Management of Dental Anxiety via Distraction Technique

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Abstract

Objective: The purpose of this study was to evaluate the use of a stress ball as a distraction technique on stress levels of patients undergoing a dental procedure. Methods: A randomized, split-mouth design was conducted using 20 adult subjects requiring scaling and root planing (Sc/RP) in all four quadrants. Each side of the mouth (maxillary/mandibular) received Sc/RP with local anesthetic with or without the use of a stress-ball distraction over two separate sessions. Subjects completed two pre-procedural questionnaires (Spielberger State-Trait Anxiety Inventory, STAI; Modified Dental Anxiety Scale, MDAS) before and after each treatment session. A Galvanic Skin Response (GSR) sensor (Neulog) was used throughout each session to measure skin conductance or sweat. The GSR, STAI, and MDAS scores were evaluated using a Wilcoxon Signed Rank Test (alpha=0.05). Results: No significant difference in GSR scores (p=0.14) was found during treatment with or without the use of the stress ball. Also, no difference in STAI or MDAS scores was found before and after treatment with or without the use of a stress ball (p>0.05). Conclusions: The results of this study found that the use of a stress ball as a distraction technique did not result in any significant reduction in stress levels in subjects undergoing scaling and root planing with local anesthesia.

Introduction

Dental anxiety is a constant challenge for both the practitioner and patient that often impairs the ability of the dentist to deliver routine care.[1-5] Anxiety of dental treatment

stems from a multitude of factors, including traumatic past dental experiences.[6,7] Often stories portrayed through media or word of mouth convey a disturbing portrayal of dentistry.[8] People also report the lack of understanding and a sense of vulnerably, specifically associated with lying in the supine position, as a cause for apprehension. Additionally, proprioceptive triggers such as smells, sounds, sight, and touch are a common source of fear. One study reported that the sight and sounds of the dental drill produces panic in some patients. Another example cites eugenol as a scent that commonly triggers dental post-traumatic stress.[9-11] All these nociceptive feelings can result in the creation of patients with the inability to cope with preventative care. Several studies have shown that anxiety has a direct impact in decreasing the pain threshold, and has been implicated in elevating pain intensity.[12-14] This psychological fear can drive patients to avoid regular dental care as stated by Coriat "any dental surgery, no matter how minor, or even dental prophylaxis, may be so postponed or procrastinated that the inroads of disease may affect the entire dental apparatus."[15]

Cognitive refocusing is a method based on theory of pain where a distraction diverts pain perception by focusing attention to more amusing attractions. In this method, pain perception is reduced due to the increased mental demand towards more pleasant stimuli.[16] A range of distraction methods that are known to work in decreasing patient anxiety and thus perceived pain perception include music, audiovisual, and touch.[17,18] The use of music and video distraction techniques have been demonstrated to be statistically significant in reducing dental anxiety.[19-22] Another method of distraction, employing stress balls, may be a more simple, yet cost effective approach to cognitive refocusing. In medical settings, the use of stress balls as a method of reducing patient

anxiety and perceived pain have shown statistically significant results.[23,24] However, the application of stress balls as a touch-distraction method has yet to be evaluated in a dental setting.

The purpose of this study was to evaluate the use of stress balls as a distraction technique and determine how it affects stress levels of patients undergoing routine scaling and root planning procedures under local anesthetic. In order to evaluate patient's anxiety in this study, continuous Galvanic Skin Response (GSR) was used in combination with the Modified Dental Anxiety scale (MDAS) and a six-item short form of the Spielberger State Trait Anxiety Inventory (STAI) assessments. Galvanic Skin Response has been utilized in previous studies to evaluate the patient reaction and perception of pain and functions by measuring change in electrical resistance, in response to the patient's emotional stress.[25] The MDAS is a self-reported assessment consisting of 5 questions that evaluates dental anxiety. Created in 1995, the MDAS is a simplified version of the Corah's Dental Anxiety Scale that makes it easier for patients to comprehend and faster to complete.[26] STAI was originally established in 1970 as an assessment to allow patients to self-evaluate their current level of anxiety.[27,28] The null hypothesis tested was that there would be no difference in anxiety assessments and galvanic skin response during scaling and root planing with local anesthesia, with or without the use of stress balls.

