Dental Hygienists Sharing with Our Communities
5 minutes in chair. 4 shades whiter.*

Introducing the new Philips Zoom QuickPro whitening varnish

There’s a revolutionary way to get noticeable whitening results in minimal time. Philips Zoom QuickPro whitening varnish:

- Breakthrough two-layer technology seals in hydrogen peroxide
- Whitens four shades* — with just a five-minute application
- Virtually no sensitivity

Once you’re done, send your patients on their way and instruct them to simply brush or wipe off the varnish in 30 minutes.

Professional whitening has never been so quick... or so effortless.

For a free demonstration call (800) 422-9448 or visit philipsoralhealthcare.com

*Average shade improvement
Editor’s Desk
With thanks to so many…

President’s Message
Prospering Through Collaboration

House of Delegates
First Anniversary Celebration

Government Relations
CDHA Legislative Day
Hygienists have direct impact on new CDT Codes: D4346 and D4355

Student Connection
Cora Ueland Scholarship Winners
Table Clinic Scholarship Winners

LifeLong Learning
Treatment Considerations for Post-Traumatic Stress Disorder Dental Patient

Members in the News
CDHA members and dental hygiene students making a difference

About the Cover:
Students and faculty of several Dental Hygiene programs joined CDHA components to share their caring skills with community members who have limited or no access to dental care.
Contributions of scientific and original articles. The Journal of the California Dental Hygienists’ Association are formatted by and published under the supervision of the Editor. The opinions expressed or implied in this publication are strictly those of the authors and do not necessarily reflect the opinion, position or official policies of CDHA nor are claims or statements by authors verified.

The only permission granted for photocopying or storage of items is for personal use, or the use by libraries; all other uses require the written permission of the Editor or President. CDHA reserves the right to illustrate, reduce, revise or reject any manuscript submitted. Articles are considered for publication on condition they are contributed solely to the Journal. Contributors are notified within 90 days if a manuscript is accepted for publication.

Correspondence should be addressed directly to the Editor:

Liz Moore, RDH, MSEd
E-mail: editorcdha@gmail.com
Mail: 86 Hancock Dr., Roseville, CA 95678

Display and classified advertising. The California Dental Hygienists’ Association does not assume liability for contents of advertisements. Inquiries regarding display advertising should be directed to:

Sean McDonald
CDHA Corporate Relations Consultant
1900 Point West Way, Suite 222
Sacramento, CA 95815-4706
Phone: 916-993-9102 • E-mail: sean@cdha.org

Copyright ©2017 by the California Dental Hygienists’ Association. The Journal is published on a regular schedule by the California Dental Hygienists’ Association. CDHA members receive the Journal as a member benefit. Dental hygiene students receive the Journal through their school as part of their CDHA fee. Non-member, out of state ADHA members and foreign subscription inquiries should be directed to: admin@cdha.org

Send all address and name changes to:

California Dental Hygienists’ Association
1900 Point West Way, Suite 222
Sacramento, CA 95815-4706
Phone: 916-993-9102 • E-mail: admin@cdha.org
With thanks to so many...

At the House of Delegates we thanked officers who had served us for the past 2 years and welcomed officers who bring us their time and talents for the next 2 years. Volunteers keep our country, as well as our organization, moving and thriving. Have you volunteered at your church, your child or grandchild’s school, your city hall? There are organizations that respond to the devastation of diseases – cancer, heart, leukemia and more – spread the message and help those in need. There are organizations that reach out to those who are hungry, afraid, threatened and just need someone to say “I care.” Our Members in the News features many CDHA members who gave of their time and clinical skills to help in their communities. Thanks to all our CDHA volunteers, wherever and however they share their skills and time and please check out your colleagues in Members in the News!

At the HOD I was impressed with comments made by Jennifer Tannehill, Legislative Advocate with Aaron Reed & Associates (ARA), with whom CDHA has worked for over 30 years. I applauded when Jennifer stated: “Your CDHA membership is important, because it gives you a voice in your Government. When you contact your legislator you can say ‘I’m a member of CDHA,’ and it sets you apart from the other calls that legislator receives.”

She continued by reminding us, “CDHA and ARA also wrote legislation that established a regulating body specific to dental hygiene, the Dental Hygiene Committee of California (DHCC). I know of no other state that has an independent Dental Hygiene regulator…one that is not controlled by dentists. You can be proud that dental hygienists direct their own profession in California.”

Jennifer added “The most important component in all of this Policy and Politics is you. CDHA cannot possibly fight all of these fronts without dedicated members like you. For the students here today, you have a chance to positively impact your profession. You get to have a say in this organization today as to what it will look like and how it will serve your profession in the years to come.”

Thanks to Jennifer for these reminders of why we support CDHA. Read the Government Relations report to see how effective we were at CDHA’s Legislative Day!

At the HOD I met a wonderful young man, Albert Facultad. He was sitting in the front row of delegates with a fabulous looking camera and an enthusiastic attitude and he graciously let me scoop him up to take photographs of the meeting’s events. A student at San Joaquin Valley College, Albert is a professional photographer – skilled and talented – and he very generously donated his services and his photographs to CDHA and we can’t thank him enough!!

So… thanks to the many volunteers who represent us to the public and make CDHA strong!

Jennifer Tannehill, CDHA Legislative Advocate, Aaron Reed & Assoc.

Liz Moore, RDH, MEd
Editor
President’s Message

Prospering Through Collaboration

We heard a lot about the future at the 2017 CDHA House of Delegates. While the future seems to bring both excitement and concern for members, I believe there is confusion related to when and what the actual future is for CDHA.

In 2016-17 President Julie Coan led us through a transition to our first anniversary as an independent association. Her motto, “Transitioning to the Future” was perfect for her vision and the purpose of our first year.

But the CDHA future is right here, now, right now – it’s TODAY! Everything we do now creates the future tomorrow. We have arrived. With Julie’s drive and passion the transition happened.

What’s next….?

Students are vital to the future of CDHA. I think that leaders, past and present, those seasoned and experienced mentors I turn to for advice, are also the future. Without these trail blazers, the vision of our future is greatly diminished. Every member of CDHA is our future, whether 19 or 99. Your input, knowledge and ideas are needed right now for our future!

Partnership….

As we create and shape our opportunity, our next frontier, I would like to ask a few simple things:

1. **No whining.** This method of communication is not effective nor does it create an environment of collaboration.

2. **Voice your concerns and complaints.** Let your leaders know where you see need for change.

3. **Every concern and complaint needs to come with a suggestion or solution AND your role in addressing it.** If you are not willing to help, you give up the right to put that burden on others.

4. **Leave fear at the door.** Fear and apprehension are not necessary components of change and they are deterrents to collaboration. Take a chance based on evidence of likely success. Turn to those who have survived change in the past for guidance and assurance. Know that once you get past the fear, all new possibilities exist. Limits and boundaries disappear. Keep your eyes open, your steps purposeful and your direction true. The past is done and the future is in 1 second. Blink and you miss it.

5. **Create collaborations EVERYWHERE.** We have much to offer with healthcare and skills necessary to create health in the population. But those skills stay hidden when we fail to collaborate with groups and associations holding common goals. Collaboration can start small; in an office with teammates, in your community with other healthcare providers, in our schools, community centers, youth organizations and churches. CDHA has opportunities to continue collaborations with associations such as the California Society of Periodontists and the California Dental Association. There are even bigger prospects on the horizon if we leave fear behind and reach for our wildest dreams.

My theme, “Prospering through Collaboration”, is a promise, a goal and bold statement to all CDHA members from me. It is also our message to others questioning our commitment to healthcare.

May CDHA live in the present knowing the future is in our control. Live long and prosper!!!

Lory Laughter, RDH, MS
CDHA President

With a nod to Mister Spock

Lory Laughter, RDH, MS
CDHA President

With a nod to Mister Spock
Attendees at the 2017 House of Delegates, celebrated CDHA’s first anniversary as an independent organization and committed to move our new association and our profession forward. San Diego was a beautiful backdrop for the meeting that recognized Julie Coan’s unprecedented year as President of the newly formed California Dental Hygienists’ Association as she worked with our Board of Trustees to support her theme of “Transitioning to a New Future.”

President Coan began Opening Ceremonies by leading the assembly in a heartfelt rendition of Happy Birthday to CDHA. Her daughter, Mackenna Coan, brought the assembly an inspirational message. Past ADHA and CDHA President Katie Dawson was warmly welcomed as President Coan’s guest speaker. Reflecting President Coan’s belief in recognizing our relationship to all dental hygiene organizations, her invited guests included ADHA President Betty Kabel and President-Elect Tammy Filipiak.

