Ambivalence in Coping with Dental Fear and Avoidance: A Qualitative Study

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Abstract

Dental phobia is a widespread problem, which can have significant impact on the individual's health and daily life. This grounded theory study aims to explore the situation of dental phobic patients: how dental phobia interferes with their normal routines and functioning, social activities and relationships, what factors contribute to the maintenance of dental fear and how they cope with their fear. In the qualitative analysis of thematized in-depth interviews four main categories were developed: threat to self-respect and well-being, avoidance, readiness to act and ambivalence in coping. The results show that several psychological and social factors interact in determining how dental phobic individuals cope with their fear, and demonstrate in what way dental fear affects their daily lives.

Keywords

behavioral science, coping, dental phobia, qualitative method, quality of life

Introduction

ONE OF THE most prevalent fears is the fear of dentistry (Agras, Sylvester, & Oliveau, 1969; Fiset, Milgrom, Weinstein, & Melnick, 1989; Fredrikson, Annas, Fischer, & Wik, 1996). In Scandinavia, epidemiological surveys have shown that about 7–10 percent of adult populations are highly anxious about dental care (Hakeberg, Berggren, & Carlsson, 1992; Moore, Birn, Kirkegaard, Brodsgaard, & Scheutz, 1993; Vassend, 1993). According to the *Diagnostic and statistical manual of mental disorders* (DSM-IV), severe dental anxiety should be considered a specific phobia. This is defined as a clinically significant anxiety provoked by exposure to a specific feared object or situation, often leading to avoidance behavior and/or significantly interfering with the person's normal routines, occupational functioning, social activities or relationships (DSM-IV, 1994). Thus, dental fear is a widespread problem, which can have significant impact on the individual's health and daily life.

Several studies have shown that severe dental anxiety with phobic avoidance of dental care has a negative impact on oral health (Hakeberg, Berggren, & Gröndahl, 1993; Hällström & Halling, 1984), reduces quality of life (Berggren & Meynert, 1984) and has a negative impact on psychosocial functioning (Berggren, 1993; Moore, Brodsgaard, & Birn, 1991). It has been suggested that dental anxiety creates its own vicious circle in which the phobic patients' inability to accept dental treatment leads to a real or perceived deterioration of oral health, which in its turn can create feelings of shame, guilt and inferiority, subsequently reinforcing fear and anxiety (Berggren, 1984). Moore et al. (1991) proposed that feelings of powerlessness and embarrassment in the dental situation were important social determinants in the acquisition and maintenance of dental anxiety. They referred to the 'vicious circle' suggesting that with the passing time of avoidance, social conflicts reinforce anxiety and result in further avoidance of dental care. In addition, it has been proposed that social factors appear to contribute strongly to the maintenance of dental fear, especially in long-term avoiders (Berggren, 1993). Berggren found that a majority of dental phobic patients felt that they had to curtail their social relations, and many reported widespread negative social life effects. This included family relations and perceived social support and provides further support to the vicious circle (Berggren, 1993).

Even though severe dental fear may lead to phobic avoidance from dental care, it has been reported that many patients regularly visit dentists, in spite of a severe dental fear (Hakeberg et al., 1992; Vassend, 1993). Little is known about fearful individuals who keep up regular dental contacts. These patients might have at their disposal adequate coping strategies, or simply act in accordance with compelling social norms (Vassend, 1993). Thus, dental fear patients are not a homogenous group. Accordingly, the character of dental fear and its side effects may differ in different groups of fearful patients and in individuals, and interact with personality traits and other psychological and social components (Abrahamsson, Berggren, & Carlsson, 2000; Abrahamsson, Berggren, Hakeberg, & Carlsson, 2001).

A limitation of the research on dental anxiety is that there is a lack of studies describing dental fear with the patients' own words and from their perspective. Most previous research has been performed using psychometric instruments modified from general psychology and adapted to the field of dental anxiety. However, there is always a risk that valuable information is lost when using quantitative instruments. Qualitative methods may contribute to a deeper understanding of this complex problem, and the psychosocial processes involved. Cohen, Fiske and Newton (2000) have recently presented a qualitative study exploring the impact of dental anxiety on daily living among patients attending a dental sedation unit. The authors concluded that the impact of dental fear on people's lives could be wide-ranging and dynamic, interfering with social contacts as well as having a negative effect on oral and general health. We judged it important to further explore such psychosocial factors. Thus, the aim of this qualitative study was to explore the situation of dental phobic patients: how dental phobia interferes with their normal routines and functioning, social activities and relationships, what factors contribute to the maintenance of dental fear and how they cope with their dental fear.