Methods

The Institutional Review Board at Wilford Hall Ambulatory Surgical Center, Joint-Base San Antonio, Lackland, TX approved this protocol (#FWH 20190044H). The patient population for this study was active duty or Department of Defense beneficiaries over the

age of 18 with mild, moderate, or severe periodontitis requiring scaling and root planing (Sc/RP) in all four quadrants with local anesthetic. This study used a randomized "split-mouth" design with one side of the mouth (maxillary and mandibular) receiving Sc/RP with local anesthetic with the use of a squeeze ball distraction (Why Worry? Be Happy! Neon Yellow Funny Face Stress Ball, Neliblu, Seattle, WA) at one of two appointments (experimental group). The contralateral side (maxillary and mandibular) received Sc/RP with local anesthesia without the use of squeeze ball distraction (control group). Using a random number generator, treatment (with/without squeeze balls) and order (left vs. right side) were randomized per appointment visit. Subjects completed a six-item short form Spielberger State-Trait Anxiety Inventory (STAI) (Figure 1) and a Modified Dental Anxiety Scale (MDAS) (Figure 2) before and after each procedure. Using a split-mouth design, the subjects served as their own control and a total of twenty subjects achieved a power of 80% to detect an 0.67 standard deviation difference or medium effect size in continuous outcomes for a two-sided test with a significance level of 0.05 (NCSS PASS v.11.0.8, Kaysville, UT).

The Galvanic Skin Response monitor (Neulog Galvanic Skin Response, Carolina Biological Supply Company, Burlington, NC) was used during each clinic session to measure skin conductance or sweat. Sweat creates a low-resistance path enabling the measurement of electric current. The conductivity of our skin changes according to unconscious emotional effects such as sudden noise, smell, touch, or pain. Higher GSR values are directly correlated to higher anxiety situations.[25] Velcro connectors were wrapped around two different fingers on the hand opposite the hand using the stress ball (Figure 3A and B). Data were collected using Neulog 3 GSR software with a one-hour run

time and a sampling frequency of 5 microsiemens (μS) per second (Figure 2). Monitoring with GSR and use of the distraction stress ball began when the patient was seated in the dental chair and ended with the completion of the procedure. The patient was instructed to squeeze the stress ball at any time during the procedure.

A topical anesthetic (benzocaine 20% gel Topex, Sultan Healthcare, NJ) was used to anesthetize the surface tissue at the sites receiving the injections. The method of application was as follows: 1) the gel was placed in a syringe and 0.1mL was placed on a cotton tip applicator; 2) the mucosa at each site of injection was dried with a 2x2 gauze; 3) the gel on the cotton-tip applicator was applied to the mucosa for 2 minutes. Inferior alveolar and long buccal nerve block injections were administered for injections on the mandible and buccal infiltration injections were provided on the maxillary arch. The principle investigator performed the site injections to standardize the anesthetic flow rate and technique. The inferior alveolar nerve block injection was given at the pterygotemporal depression. The long buccal nerve block injection was given between the distal mandibular alveolar crest and the external oblique ridge. The maxillary infiltration injections were given in the buccal vestibule near the facial surfaces of the maxillary first premolar and first molar teeth. The anesthetic solution (2% lidocaine with 1:100,000 epinephrine, Henry Schein, Melville, NY) was administered using a 27-gauge long needle (Monoject, Covidien AG, Neuhausen am Rheinfall, Switzerland) for the mandibular injections and a 30-gauge short needle (Monoject) for the maxillary injections, with a standard dental anesthetic syringe. A new needle was used for each injection site to ensure a fresh, sharp cutting tip and to control for injection site pain. Sc/RP was performed using hand and ultrasonic scalers.

Post treatment STAI and MDAS assessments were completed after every session. The STAI evaluation gives each item a weighted score from 1-4, with a range of scores from 20-80. (Figure 1). Anxiety items (tense, upset, worried) carry a normal scoring trend with a value of 4 indicating a high level of anxiety. Anxiety absent items (calm, relaxed, content) are reversed, and values marked as 1, 2, 3, 4 are scored as 4, 3, 2, 1 respectively. All six scores are summed up and multiplied by 20 and divided by 6. According to Bekker et al., a score range of 34-36 is considered normal.[29] Evaluation of MDAS was completed using the MDAS Scale, where each item was scored from "not anxious" to "extremely anxious", with an assigned numerical value from 1-5 respectively. The sum of all five items can range from 5-25, with 19 as a threshold indicating a potentially highly anxious patient. (Figure 2).

A median and interquartile range was determined per group for GSR and before and after treatment for both STAI and MDAS. Data were evaluated using a Wilcoxon Signed Rank Test (alpha=0.5) with statistical software (SPSS, version 25, IBM, Armonk, NY). Additionally, subjects were asked after the second appointment to indicate whether they had preferred the first session, or the second session or if they had no preference between either sessions.

Results

No significant difference in GSR scores (p=0.14) was found during treatment with or without the use of the stress ball. The use of the stress ball resulted in a median GSR of 0.74 and IQR of 0.83 µS, which was not significantly different than no use of the stress ball with a median GSR of 0.80 and IQR of 0.77 µS. Also, no differences in STAI or MDAS

scores were found before and after treatment with or without the use of a stress ball (p>0.05). See Table 1. Of the 20 subjects participating in this study, 20% preferred the use of the stress ball, 35% preferred not to use the stress ball, and 45% had no preference.

