SEDATION PSYCHE

"Understanding your patient's fears"

Understanding ***sedation psyche*** will enable a practitioner to:

- Develop better diagnostic skills to assess fears
- Individualize treatment plans to reduce anxious behaviors that interfere with treatment
- Make better case presentations to avoid scaring off fearful patients
- Achieve more optimal pain and anxiety control
- Improve post-operative management
- Create a safe and welcoming environment that is non-threatening and non-judgmental

Patients who are fearful express themselves by describing their chief complaint:

Pain or being hurt	34%
Lack of Control	19%
Embarrassment or being judged	15%
Noises like the drill or ultrasonic	12%
Panic attacks	11%
Others	8%

Look for the signs of fear that manifest themselves in two categories:
Behavioral Indicators: These are the signs that are most prevalent in the reception room. Examples are: fidgeting with hands or objects; sitting on the edge of the chair leaning forward; pacing; changing sitting positions frequently; startled reactions to ordinary office noises and rapid head movement.

Physiological Indicators: These are the signs that are activated by the body due to the autonomic nervous system when the body is under stress. There are three indicators that are easy to observe and measure. The first is excessive perspiration seen on the palm of the hands, underarms, forehead and upper lip. Just shake the patient's hand. The second indicator is the increased pulse and blood pressure – easily monitored with your pulse-oximeter. The last indicator is the respiratory depth and rate. Here you will observe rapid shallow breathing or a patient holding their breath.

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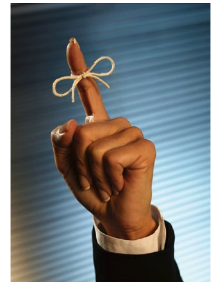
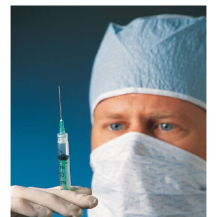
EIGHT SEDATION PSYCHE LAWS:

1. Just because a patient seems to be cogent doesn't mean they are. Many high fear patients will try to fight the effects of the sedative. They may appear to be free of the influence of our techniques but are often putting on a show. They will forget most of what they say and can be easily be relaxed with some simple relaxation techniques. Remember, they will remember what you say. A few of the techniques that can be used are "the placebo effect", pacing and leading (slowly softening and slowing your voice) and providing a low concentration of nitrous oxide. Many times, just having a patient breath oxygen slowly and rhythmically through their nose is enough to break the fight.



2. Never give a fearful patient details of their upcoming or present appointment unless they specifically request it. If a patient request more information, only give a small dose of it to test their tolerance to the information. Remember to observe their behavioral and physiological response to the information to determine if they are comfortable enough to understand more. **These patients require a level of trust in us, not an understanding of the procedures.** Many dentists and hygienists have to fight their natural tendencies to be a teacher and explain the details of a visit. Please, for the sake of the health of your new high fear patient, do not explain details unless asked. When asked during an initial appointment for information, recognize that the details maybe for a trusted love one to help them make a decision. Usually the high fear patient is too nervous to relay details to them anyway. So, we recommend that you ask how much detail the patient requires to make a decision and how much detail they need to convey to someone else if they are seeking counsel. Most of these patients will not review any written literature you give them, but it is helpful for there loved ones. Strong, encouraging descriptions like, "We are going to give you a new smile", or "We will help you have a healthy mouth", or "We are going to work on the top today" are the best type of responses when questioned for details during a sedation appointment.

3. Remove all fearful stimuli from the operatory before escorting a fearful patient in. The worst-case scenario is when a patient is escorted into an operatory where all the instruments are laid out and a "helpful" dental professional explains what all the "tools" are for. These patients are programmed like computers to have reactions to certain words, sights, sounds, tastes and feels. In the psyche of the fearful patient, these "triggers" are followed by a series of events that



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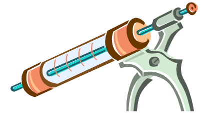
are undesirable for the dental practitioner. The triggers elicit behavioral and physiological responses that are signals for the fearful patient to get out of there as fast as possible. Therefore, make the operatory a friendly and sparsely instrumented facility. Once the patient is sedated and their anxiety is relieved, bring out the "tools of the trade".



4. Always be encouraging. The sedation patient psyche is not complicated regarding this issue. If we are encouraging and give praise often, the fearful patient remains relaxed and experiences a successful visit. This success is crucial to maintaining a lasting patient/doctor relationship. A fearful patient that continues to experience successful visits is most likely to complete their treatment plan and become a recare patient.

