— What Dental Professionals Should Know about Psychiatric Disorders —

- They are prevalent.
- They are under-recognized and under-diagnosed.
- They are frequently misunderstood.
- They are associated with high rates of medical co-morbidity and increased dental problems.
- They are associated with reduced rates of compliance with dental and medical treatments.
- Psychiatric illness may present with physical symptoms (e.g., pain).
- Psychiatric disorders are associated with higher rates of substance use disorders.
- Psychotropic medications may have short- and long-term adverse effects.
- Psychotropic medications may interact with drugs used in dentistry and with other medications patients are taking.

Adapted from: Stephen Ferrando, M.D., Northwestern University

### Comparative Prevalence Rates of DIS/DSM III Disorders*

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Lifetime</th>
<th>6-Month</th>
<th>1-Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Mental Disorder</td>
<td>32.2</td>
<td>19.1</td>
<td>15.4</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>14.6</td>
<td>8.9</td>
<td>7.3</td>
</tr>
<tr>
<td>Substance Use Disorders</td>
<td>16.4</td>
<td>6.0</td>
<td>3.8</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>13.3</td>
<td>4.7</td>
<td>2.8</td>
</tr>
<tr>
<td>Drug Abuse</td>
<td>5.9</td>
<td>2.0</td>
<td>1.3</td>
</tr>
<tr>
<td>Major Expressive Episode</td>
<td>5.8</td>
<td>3.0</td>
<td>2.2</td>
</tr>
</tbody>
</table>

*per 100 subjects 18 years and older (ECA)

### ECA Data from NIMH*

The major source of prevalence data on mental disorders in the adult U.S. population is the Epidemiologic Catchment Area (ECA) program, a large epidemiologic survey conducted from 1980–1985 by NIMH.


- One-third of persons in the United States will have at least one psychiatric disorder during their lifetime (lifetime prevalence is 1 in 3).*
- 20% of adults in the United States will suffer from one or more psychiatric disorders during a one-year period.
- 3% of adults have a severe mental disorder (chronic mental illness).

*More recent published studies report that about 25% of all US adults have a mental illness and that nearly 50% will develop at least one mental illness during their lifetime.

March 2013
Working with Fearful, Anxious, and Phobic Patients
– Some Principles for Dental Personnel –

1. Be aware of the possibility that your patient may be phobic or distrustful. Learn to recognize signs of fear, and when in doubt, ask your patient in an accepting way about possible fear. Numerous questions or comments on prior dental experiences may be a sign of distrust.

2. Explain procedures and their rationale, and obtain patient’s permission before doing each procedure. For some patients, explanation and permission may be advisable even for actions such as lowering the back of the dental chair.

3. It is much more important that the patient return for the next appointment than it is to complete a set amount of dental work at the first appointment.

4. Schedule short, simple procedures first to give the patient a good experience; work up to more difficult procedures as the patient can tolerate them.

5. For many fearful patients, control over what happens in the dental chair is very important. If a patient indicates fear or distrust, STOP and listen to the patient. If the patient appears unassertive, you, as the dental professional, should schedule rest breaks, elicit the patient’s feelings about work in progress, and respond appropriately. Review principle #3.

6. Patients who have trouble receiving dental care are not all the same. For distrustful patients, present your most competent self and provide lots of information. Don’t let yourself be rushed into treatment decisions, but take extra time to be certain you have all necessary information. Distrustful patients often find simple reassurance disquieting, but are impressed by personnel who make careful, informed decisions about their care in consultation with the patient.

Reassurance can be helpful for patients who are primarily anxious. Techniques of relaxation, distraction, and stepwise progression at their pace can also be effective.

7. If the patient complains of pain, believe the patient and respond accordingly. Inadequate pain control can cause dental fear. Adequate pain control is often a problem for patients with a history of substance abuse, and it has been established that when drugs for pain control are used in a controlled medical (or dental) setting, they are unlikely to lead to substance abuse.

8. In perhaps 10-15% of fearful patients, pre and post medication can facilitate care and comfort. However, it is preferable to use and teach cognitive-behavioral techniques to give the patient a means of control that can be applied in the dental setting and other settings.

9. If presenting problems seem beyond your level of expertise, refer the patient to a dental fears clinic or consult with a psychologist or other mental health practitioner skilled in work with phobic clients.

10. Remember, although phobic patients may require much patience and stepwise care, if you can win their trust, they can become some of your best patients.

Adapted from: Alison Longley
Pacific Sciences Institute

For additional information on dental fear and pre- and postmedication guidelines, see: Milgrom, P, Weinstein, P: Treating Fearful Dental Patients: A Patient Management Handbook. Behavioral Dental Resources, 2009. Available through Philip Weinstein, PhD. e-mail: phil@u.washington.edu
Guidelines for Dental Professionals in Treating Patients with Severe Mental Illness

General Treatment Guidelines

1. Know the major categories of psychiatric disorders, the major symptoms of the common disorders, and the medications used to treat them as well as the side effects of these medications. Be aware of the biological, psychological, and sociological components of psychiatric disorders.

2. Obtain a complete medical history including all medications. Ask for their physician’s name in the event you need to consult about treatment or drug interactions. Consult with other health care professionals who work with the patient to help ensure comprehensive care and to identify patients who might require special management. Patient consent for consultation must be obtained.

3. Local Anesthetic Guidelines — Limit or avoid the use of epinephrine and other vasoconstrictors in patients taking certain psychotropic drugs* due to the potential of serious hypotension or hypertension and/or cardiac arrhythmias (including tachycardia).

4. Nitrous Oxide (N₂O) Guidelines — N₂O should be used with extreme caution in people who are on psychotropic medications for the following reasons: (a) an increased risk of lowering blood pressure and initiating a hypotensive reaction, and (b) an increased risk of hallucinations in psychotic patients. N₂O should not be used on recovered alcoholics and drug abusers due to the increased potential for initiating a relapse.

5. Consult with the patient’s physician prior to significant oral surgery.

6. Prescribe medications with caution. Psychotropic drugs potentiate the side effects of analgesic and anesthetic medications.*

7. Keep appointments short. These patients cannot tolerate long procedures.

8. Allow for physical distance and “time out” breaks. When you are working in the oral cavity it is easy for the patient to incorporate you into their delusional system.

*Refer to handout on “Selected Drugs Used in Psychiatry.”

Special Considerations for Substance Abusers

1. Patients may have cognition impairment and memory problems due to alcoholic dementia.
2. They may have a low pain threshold and may require more local anesthesia.
   • For cocaine abusers, do not use vasoconstrictors (can be lethal) within 24 hours of cocaine exposure to allow for elimination of the drug and its active metabolites.
3. It is best to avoid the use of mood altering drugs, e.g., narcotic analgesics, N₂O.
4. They may have unpredictable metabolism of drugs due to liver disease, e.g., local anesthesia, N₂O, IV sedation.
   • This may cause pain control problems.
   • Avoid N₂O and IV sedation due to unpredictable reactions and increased tolerance.
5. They may have increased bleeding problems due to decrease in clotting factors associated with liver pathology (alcoholic cirrhosis).
   • Limit acetaminophen (Tylenol, others) dose to <2 grams per day in chronic alcohol users to minimize risk of liver damage.
6. They are more susceptible to infection due to suppression of white blood cells.
7. It is best to avoid mouth rinses containing alcohol.

For additional information contact:
Patricia E. Doyle, RDH, BS, FADPD, pedoyle@u.washington.edu
Patient Characteristics

1. The patient dictates how much you can accomplish in any one appointment. Be flexible and willing to adapt.

2. The patient with chronic mental illness may have difficulty sitting still, and may have tremors and a desire to move around. Be alert to the possibility of extrapyramidal syndrome and tardive dyskinesia:
   a. Extrapyramidal syndrome (EPS) — movement disorders that may occur as a reversible neurological side effect of antipsychotic drugs; e.g. akathisia — an intense, unpleasant need to move and an inability to sit still; characterized by motor restlessness, frequently with symptoms of anxiety and/or agitation.
   b. Tardive Dyskinesia (TD) — abnormal, involuntary movements that usually start in the mouth and face (e.g., a rolling tongue), but can progress to the trunk; most commonly caused by long-term, high-dose use of typical antipsychotics.

3. If the person looks angry, ask about it, and ask about his or her affect (mood). The person may not be feeling angry at all. The person with mental illness needs to know that someone cares about what he or she is experiencing.

4. The person’s “voices” are an inroad into their internal life. Listen and look for the “kernel of truth” in what the person is saying. Avoid arguing about their delusions and hallucinations. Their voices are real for them and you cannot talk a person out of hearing the voices. Persons on psychotropic medications often still hear voices but learn to ignore them. Some patients will benefit from reassurance regarding their delusions.

5. The person with severe mental illness may have cognitive and/or memory difficulties. Short attention span and difficulty understanding information and directions are common, even with persons who are very bright. Catch their attention and make your point quickly and simply.

6. Patients may be fearful of dentistry or lack trust in dental personnel. They frequently have a history of physical or sexual abuse, which can contribute to dental fear. Management of dental fear is important.

7. Substance abuse is not uncommon among persons with severe mental illness. They may self-medicate to make themselves feel better. Therefore, precautions recommended for substance abusers may also apply.

Communication Guidelines

1. Develop good interviewing skills to obtain information and assess the person’s feelings and behaviors.

2. Talk to a mentally ill person in a way that doesn’t degrade; always treat the person with respect.


4. If you don’t understand what someone is saying, ask for clarification and repeat what the person said. A mentally ill person may respond slowly; allow time for response.

5. Dental procedures cut off the ability to communicate, so indicate that you will be aware of nonverbal responses and suggest what the person can do to signal the need for a break to rest or talk.

