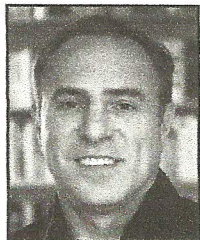


## COMPLEXITIES OF CULTURE: SEEING OURSELVES IN OTHERS

# Cognitive Behavioral Therapy for Treatment of Medical and Dental Phobias

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Anxieties and fears about receiving treatment from doctors and dentists, visiting a hospital, having blood drawn or getting injections are quite common. An estimated 30 million people have medical/dental anxieties and that for one-third of that group, the anxiety is severe enough to be termed a phobia (Curtis et al., 1998).

Medical and dental anxieties often begin in childhood at an average age of 7.9 years but do not usually reach phobic levels until 14.5 years of age (Antony & Watling, 2006). For some people, these fears are focused on specific aspects of care, but often they are widespread and interrelated. For example, one study found that 53% of people with dental phobias also had a fear of needles (Poulton et al., 1998). Direct experience is the most common trigger for developing these kinds of fears, and over half of the people with dental, blood, and needle phobias report a personal experience as the primary cause (Antony & Watling, 2006).

Medical and dental fears can have a significant impact on health. Not treating early symptoms of disease, not receiving preventive treatment, avoiding going to the dentist, staying away from loved ones in hospitals, and not receiving injections for diseases such as diabetes can have damaging effects on one's life and can be life threatening.

The consequences are also particularly severe because phobias tend to persist until a person seeks treatment or circumstances force repeated exposure to the feared situation.

The initial symptoms of most phobias are typical panic reactions, such as racing heart, rapid breathing, and sweating. These symptoms are also common for medical/dental phobias. However, in a significant number of phobic patients, blood pressure decreases rather than increases. This drop in blood pressure is caused by vasovagal syncope and leads to a higher likelihood of fainting (Ost et al., 1984). More than half of people with needle phobias and almost three-quarters of those with blood phobias report a history of fainting in situations they fear (Ost, 1992).

In terms of treatment, anti-anxiety medications, such as benzodiazepines, can be helpful in providing short-term relief (Thom et al., 2000). However, studies do not support the efficacy of such medications in overcoming these kinds of fears. In fact, taking an anti-anxiety medication can actually increase the likelihood of fainting by reducing the patient's heart rate and decreasing blood pressure (Antony & Watling, 2006). The lack of sustained benefit from medications and the potential increase in a person's tendency to faint make psychotherapeutic intervention the treatment of choice for this disorder.

A simple procedure called "applied muscle tension" is designed to increase blood pressure and temporarily prevent fainting. To initiate this technique, the patient focuses on tensing the skeletal muscles, i.e., legs, arms, and torso. The patient holds that contraction for ten to 15 seconds and then relaxes the muscles for 30 seconds, repeating these steps four times (Antony & Watling, 2006). The patient practices and employs this method before undergoing medical procedures or upon detecting early warning signs of fainting, such as lightheadedness, nausea, and hot or cold flashes.

Treatments for medical and dental phobias employ both cognitive and behavioral techniques. The first step requires the therapist to find out what the patient fears. After the therapist explores and evaluates the thoughts associated with these fears, cognitive restructuring begins. The therapist addresses the patient's distorted thinking by reframing cognitive errors, such as negative predictions of the future, overestimation of threat, and catastrophizing. The therapist instructs the patient to keep a written record of such thoughts to evaluate their accuracy and to generate rational responses in order to reduce fear and anxiety.

When a person fears a situation, he or she often avoids it. Unfortunately, avoidance reinforces phobia and prevents new learning in which the patient might discover that the anxiety and the disgust often associated with medical/dental fears are exaggerated. Exposure with response prevention is deemed the most effective strategy for counteracting avoidance and promoting new learning.

The therapist and the patient list a hierarchy of triggering situations in steps of increasing intensity, which might include imagining sitting in a phlebotomist's waiting room, getting an injection, observing another's blood drawn, and having one's own blood drawn. The patient moves through the list of fear-inducing situations with 30-minute exposures. The therapist initially rehearses these procedures in the office; the patient then practices them between sessions in real-life situations. Habituation leads to a decrease in anxiety and fear response.

The following is a composite case example that I hope will provide a sense of treatment procedure:

### Case Example – Dental Phobia

Joanna is a 45 year-old woman who runs a successful business. She has a satisfactory home life and reports no significant history of abnormal anxiety or depression. Lately, however, her anxiety has markedly increased, and she has limited her social activities because she has become extreme-



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ly embarrassed about a large visible cavity in one of her front teeth that she is too fearful to get fixed.

Joanna's fear started when she was ten years old. The difficult extraction of a decayed baby tooth triggered an aversion to going to the dentist. Her mother forced her to go, but after Joanna became an adult and responsible for her own care, she went only intermittently. When she did manage to go, she used various techniques to get through each experience. These methods involved distractions: looking away when the dentist injected her, concentrating on music to drown out the sound of the drill, and insisting that appointments be short so that she could get out of the dental office as soon as possible. However, this latest problem made her anxiety unmanageable, and she was no longer able to schedule care.

She envisaged herself gagging and unable to tell the dentist to stop. She had thoughts that the pain would be unbearable, and feared that she would make a fool of herself by crying. In therapy, she evaluated and cognitively restructured her thinking: Did she have a history of gagging? Would the dentist not be able to tell if she were choking? She had experienced a burst appendix and had given birth to three children. On a scale of one to ten, how likely could the dental treatment be worse?

Treatment for medical and dental phobias usually takes ten to

15 sessions, accounting for variables such as comorbidity and patient motivation. As Joanna reframed her fear-responses, her anxiety and expectation of disastrous results significantly decreased. She also incorporated practical solutions: she brought her daughter with her for early visits; she communicated her fears to the dentist; she made longer appointments; and she scheduled appointments as soon as possible after calling in order to prevent her anxiety from building. During her three-month course of treatment, Joanna received X-rays, got a long-delayed cleaning, had her front tooth repaired, and resumed normal social activities.

Dental phobias are common but often neglected. Fortunately, they often are readily treatable. ▲

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References are available on request from the LACPA office, lacpa1@gmail.com.