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Department of **Counselling Psychology**

The University of British Columbia
Vancouver, Canada

Date **April 23, 1993**
ABSTRACT

A case study approach was used to investigate the life narratives of nine individuals in relation to their dental avoidance. The participants were three women and six men who had periods of 2 to 20 years duration when they avoided dentists. Of the nine participants or co-researchers, two are still in avoidant patterns. These two people differed from the others in that they both received their childhood dental care early in this century. At that time dentistry was primitive compared to present standards; little was understood about the role of prevention, and individuals often felt traumatized by the effects of dental treatment. In order to understand the circumstances which led the individual to avoid dental care and perhaps jeopardize oral health, I examined their personal experiences within the context of their lives. After interviews with each of the persons, detailed accounts were constructed. From these accounts, a common story was composed called the general story.

The beginning of the general story of dental avoidance often has its origins in individuals' formative years. Chronic influences on the development of avoidant behaviour, such as personal and family values, arise out of the historical and cultural milieu in which individuals find themselves. Acute influences from dental or non-dental experiences also effect avoidant behaviour. Growing out of these influences are emotions and beliefs which become associated with dentistry. If a person experiences violation or mistrust within a dental setting, a disequilibrium begins which unbalances the person's ability to seek care.

In the middle of the general story, tendencies towards avoidance grow. For some, these tendencies are a result of slowly developing responses to dental care, for others, a single event may provide the precipitating event that triggers the beginning of an avoidant episode. As individuals struggle with the external events of pain and deteriorating teeth and gums as well as the increasing emotional responses, their lives become increasingly difficult. They may defend their avoidant behaviour in active or passive ways. In addition to resorting to defensive behaviour, people coped by seeking emergency care for the short term relief of pain. Interruption in the avoidant cycle occurs when the person's defences are shattered. The suspension of avoidance may occur as a result of an event, either dental or non-dental, or as a result of a growing awareness of the severity of the situation.

The end of the story occurred as a consequence of individuals seeking help for their dental distress. With this help, they appraised their previous values and developed new ones. They also experienced improvements in their lives that were more far reaching than their immediate dental relief. For two people, the story ended differently as they chose not to seek
help as a way of avoiding the greater discomfort of entering a dental office. For several individuals, the avoidant experience has been so profound that they felt that the condition of their teeth had become a metaphor for their lives.

Although previous research has identified several causal factors as the reason in dental avoidance, this narrative study, by examining dental avoidance in the context of people's lives, indicates that it is a decidedly more complex phenomenon. For example, the co-researchers agreed that the issues have less to do with the procedures and more to do with how the dental professionals treat them. Three models of dental health-related behaviour, Becker's (1974) Health Belief Model, Antonovsky's (1979) Salutogenic Model of Health, and Lazarus and Folkman's (1984) stress, appraisal and coping theory, were examined. This study supports the transactional nature of the three models. As well, this study demonstrates many of the health-related behaviours identified by these model. However, it suggests that these models are simplistic in that they do not take into account the richness and complexity of the avoidant experience within a person's life. Moreover, they do not clearly identify the importance of the interpersonal relationship with the dentist for the individual.

The practical implications of the study suggest the viability of the general story as a model in the study of dental avoidance. In order to affect the outcome of dental avoidant behaviour within the dental setting, this story suggests that it is essential that the dentist and dental personnel have an awareness of the issues of dental avoidance for an individual, have sufficient interpersonal skills to relay their empathy and understanding of the seriousness of this phenomenon for this person, and be skilled in empowering each person who seeks their care.
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Wayfarer, there is no road,
you make the road as you walk.

Machado

The creation of my thesis embodied a heroine's journey. As I journeyed alone, across the vast uncharted lands and seas of the preparation of this thesis, I was offered encouragement and sustenance by many companions, who were constant in their support of my dream.

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In honour of my parents:

Marion Grace (Rennie) Paterson  
(1910-1990)

and

William Cook Paterson  
(1906-1951)

with gratitude
for their gift of love
CHAPTER I - INTRODUCTION

Dental avoidance is a widely identified phenomenon within the dental and public health professions (Bomberg & Ernst, 1986; Gambucci, Martens, Meskin, & Davidson; 1986; Heine, Jong, Casamassimo, Osterbrook, & Call, 1983; Nyyssonen, Herranen, & Rimpala, 1984). In spite of the evolving sophistication of care with its increasing emphasis on prevention (Davis, 1980), avoidant behaviour continues to persist.

Although avoidant behaviour has been identified within dentistry and public health as being widespread, the statistics may be misleading and offer inconclusive evidence. Moreover, the understanding of what constitutes dental avoidance appears to be poorly defined. There are individuals who do not seek care and do not consider themselves as exhibiting avoidant behaviour; those who perceive no need to seek dental care (much in the way that some people see no need to seek the care of a doctor); and those who are without teeth (edentulous).

Therefore, an examination of a recent Canadian governmental report called Health and Social Support: 1985 (Statistics Canada, 1987), which states that only 51% of Canadians attended a dentist in a year does not give an accurate indication of how many individuals actually have avoidant problems. The results of a 617 telephone interviews of individuals who were considered representative of the population of British Columbia, prepared for the British Columbia College of Dental Surgeons in 1990, showed that only 61% of residents stated that they visit the dentist regularly for cleaning and checkup. Again, it is difficult to determine within the 39% of the population in British Columbia who do not attend, just how many might be considered as exhibiting avoidant behaviour. Complicating the determination of the extent of avoidance in British Columbia is the fact that the use of telephone surveys is considered to result in biased results (Ettinger, & Beck, 1982; Mellor, 1992). Telephone surveys may yield a "somewhat healthier (not institutionalized) and economically more advantaged (able to afford telephones) sample than may have selected by other methods" (Holtzman, Berkey, & Mann, 1990. p.165).

The Statistics Canada report indicating that the "likelihood of consultation with a dentist declines with age" (p.75), does not give a clear picture of the extent of avoidance as more older persons are edentulous (Ettinger & Beck, 1982) or perceive less need to seek care (Kiyak, 1987; MacEntee, 1990). A report of the American Dental Association in 1979 found that less than 33 percent of the elderly sought regular dental care (Marinelli, Sreebny, & Kamen, 1982). This finding may not be a true indicator of avoidant behaviour, for some older people attend only when they have a perceived need (Kiyak & Miller, 1982). Further complicating this situation is that "[m]ost reports indicate that about two-thirds of the elderly population have poor oral health but that only about one-third complain of a problem" (Mojon & MacEntee, 1992, p.48).
Avoidance does not appear to be gender specific as similar proportions of females and males appear in all age groups except the 25 to 44 and the 75 years and over where females report a higher utilization (Statistic Canada, 1987). The frequency of avoidant behaviour in North America appears to be reflected in European countries. A study in Finland in 1981 revealed that one-fifth of the representative population were found to have no treatment during the previous five years, and one fifth had had one course of treatment (Nyyssonen, Herranen, & Rimpela, 1984).

For many persons the phenomenon of dental avoidance with its consequences has been extremely distressful. Research by Locker (1992) reveals that a substantial number of independent adults over the age of 50 feel that their quality of life is compromised by poor dental health. The researcher found that 30.5% were unable to chew one or more foods; 37.2% suffered oral or facial pain in the previous four weeks; 67.5% experienced one or more oral symptoms such as pain; and one third reported problems with eating and communication. As well as quality of life being affected by dental health, there is a possibility that poor oral health may compromise the general health of some individuals (Limeback, 1990; Mattila et al., 1989). As well as dental health affecting quality of life and compromising health, psychological difficulties may arise as a result of avoidant behaviour. Many people express feelings of shame, helplessness, and lack of control in regard to their avoidant behaviour. Thus, the effects of dental avoidance impact both the individual's physical and social well-being.

There have been many suppositions as to the reasons for avoidant behaviour. Some of the more commonly cited factors that have been linked to dental avoidance are fear, age, gender, race, socioeconomic status, education, lack of teeth, and disability. (Bomberg & Ernst, 1986; Branch, Antczak, & Stason, 1986; Holtzman & Akiyama, 1985; Perich, 1986; Stege, Handelman, Baric, & Espeland, 1986; Warren, 1984).