Jennifer Tannehill, CDHA’s Legislative Advocate from Aaron Read & Associates, addressed the assembly and presented President Coan with a Legislative Proclamation in recognition of her successful year guiding CDHA. To honor the collaborative legislative efforts of CDHA, CDA and CSP (California Society of Periodontists), Ms. Tannehill also presented CDHA with a framed copy of Senate Resolution 19 declaring March as Periodontal Disease Awareness Month.

An early morning SHOR, attended by over 100 students, was facilitated by Student Relation Council Chair Kristy Menage Bernie. The students had already elected their two voting student delegates: Allison Yochim from UOP and Chanta L’Heureux from Cerritos College. The student meeting was led by Speaker of SHOR Jewells Beverly from Cerritos College.

Friday continued when the First House was called to order by Speaker Susan Lopez, followed by members and students providing testimony on the proposed bylaw amendments and resolutions presented at the Reference Committee Hearings.

Saturday morning started with an early morning fundraiser walk for DHAI. The morning continued with the Candidates Forum which preceded the Educational Sessions. In response to requests from CDHA members, Government Relations Council Chair Okamoto facilitated a session led by Deborah Graves from the Department of Industrial Relations explaining the appropriate work classification of independent contractor vs. employee. CDHA Corporate Development Consultant McDonald informed members of the opportunity to purchase CDHA’s newly available group disability and life insurance benefits in the second session.

CDHA’s many outstanding leaders were recognized and thanked by President Coan during the President’s Recognition Luncheon. Vickie Kimbrough, RDH, PhD was presented the 2017 President’s Recognition Award. The festivities continued Saturday evening at the

Continued on Page 6
President’s Reception where members came as their favorite 70’s Sitcom characters.

The second Session of the House was called to order early Sunday morning. Tellers Committee Chair Carole Broder (South Bay) supported by committee members Laura Birchett (San Diego), Angel Gomez (San Francisco), Rachel Richards (Los Angeles), and Naleni Tribble (East Bay), presented the winning slate of candidates. Newly elected officers for the 2017-2018 year are:
- Speaker of the House – Susan Lopez
- VP of Membership and Professional Development – Jeannette Diaz
- Secretary/Treasurer – Yvette Warren
- President – Elect – Beth Wilson

Reference Committee Reports were heard and voted upon by the delegates. Reference Committee A, chaired by Lisa Okamoto (Peninsula) and with members Stormy Li (Tri County), Jeanette Diaz (Long Beach), Maureen Titus (Central Coast), Trale Broudy (Redwood), worked long into the night to present a balanced budget along with a recommendation of Referral of the Proposed Bylaw amending the composition of the House of Delegates.

Reference Committee B, led by Laurel Bleak (Los Angeles) with members Rhonda McMorran (Orange County), Janeen Duff (Tri-County), Gisselle Rullier (San Francisco), and Lynette Garcia, (East Bay) recommended Referrals of Proposed Resolutions for the use of and educational standards for lasers, and for a new Code of Ethics for CDHA, as well as rejection of the Proposed Bylaw amendment to combine IT and Membership Councils. The members supported these recommendations.

The House Sessions proceeded efficiently and effectively due to the support and guidance from our Credentials Committee chaired by Fred Thomas (San Joaquin) with Trish Thomas (San Diego) and Kayla Allison (East Bay) and our Parliamentarian Gerry Olsen. The Speaker extends a special thank you to our Sergeant at Arms Nadine Lavell who allayed all challenges with her calm and efficient nature.

Incoming President Lory Laughter RDH, MS was installed by Toni Adams RDH, MA. Tricia Osuna RDH, BSDH, FAADH continued the installation of officers and trustees.

The “Second” Annual Meeting of the CDHA House of Delegates will be held in Sacramento June 8-10, 2018, at the Hyatt Regency. Plan to attend and be part of advancing and celebrating your profession and your professional association.
March 21, 2017
CDHA Legislative Day
By: Lisa Okamoto, RDH, AS; Maureen Titus, RDH, RDHAP, BS

As a late winter storm heralded spring, California dental hygienists from across the state converged on the Sacramento Capitol on March 21, 2017. This was CDHA’s first Legislative Day in over two decades.

CDHA Legislators Aaron Read & Associates (ARA) and CDHA Government Relations Council, coordinated all events for the day including setting up meetings with participants’ legislators and providing a unified message. Along with Aaron, Terry McHale and Jennifer Tannehill, guest speakers Assemblyman Jim Wood, DDS (Assembly Health Committee Chair) and Donna Campbell (Legislative Advisor on Health to Governor Brown), shared insights on the legislative process.

Per Donna, Governor Brown often notes that there are many needs, wants and desires but not enough resources to cover them all. Tough decisions must be made daily. Donna encouraged us to keep trying, “It’s great that you are here – it matters. The more you are part of the conversation, the better!”

Following a morning orientation, including a mock meeting with a legislator (well enacted by Jennifer Tannehill, Maureen Titus and Brian Pepperill) and armed with talking points, participants conveyed our messages with calm logic, fueled by passion. Officially, 28 hygienists met with 33 legislators and/or their staff, but we cast our message widely. Participants were so energized that some spontaneously stopped by other legislator offices, leaving printed information about hygienists and our issues.

President Julie Coan also presented Senator Anthony Canella with our first CDHA Legislator of the Year Award for his commitment to a healthier California, improving access to dental hygiene care and his work to hold Denti-Cal accountable. Senator Canella’s office subsequently issued a press release thanking CDHA and reaffirmed his commitment to working with us.

The timing of our 2017 Legislative Day was perfect with a number of legislators commenting that they had just received

Continued on Page 8

Our core message was clear:

- **Dental hygienists can help; utilize us!** We are a well-educated and qualified workforce that could be better utilized to help California meet the healthcare needs of its citizens, in more settings and with less restrictive supervision.

- **Improve the public’s health and save money too!** Dental hygienists specialize in preventive oral health care services, in particular periodontal disease prevention and treatment which statistics show improve overall health and reduce total health care spending for both patients and the State.

- **Revise Denti-Cal policies!** The Dept of Health Care Services (DHCS) changed its Denti-Cal policies in 2016 for the approval of periodontal disease treatment and maintenance by Registered Dental Hygienists in Alternative Practice (RDHAPs), as well as slashed reimbursement rates, resulting in denied oral health care for patients and fewer RDHAPs able to continue as Denti-Cal providers.
the Winter issue of the CDHA Journal! Is it coincidence or telling that Senate Concurrent Resolution (SCR) 19, co-sponsored by CDHA and the California Society of Periodontists, swiftly passed with no opposition following our Legislative Day? SCR 19 proclaims March as Periodontal Disease Awareness Month, with the goal to increase oral health literacy and reduce the prevalence of this chronic disease. We can make a difference and effect change!

Our 2017 Legislative Day wrapped up with a reception in the ARA conference room, hosted by the Sacramento component, GRC Co-Chairs Lisa Okamoto and Maureen Titus and CDHA Executive Administrator Vickie Kimbrough. As we shared our take-aways and the highs and lows of our meetings, the sun shone brightly through the ARA windows and down upon the Capitol across the street.
Outstanding disability insurance coverage is vital to the dental hygienist. CDHA is proud to announce the disability group coverages for CDHA members took effect on July 1st. This is currently the only group disability policy available to dental hygienists in the country!

Short Term Disability
If you’re sick or injured, maintain your income with group short-term disability insurance with CDHA. Short-term disability insurance replaces part of your paycheck for a limited period—usually nine weeks to a year—so you can focus on recovery with less concern for your finances.

Long Term Disability
Long-term disability income insurance protects your income if an on- or off-the job incident prevents you from working for an extended period. If you’re injured or become disabled—whether from a sudden accident or chronic condition—long-term disability income insurance with CDHA replaces part of your paycheck until you reach normal Social Security retirement age.
A Bit of History

From 1990 to 1995, the American Dental Association had, in CDT-1, a procedure code, [0]4345, which could be used for treatment of gingivitis. The title of this code was “Periodontal Scaling performed in the presence of gingival inflammation.” The definition:

Gingivitis can be characterized clinically by marked changes in color, gingival form, position, surface appearance, presence of bleeding and/or exudates. With no loss of attachment or bone loss in gingivitis, this scaling treatment is more precise in describing therapy for generalized gingivitis and is not meant to be performed on a routine basis. This is a scaling only procedure; it may require single or multiple visits. Should not be reported in conjunction with an adult prophylaxis; for reporting periodontal scaling performed in conjunction with root planing, see [0]4341.

When CDT-2 (1995-2000) was published, CDT-1 was eliminated. For the next 16 years every time the ADA updated their CDT manuals various forms of this pro-cedure/code were submitted for review and inclusion in the next manual. Each time they were rejected by the Committee on Dental Benefits/Code Maintenance Committee.

