7

Barriers to accessing dental care: patient factors

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This article discusses those factors which may prevent a patient from accessing dental care.

The idea that barriers to accessing and accepting dental care were related to psycho-social factors, which could be explained as resistances, has been previously considered (see part 6 of this series). It was proposed that barriers to accessing and accepting dental care could be thought of within a two-person framework which reflected the dentist–patient relationship. It was further suggested that there was a need to examine the sources of the barriers themselves, from both patient and practitioner perspective (see part 8 of this series), since, by doing so would allow a greater understanding of patient compliance and the role of the dentist with regard to providing accessible dental care. The purpose of this paper is to examine the role of barriers from the patient point of view.

The source of the barriers that patients' experience in relation to accessing dental care are said to arise as a result of their life experiences and psycho-social background. These psycho-social factors are thought to provide the environment which help or hinder patients accessing care. In the dental literature, lists of psycho-social factors are given to explain patients' avoidance of dental care and to provide reasons for non-compliance with treatment and preventive regimes. These factors are said to include socio-economic status, age, gender, ethnicity, perception of need, dental anxiety states, feelings of vulnerability and so forth.[1] From this list of factors four main groups[2] of barriers have been identified. These are dental anxiety, financial costs, perceptions of need and lack of access.

With such a plethora of psycho-social factors acting as barriers what remains important is to consider how they influence dental attendance and affect compliance with treatment and preventive regimes. It is proposed that psycho-social factors do not act independently of each other but combine to act in unison. It is the quantitative nature of their combination which reduces access to care, resulting in non-attendance and non-compliance. For example, lifestyle commitments together with dental anxiety, may combine and form a barrier which hinders access to care. The division, therefore, of psycho-social factors into individual barriers may be, in this regard, artificial. Nevertheless, using a psycho-social structure allows the patient's dental attendance and compliance with preventive regimes to be understood.

Psycho-social factors as barriers to accessing dental care.

Dental anxiety states

Dental anxiety[4,5] has been highlighted as being one of the most important barriers with regard to dental attendance. There is the view that anyone who presents with fear of dental treatment experiences an equivalent intensity of emotion or affect which results in the avoidance of dental care. However, despite their considerable dental fears some patients accept regular dental treatment.[6] It would seem that the relationship between dental anxiety and avoidance is not a simple one. Depending on the intensity of anxiety experienced the fearful patient may find dental treatment troublesome or look upon it as an intolerable encounter.

Psycho-social factors which act as barriers to accessing dental care

- Dental anxiety states
- Financial costs
- Perceptions of need
- Lack of access

How can such clinical observations be understood? The answer lies in defining what is meant by dental phobia* and differentiating it from dental anxiety. The diagnosis of dental phobia cannot be made solely on the basis of the presenting complaint (the patient's anxiety state) but only in conjunction with the patient's previous dental attendance history. The patient who experiences a high intensity of anxiety together with a history of avoiding dental care invites a diagnosis of dental phobia to be made. It is for these patients that fear and anxiety acts as a barrier to accessing and accepting regular dental care.

The distinction between dental anxiety and

A phobia is an irrational fear of a place or an object with avoidance of that place or object.

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dental phobia is important. It provides the dental health professional with the means of assessing the likelihood of success with the fearful patient. For instance, the patient with high dental anxiety whose anticipatory fears can be ventilated may be successfully treated.[7] The dentally phobic patient's anxiety will destroy the treatment alliance (see part 2 of this series) rendering dental care impossible. Thus the dental phobic will remain an irregular dental attender.

Dental health professionals must be able to identify patients who have special psychological needs. The use of psychological questionnaires such as the Dental Anxiety Scale[8] or the Modified Dental Anxiety Scale[9] may be helpful in identifying such individuals. These simple questionnaires are short, quick, easy to complete and the user is provided with cut off scores above which a patient may be designated as being dental phobic. When they are used in conjunction with questions relating to the patients' dental history, the dentist will be in a position to identify the patient who has psychological special needs. In this way the dentist will be in a position to assist the dentally anxious or dentally phobic patient access dental health care.

As a barrier to accessing dental care, dental anxiety in children may be a consequence of the child's stage of personality development, parental dental anxieties or the parent's fears and wishes to deny her child any distress or anxiety. This wish may be a culmination of mother's own anxieties together with her disquiet at the sight of her child's distress and unhappiness. Such difficulties on the parent's behalf may result in the parent delaying care. Only when an emergency situation arises can the parent bear to subject the child to treatment. The following two vignettes are illustrative. Both of the boys, mentioned below, were aged 8 and had experience of extractions under general anaesthetic. Both returned for a prophylaxis and discussion of future preventive and restorative treatments. However, whereas Paul's mother readily accepted her child's anxieties, Rob's mother, because of her own fears and concerns for her child's well-being, denied their existence. This resulted in Paul (Case 1) managing his worries and Rob (Case 2) being treated with difficulty.