Method

Study sample

The sample consisted of 18 patients, 12 women (aged 22 to 61 years, $M = 39.5$) and six men (aged 29 to 55 years, $M = 39.2$), strategically selected among patients applying for treatment at a specialized dental fear clinic in Göteborg, Sweden, to form a heterogeneous group of patients with dental phobia. Patients' educational background varied: four patients had nine-year compulsory school or less, nine had completed secondary school and five participants had higher education. The patients answered some questionnaires about background factors including dental anxiety. Dental anxiety was assessed by Corah's Dental Anxiety Scale (DAS) (Corah, 1969; Corah, Gale, & Illig, 1978), which is designed to evaluate overall dental fear. The inclusion criterion for the present study was a DAS score indicating severe dental fear (mean 18.0; SD 2.4). All patients refused conventional dental care (due to dental fear) at the time of the study. The mean avoidance time of regular dental care was 6.8 years (SD 4.5). Three patients reported a history of regular dental care (at least once a year) in spite of their dental fear. However, they reported that it had become more and more impossible to manage dental care. Two of the patients reported that they had never managed regular dental care.

In-depth interviews

Audio-taped, open-ended interviews were conducted by the first author. The purpose of using open-ended interviews in the data collection was to explore the situation of dental phobic patients, as expressed by patients themselves. All the interviews took place in a convenient room at the Faculty, but outside the treatment clinic and lasted for 50 minutes to one-and-a-half hours (mean 58 minutes). An interview guide was used as a basic checklist to make sure that relevant topics were covered (onset of dental fear, family, experiences in dental care, health and effects on everyday life, coping strategies). Topics related to these areas of interest were either brought up spontaneously by the informants, or introduced by the interviewer. The interviews were introduced by questions such as: 'Does your dental fear have an impact on your daily life?', 'In what way?', 'What do you do?', 'feel?', etc. Each interview was transcribed verbatim. Data were analyzed and reported in two separate reports. One report considered dental phobic patients' view of dental anxiety and experiences in dental care (Abrahamsson, Berggren, Hallberg, & Carlsson, 2002). In the present analysis and report we focused on how dental phobia interferes with daily life, what factors contribute to the maintenance of dental phobia, as well as on coping strategies among adult individuals suffering from dental phobia.

Ethical considerations

The project was approved by the Ethics Committee of Göteborg University. Patients with language difficulties and with significant psychiatric problems or diagnoses, other than dental phobia, were excluded. Patients received information about the study verbally and in written form. It was stressed that participation was voluntary. Before the interview all patients were informed about full confidentiality and about their right to break off participation at any time. They were also asked to sign a written agreement for participation in the study.

Analysis of data

The interview protocols were analyzed inspired by the constant comparative method for grounded theory (Annells, 1997; Charmaz, 1995; Glaser & Strauss, 1967; Strauss & Corbin, 1998). The aim of this method is to focus on different qualities of a phenomenon in order to generate a model or a theory, rather then testing hypotheses based on existing theory. The basic rules include looking for psychosocial processes, discovering existing problems and how the people involved handle them. The coding process can briefly be described in two steps; open and selective coding. In the open coding process the interviews were analyzed line-by-line and broken down into segments reflecting the substance of the data, i.e. substantive codes. Codes with the same content were grouped together to form more abstract categories. In the selective coding process connections between categories were sought, and the central phenomena and the core categories were systematically identified. Data collection and data analysis were carried out in parallel, starting after the first interview and

proceeding until 'saturation' of information was reached, i.e. additional data did not give new information (Strauss & Corbin, 1998). Reliability and validity in qualitative research are discussed in terms of 'adequacy of evidence' and 'trustworthiness', i.e. when similar relationships repeatedly emerge from data and are validated in additional interviews (Strauss & Corbin, 1998).