Fast Forward to 2013

The California Dental Hygienists’ Assn., responding to a resolution submitted by Dorin Raffi and passed at their House of Delegates, created a Task Force on Debridement whose assignment was to develop a new and relevant definition for D4355, Full Mouth Debridement, and submit to the ADA Code Maintenance Committee for consideration in CDT 2016. I was one of the 8 hygienists asked to serve on this committee. After several meetings and much dialogue, the submission to revise was:

- Nomenclature: Full mouth debridement to enable a comprehensive evaluation and diagnosis.
- Descriptor: The purpose of the Full Mouth Debridement is to enable a comprehensive evaluation and diagnosis. It involves the preliminary removal of supra-gingival plaque, calculus, and debris specifically to be followed by appropriate definitive procedure(s).
- Rationale: The intent behind D4355 was clear; however, the current definition is problematic. Insurance carriers and dental professionals can agree that the language is outdated and thus confusion and misuse occurs. The new definition provides current terminology by eliminating “gross” removal and includes a preliminary removal, a much more accurate description. It eliminates the confusion over whether this is interim treatment (yes) or conclusive treatment (no).

In addition, it was suggested that while a new definition was being submitted for D4355, why not consider submitting a code which would be “in between” a D1110 Adult Prophylaxis and D4341/4342 Scaling and Root Planing. The Task Force wanted the title as well as definition to be based on current language and treatment options. They knew that the current codes document treatment procedures for patients with a healthy periodontium or patients with periodontal disease that has accompanying loss of attachment (e.g. periodontal pockets and bone loss). There was no CDT Code available to report therapeutic treatment of patients with gingival disease with no attachment/recession/bone loss.

After lengthy discussions and re-writes, the final submission, which contained some of the language from the original [0]4345 procedure code, expanded upon the rationale in order to provide clarity. The definition submitted for inclusion in CDT-2016:

- Nomenclature: Scaling performed in the presence of moderate to severe gingival inflammation.
- Descriptor: Scaling performed in the presence of moderate to severe gingival inflammation with no clinical attachment loss (e.g. recession, bone loss, etc.)
- **Rationale:** Dentists and dental hygienists promote regular dental visits in order to evaluate the current dental status of patients and recommend preventive, therapeutic and/or restorative treatment. When it comes to preventive and therapeutic procedures related to periodontal structures, selection of an appropriate procedure code which reflects the appropriate treatment provided is limited.

Once preventive/periodontal treatment has been determined, selection of a procedure code must be either Preventive (Adult Prophylaxis) or Periodontal (Full Mouth Debridement, Scaling and Root Planing or Periodontal Maintenance if history of SRP). There is currently no procedure code for a patient who presents with significant gingival inflammation as well as significant amounts of calculus and plaque but exhibits NO clinical attachment loss (which includes recession and bone loss).

**April 10, 2015, ADA Code Maintenance Committee Meeting**

Although the revision to **D4355 Full mouth Debridement to enable a comprehensive evaluation and diagnosis**, entertained much discussion from the committee members, the ultimate decision was to decline the submission (Yea-5, Nay-15, Abstain-1) with the rationale being: “The Code Maintenance Committee determined that the proposed wording changes, as submitted and amended, do not add clarity or improved understanding to the current CDT Code entry, and unnecessarily confuses selection of the appropriate code to document the delivered procedure.”

Regarding **Scaling performed in the presence of moderate to severe gingival inflammation**, it was determined that since the submission and two others dealt with this specific issue, it was motioned to table these definitions and “refer to a CMC Ad-hoc Working Group for review and preparation of a recommendation for action during the 2016 CMC meeting”.

**November 2015**

The ADA Code Maintenance Committee Working Group submitted the following to be included in CDT-2017: **D4346 Scaling in presence of generalized moderate or severe gingival inflammation, full mouth, after oral evaluation.** [language almost identical to what was submitted by the CDHA Task Force]

- **Descriptor:** The removal of plaque, calculus and stains from supra-and sub-gingival tooth surface when there is generalized moderate or severe gingival inflammation in the absence of periodontitis. It is indicated for patients who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing. Should not be reported in conjunction with prophylaxis, scaling and root planing, or debridement procedures.

- **Rationale:** There is a CDT Code gap. Current codes document treatment procedures for patients with a healthy periodontium, or patients with periodontal disease that has accompanying loss of attachment (e.g. periodontal pockets and bone loss). D1110 is a preventive procedure applicable for patients with healthy periodontium. Codes D4341 and D4342 are therapeutic and are indicated for patients who require both scaling and root planing due to loss of attachment. However, there is no CDT Code available to report therapeutic treatment of patients with gingival disease and no loss of attachment loss.

It appears that after all these years, the American Dental Association recognized that now was the time to reinstate a code to cover this gap, and it is clear the language for this new code was influenced by the submission from the Task Force of the California Dental Hygienists’ Assn. (The Descriptor and Rationale use similar language and intent as submitted by the Task Force.)

**But what about Full Mouth Debridement?**

Dorin Raffi (original submitter of HOD resolution back in 2013) and I were still feeling that a new definition of D4355 should be submitted again. We reviewed the comments/amendments made by the CMC during their discussions in March of 2015 and felt we understood the stumbling blocks which revolved around the descriptor. So, we moved forward to try again, on our own! The result:

- **Nomenclature:** D4355 Full mouth debridement to enable a comprehensive oral evaluation.

- **Descriptor:** The Full Mouth Debridement involves the preliminary removal of a supra-gingival plaque and calculus which may interfere with the ability of the dentist to perform a comprehensive oral evaluation and diagnosis. This procedure is intended to lead to more appropriate definitive treatment.

- **Rationale:** Submitted for consideration last year, it was clear from the suggested amendments made

*Continued on Page 12*
by the committee that there was agreement the current definition was outdated and problematic. We reviewed those suggestions and believe our amended descriptor incorporates our original intent plus those of the committee. This new definition provides current terminology by eliminating “gross” removal (clearly the committee agreed) and includes preliminary removal. It eliminates the confusion over whether this is interim treatment (yes) or conclusive treatment (no).

I completed the CDT Code-Code Action documents and submitted them November 12, 2015. My mistake . . . the deadline for CDT 2017 was November 1, 2015. Feeling very embarrassed for missing such an important deadline (I kept thinking the deadline was November 30), I let Dorin know we had to wait another year. I appealed to the ADA Code Maintenance Committee to include our submission but their response was “No.” After all, they must draw the line somewhere, but I was told it would automatically be “in the queue” for CDT 2018. So, we waited.

March 9, 2017, ADA Code Maintenance Committee Meeting

This was my first time attending the CMC meeting in person. I was impressed with how efficiently the meeting was run as well as the respectfulness of the members when considering each submission (85 to be exact). Those who provided testimony were given equitable opportunity to provide additional information and respond to questions posed by the members.

When revised D4355 was introduced, there were some questions, but also discussion of amendments. When it appeared that we were heading to a consensus, Dr. Marie Schweinbraten, Committee Member representing the American Academy of Periodontology, suggested that she and I meet during a short break to hammer out final wording. The motion to consider an amended version was passed by a vote of Yea-21/Nay-0/Abstain-0.

- **Nomenclature:** D4355 Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit.
- **Descriptor:** Full mouth debridement involves the preliminary removal or plaque and calculus that interferes with the ability of the dentist to perform a comprehensive oral evaluation. Not to be completed on the same day as D0150, D0160, or D0180.

In Conclusion

The California Dental Hygienists’ Association deserves to be commended for stepping out and addressing this important aspect of dental hygiene services – language which adequately and accurately describes the services which we provide to patients. At no other time have dental hygienists had a direct impact on the development of (D4346) or definition of (D4355) procedures included within the ADA CDT manual. I am personally encouraged that the ADA’s Code Maintenance Committee is listening to hygienists’ recommendations and moving forward with procedure codes which are relevant to current treatment options.

About the Author

Kathy has been a dental hygienist, educator, speaker, author, consultant, seminar and study club leader for over 30 years. She speaks frequently about the correct classification, documentation, treatment planning, procedure code selection and long-term case management for patients with periodontal disease.

She is owner of Professional Dental Seminars, Inc., a continuing education provider. Her engagements include sold-out presentations at the American Dental Association 2016 Annual Meeting as well as the ADHA CLL, RDH Under-One-Roof and numerous state and component meetings.

Kathy is a contributing author for the Insurance Solutions Newsletter, where she addresses issues related to dental hygiene procedures and proper billing practices as well as articles on similar topics published in RDH Magazine.

During her long career in education she most recently taught the Periodontics curriculum and clinic in the Dental Hygiene Program at Pierce College in Tacoma, WA as well as the Teaching Practicum Series for Eastern Washington University’s Degree Completion program (at Pierce College) for licensed dental hygienists seeking their Bachelor’s Degree.

Kathy and her husband recently moved to Colorado after spending 2 years in Southern California where she served on The California Dental Hygienists’ Association’s Task Force investigating and developing procedure codes and definitions which better reflect established dental hygiene treatment protocols.
Volunteerism enriches my life by enriching others’ lives.

