with patients. In this article, active and passive listening are discussed and broken down into several skills, which can be learned and practiced in order to be a more effective listener.

AUTHOR

**Harold L. Pruett, PHD**, is an adjunct professor at the University of California, Los Angeles, Graduate School of Education and Information Sciences. He is a clinical professor of psychology at UCLA in the Department of Psychology, and recently retired as the Director of Student Psychological Services at UCLA.

The ability to "really" listen to patients is one of the most important tools in the helping professions. The art of listening is the most basic skill needed to form good working relationships and should be the foundation of any helping profession.

The practice of dentistry is one of those helping professions with built-in road blocks to effective listening. The patient does not, or is not, in a position to discuss his or her fears and concerns, let alone topics of the day. With mouth wide open and instruments and probing occurring, the patient is in no position to do a lot of talking.

The dentist faces a real challenge: How to establish rapport in a limited amount of time. Establishing rapport requires interest and active attention and listening and can't be done in the middle of a procedure. The dentist must take time, no matter how short, to establish a working relationship prior to a procedure.

People often say, "But I already know how to listen and I do it all the time." The truth is most of us haven't the slightest idea how to actively listen so that we communicate our interest. Fortunately, there are basic skills that can be learned in order to become a more effective listener.[1] This article presents the skills and some examples.

Carl Rogers, a prominent psychologist and proponent of active listening, at one time noted, "In work with various groups it has been sobering to observe how little the members attend to what others say. Without attention there can be no understanding and hence, no communication. Apparently the act of attending carefully to another person is a difficult task for most people. They are usually thinking what they will say when the speaker stops."[2]

While attending to what someone is saying is basic, it is not enough. There are other behaviors necessary in order for the speaker to feel heard. Eye contact, attentive body language, and verbal following are ways to communicate interest and concern.

**EYE CONTACT.** We show interest in a person by looking at them. In addition, facial expression and body language are more evident. Pain and tension become obvious by looking at the patient and is valuable information for a dentist. When dentists don't look at patients, they don't pick up nonverbal cues and don't show our interest.

**ATTENTIVE BODY LANGUAGE** comes with a comfortable, relaxed style with patients. A slight, forward lean is usually how one conveys interest. A nodding head, a smile, arms relaxed are also important. Folded arms across the chest, a nonsmiling face and looking away are not going to communicate interest or concern.

**VERBAL FOLLOWING** relates to what the patient has said and encourages further focus on an idea and expresses attention. Comments such as "I see what you mean," or "I can really appreciate that," often help the patient and assures them they are being heard. Using short phrases such as "I see," "uh huh" are also helpful in communicating interest.

To summarize effective attending behaviors: establish contact through looking at the person who is talking; maintain a natural, relaxed, open posture, which indicates interest, and use natural gestures; and use verbal encouragements, which relate to the patient's statements without interrupting unnecessarily.

In addition, there are more active verbal behaviors that facilitate communication and express interest. Paraphrasing, clarifying and perception checking are primary.[3]

**PARAPHRASING** is simply the restatement of the patient's basic message but in simpler and fewer words. The primary purpose of paraphrasing is to test whether the dentist understands what the person is saying and to communicate that the dentist is trying to understand the basic message. Dentists should ask themselves, "What is the basic message this person is saying to me?" An example of a leading phrase into paraphrasing might be, "Sounds like you're saying … "

**CLARIFYING** brings vague material into a sharper focus. It goes beyond paraphrasing in that the doctor makes a guess at what the basic message might be and offers it to the patient or admits confusion. Some examples are, "I think I lost you there, let me see if I understand …" "I am not sure I understand; could you say more?" "You seem to be saying … is that correct?" When clarifying, admit confusion about the patient's meaning and try a restatement or ask for clarification, repetition, or an illustration.

**WHILE A DENTIST'S** primary job may not be to listen to patients, listening is basic to good working relationships.

**PERCEPTION CHECKING** is simply asking the patient for verification of your perception of what was said over several statements. It is asking for feedback about the accuracy of listening. Perception checking is effective as a listening skill in that it is a method of giving and receiving feedback on the accuracy of the communication. Examples include, "I was wondering if the procedure you chose is the one you really want. You expressed some doubt if I heard you correctly." "I want to check with you before we proceed to see if I understand."

**REFLECTION OF FEELING** although not a basic listening skill, is helpful in enhancing communication and exploring concerns. It involves expressing in fresh words the essential feelings, stated or implied, by the patient. By selectively attending and reflecting observed feelings, the listener is consciously reinforcing emotional states. The purpose of reflecting on feelings is to focus on emotion rather than just content, to bring vaguely expressed feelings into clearer awareness and to assist the patient to own his or her feelings. The usefulness of this or any other skill depends upon what we want to accomplish. Many times dentists are primarily interested in content, but feelings often give content the color and help to overcome difficulties. Sometimes a patient may be saying one thing, but there is an underlying fear or concern they have. By reflecting on this fear or concern, clarifying and having the patient discuss it, dentists are more likely to have a better working relationship with this patient. Otherwise, dentists may never see the patient again.

## Summary

In summary, the following steps are important in reflecting feelings: the feeling must be labeled, which might be the actual words used by the speaker or through observation. An example might be using a sentence stem such as "You seem to feel … " or "Sounds like you feel … "

Although listening is a basic and important skill, the time limitations of the dentist make it important to focus the conversation and to take the lead. The purpose of leading is to encourage the patient to respond in the direction wanted. Indirect leading and direct leading are two techniques to get conversation moving.

**INDIRECT LEADING** is used to get the patient started and to keep responsibility on him or her for keeping the conversation going. Examples are, "Tell me more about that." "You were saying."

**DIRECT LEADING** is a method of focusing the topic more specifically. Example: "Suppose we explore your ideas about doing that a little more." "Can you think of another example?" When leading, determine the purpose of the lead;

express the purpose in words, which elicit specific elaboration; allow the patient the freedom to follow your lead.

Many of the leads used are in the form of open-ended questions. Open-ended questions leave the patient free to take a conversation where he or she wishes. "When did you first notice the pain?" "What decided you to make the appointment?" Open-ended questions usually begin with "what," "how," or "why," or "could." "What" questions are usually associated with facts and information gathering. "How" questions are associated with process and feelings, and "Why" questions with reasons.

The purpose of this brief paper is to emphasize a few basic skills, which help to make a better listener and communicator. While a dentist's primary job may not be to listen to patients, listening is basic to good working relationships. A dentist is trained to perform a multitude of procedures, most of which involve the open mouth and listening is not a major job. Communication and listening are a challenge under those circumstances, yet most patients want their dentist to be well-trained and skilled in dentistry, and at the same time to be compassionate, concerned, and understanding. A little practice in listening skills will go a long way to show interest and concern and promote better relationships with patients. ■■■■


**REFERENCES**

**1.** Brammer LM, The Helping Relationship: Process and skills. Prentice-Hall, Englewood Cliffs, NJ., 1973.
**2.** Rogers C, Client-centered therapy. Houghton Mifflin, Boston, page 349, 1951.
**3.** Cormier S, Nurius PS, Interviewing and change strategies for helpers. Brooks/Cole, Pacific Grove, Calif., pages 84-112, 2003.



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# The Difficult Patient: A Psychodynamic Perspective

CRAIG D. WOODS, DDS, MA

**ABSTRACT** Managing the "difficult" patient is a challenge all dentists face. This paper describes a psychodynamic model that pictures the dentist-patient relationship as a two-way interaction that involves unconscious processes. The model uses the three ego states: the parent, the adult, and the child, to understand problematic encounters and how to manage them. Using this model has the potential to enhance the therapeutic alliance, decrease malpractice claims, and lessen anxiety for the patient and the dentist.

GUEST EDITOR

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She stares at me and says, "This still hurts. Is that normal? Shouldn't I be better by now? Maybe you missed the diagnosis. Certainly you did the wrong treatment. I thought you were supposed to know what you're doing." The criticism keeps coming and the attitude gets more sarcastic as I sink into my chair wondering why I'm taking this abuse. I have a vague recollection that I was a confident and competent dentist just five minutes ago. Why do I feel so helpless now?

Most dentists can provide multiple examples of the so-called "difficult" patient. We scan our appointment schedule and cringe at the sight of their names. We visualize the prior interactions and anticipate the worst. There is something about these patients that makes us crazy or, at least, uncomfortable. The first temptation is to blame the patient. They are "rude," "immature," "demanding" or any one of many possible negative descriptors. Our colleagues reassure us that they too have similar problem patients. Even the medical and dental literature supports the view that many patients have problem personalities and chronic behavioral problems.[1-6] The practitioner's contribution is ignored.

A more reasonable view posits that the patient does not exist in a vacuum. They are not problematic without our interaction with them. This is not to say the patients are blameless. They are indeed responsible for their behavior in the operatory. But it is our reaction that truly characterizes the problematic encounter. Where do we look to understand this sometimes frustrating dynamic?

This paper offers a psychodynamic view of challenging dentist-patient interactions. Dental care consists primarily of a relationship between two adults. Both participants bring a complex personality that was defined from early childhood experience. The resulting encounter is a dynamic process of unconscious and conscious thoughts, emotions, and behaviors. Each participant tries to select

an appropriate behavioral template from their limited repertoire. At best, a relationship of mutual trust and cooperation is developed. At worst, negative personality styles are triggered in both, and a therapeutic situation cannot be realized.

Understanding the internal process enables us to change it to our benefit, or, in the case of interpersonal relationships, to our mutual benefit. In the dental operatory, a fundamental understanding of your and your patient's inner conflicts can greatly enhance your ability to facilitate cooperation and reduce anxiety. Research also strongly suggests that a favorable therapeutic alliance will improve treatment efficacy and lessen malpractice risk.[7-9]

## The Model

Applying the psychodynamic view to the doctor-patient interaction is not a new concept. In an article published in 1956, the renowned psychoanalyst Thomas Szasz coauthored an article, "A Contribution to the Philosophy of Medicine."[10] Szasz and Hollender discussed models of the doctor-patient relationship (**TABLE 1**). They noted three types of interactions that occur during differing aspects of care. The salient feature is the comparison to family dynamics from childhood.

Guidance-cooperation involves much of medical and dental practice. The patient seeks help and is willing to obediently follow the directives of the doctor. The interaction of a parent and a child is similar in that the parent is the source of knowledge and power while the child is forced by social custom to adhere to parental demands. The unequal power lends itself to efforts at manipulation or defiance, even child-like acting out by the patient. Szasz also pointed out the opportunity for "exploitation" on the part of the physician. The physician or dentist may use authoritarian strategies to overwhelm the patient's defenses. The task may get accomplished, but there will likely be lingering resentments.

The mutual participation model suggests that, at times, the patient and doctor can come together as equals. This can happen if both are willing to share power; they realize they need each other (interdependence), and the result can be satisfactory to both. This represents a patient and doctor who each possess the coping skills necessary to work through their anxieties and enter into a working relationship.

Ruth Freeman applied the Szasz and Hollender model to the dentist-patient interaction utilizing parent-adult-child ego states from "transactional analysis" to describe common interactions.[11] For example, Freeman likened the dentist performing an operative dentistry procedure on a patient (**TABLE 2**) to the patient unconsciously seeing the dentist as a parental figure and regressing into a child ego state.