Case 1
Paul was worried about going to the dentist as he had had four molars extracted at the previous visit. Paul was sure that the dentist would take out all of his teeth and told mother so. Recognising her son's dental anxiety she reassured him that this appointment was to clean his teeth. Paul was able to contain his worries and lay quietly to have his teeth polished.

Case 2
Rob has had a similar dental experience to Paul. However at his appointment he wriggled about in the chair, hardly being able to open his mouth. With difficulty his teeth were polished. When his mother was asked if Rob was nervous she stated, 'No, he's not frightened, he likes coming to the dentist'. Mother's own dental anxiety together with the denial of her son's dental fear culminated in Rob's difficulty in accepting dental care.

The need for the dental health professional to be able to identify children who are dentally anxious has been shown to be of great importance. Prior knowledge of the dentally anxious child can help the dentist improve dental treatment experiences thereby reducing the potency of dental anxiety as a barrier to accessing dental care.

As with adults, psychological questionnaires have been developed which have been shown to be of value when assessing children's dental anxiety. Assessments of child dental anxiety include pictorial representations[9] of the dental situation as well as asking the child how they feel about items of dental treatment such as the injection or the drill.[10]

Concerns that asking children about dental worries will increase their fears and anxieties have not been substantiated. In fact prior information in 'tell–show–do' scenarios have been shown to reduce child anticipatory dental anxieties and hence barriers to dental attendance.[11]

Financial costs

Financial costs of dental treatment remain a significant barrier to accessing dental care.[4,5] Statistics throughout the world show that peoples' ability to access regular dental care is directly related to their annual income. Interestingly the effect of annual income influences the entire family's dental attendance patterns. Children living in areas of social deprivation are, for instance, less likely to attend for restorative care; their irregular pattern of dental attendance mirroring that of their parents.[12] When affordability of dental care is combined with socio-economic status (SES), it appears that those from lower SES access care less often and admit to being less satisfied with treatment they received compared with others.

Dissatisfaction with dental treatment may be illustrated by the case of Jean aged 23. She was on income support. Jean was disappointed with the colour and appearance of veneers which had been fitted to her upper incisor teeth. She confided in the nurse, 'If I was paying for these he'd change them . . . he won't do it . . .'cause I get them for free'.

The difficulties and problems encountered by people on low income is said to be related to

the degree of competition for the families' disposable income. Where competition is the greatest, dental treatment may be felt as an unaffordable luxury and, while being valued, may be low on a list of priorities when compared with other essential commodities. Ideas such as these suggest that an inverse care law is operative with those in greatest need receiving the least in the way of dental health care.[12]

Perceptions of need

Peoples' perceptions of treatment need range from those who attend on a regular basis with no visible sign of normative need to those who attend only when in pain. Patients' responses[13] when invited to attend for a routine examination, appear to be influenced by dental anxiety status, previous dental experiences and lifestyle commitments. Patients' perceptions of treatment need are under the control of the psycho-social determinants of dental health. Hence the impetus to change felt need into demand for care (see part 3 of this series) is thought to be based upon a combination of psycho-social factors.

The idea that psycho-social factors can help (enable) or hinder (inhibit) access to regular dental care by influencing perception of need may be illustrated by examining demographic variables. For instance, people from a higher SES rather than a lower SES,[4,5] women rather than men, younger rather than older, those with greater access to private rather than public transport all seem to attend more regularly for dental care.

For those with busy lifestyles there is the tendency to use emergency services or delay dental treatment. Time urgency was given as the reason for attending an emergency clinic by Mr J, a long distance lorry driver. He felt that regular dental attendance was a good idea but his job made it impossible for him. He felt it would be wrong to make and break appointments and so opted for emergency care:

> *'You come here, you have to wait a bit — but that's OK . . . fits in with my job better . . . they'll take the tooth out, fill it whatever and then I'll be back at work this afternoon.'*

Time urgency as a barrier to dental attendance does not necessarily act alone and may combine with such psycho-social factors as dental anxiety and lifestyle. When working together these factors may exacerbate or alleviate time pressures thereby inhibiting or enabling access to dental care, respectively. This situation is illustrated by Case 3.