6. Keep it simple. Try to be direct and to the point. The more abstract the approach, the more confused the person becomes. Use language the patient can understand; for example, refer to gums rather than soft tissue, and debris rather than plaque. Minimize your use of gestures.

7. Do a lot of explaining, especially if you sense fear or paranoia. Be careful to show and explain all materials and equipment to be used, as any perceived attempt to conceal may increase the patient’s agitation.

8. Don’t ask too many questions. Mentally ill persons often view questions as intrusive. Talk in a way that lets them know we are working together.

9. Be empathetic and respect what the person is experiencing as his or her reality, however strange it may seem. Keep the patient’s perspective in mind when discussing the problem. Be nonjudgmental and tolerant of eccentric, bizarre, and undesirable behavior. Be consistent, predictable, and use positive reinforcement. Also be able to take some abuse and criticism, and accept that you may not be rewarded or recognized.

10. Be patient – remember the episodic nature of the illness, i.e., the patient may begin to make strides in oral hygiene, have a relapse because of the illness, and regress to a poor level of oral hygiene.

11. Develop dialog with the patient’s family or other support persons to help facilitate the dental treatment plan.

12. Maintain a sense of humor. (March 2013)
### TABLE OF SELECTED DRUGS USED IN PSYCHIATRY

<table>
<thead>
<tr>
<th>Generic Names</th>
<th>Trade Names (Examples)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANTIANXIETY DRUGS</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Antihistamine Derivatives</strong></td>
<td></td>
</tr>
<tr>
<td>hydroxyzine</td>
<td>Vistaril, *(Atarax), others</td>
</tr>
<tr>
<td><strong>Benzodiazepine Derivatives</strong></td>
<td></td>
</tr>
<tr>
<td>alprazolam</td>
<td>Xanax, others</td>
</tr>
<tr>
<td>chlordiazepoxide</td>
<td>Librium, others</td>
</tr>
<tr>
<td>clonazepam</td>
<td>Klonopin, others</td>
</tr>
<tr>
<td>clorazepate</td>
<td>Tranxene, others</td>
</tr>
<tr>
<td>diazepam</td>
<td>Valium, others</td>
</tr>
<tr>
<td>lorazepam</td>
<td>Ativan, others</td>
</tr>
<tr>
<td>oxazepam</td>
<td>(Serax), others</td>
</tr>
<tr>
<td><strong>Other Agents</strong></td>
<td></td>
</tr>
<tr>
<td>buspirone</td>
<td>*(BuSpar), others</td>
</tr>
<tr>
<td>meprobamate</td>
<td>*(Miltown), others</td>
</tr>
<tr>
<td><strong>SEDATIVE–HYPNOTIC DRUGS</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Benzodiazepine Derivatives</strong></td>
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</tr>
<tr>
<td>estazolam</td>
<td>*(ProSom), others</td>
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<tr>
<td>flurazepam</td>
<td>*(Dalmane), others</td>
</tr>
<tr>
<td>quazepam</td>
<td>Doral</td>
</tr>
<tr>
<td>temazepam</td>
<td>Restoril, others</td>
</tr>
<tr>
<td>triazolam</td>
<td>Halcion, others</td>
</tr>
<tr>
<td><strong>Other Agents</strong></td>
<td></td>
</tr>
<tr>
<td>chloral hydrate</td>
<td>*(Noctec), others</td>
</tr>
<tr>
<td>diphenhydramine</td>
<td>*(Benadryl), others; over–the–counter sleep aids</td>
</tr>
<tr>
<td>doxepin</td>
<td>*(Silenor)</td>
</tr>
<tr>
<td>eszopiclone</td>
<td>*(Lunesta)</td>
</tr>
<tr>
<td>ramelteon</td>
<td>*(Rozerem)</td>
</tr>
<tr>
<td>zolpidem</td>
<td>*(Ambien, others</td>
</tr>
<tr>
<td>zaleplon</td>
<td>*(Sonata, others</td>
</tr>
<tr>
<td><strong>ANTIDEPRESSANT DRUGS</strong></td>
<td></td>
</tr>
<tr>
<td><strong>SSRIs (Selective Serotonin Reuptake Inhibitors)</strong></td>
<td></td>
</tr>
<tr>
<td>citalopram</td>
<td>*(Celexa, others</td>
</tr>
<tr>
<td>escitalopram</td>
<td>*(Lexapro)</td>
</tr>
<tr>
<td>fluoxetine</td>
<td>*(Prozac, others; Sarafem</td>
</tr>
<tr>
<td>fluvoxamine</td>
<td>*(Luvox, others</td>
</tr>
<tr>
<td>paroxetine</td>
<td>*(Paxil, others; *(Pexeva)</td>
</tr>
<tr>
<td>sertraline</td>
<td>*(Zoloft, others</td>
</tr>
<tr>
<td><strong>SNRIs (Serotonin and Norepinephrine Reuptake Inhibitors)</strong></td>
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</tr>
<tr>
<td>desvenlafaxine</td>
<td>*(Pristiq)</td>
</tr>
<tr>
<td>duloxetine</td>
<td>*(Cymbalta)</td>
</tr>
<tr>
<td>venlafaxine</td>
<td>*(Effexor, others; *(Effexor XR, others</td>
</tr>
<tr>
<td><strong>Other Agents</strong></td>
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</tr>
<tr>
<td>bupropion</td>
<td>*(Wellbutrin, Zyban, others; *(Wellbutin SR, others; *(Wellbutin XL, others</td>
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<tr>
<td>maprotiline</td>
<td>*(Ludiomil, others</td>
</tr>
<tr>
<td>mirtazapine</td>
<td>*(Remeron, others</td>
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<tr>
<td>nefazodone</td>
<td>*(Serzone, others</td>
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<tr>
<td>trazodone</td>
<td>*(Desyrel, others</td>
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<tr>
<td><strong>Tricyclic Derivatives (TCAs)</strong></td>
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<tr>
<td>amitriptyline</td>
<td>*(Elavil), others</td>
</tr>
<tr>
<td>amoxapine</td>
<td>*(Asendin), others</td>
</tr>
<tr>
<td>clomipramine</td>
<td>*(Anafranil, others</td>
</tr>
<tr>
<td>desipramine</td>
<td>*(Norpramin, *(Pertofrane, others</td>
</tr>
<tr>
<td>doxepin</td>
<td>*(Sinequan), *(Adapin), others</td>
</tr>
<tr>
<td>imipramine</td>
<td>*(Tofranil, others</td>
</tr>
<tr>
<td>nortriptyline</td>
<td>*(Pamelor, *(Aventyl), others</td>
</tr>
<tr>
<td>protriptyline</td>
<td>*(Vivactil, others</td>
</tr>
<tr>
<td>trimipramine</td>
<td>*(Surmontil, others</td>
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<tr>
<td><strong>ANTIDEPRESSANT DRUGS (cont):</strong></td>
<td></td>
</tr>
<tr>
<td><strong>MAO Inhibitors (MAOIs)</strong></td>
<td></td>
</tr>
<tr>
<td>isocarboxazid</td>
<td>*(Marplan)</td>
</tr>
<tr>
<td>phenelzine</td>
<td>*(Nardil, others</td>
</tr>
<tr>
<td>selegiline</td>
<td>*(Emsam (topical patch)</td>
</tr>
<tr>
<td>tranylcypromine</td>
<td>*(Parnate, others</td>
</tr>
<tr>
<td><strong>COMBINATION DRUGS</strong></td>
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</tr>
<tr>
<td>amitriptyline—chlordiazepoxide</td>
<td>*(Limbitrol, others</td>
</tr>
<tr>
<td><strong>MOOD STABILIZER DRUGS</strong></td>
<td></td>
</tr>
<tr>
<td>carbamazepine</td>
<td>*(Tegretol, others; *(Equetro, *(Carbatrol, *(Tegretol XR</td>
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<tr>
<td>gabapentin</td>
<td>*(Neurontin, others</td>
</tr>
<tr>
<td>lamotrigine</td>
<td>*(Lamictal, others</td>
</tr>
<tr>
<td>lithium carbonate or citrate</td>
<td>*(Eskalith, *(Lithonate, others; *(Cibalith–S, others</td>
</tr>
<tr>
<td>oxcarbazepine</td>
<td>*(Trileptal, others</td>
</tr>
<tr>
<td>valproic acid (valproate)</td>
<td>*(Divalproex)</td>
</tr>
<tr>
<td><strong>ANTIPSYCHOTIC DRUGS</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Atypical Antipsychotics</strong></td>
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</tr>
<tr>
<td>aripiprazole</td>
<td>*(Abilify)</td>
</tr>
<tr>
<td>asenapine</td>
<td>*(Saphris)</td>
</tr>
<tr>
<td>clozapine</td>
<td>*(Clozaril, others</td>
</tr>
<tr>
<td>iloperidone</td>
<td>*(Fanapt)</td>
</tr>
<tr>
<td>lurasidone</td>
<td>*(Latuda)</td>
</tr>
<tr>
<td>olanzapine</td>
<td>*(Zyprexa)</td>
</tr>
<tr>
<td>paliperidone</td>
<td>*(Invega)</td>
</tr>
<tr>
<td>quetiapine</td>
<td>*(Seroquel)</td>
</tr>
<tr>
<td>risperidone</td>
<td>*(Risperdal, others</td>
</tr>
<tr>
<td>ziprasidone</td>
<td>*(Geodon)</td>
</tr>
<tr>
<td><strong>Typical Antipsychotics</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Phenothiazine Derivatives</strong></td>
<td></td>
</tr>
<tr>
<td>chlorproazine</td>
<td>*(Thorazine, others</td>
</tr>
<tr>
<td>fluphenazine</td>
<td>*(Prolixin, others</td>
</tr>
<tr>
<td>perphenazine</td>
<td>*(Trilafon, others</td>
</tr>
<tr>
<td>thioridazine</td>
<td>*(Mellaril, others</td>
</tr>
<tr>
<td>trifluoperazine</td>
<td>*(Stelazine, others</td>
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<tr>
<td><strong>Nonphenothiazine Derivatives</strong></td>
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<tr>
<td>droperidol</td>
<td>*(Inapsine, others</td>
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<tr>
<td>haloperidol</td>
<td>*(Haldol, others</td>
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<tr>
<td>loxapine</td>
<td>*(Loxite, others</td>
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<tr>
<td>pimozide</td>
<td>*(Orap)</td>
</tr>
<tr>
<td>thiothixene</td>
<td>*(Navane, others</td>
</tr>
<tr>
<td><strong>ANTIPARKINSON DRUGS AND PROPRANOLOL</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Anticholinergics</strong></td>
<td></td>
</tr>
<tr>
<td>benztropine</td>
<td>*(Cogentin, others</td>
</tr>
<tr>
<td>diphenhydramine</td>
<td>*(Benadryl, others</td>
</tr>
<tr>
<td>trihexyphenidyl</td>
<td>*(Artane, others</td>
</tr>
<tr>
<td><strong>Other Agents (usually for akathisia [motor restlessness])</strong></td>
<td></td>
</tr>
<tr>
<td>amantadine</td>
<td>*(Symmetrel, others</td>
</tr>
<tr>
<td>propranolol</td>
<td>*(Inderal, others</td>
</tr>
</tbody>
</table>

