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Grief and Loss: How these Entities Affect Dental Treatment, Especially After the Age of 65

A Peer-Reviewed Publication
Written by Eric Shapira, DDS, MA, MHA

Abstract

Loss and grief are emotional states found quite commonly in the older patient; influencing how we may render dental care. 80 million baby boomers are approaching the age of 65. This is the largest cohort of people in this age bracket the world has ever known. People will be living longer, necessitating ongoing dental care to restore and retain their teeth. Many of these patients carry with them specific psychological challenges that can complicate dental treatment. It is incumbent upon all practitioners to be familiar with these emotional states, such as: grief, loss, anxiety and Post Traumatic Stress Disorder (PTSD), to name a few, so that we will be able to recognize when we will need to use good communication, empathy and dental skills to treat these types of patients.

Educational Objectives:

At the conclusion of this educational activity, participants will be able to:

1. Distinguish between loss, grief and anxiety as it relates to emotional distress and psychological disorders.
2. Become familiar with the importance of good communication skills in defusing emotion and treating people in an empathic manner.
3. Increase awareness of how one relates to patients who exhibit psychological symptoms of loss, grief, anxiety, PTSD and emotional outbursts.
4. Distinguish between normal aging and the exacerbation of abnormal behavior in the dental setting.
5. Evaluate one's own limitations to treating older adults who bring their emotional symptoms to the dental office.

Author Profile

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Author Disclosure

Dr. Eric Shapira has no commercial or financial ties to disclose.

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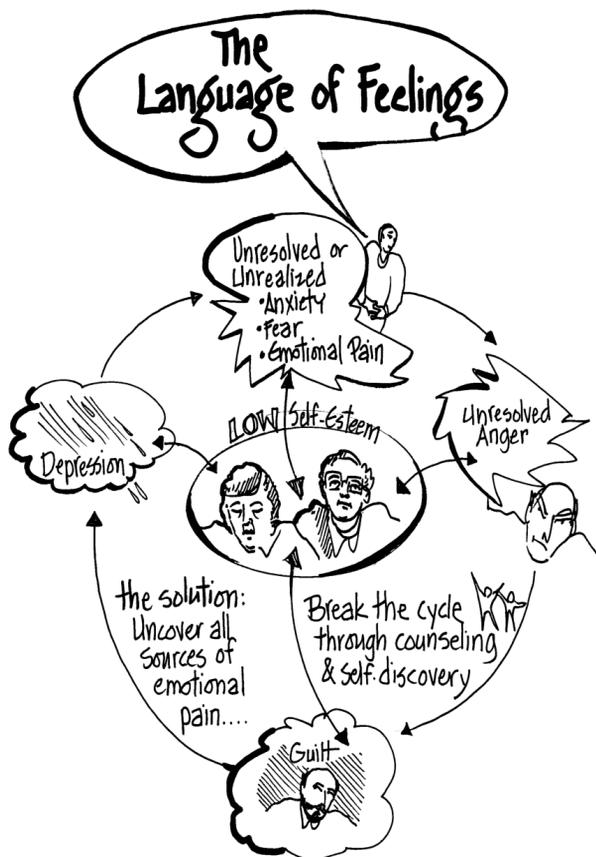
Loss and grief are emotional states found quite commonly in the older patient; influencing how we may render dental care. 80 million baby boomers are approaching the age of 65. This is the largest cohort of people in this age bracket the world has ever known. People will be living longer, necessitating ongoing dental care to restore and retain their teeth. Many of these patients carry with them specific psychological challenges that can complicate dental treatment. It is incumbent upon all practitioners to be familiar with these emotional states, such as: grief, loss, anxiety and Post Traumatic Stress Disorder (PTSD), to name a few, so that we will be able to recognize when we will need to use good communication, empathy and dental skills to treat these types of patients.

Grief, Stress and Anxiety

Grief is intense suffering, sorrow or mourning, usually due to loss of some sort.¹ Another definition of *grief* is the psychobiological response to bereavement whose hallmark is a blend of yearning and sadness, along with thoughts, memories, and images of the deceased person.² *Mourning* is the array of psychological processes that are set in motion by bereavement in order to moderate and integrate grief by coming to terms with the loss and reorienting to a world without our loved one in it, or to the loss of something that was owned, or included as part of our make-up or being.³ Many people may experience anxiety as a result of grief. Our reaction depends upon different factors including; the specific loss itself, our age at the time of the loss, our closeness to the person who we are or may be grieving over and our dependence on the person. If the anxiety is self-imposed, we may find ourselves in a state of sadness. Unresolved sadness then can lead to depression over time, as does extended grieving, through a circle of feelings connected with anger, guilt, and loss of self-esteem. These will also add to the grief one may feel and potentiate the anxiety involved. It is a vicious circle and needs to be broken in a timely manner using