The major identified factor in non-attendant dental behaviour is dental fear with its related anxiety and phobia (Kleinhaus & Rubinstein, 1985). Behaviorally, high anxiety and phobia may result in people totally avoiding dental check-ups (Dworkin, Ference, & Giddon, 1978; Lowenthal, 1981). It is likely that there are universal responses. Findings in a cross-cultural study in South East Asia of the North American Dental Fear Survey (Milgrom, Kleinknecht, Elliott, Hsing, & Choo-Soo, 1990) revealed similarities of the fear response in Asia and North America. This behaviour is often related to the assumption that dental anxiety arises from the painful nature of dental treatment. Several authors (Coriat, 1946; Marks, 1978; Milgrom, Weinstein, Kleinknecht, & Getz, 1985; Todes, 1972) believe that dental anxiety is a form of anticipatory anxiety and may not relate to the experience of pain. Often individuals seek regular dental care even in the face of feeling fearful (Milgrom et al., 1985). It is possible that dental anxiety has a psychological meaning that is independent of the fear of dental procedures. In addition to negative dental
experiences, individuals' perceptions of "their dentist's professional behavior and personality appear to be important determinants of dental anxiety" (Cohen, Snyder, & LaBelle, 1982, p.228).

In addition to dental-related anxiety, there may be unconscious aspects of the oral cavity that may have significance in dental avoidance. Early psychoanalysts led by Freud (1905), formulated theory that supported the eminence of the mouth as an area of emotional importance. A psychoanalytic approach to dentistry has not been recognized as being practical. Recently, however, there appears to be a renewed interest in psychological aspects of the mouth in relation to somatic approaches to psychotherapy (Marcher, 1989) that may have future implications for dentistry. Hebblewhite's (1989) research suggests further studies to test the "functional identity" (p.1) of the "psyche and soma" of bioenergetics theory regarding oral and rigid body types.

In spite of this widespread acceptance of identified causal factors, researchers question their validity. "Traditional health care barriers such as functional independence, sensory handicaps, poor general health, infrequent physician contact, and perceived barriers" that have been used in explaining utilization patterns in the elderly have been found to lack significance in relation to dental avoidance (Kiyak, 1986, p. 679).

Simple causal explanations seem insufficient in explaining the profundity of the emotions expressed by persons in relation to their mouth and teeth. Davis (1980) suggests a more complex view that attitudes to dental health need to be viewed in a broad "framework of shared understandings about accepted forms of behaviour in many different areas of life" (p.97). Attitudes (Fishbein & Ajzen, 1975; Kiyak, 1987) and behaviour (Davis, 1980, Dworkin, Ference, & Giddon, 1978) "cannot be isolated from their cultural context without doing violence to the manifold complexity and interrelatedness of everyday life" (Davis, p.96). Some understanding may arise from the study symbolic influences, in addition to cultural ones. References to tooth images abound in the literature of North American and European cultures. Folk and fairy tales, mythology, and references in the media reflect some of these references.

Poor dental health as a result of dental avoidance has been identified as a major public health concern. It is possible that dental avoidance has more repercussions for an individual than generally thought. Perhaps an understanding that "health is more than the absence of illness" (Jevne & Zingle, 1991, p.235) would contribute to dental avoidance being understood in a broader way then it is in the literature. The Canadian National Health and Welfare (1986) in defining health stated: "health must be viewed in terms of our personal and social resources for action...a resource which gives people the ability to manage and even to change their surroundings...a basic and dynamic force in our daily lives, influenced by our circumstances, our beliefs, our culture and our social, economic and physical environments" (p.3).
Statement of the Problem

Although there has been a moderate amount of research about anxiety as it relates to dental care and the treatment of avoidant behaviour, there appears to be a paucity of information examining the depth and complexity of the psychological aspects such as the meaning of avoidance as it affects a person's life. A search of the literature on avoidance has not revealed any exploration of it as a significant lived human phenomenon. Although researchers have examined separate aspects of avoidance, no accounts have been found that examine the meaning of the lived experience.

For the purposes of this research, people described as exhibiting avoidant behaviour will be individuals who are aware that dental avoidance has been problematic for them and have wanted to seek care but found themselves unable to take action. These individuals will have exhibited avoidant behaviour for periods of two years or longer during some period of their life. Avoidance is described by the Compact Edition of the Oxford Dictionary (1986) as "the action of avoiding or shunning anything unwelcome, or of holding aloof from a person". Therefore, dental avoidance in relation to this study could be described as avoiding or shunning dental care.

In regard to the exploration of avoidant behaviour in dentistry, many questions arise for consideration by the counsellor, dental health professional, and client. How does dental avoidance arise in a life? What is the psychological significance of the mouth, teeth, tongue, and structures surrounding the oral cavity to an individual? Do family and societal attitudes influence the avoidant behaviour? How significant are the attitudes and behaviours of dentists and dental personnel in influencing avoidant behaviour of individuals? Have experiences other than dentistry influenced attitudes toward dental care? Are there other factors influencing the dynamics of dental anxiety besides those postulated by theories of fear (Lindsay, Wege, & Yates, 1984)? How is dental avoidance maintained? What is the meaning of dental avoidance for a person? What factors influence a person in seeking dental care after an avoidant experience? Does avoidant behaviour affect other aspects of the client's life? Do existant models of health-related behaviour adequately interpret the person's experience? Are there specific dynamics that affect an individual's perception of dental anxiety in the context of aging? An exploration of these and other questions may further understanding and assist in the future formulation of interventions for health professionals and counsellors that may alleviate some of the anguish of the person who avoids care.

Purpose of the Study

The purpose of this study is to explore the phenomenon of of dental avoidance in order to answer the question: "What is the meaning of dental avoidance as it is lived over a life?" A qualitative approach, using case study or narrative account, constitutes this "empirical inquiry"
(Yin, 1989, p. 23). This inquiry "investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used (p.23).

Dental anxiety and phobia are identified as having a major influence on the ability of individuals to seek dental health (Kleinhaus, Eli, & Rubinstein, 1985). Much of the research to date has focused on the measurement and treatment of dental anxiety, "approaching the subject from a practical, rather than theoretical standpoint" (Chepin-Roen, 1982). Assumptions are often made by dental professionals as well as individuals based on this limited view. This study will attempt to augment present understandings by an exploration of the lived experience of avoidance by interpreting the expressions and texts of individuals in an attempt "to determine the meaning embodied in them" (VanManen, 1990, p.38).

Rationale

The experience of dental avoidance as lived by an individual appears to be largely unknown and unexplored. Because exploration of dental avoidance has continued to yield only fragments of the full effects of the meaning of this experience in a person's life, professionals in the dental health field have only a partial understanding of its meaning. Jung (1963) advises health professional to learn the individual's story when he states:

Clinical diagnosis are important since they give the doctor a certain orientation; but they do not help the patient. The crucial thing is the story. For it alone shows the human background and the human suffering, and only at that point can the doctor's therapy begin to operate (p. 124).

Stolar, MacEntee, and Hill (1992), in their research of independent older people, add credence to Jung's premise with their opinion that "structured survey data collection methods" are "not designed to reveal respondents' frames of reference" (p. 306).

The phenomenon of dental avoidance is complex and would appear to weave across several scientific disciplines: dentistry, gerodontics, medicine, psychology, social psychology, behavioral medicine, and health promotion. These unclear delineations of disciplines likely contribute further to the lack of clarity surrounding the totality of the lived experience of dental avoidance.

Dentistry as it is known today is a relatively young profession. In slightly more than 150 years dentistry has developed from "the ill-organised endeavours of a band of itinerent tooth-drawers operating on the fringes of a precarious person service economy, to an established, repected and powerful occupational group that has taken a central place in the burgeoning health sector of the advanced industrial societies" Davis (1980, p.10). Historically, dentistry was generally not available during childhood for the person who is now over seventy. This resulted in
individuals often having decayed teeth, frequent extractions (sometimes by the barber), and acute pain. Prior to World War Two, when dental care was primitive by today’s standards, many older persons remember experiencing traumatic experiences at the hands of the dentist. With the burgeoning size of the older population and increasing demands for quality living (Dychtwald & Flower, 1990; Papas, Niessen, & Chauncey, 1991), which include access to medical and dental care the problem of dental avoidance in the older person has become a visible societal and public health issue (Papas et al., 1991).