Transactional analysis divides the

**TABLE 1**

**Three Basic Models of the Physician-Patient Relationship** (from Szasz and Hollender[7])

| Model | Physician's Role | Patient's Role | Clinical Application of Model | Prototype of Model |
|---|---|---|---|---|
| Activity-passivity | Does something to patient | Recipient (unable to respond or inert) | Anesthesia, acute trauma, coma, delirium, etc. | Parent-infant |
| Guidance-cooperation | Tells patient what to do | Cooperator (obeys) | Acute infectious processes, etc. | Parent-child (adolescent) |
| Mutual participation | Helps patient to help himself | Participant in "partnership" (uses expert help) | Most chronic illnesses, psychoanalysis, etc. | Adult-adult |

**TABLE 2**

**Three Basic Models of the Dentist-Patient Interaction** (from Freeman[8])

| Model | Dentist's Role | Patient's Role | Clinical Application of Model | Prototype of Model |
|---|---|---|---|---|
| Activity-passivity | Does something to patient | Receives the treatment | Operative dental treatment | Parent to child |
| Guidance-cooperation | Tells patient what to do | Obeys accordingly | Dental check-up appointment | Parent to child |
| Mutual participation | Advises and negotiates with patient | Patient in equal partner care | Negotiation of treatment or preventive plans | Adult to adult |

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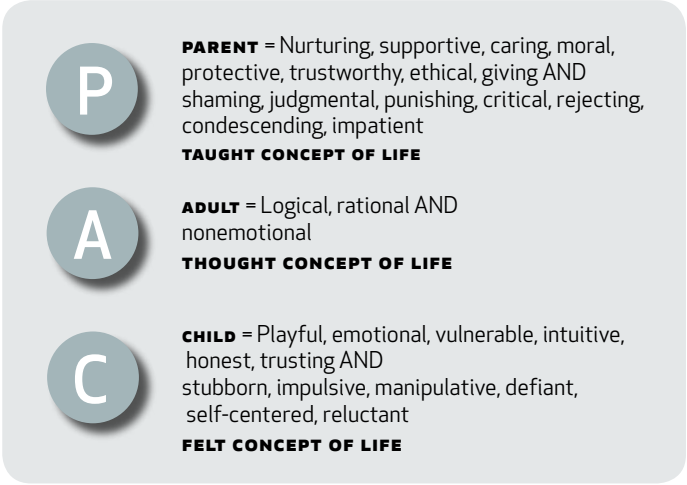


FIGURE 1. Ego states

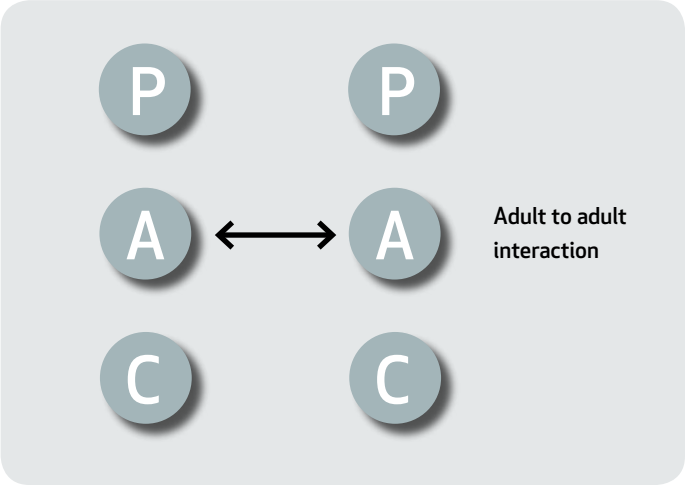


FIGURE 2. Mutual participation

personality into three parts: the adult, the parent, and the child (FIGURE 1).[12,13] In this view, the "child ego state" develops as part of the personality from birth to age five. Much is established even before language is developed (pre-verbal stage). The child observes his or her environment, primarily his caregivers, and struggles to survive. The infant first needs to know if he can trust the all-powerful caregiver. The stakes (sustenance or abandonment) are high and the emotions strong.

The child develops many characteristics that may remain within us into adulthood. The positive side is that the child is loving, open, giving, playful, spontaneous, persevering, adaptive, and creative.[14] This is the part of the patient that laughs at dumb jokes and enthusiastically discusses his recent vacation. On the other side, the inner child is stubborn, greedy, dishonest, impulsive, manipulative, defiant, narcissistic, and unpredictable. Your patient can be angry at you with a slight provocation or refuse to take responsibility for his own dental health.

The "adult ego state" is our rational, problem-solving mind. We acquire experience and create workable mental constructs. This process is ongoing as one practices life skills in new situations. The adult is logical, nonemotional, purposeful, intellectual, and deliberate.

The "parent ego state" is an accumulation of imposed rules, dictates, morals, and behaviors acquired in the earliest years, typically from primary caregivers. One can think of this as the "shoulds" (you should be a good boy, etc.). On the better side, the parent is nurturing, supportive, caring, protective, ethical, respectful, trustworthy, warm, and giving. Dentists all have patients who genuinely care about us and our families. They truly wish for our success and happiness. Unfortunately, the critical parent side can also be shaming, rigid, judgmental, punishing, overbearing, and controlling. This is the patient described in the opening paragraph of this paper. In the example, the patient wishes to punish the doctor for her discomfort by being harshly critical. The doctor responds by entering the child ego state.

The goal in one's dental operatory, as suggested in the mutual participation model (FIGURE 2), is that the dentist and patient engage while in their adult ego states. Unfortunately, anxiety often intervenes. For the patient there is the acute and realistic fear of pain. Unconsciously, one can experience a loss of control, violation of personal space, or something else. An interesting phenomenon that commonly occurs in the dental operatory is a process well described by Freud. He observed that patients would transfer feelings and attributes of significant figures in their lives onto him. He called this phenomenon "transference" and it became a very important aspect of psychoanalysis. Often, these figures were parents or other authority figures and at these times, the patient would assume the characteristics of a child. Freud termed this "regression."

## The Model in Action

In the dental operatory is a situation that is ripe for transference and regression (FIGURE 3). The patient feels anxious, vulnerable, and not in control while the dentist is the powerful, knowledgeable, and imposing authority figure. Using the model of ego states, the patient regresses into her child state and sees the dentist as a parent. The dentist may choose to exploit this power in order to complete the proposed treatment. The patient may comply but not without some emotional expense. In other cases, the child may rebel. This can be seen in cancelled appointments, late payments, or manipulative behavior.

Early recognition of regression can prevent a poor outcome. The patient may be subtly uncooperative in the chair. Simple displays such as fidgeting or squirming, a change in voice pitch, and looking away in a submissive way can be indicative of the child coming out. More

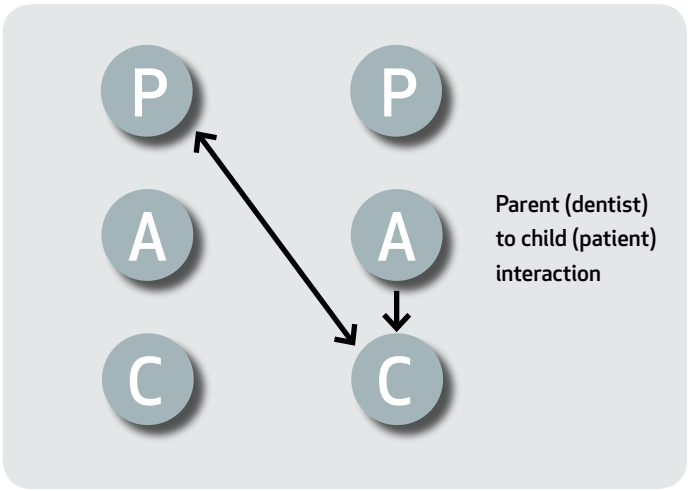


FIGURE 3. Transference and regression (parent to child)

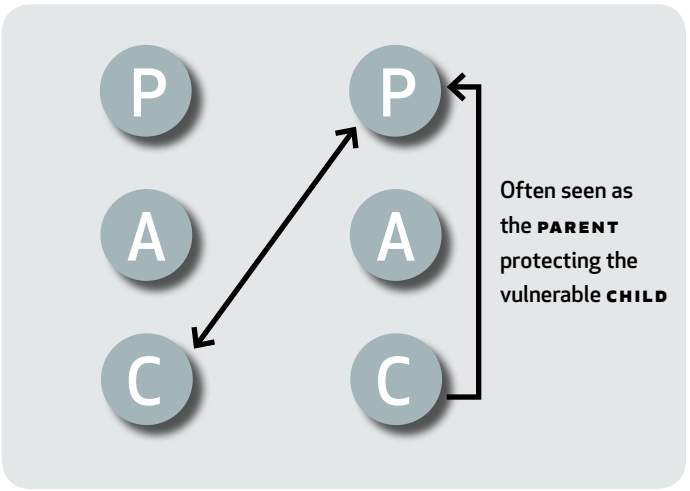


FIGURE 4. Patient as the parent (child to parent)

overt child-like behavior includes whining, crying, inappropriate statements, or outright defiance. Once recognized, the behavior can be addressed by the doctor.

A child desires comfort from a loving parent. The goal is to establish trust with the child, which will allow the patient to return to the adult ego state. The general rule in relationships is that you can only gain someone's trust by appealing to their inner child. This is a good time for dentists to remember the skills learned for pediatric dentistry. Dentists need to give explanations of everything they do in straightforward terms (remember tell-show-do?). Immediately praise the patient for each new instance of cooperative behavior, "You're doing great." Intermittently praise an already established positive behavior. Ignore uncooperative behavior and attempt to distract the patient away from it. Give choices whenever possible in order to give the patient a sense of greater control, "You can raise your left hand if you feel anything and I'll stop immediately." Acknowledge their feelings. State it is OK to feel nervous or anxious about the procedure. Use socially acceptable touch to comfort and reassure your patient. This can be done simply with a hand on the shoulder.

Once the child is comforted and feels secure, one will be able to speak to the adult. That is, it is now appropriate to deal with the rational and thinking part of the patient. Explanations can become more abstract. For instance, one may discuss long-term prognosis, treatment options, and postoperative care. One should ask about their understanding of your advice ("Am I making sense?" "What can I clarify for you?"). Listen carefully and restate back to the patient what you believe they said. ("It sounds like you would like the implant but you are concerned about the surgical part.")

Regularly update the patient on the status of the progress, "I'm 80 percent done and all is going smoothly." Even adults do not do well with the unknown. One can also ask about their feelings in order to gauge their management of their emotional state ("How are you doing?" "Are you comfortable?"). Even though your patient's adult state is now in charge it is a good idea to maintain a good relationship with your patient's child state. The author's personal favorite is to use humor. Humor is a tried and true, healthy coping mechanism for anxiety. Benign jokes, puns, and other plays on words will keep the inner child amused thus keeping his or her trust in the dentist.

Also, an adult will be capable of understanding a sincere apology. If a procedure takes too long or the dentist inadvertently hurts the patient, then an immediate, brief apology is in order. Don't dwell on it, just state your case and back to business.

On occasion, the patient's child may feel threatened to the degree that the inner parent is called in to protect him (FIGURE 4). The powerful, judgmental, and punitive parent will attempt to intimidate the doctor into a submissive position. The doctor who is in her confident adult state will not wilt. But if the child within the dentist connects back to her own family of origin then, she may assume a child-like role. This process, in which the doctor unconsciously responds to the patient's influence, is known as "countertransference." It was described by Freud as far back as 1910. Casement, a renowned psychoanalyst, stated that countertransference occurs "when a patient comes to represent some unresolved aspect of a significant relationship in the earlier life of the analyst or therapist; and this will threaten therapeutic work with that patient unless it is resolved through further self-analysis of the therapist."[15] In other words, one's childhood issues may negatively impact the working relationship.

The parent ego state can be discerned through the patient's behavior. There may be condescending looks, crossed arms, a furrowed brow, sighing, and shaking of the head. The tone of voice may change

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to become sterner. One may hear evaluative words (often critical), many "shoulds" and "oughts," and words that demonstrate black-and-white thinking such as "always," "never," and "all." There may be direct attempts to diminish the dentist by calling them diminutive names like "Doc." Now is the time to stay firm in your adult ego state. Becoming another critical parent will lead to a battle that cannot be won.

Managing your patient's critical parent is similar to managing the angry patient.[16] First, one needs to be seated at eye level with him. This conveys the idea that the dentist will be speaking as an equal. Lower one's voice to a calm, firm tone, and speak slowly and clearly. This says, "I will not back down but I won't fight you either." Eliminate all humor, as you are thinking "You and I will be serious until this issue is resolved." Listen carefully to what the patient says because the dentist must individually address each concern. Repeat it back so that both sides agree on the points of concern. Use the person's name when speaking, since this is what their adult ego state identifies with. As one makes one's points, remember, the dentist is not arguing. The dentist is stating their side as objectively as possible. Use "I" statements; that is, taking ownership of one's side of the story while not blaming or labeling the patient's behavior. Ultimately, one can expect the physical signs of the parent ego state to fall away, the tone of the patient's voice will change, and he will become cooperative again.

There are times when one's best effort does not change the patient's attitude, and one needs to seriously consider not treating this patient. Perhaps there are unconscious influences on one or both sides that cannot coexist. There is no blame to be placed. An offer to refer the patient to a respected colleague may be the best solution.

## Scenario 1

Mrs. Adams presented with pain a week after a routine restorative procedure. Her muscles were tense and she stated indignantly, "My tooth still hurts. Is that normal? I've never had this happen before." Her critical and condescending parent is paying a visit to set the dentist straight and to protect her hurt, and possibly mistrustful child. Her behavioral template from childhood tells her that a critical parent will quickly get a child to behave in a better manner. Unfortunately, she is not consciously aware of this, and has yet to realize that templates from childhood often do not work in the adult world.

**THERE ARE TIMES** when one's best effort does not change the patient's attitude, and one needs to seriously consider not treating this patient.

The doctor now has to choose a behavioral template in response. A poor choice would be to match her critical parent with his own inner critical parent. The author calls this the "soccer game" scenario: two angry parents trying to protect their own child. These confrontations appear in the newspaper the day after a physical battle. If the dentist is young and lacking in confidence, he may accept that he was bad and deserving of a reprimand. He submissively (sad-faced, pouting) solves the acute problem (redoes with work "with attitude") but may lose the respect of the patient. He also will suffer from future anxiety when this patient or similar patients are on his schedule.

