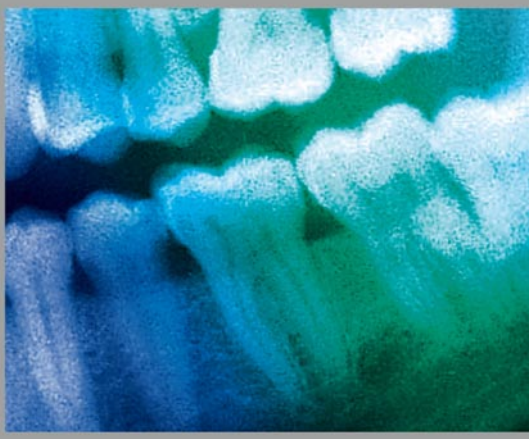
CHURCHILL'S
POCKETBOOKS

Clinical Dentistry

IVOR G. CHESTNUTT
JOHN GIBSON

THIRD
EDITION



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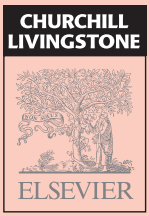

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PREFACE TO THE THIRD EDITION

Nothing cheers an author more than to see his or her own textbook being used by the target audience! So it has been delightful to see more and more undergraduate dental students, vocational dental practitioners, general professional trainees, dental surgeons in primary care and in the hospital service, as well as dental care professionals in-training and post-qualification using this readily accessible little book.

The staff at Elsevier have been delighted at the success of the Second Edition at home and overseas, making the Pocketbook their best selling dental book! It was inevitable, therefore, that a Third Edition would be requested. We thank Michael Parkinson and Janice Urquhart for their support and advice throughout this project.

For this Third Edition we have, once again, expanded the size and quality of authorship. We welcome to the team Professor Jeremy Rees and Mr. John Cameron, both bringing additional expertise in the areas of restorative dentistry and dento-legal practice respectively.

In updating this edition, each author has addressed significant change within his or her areas of expertise and we are grateful to them for their enthusiasm and great industry. As with the Second Edition, we believe that this new edition has been invigorated and enhanced. Our aims and objectives remain the same – to educate and inspire each member of the dental team, whether in-training or post-qualification.

2006

Happy reading!
I. G.C. Cardiff
J. G. Edinburgh

PREFACE TO THE FIRST EDITION

The primary objective of this pocketbook is to provide a readily accessible source of information when it is most needed, as an aide-memoire prior to carrying out clinical tasks or to enable students (at undergraduate and postgraduate level) to apprise themselves of important details prior to tutorials and seminars.

The authors of this text are experienced clinicians and teachers within their individual specialties and emphasis has been given to information of practical clinical significance. Descriptions of rarely encountered conditions and situations have been kept deliberately to a minimum.

In a publication of this nature, information must be presented in a concise and at times didactic fashion. For those who read this text and feel it could only result in superficial learning, we have deliberately included sufficient basic information to permit examinations to be passed. However, the desire of an educationalist is always to promote deep learning and the layout and content of the text are intended to motivate and guide the reader to the appropriate parts of more substantive texts, many of which have proven both inspirational and motivational for the editors and contributors of this book throughout their careers.

Glasgow 1998

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J.G.

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CHAPTER 1

PSYCHOLOGICAL ASPECTS OF DENTAL CARE

INTRODUCTION

Above all else, the practice of dentistry involves working with people. Whilst a high degree of technical skill and judgement is required, an understanding of how social and psychological factors impact on oral health is crucial.

Dental disease and the provision of dental treatment are influenced heavily by patients' beliefs, attitudes and values. The aetiology of many dental diseases (e.g. dental caries, periodontal disease and mouth cancer) is influenced greatly by behavioural and lifestyle factors. Furthermore, changes in oral and systemic physiology, induced by psychological states, play an important role in conditions such as functional disorders of the masticatory system and chronic orofacial pain.

An appreciation of psychological factors enables the practitioner to:

- communicate more effectively
- understand causes of anxiety
- understand the nature of pain
- motivate patients and influence behaviour change.

This chapter will discuss the influence of psychological factors on dental care.

SOCIAL AND PSYCHOLOGICAL INFLUENCES ON DENTAL CARE

Oral health is a standard of health of the oral and related tissues which enables an individual to eat, speak and socialize without active disease, discomfort or embarrassment and which contributes to general well-being.

Dentists' perceptions of oral disease differ markedly from that of many of their patients, for whom oral health may be a low priority. Not everyone who has disease will seek professional care, nor does the presence of disease imply an absolute need for treatment. Whilst a high proportion of people in the general population would benefit from dental treatment (as judged by clinical criteria), the frequency with which patients choose to visit the dentist varies. Some choose not attend on a regular basis, but seek treatment only when in trouble. Thus, there is a difference between the *need* for dental treatment and the *demand* for it.