In order to study the phenomenon of the meaning of avoidance in this study, a qualitative strategy called a multiple-case study approach was chosen (Yin, 1989). This approach focuses on discovery and understanding rather than verification and is appropriate in exploring the question of “what is this or that kind of experience like?” (VanManen, 1990, p.9). This approach is consistent with Polkinghorne’s (1988, p.13) view that “our encounter with reality produces a meaningful and understandable flow of experience”. He states that a narrative or case study approach is “the fundamental scheme for linking individual human actions (and events) into interrelated aspects of an understandable composite” (p.13) and “give meaning to their experience of temporality and personal actions” (p.11).

Significance of the Study

This study enhances the disciplines of counselling and dentistry by contributing a narrative or case study description of the experience of dental avoidance as lived by an individual to their research bases. Until the meaning of dental avoidance is fully explored within the context of a person’s life, professionals will be disadvantaged by the limitations of their understanding.

This study of the meaning of the lived experience of avoidance will likely increase understanding for counsellors and dental health professionals, suggest possibilities for interventions, and future research. Finally, this research will further comprehension of human consciousness by examining the meaning a person creates from lived experience.
A search of the literature reveals that most of the information about people who avoid dentists is focussed on two general topics: the causal factors of avoidant behaviour and interventions for treatment of this phenomenon. For the purposes of this study, a person who is considered to demonstrate avoidant behaviour for whom dental avoidance was problematic and has not seen a dentist for a period of two or more years. Therefore, those identified as avoiding dentistry will include those who actively or passively avoid dentists.

Little is found within dental research about theories that relate to avoidance. There are, however, three theoretical approaches used to interpret health care behaviour that have been linked to dentistry. These were examined in order to understand more fully the dynamics of a person's behaviour in relation to seeking dental health care. They are The Health Belief Model (Becker, 1974), The Salutogenic Model of Health (Antonovsky, 1979), and the Stress, Appraisal, and Coping theory (Lazarus & Folkman, 1984).

In a search of the literature these three theoretical approaches to health care behaviour will be examined first in order to create a theoretical base for understanding behaviour. The identified causal factors in dental avoidance will be then be reviewed.

Theoretical Approaches to Dental Health Care

In this section, three approaches to the understanding of individual health behaviour are examined in order to explore the reasons that people seek or avoid dental health care. They are Becker's (1974) Health Belief Model (HBM), Antonovsky's (1979) Salutogenic Model of Health, and Lazarus and Folkman's (1984) approach to stress, appraisal, and coping.

The reasons individuals choose whether or not to seek dental and medical health care are major considerations in the preventative health field. Rosenstock (1969) summarized studies of preventative health action and identified five variables. They are cited by Antonovsky and Kats (1970) as: belief in one's susceptibility and in the serious consequences of not seeking care; a perception that there are benefits but no barriers; an experience of a "cue or trigger to trip off action" (p. 377).

The Health Belief Model

HBM is the most cited and researched of the social-psychological approaches to health-related behaviours (Wallston & Wallston, 1984). It is also one of the few social-psychological models that has been "developed expressly to understand health behavior" (Rimer, 1990, p. 140).
This model is essentially a "value-expectancy" model that was generated in order to explain the actions of individuals in relation to their health in situations of uncertainty (Becker & Maiman, 1975). Behaviour is considered to be influenced by the "perceived value" of an outcome and the expectation that a particular action will lead to that outcome (Rosenstock, 1974). With respect to the HBM, Harrison, Mullen, and Green (1991) indicate that a person's preparedness to take action for a particular health predicament (state) is determined by:

1. Its value in terms of perceived susceptibility to the condition and the probable severity of the condition.
2. Its expectancy based on evaluation of the advocated health behavior, its feasibility and its estimated potential benefit in reducing susceptibility and/or severity, weighed against barriers including physical, psychologic, and financial.
3. Cues to action that trigger an appropriate health behavior, including internal cues (perception of body states) and external cues (interpersonal interaction and/or mass media communication) (p. 1).

A diagram of HBM (Rosenstock, 1990, p.46) is found in Appendix C. Despite that fact that distinct personality, social, demographic, and structural factors (such as access to care) can influence an individual's health motivation and perceptions, they are not considered to be direct causes of whether or not they seek health care (Becker & Maiman, 1975).

Many investigators have assisted in expanding and clarifying the HBM by extending it beyond its original purpose of screening behaviours to include all preventive actions, illness behaviours, and sick-role behaviours (Rosenstock, 1990). Theorists now believe that:

[Individuals will take action to ward off, to screen for, or to control ill-health conditions if they regard themselves as susceptible to the conditions, if they believe it to have potentially serious consequences, if they believe that a course of action available to them would be beneficial in reducing either their susceptibility to or the severity of the condition, and if they believe that the anticipated barriers to (or costs of) taking the action are outweighed by its benefits (p. 42-43).

Rosenstock's (1990) descriptions of the key variables of HBM provide greater clarification of the model. Perceived susceptibility refers to a person's subjective perception of the risk of contracting a health condition and the acceptance of the diagnosis, personal evaluation of "resusceptibility", and susceptibility to illness generally. Feelings about the seriousness of contracting an illness (perceived severity) or of leaving it untreated include evaluations of both medical and clinical consequences (such as death, disability, and pain) and possible social consequences (effects of conditions on family life, work, and social relations). The combination of perceived susceptibility and perceived severity have been called perceived threat by some researchers. The course of action that is taken in response to a perceived threat depends upon the belief of the effectiveness of the possible action in reducing the disease threat or the perceived benefits of taking such a health action. The possibility of negative aspects of a health
action or perceived barriers may act as impediments to the suggested action. The person may measure the effectiveness of the behaviour against perceptions that it may be dangerous, expensive, unpleasant, inconvenient, time-consuming, and so on.

Rosenstock (1990) suggests that Bandura’s (1977) concept of self-efficacy should be added to the HBM. Self-efficacy is “the conviction that one can successfully execute the behavior required to produce outcomes” (p. 44). Because the original focus of the HBM was on brief, often single preventive actions, it is likely that a person had sufficient self-efficacy in order to perform these simple behaviours. However, in working with life-style behaviours that require change over long periods, individuals require more confidence in their ability to alter their life-styles. They not only need to feel that such a change is beneficial, but also must feel that they are sufficiently competent (i.e., self-efficacious) to execute that change.

In an assessment of the predictive validity of the HBM, Janz and Becker (1984) contributed a critical review of research of the previous 10 years. Their summary provided considerable empirical support for the HBM, indicating that prospective research was as favorable as that of retrospective research. Perceived barriers were the single most powerful predictors of the HBM across all types of health behaviours and investigations (Rosenstock, 1990).

In a recent meta-analysis of the HBM (Harrison et al., 1991), of the 147 unique studies that were identified, 51 articles were chosen (including 20 that were in the review of Janz & Becker, 1984). Criteria for inclusion in these studies were that they contain the four identified dimensions of the HBM: susceptibility, severity, benefits, and costs. Using effect sizes, they found that there were significant positive relationships between HBM dimensions and health behaviors. Because they did not examine the four dimensions together, it is possible that the predictive abilities of the four basic dimensions would be less than the sum of the independent dimensions. Harrison et al. did not exclude the possibility that the interaction of the dimensions might be more effective. Although the investigators did not reject the HBM as an important tool in health behaviour, the few studies that met their requirements for the operationalization of the HBM, revealed comparatively weak relationships. Moreover, the questionable validity of the scales used in much of this research further calls into question the validity and utility of this model.