The best choice is to stay as the adult. The adult will stay out the emotional trap but realize he is dealing with a hurt child. The first step is to get the patient from parent to adult or child. In a seated position, at eye level, the dentist talks slowly and clearly while frequently using the patient's name (this is what the adult responds to). He will not argue (that's critical parent to parent) and he will not use humor (the child is not available to enjoy it yet). He will mentally reassure his own child he will handle the situation and that this angry and mean lady will not be allowed to abuse him. He will listen intently to her complaints and help her to explore her concerns (not just the pain, but needing to miss work to come in or the fear this will mean an additional procedure she might not be able to afford). He will repeat back to the patient what he heard and understood from her. It may take a few times to get this right.

At last, the patient feels understood and the critical parent is no longer needed. The dentist immediately notices the physical response. The patient is relaxed and the tone of voice changes. The person sitting in the chair is now the rational adult. Finally, it is appropriate to logically explain the diagnosis and treatment. Also, the child will now be available. The doctor can use his nurturing parent to soothe the child by smiling, placing a hand on her shoulder, and using gentle humor. The patient will now be cooperative but, more importantly, the dentist knows he has the tools to manage a "difficult" patient. There may be less anxiety the next time he sees another one on his schedule.

## Scenario 2

Dr. Whiting is having a tough day. His production for the month is down, an implant patient cancelled this morning, and he had to send a crown back to the lab. Playing in his head is his nagging, critical parent telling him how incompetent he is and how no other dentist has all the problems he does. Now, Mr. Sanders arrives for a crown prep but he questions the doctor, "Do I REALLY need this?" "Of course you need this," Dr. Whiting's critical parent answers. The procedure is accomplished in silence as the patient is passively uncooperative. Mr. Sanders is in his noncompliant child state and Dr. Whiting remains in his critical parent state. Later that day, the patient wonders if he should ever trust this dentist again while the dentist feels guilty about the shabby way he treated a nice patient. This episode would have been so much different if Dr. Whiting dealt with his own childhood issues. Using his nurturing parent, he could reassure his hurt child that everyone has a bad day and he's still a good dentist and person. Then he would have been able to comfort the patient's child when he saw the patient's initial attitude to treatment. After insuring the child's trust, the procedure would go smoothly with both participants grateful to the other.

## Summary

There are an infinite number of possible dentist-patient interactions. Using a simple, three ego state model can simplify troublesome dynamics and suggest a course of action. Although we cannot change the patient's psychological makeup, we can manage it better. On the other side, we can change our attitudes and behaviors. We can become aware of the situations that arouse our inner child or parent. Observing our emotional response to a patient (getting in touch with the child) is the first step. Then we need to be aware of the ego state (with its corresponding behavioral template) we choose. If we repeatedly utilize dysfunctional responses, then we are likely to experience anxiety and poor interactions with some of our patients. Exploring our own issues (e.g. the need to be liked, the need to be in control, etc.) may be in order. The resulting changes in our approach can enhance treatment and increase our satisfaction as caregivers. ■■■■


**REFERENCES**

**1.** Groves JE, Taking care of the hateful patient. *N Engl J Med* 298(16):883-7, April 20, 1978. Freeman R, A psychodynamic understanding of the dentist-patient relationship. *Br Dent J* 186(10):503-6, May 22, 1999.
**2.** Steinmentz D, Tabenkin H, The "difficult patient" as perceived by family physicians. *Fam Pract* 18(5):495-500, 2001.
**3.** Gamer S, Tuch R, Garcia LT, MM House mental classification revisited: Intersection of particular patient types and particular dentist's needs. *J Prosthet Dent* (89)3:297-302, March 2003.
**4.** Centore L, Reisner L, Pettingill, CA, Better understanding your patient from a psychological perspective: Early identification of problem behaviors affecting the dental office. *J Calif Dent Assoc* 30(7):512-9, July 2002
**5.** Christensen GJ, Treating the potential problem patient. *J Am Dent Assoc* 132(11):1591-3, November 2001.
**6.** Seoane J, Varela-Centelles P, et al, Concordance between undergraduate dental students and their lecturers in their attitudes toward difficult patients. *Eur J Dent Educ* 6:141-6, 2002.
**7.** Krupnick JL, Sotsky SM, et al, The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: Findings from the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *J Consult Clin Psychol* 64:532-9, 1996.
**8.** Forster HP, Schwartz J, DeRenzo E, Reducing legal risk by practicing patient-centered medicine. *Arch Int Med* 162:1217-9, 2002.
**9.** Levinson W, Roter DL, et al, Physician-patient communication: the relationship with malpractice claims among primary care physicians and surgeons. *JAMA* 277(7):553-9, 1997.
**10.** Szasz TS, Hollender MH, A contribution to the philosophy of medicine: The basic models of the doctor-patient relationship. *AMA Arch Intern Med* 97(5):585-92, May 1956.
**11.** Freeman R, A psychodynamic understanding of the dentist-patient relationship. *Br Dent J* 186 (10):503-6, May 22, 1999.
**12.** Berne E, Games people play: The psychology of human relationships. Grove Press, Inc., New York, 1964.
**13.** Harris TA, I'm OK – You're OK: A practical guide to transactional analysis. Harper & Row, New York, 1967.
**14.** Subby, R, Healing the family within. Deerfield Beach (FL): Health Communications Inc., 116, 1990.
**15.** Casement PJ, Learning from the patient. The Guildford Press, New York, 80, 1991.
**16.** Johnson SL, Therapist's guide to clinical intervention. Academic Press, second edition, New York, 295, 2004.


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# The Impact of Changing Parenting Styles on the Advancement of Pediatric Oral Health

CLARICE S. LAW, DMD, MS

**ABSTRACT** Behavior management is significant to delivery of dental care to the child. We must be able to elicit cooperation of the child for dental procedures, and of child and parents, for adherence to a preventive home care regimen. However, society has changed, affecting the ability of dentists to influence children and their parents. The purpose of this paper is to review changes in parenting styles that have impacted the nature of oral care in the child.

AUTHOR

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The way in which any individual chooses to parent can involve a wide variety of positive and negative parenting behaviors which, when taken together, indicate a parenting style. Developmental psychologists consider a continuum of two elements to define parenting styles, which would be considered within the normal range.[1]

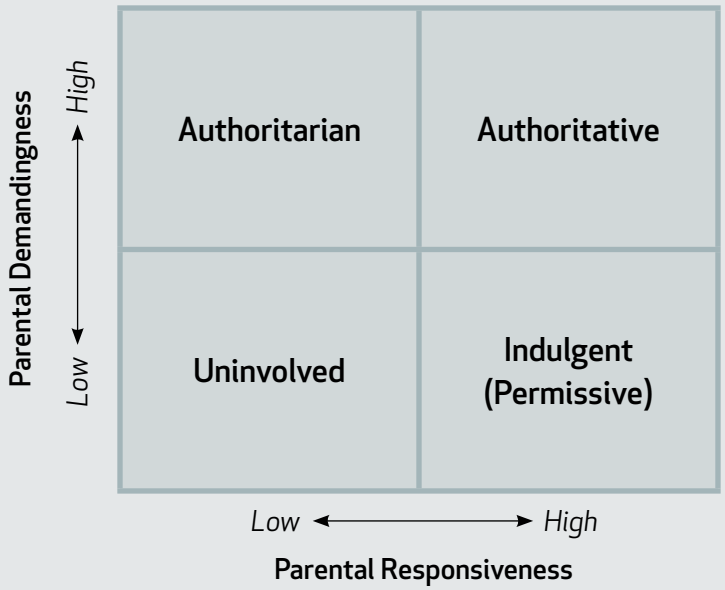
Parental responsiveness, which can also be referred to as parental warmth or supportiveness, is the first element, which is "the extent to which parents intentionally foster individuality, self-regulation, and self-assertion by being attuned, supportive, and acquiescent to children's special needs and demands."[2] The second element is termed parental demandingness, or behavioral control, which is defined by "the claims parents make on children to become integrated into the family whole, by their maturity demands, supervision, disciplinary efforts and willingness to confront the child who disobeys."[2] Determining whether these two elements are high or low results in a typology of four parenting styles (**TABLE 1**). These four styles exclude that which would be considered deviant parenting.

High parental responsiveness and high parental demandingness result in a parenting style termed authoritative. Authoritative parents "monitor and impart clear standards for their children's conduct. They are assertive, but not intrusive and restrictive. Their disciplinary methods are supportive, rather than punitive. They want their children to be assertive as well as socially responsible, and self-regulated as well as cooperative."[2]

The high parental responsiveness and low parental demandingness type is categorized as the indulgent type. This is also often referred to as a "permissive" parenting style. These parents are "nontraditional and lenient, do not require mature behavior, allow considerable self-regulation, and avoid confrontation."[2] This style can be further characterized as nondirective, often described as "parenting by default," with minimal control by the parent, or democratic, marked primarily by leniency, but with a higher level of commitment to interfacing with children.

TABLE 1

**Typology of Parenting Styles**




Low parental responsiveness and high parental demandingness is considered to be the authoritarian style of parenting. These parents are "obedience- and status-oriented, and expect their orders to be obeyed without explanation."[2] Families with this parenting type tend to be highly structured, with clear rules. This type has two sub-types. The nonauthoritarian-directive type of parent is directive without being autocratic or intrusive. The authoritarian-directive parent tends to be intrusive with his or her parental authority.

The final parenting style consists of low parental responsiveness and low parental demandingness. This type is considered to be the uninvolved parent. This style is still within the normal range of parenting, with an aspect of neglect or rejection that may border on the deviant range of parenting.

There is a third dimension of parenting that distinguishes between the authoritative and authoritarian styles. Psychological control "refers to control attempts that intrude into the psychological and emotional development of the child."[3] Practices that could be considered attempts at psychological control might include the induction of guilt, the withdrawal of love, or the use of shame. Authoritarian parents tend to be high in psychological control, expecting children to fulfill parental expectations without question, using psychological control to gain that response.

Choice of parenting style has been shown have some impact on the well-being of children.[2,4,5] In objective measures as well as self-ratings of social and instrumental competence, children of authoritative parents rate higher than the other three types. Children of uninvolved parents rate the lowest. In addition, the authoritative parenting style is also thought to have protective effects on adolescent risk behavior.[6] High parental responsiveness tends to be associated with social competence and psychosocial functioning and high parental demandingness is associated with instrumental competence and behavioral control, often viewed on the spectrum of academic performance versus deviant behavior. Thus, children of authoritarian parents, with high demandingness, but low responsiveness, may do relatively well in school and demonstrate less problem behavior. However, they may also demonstrate lower capacities for social skills and self-esteem, and may have higher rates of depression.

Children of parents of the indulgent type, in which levels of demandingness and responsiveness are reversed with respect to the authoritarian type, tend to demonstrate more problem behavior and lower academic performance. Yet, these children generally exhibit higher self-esteem, better social skills, and lower rates of depression. Overall, the literature seems to indicate that the authoritative parenting style has the most consistent positive impact on children. However, there is no clear indication of the prevalence of each of the four styles in the U.S. population.

## Perspective of Pediatric Dentists

The change in parenting style over the past decade has become a common topic of conversation among dentists who work with children. To characterize the opinions, a study was conducted targeting 1129 members of the College of Diplomates of the American Board of Pediatric Dentistry.[7] The majority (88 percent) responded either "absolutely" or "probably" that parenting styles have changed since they first started practicing, with older practitioners more likely to indicate a change than younger practitioners. Of this group, 38 percent characterized these changes as "bad," with 54 percent indicating "probably bad." In addition, 65 percent responded that parenting changes resulted in behavior that was "somewhat worse," with 20 percent indicating that it was "much worse." As a final indictment, 43 percent indicated that their satisfaction in practicing had decreased as a result of changes in parenting.

The survey went on to describe changes in disciplinary methods observed by this cohort of pediatric dentists. Respondents indicated a perceived increase in the use of

positive reinforcement by the parent and talking to influence the child. According to the framework of parenting previously discussed, this shift might indicate an increase in the element of responsiveness. Respondents also indicated observations of less physical discipline, more bribing of the child, and more acceptance of the child's disrespect. These practices might reflect low demandingness. Although changes in the prevalence of any given disciplinary practice must be viewed in its unique context, it appears that the collective change indicated by the respondents reflect an increase in parental responsiveness and a decrease in parental demandingness, consistent with the indulgent or permissive style of parenting. And indeed, the opinions of many pediatric dentists indicate that permissive and uninvolved parenting has increased while authoritarian and authoritative parenting has decreased.

In the same survey of pediatric dentists, subjects reported an increase in the attempts of parents to prevent suffering.[7] Parents also make greater efforts to protect the child's ego, with an increase in general overprotectiveness of the child. The threshold level for parental distress over the reactions of their children appears to be decreasing. It seems as if the possibility of psychological discomfort concerns parents as much as the possibility of physical discomfort during treatment once did. As a negative sequela, this particular shift in current parenting philosophy may potentially result in an eventual decrease in the coping strategies of children for all medical interventions.