counseling and a lot of *tender loving care* (TLC). Losing a loved one is difficult, to say the least. According to Elisabeth Kübler-Ross, M.D., in her 1969 book titled *On Death and Dying*, there are five stages of grief: Denial, Anger, Bargaining, Depression, and Acceptance. Many times people get "stuck" in one of these stages and never get out. This, in turn, may lead to a heightened single emotion of the stage they are in at the time. The author's father never got out of the anger phase of grief when he was chronically ill. This author believes to this day that it accelerated his death and kept him in a deep, unknown to him, psychological depression. Thus he experienced a complicated grieving process, which could have been ameliorated had he allowed himself to process the feelings he had; instead of feeling sorry for himself and obsessing about a "why me" kind of attitude.

Complicated Grief (CG) is a recently recognized condition that occurs in about 7% of bereaved people. People with this condition are caught up in constant fixation about the circumstances of their loss, about the consequences of death or excessive avoidance of the reminders of loss itself in any form.⁴ Those persons with specific personality disorders, which are akin to a disease process, such as Obsessive Compulsive Disorder (OCD) have a tendency to be hyper sensitive to conditions such as complicated grief as well as grief itself. Obsessing over anything can be deleterious to your well-being; however the potentiation of the grieving process by being obsessive can lead to a depression or a state of *dysthymia*, commonly called "the blues." This condition can go on and off over a long period of time. The person, nor anyone else, may not realize that the condition is an offshoot of sadness, which creates depression and is potentiated by OCD and the initial loss. Features of a Dysthymic Disorder are similar to those for Major Depressive Episode. Studies have suggested that symptoms may include feelings of inadequacy, generalized loss of interest or pleasure, social withdrawal, feelings of guilt or brooding about the past, subjective feelings of irritability or excessive anger, and decreased activity, effectiveness, or productivity. When Dysthymic Disorder is without prior Major Depressive Disorder, it is a risk factor for developing the condition of Major Depressive Disorder. In clinical settings, up to 75% of individuals with Dysthymic Disorder will develop a Major Depressive Disorder within 5 years.⁵ The suffering and sadness that bereaved people often have can confuse clinicians of all kinds. On one hand, it can seem inane not to treat their concerns; however, on the other hand, if we regard grief as a normal human response to loss, then this suggests it may not be the right thing to focus on for clinical treatment.⁶ If one attempts treatment, then how do we determine the who, what, where and how of treatment, if this condition is supposed to be normal in the first place? The use of good communication as a tool is first and foremost on the top of the list of mechanisms to use when confronted with a grieving person, no matter what the cause of their grief.



From "A New Wrinkle: What I Learned from Older People Who Never Acted Their Age." Eric Shapira. iUniverse Publishing, Bloomington and New York, 2011⁷.

The Use of Communication as a Skill and "Mental" Medicine

Communication, from the Greek, means "a talking together." It is a two way, simultaneous transmission of thoughts, information and feelings, usually between like-forms; which when successful, leads to common meaning and understanding. Even when we are not communicating, we are saying something to someone. This process must be practiced if we are to be adroit at it and able to use the proper communication in scenarios with patients who are exhibiting normal and abnormal behavior. This means someone who is grieving a loss of some kind may be showing us a different side of themselves or may not be showing us anything at all but silence, an indirect gaze and 'closed' body language; that is, crossed arms and legs, head down and lack of eye contact. Only 7% of what we say is words, 38% is the sound we make with our words and 55% is related to our body language according to Albert Mehrabian in his 1971 book, *Silent Messages*.⁸ So the meaning of our words is changed by the tone of our voices and how we deliver ourselves through body language when speaking, not necessarily through what we are saying. It is important to note that in order to accomplish our treatment goals, we must be able to ascertain what the patient brings

with them to the dental office in terms of previous difficulties, problems and physical as well as mental challenges such as grief, loss and bereavement issues. If we are to be successful practitioners, then we need to address these confounding entities with care, and proper communication.