By: Allison Yochim

To fulfill dental hygiene school prerequisites, I attended a post-baccalaureate medical professions program that was largely geared toward pre-medical students. There were many pre-medical student groups, but there were no resources for pre-dental students, so I created a pre-dental student group. The group stimulated dialogue between students and oral health professionals and was a support network for dental care students.

I also regularly volunteered in the pediatric and adult dental clinics of a community health center. I assisted in dental procedures and cleanings, charting, and oral health education. My administrative duties included managing patient files, re-scheduling appointments, and translating between Spanish-speaking patients and English-speaking providers. I also promoted the “Give Kids a Smile Day” event by distributing flyers, and the day of the event, I dressed in costume and ran nutrition education games.

Following my clinical experience, I decided to explore another aspect of dental health advocacy: political action. For nine months, I volunteered for a local soda tax initiative. My experience in seeing children with poor dental care as a result of soda consumption inspired me to get involved in this cause. I spoke with local merchants and canvassed door-to-door speaking with neighbors to gain support for the soda tax.

I now enjoy many volunteer opportunities as a dental hygiene student. I am my class's representative for political action on a local and statewide level, and I attend my local component's dental hygiene society meetings. I participate in my city's dental health committee for children. I recently volunteered for a school event to introduce K-12 students to dental hygiene, and I give school tour guides to prospective students. Finally, I look forward to helping about 2,000 dental triage patients at an upcoming weekend event.

About Allison

Allison is a junior in the University of Pacific's Dental Hygiene Program in San Francisco. She is honored to represent her class for CDHA, ADHA, San Francisco Dental Hygiene Society, and alumni relations.

Reaching Out to an Under-Served Community

By: Valerie Hernandez-Blouin

The community in which my dental hygiene program is located is culturally, economically, and socially diverse. Individuals in this area are not only at need for dental hygiene treatment, but also educational and preventative services as a whole.

In becoming familiar with this underserved area, I have been able to identify the needs limiting this community and have tailored my extracurricular activities appropriately. I have dedicated much of my time towards helping children from low-income communities, largely Hispanic, through mobile dental clinics and AYUDA clinics.

I have used my dental hygiene skills and Spanish-speaking abilities set to provide comprehensive dental hygiene care through oral screenings, oral hygiene instructions, dental prophylaxis, and preventive services such as sealants. My

Continued on Page 14
Spanish speaking skills have been an asset in communicating with this population and in relating to this community. This experience has been rewarding, as many of these children have never seen a dentist before, or been instructed on caring for their teeth. By providing these communities with preventative services and preliminary screenings through remote teledentistry, we are able to reach and care for communities that would otherwise be neglected.

Additionally, I have used my education to provide services to migrant families near and up to 2 hours away through a mobile dental clinic. The dental van allows us to extend care past my immediate neighborhood and provide services to individuals that never have had cleanings before. This work allows me to extend educational services on nutrition, tobacco use, maternal care, and oral hygiene.

These experiences have expanded my dental hygiene education to encompass the true meaning of health care, helping others. Dental care is an aspect of health that is too often neglected, especially among underserved communities, and I have utilized my professional skills to try and strive to mend this disparity.

About Valerie

Valerie is a second year dental hygiene student at the Herman Ostrow School of Dentistry at the University of Southern California. During her time at USC she was a student ambassador, smoking cessation co-chair, and selected as the patient education award recipient.
Table Clinic Scholarship Winners

Original

1st
Loma Linda University
“Evidence-Based Practice Knowledge, Attitude, Access and Confidence of Students”
Victoria Santiago and Mellissa Cardenas

2nd
West LA College
“Dysphagia: Under-recognized and Life-threatening”
Tang Blanton and Jose Mendez

2nd
Cerritos College
“Don’t Stress, It’s Just a Test”
Amy Mai and Alexis Venegas

3rd
Cypress College
“Kill Periodontal Pathogens with Nature’s Gas”
Amy Fink, Carissa Flores and Britnie Sepulveda

3rd
West Coast University
“Antimicrobial Properties of Frankincense, Myrrh, and Chamomile Essential Oils”
Rhozin Zargaran, Taraneh Jamali and Nancy Martirossian

3rd
Cerritos College
“Preventive Therapy for the Preventive Therapist”
Brianne Donovan and Denise Najera
CE Course: Treatment Considerations for Post-Traumatic Stress Disorder Dental Patient
By: Noel Kelsch RDH, RDHAP, MS

Course Objectives:

After taking this self-instructed course the oral health care professional will be able to:

- Recognize the signs and symptoms of Post-traumatic Stress Disorder (PTSD).
- Delineate the disorder considerations and treatment options for the dental setting for patients experiencing PTSD.
- Develop an oral treatment plan for patients who are dealing with the impact of PTSD.
- Describe the dental treatment modalities available for the treatment of Post-traumatic Stress Disorder and the health care providers roles.

Abstract: Post-traumatic Stress Disorder is an intense physical and emotional response to triggers the patient might not understand or recognize. It is a mental health disorder and has been identified as one of the contributing factors to oral diseases. Dental professionals are in a pivotal position to identify the disorder’s signs and symptoms and to assist a medical team guiding patients through dental treatment in a safe, supportive environment. As PTSD patients show a high propensity for poor compliance with medical and dental treatment, understanding how to individualize treatment and resources to help improve their medical, dental and mental wellbeing.

Sherri’s Memories – notes from the operatory

“Sherri’ always came to the office in the afternoon, usually late. This afternoon was a particularly hot summer day and she was even more wound up, anxious and hyperactive than usual. I had cared for her many times and knew each time we would have to stop frequently, often so she could get out of the chair to stand or walk around. Each time the appointment ran overtime. Each time we were both stressed.

She hated to have anyone work in her mouth and would often state she needed to stop, putting her hands over her face. After many deep breaths she would grudgingly be ready to proceed. I had tried many times to ask questions about her fears and offer insights into what the dental community knew and what I had learned over the years to help fearful patients.

As she sat in the chair, I dimmed the operatory lights and, as was my custom with anxious patients, I spoke more slowly and softly – hoping she would have to focus more to hear me and less on her anxieties – a technique that had been successful at previous appointments.

In chatting with her during her procedure, we discussed summer topics and compared fun things we had done during hot summers as children. She seemed relaxed and talked about playing with friends and siblings in her yard.

Suddenly she bolted upright in the chair – shocking me as I quickly removed my sharp scaler. Now, sitting straight up in the chair, her eyes enormous and chest heaving as she pulled in deep breaths, she stared straight ahead and quietly said, “I remember.” I sat very quietly as she remained frozen. She repeated, “I remember.” “Can you tell me what you remember?” I asked. She turned to me, riveting me with her eyes and said, “I was molested.”

We put aside dentistry and I encouraged her to let her story flow. She described a hot summer day and the man living next door had offered cool drinks and a place to play.
She sat, becoming calmer as she told her tale – it was heartbreaking to hear. I never felt so helpless, fearing I would say the wrong thing and pull her from this small comfort zone she’d found with me.

I asked if she could put those memories and her fear of dentistry together with the fear of having anyone touch her mouth? She said she could now. Her memories were vague at first – but they were still awful, a direct result of this man. She had innocently gone to his cool house many times, as he assured her this was normal “play.” Her parents knew and trusted him. Today experts would say he had, over time, groomed her to be his victim.

We talked quietly, it was as though she was talking to herself as the memories tumbled out. The words poured out and I watched her change in front of me. I knew she’d been seeing a therapist and urged her to speak to her as soon as possible. Assuring myself she felt safe, had a safe place to go to and was calm enough to drive, I wished her well and said I’d be anxious to see her again soon.

It was about 9 months before I saw her again, and she was truly a new person. So much of her life had changed and we were able to move forward with normal dental prophylaxis appointments from that point onward.

Today I can guess that she was suffering from PTSD – Post-traumatic Stress Syndrome, but in the 1980’s that was a brand new term that was not widely used, especially not in dentistry….Liz Moore, RDH, MSED, Editor

Understanding PTSD

Post-traumatic stress disorder (PTSD) is not new. References to this disorder are found in ancient Egyptian writings. Events that can lead up to this disorder include sexual abuse, war exposure, mental abuse and even dental trauma. Any occurrence that results in feeling out of control, powerless or betrayed can lead to PTSD and the key is in the perception of the victim. The National Center for PTSD estimates that 7.8% of Americans will be affected in their lifetime and women are twice as likely as men to develop the disorder. According to the Diagnostic and Statistical Manual of Mental Disorders V (DSM-V), females experience PTSD for a longer duration than males. PTSD is not just a psychological stress disorder, it is also a complex neurological, biological, biochemical and psychological disorder.

The Center for Disease Control (CDC) describes PTSD as, “an intense physical and emotional response to thoughts and reminders of the event that last for many weeks or months after the traumatic event. The symptoms of PTSD fall into three broad types: re-living, avoidance and increased arousal.”