It has been suggested that contemporary parents appear to be moving away from the traditional parent role of setting limits and saying no.[8] They seem more ambivalent about certain disciplinary practices and less likely to enforce discipline as rigorously as in the past. Instead, parents seem to be more focused on being friends to their children, with a decrease in the sense of responsibility to establish boundaries, maintain discipline, teach self-control, and instill respect for others. Contemporary parents might be generalized as being more permissive, demonstrating a greater range of acceptability for child behaviors.[8] Overall, even though more psychological problems may be diagnosed because of increased awareness of mental health issues, there is also a decrease in the amount of accountability parents take for behavioral control and discipline, with a higher expectation that the condition will be handled medically or psychologically.[8,9]

## Elements Precipitating the Current Shift

Overall, there has been an increased emphasis on parenting in the United States over the last decades. A perusal of the parenting or family section of any bookstore will reveal hundreds of titles covering a diverse range of topics affecting parents. As one author quoted, "Raising children has rated very near to sex — and to success — as an American fixation."[10] Recent polling data suggest that parents feel that it's harder to be a child in today's climate than in previous times.[11] The rate of criminal activity has increased, the Internet has opened the way to new predatory activity targeting children, and there is an increase in diagnosis of psychological disorders, among many other pressures on contemporary children. The response of parents has been to invest more in developing their children. In addition, sociologists, psychologists, pediatricians, and other child health specialists have demonstrated an increased interest in studying the impact of early childhood experiences on adult outcomes. The expanding knowledge base has resulted in policy changes and advocacy at the federal level. Public activity at this level increases the pressure on parents to be more proactive in their parenting.

In addition to the increased emphasis on parenting are signs of an increase in the strength of opinions about parenting. Before the beginning of the 20th century, parenting practices in the United States were generally passed from generation to generation with a focus on practices that worked with the daily routine of the whole family. In the early 20th century, behaviorists proposed the theory that children were molded by environmental factors. Outward structure would result in emotional control. Thus, mothers during this era were encouraged to shape their children with specific and controlled care. As for feeding, they were encouraged to follow a strict schedule. This practice became known as hyperscheduling or clockfeeding. Although the suggested level of responsiveness is not known, and probably varied from family to family, the underpinning philosophy seemed to emphasize a call for high demandingness. In general, this era of parenting has a reputation for being a time when the authoritarian parenting style was the norm.

In the 1940s, the theories of Sigmund Freud were adapted, swinging the pendulum to the opposite side. The neoprimitivistic theory held that birth trauma disrupts the in utero mother-child harmony. Nurturing the emotional and instinctive qualities of the infant was considered more important than structure at re-establishing this harmony. Feeding met nutritional as well as psychological needs. Mothers were encouraged to feed children at the first sign of irritability. However, this theory was dismissed within the decade. Baumrind's typology would classify the resulting parenting paradigm as being low in demandingness and high in responsiveness — the indulgent parenting style.

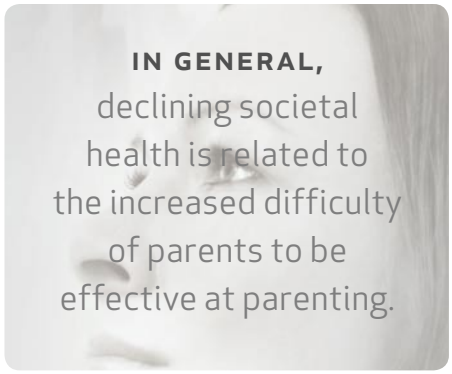
In 1946, Dr. Benjamin Spock published his first book, "The Common Sense Book of Baby and Child Care."[12,13] With his con-

cept that parents should pursue a healthy balance of structure and flexibility, Dr. Spock began a decades-long career as one of the foremost experts in baby care in the United States. This approach presented a style that balanced demandingness and responsiveness. This most prevalent style of parenting under this influence would likely be the authoritative style.

By the 1980s the theories of attachment proposed by the neoprimitivistic school of infant care began attracting more attention, resulting in a parenting philosophy called "attachment parenting."[14] Dr. William Sears, one of the strongest advocates of the parenting style, lists seven tools intended to help parents bond with their infants:

- Birth bonding — bonding with the child during the early days after birth,
- Breastfeeding — for nutrition as well as encouraging an understanding of the infant,
- Babywearing — keeping the baby close to the caregiver to promote familiarity and sensitivity and decrease fussiness and crying,
- Bedding close to baby — co-sleeping, sharing a family bed minimizes nighttime separation anxiety and facilitates nursing during the night,
- Belief in the language value of your baby's cry — to develop trust in the baby as the parent responds to his or her needs increases communication,
- Beware of baby trainers — considers schedule feeding and crying it out approaches to be "convenience" parenting with short-term gains and long-term losses by promoting distance between the parent and child, and
- Balance — promotes maintaining a healthy marriage and time for self.

The high focus on the attachment of the infant to the parents is certainly indicative of a high responsiveness style although each "tool" allows room for individualized application. Overall, however, this parenting philosophy does not appear to emphasize demandingness, possibly predisposing an attachment parenting family to the indulgent style. Although the indulgent type can be considered a variant of normal nondeviant parenting, many attachment parents set themselves apart by referring to nonattachment parenting as "mainstream parenting." Although the percentage of families choosing the attachment parenting style is not known, the seven tools promoted as elements of this style have increased in popularity, possibly related to the overall shift in parenting style over recent years.




There are other changes that have had an impact on parenting in recent years. Sociologists can measure the "overall well-being" of society, utilizing factors such as drug abuse, unemployment, school dropouts, and homicides to determine the extent of societal health. There are indications that societal health has declined.[10] In general, declining societal health is related to the increased difficulty of parents to be effective at parenting. Thus, even if parents want to be effective, external factors hinder their abilities.

Stress is another factor that affects the ability of parents to make positive impacts on their children.[10] A significant issue for contemporary parents is increased financial stress. It takes more to support a family than it once did. Work itself is a stressor. Companies expect more of employees than they did in previous years. Job-related stress is related to behavioral withdrawal, emotional withdrawal, and negative emotion spillover. This might result in a decrease in responsiveness, with no real predictions for the level of demandingness.

General parenting stress has been associated with:[10]

- Inconsistent parenting (sometimes lax or overreacting),
- More negative communication,
- Decreased monitoring/supervision of children,
- Setting unclear rules and limits on children's behavior,
- Being more reactive and less proactive, and
- Increasingly harsh discipline.

Overall, the changes associated with general parenting stress reflect low responsiveness with severe shifts in demandingness, bouncing the resultant parenting style between the uninvolved and authoritarian types.

Finally, there are more homes with two working parents who spend, on average, more time working and less time at home when compared to the norms of the past. In addition, there are increasing numbers of single parents, who must arrange for alternative childcare options. Overall, parents spend less time with family, leaving less time for them to impact their children in a positive manner. What little time parents may have with their children may be impacted negatively by stress. Alternatively, some parents may feel some guilt at not being able to spend much time with their children and may intentionally choose to adopt a more indulgent or permissive parenting style.

A final element that may be playing a role in the changing nature of parenting is

the transformation of the ethnic composition of the United States.[10] American society is becoming more culturally diverse. Different cultures have different traditional values and potentially different parenting styles. Just the addition of more cultural diversity into American society has changed what is considered to be "average" in parenting philosophies and styles.

## Implications of Parenting Changes on the Dental Professional

As dental professionals, one of our activities should be the advancement of oral health through the reduction of caries risk. As we know, caries risk is affected by diet. Thus, the philosophy of feeding in early infancy, which is affected by parenting style, may have an impact on the oral health of a child. After declining in popularity in the years after World War II, breast-feeding has become increasingly common. Pediatricians tout the benefits of breastfeeding on nutrition as well as on passive immunity. However, contemporary philosophies promote breast-feeding as a method of connecting with the infant or soothing the infant during distress, increasing the prevalence of breast-feeding in the absence of hunger. Rather than feeding according to any type of schedule or routine, a growing number of families are choosing to feed on demand well past the first few months of life when the infant needs frequent feedings to thrive. Attachment parenting promotes demand-feeding until the child "wants to quit," and also promotes co-sleeping and nocturnal breast-feeding as an approach to increase the level of attachment between parents and children.[14] Unfortunately, studies indicate an association between early childhood caries, formerly known as baby bottle tooth decay, and nighttime breast-feeding or breast-feeding in children older than 12 months. There is also an association between early childhood caries and bottle-feeding at night as a substitute for the pacifier, as well as with use on demand during the day.[15-18] Thus, contemporary changes in parenting styles and feeding philosophies that increase the duration and frequency of feeding may predispose children to early childhood caries.

Another health issue linked to poor eating habits that has received much attention in recent years is obesity. Out of the four parenting styles, obesity is most highly associated with the authoritarian parenting style.[19] In addition, children from indulgent and neglectful or uninvolved parenting styles have twice the risk of being obese than children from authoritative households. Contemporary parents more frequently allow demand-feeding and prolonged breast- or bottle-feeding. Consequently, food no longer serves just to satisfy hunger or nutritional needs, but also to serve emotional needs. Increased consumption is associated with an increased exposure to potentially cariogenic foods, also increasing the risk of caries. Thus, the recent increase in the incidence of obesity in children must be taken seriously by the dental professional, both as a health issue and as an indicator of caries risk.

**THE ADDITION OF MORE** cultural diversity into American society has changed what is considered to be "average" in parenting philosophies and styles.

As mentioned previously, changes in parenting have had direct effects on the physical and oral health of contemporary children. However, parenting changes have also impacted the ability of the dental professional to deliver oral health care services. An increasing number of contemporary parents demonstrate overprotectiveness, with concerns that their children might experience emotional distress in the dental setting. These parents tend to hover in the operatory and hinder the communication process between doctor and child. Parents with concerns that their child "might be traumatized" have the potential to "overprepare" their children for the dental visit, making the visit seem much more significant and potentially frightening than it has to be. These parents often express discomfort with seeing their children cry. In some variations of attachment parenting, crying is considered to be a bad thing, to be prevented. Any crying on the part of the child, whether due to a difficult procedure, such as local anesthetic injection, or simply due to the child's lack of desire to cooperate, might result in a response from the parent that may not promote cooperation by the child. Pharmacologic behavior management options, such as oral or intravenous sedation, have increased in acceptability because many parents don't want their children to experience standard dental treatment.

The effectiveness of behavior management has also been affected by the changes in contemporary parenting. Most dental procedures require the cooperation of the child patient. With the generalized decrease in demandingness, many children are unaccustomed to being told what to do. Instead, they are often offered unlimited choices and allowed to play significant roles in making important decisions. Some contemporary children are even allowed the choices of deferring treatment or choosing their own alternatives. In this context, with children being allowed a greater level of personal autonomy in decision-making, it is often difficult for the

dental professional to expect cooperation.

Behavior management strategies that require the dentist to exercise authority seem to be less effective than in previous eras. With the decrease in the prevalence of the authoritative and authoritarian styles and the increase in the uninvolved and indulgent types, children appear to be less accustomed to responding to authority figures. Thus, a strategy such as use of voice control may not be effective if the child is not accustomed to responding to an authoritative voice. Even parents show an increasing lack of tolerance for behavior management strategies requiring the use of authority. Again, pharmacologic behavior management strategies are increasingly more acceptable to parents who don't want their child to feel uncomfortable in the dental setting.

A final challenge to the dental professional in the 21st century is related to the advancement of oral health through preventive strategies. In order to decrease the risk of caries and periodontal disease, the family must be committed to increasing oral hygiene and monitoring the diet of the children. This requires the active participation of the parents. If parents are of the uninvolved style, they generally won't be committed to a home-care regimen. If parents are of the indulgent style, they may not be willing to insist on the development of good hygiene habits. Part of the problem of compliance is related to the changes in parenting, but compounding the shift in the parent-child relationship is a change in the parent-doctor relationship. In general, there is a diminished respect for and trust in professionals.[8] Parents have increasingly adopted a consumerist approach to oral health. The dental professional may have no authority in the perspective of many parents to request changes in lifestyle in order to promote oral health.