*Parentheses indicate a brand name product no longer commercially available but patients may still use the name to identify a medication they are taking.

BY: Karen P. Hansen, PharmD, MS, BCPP, BCPS

See additional information and sources on accompanying handout:
Some Dental Considerations for Selected Psychiatric Medications.
SOME DENTAL CONSIDERATIONS FOR SELECTED PSYCHIATRIC MEDICATIONS

ANTIDEPRESSANT DRUGS

SSRIs
Can produce xerostomia\(^1\) (generally less frequently than tricyclics). Can increase risk of bleeding (platelet effect similar to aspirin and NSAIDS but by different mechanism). Increased risk of bleeding (GI [though rare] and other) with aspirin and NSAIDS (ibuprofen, naproxen, others). May increase side effects but fewer CV risks with epinephrine and other vasoconstrictors.\(^3\)
Can decrease/eliminate analgesia from codeine, oxycodone, hydrocodone (in Vicodin, others), and tramadol due to decreased metabolism to active analgesic. Increased risk of side effects with tramadol (seizures, serotonin syndrome).

SNRIs
Same as for SSRIs (xerostomia\(^1\), bleeding risk, drug interaction risks with aspirin, NSAIDS, codeine, oxycodone, hydrocodone, and tramadol). Increased side effects/CV risks when using epinephrine and other vasoconstrictors. Limit their use. Do not use levonordefrin (Neo-Cobefrin)\(^2\).

Other Agents
Can produce xerostomia\(^1\) (generally less frequently than the tricyclics) via an anticholinergic (maprotiline) or unidentified mechanism (others). Can cause orthostatic hypotension\(^3\) (most with trazodone, nefazodone, and mirtazapine).
Increased side effects/CV risks when using epinephrine and other vasoconstrictors. Limit their use. Do not use levonordefrin (Neo-Cobefrin)\(^2,3\).

Tricyclics (TCAs)
All are anticholinergic\(^1\). All can cause orthostatic hypotension\(^3\).
Increased side effects/CV risks when using epinephrine and other vasoconstrictors. Limit their use. Do not use levonordefrin (Neo-Cobefrin)\(^2,3\).

MAO Inhibitors (MAOIs)
All are anticholinergic\(^1\), but less so than tricyclics. All can cause hypotension (especially orthostatic).
Special consideration needed when using dental anesthesia or prescribing pain medication. Limit the use of epinephrine\(^2,3\) and other vasoconstrictors. Never use meperidine (Demerol, others) or tramadol (Ultram, others). Do not use phenylephrine.
MAOIs interact with a number of medications to cause hypertensive crisis or serotonin syndrome (either of which can be fatal). Always check with a pharmacist or patient’s prescriber before administering/prescribing any medication.

MOOD STABILIZER DRUGS

Lithium
Dry mouth\(^1\) frequently reported, generally secondary to lithium-induced polyuria; may be effect of lithium on thirst and saliva flow. Rarely, stomatitis can occur. Altered taste due to taste of lithium tablet (metallic) or secretion of lithium into saliva. Can get increased lithium levels (with toxicity) with concurrent nonsteroidal anti-inflammatory agents (NSAIDs, e.g., ibuprofen [Motrin, Advil, others]; naproxen [Naprosyn, Anaprox, Aleve, others]).

Carbamazepine
Anticholinergic\(^1\) side effects. Can cause orthostatic hypotension\(^3\).

Oxcarbazepine
Increased side effects/CV risks when using epinephrine and other vasoconstrictors. Limit their use. Do not use levonordefrin (Neo-Cobefrin)\(^2,3\).
Avoid erythromycin or clarithromycin with carbamazepine (Tegretol, others) due to significant risk of severe carbamazepine toxicity.
Mouth sores and unexplained sore throat may be early signs of potentially serious hematologic toxicity (agranulocytosis, aplastic anemia). (Risk greater with carbamazepine [Tegretol, others], though rare.)

Gabapentin
Can cause orthostatic hypotension\(^3\). Increased side effects/CV risks when using epinephrine and other vasoconstrictors. Limit their use\(^3\).

Valproic Acid, Divalproex
Can increase risk of bleeding (platelet effect similar to aspirin and NSAIDs but by a different mechanism). May increase risk of bleeding with aspirin and NSAIDs (e.g., ibuprofen, naproxen, others).

ANTIPSYCHOTIC DRUGS
All have anticholinergic\(^1\) side effects. All can cause orthostatic hypotension\(^3\).
Increased side effects/CV risks when using epinephrine and other vasoconstrictors. Limit their use\(^3\).
All produce extrapyramidal\(^4\) side effects (stiffness in the jaw, neck, and other muscle groups; motor restlessness).
All can produce tardive dyskinesia\(^4\) (repetitive, involuntary movements of extremities and trunk, “chewing” motion of jaw). Early signs include abnormal movements of tongue (rolling, lateral, protruding movements) and mouth (lip-smacking, chewing motions, grimacing).
Patient can control these movements temporarily with attention.

ANTIPARKINSON DRUGS
All have anticholinergic\(^1\) side effects. Special precautions required when using epinephrine and other vasoconstrictors with propranolol.
Contact a dental practitioner familiar with their combined use for further recommendations. (Footnotes on reverse side)
FOOTNOTES for DENTAL CONSIDERATIONS ...

CV = cardiovascular
NSAIDs = nonsteroidal anti-inflammatory agents
ADHD = attention deficit hyperactivity disorder

1Xerostomia (or dry mouth) secondary to decreased flow of saliva (via anticholinergic or other mechanisms) predisposes patient to increased caries and gingival changes that may affect denture fit. Another anticholinergic side effect of dental concern is tachycardia.

2Drugs that potentiate norepinephrine directly (e.g., stimulants used to treat ADHD, bupropion) or indirectly by blocking norepinephrine reuptake (e.g., SNRIs, TCAs, bupropion, nefazodone and mirtazapine; carbamazepine and oxcarbazepine) or inhibiting norepinephrine metabolism (MAOIs) can cause a serious increase in blood pressure and/or cardiac arrhythmias (including tachycardia) with epinephrine and other vasoconstrictors (e.g., levonordefrin). Limit or avoid use. Use with caution, careful attention to administration technique and careful monitoring for CV toxicity (blood pressure, heart rate). Further precautions are necessary if concurrent cardiac risk factors, disease and/or treatment for cardiovascular disease. For specific dental vasoconstrictor recommendations: Contact a dental practitioner familiar with their combined use.

3Orthostatic hypotension caused by many antidepressants (TCAs, some other agents), most antipsychotics, carbamazepine (Tegretol, others), oxcarbazepine (Trileptal, others), gabapentin and other drugs, via alpha-1 blockade, can cause a serious drop in blood pressure when combined with epinephrine and similar vasoconstrictors. Limit their use. Use with caution, careful attention to administration technique and careful monitoring for CV toxicity (blood pressure, heart rate). Further precautions are necessary in patients with cardiac disease or risk factors (see footnote 2 above). For specific dental vasoconstrictor recommendations: Contact a dental practitioner familiar with their combined use.

4Atypical antipsychotics cause fewer of these (muscle) side effects.

NOTE: All psychiatric medications (except stimulants) are to some degree sedating. All can potentiate both anesthesia and the effects/side effects of sedating pain medications.

NOTE: Limit acetaminophen (Tylenol, others) dose to 2 grams per day in chronic alcohol users to minimize risk of liver damage.

NOTE: Nitrous Oxide (N₂O) should be used with extreme caution in people who are on psychotropic medications due to potential for initiating a hypotensive reaction and an increased risk of hallucinations in psychotic patients. Do not administer N₂O to recovered alcoholics and drug abusers as it may increase the risk of a relapse.

ADDITIONAL RESOURCES:


Articles:


By: Karen P. Hansen, PharmD, MS, BCPP, BCPS; (except dental resources and nitrous oxide recommendations)

For additional information, contact: Patricia E. Doyle, RDH, BS, FADPD

March 2011
— Brief Definitions of Axis I Clinical Disorders, as Defined by the DSM-IV-TR —

- **Adjustment Disorder** — The development of emotional or behavioral distress that is more than would be expected, that occurs within three months after onset of stressor and persists no longer than six months after the stressor has terminated.