Rosenstock (1990) provided five criticisms of the HBM. One repeating criticism, that may well apply to the whole field of social psychology, is that belief-behaviour relationships have never been consistently established. It has been suggested that further research be done to determine the conditions under which particular beliefs and behaviours are causally related and the conditions under which they are not. In spite of this difficulty, Rosenstock emphasizes that: “To reject approaches to explaining behavior that emphasize the role of beliefs seems tantamount to throwing out the baby with the bathwater” (p. 48). A second, associated criticism, is that direct
efforts to change beliefs are often unsuccessful and that some alternative approaches are required. A third criticism is that both individual and socio-environmental factors should be targeted for health interventions. The HBM is "a psychosocial model; as such, it is limited in accounting for as much of the variance in individuals' health related behaviours as can be explained by their attitudes and beliefs" (p.49). Other influences affect health actions. Janz and Becker (1984) suggest that the habitual component of some behaviours; health-related behaviours undertaken for nonhealth reasons; and economic or environmental factors may be factors. Also, alterations of the environment often occur as an aftermath of personal decision-making. A fourth criticism of the HBM is that it has not operationalized the variables: susceptibility, severity, benefits, and barriers (and now, self-efficacy) by providing numerical coefficients. The fifth relates to the danger that "victim-blaming" may be encouraged by focusing on the individual determinants of health behaviours (Sontag,1979; Wilber, 1991). Harrison et al. (1991) caution "that there is a difference between individual beliefs and a health belief model that includes four dimensions" (p. 8). They further admonish that if future investigation shows that some dimensions of the HBM relate independently to various health behaviours and do not systematically interact with other dimensions, "then the concept of a model should be laid to rest" (p. 8).

The dental implications of the HBM were discussed in an embryonic article by Kegeles (1961). As one of the developers of HBM, Kegeles identified four perceptual factors that he judged as critical in determining whether a person would seek dental care. These variables were susceptibility, severity, salience (the feeling that doing something about the disease was more important than doing other things), and benefits. Kegeles (cited in Haefner, 1974) cautioned that research should not "consist merely of surveys of existent attitudes and beliefs" but must prove "the relationship of attitudes, motives, and beliefs to subsequent behaviour,...the effects of changing certain attitudes and beliefs on dental behaviour,...and the effect of changing dental behaviour on attitudes and beliefs" (p. 93).)

Kegeles' (1961) opinion, cited by Haefner, was that one of "the major weaknesses in the development of the HBM as a means of accounting for dental behaviour is the absence of systematic research" (p. 102). Although he believes that the HBM is an appealing way to account for preventive behaviour in the dental health field, it is of little practical application as a conceptual model because it "postdicts" everything and predicts little. Toneatto (1987) in testing the validity of cognitive models of oral health behaviour (OHB) such as the HBM, found it to be inadequate in accounting for variance in OHB's, such as the behaviours of flossing and brushing. "Beliefs relevant to the health aspect of brushing and flossing failed to significantly predict the frequency of flossing or brushing" (p. 1).
The HBM is one of the few social-psychological models developed primarily to understand individuals' health-related behaviours (Rimer, 1990, p. 140). It has been widely used not only by health educators, but also by physicians, dentists, nurses, psychologists, and other professionals in understanding why people seek or avoid health care. Although it advances comprehension of some of the variables in health-related behaviours, it may not apply equally to all diseases or all behaviours. Further research is necessary to understand the conditions under which it applies and to standardize and refine the measurement of its concepts. Although dental professionals through their understanding of the HBM, may have "engineered" (Rosenstock, 1990, p. 50) people into accepting treatments today, it offers no assurance that they would seek dental care in the future.

The Salutogenic Model of Health

In his search for an approach that would adequately represent the concept of a health continuum, Antonovsky (1979) proposed an approach that he named the Salutogenic Model of Health (p. 184-185). A diagram of this model is found in Appendix C. This approach represents a salutogenic or health generating paradigm and "emphasizes integration and union of the self and the world" (Lazarus & Folkman, 1984, p. 67). Antonovsky (1979, 1987) had questioned whether the principal paradigm in Western medicine, with its pathogenic orientation, that dichotomously classifies a person as being either sick or healthy, was adequate. In his opinion, people's health ranged along a "breakdown" continuum, with "health-ease" at one end and "dis-ease" at the other.

In the Salutogenic Model of Health, a sense of coherence is an essential mobilizing and strengthening factor that influences a person's health-seeking behaviour. Antonovsky (1979) describes this sense of coherence as "a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that one's internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonably be expected" (p. 10). In Lazarus and Folkman's (1984) opinion, the concept of coherence is similar to Kobasa's (1979) concept of hardness as a personality style, Kanungo's (1979) notion of "involvement,....related ideas such as positive self-esteem, authenticity, self-confidence, and the sense of mastery" (p. 67).

In his attempt to find an explanation for health behaviour, Antonovsky (1979) studied generalized resistance resources (GRR). The GRR is "any characteristic of the person, the group, or the environment that can facilitate effective tension management" (Antonovsky, 1979, p. 99). Antonovsky and his colleagues posit that of the many resistance resources that were related to breakdown, one appeared to be more highly correlated with his standard of overall health status. They named this variable, which appeared not to be just another generalized resistance
resource but a way of looking at the world" (p. 8), a sense of coherence. In Antonovsky's opinion "the extent to which our lives provide us with GRRs is a major determinant to the extent to which we come to have a generalized, pervasive orientation that I call a strong sense of coherence" (p. 136).

In addition to GRR's, there are specific resistance resources (SRRs) which are "appropriate to the particular stressor" (Antonovsky, 1979, p. 194). A person with a strong sense of coherence can mobilize both GRRs and SRRs in order to overcome a particular stressor and resolve tension. In turn, by overcoming stress and resolving tension, one's sense of coherence is reinforced. "By overcoming a stressor we learn that existence is neither shattering nor meaningless" (p. 194).

In Antonovsky's (1979) opinion, the central question in the field of health promotion is "What conditions are central in providing adequate GRRs to develop, reinforce, and maintain a strong sense of coherence?" (p. 137). Childrearing patterns, social role complexes, idiosyncratic factors and change build up GRR's. The major psychosocial GRR's are material, knowledge and intelligence, ego identity, coping strategies (rational, flexible, farsighted), social supports (ties), commitment (continuence, cohesion, control), cultural stability, magic, religion, philosophy, art (a stable set of answers), and a preventive health orientation.

Antonovsky's sense of coherence does not represent a fixed state but rather ranges along a continuum. He sees a danger in a salutogenic orientation that would study coherence only at the strong end. These findings might possibly result in a fake sense of coherence exhibiting behaviours of "hysterical rigidity" (p. 159). A fake sense of coherence can be identified when "there is a contention that all problems have an answer, when challenge or doubt is intolerable, when there is no flexibility to adapt to changing circumstances, when one claims to be in control of all things or to understand everything, when there is a denial of sadness, and when there is an incapacity to admit to the uncontrollable without being overwhelmed" (p. 159).

There appears to be limitations to the Salutogenic Model of Health. Lazarus and Folkman (1984) are troubled by the fact that this concept "is apt to be treated solely as a person factor without regard to the society in which the person lives" (p. 67). They question whether such "a highly global and overarching concept about human beliefs...that implies a monolithic pattern of beliefs" (p. 67) is sufficient to account for the fact that individuals often struggle with several contradictory beliefs at once. The problem of using "global concepts" in order to predict behaviour has been a difficulty in personality research for some time. It would appear, "belief systems are too complex, rich, and contradictory to be massed into a simple unidimensional concept" (p. 68).
Stress, Appraisal, and Coping Theory

The approach of Lazarus and his colleagues to stress, appraisal, and coping furthers our understanding of individuals' health-related behaviours (Folkman & Lazarus, 1980; Lazarus & Folkman, 1984, Lazarus, 1990). The importance of such an approach is reflected in the increasing belief among investigators that people's ability to cope with stress affects "their psychological, physical, and social well-being" (Folkman & Lazarus, 1980, p. 219). Lazarus (1966,1984, 1990) developed a cognitive-phenomenological theory of psychological stress in which there is an ongoing relationship of the interchangeable action of appraisal and coping. A diagram of this model (Lazarus, 1990, p.4) is found in Appendix C. Each is "affecting and in turn being affected by the other" (Folkman & Lazarus, 1980, p. 223). The "sphere of meaning" in which psychological stress belongs is described as:

[A] particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being (Lazarus & Folkman, 1984, p. 19).