## Conclusion

Overall, managing the behavior of the 21st century child is proving to be a significant challenge to the dental professional. The average contemporary parent generally has a higher value for responsiveness, but appears to have a decreased value for demandingness. This indicates an increase in the prevalence of the uninvolved and indulgent styles of parenting and a decrease in the authoritative and authoritarian styles of parenting. With these specific shifts in parenting styles, there is an increasing potential for caries risk and obesity to escalate. At the same time, the effectiveness of nonpharmacologic behavior management strategies may be affected by a limited behavioral capacity of the child as well as a diminished willingness of the parents to expect the cooperation of their children. Finally, we may be in an era where adherence to recommended treatment is also limited by the values of contemporary parents. For the dental professional who simply wishes to focus on restoring active carious lesions, the answer may simply be to propose pharmacologic solutions that will be acceptable to parents and children. However, for the dental professional who wants to promote a lifetime of good oral health, the solution is more complicated. The entire family must be engaged in the commitment to advancing oral health. In the current climate, one possible tactic may involve a two-pronged approach. The first component would be to maintain a high level of responsiveness, which will most likely be acceptable to all parents. The second component is to work with parents to achieve acceptance of higher demandingness in the dental setting as well as at home. This might require significantly more effort, but may achieve a better end result. Not only might we promote oral health, but we may be able to promote future shifts in parenting styles that advance psychological and emotional health as well. ■■■■


**REFERENCES**

**1.** Maccoby EE, Martin JA, Socialization in the context of the family: Parent-child interaction. Wiley, New York, 1983.
**2.** Baumrind D, The influence of parenting style on adolescent competence and substance abuse. *Journal of Early Adolescence* 11(1):56-95, 1991.
**3.** Barber BK, Parental psychological control: Revisiting a neglected construct. *Child Dev* 67(6):3296-319, 1996.
**4.** Miller NB, Cowan PA, et al, Externalizing in preschoolers and early adolescents: A cross-study replication of a family model. *Developmental Psychology* 29(1):3-18, 1993.
**5.** Weiss LH, Schwartz JC, The relationship between parenting types and older adolescents' personality, academic achievement, adjustment, and substance use. *Child Dev* 67(5):2101-14, 1996.
**6.** DeVore ER, Ginsburg KR, The protective effects of good parenting on adolescents. *Curr Opin Pediatr* 17(4):460-5, 2005.
**7.** Casamassimo PS, Wilson S, et al, Effects of changing U.S. parenting styles on dental practice: Perceptions of diplomates of the American Board of Pediatric Dentistry. *Pediatr Dent* 24(1):18-22.
**8.** Sheller B, Challenges of managing child behavior in the 21st century dental setting. *Pediatr Dent* 26(2):111-3, 2004.
**9.** Harper DC, D'Alessandro DM, The child's voice: Understanding the contexts of children and families today. *Pediatr Dent* 26(2):114-20, 2004.
**10.** Long N, The changing nature of parenting in America. *Pediatr Dent* 26(2):121-4, 2004.
**11.** Halfon N, McLearn KT, et al, Child rearing in America: Challenges facing parents with young children. Cambridge Press, New York, 2002.
**12.** Spock B, The common sense book of baby and child care. Duell, Sloan and Pearce, New York, 1946.
**13.** Spock B, Rothenberg MB, Dr. Spock's baby and child care. Dutton, New York, 1992.
**14.** Sears W, Sears M, The attachment parenting book: A commonsense guide to understanding and nurturing your baby. Little, Brown and Company, New York, 2001.
**15.** Douglass JM, Tinanoff N, et al, Dental caries patterns and oral health behaviors in Arizona infants and toddlers. *Community Dent Oral Epidemiol* 29(1):14-22, 2001.
**16.** Hallett KB, O'Rourke PK, Early childhood caries and infant feeding practice. *Community Dent Health* 19(4):237-42, 2002.
**17.** Azevedo TD, Bezerra AC, et al, Feeding habits and severe early childhood caries in Brazilian preschool children. *Pediatr Dent* 27(1):28-33, 2005.
**18.** Sayegh A, Dini EL, et al, Oral health, sociodemographic factors, dietary and oral hygiene practices in Jordanian children. *J Dent* 33(5):379-88, 2005.
**19.** Decaluwe V, Braet C, et al, The association of parental characteristics and psychological problems in obese youngsters. *Int J Obes* (Lond) 30(12):1766-74, December 2006; Epub April 11, 2006.



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# Diagnostic and Treatment Challenges in Occlusal Dysesthesia

JOHN L. REEVES, II, PHD, MSCP, AND ROBERT L. MERRILL, DDS, MS

**ABSTRACT** The aim of this chapter is to provide the dentist with an overview of potential diagnostic and treatment challenges posed by patients who present with occlusal dysesthesia or "Phantom Bite." Occlusal dysesthesia is seen as a form of somatoform disorder where dental treatments must be avoided and instead the focus should be on addressing the somatoform disorder through behavior change.

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*Men are disturbed not by things, but by the view which they take of them.*

EPICTETUS, 55-135

In dental practice one will encounter patients who are extremely focused, if not obsessed, with an orofacial complaint. The patient may complain of cosmetic concerns that are imperceptible, of irrational fear of oral cancer in spite of negative physical findings, or they may present with a debilitating atypical pain, again without clear etiology. However, one of the most perplexing conditions is the patient who presents with occlusal dysesthesia, also referred to as "Phantom Bite."[1] Patients with occlusal dysesthesia are preoccupied with their dental occlusion and convinced that their bite is off and abnormal.[2,3] The patient will be constantly checking their bite or attempting to reposition their jaw to find their bite. Frequently, the complaints are long-standing and can occur at any stage of dental care ranging from simple fillings to more extensive restorative procedures, orthodontics, or oral surgeries. Their perception of an abnormal occlusion persists despite repeated failed attempts to adjust the patient's occlusion. No dental or pharmacological treatments have proven to be effective in reducing occlusal dysesthesia.

Repeated failed treatments further reinforce the patient's illness conviction that something is seriously wrong with their occlusion. When the dentist provides reassurances that nothing is wrong with their occlusion, their distress escalates further. In an attempt to reassure the patient and reduce their distress and concerns, the dentist may refer the patient to an orofacial pain or TMD specialist for a second opinion. Though well intentioned, the referral may do the opposite and further increase the patent's anxiety, somatic preoccupation, and illness conviction. The patient misinterprets the referral as an indication that the dentist believes the problem to be very serious and is providing a referral to a specialist to confirm

the severity of the disease. Thus, these patients not only misinterpret physical sensations regarding their occlusion, but also most health-related communications.

Occlusal dysesthesia patients are persistent in seeking multiple opinions and are frequently unreasonable in their demands for their problem to be "fixed." The occlusal dysesthesia patient frequently presents with "tedious" verbal and written monologs chronicling the details of their dental problems and past treatment failure.[3] They are invariably dissatisfied and angry with all of their dentists' prior failures to resolve their occlusal complaints. Moreover, it is not unusual for these patients to be very litigious and want to "get back at" the dentists they perceive as having caused them harm. In spite of this, they persist in looking for the "fix" and this eventually results in the patient falling victim to iatrogenic complications as a result of overly zealous attempts to accommodate the patient's persuasive demands to "fix" their occlusion.

The patient's symptoms and lack of clear physical findings may appear to the dentist to be a relatively minor problem and certainly not warranting the degree of distress and disability being displayed by the patient. Further occlusal adjustments, splints, orthognathic, orthodontic, or surgical interventions will not alleviate the occlusal dysesthesia, but may even exacerbate the problem. Since no dental or neurological findings have been reported that can account for occlusal dysesthesia, it is possible these patients may, as a result of a psychological condition called somatoform disorder, be somatizing, that is, exhibiting severe somatic focus and mysterious occlusal complaints. Until the somatoform disorder is addressed with psychological treatments, continued dental treatments will in all likelihood fail, if not worsen the problem.

**TABLE 1**

**Somatoform Disorders**

| |
|---|
| **1.** Somatization Disorder: Historically referred to as hysteria, is a polysymptomatic disorder that begins before the age of 30, extends over a period of years and is characterized by a combination of pain, gastrointestinal, sexual, and pseudoneurological symptoms. |
| **2.** Undifferentiated Somatoform Disorder: Characterized by unexplained physical complaints lasting at least six months that do not exceed the threshold for the diagnosis of somatization disorder. |
| **3.** Conversion Disorder: Unexplained symptoms or deficits affecting the motor or sensory function that suggest a neurological or other general medical condition. Psychological factors are judged to be associated with the symptoms or deficits. |
| **4.** Pain Disorder: Pain is the predominant focus of attention. Psychological factors are judged to have an important role in its onset, severity, exacerbation, or maintenance. |
| **5.** Hypochondriasis: Preoccupation with the fear of having, or the idea of having, a serious disease based on a person's misunderstanding of bodily symptoms or bodily functions. |
| **6.** Body Dysmorphic Disorder: Preoccupation with an imagined or exaggerated defect in physical appearance. |
| **7.** Somatoform Disorder Not Otherwise Specified: Any somatoform symptom not meeting the full criteria for the other specific somatoform disorders. |

What is somatoform disorder? What is its etiology? What can be done to treat patients with somatoform disorder? How does one tell a patient they think their problem has a psychological overlay and that further dental treatment is uncalled for? This paper provides the dental practitioner with guidelines to address these questions.

## What is Somatoform Disorder?

Patients presenting with occlusal dysesthesia frequently meet the criteria for somatoform disorder. They present with a history of excessive preoccupation with vague recurrent somatic complaints and specifically with a perception their bite is not correct or "off" in the absence of collaborating dental/neurological evidence. This somatic focus and symptom constellation is termed somatization and is the hallmark of the psychological disorder known as somatoform disorder. The complaints are usually generalized but may have a single focus, such as the patient's bite or cosmetic concerns. More recent conceptualizations of somatization refer to it as health anxiety.[4] When pathophysiology is present, the symptoms are in excess of what might be expected. The inexplicable complaints result in treatment-seeking or doctor-shopping and psychological, social, and occupational impairment. Patients with somatoform disorder incur healthcare expenses that are at least six to 14 times higher than the U.S. average, and result in enormous indirect economic costs due to lost work productivity.[5,6] Under the classification of somatoform disorder, the Diagnostic and Statistical Manual-IV (DSM-IV) of the American Psychiatric Association (1994) defines several categories of somatoform disorders.[7] **TABLE 1** lists the different somatoform disorders. **TABLE 2** lists the general diagnostic features of somatoform

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TABLE 2

**DSM-IV Diagnostic Criteria for Somatoform Disorder**

The DSM-IV lists several categories of somatoform disorders. The following summarizes the key features for diagnosing somatoform disorder:

**A)** One or more physical complaints (e.g., fatigue, loss of appetite, GI distress, urinary complaints, pain).

**B)** Either i or ii

i. After appropriate investigation, the symptoms cannot be fully explained by a known medical condition or direct effects of a substance (e.g., drug abuse, medication);

ii. Where there is a related medical condition, the physical complaints or resulting social or occupational impairment is in excess of what would be expected from the history, physical, or laboratory examination;

**C)** The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

**D)** The duration of the disturbance is at least six months.

**E)** The disturbance is not better accounted for by another mental disorder (e.g., depression, anxiety, psychosis).

**F)** The symptoms are not intentionally produced or feigned (i.e., malingering).

disorder as adapted from the DSM-IV.

In general dental practice, the incidence of patients presenting with somatization as 8.7 percent with women making up 73 percent of those meeting the criteria for somatization.[8] Moreover, depression was found to be highly co-morbid with somatizing, and this is consistent with other findings in the literature.[9]

## Etiology of Somatoform Disorder

### *Dental and Neurological Theories*

Dental and neurological explanations for occlusal dysesthesia that lead to effective treatments have been conspicuously lacking. Like phantom limb, frequently seen following amputation of a limb, Marbach hypothesized that occlusal dysesthesia involved neural plasticity in the brain. He suggested that loss of sensation resulting from a peripheral sensory lesion secondary to dental treatment resulted in diminished input to the corresponding area of cortical representation. Thereafter, these cortical areas could be reactivated by adjacent neurons. Thus, the reorganized cortex would continue to infer occlusal changes even in the absence of peripheral input. Klineberg has also proposed a physical etiology of occlusal dysesthesia.[11,12] He suggested that occlusal dysesthesia is a result of centrally mediated occlusal hyper-awareness or iatrogenic dysproprioception. He further suggested that because of this hyper-awareness, occlusal dysesthesia patients were unable to re-learn necessary new jaw movements following even very small changes in their dental occlusion. However, the idea that these patients may exhibit heightened proprioceptive sensitivity has not received scientific support. For example, Baba et al. in 2005 found no differences in occlusal dysesthesia patients and controls in their sensory perceptive and discriminative abilities using occlusal registration foils in a thickness sensory discrimination test.[13] Thus, it appears that rather than being more proprioceptively sensitive or having a heightened awareness the patient with occlusal dysesthesia is misinterpreting or overinterpreting normal occlusal sensations. Certainly more research is needed to understand the peripheral and central mechanisms that mediate the occlusal dysesthesia experience.

### *Psychological Theories*

Since dental and neurological evidence has been lacking to adequately explain the symptoms of occlusal dysesthesia, psychological theories have been proposed as etiological factors. Marbach may have been the first to formally propose a psychological explanatory mechanism for occlusal dysesthesia, which he termed "phantom bite." Based on older and mostly outdated psychodynamic concepts, he described occlusal dysesthesia as being a form of a rare psychiatric disturbance known as monosymptomatic hypochondriacal psychosis. Monosymptomatic hypochondriacal psychosis is characterized by a single delusion or unwavering false belief; in the case of occlusal dysesthesia, that something is wrong with their occlusion. The psychodynamic perspective further posits that occlusal dysesthesia represents a regression to an infantile narcissistic state in which patients withdraw emotional involvement from others and instead fixate on their physical symptoms.[1,14] They have a fixed and resolute belief that their physical symptoms are real and indicative of serious pathology. To date, no empirical evidence exists to support this psychodynamic interpretation, nor has psychodynamic treatment proven to be effective in reducing somatization.

