

Perspectives from a Dental School-Based Fear Clinic*

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Millions of adults and children now receive dental care from general practitioners and specialists in their communities and most are at least slightly anxious about aspects of the experience. Prevention is the key to avoid creating a large number of highly fearful individuals among them. Aversive painful experiences contribute heavily to the development of fears.¹ Negative interpersonal experiences with dental personnel, belittlement of poor oral hygiene, and fear-related behaviors are at the root of much avoidance behavior.² Thus, prevention of the iatrogenic fear of treatment is the primary mission of the community dentist. The skills needed for optimal preventive care are readily learned by the caring practitioner and are consistent with the need to build and maintain a viable practice. Nonetheless, most practitioners do not have these skills.³ Furthermore, only a few community practitioners will have the energy, skills, and interest to treat those individuals with a well developed phobia.^{3,4}

There are 20 to 40 million individuals in this country who fail to utilize the dentist at all or who are, at best, symptomatic users because of anxiety and fear. These individuals are best served by highly visible specialized facilities combining the talents of the various dental specialties, psychology, and psychopharmacology. Moreover, it is within these sophisticated facilities that clinically relevant and appropriate research should be carried out. As such, the centers become not only the source of new knowledge but also advanced training. I assert in this paper that community practitioners be responsible for the prevention and treatment of simple fears while specialized centers should be the focus for the care, research, and training of individuals with well developed phobias and anxiety.

Development of Access to Care

The most compelling reason for establishing specialized clinics for the care of dental phobics throughout the country is that phobics avoid contact with

dentists, even when they acknowledge the potential benefit of pain relief and improvement in esthetics and function.⁵ Thus extraordinary efforts are required, usually through the media, to let individuals know of the existence of an appropriate facility. Our efforts attract two to four patients each week, and we know from them that they feel they have nowhere else to go. Furthermore, except for the recent but preliminary work of Gatchel and colleagues,⁶ little is known about how to attract the phobic.

Specialized clinics should be involved in this research as a public service. Moreover, a major argument for investment in this research is the need to develop large enough representative populations for useful clinical investigation. This problem is amply demonstrated by discussions with investigators about attracting truly fearful individuals, and by the failure of many experiments and descriptive studies in the literature to include meaningful clinical populations. This is equally true for behavioral and drug studies. The establishment of specialized facilities will also lead to referrals from medical professionals who often see these individuals for the symptoms of their anxiety. I urge that multicenter collaborative trials be developed to experiment with methods to attract fearful individuals. Such research has utility far beyond dentistry as epidemiologic studies show most phobics go without needed medical treatment.⁷

Access to care will be enhanced by facilities able to provide behavioral, pharmacological, and combined behavioral-pharmacologic therapies for clearly delineated patient syndromes.⁸ Existing sites will, in most cases, have to develop a broader clinical research mission and their staff and facilities may be at present inadequate. Nonetheless, research, rather than simply service, needs to form the foundation of such efforts.

Research on Diagnosis and Treatment

Greater efficiency and productivity can be gained by developing a mechanism by which fear research clinics can collaborate. Approaches that have worked well in other research areas are multicenter cooperative trials⁹ and disease registries.¹⁰ Multicenter research increases productivity by increasing the available pool of subjects as well as contributing to the generalizability of results. Cooperative trials are employed with diseases that are rare, such as specific forms of cancer, or where subjects are hard to obtain, such as with transplants. Although the

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health problem is different and not rare, subjects for phobia research appear to fall in the latter category as they are hard to obtain.

Before coordinated research can occur there needs to be agreement on the diagnostic and outcome measures used. A review of existing intervention studies shows no such agreement exists at present and is a major drawback to the usefulness of existing research.¹¹ A computer-accessible national register of fear cases may be a way to achieve this coordination. By this I do not mean a registry in the formal epidemiologic sense, that is, a complete listing of all incident cases in the United States, as such a listing is clearly infeasible. Rather, I mean a data bank which could be accessed and data entered from distant sites via remote terminals and telephone lines. The technology for this data entry, including transmission of physiologic data, is well established in medicine and its cost today is reasonable. Accredited clinics, using identical measures, could list their cases in the data bank. This would provide means for researchers to work together on trials and might increase the efficiency of some research by providing historical controls.

Nonetheless, there are major threats to the reliability and validity of registries. In a formal epidemiologic data bank completeness (i.e., capturing all cases) and the quality of data are the problem. In order to attempt to overcome these threats, a multisite working group will have to be established. This should include a broad group of research clinicians with subgroups, if necessary, on instrumentation and other topics. Support will need to be developed for the activities of this working group and for the development of a central data banking unit. Such support should not come at the expense of the individual investigator-developed project: this area is a major dental public health problem worthy of attention and expenditures. Furthermore, the support need not come from the government, alone as a multisite approach could be a powerful tool for working with the pharmaceutical industry as well.