Discussion

Pain has been reported as a multidimensional experience, influenced by multiple interactions.[30] Tracey and Mantyh described the perception of pain as a cognitive-evaluative, motivational-affective, and sensory-discriminative experience.[31] Legrain et al. described a hypothesis where in a "neurocognitive model of attention, pain perception could be decreased by increasing the cognitive load." In that model, pain sensation is decreased by an attention-grabbing task that increases the demand of attention away from the pain source.[32] However, in this study, there was no difference in anxiety assessments and galvanic skin response during scaling and root planing with local anesthesia, with or without the use of stress balls. Therefore, the null hypothesis was not rejected.

A study looking at the ability of children to reduce the stress of venipuncture through the use of stress balls showed no significant results. However, the average age was only nine years old and the procedure was a blood draw, two factors which may have limited the success of the technique.[33] A potentially more relative study involved the use of distraction techniques to include video, stress balls, music, conversation, or treatment as usual (control). The study examined 398 adult subjects during minimally invasive venus surgery under local anesthetic. Similar to this study, a pre- and post-procedural

STAI was utilized to evaluate levels of anxiety. The authors also utilized a pain questionnaire and a numeric rating scale to assess intraoperative pain and anxiety. The results of their study demonstrated that conversation, watching a video, or the use of stress balls significantly reduced patient stress and anxiety during the procedure.[34] However, unlike this study, the researchers did not evaluate galvanic skin response to objectively measure patient stress and anxiety. In addition, this study utilized a within-subject design with subjects serving as their own control, potentially increasing the power to detect the effect of the use of stress balls on stress and anxiety.

The efficacy of GSR has been evaluated in multiple studies. In a 2016 literature review by Appukutan, it was concluded that "An extremely accurate objective method used in various studies to measure dental anxiety is galvanic skin response."[19] Caprara et al. conducted a study that demonstrated that GSR had a statistical significant correlation to dental anxiety. In that study, the data identified that the highest anxiety levels were a result of the local anesthetic injection.[35] In another study evaluating GSR's predictability in measuring children's dental anxiety, 151 children from ages 5-7 were screened and confirmed for dental anxiety with a modified dental anxiety scale (MDAS), then subjected to simple dental restorative procedures while undergoing GSR monitoring. The results demonstrated that GSR was correlated to the pre-procedural MDAS evaluation and was a statistically significant method in evaluating children's dental anxiety. Furthermore the used of heart rate for objective measurement was ruled out due to the potential side effects of the epinephrine, such as an epinephrine rush causing an increase in heart rate as a direct effect of the epinephrine and not the patient's anxiety.[25]

Several studies have evaluated the legitimacy of the MDAS and STAI.[36-41] One of the largest studies evaluating MDAS took place in 2000 with a sample size of 800 patients from 3 different countries - Northern Ireland, Finland, and Dubai. The patients attending dental clinics were handed a questionnaire booklet and then followed up with an invitation to participate in the study. The results demonstrated that the MDAS had high levels of consistency and validity.[37] The original STAI contained 40 items and was extensively used in medical settings.[38] In a study by Marteau and Bekker, the 40 items were shortened to only six items and produced correlation coefficients greater than 0.90.[39] In a follow up study, Tluczek et al. revisited the six-item short form SATI created by Marteau and Bekker and assessed 288 subjects at 2, 6, and 12 months. The short form was highly correlated with the 20-item STAI score, and all internal consistency reliabilities were greater than 0.90.[40] The effects of pre-procedural MDAS and STAI on patient anxiety levels has also been studied. In a study conducted by Humphris and Hull, the use of pre-procedural anxiety assessments did not increase patient anxiety.[41]

This was the first study evaluating the use of stress balls as a distraction technique in a dental setting. Limitations to this study include the inability to control factors such as rate of injection administration, extent of probing depths, and severity of periodontal disease. Some subjects commented that the stress ball was either too firm or too large or small. These concerns can be a limiting factor since they could prevent the patient from actively engaging in the use of the stress ball. One subjective finding to note was that 30% of subjects did indicate that they thought the stress ball helped decrease anxiety during administration of local anesthetic. Additionally, of the ten subjects that used the stress ball in the first session, two requested the use of the stress ball at the subsequent

appointment even though they were not randomized to use it. Future studies could evaluate the use of the stress ball only during the administration of local anesthetic. In addition a post-procedural questionnaire could include a scale of 1-10 on how likely they are to use the stress ball at follow up appointments.

Conclusions

The results of this study found that the use of a stress ball as a distraction technique did not result in any significant reduction in stress levels in subjects undergoing scaling and root planing with local anesthetic.