How we communicate depends upon how the patient is acting. We need to address their behavior from a physical standpoint first before they ever say anything at all. People who are grieving may be crying, have red, blood-shot eyes, or may be very taciturn and not saying anything at all. This should create concern on the part of the dentist, hygienist and the dental office staff. "Owning" another's pathology or problems that they try to project onto us, will not help us treat the patient. We need to address the behavior with an "I" message such as, "I sense that you are sad today about something. Is that what you are feeling?" If the patient then says to you "No, I am not sad, I'm angry!!!" You might buy into this verbiage by saying "I'm sorry, was it something that I did or said or my staff did or said to you?" This is what one should not do or say. It is imperative to respond through active listening and say, "I see. What is it that you are angry about?" This way, one can prevent the so called "buy-in" of owning the other persons words and feelings, not having to make an excuse for what they perceived might have caused the behavior; rather than echoing the behavior through listening and responding in kind. This is an empathic response and is what we need in order to show the patient we are concerned or care about them. It will get them to open up and talk about what it is they have brought with them that day as far as their emotions are concerned. Having someone in the chair start to cry when you pull out your syringe to give them an injection may elicit a comment from you like, "Oh, I am truly sorry, this won't hurt at all, just pinch for a second." The clinician may interpret the tears as fear of an injection which caused the patient to cry. A better response would be, "I sense you are sad about something today, is that what you are feeling?" With this response, one would have found out that the patient had been in a hurry to get to your office. When she backed her car out of the driveway, she inadvertently backed over her cat and killed it! This was a real-life situation that happened to the author when treating an actual patient. The author's reaction to her explanation, syringe in hand, was, "I don't think we are going to do any dentistry today as I see how upset you are and I think that you might want to grieve in the privacy of your home. Is that alright with you? When you feel better, please reschedule your appointment and we will be happy to see you again." If we use empathy as our guide, a non-judgmental paraphrasing of what we think someone is saying, then we can't go wrong. Using empathy in conjunction with the active listening techniques of phrasing, rephrasing and verifying what we think someone has said to us demonstrates that we hear their concerns and are in-tune with them by respecting their situation. Communication is "Mental Medicine," which

provides us with the ability to ask and receive information, thoughts and feelings about specific situations, gives us clarity of mind as well as unification of specific thought processes. Without a mechanism to communicate we would be lost within our own thoughts. Effective communication becomes a healing process, helping to relieve doubt and soothe the individual.

Stress as a Side-Effect of Loss

Grieving in itself can cause a person a great deal of stress and angst. In turn, stress can have multiple side effects on the human organism. "Stress is the body's reaction to a change that requires a physical, mental or emotional adjustment or response. Stress can come from any situation or thought that makes one feel frustrated, angry, nervous, or anxious. Stress is caused by an existing stress-causing factor or 'stressor.'"⁹ Dealing with a serious illness or caring for someone who is involved with a stressful issue can cause a great deal of stress for either party: the dentist, hygienist or the patient.

Stress, especially chronic stress, can have serious consequences which do affect the human body in multiple ways, especially the oral cavity. Excess stress can lead to xerostomia, painful aphthous ulcers, herpetic lesions of the mouth and body, clenching, grinding, temporo-mandibular diseases including; joint problems, jaw and muscle pain as well as migraine and cluster headaches. These challenges pose a great threat to following through with already projected dental care.

Anxiety is one of the most common complaints seen in both medical practices and dental offices alike. Most people may experience feelings of anxiousness before a big event, an examination of any kind, a first date, or business presentation. It may be brief and possibly very mild. However, people who are anxious have reported subjective feelings of apprehension, uneasiness, tension or terror in response to danger. This may be related to anxiety itself or attributed to an Anxiety Disorder, which affects over 19 million adults in the United States.¹⁰ Anxiety Disorders can have their roots in diagnoses such as Post Traumatic Stress Disorder, Panic Disorder, Obsessive-Compulsive Disorder and Phobias. Certainly, grieving and loss due to a traumatic event can be manifested in both simple anxiety and an Anxiety Disorder. Dental practitioners who attempt to practice dentistry on these types of patients may find it not only extremely difficult but almost impossible at times due to the differentiated symptomology these conditions exhibit. Sedation might be an option before treating these patients and making sure they have received counseling and *TLC* beforehand as well. Persons who are witness to a death for the first time may be subject to PTSD. Not having ever experienced the death of a friend or loved-one can have a myriad of effects on someone who does not know what to expect. Post-Traumatic Stress

Disorder does have persistent symptoms that occur after experiencing or witnessing a traumatic event. Nightmares, flashbacks, numbing of emotions, depression, and feeling angry, irritable or distracted and being easily startled are very common symptoms of this disorder.¹¹ "Most people with PTSD relive their trauma in their thoughts during the daytime and in nightmares when they sleep. These constant thoughts are called *flashbacks* and can have dangerous side-effects at a moment's notice," according to leading experts at the National Institute of Mental Health. Having a dental patient with active, continuous *flashbacks* sit in one's dental chair; expecting them to stay there for a complicated procedure without discussion or understanding on both person's parts, and a previous knowledge of what might trigger a negative reaction is an accident waiting to happen.