Lazarus and Folkman (1984) have examined stress at the physiological, psychological, and sociological levels of analysis. Stress may be experienced at one analytic level and not necessarily at another, and may also be experienced differently at each level. "Cognitive appraisal is the critical psychological link among the levels when concerning the individual" (p. 325). It is through cognitive appraisal that a judgement is made that "a particular person-environment relationship is stressful" (p. 21).

Lazarus and Folkman (1984) have developed a transactional model of cognitive theory in relation to stress. This model contrasts to traditional research on stress which has focussed principally on antecedent-consequent or stimulus-response models. In Lazarus and Folkman's opinion, the antecedent-consequent model is limited in that it has a linear and unidirectional approach to the variables and views them as "static phenomenon" (p. 325). In the transactional model, the person and the environment are viewed in a "mutually reciprocal, bidirectional relationship" (p. 325) so that an effect at one time can become a cause at another. Threat for example, is the integration of both person and environment in a given transaction. Their transactional approach contrasts with other models that have dominated the measurements of stress which primarily assess major environmental changes or life events. In their opinion, the approach that postulates that change alone is stressful and that life events must be extreme in order to create enough stress to impair health is limited.

Lazarus and Folkman (1984) have defined the two major aspects of stress as appraisal and coping. Appraisal is the cognitive process "of categorizing an encounter, and its various facets, with respect to its significance for well-being" (Lazarus & Folkman, 1984, p. 31). The two
main evaluative issues of appraisal are "'Am I in trouble or being benefited, now and in the future and in what way?' and 'What if anything can be done about it?'" (p. 31). When an encounter is evaluated with respect to what is at stake a primary appraisal occurs and when coping resources and options are considered a secondary appraisal occurs (Folkman & Lazarus, 1980, p. 223).

The three types of primary appraisal are (a) irrelevant, (b) benign-positive, and (c) stressful (Lazarus & Folkman, 1984). If the environment offers no inferences for a person's well-being the encounter is considered irrelevant. When the outcome of an appraisal is called positive ("preserves or enhances well-being or promises to do so" p. 32), it is considered benign-positive (p. 32). Stress appraisals include harm-loss or damage that has previously occurred, threat or the sense of anticipatory loss or harm, and challenge or the sense of anticipatory mastery or gain. Threat and challenge are similar in that they both call for the mobilization of coping efforts. They differ in that threat is characterized by "negative emotions such as fear, anxiety, and anger"; whereas challenge is characterized by "pleasurable emotions such as eagerness, excitement, and exhilaration" (p. 33).

Secondary appraisal, which is an evaluation of coping resources and available alternatives (Folkman & Lazarus, 1980, p. 223), occurs when a person is in jeopardy. The person knows that whether the stressor be a threat or challenge "something must be done to manage the situation" (Lazarus & Folkman, 1984, p. 35). Secondary appraisal is "crucial" to every stressful situation. The outcome of this appraisal is dependant upon weighing the possible consequences as well as the anticipated action. Secondary appraisals interact with each other in determining "the degree of stress and the strength and quality (or content) of the emotional reaction" (p. 35).

A reappraisal occurs when an appraisal is changed as the result of new information from the environment and/or information from the individual's personal reaction. Another form of reappraisal can also occur that has been called defensive reappraisal. This reappraisal relates to any attempt to reinterpret the past in more positive terms, or to deal with the present harms and threats in less threatening and/or damaging ways (p. 38). "(I)n order to survive and flourish, people must distinguish between benign and dangerous situations" (Lazarus & Folkman, 1984, p. 23).

Another aspect, besides appraisal, that relates to stress, is that of coping. Coping is the "constantly changing cognitive and behavioral effort to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (p. 141). There are three aspects of coping. First, contrary to the trait approach which is concerned with what people usually do, would do, or should do, the process approach is concerned with what people actually think and do. Second, what people think and do is examined within specific contexts. Third, coping is a "shifting process" in which thoughts and actions change as "a stressful encounter unfolds" (p. 142.). As the status of the person-environment changes, people may rely
more heavily at one time on defensive strategies of coping, and at another on problem-solving strategies.

Coping process describes what the person thinks and does in a specific interaction and to changes in these efforts as the interaction progresses during one episode or across other episodes that appear to be related to the common stressful interaction. Although coping efforts are a result of a response to stress appraisals, appraisal and coping dynamically interact with each other throughout a transaction. The recognition of appraisal as a pivotal aspect of coping, or of coping as a pivotal aspect of appraisal, depends upon where the ongoing, vigorous interaction between the two is interrupted.

In the opinion of Lazarus and his colleagues (Lazarus & Folkman, 1980), coping serves other functions in addition to problem solving and effective coping. Not to be confused with coping outcomes (effect of a strategy), a coping function "refers to the purpose a strategy serves" (p. 149). An important distinction that is common to many coping definitions, is that there are two coping functions; emotion-focused coping and problem-focused coping. Folkman and Lazarus (1980) and Lazarus and Folkman (1984) define the two functions as follows:

emotion-focused coping - the regulation of stressful emotions
problem-focused coping - the management or alteration of the person-environment relationship that is the source of stress (Folkman & Lazarus, 1980, p. 223).

Emotion-focused strategies are concerned with the cognitive processes that are directed at decreasing emotional distress. Several emotion-focused strategies for reduction of emotional distress are "avoidance, minimization, distancing, selective attention, positive comparison, and wrestling positive value from negative events" (Lazarus & Folkman, 1984, p. 150). In the problem-solving approach, problems are defined, alternative solutions are generated, benefits and costs of the alternatives are weighed, choices are made, and actions are taken (p. 152).

Lazarus and Folkman (1984) described emotion- and problem-focused coping as ubiquitous. In their analysis of 1,332 episodes of stressful encounter (Folkman & Lazarus, 1980), in only 18 of the episodes was one function used. This finding suggests that people use "both problem- and emotion-focused coping strategies to deal with the internal and/or external demands posed by real-life stressful situations" (Lazarus & Folkman, 1984, p. 156). Moreover, the relationship between emotion- and problem-focused coping can be facilitating or hindering. When a person uses a problem-focused coping strategy and emotional distress is alleviated, this interaction is facilitative. In another instance, the use of a problem-focused coping effort might exacerbate an individual's emotional distress, thus impeding problem-solving coping efforts to cope (p. 154).
As a person ages, differences in coping might be related to changes in the sources of stress (Folkman & Lazarus, 1980). Emotion-focused coping (relating to health) may increase, and problem-focused coping (concerning work) may decrease. Folkman and Lazarus (1980) suggest further research is necessary to determine whether these changes relate to sources of stress or to personality factors. Although men appeared to have more problem-focused coping than women, it was likely related to work, or to situations requiring acceptance and more knowledge. Despite the fact that women reported more stressful events relating to health, it appeared that few differences existed between the way men and women appraised health-related episodes and utilized emotion-focused coping responses. The researchers were most puzzled by the fact that in situations that had to be accepted, men used more problem-focused coping behavior than women. The researchers concluded that "women and men do not differ in their use of emotion-focused coping within similar contexts of living, but they do differ in the contexts in which their stressful encounters occur" (p. 235).

Lazarus and Folkman (1984) have advanced understanding of the complexity of the person engaged in avoiding dentistry with their research design (p. 326) that is naturalistic rather than experimental. This approach would permit both intra- and interindividual comparisons within a dental situation. An intraindividual analysis would enable dental health professionals to investigate issues such as the client and situation antecedents of appraisal and coping, variability, and stability in coping. This analysis would also allow opportunities to appraise coping effectiveness and ineffectiveness. Accumulated data could be used for interindividual comparisons.