- **Bipolar Disorder** — A mood disturbance in which there is one or more manic episodes, usually accompanied by one or more major depressive episodes. (Bipolar I, Bipolar II, Cyclothymic)

- **Depression (Major)** — A mood disorder in which there is either depressed mood or loss of interest or pleasure in all or almost all activities with multiple associated symptoms that last for at least two weeks.

- **Dissociative Identity Disorder** (formerly Multiple Personality) — A disruption in the usually integrated function of consciousness, memory, identity, or perception of the environment. This can include amnesia, presence of two or more identities or personality states, or experience of feeling detached from one’s body or mind.

- **Dysthymia** — A chronic disturbance of mood involving depressed mood, for most of the day and more days than not, for at least two years.

- **Eating Disorders** — Severe disturbances in eating behavior and in the way a person experiences the body (i.e., Anorexia Nervosa, Bulimia Nervosa).

- **Generalized Anxiety Disorder** — Unrealistic anxiety and worry about two or more life circumstances, for six months or longer, during which the person has been bothered by these concerns more days than not.

- **Obsessive-Compulsive Disorder** — Recurrent obsessions or compulsions sufficiently severe to cause marked distress, be time consuming, or significantly interfere with the person’s normal routine, occupational functioning, or usual social activities or relationships with others.

- **Panic Disorder** — Recurrent panic attacks, that is, discrete periods of intense fear or discomfort. It cannot be established that an organic factor initiated and maintained the disturbance.

- **Posttraumatic Stress Disorder** — The re-experiencing of a psychologically distressing event that is outside the range of usual human experience, manifesting as avoidance of stimuli or memory associated with the event, and/or numbing of general responsiveness and increased arousal (hyper-irritability rather than sexual).

- **Schizophrenia** — A thought disorder that can range from mild to severe. Symptoms of at least one month duration can include delusions, hallucinations, disorganized speech and behavior, paranoia, catatonia, emotional flatness, and apathy. It is a spectrum of illnesses.

- **Schizoaffective Disorder** — Includes Major Depression or Bipolar Disorder concurrently (with Schizophrenia).

- **Somatization Disorder** — Recurrent and multiple somatic complaints, of several years’ duration, for which medical attention has been sought, but that apparently are not caused by any physical disorder.

- **Somatoform Pain Disorder** — Preoccupation with pain in the absence of adequate physical findings to account for the pain or its intensity for at least six months.

- **Specific Phobia** — Characterized by clinically significant anxiety provoked by exposure to a specific feared object or situation, often leading to avoidance behavior.

- **Substance Abuse Disorder** — A maladaptive pattern of psychoactive substance use characterized by continued use of the substance despite a recurrent social, occupational, psychological and/or physical problem that is caused by use of the substance, and/or recurrent use of the substance in situations when use is physically hazardous (for example, driving while intoxicated).

A Personality Disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.

- **Paranoid Personality Disorder** is a pattern of distrust and suspiciousness such that others’ motives are interpreted as malevolent.
- **Schizoid Personality Disorder** is a pattern of detachment from social relationships and a restricted range of emotional expression.
- **Schizotypal Personality Disorder** is a pattern of acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behavior.
- **Antisocial Personality Disorder** is a pattern of disregard for, and violation of, the rights of others.
- **Borderline Personality Disorder** is a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity.
- **Histrionic Personality Disorder** is a pattern of excessive emotionality and attention seeking.
- **Narcissistic Personality Disorder** is a pattern of grandiosity, need for admiration, and lack of empathy.
- **Avoidant Personality Disorder** is a pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation.
- **Dependent Personality Disorder** is a pattern of submissive and clinging behavior related to an excessive need to be taken care of.
- **Obsessive-Compulsive Personality Disorder** is a pattern of preoccupation with orderliness, perfectionism, and control.
- **Personality Disorder Not Otherwise Specified** is a category for two situations: (1) the individual’s personality pattern meets the general criteria for a Personality Disorder and traits of several different Personality Disorders are present, but the criteria for any specific disorder are not met; or (2) the individual’s personality pattern meets the general criteria for a Personality Disorder, but the individual is considered to have a Personality Disorder that is not included in the classifications (e.g., passive-aggressive personality disorder).


**— Common Causes of Psychiatric Symptoms —**

Many medical problems can cause psychiatric symptoms, which may resolve if the underlying medical condition is treated. Persons with identified psychiatric disorders have an approximately 50% higher rate of physical (medical) conditions. A compelling literature documents that there is much “physical” in “mental” disorders and much “mental” in “physical” disorders.

<table>
<thead>
<tr>
<th>Immune Disease</th>
<th>Neurological Disease</th>
<th>Nutritional deficiencies</th>
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<tr>
<td>Systemic lupus erythematosis</td>
<td>Cerebrovascular disorders</td>
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<td>AIDS</td>
<td>Dementia of the Alzheimer’s type</td>
<td>Primary psychiatric illness</td>
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<td>Infection</td>
<td>Epilepsy</td>
<td>Toxins</td>
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<td>Metabolic and Endocrine Disease</td>
<td>Head trauma</td>
<td>Prescription medications</td>
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<td>Thyroid</td>
<td>Hydrocephalus</td>
<td>Alcohol and other drugs</td>
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<td>Parathyroid</td>
<td>Huntington’s disease</td>
<td>Environmental toxins</td>
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<td>Pituitary</td>
<td>Migraine</td>
<td>Tumor</td>
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<td>Adrenal</td>
<td>Multiple sclerosis</td>
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<td>Renal failure</td>
<td>Parkinson’s disease</td>
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<td>Hepatic failure</td>
<td>Pick’s disease</td>
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Xerostomia (Dry Mouth)

You should be evaluated for xerostomia (dry mouth) when any of the following occur:

- Difficulty chewing, swallowing food
- Difficulty speaking
- Need for frequent sips of water or other liquid to keep mouth moist
- Sensation of burning, dryness, or tingling of the mucosa
- Altered taste or diminished taste ability
- Difficulty wearing dentures
- Increased incidence of caries
- Dry eyes, vaginal dryness

Causes of Xerostomia

Drug Intake:

- Appetite suppressants
- Anticholinergics
- Antidepressants
- Antipsychotics
- Diuretics
- Sedatives and Hypnotics
- Antihistamines
- Antiparkinsonism drugs
- Antihypertensive drugs

Diagnosis of Symptoms of:

- Sjogren’s Syndrome
- Rheumatoid Arthritis
- Systemic Lupus Erythematosus
- Progressive Systemic Sclerosis
- Primary Biliary Cirrhosis
- Polymyositis or Dermatomyositis
- Graft vs. Host Disease
- Sarcoidosis
- Autoimmune Hemolytic Anemia
- Diabetes
- Acquired Immunodeficiency Syndrome
- Bulimia
- Malnutrition
- Dehydration, debilitation

Clinical Signs

- Dry oral tissues
- Mucosal infection (commonly yeast)
- Inflamed, fissured tongue
- Rampant caries (especially cervical and root surface areas)
- Enamel or dental erosion
- Unilateral or bilateral glandular enlargement
- Glandular infection

If you suspect you have xerostomia:

- Undergo a complete evaluation of your teeth and oral cavity.
- Measurement of your salivary flow rates is recommended to determine the extent of dysfunction.

If you have xerostomia, you must:

- Maintain meticulous oral care.
- See your dentist regularly.
- Use fluoride gel or rinse daily.
- Avoid foods that promote dental decay.
TIPS FOR CONSULTING WITH XEROSTOMATIC PATIENTS

Review patient’s current medications and xerostomic effect.

Advise patient to:

- Conduct a daily mouth exam; check inside mouth for red, white, or dark patches and report these to their doctor.
- Visit their dentist regularly for prophylactic maintenance, and request fluoride treatments.
- Maintain meticulous oral hygiene using fluoridated, SLS-free toothpaste.
- Moisten mouth with artificial saliva as needed.
- Have their doctor prescribe a pilocarpine if necessary.
- Apply lip lubricants without menthol as required.
- Drink liquids with meals and add sauces or gravies to make food easier to swallow; try to avoid dry foods.
- Try eating smaller, more frequent meals.
- Carry a water bottle during the day.
- Chew sugarless gum and suck sugarless hard candies.
- Avoid alcoholic, carbonated, citrus, and caffeine drinks.
- Avoid alcohol-based or peroxide-based mouthwashes.
— Brief Glossary of Psychiatric Terms —

• **Addiction:** Dependence on a chemical substance to the extent that a physiological need is established. Withdrawal symptoms are manifested when the substance is removed. Narcotics, alcohol, and most sedative drugs may produce addiction.

• **Affect:** Patient’s external expression of emotional responsiveness. Affect and emotion are commonly used interchangeably. Affect is observed as patient’s facial expression, including the amount and range of expressive behavior. Affect is described as within normal range, constricted, blunted, or flat.

• **Agoraphobia:** Anxiety about being in places in which escape might be difficult or embarrassing should a panic attack occur. Fears typically relate to leaving one’s home, being in a crowd, or traveling by car or plane. Agoraphobia usually occurs as part of panic disorder.

• **Alzheimer’s Disease:** A degenerative organic mental disease with diffuse brain deterioration and dementia.

• **Anxiolytic:** A drug having an anti-anxiety effect and used widely to relieve emotional tension. The most commonly used antianxiety drugs are the benzodiazepines.

• **Attention Deficit / Hyperactivity Disorder (ADHD):** A DSM IV category for a childhood disorder characterized by developmentally inappropriate short attention span, poor concentration, and frequent hyperactivity. The symptoms sometimes continue into adulthood.

• **Compulsion:** Repetitive, ritualistic behavior such as handwashing that aims to prevent or reduce stress. The person feels driven to perform such actions, though the behaviors are recognized to be excessive or unreasonable.