5. To the sedation patient, the dental visit always goes as well as you and your team project that it went. It is easy to project a successful visit to a patient when you complete 3 molar root canals (and fill to 1mm of the apex on all roots), extract (without breaking) a hopeless tooth with twisted roots and take (on the first try) a perfect full upper arch impress of 8 teeth. The question is… what if you weren't so successful? Would you and your team be able to observe the 4th law of being encouraging? Would you be able to project the "feeling" of a successful visit, even if you overfilled 2 roots, underfilled 3 roots, broke the twisted hopeless tooth and pushed the root tip into the sinus and had to take the final impression 5 times and still had missed margins? Not that this has ever happened to you. But if it did, could you project a calm demeanor, treat your team with dignity and tell the patient that all is well? You must for the sake of your patient. You have the skill to come back another day and make it right. Your patient needs you to be confident, calm and project that all has gone as planned. You may have had to change the plan, but you can convey this detail to the patient the next day when both of you are better suited to handle the fact that an additional appointment or two is required.

6. Raising your voice for cooperation is not yelling to the sedated patient. Many of us grew up in households where a raised voice was a sign of anger and meant punishment was soon to come. Because of this, we as adults are less likely to raise our voices purposely, especially in a professional environment. There is a distinct difference between yelling and speaking loudly. The intent of yelling to express anger. The intent of raising ones voice when communicating with a sedated patient is to illicit cooperation from someone whose consciousness is slightly depressed. Can you hear the difference between a raised voice and a yelling one? To perform a needed task, such as taking a bite registration, it may

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be necessary to raise your voice to gain the appropriate amount of control with your patient to get him or her to bite completely and continuously for the time required. Remember to use additional stimulation, such an ounce or two of Gatorade, to help bring the patient to a more cooperative level.

7. Every visit must be a perceived success. All high fear patients, no matter how many times they have been to your office, must perceive each experience as a pain-free, successfully completed appointment. This starts on the first appointment. Do not try to accomplish x-rays or an intraoral exam on the first appointment if you suspect that the patient may not tolerate this well. You are much better off waiting until they are sedated and will have little to no memory of the experience. Rules #5 and #6 apply here very well. If a sedation patient perceives an appointment as a failure, they are likely to regress to be a non-patient.

8. Pain is subjective. This is such a simple law but is often overlooked. “You’re not feeling pain, that’s pressure,” or, “I haven’t done anything yet, how could you feel any pain?” Are good examples of how we sometimes miss the boat. **Pain is in the mind of the beholder.** High fear dental patients give us great examples of both of the extremes to this statement. These patients are so tuned into their own fear and pain that they often feel a needle before it touches the mucosa. Be respectful of this. Even if they are consciously sedated, please be slow, careful and use a topical anesthetic gel. On the other side of perception is when a high fear patient returns with a “very slight rubbing” of a new removable appliance and you observe that the flange of your appliance has created a massive ulcer that has eroded the tissue thru to the bone. Pain is subjective. Respect this and your visits will go well.

Initial Visit:

Interviewing skills are paramount. Your ability to ask non-judgmental questions, use reflective listening skills and reply with non-critical responses is the key to the initial visit rapport. Here are a few good questions to ask a fearful patient on their first visit.

- ✔ What brought you in today?
- ✔ What was your last dental appointment like?
- ✔ If we work together to make your mouth/tooth feel better, what can I do to make you feel more comfortable?
- ✔ What is it like for you when you go to the medical doctor?

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- ✔ Did you sleep OK last night?
- ✔ How do you feel this morning?
- ✔ When you went to the dentist before did you have nitrous oxide or a pill?

Steps to introduce x-rays:

1. Let the patient practice without pressure
2. Begin with easy positions and be flexible
3. Encourage breathing
4. Position head first
5. Count when placing film
6. Allow the patient to remove the film and holder after the x-ray has been taken (control)
7. Provide praise

When is a sedation patient ready to "do it" without the any sedative medication?

This is an important question that should be considered very carefully before proceeding. In order to ensure the best oral health of a sedation patient, what is more important: Getting the patient to come in for a prophylaxis or dental visit without the use of a sedative? Or preventing any possible set-back caused by painful or fearful stimuli? If a patient has avoided care for many years due to fear, and they are now comfortable receiving routine care while they are sedated, when is it appropriate to approach the possibility that they are ready to "do it" without a sedative? If you and the patient can answer the following questions in the affirmative, then they may be ready.

Do you and your patient think they can master the following required behavior?

- Radiographs without gagging
- Injections without jerking the head
- Rubber dam placement without choking
- Drilling without gripping the chair

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