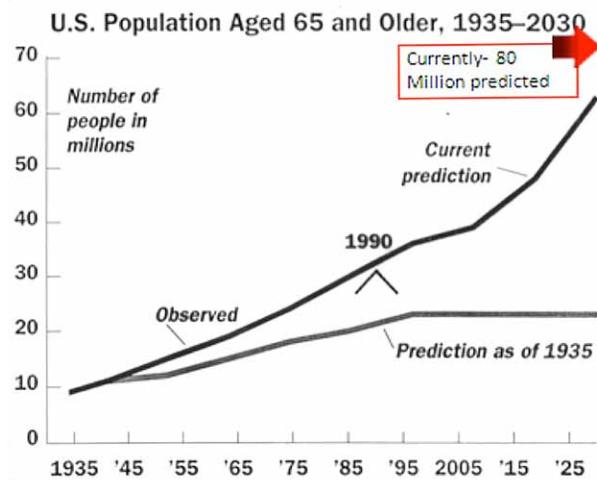
Dentistry is predicated upon the Hippocratic Oath: "Do no harm." The lack of knowledge about a patient's mental, physical, oral, or social history is akin to making a large mistake and inevitably causing harm to the patient and angst for the dental team. For example, not knowing that a patient has a prosthetic joint in the process of extracting a tooth without prescribing pre-op antibiotics, places the patient at risk for contracting an infection. The same rationale is true for a person who has been traumatized in some way, no matter how deeply, by an emotionally disturbing event such as the loss of someone close, an accident or natural disaster. When we know that someone is suffering from an emotional malady stemming from loss, and is in a state of bereavement or grief, we can use preventative measures to make sure our treatment regimen will not be harmful, will not create a negative scenario such as anger, as well as no personal harm affecting the patient. Over 7.7 million people in America are affected by PTSD that we know about; occurring at any age, including childhood.¹² PTSD is often accompanied by depression, substance abuse, anger, aggression, irritability and violence in the extreme case.¹³ It behooves us as practitioners to take accurate, thorough histories, not take anything for granted and continually update our charts each time we see the patient. The example of the patient who ran over her cat is a good one because it illustrates the clinician's perception. For most people perception is their reality. This is why we need to keep our judgments to ourselves. It is judgment that skews the communication process in the wrong direction. Clarifying everything is the right way to go when communicating. If one does not understand, then clarify. The old adage, spoken by Epictetus in ancient times, sends all of us a message of truth: "We have two ears and one mouth, so we should listen twice as much as we speak."

Listening is the gift we give to other people. Dr. Mehrabian also stated from his research that we only listen to 7% of what we hear. It is a kind of selective listening. It is incumbent upon all practitioners to practice more efficiently by using better listening skills. Listening with all

of our senses is important because of the statistics previously quoted. We don't want to miss anything that might cause both the patient harm and the practitioner a potential problem or mistake.

The Aging Process and Dentistry

Aging is a process that emanates from birth and ends with death. Like *Time*, it cannot be stopped, except by death itself. As practitioners we need to know that we are in the midst of the largest cohort of people turning 65 years old or greater in the history of mankind. There will be approximately 80 million baby-boomers turning 65 years of age by 2025.¹⁴ This illustrates that we are living longer lives; which in turn will require the aging population to seek out continuous dental care. Old age will demand tooth retention and consequently the need for restorative care. Retaining teeth in a disease-free condition and maintaining them amidst a multitude of risk factors associated with old age, is a multi-faceted challenge. To have quality of life in old age, one needs teeth not only for the enjoyment and digestion of food but also for proper nutrition and a pleasant appearance. There is also evidence that oral diseases impact cardiovascular, endocrine and pulmonary health particularly in the elderly, which may provide additional stimuli for the elderly to seek out dental care.¹⁵ Being prepared to meet these needs and treat this cohort of people, is extremely important for us.