Results

In the analysis four main categories were identified and labeled: *threat to self-respect and well-being*; *avoidance*; *readiness to act*; and *ambivalence in coping*. One category, *threat to self-respect and well-being*, was identified as the core concept, describing the central meaning of the informants' experiences of their ambivalence in coping with dental fear. The ambivalence was between, on the one hand their tendency to avoid dental care, and on the other hand the demands they felt and their active problem solving strategies, i.e. being ready to act. This ambivalence in coping and the consequences for self-respect and well-being is schematically illustrated in Fig. 1. Each main category was composed of a number of descriptive categories and subcategories (see Fig. 2). The categories will be described and illustrated by interview excerpts as follows.

Threat to self-respect and well-being

This core category, threat to self-respect and well-being, described the central meaning of the informants' ambivalence in coping with dental fear. The core category was composed of two dimensions, elucidating experiences of a threat to health and social activity, respectively (Fig. 2).

Threat to own health The informants described the threat to oral health as a significant aspect of their dental fear. They also expressed a worry about general health deteriorating on account of dental fear and deterioration of the teeth. Serious worries about tooth loss were common. One informant described her fear and anxiety about loosing her teeth and the inability to do anything about it: 'I'm living in a sort of fantasy world . . . and soon reality is going to catch up with me and I'll lose my teeth. It won't be long' (IP9). One of the patients with regular dental care, a young woman, expressed

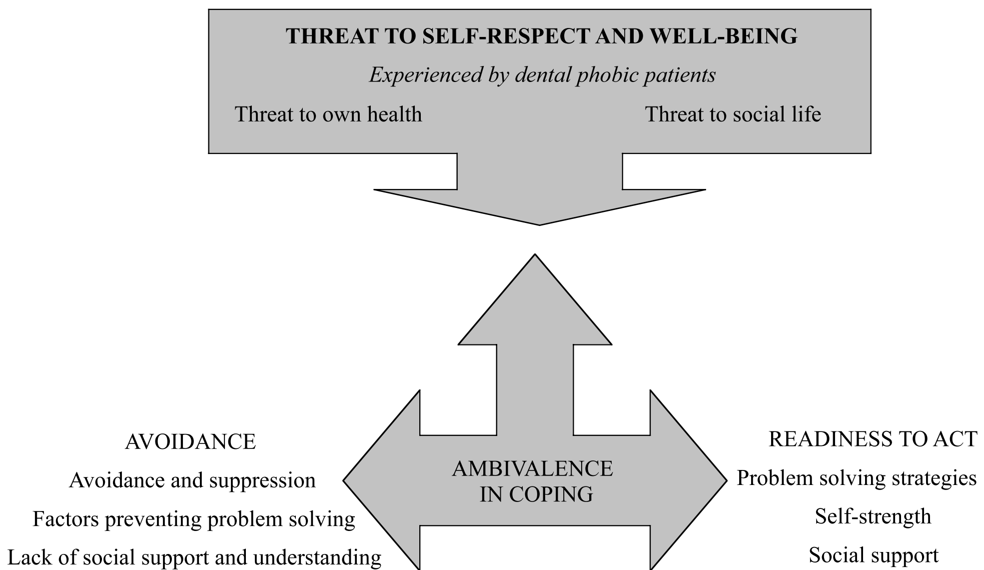

Figure 1. A preliminary model: ambivalence in coping with dental phobia, depicting the core category 'threat to self-respect and well-being'.

THREAT TO SELF-RESPECT AND WELL-BEING
Threat to own health
Threat to oral health
Threat to general health
Nightmares about poor oral health
Feelings of shame, impurity, loss, degradation and sorrow

Threat to social life
Limitations on social life
Interaction with other people
Intimate relations
Work

AVOIDANCE
Avoidance and suppression
Avoidance of dental care
Avoidance of information
Avoid looking at my own teeth
Avoid oral hygiene procedures
Wishful thinking
Suppression

Factors preventing problem solving
Financial position
Fear
Shame
Pain and oral status

Lack of social support and understanding
Inferiority
Low self-esteem

READINESS TO ACT
Problem solving strategies
Searching for information
Talking to others about my dental problems
Self-care
Handling dental care situations
Financial planning

Self-strength
Self-image
Norms of behavior

Social support
Encouragement
Protection

AMBIVALENCE IN COPING
Working and struggling with myself

Figure 2. Description of main categories, descriptive categories and examples of related subcategories.

her worry thus, 'I'm so terribly afraid that my teeth will get in a bad state if I don't go. I go regularly although I'm so frightened . . . I absolutely don't want to get new holes or lose my teeth' (IP4). The informants reported that the very avoidance of dental care and regular check-ups created stress, as they did not know 'how bad things were'. Difficulties with oral care procedures were common and the patients felt anxious about not being able to take care of their teeth. The informants reported that their worry and anxiety had got worse over time and that they had become extremely focused on their dentition: 'One has it in the back of one's mind all the time . . . and one gets really scared if you feel a jab . . . Oh my God! Was it something in the food, or was it my tooth that went' (IP9).