More recent cognitive-behavioral conceptualizations of somatoform disorder have proven effective in terms of generating a heuristic model that has been successful in reducing somatization. It has

not, as yet, been systematically studied in occlusal dysesthesia. However, research is on its way and the application of cognitive treatments to other forms of somatoform disorder shows much promise.[15-18]

The cognitive-behavioral theory proposes that the tendency to misinterpret health-relevant information can be best understood in terms of the way in which knowledge of past experiences of illness (in self or others) leads to the formation of assumptions about symptoms, disease, health behaviors and the dental and medical profession.

Misinterpretation of ambiguous sensations, situations or stimuli as more threatening than they really are is central to the experience of somatoform disorder and occlusal dysesthesia. The meaning that an individual attaches to a stimulus or situation is therefore crucial in generating occlusal dysesthesia. For example, occlusal dysesthesia patients are fixated on their belief that their symptoms are a sign of severe occlusal pathology; thus, they perceive heightened threat or health anxiety and become pathologically preoccupied with these concerns.

The cognitive-behavioral theory further specifies that the impact of any misinterpretation leading to health anxiety is a function of the degree of perceived threat, and that is in turn a function of four core factors:[4] First, is the patient's perceived likelihood of illness and this interacts with the perceived awfulness or burden of the illness (this refers to general consequences such as loss of self-image and role, disturbance to loved ones, financial consequences, etc.). The other core factors are perceived ability to cope with the problem, that is, the extent to which the patient perceives themselves as being able to effectively control their symptoms and prevent them from worsening, and finally, the extent of perception of external rescue factors or external medical and dental factors intervening to help or rescue the patient. This interaction of core factors determines the degree of health anxiety (perceived threat) and is represented in **TABLE 3**.

**TABLE 3**

**Core Factors Determining Health Anxiety**

$$\text{Perceived threat (health anxiety)} = \frac{\text{Perceived likelihood of illness}}{\text{Perceived ability to cope}} \times \frac{\text{Perceived awfulness}}{\text{Perception of external dental/medical rescue}}$$

Salkovskis and Warwick, (2001)

Thus, it is possible for a patient to display a high degree of health anxiety about an orofacial condition with a relatively low perceived likelihood of illness, but a high degree of perceived awfulness (i.e., "If I have cancer it will cripple me with pain and I will become physically disfigured and repulsive and a burden. I will be rejected by my colleagues and loved ones."). If one adds a high degree of perceived likelihood of illness to the mix then the results will be an extremely high degree of health anxiety. If the patient has poor coping skills, and/or feels that the doctors are not listening or able to solve the problem, this also significantly increases the perceived threat. All four core factors need to be addressed in the formulation of any treatment program for patients displaying a high degree of health anxiety and potential somatoform disorder.

## Cognitive Treatment Strategies

Patients with somatoform disorder perceive their symptoms as intense and noxious, and there is variability in the degree to which these symptoms are perceived as bothersome.[19,20] Barsky, using a cognitive-behavioral perspective, has delineated four target areas for treatment that are important modulators of the intensity of a given symptom.[21] They are cognition, attention, context, and mood.

**COGNITION.** Cognition is an important modulator of physical sensations. We experience bodily sensations in terms of the information, beliefs, opinions and ideas we have about them. Two patients with identical symptoms may have very different reactions based on their information, beliefs, opinions, and ideas they have about their symptoms.

**ATTENTION.** Attention to symptoms amplifies them, whereas distraction diminishes them. Patients who closely attend to their symptoms will experience a greater degree of these symptoms while those who manage to distract themselves will experience less intense symptoms.

**CONTEXT.** Context furnishes clues that are used to infer the meaning and significance of bodily sensations. This influences how intense and noxious the symptoms are perceived to be. Context also influences perception by shaping expectations of future experiences. A patient who has had someone close to them die of oral cancer may be much more likely to be overly preoccupied with oral symptoms and convinced they will ultimately prove to be cancer.

**MOOD.** Depression, anxiety and other psychological factors may amplify bodily sensations. Anxiety, for example, results in perceived symptoms being more serious, dangerous and alarming. Depression, with its morbid self-preoccupation, can further amplify symptoms, resulting in an enhanced sense of hopelessness thus limiting the patient's sense of self-efficacy or control over their symptoms.

Cognitive-behavioral therapy for somatoform disorder focuses on targeting cognitions, attention, context and mood. Cognitive-behavioral therapy treatment

involves up to 10 individual sessions. The aims of the structured cognitive-behavioral therapy approach, as adapted from Allen,[15] are shown in **TABLE 4**.

TABLE 4

**Aims of Cognitive-Behavioral Therapy for Somatoform Disorder**

| |
|---|
| **1.** Reduce physiological arousal and reactivity through relaxation and mindfulness techniques, |
| **2.** Enhance activity regulation through increasing exercise and pleasurable and meaningful activities; teach pacing skills, |
| **3.** Increase awareness of emotions; teach emotional regulation and tolerance of distress, |
| **4.** Modify dysfunctional beliefs through cognitive restructuring, |
| **5.** Teach distraction approaches, |
| **6.** Enhance communication of thoughts and emotions, |
| **7.** Reduce spousal reinforcement of illness behavior, and |
| **8.** Address co-morbid mood disturbance. |

## Occlusal Dysesthesia Case Presentation

### *History*

Mrs. X, a 61-year-old married, Caucasian female, was referred to the Orofacial Pain Clinic for evaluation of her bite. She was obviously in a lot of distress, angry and anxious, and indicated her bite had been changed by several dentists and she no longer knew where her teeth should meet. As she sat in the examination room, she was intermittently clenching her teeth. She stated she was doing this to check the bite. She reported the problem developed when she went to a temporomandibular joint doctor regarding jaw pain. The doctor recommended she wear a TMJ appliance full time for one month, and then she would need some restorative dental work done to fix her bite. She stated her pain levels had decreased with the use of the appliance, but that only her anterior teeth contacted when the appliance was removed. She reported that the TMJ doctor then made crowns and bridges to restore the bite, but she felt the bite was not right and returned to have the bite adjusted. After several attempts to get her bite adjusted, the dentist referred her to a colleague for evaluation. The colleague reevaluated her bite and recommended the crowns and bridges be removed and redone. This was done, but she continued to report bite discomfort. After several visits to have the new dental work adjusted, she went to another dentist on her own. The new dentist evaluated the work and told her one of the bridges would have to be replaced since it had been ground down to a point the metal was showing through the porcelain and the bridge was out of occlusion. This dental work was also redone, but the patient continued to complain of her bite being off. She saw a fourth and a fifth dentist, both of whom tried to adjust the bite but without resolution of her complaint. By this time, she had spent several thousands of dollars to get her bite comfortable. She would go to the dentist, have him adjust a specific tooth and feel that it was now normal, then leave only to find when she returned home that another area was now "off" and needed to be adjusted. The same routine occurred with all of the dentists.

In the OFP clinic, when the patient's bite was checked with Mylar, there were no obvious premature contacts and, in fact, several of the areas where she complained contact was too hard were out of occlusion from previous adjustments. The patient was told there was nothing wrong with the bite and that she should stop checking it. She would listen to what was being said, then immediately come back to her mouth and say, "But this area here is meeting too soon and needs to be adjusted." When the area or tooth was checked and no premature contacts were noted, the doctor would inform the patient and she would appear to listen, then immediately point to another area that she felt needed to be adjusted.

### *Physical Examination*

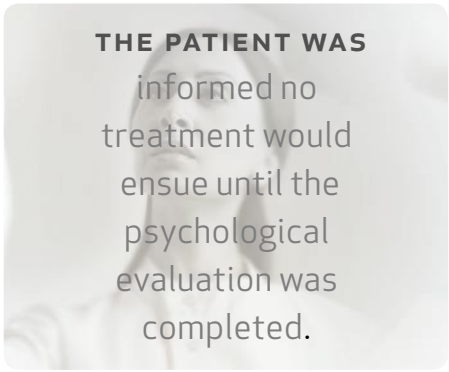
The examination of this patient included a stomatognathic assessment looking for TMJ function, a palpation examination looking for joint pain, muscle tenderness and myofascial trigger points. There was mild-to-moderate tenderness over the lateral pole of the right TM joint and there were myofascial trigger points in the masticatory muscle bilaterally. Mild crepitus was noted bilaterally in the TM joints. Tongue/cheek ridging was moderate to severe, indicating parafunction. The neurologic examination was grossly intact.

Since in the first session the dentist observed the patient was showing signs of anxiety, depression and extreme obsessive somatic focus and parafunction, she was referred to a health psychologist for a psychological evaluation prior to pursuing any dental or pharmacological interventions. The patient was informed no treatment would ensue until the psychological evaluation was completed. She was informed this was a standard and important component of the comprehensive evaluation process all patients with occlusal dysesthesia and orofacial pain underwent in the OPC. She became very upset with the idea of seeing a psychologist for her real occlusal problem and

that the dentist thought it was all in her head. The dentist reassured the patient he did not think her problem was all in her head. He reiterated that all patients with occlusal dysesthesia and orofacial pain underwent such an evaluation because he understood the tremendous impact that such problems can have on patients and their families. He further stated he could see how distressed she was about her problem and the toll it had taken on her, and there were psychological approaches that could help control her symptoms safely, and reverse the negative impact that the occlusal dysesthesia was having on her. He discussed the role her occlusal symptoms can have in creating distress, anxiety, and depression leading to increased muscular tension and how the muscular tension could in turn increase the distress, creating a vicious cycle. The dentist also discussed the important role that masticatory muscle tension has on the perception of occlusal problems, and that the psychologist has relaxation and biofeedback techniques that may be beneficial in reducing this tension as well.

### *Psychological Evaluation*

The patient underwent a one-hour clinical consultation with a health psychologist. Several psychometric tests were administered. These included the MMPI-2 (Minnesota Multiphasic Personality Inventory); the Beck Depression Scale-2 (BDI-2); Beck Anxiety Scale; the Whiteley Index. The MMPI-2 accurately portrayed the patient as exhibiting extreme somatic focus and illness conviction with severe depression and obsessive-anxiety, and an intense interpersonal style. The patient displayed poor coping resources and thought processes that were bizarre, if not mildly delusional, though not meeting the criteria for a psychotic disorder. The MMPI suggested the patient's occlusal dysesthesia symptoms were used to modulate her significant underlying emotional distress. Thus somatization was extreme. Her symptoms also served to remove her from stressful psychosocial responsibilities and a life-long pattern of interpersonal conflict secondary to passive dependent personality traits and labile and frequently irritable mood. In actuality, the symptoms seemed to be serving the purpose of reducing the patient's overwhelming emotional distress by substituting a less threatening and stressful symptom, i.e. the occlusal dysesthesia. The other psychometric tests and clinical interview supported the MMPI-2 findings.




Several psychological recommendations were made by the health psychologist based on the psychological interview and testing results:

- Patients with similar profiles are severely prone to side effects to medications and are poor interventional candidates. Therefore, avoid interventional treatments, occlusal adjustments, etc, and carefully enter into any medication trial if indicated.
- The patient may benefit from a psychiatric evaluation for psychotropic medications to deal with their depression and labile mood. Specifically recommended was a selective serotonin reuptake inhibitor such as sertraline, citalopram or escitalopram or a dual action serotonin/norepinepherine reuptake inhibitor such as venlafaxine or duloxetine. The latter have proven more effective in pain management than the SSRIs, but the SSRIs have superb antiobsessional properties. The labile mood and bizarre focus may also respond to an antipsychotic such as aripiprazole or ziprasidone. This, however, should be considered a last resort and only after an adequate trial of the antidepressant fails to yield adequate results. Side effects will be the limiting factor with respect to medications, thus start low and go slow with the medications and prescribe them in a sequential rather than simultaneous manner. Finally it was suggested that benzodiazepines be avoided since these patients have a tendency to rapidly become dependent on them.
- The patient should be referred to a health psychologist and provided with cognitive-behavioral therapy to enhance coping resources, be taught cognitive restructuring, distraction and relaxation and stress management techniques. In addition, the focus of cognitive therapy should be to teach the patient emotional self-regulation, tolerance of phantom sensations and more adaptive interpersonal skills.
- Consider electromyographic biofeedback of masseter muscles in order to relax the jaw.
- Strict limits should be set with respect to the dentist's time with the patient, in answering phone calls, responding to letters or e-mails and discussing medications.
- No further dental treatment for the occlusal dysesthesia is recommended. If treating co-morbid pain or dental pathology is indicated, then this should be done slowly and with great care since they may worsen occlusal dysesthesia symptoms.