Although the general public's perception of dentistry has improved in recent times, some still view a visit to the dentist as a

negative experience, and the decision to attend will be influenced by many factors.

These include:

- value placed on oral health by patient
- perceived ability to influence the maintenance of oral health or outcome of disease
- worsening of symptoms – patients may accept intermittent pain and seek care only when pain becomes constant or intolerable
- perceived seriousness of a disease – may encourage or discourage attendance. Some patients will deny the existence of a disease if it is thought to be very serious (e.g. cancer)
- access to dental care – influenced not only by geographic location of the dentist but also by factors such as availability of public transport
- disruption of daily life – attendance may involve having to take time off work, arrange a childminder, etc.
- financial implications – cost may be a barrier, even to those who can afford to pay
- advice from family and friends – can have positive or negative influences.

In the past, an emphasis on restorative care has forced dental decay, restorations and tooth loss to be viewed by some patients as an inevitable consequence of ageing.

In common with health in general, oral health is influenced markedly by social class and is related to income, education, living and working conditions.

COMMUNICATION

The ability to communicate effectively is an essential skill and is necessary when:

- eliciting a history from a patient
- explaining proposed treatment and the merits of available options
- managing anxious patients – reducing anxiety requires skilled communication
- encouraging behaviour change.

Successful dental practice requires the development of a relationship between dentist and patient. Patients frequently place

as much emphasis on the dentist's personality and clinical manner as on their technical skill; *how* something is said can therefore be as important as *what* is said. The use of good communication skills will greatly enhance patient satisfaction and compliance with advice. As the professional partner in the relationship, the responsibility for good communication lies with the dentist.

Factors inhibiting good communication include:

- difference in social class between dentist and patient
- priorities of the clinician may differ markedly from those of the patient
- supine dentistry places the patient in a passive (and often threatened) position
- technical language is not understood by patients
- 'lay theories of disease' (e.g. 'soft teeth' lead to caries) – patients may have their own concept of a particular problem and be reluctant to accept the correct scientific explanation
- time pressures may lead to information being presented too quickly for the patient to understand
- anxiety hinders ability to absorb information.

NON-VERBAL COMMUNICATION

Non-verbal communication is also very important in the context of providing dental care. This applies not only to the environs of the dental surgery and the postures, gestures and expressions of the clinician but also to the patient's reaction. Much information can be gained from observation of the patient and may give an indication of a patient's true feelings.

COMMUNICATION WITHIN THE DENTAL TEAM

Good communication skills are important, not only in dealing with patients but also in managing the dental team. As leader, it is the dentist's responsibility to communicate effectively with members of the practice staff – dental nurse, hygienist, therapist, receptionist and technician. Effective transfer of information is essential to the efficient operation of any organization.

BEHAVIOUR CHANGE

Prevention of the major dental diseases is possible if patients can be persuaded to adopt appropriate changes in behaviour and

lifestyle. However, persuading and enabling patients to adopt and maintain healthy behaviour is a complex process.

Before behaviour can be changed, patients must:

- want to change
- believe they *can* change
- believe change will have the desired effect
- possess or be provided with the knowledge and skills to permit change.

THE PROCESS OF BEHAVIOUR CHANGE

It is recognized that changing behaviour is a complex process, involving different stages. The most commonly used model to explain behaviour change is the so-called 'stages of change model' which describes four stages: precontemplation, contemplation, action and maintenance.[1] This theory of behaviour change is explained below and discussed further in the context of helping patients give up smoking in Chapter 8 (Figure 8.3).

The stages of change model

Precontemplation

In this stage patients are not thinking about behaviour change.

Contemplating change

To promote behaviour change, patients must be made aware of alternatives to their present behaviour because, without information, patients will be unable to contemplate change. However, simply providing information (e.g. 'brush your teeth twice daily') is frequently insufficient to induce patients to adopt this habit.

In providing information it is necessary to:

- establish a current knowledge base (e.g. has the patient ever been shown previously how to brush?)
- establish the patient's current practice (e.g. how frequently do they brush at present?)
- provide an explanation of why behaviour change is necessary and desirable.

Written information (e.g. in the form of a leaflet) may be helpful but it should be personalized to the patient and appropriate to reading ability, level of understanding, account for linguistic and cultural factors. Be aware of the relatively high prevalence of illiteracy in the general population.

Information overload should be avoided. Changes should be introduced gradually. Having made choices explicit, it is often better if the patient then actively chooses to translate knowledge into action.