Much of the research literature about dental avoidance has been linked with causal factors or treatment of anxiety in people. Lazarus and Folkman (1984) have made a main contribution to the measurement of key concepts of stress with their development of measurements for stress, appraisal, and coping. Traditional approaches such as the conditioned emotional response (Milgrom, Weinstein, Kleinknecht, & Getz, 1985, p. 33) that have been applied to understanding how a direct experience may lead to dental fear and avoidance demonstrate a linearity that does not fully explain the intra- and interindividual aspects of a dental experience. Self-report is the primary source of information about stress, appraisal, emotion, and coping. Although self-report is more demanding than empirical reporting because of the challenges of assessing the relevant variables of self-report, Lazarus and Folkman (1984) believe that it is the method of choice in obtaining people’s "rich patterns of thought and feeling through language" (p.322). In spite of the limitations, Lazarus and Folkman (1980, 1984) believe that their transactional approach and its theoretical framework could significantly advance understanding of the myriad of bewildering questions about stress, coping, and the adaptational outcome.
Summary

The three models examined in the literature review have been used in dentistry as a way attempting to comprehend the dynamics of dental health-related behaviours. None of these models was primarily designed with dentistry as the focus. With all three models, there is a lack of systematic research in dentistry relating them to dental behaviour. It would be difficult to develop quantitative criteria for the measurement of the variables of the HBM and Salutogenic Model of Health. Despite the fact that Lazarus and Folkman (1984) have developed a "Ways of Coping" (p.328) questionnaire, more remains to be done in order to have an effective survey instrument for dentistry. Although these three approaches advance understanding by identifying some of the elements of dental health-related behaviour, none appear adequate in explaining the full complexity of the avoidant experience for an individual.

Causal Factors in Dental Avoidance

Theoretical considerations of dental avoidance within the dental literature appear to be largely unexplored. However, many causal factors in dental avoidance have been identified in the literature; fear being the primary one. In order to investigate the present theory regarding dental avoidance, an examination of the causal factors reported in the literature is recounted here. The literature contains sources of a tendency towards dental avoidance as well as immediate causes. Although references to dental avoidance are found within the disciplines of dentistry, psychology, behavioral medicine, psychiatric medicine, and medical psychology, the research fails to address the complexity of the experience of a person who is avoiding dentistry. There appears to be little or no research on the experience of avoidant behaviour, its meaning, how it effects the life of an individual, and, in particular, how it may influence the seeking of dental care.

In order to create greater clarity, the literature about dental avoidance and related material is discussed under two major areas within which most of the material appears to fall. They have been named Sources of A Tendency Towards Dental Avoidance and Immediate Causes of Avoidant Behaviour in Dentistry.

Sources of A Tendency Towards Dental Avoidance

This section, includes some of the most frequently stated suppositions for the sources of a tendency towards dental avoidance. Named sources of tendency are origins of oral health attitudes; age; socioeconomic status; gender; and ethnicity. Long standing causes include dentate status; lack of mobility and ill health; availability; economic constraints; and past experiences.
Origins of Dental Health Attitudes

In this section, literature on the psychological aspects of the mouth, family, and cultural influences that affect the individual's attitudes about oral health is discussed. Understanding the psychology of the mouth and how it influences personality; family and cultural influences from which attitudes and beliefs arise helps one view the dynamics of dentistry and the impact on the individual.

The Psychological Aspects of the Mouth.

This section includes much of the present work that has evolved from early psychoanalytic tradition. In addition to the mouth, elements of the oral cavity, such as the teeth, tongue, and structures surrounding the oral cavity are included.

An understanding of the psychology of the mouth creates a base from which to view the psychological dynamics of dentistry for an individual. Orality in the context of this research encompasses psychological theory. Exploration of theory furthers understanding as most studies on dental avoidance to date have been mainly investigative with little theoretical perspective (Chepin-Roen, 1982). In order to further understanding of the phenomenon of dental avoidance, the psychological meanings associated with the oral cavity are examined here.

The concept of "orality" is a psychoanalytic term that relates to the psychology of the mouth. Orality is attributed to Freud. He described dynamics that he later named the oral sexual system in a letter to Fliess (Freud, 1987). Chepin-Roen (1982) states that it is possible that dental-related anxiety may arise from early conflicts during the first stage of psychosexual development, Freud's (1905) oral stage, as well as his anal and Oedipal/genital stages. Freud (1905) identified the mouth as the first erotogenic zone and later researchers described the mouth as the primary organ of sexual and aggressive satisfaction (Sandler & Dare, 1970). A psychoanalytic overview from a Jungian perspective is found in Whitmont's (1969) definition of orality:

Orality, as in sucking, drinking and kissing, represents a stage of dependence which expresses receptiveness and yielding, but also demandingness. The use of the teeth as in biting and eating expresses clinging, grasping, even greediness. Orality expresses the basic need for sustenance, support and protection, the aboriginal source of which is actualized through the mother's breasts. The mouth is the first organ of perception as well as acquisition; orality thus expresses the drive toward taking into oneself, absorbing, contacting, grasping (in the sense of understanding)--as well as grabbing into one's possession. (p. 240).

The mouth and oral responses have long been important aspects of development and character formation in psycholanalytic theory according to Goldman-Eisler (1951). As well, the mouth plays a major role in the psychosexual development of individuals (Abraham, 1924;
Formation of personality was alleged to originate in the oral stage; "if a person was satisfied during that stage the personality traits shown are friendliness, optimism, generosity, and dependence (the Oral-Receptive Character); if he was not satisfied he develops an 'Oral-Agressive Character" (Sutherland, 1989, p. 295). Abraham (1927) believed that distinct characterological dispositions resulted from either an overly-frustrating or an over-gratifying neonatal period especially in relation to sucking and other sensory experiences (Shiffner, 1984). Therefore, individuals with oral dependency would experience themselves to be dependent on others in that they experienced themselves as being unable to survive on their own.

The mouth has been identified as the basis for a child to perceive differences between internal and external experience as the child "takes-into" or "spits-out-of" the mouth (Fenichel, 1945). Chepin-Roen (1982) states that in addition to its psychosexual developmental aspects, the mouth may be important in the "formation of both body and ego boundaries" (p.28). Todes (1972) and Moulton (1955) assert that the mouth's importance continues throughout a person's lifetime, contributing to the functions of survival, communication, and emotional expression (verbal and nonverbal), and plays a major role in both the sexual attraction and sexual function of adult sexuality.

The mouth's psychological significance is further elaborated by its nearness to the "subjective localization of the 'self" (Borland, 1962). In our culture, people are inclined to identify the "self" as "located in the head, somewhere behind the eyes" (Chepin-Roen, 1982, p.28). Borland elucidates his view by the assertion that when individuals want to threaten others physically, they "are prone to attack his mouth" (p.686). Moulton (1955) describes the special sensitivity of the mouth to pain.

Early psychoanalytic research, with its emphasis on the psychosexual aspects of development, has been expanded. Rather than a unidimensional focus on the effect of a given trait such as orality, interpersonal effects are examined within the context of the interpersonal situation (Asch, 1946; Bowers, 1973). In addition, Langs (1978) with his theory of "the adaptive context" places greater emphasis on the environmental context of "the here and now (present time). Baum (1981) goes further by postulating that the concept of orality, with its biological and instinctual implications, is outdated and is now supplanted by more highly differentiated constructs such as object-relations. Object-relations theory is concerned with the predictability of developmental sequences in which the initial experiences of the self change in relation to an increasing awareness of others (Corey, 1986). Baum is supported in his views by Sandler and Dare (1970) who state that "all the character traits which have been described as 'oral' can be also considered from the point of view of object relationships" (p. 219). Orality is now being
examined in a discriminating way by psychoanalytic theorists. Rather than blindly responding in an instinctive way, a person who is described as having an oral character with adequate ego strength can "monitor the environment for sources of nurturance and modulate his behavioral response" (Shiffner, 1984, p.8).