It is not unusual for people to experience symptoms of PTSD even years after the traumatic event, yet they can also start within days. Psychological symptoms include nightmares, flashbacks, detachment, poor concentration and inappropriate feelings of danger. Physical symptoms include sleep disturbances, shakiness, racing heartbeat, TMD, chronic pain, breathlessness, and agitation.

What Is PTSD?

Post-traumatic stress disorder (PTSD) is an intense physical and emotional response to thoughts and reminders of the event that last for many weeks or months after the traumatic event. The Center for Disease Control states, “the symptoms of PTSD fall into three broad types: re-living, avoidance and increased arousal.

- Symptoms of re-living include flashbacks, nightmares, and extreme emotional and physical reactions to reminders of the event. Emotional reactions can include feeling guilty, extreme fear of harm, and numbing of emotions. Physical reactions can include uncontrollable shaking, chills or heart palpitations, and tension headaches.
- Symptoms of avoidance include staying away from activities, places, thoughts, or feelings related to the trauma or feeling detached or estranged from others.
- Symptoms of increased arousal include being overly alert or easily startled, difficulty sleeping, irritability or outbursts of anger, and lack of concentration.

Other symptoms linked with PTSD include: panic attacks, depression, suicidal thought and feelings, drug abuse, feelings of being estranged and isolated, and not being able to complete daily tasks.”

According to the National Institute of Mental Health (NIMH), when a person is in danger, it is natural to feel afraid. Fear triggers many split-second changes in the body to avoid or defend against the danger. This normal fight-or-flight response reaction is meant to protect a person from harm. With patients dealing with PTSD, this reaction can be triggered without a true danger present, even in a dental office chair.

**Signs and Symptoms of PTSD**

According to the DSM-V the clinical presentation of PTSD can vary widely. While for some individuals fear-based re-experiencing, emotional and behavioral symptoms may predominate, to others anhedonic (inability to feel pleasure) or dysphoric (state of unease) mood states and negative cognitions may be most distressing. In still other individuals, arousal and reactive-externalizing symptoms are predominant and some individuals exhibit combinations of these behavior patterns.

The characteristics of PTSD fall into three distinct symptom clusters: 1) Intrusive memories or re-experiencing events, 2) avoidance behaviors, and 3) persistent elevated arousal. Other symptoms may include mood disturbances, memory problems and cognitive difficulties. PTSD is associated with high levels of social, occupational, and physical disability, as well as considerable economic costs and high levels of medical utilization.

According to the DSM-V, individuals with PTSD are 80% more likely than those without PTSD to have symptoms that meet diagnostic criteria for at least one other mental disorder. Co-morbid substance use disorder and conduct disorder are more common among males than females. Among U.S. military personnel and combat veterans who have been deployed to recent wars in Afghanistan and Iraq, co-occurrence of PTSD and mild Traumatic Brain Injury is 48%. Although most young children with PTSD also have at least one other diagnosis, the patterns of co-morbidity are different than in adults, with oppositional defiant disorder and separation anxiety disorder predominating. Finally, there is considerable co-morbidity between PTSD and major neurological disorder and some overlapping symptoms among these disorders.

---

**Oral Indications of PTSD**

- Bruxing and associated symptoms (abfractions, occlusal wear facets, recession, muscle spasms, TMD)
- Tooth sensitivity and/or oral pain for which the cause may not be evident
- Xerostomia
- High levels of biofilm
- Periodontitis and gingivitis
- Excess caries
- Tooth loss
- Anesthesia complications (delays in either sedation or recovery from sedation, other adverse reactions)
- Trouble swallowing or a lump in the throat

---

**Mark’s struggles in the dental office – a case study**

With the addition of PTSD to the third edition of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)* in 1980, the ability of the dental practitioner to identify and more effectively provide oral healthcare treatment to the patient was greatly enhanced.

Mark’s case demonstrates how knowing the signs, symptoms and strategies can help the patient cope with the incoming stimuli to create a successful dental appointment and treatment.

**Case Study:** Mark, age 45, presented to the dental office with intermittent pain in #2 and #31, generalized sensitivity and a “rough spot” on #18. He had a lapse of 3 years in dental care after an extreme episode of PTSD in a dental office. He reported that during his last visit to the dental office he had a racing heart and cold sweats and was unable to complete treatment. With motivational interviewing the dental team was able to assess Mark’s trigger points.

Previously, when a rubber dam was placed in preparation for a crown, he swung his arm out and hit the dentist. He started trembling, and reported his mouth felt dry and he felt he couldn’t swallow. His mind had taken him back to a traumatic experience he had 20 years previously in military service that included being captive in a prisoner of war camp.
Mark had been unable to complete treatment and had not entered a dental office again until he was forced to by pain, the urging of his spouse (who accompanied him to the appointment) and a strong referral from his physician.

Mark frequently brought his grandchildren to the dental office for their appointments but always paced outside while he waited for them. When he was required to enter the room to hear about them, he would remain silent, tremble, seem agitated and have difficulty communicating.

Visit 1 Assessment: During his initial interview Mark was unable to recline in the chair. Persons dealing with PTSD who present as hyperaroused are prone to a high level of sensory sensitivity and Mark had difficulty when a loud sound came from another room. Mark revealed his history of PTSD, saying no one in a dental setting had ever asked him about it so he had not shared the condition. When the rubber dam placement aroused his perceived risk of injury and fight or flight response, the stop signal of raising his left hand and/or repeatedly blinking his eyes was developed.

During the assessment Mark was taken to a quiet, separate room with limited stimuli. He was asked questions that allowed him to make choices and feel in control such as “would you prefer to sit up or recline?” “Head phones can limit noises that might trigger anxieties, would you prefer to have head phones or no head phones.” Mark shared that he needed to stand up and the first appointment ended there. After his first visit he gave the dentist permission to work with his medical team. Mark’s therapist confirmed his PTSD diagnosis and helped develop a plan for desensitization. When antianxiety premedication was discussed Mark declined, stating he had a history of “self medication” and did not want to use drugs.

Visit 2 Assessment and Examination: At the next visit Mark gave permission for desensitization therapy in the dental setting. He brought headphones and a blanket from home to limit stimuli and help him feel safe with familiar items. He declined aromatherapy, explaining that odors from encampment mimicked many of the smells. Mark was slowly shown the equipment and exposed to the sounds that would occur in the dental environment during treatment to help desensitize him. The sound of the drill caused Mark to become reactive and he asked to have a drink of water. After sitting up and having the drink, he agreed to allow the dentist to evaluate his condition. Mark put on his headphones and the dentist did the examination standing up. The assistant was then able to take x-rays using a distraction technique of rinsing with salt water between each x-ray. Due to short term memory issues with PTSD, all instructions were given to Mark and his spouse both orally and in writing.

Clinical findings included deep wear facets on the occlusal of #2 and #31 but no active dental decay. Moderate periodontitis with generalized recession averaging 2 - 3 mm was observed with #31 being the most involved area at 4 mm. Abfractions were present on all posterior teeth and #18 had extensive caries with a distal wall fracture that necessitated a crown.

Mark complained of dental sensitivity on inhalation of cold air and allowed the dentist to paint on a desensitizer. The desensitizer container was warmed under warm tap water before application to prevent cold sensitivity during application and Mark reported immediate relief in the area. Mark’s anxiety was managed but still apparent as he got up from the chair for frequent breaks and paced the front of the office. He used the restroom frequently and requested several drinks of water. During this visit Mark’s wife reported that he ground his teeth at night and clenched during the day. A night guard was recommended, the process was explained, the equipment was shown to Mark and the process was reviewed. Having discussed the option with his therapist, Mark asked about antianxiety drugs that could be used during treatment. An appointment with a visiting periodontist who used the same facility was made. The appointment ended and Mark had tolerated the dental environment for a total of 28 minutes.

Continued on Page 20
Visit 3 Assessment and Treatment: Mark came in with his spouse and was premedicated with ® as directed by his outpatient psychiatric medical provider. Mark stepped outside with his wife after the drug was administered and walked around the block. He brought a blanket, headphones and a “lucky rabbit foot” that he rubbed during treatment. Desensitization of sights and sounds were performed and night guard impressions were taken. He was introduced to the periodontist who did motivational interviewing and desensitization therapy at the end of the visit. He requested a drink of water and got up 2 times to pace. All instructions were given to Mark and his spouse both orally and in writing. Mark was able to stay in the environment for 41 minutes.

Visit 4 Treatment Phase: Mark again was premedicated and brought his blanket, headphones and lucky rabbit foot. Mark was apprehensive to see the periodontist because there was an assistant he had not seen before. The general dentist’s assistant replaced her and the periodontist was able to complete the examination with desensitization therapy using instruments and procedures. Because it is important to maintain the same staff with the patient if possible, the periodontist’s assistant stayed in the room for the entire procedure so that Mark could become familiar with her. This simple action reassures patients and allows them to feel safe in the environment. Again, all instructions were given to Mark and his spouse both orally and in writing due to premedication and short term memory issues with PTSD.