Graph from the US Census Bureau, Department of Statistics and Aging, 2004¹⁶

What we can do is learn the signs and symptoms of disease, both oral and systemic. We can learn to be better communicators. We can learn to understand the ramifications of the aging process so that if an adverse action happens we will be prepared for it. Learning all we can, keeping on top of medical emergencies by practicing drills in the office will make all of us better practitioners. Practice makes permanence. Learn to look for signs and symptoms: Listen to your patient's tone of voice; how they carry themselves; their gait; their eye contact; whether they smile or frown; whether

they are breathing from their mouth or nose; whether their breathing is labored; if they whisper or are extra loud when they speak; look at whether they can write, sign their name or read; and if they can remember what you said a few moments ago by asking them if they understand what you said in the first place. Take a good hard look at their face and try to envision if they have suffered loss and what kind, then ask them about it.

| What can happen as we age? | |
|-------------------------------------|---|
| Memory loss | |
| Hearing loss | |
| Vision loss | |
| Sensory loss | |
| Tooth loss | |
| Physical disabilities | |
| Loss of personal friends and family |  |
| Health decline | |
| Decreased mental abilities | |
| DEATH | |

From Geriatric Dentistry lectures, Eric Shapira, DDS, 2012¹⁷

A case this author had recently proved very difficult. An 85 year old woman came to the author's office for dental treatment on an emergency basis. She had a loose anterior PFM bridge from tooth #6 to #9. Tooth #8 was a pontic. She had through and through decay that had separated the crown of #6 with the root in its entirety under the porcelain fused to metal crown. An explanation of the treatment plan was provided. Less than 10 seconds later the patient asked, "What are you doing and why?". The author was aware that she had Mild Cognitive Impairment (MCI), a precursor to dementia. The severity of the the MCI was not known nor the extent to which she manifested the symptoms.

She stated that she had some memory issues when asked her about her medical history. Her memory issues were obvious and considerably encumbering. Over the course of sectioning her bridge, performing an endodontic treatment on tooth #6 with a post and core build-up, she asked at least 10 times, "What are you doing?" The author found this very difficult because we had to stop each time and explain what was happening to her and why. One thing that practitioners need to understand is that medically or mentally challenged older patients need not only *TLC*, but more time for treatment as illustrated by this example. During consultation with the other dentist in the office at the time, it was explained that the root of tooth #6 was long and stable and needed to anchor the new bridge. Final impressions were completed and a provisional bridge was fabricated; however, a week later she "snapped" tooth #10 off at the gum line! Needless to say, production of the bridge was halted

and her treatment reconsidered. The patient's questions resumed when an attempt was made to restore the brittle root of tooth #10; which she fractured after it was restored with pins and build-ups. At this juncture, it was decided to make her a temporary stayplate and opt for some implants versus a removable partial denture. The rationale here included a realization that she will continue to decline as far as her memory is concerned and making her a removable appliance at this time would not be prudent due to the distinct possibility of her misplacing it. The patient had a history of losing things on a consistent basis. This included her purse, money, DVD's, clothes, etc. With increased memory deficit in the future, providing crowns and bridges that cannot be lost or misplaced was an important consideration. This patient has been diagnosed with Dementia. She is also a borderline type II diabetic. It has been recently discovered that type II diabetes can make memory worse with aging.¹⁷ Her vascular dementia coupled with type II diabetes could mean that she will experience an exacerbation of the memory decline. In turn, this will create many problems for her and many challenges for those practitioners that she might visit along the way. Healthcare practitioners need to, "Be Prepared."

Other medically compromised patients might opt out of doing anything to their teeth under the same circumstances. However, the previous patient was a professional model most of her life and was keyed into her smile and beauty; so looking good was a priority for her.

As our population ages, we must understand how to extend the "healthspan" of this cohort of people—i.e., the maintenance of health, vigor, and quality of life with aging.¹⁸ We know that people are living longer, but many of them are not maintaining their "healthspan." Physiologically as we age, our bodies change. Our thirst lessens causing subsequent xerostomia as well as dry skin, loss of elasticity, and dehydration with secondary memory loss. As dental practitioners we see patients repeatedly, usually more than a physician does. We have the opportunity to look for things that might get missed medically. For example, a young senior person presented with a complaint of pain in her mouth. She isolated it to two or three teeth. She was in her sixties and still in business. In fact, she was competing with males in her company for the position of vice-president. She worked late and on weekends. She was under considerable stress and indicated on the health history that she was taking Ginkgo Biloba, an herb to help one's memory. Bruises were noted on her legs and arms; being a mandated reporter, asked if she had been abused. She replied that she had not. The pain in her teeth came from fractures created by bruxing and clenching. Fracturing these teeth made them responsive to pain. She took lots of pain killers including: aspirin, Tylenol®, Darvon®, Empirin® with codeine and more. Between these drugs and the Ginkgo, her platelet count was low, which subsequently affected her ecchymotic areas of bleeding under her skin, and created a dental treat-