## Treatment/Results

The dentist and psychologist devised a comprehensive treatment plan to treat the musculoskeletal issues and somatoform disorder. On the first treatment visit, following completion of her psychological evaluation, she was given instructions for the N-position stretch and N-position rest exercises and told that this would become her focus. These stretches were to be done six times per day. In addition, she was told to do an extra set of stretches if she caught herself checking her bite at anytime during the day. The relationship between the tight muscles guiding the bite and stress were explained to her.

On the subsequent visit, the patient indicated there had been no change in her bite. On questioning her about this, she indicated she was doing the stretches, but that she would still occasionally check the bite to see if the treatment was working. She was asked to demonstrate the exercises and it was apparent that she was doing them incorrectly, and was not taking the time to stretch out the tight muscles. The patient was praised for doing the stretches, although incorrectly, and was reinstructed and encouraged to continue. In addition, she was instructed to go out in public, e.g. to the mall on a daily basis and/or do an aerobic walk for 10-15 minutes each day — always actively keeping the teeth apart and avoiding tooth-to-tooth contacts.

The patient underwent six one-hour cognitive-behavioral therapy sessions with the health psychologist using the protocol previously described. She was also provided with electromyographic biofeedback to relax her masseter muscles during these sessions. After three visits and ongoing work with the psychologist, the patient came to the clinic and when questioned, indicated her bite was starting to come back to normal. She was again instructed to continue the exercises and avoid checking the bite. She was given more encouragement, and it was apparent her mood and focus were beginning to change.

She was seen five times by the dentist over a two-month period, and was then discharged from active treatment. No psychotropic medications were prescribed. Her mood improved dramatically, as did her symptoms. She rated her occlusal dysesthesia as having a 95 percent improvement at a one year follow-up. She will go for a week without thinking to check her bite and she reported that what symptoms she does have do not cause distress.

**DENTISTS CONTINUE** to make the mistake of targeting the occlusion in an attempt to fix the bite when a patient presents with concomitant pain, TMD, and bite changes.

## Discussion

The authors have attempted to provide the reader with not only an overview of the diagnosis and treatment of occlusal dysesthesia, but also a feel for the nature and challenges these patients present with to the dental practitioner. **TABLE 5** lists red flags for the dentist alerting them that they have maybe a patient with occlusal dysesthesia.

As stated previously, the focus of treatment is not dental but behavior change since dental treatments have proven ineffective in occlusal dysesthesia and frequently result in iatrogenic complications. Nevertheless, dentists continue to make the mistake of targeting the occlusion in an attempt to fix the bite when a patient presents with concomitant pain, TMD, and bite changes. Indeed, the perfect bite probably does not exist.

Current treatment recommendations from the leading OFP programs around the country advocate not adjusting the bite unless there is a direct correlation between bite changes and very recent restorative dental work. Moreover, it is now widely accepted in the scientific community that TM disorders generally are not related to the bite or cuspal interferences but that disease or tender tight muscles affect or alter the bite.[22-25] The recommendation therefore is to work with the muscles to get them to relax prior to adjusting the bite, unless there is a direct correlation between the bite complaint and recent dental work. Furthermore, there are other conditions that can alter a bite, such as degenerative changes in the TMJ due to osteoarthritis or rheumatoid arthritis, acute inflammation of a TMJ and lateral pterygoid trismus. Rushing in to do an occlusal adjustment in these cases would not solve the primary etiology of the bite change, and would divert attention away from proper evaluation and treatment. When the dentist becomes focused on the bite this can further reinforce the patent's somatization and create more difficulty in treating the patient.

To date, there are no dental models of occlusal dysesthesia that have pointed to effective treatments. The authors propose a multidisciplinary biopsychosocial model that suggests the etiology resides in an obsessive misinterpretation of normal occlusal events as indicative of pathology as a result of somatoform disorder. The authors propose specific physical medicine and psychological strategies to effect behavior change and reduce occlusal dysesthesia complaints and somatization that maintains the occlusal dysesthesia experience.

TABLE 5

**Red Flags for Occlusal Dysesthesia**

| |
|---|
| **1.** Reporting severe bite/occlusal symptoms that do not make scientific, anatomical, or dental sense, and are seemingly overly disabling, |
| **2.** Showing significant obsessive somatic focus, |
| **3.** Emotional distress that is in excess of what might be expected, |
| **4.** Patients who bring in detailed histories of their problem and of prior treatment failures, |
| **5.** Patients who are angry at their prior dentists, and |
| **6.** Patients who are overly ingratiating toward you, your reputation, and their expectations of you. |

### *The Biopsychosocial Model of Occlusal Dysesthesia*

The bite is guided by the closing muscles of the jaw. Occlusal studies and anecdotal observations show that the bite shifts throughout the day, depending on a number of factors such as conscious or unconscious jaw posture and muscle tension. Stress can increase baseline electromyographic muscle activity, resulting in shortening of the muscle fibers. The heightened tightness in the closing muscles affects the way the teeth come together, causing slight premature contacts on one side or the other. These premature contacts tend to change and/or resolve throughout the day and go largely unattended to by the vast majority of people.

However, because of their somatoform disorder, patients with occlusal dysesthesia become alarmed at these changes especially if they occur in close association with recent dental work. This enhances the perceived threat and somatic focus. The alarmed focus can then cause short-ening of the closing muscles independent of the matching muscles on contralateral side of the jaw, with the result that the jaw shifts slightly and the bite is now perceived as off. When the patient checks the bite over and over, this behavior confirms and recharges the alarm mechanism and kindles the patient's somatic focus and health anxiety.

If the patient goes to a dentist to have the bite adjusted, the fact that the dentist listens to the patient and attempts to alleviate the problem can lead to a decrease in stress resulting in immediate relaxation of the muscles and normalization of the bite (TABLE 3). Thus the dentist is seen as a miracle worker and the patient leaves, satisfied the dentist has solved the problem. However, within a very short time the patient, out of an overlearned habit or for fear that something may have been missed, has to recheck the bite to confirm it is still normal. As this occurs, the muscles begin to tighten again, causing a slight shift in tooth contact. Anxiety and distress increase and the patient begins desperately checking to see if it is just their imagination but, again, the bite is off, requiring an immediate or subsequent visit to the dentist. Thus, the dentist who persists in focusing on the bite becomes part of the patient's problem, confirming their alarmed focus on the bite, re-priming the alarm reaction each time adjustments are made and reinforcing the patient's somatization and health anxiety.

The authors hypothesize that these patients are not responding to an abnormal event but to normal changes in their bite that occur in everyone throughout the day. Rather, as a result of a somatoform disorder, they are misinterpreting and amplifying normal sensations. They are obsessively focusing and somatizing on these normal changes in the bite, which enhances their health anxiety and illness conviction. This focus is driven by their cognitions (beliefs, opinions, and ideas about their sensations); attention to their bite (and lack of ability to distract themselves from focusing on their bite); the context which furnishes them clues to decide the meaning of, and significance of, their sensations, and finally, their mood. The anxious or depressed patient will exhibit heighten somatic focus and sensations, as well as exhibiting poor coping resources needed to tolerate their distress. As the authors have emphasized previously, the treatment of choice is behavioral change, not dental. The authors instead propose that the treatment for occlusal dysesthesia involves cognitive-behavioral therapy and physical medicine/stretching modalities targeting the facial muscles and relaxation, and not occlusal adjustments. Co-morbid physical and psychological symptoms may also need addressing.

Based on the authors' biopsychosocial model, the following specific treatment strategies for occlusal dysesthesia are proposed:

- Dentists attempting to treat occlusal dysesthesia using rational counter arguments will become entangled in protracted debates, which are doomed to failure. Do not try to convince the patient nothing is wrong with their bite, but rather present the model described previously.
- The treatment needs to be structured and time-limited to six to eight visits, with an emphasis on behavior change through self-management modalities. The patient needs to understand symptom reduction will occur only through their actions and efforts, and not those of the dentist or psychologist. This will involve physical medicine modalities targeting the musculoskeletal system and also cognitive-behavioral therapy and relaxation.

■ Obtain informed consent regarding each step of treatment.

■ The patient should be referred to a health psychologist for assessment of somatoform disorder. Cognitive-behavioral therapy and relaxation may need to be initiated before the physical medicine modalities. The psychologist will determine if the patient should be referred to a psychiatrist for psychopharmacological management to help manage co-morbid psychological problems such as depression and anxiety. It may be important to treat the co-morbid psychological disturbances first before embarking upon the physical medicine component.

■ The dentist should not attempt to treat the bite complaint with occlusal adjustments before working with the tight and/or painful muscles. If the patient has a night guard or splint, the dentist may check the bite but it is suggested that it not be adjusted unless it is obviously in need. Contacts should be even over the surface of the appliance. Once this is achieved, do not readjust. Remember, adjusting the bite feeds the somatization and shifts the patient's attention to their bite or splint.

■ The role of the dentist in this process is to help the patient detach the bite from the obsessive focus by helping them to alternatively focus on something that is beneficial for them, such as doing jaw stretching throughout the day and maintaining a jaw posture where the teeth are not touching. Their symptom thus becomes a cue to engage in adaptive coping behaviors.

■ The patient should be given a daily diary to remind them about the jaw stretching and jaw posture. The jaw stretching exercise is usually a simple jaw stretch with the tongue placed on the palate behind the maxillary incisors and stretching as wide as possible in this position while not allowing the tongue to come off of the palate. The tongue serves to limit the opening, avoiding the possibility of overstretching that an obsessive person might do. These should be done six times in a row, at least six times a day and held for six seconds each (termed 6 x 6 exercises).

■ The patient should maintain the jaw posture when not functionally using the jaw to eat or speak and to try to maintain a relaxed jaw position. The posture requires the tongue to be placed in the same position as used in the jaw stretch, but the teeth are kept apart and the lips are together (the N-rest position).


■ The patient is instructed to not check the bite or allow the teeth to come together. If they find they are checking the bite, they are to do an additional set of stretches and go back to the N-rest position. Another strategy involves having the patient snap a rubber band placed around one wrist when they find they are checking their bite. This provides negative feedback and a cue to affect the behavior change.

■ The patient should be given positive feedback for their attempts to comply with the recommendations and encouraged to persist if they fall back. However, don't get manipulated into adjusting the bite "just one more time."

■ The prognosis is poor for continued dental treatment, but is not poor for enhancing the patient's ability to cope effectively with their problem and improve their mood, functioning and quality of life. Thus, set strict limits but do not be judgmental with these patients. They are suffering and deserve a supportive and reinforcing environment to successfully affect their behavior change.

The bottom line message to the patient is that further occlusal adjustments or dental interventions will not yield favorable results and may, in fact, worsen their symptoms. They need to understand that only by taking control through the application of self-management physical medicine and cognitive-behavioral modalities will they be able to improve their symptoms and enhance the quality of their lives. Not all patients are going to respond to treatment, depending on the severity of their disorder and co-morbid physical and psychological conditions, but working with a health psychologist using cognitive-behavioral therapy can optimize the outcome. It is imperative for the dentist to partner with a health psychologist who has expertise with cognitive-behavioral therapy when deciding to treat a patient with occlusal dysesthesia. ■■■■

**REFERENCES**

**1.** Marbach JJ, Varoscak JR, et al, Phantom bite: Classification and treatment. *J Prosthet Dent* 49(4):556-9, 1983.

**2.** Marbach JJ, Lipton JA, et al, Facial pains and anxiety levels: considerations for treatment. *J Prosthet Dent* 40(4):434-7, 1978.

**3.** Jagger RG, Korszun A, Phantom bite revisited. *Br Dent J* 4;197(5):241-3, 2004.

**4.** Salkovskis P, Warwick H, Meaning, misinterpretations, and medicine: A cognitive-behavioral approach to understanding health anxiety and hypochondrisis. In: Starcevic V, Lipsitt D, editors. Hypochondriasis: modern prespectives on an ancient malady. Oxford Press, New York, pages 202-22, 2001.

**5.** Smith GR Jr., Monson RA, Ray DC, Psychiatric consultation in somatization disorder. A randomized controlled study. *N Engl J Med* 314(22):1407-13, 1986.

**6.** Katon W, Lin E, et al, Somatization: A spectrum of severity. *Am J Psychiatry* 148(1):34-40, 1991.

**7.** APA, Diagnostic and statistical manual of mental disorders, fourth ed., Washington DC: American Psychiatric Association, 1994.