Visits 5 through 11 Treatment Phase: For visits 5 through 9 Mark again came in with his spouse and was premedicated with Ativan® as directed by his outpatient psychiatric medical provider. In consultation with Mark’s therapist, the periodontist determined that, due to the reactions PTSD patients often have to general anesthesia, Mark would not be sedated. Half hour appointments were made and the periodontal treatment was done in sextants. Mark came to feel safe in the environment and could tolerate many of the stimuli that had triggered him previously. The restorative procedures were completed after the periodontal treatment. Durable materials were used due to bruxism and his history of not returning routinely to the dental setting. Appointments were short and due to Mark’s reaction to the rubber dam it was not used during treatment.

At visit 10 Mark reported he wanted to try the next procedure without antianxiety premedication and was able to tolerate treatment although once he did request to stand and take a drink of water the during the procedure. Visit 11 also included a break but Mark was able to handle the treatment and asked to have treatment completed because he was able to tolerate a longer period of time even without antianxiety premedication. Visits averaged 30 minutes each.

Maintenance Phase: Mark worked with his the dental team to determine intervals for future care and preventive measures including periodontal maintenance visits every 3 months, routine examinations, treatment as needed and preventive care. For preventive measures he uses an interdental cleaner, an electric toothbrush and a product that reduces demineralization.

Although patients dealing with the impact of PTSD typically have a high propensity to avoid treatment after the initial visit, Mark has been able to return for treatment to maintain his oral health. His support system has enabled him to return to the dental setting with limited reaction and he has continued to successfully use coping techniques. This approach will not work with all patients.

Creating a Successful Dental Appointment for the Patients Dealing with the Impact of PTSD

Fight or Flight: When an individual encounters a stressor such as a traumatic event, the hypothalamic-pituitary-adrenal (HPA) axis becomes activated, resulting in higher levels of cortisol, nor-epinephrine, and epinephrine to help the individual respond to the stressor in an acute manner (i.e., the fight or flight response). Cortisol’s role is to augment energy resources by reducing the activity of bodily systems, including the immune system, as well as elevating blood glucose levels. These mechanisms are protective if the stressor is acute; however, if the stressor is excessive or prolonged, adaptations can increase the risk of excessive inflammation.10, 30

Balance of Immune Function: The immune system is greatly affected by PTSD. Results may include excessive inflammation through insufficient regulation of immune function and this imbalance can be difficult to correct. This condition has been associated with immune and metabolic disturbances, including endothelial inflammation, altered
cytokine balance, hypercoagulation of the blood, carbohydrate intolerance, dyslipidemia, and insulin resistance. Chronic inflammation is associated with symptoms of chronic pain and increased risk for the development of arthritis, diabetes type II, myocardial infarctions and cardiovascular disease and Th1 autoimmune related disorders of rheumatoid arthritis, diabetes type 1, and multiple sclerosis.10

A study conducted by Geisinger Health System examined the health status of 4,462 male Vietnam era veterans 30 years after their military service. Researchers found that having PTSD indicated a person’s health status just as well as did having an elevated white blood cell count, which can indicate a major infection or serious blood disorder, such as leukemia.11

The study also found that veterans with high erythrocyte sedimentation rate, which indicates inflammation, were also at risk. There was a similar finding for a possible indicator of serious neuroendocrine problems. The study showed that exposure to trauma has both psychological and biological risks, yet few health care providers screen for PTSD the same way they do for other chronic disease risk factors.11

**Common dental concerns:** Studies have shown that PTSD can also lead to dental diseases. Dr. Sebastian Ciancio studied the teeth of 40 people with PTSD and compared their oral health to 40 people who were not dealing with the disorder. “What we see is that the wear patterns are mainly along the necks of the teeth, and there’s loss of tooth structure near the gum line,” Ciancio said. “They look like grooves, but there’s no pattern to them.”12

These results were significant with increased wear of tooth surfaces in three dimensions near the gum line -- vertical, horizontal and depth -- in those with PTSD compared to controls. Erosion vertically was more than three times greater, horizontally more than four times greater and more than ten times greater in depth than controls. Ciancio concluded that these results were consistent with documentation of habitual tooth grinding and clenching among persons with PTSD.12 “Dental patients with PTSD need additional treatment planning to prevent further loss of tooth surfaces,” he said, “and need to work with their dentist to rehabilitate the damaged teeth.”12

The study also revealed plaque and gingivitis scores of 183 percent and 140 percent higher, respectively, in the people with PTSD.12 It is well documented that PTSD could also lead to periodontal, abfraction and occlusal wear problems from bruxism.13

Periodontal disease is a known inflammatory response and in a healthy patient the immune system is well regulated. Psychological stress can exert an excessive demand on regulatory functions, particularly if the stressor is excessive or prolonged, resulting in the risk of excessive inflammation.14 The hypothesis is that PTSD can impact the occurrence of periodontal disease because it is an inflammatory disease.

Pain (even oral pain) can serve as a traumatic stimulus for the onset of PTSD symptoms such as hyperarousal, stress intolerance, selective attention, and acute pain. It was found that individuals with a lifetime of PTSD reported significantly greater current bodily pain than those without a lifetime of PTSD, even after adjusting for demographic features, as well as major depression and psychosocial factors often correlated with chronic pain.2 PTSD, associated with higher levels of pain and affective distress, can complicate clinical management.17 Dental issues may include orofacial and TMJ pain.

This is a difficult medical situation as patients dealing with PTSD have difficulty describing or even being aware of their feelings, emotions or mood. Patients may also demonstrate a diminished capacity to employ adaptive and coping strategies to manage pain.16

According to research by Delahanty et al, PTSD was associated with smaller changes in cortisol levels throughout the day and higher CD4 cell counts. It was also noted that this patient group had low levels of medication compliance.19 They reported higher levels of tinnitus, sudden onset and difficulty with sound tolerance and sound-triggered tinnitus; even when compared with patients who had tinnitus without PTSD.19, 20 Keeping this in mind, the practitioner should be aware of symptoms and complaints of auditory stressors as they may negatively affect treatment outcomes if not addressed. It has also been shown that patients with PTSD have higher levels of avoidance of treatment and lower levels of medication compliance.19

Startle response, anxiety and misperceptions of danger are behaviors observed and reported by these patients.19, 20 Many of the clients reported auditory sensitivity.20 Asking questions
in the intake as a follow up to confirm PTSD such as, “do you have any auditory or visual triggers or sensitivities” may reduce symptomology. These assessments should be of particular importance in the dental office with its' distinctive and high pitched sounds.

**Oral Treatment Plan:** Patients who develop PTSD may initially seek help for physical symptoms before the psychological symptoms; the first symptoms may occur in the dental setting. PTSD can be a direct result of dental care and dental treatment can exacerbate PTSD. Patients with PTSD may react way out of proportion to the treatment being done as the dental treatment may trigger memories of the traumatic event. In these cases, it is vital that the patient be referred to a mental health care professional for behavior assessment.

Dental treatment has been identified as a trigger for PTSD. Psychological symptoms include nightmares, flash-backs, detachment, poor concentration and inappropriate feelings of danger. Physical symptoms include sleep disturbances, shakiness, racing heartbeat, TMD, chronic pain, breathlessness, and agitation. Despite the risks of possible triggering events during dental treatment or any form of surgery, exposure to possible triggers in a safe environment, otherwise known as exposure therapy, is known to be the gold standard of care. Helping the patient through these experiences should be a part of every treatment plan.

Every health history should have a section on PTSD. These questions cannot only identify both those who have been diagnosed and those who have not.

In the past, dental health care professionals have tended to focus on the oral needs of the patient and have not taken into consideration their mental health and emotional needs. As patients dealing with PTSD enter the dental environment, it is key to not only look at their oral health, but to also address their other needs. Working with a medical team, including their physician and mental health care provider, is imperative for the long-term success of treatment. Each patient must be assessed individually for his or her ability to tolerate treatment in the dental environment. The medical team must develop a treatment together with the patient to achieve the greatest outcome.

**First meeting:** Providers need to be mindful of both verbal and nonverbal interactions with patients dealing with PTSD and avoid sounding judgmental or condescending, as this will deter an already uneasy patient. It is important to take the time to ask non-judgmental questions and assess the patient’s ability to receive treatment. Making the patients aware of your concern for their comfort can help relieve anxiety. Questions such as “is there any part of dental treatment that is particularly difficult for you?” or “is there anything I can do to make you feel more comfortable?” will allow the patient to share needs that they may not even be aware of. Simple adjustments in treatment and the environment can help the patient feel safe and in control. Reclining and adjusting the chair as the patient desires may stop the patient from reliving past experiences, as the supine position can be very difficult for some patients and can elicit threat cues. Long treatment times and confining procedures such as rubber dams must be assessed and adapted. Frequent breaks and adapting to patient requests is a must when seeing these patients. Simple reassuring stimuli such as headphones, headgear, movies or a warm blanket, can distract patients and help them avoid re-experiencing or emotional flooding.