• **Delusion:** A false belief firmly held despite obvious proof or evidence to the contrary. In addition, the belief is not one ordinarily accepted by other members of the person’s culture or subculture.

• **Delirium:** An acute cognitive disorder characterized by impairment in consciousness, attention, and changes in cognition.

• **Dementia:** A cognitive disorder characterized by defective memory, language, motor activity, and ability to recognize objects, and problems with abstract thinking and planning.

• **Dependence (Substance):** Habituation to, abuse of, and/or addiction to chemical substance. Largely because of psychological craving, the life of the drug-dependent person revolves around the need for the special effect of one or more chemical agents on mood or state of consciousness. Dependence includes not only the addiction (which emphasizes physiological dependence), but also drug abuse (where the pathologic craving for drugs seems unrelated to physical dependence). Examples: alcohol, opiates, barbiturates, other hypnotics, sedatives and some antianxiety agents, cocaine, marijuana.

• **Depersonalization:** Feelings of unreality or strangeness concerning either the environment, the self, or both.

• **Diagnosis:** The process of determining, through examination and analysis, the nature of a patient’s illness. The purpose of diagnosis is to identify psychiatric disorders and psychological responses to the physical illness, and to identify the patient’s personality features and characteristic coping techniques in order to recommend the therapeutic intervention most appropriate for the patient’s needs.

• **Disorientation:** Loss of awareness of the position of the self in relation to space, time, or other persons; confusion.

• **Dissociation:** A disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment. The disturbance may be sudden or gradual, transient or chronic.

*continued*
• **Distractibility**: Inability to maintain attention; shifting from one area or topic to another with minimal provocation. Distractibility may be a manifestation of an underlying medical disease, medication side effect, or a mental disorder such as an anxiety disorder, mania, or schizophrenia.

• **Dual Diagnosis**: In mental health settings this term refers to the dual diagnosis of mental illness with substance abuse of alcohol and/or drugs. Also called **Comorbidity**.

• **Dysthymia**: Characterized by chronic, nonpsychotic signs and symptoms of depression that do not meet the diagnosis criteria for a major depressive episode. Dysthymia is conceptualized as a chronic disorder, not an episodic disorder with extended asymptomatic periods.

• **Flight of Ideas**: A nearly continuous flow of accelerated speech with abrupt changes from topic to topic that are usually based on understandable associations, distracting stimuli, or plays on words. When severe, speech may be disorganized and incoherent. Sometimes seen in bipolar disorder.

• **Grandiosity**: Exaggerated belief or claims of one’s importance or identity, often manifested by delusions of great wealth, power, or fame.

• **Hallucination**: A sensory perception that has the compelling sense of reality of a true perception but that occurs in the absence of an external stimulus. May occur in any of the senses — e.g., auditory, gustatory, olfactory, somatic, tactile, visual.

• **Identity**: A person’s global role in life and the perception of his/her sense of self.

• **Intoxication (Substance)**: The acute effects of overdosage with chemical substances that cause maladaptive behavior because of their effects on the central nervous system.

• **Loosening of Associations**: A disturbance of thinking in which ideas shift from one subject to another in an unrelated manner. The speaker is unaware of the disturbance. When loosening of associations is severe, speech may be incoherent. Contrast with flight of ideas.

• **Magical Thinking**: The erroneous belief that one’s thoughts, words, or actions will cause or prevent a specific outcome in some way that defines commonly understood laws of cause and effect. A conviction that equates thinking with doing.

• **Malingering**: Deliberate simulation or exaggeration of an illness or disability in order to avoid an unpleasant situation or to obtain some type of personal gain.

• **Manic**: A mood disorder characterized by excessive elation, hyperactivity, agitation, and accelerated thinking and speaking. Sometimes manifested as flight of ideas. Mania is seen in mood disorders and in certain organic mental disorders.

• **Mental Disorder / Mental Illness**: A persistent mental state that leads to disability. An illness with biological, psychological, and sociological components, and characterized by symptoms and/or impairment in functioning.

• **MICA**: This term refers to “mentally ill chemical abuser.” (See Dual Diagnosis)

• **Mood**: The affect — a pervasive and sustained emotion that, in the extreme, markedly colors one’s perception of the world. Common examples of mood include depression, elation, and anger.

• **Neuroleptic**: An antipsychotic drug.

• **Obsession**: A persistent, unwanted idea or impulse that cannot be expunged by logic or reasoning.

*continued*
• **Panic Attack:** Discrete periods of sudden onset of intense apprehension, fearfulness, or terror often associated with feelings of impending doom, fear of going crazy or losing control, and physical symptoms such as shortness of breath, palpitations or accelerated heart rate, chest pain or discomfort, and choking.

• **Paranoid Ideation:** Suspicious or delusional belief that one is being harassed, persecuted, or unfairly treated.

• **Phobia:** A persistent, irrational fear of a specific object, activity, or situation that results in a compelling desire to avoid it.

• **Psychiatric Disorder:** See Mental Disorder.

• **Psychotic:** A term that describes the inability to distinguish reality from fantasy, as well as impaired reality testing, with creation of a new reality.

• **Psychotropic:** A term to describe drugs or a drug used to alter abnormal thinking, feelings, or behavior; traditionally divided into classes of antipsychotic, antidepressant, mood stabilizers, and antianxiety (anxiolytic) drugs.

• **Remission:** Abatement of an illness (decrease in amount, intensity, or degree). Active symptoms of an illness are in “remission.”

• **Somatization:** The tendency to experience and report numerous somatic symptoms. May be associated with emotional disturbance and/or excessive treatment seeking for physical symptoms.

• **Substance Abuse:** Impairment in functioning resulting from a pathological and “compulsive” use of a chemical substance such as alcohol or drugs. Largely because of psychological craving, the life of the substance abusing person can revolve around the need for the specific effect of the “abusing substance.”

• **Syndrome:** A configuration of signs and symptoms that occur together and suggest a common underlying pathogenesis, course, familial pattern, or treatment solution.

• **Tic:** An intermittent, involuntary, spasmodic movement of a group of muscles, often without a demonstrable external stimulus. A tic may be an expression of an emotional conflict, the result of a neurologic disorder, or an effect of a drug.

• **Tourette’s Disorder:** A syndrome usually beginning in early childhood and characterized by repetitive tics, other movement disorders, uncontrolled grunts, unintelligible sounds, and occasionally verbal obscenities.

• **Tolerance (Substance):** The need for markedly increased amounts of the substance to achieve the desired effect that results from repeated use of a drug. People vary widely in the amount of substance they can tolerate independent of their experience with the substance; alcohol tolerance is an example.

• **Withdrawal:** The constellation of symptoms due to cessation or reduction of substance use that has been heavy and prolonged.

SEE ALSO: Handout on Axis I and Axis II Disorders.

SOURCES:


The Dental–Mental Connection:
Dental Care for Persons with Chronic Mental Illness

The American Psychiatric Association reports:
• 1 in 5 Americans suffers from mental illness.
• 3 of every 100 people become chronically mentally ill (CMI).
• 1 of 25 families is directly affected by CMI.

Nearly 45% of those with any mental disorder meet criteria for 2 or more disorders, with severity strongly related to comorbidity.

Many persons with chronic mental illness (CMI) have severe oral health problems.

Dental care providers, mental health case managers, and families need to network to ensure that the client receives comprehensive dental care. Dental personnel in both community clinics and private practice must be involved in this process. Optimum oral health enhances the life of the person with a major psychiatric disorder and needs to be an integral part of rehabilitation and recovery.

Guidelines for Communication with a Person with a Major Psychiatric Disorder

<table>
<thead>
<tr>
<th>Persons with Mental Illness …</th>
<th>So you need to …</th>
</tr>
</thead>
<tbody>
<tr>
<td>have trouble with “reality”</td>
<td>be simple, truthful</td>
</tr>
<tr>
<td>are fearful</td>
<td>stay calm</td>
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<tr>
<td>are insecure</td>
<td>be accepting</td>
</tr>
<tr>
<td>have trouble concentrating</td>
<td>be brief, repeat</td>
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<tr>
<td>are overstimulated</td>
<td>limit input, not force discussion</td>
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<tr>
<td>easily become agitated</td>
<td>recognize agitation and allow escape</td>
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<td>have poor judgment</td>
<td>not expect rational discussion</td>
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<tr>
<td>are preoccupied</td>
<td>get attention first</td>
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<tr>
<td>are withdrawn</td>
<td>initiate relevant conversation</td>
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<td>have changing emotions</td>
<td>disregard</td>
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<td>have changing plans</td>
<td>keep to one plan</td>
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<tr>
<td>have little empathy for you</td>
<td>recognize as a symptom</td>
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<tr>
<td>believe delusions</td>
<td>ignore, don’t argue</td>
</tr>
<tr>
<td>have low self-esteem, lack motivation</td>
<td>stay positive</td>
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</tbody>
</table>

For additional information, contact:
Patricia E. Doyle, RDH, BS, FADPD
pedoyle@u.washington.edu