Once common measures are implemented, multicenter trials will follow. Open trials, where a therapy is carefully evaluated with pre- and postmeasures, are a logical first step from the analog and preclinical studies of the past. Single subject designs need to be explored. They overcome the not inconsiderable problem of assigning clinical subjects to placebo and less effective strategies often called for by traditional control group designs. They allow development of larger research patient populations because the clinician researcher is not put in the ethical bind of having to treat some patients suboptimally. Thus more patients will be enrolled with fewer refusals or incomplete cases caused by clinicians pulling subjects off of protocols because they are ineffective. The multisite nature of the research will contribute to its validity even without controls.

Following from this approach will be the formal control group studies which are needed. Single subject studies using cross-over and repeated measures designs may be appropriate. Most important here are studies that compare effective treatments, both behavioral and pharmacological, and aim to discover the essential components of effective therapy. However, they are much more likely to be clinically relevant, and the results more meaningful, if developed collaboratively. Long-term follow-up should be an important component of these efforts.⁸

Training and Prevention

Corah and colleagues³ found that dentists surveyed are aware of and consider patient anxiety important. Nonetheless, they reported "trial and error" as the major mechanism by which the practitioners they studied acquired their patient management skills. They also found many of the dentists surveyed were uncomfortable with fearful persons and unwilling to inquire in detail about their fears. As they point out, many of these patients are "selected out" of these practices as they are rarely compliant, dentally sophisticated or interpersonally responsive. More likely, they are chronically late for appointments, cancel at the last moment, or don't show. Clinical research sites can be a resource to practitioners who seek the training required to care for these individuals, and it is highly desirable from a public health point of view that such training be provided. This can take the form of traditional continuing dental education, or better yet, clinical training can be offered. Clinical training in the care of the disabled is offered by our institution and others under state and federal grants. Evidence suggests that practitioners who are clinically competent and secure in the care of the disabled will develop more favorable attitudes toward special populations.¹² Perhaps similar mechanisms to support training in the area of phobias and anxiety can be developed.

The importance of an adequate diagnostic work-up has already been stressed as an essential foundation for effective management of the patient with anxiety. The patient must feel that the clinician has gathered adequate information and understanding of the problem before any reassurance or counseling or drug can be maximally effective. A general practitioner needs to be aware of his or her own feelings toward phobics, and be able to establish a relationship with the anxious patient that will facilitate an interview and data collection. In this way, the practitioner can recognize and counsel patients about unifocal fears, and at the same time, detect and refer problems which are beyond his or her level of expertise. The general dentist in the community should serve as an advocate. In the care of simple phobic, the dentist needs to provide care using primarily behavioral techniques. The use of psychoactive medications as adjuncts should be used with consultation.¹³

We need to support training designed to teach clinical dental techniques to manage patients without iatrogenic problems. One major element of this is early exposure to caries preventive modalities that limit the young child's exposure to painful treatment.¹⁴ A second element is to end the teaching of aversive child management strategies. The efforts in the last decade to teach communication skills are laudatory. It would be interesting to know if the patients who report poor interactions with dentists have seen dentists who have had this training. However, I believe this training should be encouraged and incorporated in new courses dealing directly with prevention of fear in adults and children. These courses will need a clinical component to be successful. At the University of Washington all students are videotaped providing treatment to a child patient and receive considerable feedback. Simulation and use of remote broadcasting equipment to provide cues and feedback to students during treatment has also been accomplished.¹⁵

At the operative level, a major shake-up needs to occur in the teaching of pain control methods. In our own research we have found that one-fifth to one-quarter of dental patients report being hurt during drilling.¹⁶ In the absence of some form of patient-perceived control, inadequate anesthesia results in unnecessary patient fears and avoidance.^{17,18} However, regardless of the mechanism of phobic development, our knowledge of the relationship between pain and anxiety should cause us to focus our educational efforts in this area. Too much of the teaching of pain control is done today by specialists who often rely on adjunctive medications and less often establish a long-term relationship with the patients. Few behavioral strategies are incorporated in this pain control instruction and the practice in the use of these regimens is almost unsupervised and nearly always unevaluated.¹⁹

In our own institution we now require senior dental students complete a course in the management of fearful patients. In this course, the students are made aware of the extent of the problem and strategies to prevent iatrogenic outcomes. Furthermore, through observing the case conferences where treatment plans are evolved they see the interaction of psychologists and dentists in solving clinical problems. Through our research clinic they become aware not only of the complexity of the psychological and dental problems but also of the availability of a referral resource in their community. Through our continuing dental education program we are able to teach these skills to established practitioners and they become the backbone of a network or practitioners to whom we can refer patients who are successfully treated.

Conclusion

Enhancing access to optimal care involves two quite different tasks. For those whose fears prevent

attendance at all, or who are primarily symptomatic users, specialized care facilities are needed. These facilities should be the focus for research, clinical care, and training. For the patients who now seek care in the community, many practitioners will need to be taught to prevent or minimize the development of fears and their sequelae. Carrying out these steps will be a major contribution to public health.

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