Advance care planning

The importance of acknowledgement of emotions in routine patient psychological assessment: The example of the dental setting

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\textbf{A R T I C L E I N F O}

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\textbf{A B S T R A C T}

\textbf{Objective}: To investigate, by means of a conceptual model, the effect of dental staff engaging with their patients who share their level of dental anxiety in a short screening questionnaire. Methods: Three consecutive studies based in the UK primary dental care services were conducted. Each study adopted a randomised group design to focus on the possible influence on patient state anxiety of the dentist becoming aware of their patients’ dental anxiety from the self-reports of the Modified Dental Anxiety Scale (MDAS). Results: A consistent finding in the first two studies was that the presentation of MDAS score sheet to the dentist was effective in reducing patient state anxiety when leaving the surgery. The third study provided supportive evidence that a more permanent anxiolytic effect of the presentation of the MDAS to the dentist was associated with the dentist responding openly to their patient about the fears expressed. Conclusion: The active engagement of dental staff in the formal presentation of dental anxiety screening confers a reliable benefit to dentally anxious patients. Clinical implications: Anxiety assessments in clinical service may give patients significant relief when staff acknowledge and engage patients when presented with their self-reported ratings.

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1. Background

Communication within dentistry has always been considered essential [12]. The majority of dental schools internationally require students to be trained and assessed in their interaction with their patients. The intention is to provide patients with dental treatment and care with comparative ease. This extends, to the provision of health education, advice on oral hygiene, diet and use of fluoride [3]. An area that is very demanding, as it requires frequent use of extensive communication techniques, is the dentally anxious patient [4,5]. Just over 10% of the population are extremely dentally anxious and of these will consist of a large proportion of patients who are dentally phobic [6,7]. Communication strategies in dentistry are important as they have a complex association with patients’ anxieties, trust and their beliefs about control in the dental chair [2,8].

The assessment of dental anxiety is well-established utilising developed self-report inventories [9]. A widely used screening questionnaire with UK norms and good psychometric properties is the Modified Dental Anxiety Scale (MDAS) consisting of 5 items about various key procedural elements when visiting the dentist [10]. The scale is a modification of the original 4 item dental anxiety scale [11], and included an additional question about local anaesthetic injection. Each question is rated in 5 categories from 1 (not anxious) to 5 (extremely anxious). A copy of the scale can be downloaded, and further information about psychometrics is available (www.st-andrews.ac.uk/dentalanxiety). The measure has been reported as a research instrument, but also can be used as clinical device for the patient to complete and give to the receptionist or to the dentist directly. The completion of the MDAS has been shown not increase dental anxiety [12]. The method of ‘delivery’ of this information from the patient to the dental practitioner provides an opportunity to unravel the possible mechanisms that may alter the patients’ dental anxiety state. There are at least three separate scenarios that can be easily identified. First, is the case where the patient completes the MDAS and simply hands it to the receptionist. The patient may have expectations about the dentist being told by the receptionist their MDAS score.
The second scenario is when the patient completes the MDAS and hands it to the receptionist. The patient is informed by the receptionist that the dentist will see their MDAS score before the appointment starts. The third scenario, the patient is instructed to hand the completed MDAS to the dentist on meeting with her in the surgery. Fig. 1 presents a conceptual model to indicate the hypothesised psychological processes that might be in operation. Both the patient and the dentist will meet in the dental surgery and engage briefly prior to the patient taking their place in the dental chair. The MDAS completed prior to meeting their dentist is physically handed to them by the patient. This ‘act’ is hypothesised to add an extra positive element to the communication and engagement process.

The description of these scenarios illustrates that there are some unique features in the dental surgery appointment which are suitable for detailed study. Of special relevance is the manner in which the dentally apprehensive patient negotiates their dental visit [13]. The patient will be vigilant about the dentist’s communication and concerned that the dentist is aware of their dental anxiety status [14]. It is likely that at the introductory phase of the dental treatment appointment the communication between the patient and dentist is crucial. The MDAS rating profile may assist in this communication to increase awareness for the dentist of the patient’s anxiety status and possible reasons of anxiety (e.g. extreme score for local anaesthetic needle injection). Without this aide the dentist may attempt to conduct the procedure in a routine manner to prevent undue attention on a particular element in the hope that this will minimise any distress. Such avoidance however can be interpreted negatively, by the patient as it could be perceived as uncaring.