The informants expressed worries about infections from bad teeth spreading in the mouth, or even worse to the whole body: 'What I'm most afraid of is that infections will spread . . . I've had a lot of colds in the past year . . . I don't know if it has anything to do with my teeth. I only know that I've waited much to long' (IP8). In some cases poor oral health caused difficulties in eating properly and the informants were worried about this. Some informants even felt anxious about their mental health, illustrated by one male informant with a long history of avoidance of dental care: 'The idea of having false teeth at 45, then I'd be at rock bottom . . . I don't know if I could handle it psychologically' (IP15).

Recurrent nightmares about poor oral health were common and the informants expressed feelings of shame, impurity, loss, degradation and sorrow. One of the younger male informants described his feelings:

> When you see some down and outs who still have their own teeth it bothers me. Why have they still got their teeth? What have I done to deserve this? I don't even understand myself. How the hell did I get in this position? They (my teeth) won't come back . . . it's final. (IP18)

All patients said that their present dental problems or worries about future problems were the main reason for seeking treatment for their fear. They described it as a problem demanding attention: 'It nags on at me all the time . . . it just keeps on irritating me' (IP6).

Threat to social life Most informants felt that their dental fear had a general negative effect on their lives. Many described how dental phobia limited their social life and stated that their poor oral status influenced their behavior toward other people: 'It's so horrible that this thing with my teeth affects my whole personality . . . I'm actually really a happy person' (IP2). Avoidance of talking and laughing in the presence of other people was frequently described. The informants said that they often hid their mouths with their hands when talking to other people. One man reported that he had grown a beard to hide his mouth. In addition, the informants perceived their poor oral condition as negatively influencing intimate relations. This was more pronounced among those who were single. As one woman expressed it: 'It also affects things with the opposite sex. I'll never get married if I don't have nice teeth . . . (I'm afraid of) it being unattractive' (IP9). From the interviews, it was obvious that deteriorating oral health results in a restricted social life.

It was also obvious that dental fear/poor oral condition caused problems at work. Some informants described avoiding situations such as work-meetings. One informant said that he used to lecture but that he was not able to do so any more because of his oral condition. Further, several informants described that pain from the mouth affected their ability to work. For some it was also problematic working during days when dental treatment was scheduled. One woman reporting regular dental care said, 'If I've got an appointment in the afternoon . . . some people could go to work, but not me' (IP4). A few informants said that their situation at work had become more and more impossible, and that they therefore had to take time off on sick leave: 'After all these years of tension this anxiety has led to me being off sick on part-time basis. I often say to my friend at work that I can't take it any longer . . . I can't take coming here any more' (IP2).

Avoidance

This main category, describing the dental phobic patients' avoidance, was composed of three categories which were labeled as follows: avoidance and suppression; factors preventing problem solving; and lack of support and understanding (Fig. 2).

Avoidance and suppression Phobic avoidance of dental care was common and often connected with a history of frequently missed or cancelled appointments. The informants described that they felt relieved when they had just made a cancellation. This relief was only temporary and accompanied by feelings of shame and guilt. 'Wishful thinking' about the dentist being ill, etc. was also common: 'If the motorway had collapsed and the bridges had fallen in no-one would have been happier than me' (IP14). Some informants said that it was easier to 'just forget the appointment' in order to avoid confrontation with the dental team. One male informant said, 'I'm the kind of person who if I've said a time I try to keep to it. But it's very easy not to take the first appointment . . . then one hasn't started anything' (IP10).

Avoidance of information about teeth and dental care, i.e. on television and in advertisements was common. Informants described avoiding talking about their dental problems and 'laughing it off' if it was brought up among friends. In addition, many informants described avoiding looking in the mouth and performing oral hygiene procedures: 'If you start brushing your teeth then you get that feeling of nausea all the time. Some dental hygienists have tried to get me to brush and so on, but I just can't manage it' (IP17).