ment challenge. The stress of her job created numerous psychological problems for her as well. She did not look me directly in the eyes. She fidgeted in the dental chair and she cried a lot. When questioned, she felt as if she was losing her ability to compete with her colleagues as well as losing her professional "edge." She could not keep a relationship going and her tolerance level for just about anything was nil. She was exhibiting a great deal of anxiety and anger. The author believes that she was already grieving the loss of not being chosen to be the vice-president of her company; however, she was unaware of this fact consciously. One could say that she was "willing" this upon herself and projecting the loss. She was nearly impossible to anesthetize and to work on due to her nervousness and fidgety nature. Much to her chagrin, she was referred to an endodontist who used IV sedation and was able to complete the endodontic treatment. Following endodontic therapy, the patient was referred to a prosthodontist to complete her treatment. The decision was made after the realization that completing treatment would be difficult and stressful for the author and the patient. It is important to know one's limits in treating patients.

More than 50% of patients over the age of 60 are medically compromised and are on medication.¹⁹ Most commonly seen medical conditions are diabetes, hypertension, cardiovascular diseases, arthritis and neuromuscular diseases such as Parkinson's disease and Alzheimer's disease.²⁰ As health care providers we need to be familiar with the course and potential complications associated with these disease conditions and the prophylactic guidelines provided for various medical conditions when we are embarking upon dental treatment for these patients.²¹ One might think of treating some patients who may have a form of cardiovascular disease who are vulnerable to physical or emotional stress that may be encountered during dental treatment. The treatment plan should include low stress protocols and shorter appointment times. Usually, the author recommends seeing these patients in the morning when their energy levels are high and they are "fresh." Vasoconstrictors should not be administered to patients with unstable angina, uncontrolled hypertension or people with recent myocardial infarction and coronary by-pass grafts. Prophylactic antibiotics may be necessary for those patients with a history of high risk cardiac conditions while undertaking endodontic treatment.²² In general, appointments for diabetic patients should be scheduled with consideration to the patient's normal meal and/or insulin schedule. In the presence of acute infections, hypoglycemic control needs to be altered in consultation with the patient's physician. Drug interactions and adverse drug reactions are more likely in the aged patient population as many of them are under multiple drug therapy; as many as 20+ per day. Therefore, careful evaluation of the patient's medical/medication history, followed by consultation with the appropriate medical professional is highly recommended for optimal care.²³

Questions to answer when treatment planning for older patients

- **Prognosis:** What are the consequences of not treating the dental problem, and how long should the treatment be delayed?
- **Dentist's limitations:** Does the doctor have the appropriate equipment to do the recommended treatment at the chosen site?
- **Staff responsiveness:** Does the staff have the training, expertise, knowledge of the patient, and are they able to give emotional support to patient care?
- **Finances:** Does the patient have the appropriate finances for the treatment being planned? How can you make it affordable for the patient? Always have alternative treatment plans....

From Geriatric Lectures, Eric Shapira, DDS, MA, MHA, 2012

Questions to answer when treatment planning for older patients

- **Patient attitude:** To what degree does the patient desire dental treatment and will he or she give their informed consent to institute treatment?
- **Quality of life:** How much is the patient affected either physically or emotionally by the dental problem and how will he or she respond to different levels of tx?
- **Limitations of treatment:** How much do existing medical, psychological, or social problems limit the patient's ability to benefit for treatment?
- **Iatrogenic potential:** How much possibility is there of creating iatrogenic problems, either by medical emergency, a drug reaction, or a dental problem associated with the projected or accepted treatment plan?

From Geriatric Lectures, Eric Shapira, DDS, MA, MHA, 2012²⁴

All too often we forget what our own capabilities are in treating patients. We have to be honest with ourselves about what we feel comfortable treating and when to refer. We also have to know that our staff is knowledgeable and can be supportive in treating the older, medically compromised patient as well. Learning about the diseases and conditions that affect the older adult is not only important but helps us in our treatment of people with these issues.