2. Aim

The overall aim of this brief paper is to show that through a careful design of discrete interventions the researcher can investigate some of the multiple factors that construct the smooth performance in the communication process of the dental staff with their patients. The structure of the paper is to present summaries of three studies conducted by the authors, two of which are already published [15,16]. The final study is reported in an unpublished doctoral thesis [17]. They comprise a series of integrated findings that show the importance of using routine psychological assessments in a considered but creative manner. In addition they introduce a straightforward framework that clinicians can enhance their practice of communication and patient engagement.

3. Methods and results

Study 1 tested the hypothesis that informing dentists about patients’ dental anxiety prior to commencement of treatment reduces patients’ state anxiety [15]. A randomised controlled trial was conducted. Eight General Dental Practitioners in North Wales participated. Patients attending their first session of dental treatment, and accumulating a score of 19 or above, or scoring 5 on the MDAS on any one item were recruited. Patients were instructed to complete the Spielberger state anxiety inventory-short form (STAI-S) pre- and post-treatment [18]. The reliability of this measure has been reported to be high–Cronbach’s alpha equals 0.95. There are six questions with scores of 1–4 per question on a rating scale. Patients (n = 119) were randomly allocated to intervention (dentist given MDAS score sheet) and control (dentist not given MDAS sheet) groups. Intervention patients demonstrated lower mean change STAI-S scores (see Table 1) compared to controls. The finding from this study was consistent with patients receiving a benefit from their dentist being informed of the patient’s dental anxiety before treatment and the patient instigating this exchange.

Study 2 tested the hypothesis that different components of the process of informing the dentist about high patient dental anxiety were associated with differing levels of anxiety reduction [16]. Patients attending two Dental Access Centres were recruited (two dentists at each Centre), who typically were not regular attenders and where the dentist did or did not receive the patients’ assessment of dental anxiety. Patients completed the Modified Dental Anxiety Scale (MDAS). Those that scored high (same criteria as Study 1) completed the same state anxiety questionnaire (STAI-S-S) and were randomised into three groups (n = 182). Group 1 were controls (n = 60), Group 2 gave their MDAS to the receptionist who passed it onto the dentist unknown to the patient (n = 62) and Group 3 handed their MDAS to the dentist (n = 60). Immediately after their appointment the patient repeated the STAI-S. Overall there was a significant group effect (Wald χ² (2) = 6.84, p = 0.033), Patients in Group 3 were less state anxious (by more than STAI-S-3 scale units) on leaving the surgery than those from the other groups. This was highlighted if the patient entered into a discussion with the dentist about their concerns (difference of 5.8 scale units). Hence the dental anxiety screen shared between patient and dentist reduced anxiety at appointment completion.

Study 3 tested the hypothesis that it is the handover process of the MDAS by the patient to the dentist that is crucial in reducing patient anxiety. Patients were observed directly with video and physiological measures (heart rate) being recorded. Patients were recruited from six salaried dental practices in NHS Highlands. Selection criteria were identical to previous studies. Over 1000 patients were recruited. The number that met the inclusion criteria

![Fig. 1. Conceptual diagram showing the influence of the patient on the dentist by the presentation of the MDAS screen questionnaire and the separate influence of each person on communication and patient engagement, treatment and eventual post-treatment dental anxiety.](image_url)

| Table 1 Mean change in adjusted state anxiety (STAI-S scores) of patient from baseline to immediate follow-up by Group (Experimental Group patients handed dentist copy of completed MDAS, Control Group patients gave Completed MDAS to receptionist). |
|-----------------|--------|---------|---------|-------|
| Group           | Mean   | SE      | CI 95%  | N    |
| Experimental    | 4.1    | 0.54    | 3.1, 5.1| 60   |
| Control         | 1.9    | 0.49    | 0.8, 3.00| 59   |

* Higher score denotes improvement in state anxiety (i.e. reduced STAI-S score at follow-up).
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