Taking action

An important step in encouraging behaviour change involves setting *goals*. This provides both patient and clinician with markers to gauge success. Differences in emphasis between dentist and patient should be borne in mind when setting goals – e.g. the dentist may be more concerned with aetiological factors of disease whereas patients may be more concerned about factors such as fresh breath or an attractive smile.

Targets for behaviour change should be:

Achievable Setting targets outwith the patient's ability will lead to failure and disillusionment.

Realistic If patients are to change behaviour, they must believe the actions required will have a positive benefit for them.

Important to the patient Identify and emphasize factors perceived as important to the patient, e.g. aesthetics.

Measurable Enables progress to be determined. Success will act as positive reinforcement.

Positive Targets should be positive – e.g. if encouraging avoidance of between-meal sugar consumption, occasions when snacks were avoided should be recorded rather than those occasions when snacks were taken.

Time related Enables progress to be measured.

Specific Avoid non-specific advice such as 'brush your teeth better'.

Health locus of control

The likelihood of an individual patient adapting to a preventive behaviour is influenced by many factors. An important concept is the patient's *perception* of factors influencing health outcomes. This is known as the health locus of control (HLOC), and three components have been described:

Internal HLOC The belief that by taking certain actions, health outcomes can be influenced. Therefore patients with a high internal HLOC will, for example, believe that regular toothbrushing with a fluoride toothpaste will prevent dental caries.

Powerful others HLOC The belief that, whilst health outcomes can be influenced, control lies with powerful others such as dentists. Such patients may therefore view regular dental attendance as important, but be less inclined to believe that health outcomes can be influenced by their own actions.

Chance HLOC The belief that health outcomes are largely a matter of chance or fate and that little can be done to influence the inevitable.

It should be noted that HLOC is a belief system and describes what patients actually believe rather than what they do.

Another important factor influencing patients' attitude to behaviour change is their perception of the future. Some patients are more willing to make sacrifices now in return for future benefits. The consequences of dental disease are long term and in the future. The rewards of sugar consumption are immediate! Furthermore, patients frequently do not experience the consequences of poor behaviours until it is too late.

MAINTAINING CHANGE

Maintenance of behaviour change is difficult. The clinician's role is ongoing. Reinforcement and encouragement is required to prevent relapse. Rewards (e.g. provision of sticky badges to children on successful completion of a toothbrushing programme) can be useful in promoting change. However, in the longer term the ultimate aim is to integrate positive behaviour into patients' everyday lifestyles to the point where they become habitual.

RELAPSE

Failure to encourage patients to change their behaviour can be frustrating and it is tempting to ascribe a patient's failure to comply with instructions as lack of motivation. It should be remembered that members of the dental team see their patients for a very brief period of time and are often faced with changing the habits of a lifetime. Behaviour change is cyclical in nature with patients frequently experiencing relapses and setbacks before achieving their goal (Figure 8.3).

Change – bearing in mind the principles outlined in this section – requires realistic goals, positive incentives, long-term follow-up, support and encouragement.

ANXIETY

Most patients are likely to be anxious to a greater or lesser extent at the prospect of dental treatment. This can vary from mild apprehension to anxiety sufficient to prevent the patient seeking care.

Anxiety may relate to the prospect of dental treatment in general or may be more specific and relate to fear of an individual object (e.g. needle) or procedure such as tooth extraction.

There are many possible causes of anxiety. Principal factors include:

Fear of pain Anxiety may affect pain threshold.

Uncertainty Fear of the unknown; anxious patients are pessimistic and 'expect the worst'.

Previous experience Many anxious patients ascribe their anxiety to previous 'bad experiences'. These frequently relate to the personal characteristics of a dentist. Parents can pass on their own anxiety to children.

Preparedness Some patients are 'innately' anxious. This is related to personality and such individuals are anxious in all sorts of situations, particularly those they have not previously encountered.

MEASURING ANXIETY

Questionnaires are available which can be used to measure anxiety. The patient is asked a series of questions related to potential threatening situations. Answers are scored according to severity and can be used to quantify anxiety. One of the best known is the *Dental Anxiety Scale*.

REDUCING ANXIETY

The ability to cope with anxious patients and to help alleviate anxiety is crucial in the practice of dentistry. Behaviour management techniques for use in dealing with anxious patients are discussed on page 170. The emphasis should be on helping patients acquire the skills necessary to cope with dental treatment.

Other factors which may help alleviate anxiety include:

- friendly and understanding attitude of the dental team
- welcoming environment – sights and smells are frequently cited as causes of anxiety
- communication during treatment – warn patients before reclining chair, blowing air from 3-in-1 syringe, etc. Explain the sensations that the patient is likely to experience
- decrease vulnerability – anxious patients feel vulnerable when supine. Instructions such as 'raise your hand if you want me to stop' help patients feel they have some control