Another example of working with a compromised patient would be an elderly WWII veteran with undiagnosed PTSD, who might be shocked by our treatment when we use a laser, a Cavitron™, a high speed handpiece for any length of time or even an x-ray unit that might trigger an anxiety attack related to a war experience he or she might have had in their unconscious memory. Trying to treat this person, let alone keep them in the dental chair, would be difficult or futile. Loss of any kind, anger, grief, anxiety, emotional pain, physical disease, mental challenges like memory loss and fear of anything, including dentistry, can have a deleterious effect if we cannot recognize it and learn to work with it.

There are many other scenarios, disease states and protocols to consider when treating older, medically compromised individuals. It is the unseen states of loss, grief and anxiety that may cause us, as practitioners, the most difficulty in treating the older patient. Therefore we need to be acutely aware of these entities and learn how to reduce the possibility of an outburst or anxiety attack during a dental visit.

In conclusion:

- Increased life expectancy is causing an exponential increase in the aging population that will continue now and in the future.
- Healthcare and healthcare insurance will be more available to people who have gone without it in the past; thus enabling them to have dental treatment.
- Improved quality of life at old age will demand tooth restoration and retention. Retaining healthy teeth and maintaining them amidst the multitude of risk factors associated with old age is a multi-faceted challenge for all of us. It is important to include the patient's physician, ancillary professionals and family into the dental treatment decisions when necessary and applicable.
- Every dental professional should be conscious of the needs of the elderly patient, provide the necessary infrastructure, comprehend their psychological demeanor, offer them empathetic care to ensure peace of mind and augment the patient's state of dignity as well as their sense of well-being with advancing age.
- Lastly, we need to recognize that we are not in a "throw-away" society concerning our elders and due respect is owed to them when dental concerns are a major factor in their quality of life.

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Grief and Loss: How these Entities Affect Dental Treatment, Especially After the Age of 65

Name: _____ Title: _____ Specialty: _____

Address: _____ E-mail: _____

City: _____ State: _____ ZIP: _____ Country: _____

Telephone: Home () _____ Office () _____

Lic. Renewal Date: _____ AGD Member ID: _____

Requirements for successful completion of the course and to obtain dental continuing education credits: 1) Read the entire course. 2) Complete all information above. 3) Complete answer sheets in either pen or pencil. 4) Mark only one answer for each question. 5) A score of 70% on this test will earn you 2 CE credits. 6) Complete the Course Evaluation below. 7) Make check payable to PennWell Corp. **For Questions Call 216.398.7822**

Educational Objectives

- To be able to distinguish between Loss, Grief and Anxiety as it relates to emotional distress and psychological disorders
- To be able to become familiar with the importance of good communication skills in defusing emotion and treating people in an empathic manner
- To be able to increase awareness of how one relates to patients who exhibit psychological symptoms of Loss, Grief, Anxiety, PTSD and emotional outbursts
- To be able to distinguish between normal aging and the exacerbation of abnormal behavior in the dental setting
- To be able to evaluate ones' own limitations to treating older adults who bring their emotional symptoms to the dental office

Course Evaluation

- | | | |
|---|----------------------|----------------------|
| 1. Were the individual course objectives met? | Objective #1: Yes No | Objective #4: Yes No |
| | Objective #2: Yes No | Objective #5: Yes No |
| | Objective #3: Yes No | |

Please evaluate this course by responding to the following statements, using a scale of Excellent = 5 to Poor = 0.

- | | | | | | | |
|--|---|-----|----|---|---|---|
| 2. To what extent were the course objectives accomplished overall? | 5 | 4 | 3 | 2 | 1 | 0 |
| 3. Please rate your personal mastery of the course objectives. | 5 | 4 | 3 | 2 | 1 | 0 |
| 4. How would you rate the objectives and educational methods? | 5 | 4 | 3 | 2 | 1 | 0 |
| 5. How do you rate the author's grasp of the topic? | 5 | 4 | 3 | 2 | 1 | 0 |
| 6. Please rate the instructor's effectiveness. | 5 | 4 | 3 | 2 | 1 | 0 |
| 7. Was the overall administration of the course effective? | 5 | 4 | 3 | 2 | 1 | 0 |
| 8. Please rate the usefulness and clinical applicability of this course. | 5 | 4 | 3 | 2 | 1 | 0 |
| 9. Please rate the usefulness of the supplemental bibliography. | 5 | 4 | 3 | 2 | 1 | 0 |
| 10. Do you feel that the references were adequate? | | Yes | No | | | |
| 11. Would you participate in a similar program on a different topic? | | Yes | No | | | |

12. If any of the continuing education questions were unclear or ambiguous, please list them.

13. Was there any subject matter you found confusing? Please describe.

14. How long did it take you to complete this course?

15. What additional continuing dental education topics would you like to see?

If not taking online, mail completed answer sheet to
Academy of Dental Therapeutics and Stomatology,
 A Division of PennWell Corp.
 P.O. Box 116, Chesterland, OH 44026
 or fax to: (440) 845-3447

For IMMEDIATE results, go to www.ineedce.com and click on the button "Take Tests Online." Answer sheets can be faxed with credit card payment to (440) 845-3447, (216) 398-7922, or (216) 255-6619.