**8.** De Jongh A, Clinical characteristics of somatization in dental practice. *Br Dent J* 195(3):151-4; discussion 45, 2003.
**9.** Davis PJ, Reeves JL II, et al, Depression determines illness conviction and pain impact: A structural equation modeling analysis. *Pain Med* 1(3):238-46, 2000.
**10.** Marbach JJ, Orofacial phantom pain: Theory and phenomenology. *J Am Dent Assoc* 127(2):221-9, 1996.
**11.** Klineberg I, Occlusion as the cause of undiagnosed pain. *Int Dent J* 38(1):19-27, 1988.
**12.** Klineberg I, Occlusion: Principles and Practice. New York: Oxford, Butterworth, Heineman, 1991.
**13.** Baba K, Aridome K, et al, Sensory perceptive and discriminative abilities of patients with occlusal dysesthesia. *Nihon Hotetsu Shika Gakkai Zasshi* 49(4):599-607, 2005.
**14.** Marbach JJ, Raphael KG, Phantom tooth pain: A new look at an old dilemma. *Pain Med* 1(1):68-77, 2001.
**15.** Allen LA, Woolfolk RL, et al, Cognitive-behavioral therapy for somatization disorder: A randomized controlled trial. *Arch Intern Med* 166(14):1512-8, 2006.
**16.** Warwick H, Salkovskis P, Cognitive-behavioral treatment of hypochondriasis. In: Starcevic V, Lipsitt D, editors. Hypochodriasis: Modern prespectives on an ancient malady. Oxford Press, New York, pages 314-28, 2001.
**17.** Woolfolk R, Allen L, Treating somatization disorder: A cognitive-behavioral approach. Guildford Press, New York, 2006.
**18.** Kroenke K, Swindle R, Cognitive-behavioral therapy for somatization and symptom syndromes: A critical review of controlled clinical trials. *Psychother Psychosom* 69(4):205-15, 2000.
**19.** Barsky AJ, Palpitations, arrhythmias, and awareness of cardiac activity. *Ann Intern Med* 134(9 Pt 2):832-7, 2001.
**20.** Barsky AJ, Amplification, somatization, and the somatoform disorders. *Psychosomatics* 33(1):28-34, 1992.
**21.** Barsky A, Somatosensory amplification and hypochodriasis. In: Starcevic V, Lipsitt D, editors. Hypondriasis: Modern Prespectives on an ancient malady. Oxford Press, New York, pages 223-48, 2001.
**22.** Droukas B, Lindee C, Carlsson GE, Relationship between occlusal factors and signs and symptoms of mandibular dysfunction. A clinical study of 48 dental students. *Acta Odontol Scand* 42(5):277-83, 1984.
**23.** Pullinger AG, Seligman DA, Gornbein JA, A multiple logistic regression analysis of the risk and relative odds of temporomandibular disorders as a function of common occlusal features. *J Dent Res* 72(6):968-79, 1993.
**24.** Stohler CS, Muscle-related temporomandibular disorders. *J Orofac Pain* 13(4):273-84, 1999.
**25.** Clark G, Simmons M, Occlusal dysesthesia and temporomandibular disorders: is there a link? *Alpha Omegan* 96(2):33-9, 2003.

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# Evaluating Psychosocial Function in Elderly Dental Patients

MELANIE W. GIRONDA, PHD, MSW

**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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More 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.[1] 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.[2] 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.[3]

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.[4] 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.[5] 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 form of anxiety is Generalized Anxiety Disorder, manifesting as constant worry about everyday problems for at least six months.[6] 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.[6] Although anxiety is the most common form of mental illness among older adults, it is often undetected and untreated.[5]

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One reason so many older adults suffer in silence is the perceived shame and embarrassment associated with mental illness in general.[7,8] 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.[9] 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.[10] 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, depressions is a chronic condition they have dealt with throughout their lives. For others, depression is a new experience brought on by medical illness, stress-

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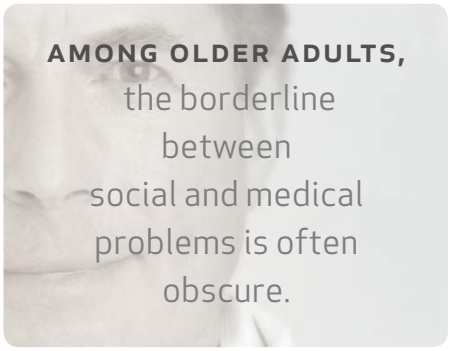
ful events, and/or multiple losses.

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.[6] Both psychotherapy and pharmacology have proven to be effective treatments. For more detail regarding mood disorders, the reader is referred to the Diagnostics and Statistical Manual of Mental Disorders, DSM-IVR, 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.[11] For a detailed description of the various instruments used in assessing cognitive function, mood and behavior, Ashla discussed and compared commonly used measures.[11] 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.[12] 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.[13] 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?[12] 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.[8,14-17] 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.[14,15] 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.[11-13] 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.[9,18,19] 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?[20]

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.

**DENTAL** professionals are in a key position to identify elder abuse and neglect.

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.[21] 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.[21] 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.[22-24] 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?[24]

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.

## A Case Vignette

Bob Smith, a retired federal employee, and his wife of more that 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 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 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."

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

## 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 sensitive 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.[9]

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. ■■■■

**REFERENCES**

**1.** Niessen LC, Gibson G, Aging and oral health for the 21st century. *Gen Dent* 48(5):544-9, 2000.

**2.** Kiyak HA, Reichmuth M, Barriers to and enablers of older adults' use of dental services. *J Dent Educ* 69(9):975-86, 2005.

**3.** California Health Interview survey, 2001 www.chis.ucla.edu. (Accessed Jan. 22, 2007.)

**4.** Pyle MA, Stoller EP, Oral health disparities among the elderly: Interdisciplinary challenges for the future. *J Dent Educ* 67(12):1327-36, 2003.
**5.** Alwahhabi F, Anxiety symptoms and generalized anxiety disorder in the elderly: A review. *Harv Rev Psychiatry* 11(4):180-93, 2003.
**6.** American Psychiatric Association, Diagnostic and statistical manual of mental disorders. American Psychological Association, fourth ed., Washington, D.C., 1994.
**7.** Hooyman NR, Kiyak HA, Social gerontology: A multidisciplinary perspective. Allyn and Bacon, sixth ed., Boston, Mass., 2002.
**8.** De Jongh A, Adair P, Evaluating psychosocial functioning in dental patients. *Refuat Hapeh Vehashinayim* 21(3):6-14, July 2004.
**9.** Van Etten D, Psychotherapy with older adults: Benefits and barriers. *J Psychosoc Nurs Ment Health Serv* 44(11):28-33, November 2006.
**10.** Lichtenberg PA, Ross T, et al, The relationship between depression and cognition in older adults: A cross-validation study. *J Gerontology B Psychol Soc Sci* 50(1):P25-32, January 1995.
**11.** Ashla MM, Cognitive function, mood, and behavior assessments, in Osterweil D, Brummel-Smith K, Beck JC, (eds.), Comprehensive Geriatric Assessment, McGraw-Hill, New York, NY, 2002.
**12.** Enoch M, Goldman D, Problem drinking and alcoholism: Diagnosis and treatment. *Am Fam Physician* 65(3):441-8, 2002.
**13.** National Institute on Alcohol Abuse and Alcoholism, alcohol and the elderly. Alcohol alert No. 16, PH 315, April 1992.
**14.** Berkman LF, Glass T, Social integration, social networks, social support and health, in LF Berkman LF, Kawachi I (eds.), Social Epidemiology, Oxford Press, New York, pages 137-73, 2000.
**15.** House JS, Social isolation kills, but how and why? *Psychosom Med* 63(2):273-4, March-April 2001.
**16.** Lubben JE, Gironda MW, Centrality of social ties to the health and well-being of older adults, in Berkman B, Harooytan LK (eds.), Social Work and Health Care in an Aging World, Springer Press, New York, NY, pages 319-50, 2003.
**17.** Gironda MW, Lubben JE, Atchison KA, Social support networks of elders without children, *J Gerontological Social Work* 27:63-84, 1999.
**18.** Gironda MW, Lubben JE, Preventing loneliness and isolation in older persons, in Gullotoa T, Bloom M (eds.) Encyclopedia of Primary Prevention and Health Promotion, Kluwer Academic/Plenum Publishers, New York, 2002.
**19.** Lubben JE, Gironda MW, Social support networks, in Osterweil D, Brummel-Smith K, Beck JC (eds.), McGraw-Hill, Comprehensive Geriatric Assessment, New York, NY, 2000.
**20.** Lubben JE, Blozik E, et al, Performance of an abbreviated version of the Lubben social network scale among three European community-dwelling older adult populations, *Gerontologist* 46(4):503-13, August 2006.
**21.** Tilden VP, Schmidt TA, et al, Factors that influence clinicians' assessment and management of family violence. *Am J Public Health* 84(4):628-33, April 1994.
**22.** Glassman PD, Chavez, EM, Hawks D, Abuse and neglect of elderly individuals: Guidelines for oral health professionals, *J Calif Dent Assoc* 32(4):323-335, April 2004.
**23.** Garvin J, Elder Abuse How to Spot It, *AGD Impact* 33(6), April 2005.
**24.** Herren MC, Bryon, RJ Jr., Elder abuse update, *Gen Dent* 53(3):217-9, May-June 2005.

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# Tea and (Not Much) Sympathy

She tapped my belt buckle knowingly with a bony forefinger. "Are you taking your flaxseed regularly?"

Robert E. Horseman, DDS

ILLUSTRATION BY CHARLIE O. HAYWARD

Elizabeth and Agnes; you gotta love 'em! These octogenarian patients of mine have much in common. They are both flyweights whose combined weights fall more than 50 pounds short of my own. In specialty shops they would be petites, but in my eyes they are just plain wiry. The two are widows generously favored with that fierce independence and generosity of spirit some women are able to project even if being the beneficiary of a six-figure insurance policy wasn't their lot.

Elizabeth and Agnes don't know each other, have never met, but they should, although I would never give them appointments back-to-back. They share a fervent appreciation and special knowledge of nutrition with a subspecialty of health foods like those found only in shops catering to the anti- fat-grease-sugar-carbo crowd.

Like many healthy people, the ladies feel perfectly at ease offering me unsolicited advice. "Been hitting the bean dip a little heavy, eh, Doctor?" Agnes offered during a recent appointment. She tapped my belt buckle knowingly with a bony forefinger. "Are you taking your flaxseed regularly?"

"Flaxseed?"

"Of course! Flaxseed regularly for regularity if you get my drift," she explained. "Colon cancer, hemorrhagic fever, eyelid ptosis and Achilles heel among other things. Where've you been?"

"I use Metamucil, the orange-flavored, No. 1 doctor-recommended 100 percent psyllium fiber choice of my peer group," I declared, my seamed cheeks glowing like pippins.

"Wrong!" Agnes bleated. "Flaxseed is where it's at. Write that down!" I did.

Not long afterward, Elizabeth was in.

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**DR. BOB,** CONTINUED FROM 230

"What's wrong with your eyes," she questioned, peering at me closely.

"Nothing," I answered, "I just wear these glasses to see with."

"Well, you have the rheumy, bloodshot eyes of an 86-year-old man," she stated with lofty disregard for my humorous retort.

"I am an 86-year-old man," I whimpered, trying to summon my lifelong gift of retaining my aplomb under stress.

"Then get yourself some grape seed, Doctor, and use it. I declare, I don't know how you ever got through dental school!"

I don't either, but that's beside the point. I decided to get a second opinion and called Agnes.

"Of course get yourself the grape seed. It's good for regional fatigue," she confirmed.

"You mean retinal fatigue?"

"Whatever. Be sure you're drinking four 8-ounce cups of green tea a day while you're at it."

"I drink iced tea with lemon and a packet of some petroleum-based sweetener,"

"Oh, my God!" she brayed. "I don't know how you ever got through dental school! Let me tell you about green tea."

Forty-five minutes later when she dismissed me, her lips parched with rhetoric, I knew more about green tea than I ever wanted to know. According to my source, it is the universal cure-all for every affliction known to mankind. I did not know that.

The proprietor of the health food store knew he had a live one when I hurried in anxious to sever my ties with coffee and Diet Pepsi.

His eyes grew pensive. "There are 761 kinds of green tea, Ace. You wanna be a little more specific?" He awaited my answer much as a barista in Starbucks would when asked for a "cup of coffee."

"No, no," I pleaded, knuckling my forelock in obsiescense. "Just give me a box of each and I'll be on my way."

Doctored up with a generous squirt of Hershey's chocolate syrup and an ounce or two of half-and-half, they are palatable if not actually a substitute for tap water.

Today I have had my 14th cup of green tea. How the green tea craze assumed cult proportions remains a mystery. Most of them tasted like distilled alfalfa. A few of the other offerings seemed to be an amalgamation of bean sprouts and something called maté rooiboost, a substance much favored by certain species of birds in the Guayaki rainforest of Paraguay. Doctored up with a generous squirt of Hershey's chocolate syrup and an ounce or two of half-and-half, they are palatable if not actually a substitute for tap water.

As one prone to wintry reflections and disappointment with anything not instantly effective, I believe 14 cups of this miracle libation should have produced something epochal by now. My mirror says no. I'll consult with Elizabeth and Agnes again and get back to you. ■■■■