Some informants managed successfully to suppress thoughts and feelings about their dental problems, illustrated by this female informant with long-standing total avoidance: 'I have a little difficulty in thinking about it . . . I have repressed everything . . . just don't think about it' (IP13). However, the informants reported that they were not totally successful in suppressing the problem: 'I repressed it, but it was there all the time . . . it's like when you just don't bother paying a bill' (IP9). The informants described that their fear and aversion to dental care increased with their avoidance.

Factors preventing problem solving All informants said that fear was the main reason for avoidance but that financial considerations were also important, especially if they expected a lot of dental treatment. It was also declared that pain and poor oral status in itself prevented problem solving:

> My teeth are in such a bloody awful state. I sort of can't handle my dental fear when my teeth hurt so much. First one should get a handle on the situation . . . then I can start thinking about fixing my teeth and so on . . . . (IP14)

Some informants expressed feelings of shame and inferiority toward the dental team as a reason for further avoidance.

Lack of social support and understanding A few informants said that they did not perceive any social support, but also that they avoided seeking support. One younger male informant said that, 'My worries about going to the dentist are a matter for me and me alone . . . maybe I could tell someone but they probably wouldn't care at all' (IP18). Some informants said that 'those around them' were unable to understand, or that they even made jokes about them and their fear. One older male informant described a birthday present from friends:

> He came with an envelope and handed it over and it was an appointment to the dentist's. It was an old card, but I didn't see that of course. He said that he had booked an appointment for me and I went completely cold all down my back. My birthday was in April and the appointment was in May . . . I couldn't stop thinking about it. When the time got nearer I saw that the date couldn't be right and understood that it was a joke. (IP10)

Especially the male informants said that they were ashamed of their dental fear: 'One feels really little and pathetic . . . I feel you know as though I'm really ridiculous' (IP15). Feelings of inferiority were accompanied by feelings of low self-esteem for being childish and afraid.

Readiness to act

This main category, describing the demands dental phobic patients felt and their active problem solving strategies was composed of three categories, describing problem solving strategies, self-strength and support from the surroundings (Fig. 2).

Problem solving strategies In contrast to avoidance, several informants described that they had become active in looking for

information, i.e. reading articles about dental information, watching related TV programs. In addition, they talked to other people about their dental problems, searching for information, advice and support.

Different forms of self-care were reported. Some informants said that they really tried to do their very best to take care of their teeth, although it was difficult: 'I really try . . . to brush in the right way and use the electric toothbrush and all that . . . I try' (IP4). Some self-care could be described as strategies directed toward avoiding going to the dentist's. Nevertheless they were described as the best available solutions at that moment. Thus, informants reported the frequent use of painkillers in order to handle their daily life. In addition, some patients also used sleeping pills in order to be able to work the following day. Some informants described that they had taken out bad teeth themselves to 'deal with the problem'. One informant reporting many years of total avoidance of dental care described that she had 'learned to live with it' and that she had made her own dentures out of paraffin wax.

Even though most informants reported that they only visited dentists when they were in pain or not at all, different strategies for handling dental care were described: 'trying to think it is soon over', 'pep-talk with myself', 'trying to be nice and kind to the dentist', 'trying to relax and have control over myself', 'talking a lot', 'saying a prayer' and 'trying to distance myself from the situation'. Several strategies were often used together and were more or less successful. One informant described how she used to use local anesthetic cream at home before dental treatment.

Financial planning for dental treatment was also described:

> It'll be bloody expensive, but I've had some money set aside for this for any amount of time . . . I mean that whole bit is sort of taken care of, I know that it'll have to cost quite a bit. It's not the finances that have hold me back. (IP14)

Self-strength This category reflected self-image and norms of behavior. Several informants stated that they saw themselves as being 'strong' and that their dental fear did not fit in with the rest of their personality. Some informants said that they had managed other difficult things in their lives, which had also made them strong. They said that they had to believe in their own ability to manage their dental fear. This was illustrated by a young female reporting anorexia in her teens: 'I had to go to an inpatients, clinic (for anorexia) . . . after an enormous struggle and a lot of spilled tears I made it. That's why I feel that I'm damned well going to manage this too' (IP6).