Several researchers question the value of a psychoanalytic approach in dentistry and in psychology. Although Bochner (1988) concedes that "there is an element of truth in many of Freud's original propositions" (p. 156), he cites Erwin (1980), Eysenck (1966), and Rachman (1971) in arguing that psychoanalysis as a therapeutic intervention in dental treatment does not have a very high success rate, compared to other treatments. Nathanson (1992) states that "(v)ery little of Freud's original theoretical system linking sexuality and the mental-emotional system holds any water today" (p. 119). With this decreasing acceptance for Freud's theory of sexual drive has also come a questioning of Freud's other drive, aggression. "So extensive is the modern study of affect in infancy and so damaging for classical psycholanalytic theory are its findings, that many eminent scholars have attempted to force some sort of reconciliation between the new and the old systems." (p. 119). In Nathanson's opinion, if "we discard the 'aggression' drive as an unnecessary and nonphysical creation of the foundation of psychoanalysis, and then reject the idea that the sexual drive is responsible for all the excitement in life, we are left with sex as just another biological drive shorn of the special characteristics given it by Freud" (p. 120). With these two assumptions, "the mysticism that surrounds psychoanalytic theory" is removed and psychology returned entirely to biological science. These changes enable scientists to ask "whether there are any special features that influence our study of the emotions" (p.120).

In this section, theoretical literature concerning the mouth was examined. The theory, although complex, has not been linked to the field of dentistry in any substantive way. It appears that the literature about psychology and the mouth does little to contribute to the understanding of the phenomenon of dental avoidance.

The teeth are one of the principle concerns of dentistry and experiences with teeth greatly affect a person's health seeking behaviour. Early childhood experiences may relate to later perceptions concerning one's teeth. The question of whether teething is painful elicits different responses from researchers. Sosnow (1962) and Weckstein (1970) agree that teething is a painful process. Lowenthal (1978, p. 14) differs in his opinion, which is that teething begins a "resolution of the soft tissues, so that growth becomes a smooth physiologic non-painful process". In his opinion, the primary source of suffering is from anxiety which occurs at the onset of weaning when the infant sees the breast, as it is withdrawn, as "outside" itself. Adding further to the infant's anxiety is the awareness of the hard, foreign bodies of teeth in the tender oral cavity. These teeth must be incorporated into the "mouth ego" (Lowenthal, 1978).
This process of teeth eruption and its proximity to the anxiety of increasing separation from the mother has also been noted by Erikson (1963, p. 78). As the teeth "bore from within" they intrude on the oral cavity which was formerly the main seat of pleasure. In Erikson's theory, a "masochistic dilemma" occurs for the infant in that the only way of alleviating the pain of teething was by biting harder. Further complicating these dynamics is the fact that if the baby bites the breast the mother may withdraw the breast. "Teething seems to have a prototypical significance and may well be the model for the masochistic tendency to assure cruel comfort by enjoying one's hurt whenever one is unable to prevent a significant loss." (Erikson, 1963, p. 248). During this early stage the teeth may "symbolize the loss of the object, the resultant rage at oneself at causing this breach and at one's impotence to repair it, as well as sadistic rage directed at the withdrawing mother/object" (Chepin-Roen, 1982).

Loss of teeth or a tooth may represent loss of power (Moulton, 1955), helplessness, and/or impotence. Suggestions have been made by Coriat (1946), Lewis (1957), Lowenthal (1978), and Sosnow (1962) that castration fears as well as penis envy and childbirth fantasies may stem from tooth loss on a symbolic level (Coriat, 1946). The loss of a tooth or teeth may come to stand for generalized punishment, mutilation and/or body trauma.

It is possible that loss of teeth or the fear of tooth loss may have significant psychological impact upon individuals. The subsequent anxiety that may ensue for some persons after the extraction of a tooth may later contribute to avoidant behaviour.

The tongue has also been considered to play a major role in the developmental process. The tongue functions from earliest infancy in directing milk and protecting the trachea from fluids. It is a source of pleasure enabling discrimination of textures and tastes in the infant as well as enhancing balance in its continual return to the midline. In addition, Bonnard (1960, p. 304) emphasizes the tongue's importance as having the "richest direct supply of cranial nerves and is the single operator of more varied skills than is any other muscular organ or part of the body". This opinion has been born out in Wilder Penfield's charting of the homunculus of the brain in which he identified that a disproportionate area of the sensory cortex of the brain was given over to the tongue (p. 304). The tongue is the most controllable part of the body of the infant enabling the baby to define both external objects and internal self as well as boundaries external to the body. Chepin-Roen (1982, p. 32) calls the tongue "a 'sensory bridge' between internal and external reality, and of some significance in the development of the body-ego as well as a medium of object cathexis". Further aspects of the autonomy of the tongue are found in its role in the essential development of speech. The tongue's extreme sensitivity to sensations and association with sexual activity as well as necessary immobilization during dental treatment may contribute to dental anxiety which has been identified as contributing to avoidance of dentistry.
The act of having a dentist working in an individual's mouth can have great impact upon that person. This experience may contribute to that person feeling anxious and may contribute to dental avoidance at some future time. In addition to being perceived as the "seat of the self" (Borland 1962), the mouth is situated within the human skull, which contains the brain, and may act as a resonating chamber for the sounds of dental procedures such as drilling. All of the receptors of the major sense organs of the body are implicated when people receive dental treatments as the mouth is seated amid its other powerful relations; the nose, the gustatory tract, the ear, and the eye.

The nose "may act as the sentinel of the mouth" (Nathanson, 1992, p. 125). The dynamic most strongly associated with the nose is named dissmell. It is defined as the "sense of some interferance with the act of smelling" (p.121). Nathanson identified a biological disorder of dissmell in his treatment of a woman who had been referred by her dentist as experiencing herself as having bad breath and had distanced herself from others in order to protect herself from their avoidance of her. Negative associations with odours in dental offices may contribute to avoidance.

Ears and eyes are often implicated in dental treatments and experiences relating to them may contribute to dental avoidance. Often individuals speak of their aversions to the high pitched sound of the drill. The literature contains little in reference to the effects of the sound and vibrations created by the dental drill as it is used to remove decay from a tooth. This aversion, in combination with feelings of entrapment relating to their immobility, is particularly problematic for some people. Campbell in a 1990 seminar at the Institute of Music, Health, and Education, indicated that there appears to be a direct influence on the pain centre of the brain by the dental drill's vibration as it resonates in the skull.

That individuals' eyes are extremely vulnerable to injury is a widely recognized phenomenon, no literature was found about a connection between this fact and dentistry. The possibility of physical injury to the eyes during dental treatment is acknowledged by many dental professionals when they request that clients wear safety glasses. Many experience their centre of consciousness to reside in or around the eyes and this adds to their perceived vulnerability when sitting in a dental chair.

In this section, theoretical literature concerning the mouth was examined. The theory although complex has not been linked to the field of dentistry in any substantive way. It appears that the literature about psychology and the mouth does little to contribute to the understanding of the phenomenon of dental avoidance.
Family Influences.

The experience within one's family has been described as influencing whether a person would seek or avoid dental care (Chepin-Roen, 1982; Shoben & Borland, 1954). Parental influence has been cited by Milgrom, Weinstein, Kleinknecht, and Getz (1985) as the most frequent aspect of "vicarious fear development" (p. 38). In Mark's (1978) opinion, the attitudes of a person's family are the important factor in the determination of anxiety. Milgrom et al., postulate that when children hear their parents talk about their fear or dislike of dentistry or when they see their parents reacting adversely to dentistry, they "can acquire both the information that says 'dentists are to be avoided' and they can acquire the parents' emotional reaction to the whole concept of dentistry" (p. 38). Shoben and Borland (1954) found unfavorable family dental experiences and unfavorable family attitudes towards dentistry as being the only two factors that were statistically significant in their study of factors influencing dental reactions. This study had also included traumatic dental, medical, and facial experiences, high anxiety level, low pain tolerance, emphasis on appearance and orality, dependency, and trouble with authority. Shoben and Borland’s (1954) premise that fear is a result of family experience and attitudes is too simple. In Forgione and Clark's opinion (1984), dental fears are "decidedly more complex" (p. 496).

Molin and Seeman's (1969) findings yielded different results. The people interviewed, regarded family attitudes as less salient and less emotionally charged for them than issues arising from their previous experiences with dentists. In Lautch's (1971) research on dental phobia, a minority of people who were dentally phobic had other family members with the same phobia. Lautch concludes that fear of dental treatment in a family member, particularly if that relative was the mother, is a salient predisposing factor in the etiology of dental phobia.

The results of the studies on the influence of family attitudes appear to be contradictory and offer no conclusive evidence of the influence of family upon fear and dental avoidance.