Courtesy of:
Alliance for the Mentally Ill, New Mexico

March 2013
<table>
<thead>
<tr>
<th></th>
<th>CAUSES UNKNOWN</th>
<th>Psychotic</th>
<th>PRECIPITATING EVENT</th>
<th>ORGANIC CAUSES</th>
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<tbody>
<tr>
<td></td>
<td>Schizophrenia</td>
<td>Depression</td>
<td>Brief Reactive</td>
<td>Delirium</td>
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<td>Psychosis</td>
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<td>SOCIAL FUNCTION</td>
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<td></td>
<td>Significantly impaired</td>
<td>Increased activity</td>
<td>Loss of energy, interest, and pleasure</td>
<td>Impaired by identifiable precipitating event</td>
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<tr>
<td></td>
<td>At least 6 months</td>
<td>Decreased need for sleep</td>
<td>Vegetative signs</td>
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<td>Rapid, but symptoms at least 2 weeks</td>
<td>Gradual</td>
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<tr>
<td>AFFECT</td>
<td>Blunted, flat or inappropriate</td>
<td>Euphoric but labile</td>
<td>Depressed, worried hopeless, guilty</td>
<td>Variable but explainable by precipitating event</td>
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<td></td>
<td>Labile</td>
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<tr>
<td>SPEECH</td>
<td>Derailment/intermingling</td>
<td>Grandiose content</td>
<td>Sparse or absent</td>
<td>Variable</td>
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<td></td>
<td>Bizarre content</td>
<td>Fluent</td>
<td>Understandable</td>
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<td></td>
<td>Blocking/Latency</td>
<td>Rapid and pressured</td>
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<td>Variable</td>
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<tr>
<td>THOUGHT</td>
<td>Delusions</td>
<td>Racing out of control</td>
<td>Decreased ability to think Death-related thoughts Delusions of being dead</td>
<td>Possible delusions always related to precipitating event</td>
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<tr>
<td></td>
<td>• paranoia</td>
<td>Delusions of grandeur</td>
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<td>• thought broadcast</td>
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<td>• thought control</td>
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<td>• thought insertion</td>
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<td>• thought withdrawal</td>
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<td></td>
<td>• religiosity</td>
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<tr>
<td>PERCEPTION</td>
<td>Auditory hallucinations</td>
<td>Grandiose auditory hallucinations</td>
<td>Auditory or olfactory negative/depressive hallucinations</td>
<td>Possible hallucinations related to precipitating event</td>
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<tr>
<td>COGNITION</td>
<td>Not impaired</td>
<td>Not impaired</td>
<td>Psuedo impaired</td>
<td>Possible confusion disorientation recent memory loss</td>
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<tr>
<td>(intellectual ability and memory)</td>
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<td>PROGNOSIS</td>
<td>Will not return to premorbid function (prior to onset of psychosis)</td>
<td>Return to premorbid function</td>
<td>Return to premorbid function</td>
<td>Return to premorbid function</td>
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FROM: Connections. NAMI Greater Seattle (Chart courtesy of McNeil Laboratories)
Meeting the Dental Care Mandate for Mental Health Clients:

How to Include Dental Care in Mental Health Care

Patricia E. Doyle, RDH
Karen Israel, OTRL
Alison Longley, PhD

1. ASSESSMENT

Dental assessment is an element of intake as well as ongoing case management services* for your mental health clients. Your assessment should include your client's need for dental treatment expressed as "medical necessity," funding options, possible dental care providers, and barriers to dental care as well as the effects of medication, nutrition, and other health-related behaviors on your client.

* Washington Administrative Code, Community support services - WAC 388-865-0456 - mandates case managers to make referrals to needed services including treatment for co-occurring disorders and health care. Previously, WAC 275-57-420(1)(iv) identified dental services as part of community support services for mental health clients and by inclusion of the word "dental" placed oral health in the realm of necessary services including housing, food, and income. Although the "dental" word is now missing from the WAC, oral health is still to be regarded as part of health care.

2. FUNDING

Currently, in Washington State, Medicaid covers only emergency dental services for eligible adults. Dental emergencies are defined as pain, trauma, or infection of the mouth or jaw. Documentation is required. Since January 1, 2011, Medicaid will no longer pay for preventive or routine dental care for adults other than those with developmental disabilities, pregnant women, or clients residing in nursing homes or institutions. It is not known when more comprehensive care will be restored under Adult Dental Medicaid.

Previously, the Categorically Needy Program (CNP) offered the most dental coverage for Medicaid clients. CNP covered basic dental care and some specialty care. Disability Lifeline (DL - formerly GA-U) covered only medically necessary dental care. DLX (formerly GA-X) included CNP Medicaid coverage. Clients enrolled in Social Security Disability Insurance (SSDI) could be eligible for Medically Needy (MN) Medicaid coverage, which required spend-down, thus case managers who carefully scheduled dental and medical appointments could reduce clients’ out-of-pocket spend-down costs for needed care. Details related to earlier Adult Dental Medicaid coverage are available in the billing manual on the DSHS /HRSA web page. Click on Provider Publications.

Other ways to pay for care include saving money, asking for help from clients’ families, and/or working out a payment plan with a dentist. ProviderOne, Medicaid’s provider payment system, offers current billing information on the web at http://hrsa.dshs.wa.gov/providerone/ or https://www.waprovponsorone.org/ or by phone at 1-800-562-3022, or TTY/TCC at 1-800-848-5429.

3. PROVIDERS

As a case manager, you may need to locate dental professionals who are willing to work with your mental health clients. Both community clinics and private practice dentists can provide dental care to your clients. Local dental societies can be a resource for dental referrals. As a case manager, you need to be prepared to provide information about your client's behaviors and medications to prospective dental providers. You may also need to coordinate appointments as well as transportation and provide reminders to your client. Staying with your client at dental appointments may be helpful or even necessary to ensure the success of his/her dental care.
4. BARRIERS

Be prepared to help your client succeed with keeping dental appointments.

Clients may forget dental appointments because of cognitive issues or fear of the dentist. You can help overcome this barrier by pairing dental appointments with other regular activities, encouraging the use of personal planners, and/or calling your client with appointment reminders.

If fear of the dentist is a barrier to your client, arrange for treatment of dental phobia, coordinate a meeting for your client with prospective dental care providers to see the dental setting when no treatment is scheduled, and/or start with a separate appointment for x-rays only.

Help your client select dental professionals who are willing to go at the patient's pace, give control of the process to the patient, explain procedures, and ask the patient's permission to proceed.

Since people vary in their sensitivity to pain and people with a history of substance abuse may experience heightened resistance to local anesthesia, help your client choose dental professionals who understand that addiction as a result of the use of prescribed drugs in health care settings is extremely rare and who rely on patient self-reporting to determine how much anesthetic is needed.

5. CLIENT EDUCATION and REINFORCEMENT of DENTAL SELF-CARE

Practicing good oral health self-care has a positive effect on your client's self-esteem and general sense of well-being. As a case manager, you can play an important role in helping your client learn about and practice good oral health habits. Although many mental health clients do not practice daily oral hygiene and optimum self-care is not always possible, your encouragement and monitoring can help your client increase his or her frequency of oral hygiene self-care.

As a case manager, you can help build your client's awareness of how dental health is affected by the following:

⇒ POOR NUTRITION like sugary snacks can lead to tooth decay and gum problems.
⇒ MEDICATIONS can cause dry mouth, mouth sores, and gum changes that affect denture fit.
⇒ SMOKING increases the incidence of mouth lesions, stained teeth, bad breath, and early death.
⇒ ALCOHOL ABUSE can lead to gum problems, gumline cavities, and poor oral hygiene.
⇒ PEOPLE who both smoke and drink alcohol have the highest incidence of oral cancer.
⇒ DRUG ABUSE can lead to lower levels of self-care which contribute to tooth and gum problems.

Many mental health clients lose teeth unnecessarily. As a case manager, you can help your client attain an improved level of regular oral hygiene self-care and routine professional dental care that can prevent unnecessary tooth loss. Dental professionals can also prescribe or recommend over-the-counter (OTC) products that address specific oral health problems experienced by mental health clients.

For additional information, contact Patricia E. Doyle, RDH, pedoyle@u.washington.edu
60 Tips on Coping with Mental Illness in the Family