Disclaimer: The voluntary, fully informed consent of the subjects used in this research was obtained as required by 32 CFR 219 and DODI 3216.02_AFI 40-402. The views expressed are those of the authors and do not reflect the official views or policy of the Uniformed Services University, Department of Defense, or its Components. The authors do not have any financial interest in the companies whose materials are discussed in this manuscript.

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Figure Legends

Figure 1: Six-item short-form Spielberger State-Trait Anxiety Inventory (STAI).

Figure 2: Modified Dental Anxiety Scale (MDAS).

Figure 3: A. Velcro connectors were wrapped around two different fingers on the hand opposite the hand using the stress ball. B. Patient squeezing stress ball with dominant hand.

Figure 4: Data was collected using Neulog 3 GSR software with a one-hour run time and a sampling frequency of 5 microsiemens (µS) per second.

Figure 1: Six-item short-form Spielberger State-Trait Anxiety Inventory (STAI).

	Not at all	Somewhat	Moderately	Very much
1. I feel calm …...………………………	1	2	3	4
2. I am tense ………………….…...	1	2	3	4
3. I feel upset …………..……………	1	2	3	4
4. I am relaxed …………………………	1	2	3	4
5. I feel content …………….....……..	1	2	3	4
6. I am worried ……………...…………	1	2	3	4

Figure 2: Modified Dental Anxiety Scale (MDAS).

1. **If you went to your Dentist for TREATMENT TOMORROW, how would you feel?**

   Not Anxious ☐   *Slightly Anxious* ☐   *Fairly Anxious* ☐   *Very Anxious* ☐   *Extremely Anxious* ☐

2. **If you were sitting in the WAITING ROOM (waiting for treatment), how would you feel?**

   Not Anxious ☐   *Slightly Anxious* ☐   *Fairly Anxious* ☐   *Very Anxious* ☐   *Extremely Anxious* ☐

3. **If you were about to have a TOOTH DRILLED, how would you feel?**

   Not Anxious ☐   *Slightly Anxious* ☐   *Fairly Anxious* ☐   *Very Anxious* ☐   *Extremely Anxious* ☐

4. **If you were about to have your TEETH SCALED AND POLISHED, how would you feel?**

   Not Anxious ☐   *Slightly Anxious* ☐   *Fairly Anxious* ☐   *Very Anxious* ☐   *Extremely Anxious* ☐

5. **If you were about to have a LOCAL ANAESTHETIC INJECTION in your gum, above an upper back tooth, how would you feel?**

   Not Anxious ☐   *Slightly Anxious* ☐   *Fairly Anxious* ☐   *Very Anxious* ☐   *Extremely Anxious* ☐

Figure 3: A. Velcro connectors were wrapped around two different fingers on the hand opposite the hand using the stress ball. B. Patient squeezing stress ball with other hand.

Figure 4: Data was collected using Neulog 3 GSR software with a one-hour run time and a sampling frequency of 5 microsiemens (µS) per second.

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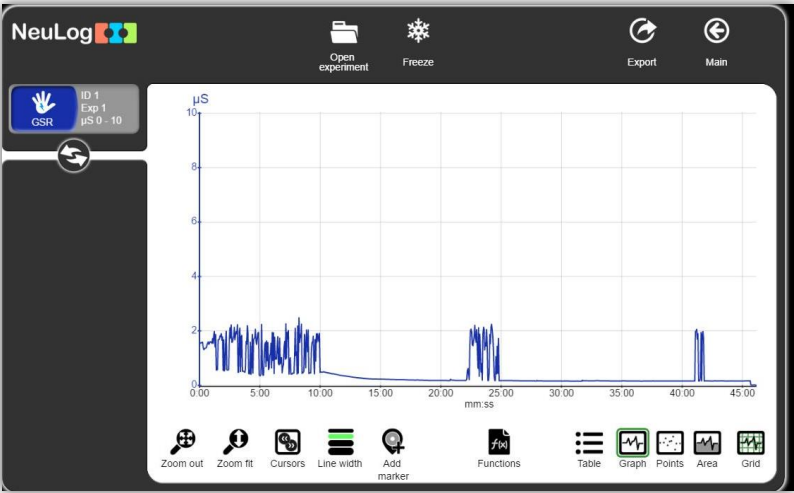
Spielberger State-Trait Anxiety Inventory and Modified Dental Anxiety Scale (median, IQR)						
	No Stress Ball		P	Stress Ball		P
	Before	After	value	Before	After	value
STAI	28.3 (28.2)	30.0 (23.0)	0.13	30.0 (12.6)	25.0 (19.2)	0.33
MDAS	11.0 (6.0)	10.0 (5.5)	0.16	11.0 (4.5)	10.5 (5.8)	0.72

Table 1: Results of the Spielberger State-Trait Anxiety Inventory and Modified Dental Anxiety Scale.