It is important to establish rapport and help patients make a connection between their current physical and emotional distress and PTSD symptoms. This can also provide the basis for offering pharmacotherapy. Offering the patient an explanation for untreated emotional pain as an aggravating, but not causative factor for physical pain may be a useful step in building a therapeutic relationship, which can make it easier for the client seeking treatment.
Treatment Planning for Success

When treatment planning for these patients, it is vital to have a protocol set up ahead of time, but also to be adaptable to the patient’s experience. Plans must be altered if the patient is unable to tolerate the planned treatment. PTSD is a chronic and potentially relapsing disorder; patients may take one step forward and then two steps back.

**Getting to know the patient and they get to know you:**
In this phase, information is gathered to develop a plan with the patient. All health care providers must be included in this phase.

It is essential to establish a relationship with the patient and their community support person. Ask the patient who their therapist and/or prescribing psychiatrist is and request a release of information to coordinate care so that any possible triggers or adverse interactions of psychiatric and dental medications including analgesics, sedative agents and antibiotics can be addressed in advance.

Ask the patient about their triggers and coping tools. Invite them to bring in items that help them stay calm and feel safe. Discuss the possibility of needed premedication and about, their past responses to nitrous oxide, general and local anesthesia. Ask the patient if they have a mindfulness or relaxation exercise that you can prompt them to do during procedures.

Plan for desensitization and premedication with anti-anxiety medications, if indicated, at this meeting. In most cases this phase will occur in a meeting room, not in the operatory, which will allow the patient to adapt to the surroundings and develop a relationship of trust with the dental professionals. If the patient agrees some desensitization therapy, such as a brief tour of the office, can be presented at this time. The patient can develop a stop signal and patient assessment should occur along with creation of a plan for the following meeting. This appointment can be broken into two sessions if the patient is unable to tolerate the length of time or situation. Plans for prevention of oral diseases should be introduced. Assess past dental and health history and obtain a list of medications the patient is taking. Allow the patient to set their goal for oral health.

**Creating a safe, comforting environment:** At this point, simple diagnostic tools are introduced and, if the patient is able to tolerate the environment, desensitized to the operatory. Dental charting, X-rays and possibly cast models can be initiated if done slowly, giving the patient a sense of control over the procedures. It is vital to have a staff member stay with the patient for support and to monitor the patient’s visual cues if they struggle to express themselves. Assessment of oral conditions can occur at this appointment if the patient is able to tolerate the procedure. Simple preventive measures can be added, including application of desensitizer, fluoride varnish, dry mouth products, etc. as these noninvasive procedures can build a sense of trust and safety.

**The treatment challenge:** Treatment can be the most challenging phase for a patient with PTSD. Treatment time in the chair must be dictated by the patient’s needs, with emphasis on short, flexible appointments and goals that incorporate the patient’s input. Simple procedures such as fabrication of a night guard should be the priority unless the patient is in pain. Describe each step of a procedure before it is done to increase the client’s feelings of safety and control. It is not unusual for a patient to suddenly accept treatment after repeated visits but the dental team must also be prepared for sudden onset of symptoms after success. This is a chronic relapsing disorder; success at one appointment does not guarantee success at another appointment. With this population it is important to use restorative materials that are durable and long lasting due to high propensity for avoidance of oral healthcare treatment.

**Creating a patient who wants to return:** The long term goal is to maintain oral health for these clients. All patients who complete treatment should have an understanding of the tools and time frame of visits to prevent dental diseases from recurring. Frequent visits and follow ups are a necessary part of the treatment plan, though the patient’s tolerance, which can vary widely during one appointment, should be kept in mind when discussing treatment expectations. It may help to address one treatment goal at a time.

**When the problem overcomes the solution:** Even with caring and in-depth preparation for the patient, years of fear, lack of control and behaviors may overwhelm him/her.

*Continued on Page 24*
and the therapist, or medical provider, may need to become part of the treatment plan to help the patient minimize possible PTSD symptoms. In consultation, the therapist may prescribe medications such as Xanax® or Ativan®, which requires supervision of the patient pre and post procedure. The patient will require a support person, such as a friend or spouse, to be with them before and after treatment. Further, having the patient drive himself or herself home if they have been administered premedication is contraindicated.

After Each Appointment: Research has shown that the patient may not recover from anesthesia in the same manner or time as the general population so it is vital to observe the patient before dismissal. Additionally, because patients dealing with PTSD may have difficulties with memory, long-term recall and sustained attention, it is critical to send home all post treatment instructions in written form.

Conclusion

While the patients dealing with PTSD can present unanticipated and complex challenges, the ability to help them problem solve their dental needs can be among your most satisfying professional experiences. Part of our professional responsibility is to educate ourselves on how to be the help these patients need. The following resources and charts are designed to make that education easier and in a usable format in an operatory setting.

Resources/Further Reading/References
On page 27

About the Author

Noel Brandon-Kelsch RDH, RDHAP, MS, is an international speaker, writer, Registered Dental Hygienist in Alternative Practice and program director for Cabrillo College Dental Hygiene program. She received her Master of Science from UCSF with research on Infection Control Compliance in the Dental Setting. She is passionate about oral health and uses humor and cutting edge information to educate.

She is the infection control columnist for RDH magazine, a syndicated newspaper columnist and has been published in many books and magazines.

Reaching out to underserved populations, Noel takes her message and oral disease prevention methods to the street with her clinical research on the impact of Methamphetamine Abuse on the oral cavity.

Noel has received many national awards including: Top 25 Women in Dentistry 2014, Who’s Who in Infection Control 2014, Colgate Bright Smiles Bright Futures, RDH Magazine Sun Star Butler Award of Distinction, USA magazine Make a Difference Day Award, President’s Service Award, Foster Parent of the Year.

Noel is a current member of the DHCC, a Past President of the California Dental Hygienists’ Association and Key Organization Leader for many dental corporations.
Coping Tools in the Operatory

When a client uses a pre-determined stop signal, consider asking if they need to take a break to do one of the following distraction activities. When completed, check to see if the patient is ready to continue with treatment or if they prefer to schedule for another day.

Control the breath as a means for full body relaxation

- This exercise may be helpful for a patient feeling fear or anxiety in the dental setting
- Have the patient breathe in through their nose and think the word “Feeling.”
- Have the patient breathe out through their mouth and think the word “Calmer.” Repeat 3-5 times or until the patient’s hands and face relax. Remind them that they can use this tool throughout their visit.

Focus the 5 Senses

When a patient reports high levels of anxiety or an out of body feeling, recommend the following exercise that focuses on the 5 senses to bring them into the moment and feel in control. For patients who cannot speak during a dental procedure, instruct them to answer silently in their minds. Tell the patient to focus on the sense that brings about the most pleasing response.

Ask the patient the following questions:

- “What do you see in this room? What colors? What objects?”
- “What do you feel on your hands? On your feet? How does your chair feel? What does the temperature of the room feel like?”
- “What sounds do you hear in the room? What style of music is playing?”
- “What smells are in the room?”
- “What do you taste? Are there any textures in your mouth?”

Take a Break

At times symptoms of PTSD can be eased by titrating activities, allowing the patient to switch gears periodically can allow for longer treatment times.

Some activities that may help are:

- Drink a warm or cool beverage
- Take a walk outside
- Use a hand held electronic device for distraction (there are many versions of programs that assist persons struggling with PTSD)
- Read a magazine or observe things in the lobby such as a fish tank if possible
Helpful Hints for Treating Patients Living with PTSD

Before the appointment

- **Medical support team:** All patients dealing with PTSD must have a medical team. Pain may bring the person to the dental office, but patients must know that other care-givers may need to back up the dental team. These could include a general physician to determine the impact on the body and manage the case, a therapist to help with the mental impact of the disorder, a psychiatrist to offer medicinal treatment options and a support person (such as a friend or spouse) to help them navigate services and provide support.

- **Support person:** Ask patient whether they would like to bring a safe and familiar person to their appointment. This person could calm the patient by being present, and also help if the patient should have a delayed recovery from anesthesia or need time to recover from premedication.

- **Set the stage for a non-stimulating environment.** Limited stimulation may improve the patient’s response to treatment and prevent the onset of PTSD symptoms:
  - Assure that the room is quiet and the light is dim.
  - Cover the instruments
  - Limit use of procedures that can make the patient feel trapped (mouth guards, oxygen masks)

During the appointment

- **Staff members interacting with the patient should remain the same as much as Desensitize the patient with slow exposure to procedures over time. This may take several visits.**

- **Breathing:** Watch the patient’s breathing. Encourage breathing through the nose as explained in the “On the Spot Coping Tools” box. Steady breathing will aid in clearing their thoughts and removing them from the stressful event.