Payment of \$49.00 is enclosed.
(Checks and credit cards are accepted.)

If paying by credit card, please complete the following: MC Visa AmEx Discover

Acct. Number: _____

Exp. Date: _____

Charges on your statement will show up as PennWell

- | | |
|---------------------|---------------------|
| 1. (A) (B) (C) (D) | 16. (A) (B) (C) (D) |
| 2. (A) (B) (C) (D) | 17. (A) (B) (C) (D) |
| 3. (A) (B) (C) (D) | 18. (A) (B) (C) (D) |
| 4. (A) (B) (C) (D) | 19. (A) (B) (C) (D) |
| 5. (A) (B) (C) (D) | 20. (A) (B) (C) (D) |
| 6. (A) (B) (C) (D) | 21. (A) (B) (C) (D) |
| 7. (A) (B) (C) (D) | 22. (A) (B) (C) (D) |
| 8. (A) (B) (C) (D) | 23. (A) (B) (C) (D) |
| 9. (A) (B) (C) (D) | 24. (A) (B) (C) (D) |
| 10. (A) (B) (C) (D) | 25. (A) (B) (C) (D) |
| 11. (A) (B) (C) (D) | 26. (A) (B) (C) (D) |
| 12. (A) (B) (C) (D) | 27. (A) (B) (C) (D) |
| 13. (A) (B) (C) (D) | 28. (A) (B) (C) (D) |
| 14. (A) (B) (C) (D) | 29. (A) (B) (C) (D) |
| 15. (A) (B) (C) (D) | 30. (A) (B) (C) (D) |

AGD Code 752

PLEASE PHOTOCOPY ANSWER SHEET FOR ADDITIONAL PARTICIPANTS.

COURSE EVALUATION and PARTICIPANT FEEDBACK
 We encourage participant feedback pertaining to all courses. Please be sure to complete the survey included with the course. Please e-mail all questions to: hhodges@pennwell.com.

INSTRUCTIONS
 All questions should have only one answer. Grading of this examination is done manually. Participants will receive confirmation of passing by receipt of a verification form. Verification of Participation forms will be mailed within two weeks after taking an examination.

COURSE CREDITS/COST
 All participants scoring at least 70% on the examination will receive a verification form verifying 2 CE credits. The formal continuing education program of this sponsor is accepted by the AGD for Fellowship/Mastership credit. Please contact PennWell for current term of acceptance. Participants are urged to contact their state dental boards for continuing education requirements. PennWell is a California Provider. The California Provider number is 4527. The cost for courses ranges from \$20.00 to \$110.00.

PROVIDER INFORMATION
 PennWell is an ADA CERP Recognized Provider. ADA CERP is a service of the American Dental Association to assist dental professionals in identifying quality providers of continuing dental education. ADA CERP does not approve or endorse individual courses or instructors, nor does it imply acceptance of credit hours by boards of dentistry.

Concerns or complaints about a CE Provider may be directed to the provider or to ADA CERP at www.ada.org/cotocerp/

The PennWell Corporation is designated as an Approved PACE Program Provider by the Academy of General Dentistry. The formal continuing dental education programs of this program provider are accepted by the AGD for Fellowship, Mastership and membership maintenance credit. Approval does not imply acceptance by a state or provincial board of dentistry or AGD endorsement. The current term of approval extends from (11/1/2011) to (10/31/2015) Provider ID# 320452

RECORD KEEPING
 PennWell maintains records of your successful completion of any exam for a minimum of six years. Please contact our offices for a copy of your continuing education credits report. This report, which will list all credits earned to date, will be generated and mailed to you within five business days of receipt.

Completing a single continuing education course does not provide enough information to give the participant the feeling that s/he is an expert in the field related to the course topic. It is a combination of many educational courses and clinical experience that allows the participant to develop skills and expertise.

CANCELLATION/REFUND POLICY
 Any participant who is not 100% satisfied with this course can request a full refund by contacting PennWell in writing.

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