In other circumstances dentate status will combine with age and treatment perception[5] to enable or inhibit access to dental attendance. For instance when asked about dental attendance an 80 year old edentulous woman commented:

Case 3
Lack of time was given as a reason for non-attendance by a woman lawyer. She had fractured a molar and a temporary dressing had been placed in the tooth. After a considerable length of time and a number of broken appointments she attended. She admitted that her busy lifestyle was an excuse for broken appointments, 'I find the whole dental business a bit anxiety-provoking' she said 'If I'm honest, it's the local anaesthetic injection that really puts me off'.

> *'I ain't got no teeth so I'm lucky no need to go. . . haven't been to the dentist since these teeth were fitted. . .that must be . . . oh . . . at least 20 years ago'.*

Whereas a 70 year old woman with her own teeth perceived dental care as an important part of her overall health care regime:

> *'I'd be worried about what would happen to my teeth if I didn't go. . . I don't want too much treatment just enough to make sure my teeth last me out'.*

Pre-adolescence and adolescence

Pre-adolescence and adolescence are times when changes are observed in needs perception, dental attendance and compliance with preventive advice. These changes start in pre-adolescence (approximately 12–14 years of age).[14] The pre-adolescent patient who a year or so earlier was so particular about his oral hygiene, now cares little about brushing his teeth and the dentist, when viewing his bite-wings, fears the presence of inter-proximal lesions. Such shifts in compliance with respect to oral hygiene and sugar consumption are to be expected in the pre-adolescent. Associated with this stage of development is a craving for sweet foods and drinks as well as lack of concern for personal hygiene of any kind. The influence of psychological development as a barrier must be recognised by the dental team. Using this information the dental team can gently inform and encourage the pre-adolescent to accept dental care and advice knowing that this is time well spent. Within a short period of time the patient will enter adolescence when a nice smile and their appearance become all important.

By the time adolescence[15] is reached psycho-social factors such as parental dental attendance, gender and educational aspirations seem to have positive and negative effects, in that, they may heighten or lower the adolescents' awareness of their dental health needs.[16] For instance, girls and those adolescents intending to enter tertiary education have a more regular pattern of dental attendance compared with boys and those intending to leave school without any qualifications. It

would seem that depending on the specific characteristics of the adolescent, dental health care in its widest sense may be disturbed or consolidated during this period of development.

What the dentist is observing in these changing behaviours are the vicissitudes of pre-adolescence and adolescence. During adolescence the psychological changes which occur are due to the adolescents' evolving relationship with their parents. This has consequences for dental attendance and the need to establish a new more adult, real relationship and treatment alliance with the dentist. Therefore on the one hand the dental health professional may be viewed as a parental figure whose authority must be questioned resulting in failed appointments and non-compliance: on the other the adolescents' interest in their appearance† may provide the impetus for regular attendance and increased perceptions of treatment need. Understanding the adolescents' seemingly bizarre behaviour will enable the dentist to provide accessible dental health care for this patient group.

Lack of access

While this final barrier may represent more clearly than any other the physical aspects of accessing dental care it also refers to difficulties encountered in relation to problems with communication and language.

Language and communication problems can lead to misunderstandings which exacerbate worries and concerns about dental treatment. In addition to dental fears and costs of dental treatment people from ethnic minority groups, for example, cite language and communication difficulties as considerable barriers to accessing dental care. The dental team which does not appreciate that differences in cultures exist may inadvertently inhibit rather than help their patients access dental care.[17]

With regard to the physical difficulties encountered, lack of access refers to any problem experienced when gaining entrance to practice premises such as wheelchair access to waiting areas, lavatories, the dental surgery itself as well as transport problems and reliance on public transport. Lack of access particularly affects people with special dental health care needs. Older people, those with physical or sensory disabilities and learning difficulties may experience problems when accessing dental care. If this lack of access is due to physical problems experienced at the dental surgery, they will be compounded by the need to use public transport.[4]

Conclusions

It has been proposed that barriers to accessing dental care have their sources within the patient's previous life experiences and their psycho-social background. These factors combine together to construct barriers reducing the patient's ability to access dental health care.

For adult patients the barriers include dental anxiety, financial costs of dental treatment, perceptions of dental need and lack of access. For younger children their barriers to dental care will be affected by parental attitude and anxieties. For pre-adolescents and adolescents dental attendance and compliance with preventive advice will be influenced by their stage of psychological development. Irrespective of the category of barrier to accessing dental care it is the place of the dental health professional to acknowledge that barriers exist and within the two-person endeavour which is the dentist-patient interaction, assist their patients to access and accept dental health care.

†*Health actions which are carried out to improve health are called 'health-directed behaviours'. Those health actions which are carried out to improve appearance (e.g. oral hygiene to have nice smile) and have a health spin off (e.g. less plaque, less gingivitis) are called 'health-related behaviours'. Health-related behaviours provided an important preventive strategy for adolescents.*

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