- **Use of oxygen and/or nitrous oxide/oxygen sedation:** The oxygen hood can make the patient feel trapped. Discuss its use before attempting to introduce it. Administer nitrous oxide with great care as patients dealing with PTSD may have an exaggerated reaction to it.

- **Do not drop items or allow startling noises** behind the patient

- **Control:** Allow patient to have choices whenever possible to enhance feelings of control. Patients may:
  - Use an established stop signal (see “On the Spot Coping Toole” box)
  - Use headphones
  - Choose the flavor of the prophylaxis paste
  - Hold the saliva ejector
  - Be allowed to speak as long as they want
  - Decide whether to recline or sit up and other ways to position the chair
  - Select a calming aroma therapy scent (place a drop or two on the patient napkin)
  - Decide about using a warm blanket and/or pillow. Have these available, or the patient may prefer to bring their own.

Clinician communication

- Use calming words. Speak in a low voice, in a positive manner, and avoid judgment. Try to talk about reassuring and distracting topics.

- Be honest. Avoid surprise. Do not try to sneak in unexpected procedures. Ask patients how much they want to know, then inform them of what to expect if they choose. Allow the patient to hear what they are capable of hearing.

- Praise. Commend patients for even the smallest success, such as coming to the appointment or making slight progress in treatment.

- Ask patients what situations they need to avoid.

- Ask open-ended questions that invite the patient to explain situations that make them uncomfortable.

Resources/Further Reading/References

Resources:

- **National Institute of Mental Health.**
  Accessed 7/10/2013

- **National Alliance on Mental Illness.**
  Accessed 7/10/2013
  http://www.nami.org/Template.cfm?Section=posttraumatic_stress_disorder

- **Make the Connection-PTSD resources for Veterans.**
  Accessed 7/10/2013
  http://maketheconnection.net/conditions/ptsd

Further Reading:


References:


14. Eva Fries, Judith Hesse, Juliane Hellhammer, Dirk H. Hellhammer, Department for Psychobiology, University of Trier, Johanniterufer 15, 54290 Trier, Germany


27. Post-traumatic stress disorder: psychopathology, medical management, and dental implications Arthur H Friedlander, DDSa, Corresponding author Ida K Friedlander, RN, MSb, Stephen R Marder, MDc


1. Post Traumatic Stress Disorder (PTSD) is an intense physical and emotional response to ______________ and ______________ of a traumatic event.
   a. Vectors and vehicles
   b. Weather and humidity
   c. Thoughts and reminders
   d. None of the above

2. Which of the following statements is FALSE?
   a. Women are more likely to experience PTSD
   b. PTSD can be a contributing factor to oral disease
   c. PTSD is associated with genetic factors and life changes
   d. PTSD can be a factor in TMD and chronic pain

3. The “re-living” cluster group of PTSD symptoms includes which of the following?
   a. Nightmares and flashbacks
   b. Staying away from activities and places
   c. Poor appetite and increased salivation
   d. Feelings of isolation and estrangement

4. Potential oral indications found in PTSD patients include all of the below EXCEPT:
   a. Bruxing and associated symptoms
   b. Anesthesia complications (delayed onset or recovery)
   c. Gingival hyperplasia and fibrosis
   d. Xerostomia and increased tooth sensitivity

5. Exposure to potential “triggers” for PTSD in a controlled safe environment prior to beginning dental treatment:
   a. Is an accepted form of treatment and known as the gold standard of care
   b. Is not acceptable because of the potential risks it presents
   c. Is contraindicated because of the elevated heart rate and blood pressure

6. What type of strategies are advisable for treating patients with PTSD?
   a. Pre-consultation or collaboration with a physician, therapist or psychiatrist
   b. Let patients know it is okay to bring a support person
   c. Establish a non-stimulating office environment
   d. Allow patients to have choices when possible
   e. All of the above

7. Instructions for home care activities are more successful if given:
   a. In pamphlet format
   b. With detailed verbal explanations
   c. In verbal and written formats
   d. In video format

8. Events which encompass feelings of “powerless, betrayal and out-of-control” and that lead up to PTSD include:
   a. War experiences
   b. Sexual and or mental abuse
   c. Extreme trauma or perception of danger
   d. Any of the above

9. Which of the following behaviors can be categorized with the “increased arousal” cluster group of PTSD symptoms?
   a. Staying away from activities and places
   b. Outburst of anger or irritability
   c. Isolation
   d. Depression

10. What type of support might be needed to insure successful dental treatment?
    a. Pre-consultation or collaboration with a physician
    b. Friend or family to accompany them
    c. Pre-consultation or collaboration with psychiatrist and or therapist
    d. Any of the above

The following information is needed to process your CE certificate. Please allow 4 - 6 weeks to receive your certificate. Please print clearly:

CDHA Membership ID#: ________________________  ❑ I am not a member
Name: ____________________________________________ License #: ____________________________
Mailing Address: ____________________________________________
Phone: ______________ Email: ______________ Fax: _______________________
Signature: __________________________________________________________________________

Please mail the completed Post-test and completed information with your check payable to CDHA:
1900 Point West Way, Suite 222, Sacramento, CA  95815-4706
Keep a copy of your test for your records.
Members in the News

Project Homeless Connect

San Diego component, with Southwestern Community College and Concorde Career College and other community partners, participated in “Project Homeless Connect.” Oral screenings, oral cancer screenings, oral health instruction, and fluoride varnish were given to homeless/low income populations. Referrals to dental homes were also provided.

“Kids are First - Family Safety and Health Festival”

California State Senator Holly Mitchell thanked local volunteers stating, “partnering with Kids Are First to present the Family Safety and Health Festival in Exposition Park is one of the highlights of my job. The festival provided resources, exhibits, services and training demonstrations free of charge to help families protect children from hazards and health problems. West LA College and UCLA Medical Center were also in attendance and offered each youth free health and dental screenings. It was an honor to greet families and thank the organizations for their donated services, including California Highway Patrol officers and staffers of local non-profits.”

Tooth Fairy

In February PHC chair and LA Trust advisory Board memeber Laural Bleak, and PHC Member Katie Conklin participated in the annual LA Trust Tooth Fairy convention. Hundreds of LA Unified School District families recieved free dental screenings, oral hygiene instruction, and referrals to local dentists. The LA Trust is a non-profit organization that works to support the academic success of the students of LAUSD by improving their health, including the creation of 14 school-based Wellness Centers.

CDHA Represented at Miss California Pageant

Shiva Abadi, RDH, MS, San Diego Component President, is a UCSF graduate and a practicing dental hygienist who hopes to teach and work in public health outreach programs. She has also been selected to represent San Diego County at the Miss California Pageant on December 1-3, 2017, held at the Long Beach Convention Center.

She thinks that winning Miss California will afford her the opportunity to have her voice heard on issues such as the environment, raising awareness about mental illnesses and oral health, promoting diversity, and animal welfare.

Shiva feels this is the chance of a lifetime and we wish her well – we’ll be cheering her on.

2017 LA Care Harbor

West LA College students, Cerritos College Students and other community professionals served over 2,100 patients from underserved populations at the January Los Angeles Care Harbor event. Among those, 1,200 dental patients who received dental screenings, cleanings, fillings, extractions, plus referrals to dental home, vaccines, vision, medical, and social services.
TIME TO FIND A JOB YOU LOVE?

Join DentalPost, the premier online and mobile job board and community.

BUILD  SEARCH  APPLY

Special CDHA member offer*

*Receive a free 90-day dental professionals premium account upgrade
Email CDHA@dentalpost.net to redeem

VISIT WWW.DENTALPOST.NET TO LEARN MORE.

/ DENTALPOST  @DENTALPOST
2017-2018 Calendar of Events

2017

July 22-23
CDHA Exec Committee Mtg
Sacramento Central Office

August 5 / August 6
CDHA Leadership Workshop / Board of Trustees Meeting
LAX Hilton

September 23
CDHA Exec Committee Mtg
Sacramento Central office

October 21
CDHA Board of Trustees Meeting
Virtual

2018

February 24-25
CDHA Exec Committee/Admin Council Mtg
Sacramento Central Office

March 24-25
CDHA Board of Trustees Meeting
North/Location TBD

May 18
CDHA Spring Scientific Session
Anaheim

June 8-10
CDHA House of Delegates
Hyatt Regency, Sacramento

SUPERIOR TREATMENT & PROTECTION
vs. regular sodium fluoride toothpaste

* With continued use vs. ordinary toothpaste. Starts fighting plaque and protecting enamel from Day 1.

© 2016 P&G ORAL-19339