1. You cannot cure a mental disorder for a family member.
2. Despite your efforts, symptoms may get worse, or may improve.
3. If you feel much resentment, you are giving too much.
4. It is as hard for the individual to accept the disorder as it is for other family members.
5. Acceptance of the disorder by all concerned may be helpful, but not necessary.
6. A delusion will not go away by reasoning and therefore needs no discussion.
7. You may learn something about yourself as you learn about a family member’s mental disorder.
8. Separate the person from the disorder. Love the person, even if you hate the disorder.
9. Separate medication side effects from the disorder/person.
10. It is not OK for you to be neglected. You have needs and wants too.
11. Your chances of getting mental illness as a sibling or adult child of someone with MI are 10–14%. If you are older than 30, they are negligible for schizophrenia.
12. Your children’s chances are approximately 2–4%, compared to the general population of 1%.
13. The illness of a family member is nothing to be ashamed of. Reality is that you may encounter discrimination from an apprehensive public.
14. No one is to blame.
15. Don’t forget your sense of humor.
16. It may be necessary to renegotiate your emotional relationship.
17. It may be necessary to revise your expectations.
18. Success of each individual may be different.
19. Acknowledge the remarkable courage your family member may show in dealing with a mental disorder.
20. Your family member is entitled to enjoy his or her own life journey, as you are.
21. Survival-oriented response is often to shut down your emotional life. Resist this.
22. Inability to talk about feelings may leave you stuck or frozen.
23. The family relationships may be in disarray in the confusion around the mental disorder.
24. Generally, those closest in sibling order and gender become emotionally enmeshed, while those further out become estranged.
25. Grief issues for siblings are about what you had and lost. For adult children the issues are about what you never had.
26. After denial, sadness, and anger comes acceptance. The addition of understanding yields compassion.
27. The mental illnesses, like other diseases, are a part of the varied fabric of life.
28. Shed neurotic suffering and embrace real suffering.
29. The mental illnesses are not a continuum with mental health. Mental illness is a biological brain disease.
30. It is absurd to believe you may correct a physical illness such as diabetes, the schizophrenias, or bipolar disorder (manic depression) with talk, although addressing social complications may be helpful.
31. Symptoms may change over time while the underlying disorder remains.
32. The disorder may be periodic, with times of improvement and deterioration, independent of your hopes or actions.
33. You should request the diagnosis and its explanation from professionals.
34. Schizophrenia may be a class of disorders rather than a single disorder. (continued)
35. Identical diagnoses do not mean identical causes, courses, or symptoms.
36. Strange behavior is a symptom of the disorder. Don’t take it personally.
37. You have a right to ensure your personal safety.
38. Don’t shoulder the whole responsibility for your mentally disordered relative.
39. You are not a paid professional caseworker. Work with them about your concerns. Maintain your role as the sibling, child, or parent of the individual. Don’t change your role.
40. Mental health professionals, family members, and the disordered all have ups and downs when dealing with a mental disorder.
41. Forgive yourself and others for mistakes made.
42. Mental health professionals have varied degrees of competence.
43. If you can’t care for yourself, you can’t care for another.
44. You may eventually forgive your family member for having MI.
45. The needs of the ill person do not necessarily always come first.
46. It is important to have boundaries and set clear limits.
47. Most modern researchers favor a genetic, biochemical (perhaps intertural), or viral basis. Each individual case may be one, a combination or none of the above. Genetic predisposition may result from a varied single gene or a combination. Psychoanalytic and family interaction theories are now largely discounted. Stress theories have no supporting data, although once manifest, the disorders are stress sensitive. Evidence does not support drug abuse theories.
49. From Surviving Schizophrenia: “Schizophrenia randomly selects personality types, and families should remember that persons who were lazy, manipulative, or narcissistic before they got sick are likely to remain so as schizophrenic.” And, “as a general rule, I believe that most persons with schizophrenia do better living somewhere other than home. If a person does live at home, two things are essential – solitude and structure.” And, “In general, treat the ill family member with dignity as a person, albeit with a brain disease.” And, “make communication brief, concise, clear and unambiguous.”
50. It may be therapeutic to you to help others if you cannot help your family member.
51. Recognizing that a person has limited capabilities should not mean that you expect nothing of them.
52. Don’t be afraid to ask your family member if he/she is thinking of hurting himself/herself. A suicide rate of 10% is based on it happening to real people. Your own relative could be one. Discuss it to avoid it.
53. Mental disorders affect more than the afflicted.
54. Your conflicted relationship may spill over into your relationships with others. You may unconsciously reenact the conflicted relationship.
55. It is natural to experience a cauldron of emotions such as grief, guilt, fear, anger, sadness, hurt, confusion, etc. You, not the ill member, are responsible for your own feelings.
56. Eventually you may see the silver lining in the storm clouds: increased awareness, sensitivity, receptivity, compassion, maturity, and you may become less judgmental and self-centered.
57. Allow family members to maintain denial of the illness if they need it. Seek out others whom you can talk to.
58. You are not alone. Sharing your thoughts and feelings with others in a support group is helpful and enlightening for many.
59. The mental disorder of a family member is an emotional trauma for you. You pay a price if you do not receive support and help.

60. Support NAMI and the search for a cure!

SOURCE: Rex Dickens for the NAMI Sibling and Adult Children Network
### The Ten Leading Causes of Disability in the World

<table>
<thead>
<tr>
<th>Type of Disability</th>
<th>Cost (in DALYs)</th>
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<tr>
<td>Unipolar major depression</td>
<td>42,972</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>19,673</td>
</tr>
<tr>
<td>Road traffic accidents</td>
<td>19,625</td>
</tr>
<tr>
<td>Alcohol use</td>
<td>14,848</td>
</tr>
<tr>
<td>Self-inflicted injuries</td>
<td>14,645</td>
</tr>
<tr>
<td>Manic–depressive illness (Bipolar)</td>
<td>13,189</td>
</tr>
<tr>
<td>War</td>
<td>13,134</td>
</tr>
<tr>
<td>Violence</td>
<td>12,955</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>12,542</td>
</tr>
<tr>
<td>Iron deficiency anemia</td>
<td>12,511</td>
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Figures of costs due to disability for people between 15 and 44 years old.

Disability-Adjusted Life Years (DALYs) are a composite measure of time lost due to premature mortality and the time lived with the disability. A loss of one DALY is equivalent to the loss of one year for one person. Among people in the prime of life, depression costs society more than any other disease, and four mental illnesses are in the top ten. Self-inflicted injuries (usually suicide as a consequence of mental illness) is also in the top ten. (Suicide claims approximately 10% of people with schizophrenia and 10% of those with depression.)


### Costs to Health Industry Care

- Mental health issues and medically unexplained symptoms account for more than 75% of primary care visits.
- 10% of patients account for more than one-third of total office visits and more than 25% of prescriptions.
- Increased costs due to returning visits, referrals to specialists, laboratory tests, imaging studies, exploratory interventions, etc.
Dental – Mental Connection

By Patricia E. Doyle, RDH, BS, FADPD; Alison J. Longley, BA, PhD; and Patricia S. Brown

The National Association of Mental Illness defines mental illness as "a medical condition that disrupts an individual's thinking, feeling, mood, ability to relate to others, and daily functioning. The change in mental awareness may often result in a diminished capacity for coping with the ordinary demands of life." Often this inability to deal with daily mundane tasks includes oral self-care. People with mental illness may also experience xerostomia caused by medication use. This combination can lead to severe oral complications. Dental hygienists who are responsive to such challenges have the opportunity to provide patients with quality treatment and recommendations that may restore balance to the oral cavity. This month's Sunstar Spotlight features Doyle, Longley, and Brown, all of whom have extensive experience in assisting people with these specific needs. Their expertise provides dental professionals with a wealth of information to help ensure successful dental visits and improve the oral health of this vulnerable population.

—Jackie L. Sanders, RDH, BS
Manager, Professional Relations
Sunstar Americas Inc

Article

One in three adults in the United States will experience mental illness at least once. One in four has suffered a mental illness in the past year. Approximately 3% of American adults are affected by severe and chronic forms of mental illness. Diminished oral health is often a direct result of mental illness. In general, the longer a person has been mentally ill, the more likely his or her oral health needs have gone unmet.

Prior to the Community Mental Health Act of 1963, large state hospitals provided much of the shelter, support services, and oral health treatment received by patients with mental illness. Its success was mixed, but deinstitutionalization did open the door for community dental hygienists to help meet these needs. Today, dental hygienists can effectively treat patients with mental illness by providing oral health care that considers the whole person. To implement this approach, dental hygienists need to understand the basics of psychiatric disorders and their effects on oral health and treatment delivery (Table 1).

Barriers to Oral Health Care

Mental illness can interfere with the ability to work and/or perform ordinary social functions, including making and keeping dental appointments. Patients dealing with severe depression, schizophrenia, or substance abuse may find even basic oral self-care impossible (Figure 1). People with mental illness may also experience altered taste perceptions and reduced salivary flow caused by medication use. Xerostomia can promote caries and mucosal infection; inflamed, fissured tongue; enamel erosion; and glandular enlargement, as well as infection and inflammation of the gingiva. Many patients with severe mental illness smoke, and high sugar consumption is common. About 40% of those with mental illness also have a substance abuse disorder. In short, the odds are against optimal oral health for patients who are mentally ill.
Mental illness can also affect the ability to receive treatment. Patients with a history of panic attacks may avoid the stress of seeking professional dental care. Individuals with dental phobias may seek treatment only when oral pain persists. Unless the phobia is addressed, these patients may continue to avoid oral health care once the pain is resolved. People with schizophrenia can be excellent dental patients, but their delusions can extend to the oral cavity.

Cost is another barrier to care among people with mental illness. Those with severe mental illnesses are often supported by Social Security disability programs and have very little income. Dental professionals serving these populations need to be willing to explore options for payment, including dental insurance, Medicaid, family support, community clinics with sliding fee scales, and private practice discounts. If applicable, the patient's case manager should be included in the search for payment options and helping him or her make and keep dental appointments. When working with state agencies, advocating for what is medically necessary is a must. The consequences of overlooking oral health needs can be devastating (Figure 2) and even fatal.

How Can Dental Hygienist Help?

Initial intake is critical to providing quality care, and it is the first opportunity to get acquainted with the whole person. Questions about psychiatric or mental health care, substance use, dental fear, and depression or anxiety are helpful in eliciting mental health history. Because 60% of mental illnesses go undiagnosed, dental professionals may be the first to notice psychiatric disorders. If a referral for mental health treatment seems advisable, stepping out of the "dental role" and caring for the whole person may encourage the patient to seek help.
Prescription, over-the-counter, and alternative medications taken in the past 12 months should be listed, along with the condition being treated. Systemic health problems are more common among people with mental illness, and some medical illnesses can cause psychiatric symptoms. Psychotropic medications have both short and long-term effects. They may interact with drugs used in dentistry, as well as other medications patients are taking. For example, epinephrine and other vasoconstrictors should be limited or avoided in patients taking certain psychotropic drugs due to the potential for serious hypotension and/or cardiac arrhythmias. Nitrous oxide can interact with psychotropic medication, causing hypotension, and may increase the risk of hallucinations in patients with psychosis.11

The patient's prescribing physician(s) should be identified, but patient consent is required for consultation. A matter-of-fact approach should be used. The patient will express what he or she is comfortable discussing. Developing an ongoing relationship with patients is critical. If possible, work closely with family, mental health professionals, or friends to facilitate comprehensive dental care. Schedule appointments for patients with cognitive impairment on the same day of the week and time of day. Appointments should be short with frequent breaks. Begin with simple procedures, such as prophylaxis, to give the patient a good experience, and offer consistent positive reinforcement. Let the patient be the guide to what can be accomplished during one appointment. For some patients, emergency care may be all they can handle.

TABLE 1. Mental Illnesses and their Dental Implications5–7 (See larger version at end of paper – page 6).