Some informants reported that they felt strong pressure to live up to what they had learned from their parents that 'a healthy mouth is most important'. Some young women said that they also wanted to be 'good girls' and that they made high demands on themselves to 'do the right thing'. This was especially evident among the informants reporting regular dental care:

> Mum and Dad said as well that you have to go to the dentist's . . . then you don't want to have holes either, it doesn't feel good. (I) do what I'm told and want to have nice teeth. I'm really conscientious . . . it's always been the case in everything I've done. It just comes naturally. (IP1)

A healthy mouth, as well as being in control, was important to maintain a positive self-image.

Social support Although the informants described that other people had difficulty in understanding them, most informants received encouragement and support from someone close. They said that their family and friends nagged at them to see the dentist, made appointments with the dentist, went with them to the dentist's and encouraged and comforted them. Some informants had this support from a work colleague. One female described that her elderly parent followed her to the dentist:

> He (Dad) says, 'What's the matter with you woman? No-one's ever died of going to the dentist'. But he comes with me . . . I feel safe; I really rely on him saving me. He's not allowed to come in with me to the dentist's. He stays in the car. (IP2)

Family and friends also had a protecting function. Social support seemed in some instances to effectively reduce the negative emotional effects of dental fear and thereby reduce the felt need

for these patients to seek care. One woman with 40 years of total avoidance and a poor oral status described how her husband had taken over most social contacts when the children were growing up. She also described how they nowadays, now that she has lost her teeth, almost never saw other people outside the family. However, despite considerable limitations on her social life she said that she had a good life with her understanding and helpful family.

Ambivalence in coping

This main category, ambivalence in coping, concerned the dental phobic patients' tendency toward avoidance, and the demands they felt and their active problem solving strategies. They seemed to oscillate between a state of avoidance and a state of being ready to act. The informants described how they 'worked with themselves' and struggled to do something about their situation and their dental fear. They really wanted to deal with their fear and to be able to see a dentist on a regular basis in the future:

> I would really love to get over my problem. Just think after going around being really scared for all these years, to have it just go away . . . it would be wonderful. Not because I think that could happen . . . but if only I could just be half as scared. Then I wouldn't ring and cancel appointments. I would go there and do everything just as one's meant to. (IP2)

However, feelings of ambivalence were commonly expressed:

> I go on hoping that this will get better, but my feelings right now is that it won't. I waver between wanting to do something about it and the feelings that I don't know if I can. It's like I'm quarrelling with myself quite honestly. (IP6)

Some informants explained that somebody else had 'arranged the whole thing', but also that they realized that they had to deal with it:

> I'll be really stupid if I don't take this opportunity. Because if I were to ring a dentist myself and book an appointment then . . . we'll do it later . . . that's where I end up again. I'm aware of the fact that it's necessary, but it can wait of course. What shall I do? Either it will rot completely or something radical should be done. (IP10)

A few informants said that they wanted to have treatment for their teeth problems but would prefer just to 'sleep through it': 'Can I take this? Can I fix this now?' . . . No, I'll fix it . . . I repress it . . . Am I really doing this now? . . . and then I feel that I probably won't fix it. I'd really like to sleep through the whole thing' (IP8). The informants described that their phobic dental fear and the threat to health and social activities left them in a state of conflict, with negative consequences for self-respect and well-being.

Discussion

The aim of this study was to explore the situation of dental phobic patients: how dental phobia interferes with their normal routines and functioning, social activities and relationships, what factors contribute to the maintenance of dental fear and how they cope with their dental fear. The sample in this qualitative study consisted of a strategically selected group of dental phobic patients seeking treatment at a specialized dental fear clinic. Thus, our results only describe aspects of this special group of patients and may not apply to all individuals with severe dental fear. The findings bring out the patients' ambivalence in coping with their dental fear. They seemed to oscillate between a state of avoidance and a state of being ready to act. This ambivalence had negative consequences for self-respect and well-being. The results show that several psychological and social factors interact in determining how dental phobic patients cope with their fear, and demonstrate in what way dental fear has an impact on daily life.

Milgrom, Weinstein and Getz (1995) suggested that an approach-avoidance conflict exists when a person has two competing tendencies with respect to a situation. The individual knows that he or she needs dental care and wants to have healthy teeth. In this respect the individual is highly motivated to attend dental appointments. On the other hand the phobic dental fear leads to avoidance of the situation. These two competing tendencies leave the person in a state of conflict. Our results suggest that ambivalence in coping should be seen in a

wider perspective: ambivalence in coping should be seen as being determined by self-image, norms of behavior and social support, as well as by the strength of the threat. The informants struggled between their dental fear and the threat to their self-respect and well-being.

Berggren (1984) suggested that fearful dental patients are often caught in a vicious circle where fear and avoidance may result in a deteriorated oral status. The inability to go through with dental treatment may further result in negative emotions, i.e. shame, guilt, inferiority, subsequently reinforcing fear and leading to increased anxiety and avoidance behavior. Our results partly confirm the 'vicious circle' perspective. Most informants described the decision to put off dental care as resulting in short-term reduction of anxiety. However, the feelings of relief were temporary and were accompanied by feelings of guilt and shame both toward the dental team and toward themselves. The informants described how their fear, guilt and aversion to dental care increased with the avoidance, as did the consequences for self-respect and well-being.

Vassend (1993) suggested that dentally anxious individuals with regular dental visits might have at their disposal adequate coping strategies and/or act in accordance with social norms that have a stronger behavioral impact than the tendency toward dental avoidance. This suggestion seems to be supported by our results. Even those patients reporting regular dental care mentioned the threat to oral health as a significant aspect of their dental fear, and as the main reason for seeking treatment for dental fear. Avoidance from dental care does not seem to be an available alternative for these patients, although dental care was perceived as extremely unpleasant. They described that they felt strong demands to live up to social norms and that they had high demands on themselves to 'do the right thing', but also that they were frightened of developing avoidance behavior in the future. Thus, it must be most important to identify fearful patients with regular dental care habits and to alleviate anxiety in order to prevent further problems and avoidance behavior (Milgrom et al., 1995).

Informants in our study described that the avoidance was transferred to everything that reminded them of their dental fear, e.g. TV programs and advertisements. Difficulties in performing oral hygiene procedures were also common. Berggren (Berggren & Meynert, 1984) suggested that fear, pain and feelings of guilt and inferiority might prevent good oral hygiene habits, as well as treatment. In contrast to this, in a qualitative study by Cohen et al. (2000) it was found that dental anxiety had a positive impact on oral hygiene practices. In our study most informants perceived an oral hygiene regimen as really difficult, even though they had high demands on themselves about taking care of their teeth and felt that their oral health was threatened if they did not succeed in living up to this.

Previous studies have shown that the negative impact of dental fear on daily life is more pronounced among fearful patients with long-term avoidance of dental care and a (real or perceived) deteriorated dentition (Berggren, 1993; Moore et al., 1991). This was partly supported in the present study, although no dental examinations were performed. The informants with long-term avoidance and self-perceived poor oral health expressed a wide range of negative impacts on their daily life, i.e. interaction with other people, work and negative emotions. The informants who were single reported a more pronounced negative impact on daily life. Especially intimate relations and their ability to meet a new partner were frequently mentioned and this seemed to be one of the main reasons for seeking dental treatment. A few informants perceived lack of social support and understanding and this was reported as a reason for further avoidance and social withdrawal, with subsequent negative consequences for self-respect and well-being.

Feelings of inferiority were especially pronounced among male informants. This may reflect differences in how men and women perceive their dental fear and to what extent they seek help and social support to mitigate the negative consequences of dental fear. Negative effects on daily life among dental phobic patients have been found to be significantly more pronounced among men (Berggren, 1993). In our study, those informants reporting strong social support from their families reported fewer negative emotions, even though they perceived their oral health as poor and as limiting their social life. Thus, social support seems to

effectively reduce the negative emotions caused by dental fear. There is a lack of studies describing the relation between social support and the expression of dental fear. This needs further attention.

Problem-focused and emotion-focused coping are often described as 'positive or negative' and as being relatively independent functions. According to Lazarus (2000) it is misleading to separate these two functions of coping and compare their efficacy. Both strategies are interdependent and work together in the overall coping process. Our results suggest that the informants moved back and forth between different strategies, the most desirable strategy and the one that was considered to be the best at a particular moment. However, to decrease the threat to self-respect and well-being oral health care is desirable and beneficial. It is therefore important to further identify and to strengthen factors that contribute to improved oral health behavior among fearful dental patients. Our results indicate that personal resources for coping with oral health as well as social support and a concerned caregiver are such significant factors.

References

Abrahamsson, K. H., Berggren, U., & Carlsson, S. G. (2000). Psychosocial aspects of dental and general fears in dental phobic patients. *Acta Odontologica Scandinavica*, *58*, 37–43.