Successfully delivering oral health care to patients who are mentally ill is a balancing act. Dental hygienists must balance their communication style with what they know about the patient. While patients who are anxious respond well to reassurance, suspicious patients require lots of information. Receiving professional dental care is stressful for some patients. Watch for signs of fear and anxiety, and ask the patient if he or she is OK. Give fearful patients control over when procedures begin and end. Establish signals to use when talk is difficult, and help the patient deal with fear by using distractions, such as music or by teaching relaxation techniques.8 Respond appropriately to complaints of pain because uncontrolled pain can itself create dental phobias. While pre- and postoperative medication can be useful, patients who learn to achieve control of fear and anxiety through cognitive–behavioral methods will be more successful in dealing with recare appointments. Learning cognitive–behavioral methods to address fear can also help patients with mental illness in other settings.
Psychosocial factors often contribute to chronic or disabling orofacial pain, and dental treatment may be most effective when provided in combination with psychological treatment. The possible association between stress and medication side effects makes some dental problems, such as temporomandibular disorder, more common in people with mental illness.

Dental treatment and manipulation in the mouth can trigger strong feelings that may be unrelated to the procedures at hand. Patients with a sexual or physical abuse history may have particular difficulty accepting dental treatment. For example, tipping the dental chair back can trigger flashbacks symptomatic of post–traumatic stress disorder. Dental hygienists can give patients control over what happens in the dental chair by asking their feelings as the work progresses and responding appropriately. Ensuring that patients will return for recare is far more important than completing a specific amount of work during one appointment.

Oral self–care regimens need to be simple for patients with chronic mental illness. Individualized instruction on how to use a toothbrush, toothpaste, and interdental cleaners is integral to success. If cost isn't an issue, prescription mouthrinses, professional fluoride application, and products for xerostomia management can be beneficial. An instruction checklist should be created for the patient's bathroom wall, and compliance should be reinforced with praise.

Summary

Dental, mental, and physical health are not separate entities. Still, recognizing the importance of their interrelation has been a slow process. Dental hygienists will definitely encounter patients with mental illness in the operatory, thus, understanding its possible effects on oral health and treatment delivery is key to developing successful approaches to providing oral health care. The added physical comfort and social acceptance that accompany good oral health significantly impact quality of life. Learning how to treat the whole person expands and elevates the practice of dental hygiene.

Patricia E. Doyle, RDH, BS, FADPD, works in a general private practice in Seattle. She is also an affiliate faculty member in the Department of Oral Medicine at the University of Washington (UW) School of Dentistry in Seattle and a guest lecturer for UW's Dental Education in Care of People with Disabilities Program. Doyle volunteered for 29 years at Harborview Medical Center Mental Health Services, Outpatient Programs in Seattle, assisting clients with mental illness achieve better oral health. She is a fellow of the Academy of Dentistry for Persons with Disabilities. Doyle's life's work has focused on the dental–mental connection and she has received national recognition for her contributions to this field.

Alison J. Longley, BA, PhD, is a writer and a neuroscientist at the Pacific Sciences Institute in Friday Harbor, Wash, and has published in the fields of neuroscience and mind–body interactions.

Patricia S. Brown is the information specialist and coordinator for the UW Oral Health Collaborative. She is a past chair of the Washington State Oral Health Coalition and founder of the Yakima County Oral Health Coalition.


NOTE:
Additional content on the Web – Resources for dental hygienists and patients experiencing mental illness are available with the online version at: [www.dimensionsofdentalhygiene.com](http://www.dimensionsofdentalhygiene.com)
TABLE 1. Mental illnesses and their Dental Implications

Anxiety Disorders
Anxiety disorders include panic disorders, phobias, and post-traumatic stress disorder (PTSD). Panic disorders manifest as a sudden onslaught of symptoms of panic such as pounding heart, nausea, and fear of dying, that occur within a specific period-reaching their peak within 10 minutes. Dental fear intense enough to interfere with a person’s ability to receive dental treatment is an example of specific phobia. PTSD can occur following extreme trauma with symptoms including flashbacks (intrusive recollections) and/or distress in response to reminders of the event.

Cognitive Disorders
Cognitive disorders are interruptions in the brain’s ability to think, and they include dementia, delirium, and amnestic disorders. Dementia is characterized by impairments of memory, language, motor skills, object recognition, and the ability to plan, organize, sequence, and think abstractly. Patients with dementia may be able to converse and follow instructions, but over the course of 15 minutes to 20 minutes, they may forget where they are and how they got there. Dental professionals may need to reintroduce themselves periodically and explain what they are doing. Family members or caregivers should be involved in dental care plans, written checklists of instructions for self-care should be provided, and the dental condition should be stabilized as early as possible. Preventive measures such as antimicrobial mouthrinses and fluoride varnish should be implemented.

Eating Disorders
Eating disorders are characterized by abnormal eating habits. Bulimia nervosa, anorexia nervosa, and binge eating disorder are the most common. The presence of dental erosion, particularly among young women, should raise the possibility of bulimia, an eating disorder characterized by binge eating and inappropriate compensatory behaviors, such as self-induced vomiting. Increased caries and enlarged parotid glands may also be present. Dental hygienists are in a unique position to recognize undiagnosed eating disorders. Providing appropriate dental care includes initiating referral to a mental health professional.

Mood Disorders
Mood disorders, which include major depressive and bipolar disorders, are quite common. For every patient in a dental practice with hypertension, there is one experiencing depression. People with major depressive mood disorder may suffer depressed mood, lose interest in almost everything, and experience other symptoms, such as chronic fatigue. Bipolar disorders are characterized by periods of abnormally elevated mood, as well as depressed mood. While patients with mood disorders may have a low pain tolerance, pain medication use can increase the risk of self-harm and should be considered carefully.

Personality Disorders
Personality disorders are enduring patterns of inner experience and behavior that vary significantly from cultural norms and lead to distress or functional impairment. While patients with personality disorders may be suspicious, dependent, or perfectionist, dental professionals can help them deal with their emotions in a positive way. Choices should be offered and good communication with active listening is important.

Psychotic Disorders
Psychotic disorders include schizophrenia and other disorders characterized by delusions, hallucinations (perceptions that are felt as real in the absence of an external stimulus), and/or disorganized speech or behavior. People with schizophrenia experience abnormally reduced emotions, thinking, or volition. The symptoms persist for at least 6 months and significantly interfere with the patient’s ability to function. The confusion, apathy, and limited social support often associated with psychotic disorders can make oral self-care and dental care difficult. Distorted pain perception may create the inability to distinguish tooth pain from psychic pain. Supportive, calm appointments where the patient knows what to expect work best. Antipsychotic medications have numerous side effects that relate to oral health and the delivery of care. For the patient with orthostatic hypotension, the change from horizontal to vertical positioning should be done slowly. If the patient has extrapyramidal syndrome or tardive dyskinesia—which cause motor symptoms such as involuntary movements—a consultation with his or her physician to discuss a change in medications may be helpful. Nitrous oxide can potentially increase the risk of hallucinations, and should be avoided.

Somatoform Disorders and Atypical Odontalgia
Somatoform disorders include somatization disorder and body dysmorphic disorder. The person with somatization disorder has a history of physical complaints unexplained by a medical condition or the direct effects of a substance. These complaints begin before age 30 and may include pain, gastrointestinal, sexual, and neurological symptoms that are not intentionally produced or feigned. Somatoform disorders can present with medically unexplained pain or other symptoms, potentially leading to extractions, root canals, or other iatrogenic consequences without resolving the original symptoms. If a psychogenic origin of symptoms is suspected, the possible causes—including stressors and emotional factors that may be reduced by psychological or psychiatric treatment—should be discussed with the patient.

Those with body dysmorphic disorder are preoccupied with imagined defects in appearance that cause significant distress and/or impaired function. Informed patient consent to treatment is very important, as illustrated by a case where the wisdom teeth of a dental patient with body dysmorphic disorder were extracted, although she felt helpless to stop the procedure.

Atypical odontalgia is characterized by chronic oral or dental pain without a clear cause and it originates from sensitization of nerves. Nibbling at a pain center may spare patients unnecessary dental procedures and lead to effective treatment.

Substance-Related Disorders
Substance-related disorders result from dependence on or abuse of substances such as alcohol, hallucinogens, or other addictive drugs and/or intoxication with or withdrawal from substance use. They also include mental disorders brought about by the use of alcohol or drugs, e.g., substance-induced persisting dementia. People dually diagnosed with mental illness and a history of substance abuse may have cognitive impairment, low pain tolerance, unpredictable drug metabolism, bleeding, and susceptibility to infection. Nitrous oxide and mouthrinses with alcohol should be avoided. Although drug dependence resulting from pain control in a medical setting is extremely rare, mood altering drugs, such as narcotics, as well as pain medication, should be implemented with caution.
Psychiatric Disorders: Texts, References & Information Sources


Dental Considerations


continued

Educational/Training Opportunity
Dental Education in Care of Persons with Disabilities (DECOD), University of Washington
Interim Director: Rolf Christensen, DDS, MHA
For information, please contact: Dalila Sebring, School of Dentistry, Box 356370, University of Washington, Seattle, WA 98195; 206-543-1546; dalila@u.washington.edu

Resources for Families
3. NAMI News. National Alliance on Mental Illness, 3803 N Fairfax Dr, Ste 100, Arlington VA 22203. (703-524-7600 or 1-800-950-NAMI). NAMI is a family based organization. www.nami.org
4. Depression and Bipolar Support Alliance, 730 N Franklin, Ste 501, Chicago IL 60654 (800-826-3632; http://www.dbsalliance.org)
7. Mental Health America. (703-684-7722) www.mentalhealthamerica.net

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