Abrahamsson, K. H., Berggren, U., Hakeberg, M., & Carlsson, S. G. (2001). Phobic avoidance and regular dental care in fearful dental patients: A comparative study. *Acta Odontologica Scandinavica*, *59*, 273–279.

Abrahamsson, K. H., Berggren, U., Hallberg, L. R.-M., & Carlsson, S. G. (2002). Dental phobic patients' view of dental anxiety and experiences in dental care: A qualitative study. *Scandinavian Journal of Caring Sciences*, *16*, 188–196.

Agras, S., Sylvester, D., & Oliveau, D. (1969). The epidemiology of common fears and phobia. *Comprehensive Psychiatry*, *10*, 151–156.

Annells, M. (1997). Grounded theory method, part I: Within the five moments of qualitative research. *Nursing Inquiry*, *4*, 120–129.

Berggren, U. (1984). *Dental fear and avoidance. A study of etiology, consequences and treatment.* Sweden: Göteborg University.

Berggren, U. (1993). Psychosocial effects associated with dental fear in adult dental patients with avoidance behaviours. *Psychology and Health*, *8*, 185–196.

Berggren, U., & Meynert, G. (1984). Dental fear and avoidance: Causes, symptoms, and consequences. *Journal of American Dental Association*, *109*, 247–251.

Charmaz, K. (1995). Grounded theory. In J. A. Smith, R. Harrè, & L. Van Langenhove (Eds.), *Rethinking methods in psychology* (pp. 27–49). London: Sage Publications.

Cohen, S. M., Fiske, J., & Newton, J. T. (2000). The impact of dental anxiety on daily living. *British Dental Journal*, *189*, 385–390.

Corah, N. (1969). Development of a dental anxiety scale. *Journal of Dental Research*, *48*, 596.

Corah, N., Gale, E., & Illig, S. (1978). Assessment of a dental anxiety scale. *Journal of the American Dental Association*, *97*, 816–819.

DSM-IV. (1994). *Diagnostic and statistical manual of mental disorders*, 4th edn. Washington, DC: American Psychiatric Association.

Fiset, L., Milgrom, P., Weinstein, P., & Melnick, S. (1989). Common fears and their relationship to dental fear and utilization of the dentist. *Anesthesia Progress*, *36*, 258–264.

Fredrikson, M., Annas, P., Fischer, H., & Wik, G. (1996). Gender and age differences in the prevalence of specific fears and phobias. *Behaviour Research and Therapy*, *34*, 33–39.

Glaser, B. G., & Strauss, A. (1967). *The discovery of grounded theory. Strategies for qualitative research.* Chicago, IL: Aldine Publishing.

Hakeberg, M., Berggren, U., & Carlsson, S. G. (1992). Prevalence of dental anxiety in an adult population in a major urban area in Sweden. *Community Dentistry and Oral Epidemiology*, *20*, 97–101.

Hakeberg, M., Berggren, U., & Gröndahl, H. G. (1993). A radiographic study of dental health in adult patients with dental anxiety. *Community Dentistry and Oral Epidemiology*, *21*, 27–30.

Hällström, T., & Halling, A. (1984). Prevalence of dentistry phobia and its relation to missing teeth, alveolar bone loss and dental care habits in an urban community sample. *Acta Psychiatrica Scandinavica*, *70*, 438–446.

Lazarus, R. S. (2000). Toward better research on stress and coping. *American Psychologist*, *55*, 665–673.

Milgrom, P., Weinstein, P., & Getz, T. (1995). *Treating fearful dental patients: A patient management handbook*, 2nd edn. Seattle, WA: Continuing Dental Education, University of Washington.

Moore, R., Birn, H., Kirkegaard, E., Brodsgaard, I., & Scheutz, F. (1993). Prevalence and characteristics of dental anxiety in Danish adults. *Community Dentistry and Oral Epidemiology*, *21*, 292–296.

Moore, R., Brodsgaard, I., & Birn, H. (1991). Manifestations, acquisition and diagnostic categories of

dental fear in a self-referred population. *Behaviour Research and Therapy*, *29*, 51–60.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research. Techniques and procedures for developing grounded theory*, 2nd edn. California: Sage Publications.

Vassend, O. (1993). Anxiety, pain and discomfort associated with dental treatment. *Behaviour Research and Therapy*, *31*, 659–666.