Cultural Influences

Cultural influences in addition to personal and family attitudes have been considered a contributing factor in avoidant behaviour. Many individuals, although they have never experienced dental pain or had a negative personal experience, are fearful of dentistry. Milgrom et al. (1985, p. 37), state that most of the persons coming to their dental fear clinic exhibit a fear of root canal therapy although most have never experienced this treatment. As well, the mass media communicates the fearful aspects of dentistry through such media as cartoons or movies characterizing dentists as "inflictors of torture" (p. 39).

Although mythological and symbolic aspects of the mouth and teeth would appear to have no obvious relationship to dentistry, it is likely that everyone living in a particular culture is influenced by the effects of mythic and symbolic meanings that occur in that culture. Folk and
fairy tales, dreams, myths, and the media abound with references to teeth and the mouth. Many of these references appear to have fear evoking images associated with them.

The unconscious potency of fear and its association with the mouth is the frequent occurrence in dreams of teeth (Coriat, 1946; Whitmont, 1969). Some of these dreams may be about the extraction of teeth or of teeth disintegrating in the mouth. In Coriat's opinion "tooth dreams" and the dental anxiety of an awake state have the same psychological meaning. "[T]ooth dreams and dental anxiety do not refer specifically to the teeth but have a deeper, and more symbolic meaning" (p. 366). This is also reflected in his view that dental fear is more often found in people with unconscious and unresolved personal conflicts. Parental dictims in different cultures that admonish children "if you aren't good, I'll take you to the dentist!" may increase children's anxiety.

In a study testing the reliability of the American Dental Fear Survey (Milgrom, Kleinknecht, Elliott, Hsing, & Choo-Soo, 1990) in Singapore, the researchers found there to be a high correlation between the perception of fear in Asian and Western countries. Although there is little empirical evidence relating cultural or cross-cultural influences to fear and dental avoidance, it would appear to be implicated in the origin of dental health attitudes.

**Age**

The age of an individual is suggested as a factor in dental avoidance. In certain situations age appears to be linked with dental fear and in others with factors that may accompany the aging process such as lack of mobility, the use of dentures, financial considerations, and the perception of need.

Sonnenbern and Venham's (1977) study of 64 preschool children with no previous dental experience, cited by Chepin-Roen (1982, p. 17), demonstrated that as children increased in age, there was a decrease in their negative responses to dental situations. In Chepin-Roen's opinion, this relationship is possibly inaccurate because children may be able to suppress the external signs of anxiety as they mature rather than that they experience less anxiety. Another example of possible conservative self-reporting by individuals may have occurred in Kleinknecht and Berstein's (1978) study. People over 40 reported "the least state anxiety (or self-reported fear), expected and also experienced the least pain, and were least aroused physiologically after treatment" (p. 633). Chepin-Roen (1982) cites a study by Kleinknecht, Klepac, and Alexander (1973) of students and fear of dentistry. They described the high school group as having the greatest overall fear responses; with college students having the next greatest, followed by junior high students. It is possible that dental fear responses peak in the middle of the turbulent adolescent period, declining as the person matures. In summary, there appears to be no clear relationship between age and dental anxiety.
Gambucci, Martens, Meskin, and Davidson, (1986) in their study of dental care utilization in older adults, report that older people were more likely than younger people to visit the dental office for emergencies and less likely to make recall and new patient visits. This finding may reflect the fact that older people are more likely to have dentures than younger. MacEntee, Stolar, Hill, and Wong's (1990) study verified that older people with natural teeth and those who are aware of dental problems will search for and utilize dental services in a similar way as younger adults with teeth (Bomberg & Ernst, 1986; Branch, Antczak, & Stason, 1986; Kiyak, 1986). A study of participants at a health fair (Heine, Jong, Casamassimo, Osterbrock, & Call, 1983) revealed that 56.3% of the participants had seen a dentist within the past year in contrast to Kiyak's (1981) findings that only 30% of those 65 and older attended in a year. It is likely that the health fair participants represented a group more highly motivated to dental health than the general population. In a summary of utilization trends by the older person, Papas, Niessen, and Chauncey (1991) state that although this group had the lowest rate of dental visits of any age group during the period of 1963 to 1984, their use of dental services showed a greater increase during that period. "The use rate of the elderly will continue to increase in the coming years as middle-age adults with higher income and education levels and consequently higher dental care expectation levels reach 65 years of age" (p. 6). This trend suggests that avoidant behaviour among the elderly in relation to dentistry will likely decrease in the future.

Factors associated with dental avoidance and the aging process have been identified as being associated with declining mobility, the use of dentures, lack of finances, and perceived need. Mobility, dentate status, and cost will be discussed in following sections. Kiyak and Miller (1982) in a study of age differences in oral health attitudes and dental utilization, found that the older persons in this study generally thought that their oral health was less important than did younger persons. The limitation of this study is that the people questioned were the "low-income elderly" (p. 40) and would not be generalizable to older persons in other income levels. Some researchers consider that lack of a "perceived need" is the reason older persons often do not seek dental care (Kiyak, 1988; Dworkin, Ference, & Giddon, 1978). Implicated in this dynamic may be the fact that although older persons perceive and comprehend pain they tend to minimize their symptoms and not report them to their dentists (Papas, Niessen, & Chauncy, 1991, p.11). In contrast to exploration of medical health beliefs, little research has been done about the dental health beliefs and behaviours of older people (Dworkin et al., 1978).

The literature associating age and dental avoidance is inconclusive. Complicating this issue is the fact that the traditional concepts about aging are being called into question.

"Definitions that have more to do with functional abilities, level of vigor and vitality, and an individual's well-being will become the norm in the years to come" Dychtwald & Flower, 1991, p. 37). Also Schwab and Paviatos (1991) challenge the concept that the "mature market" (p. 332) is
composed of one large group named the elderly. This group is not homogeneous but ranges from the new mature or young old to the later mature or oldest old. Bomberg and Ernst (1986) contend that dentists and the general public appear to have stereotyped older persons in their care seeking or non-seeking behaviour. If people have established a pattern of attending or avoiding dentists earlier in life they likely will continue that pattern into old age.

In general, the literature relating the age of an individual with the seeking of dental health care, appears to link avoidant behaviour with issues that are developmental, attitudinal, and situational rather than specifically age related.

**Socioeconomic Status**

Socioeconomic status (SES) in terms of higher education, income and position, is identified as a factor in dental avoidance (Liddell & May, 1984). Kandleman and Lepage (1982), in a study of older persons in Quebec, found that the reason socioeconomic and cultural factors and level of education play such an essential role in dental health is that they "reflect the life-time behaviour of individuals" (p. 367) much more than behavioural determinants. There appears to be a direct relationship between a person's SES and the frequency of dental visits (Chepin-Roen, 1982). Those who have a higher SES have often received more education. Branch, Antczak, and Stason (1986) discovered that the use of dental services by older adults is "mediated by values often associated with higher SES" (p. 40). The seeking of dental treatment by older adults with natural teeth was greater for those adults with more formal education, who were not on a health care insurance subsidy, and who valued the health practice of maintaining adequate nutrition.

Friedson and Feldman's (1958) study indicates that when cost is considered a factor in dental neglect, there is a relationship between SES and dental visits. When fear was the stated reason for lack of treatment, there appeared to be no SES correlation. In a study of health locus of control correlates by Ludenia and Donham (1983), they cited Ayers (1979) who found that lower SES individuals, who were described as externally oriented, showed no relationship to frequency of dental visits.

Bochner (1988) cites a study of attitudes about the three qualities of the ideal dentist conducted in Amsterdam by Van Groenestijn et al., (1980). The results of this study revealed that there were social class differences: "lower SES valued reassurance and friendliness more, whereas higher SES respondents regarded professional skill and explanation and information giving as more important" (p. 18).

The literature indicates that there is a direct relationship between SES and the valuing of health care.
Gender

Gender differences have been cited as a factor in dental avoidance. It is known in the dental profession that women are more likely to seek dental care than are men (Levoy, 1992; Liddell & May, 1983). An examination of the Canada Health Survey (1978-1979) indicates the differences may not be as large as popularly thought. The survey indicates that 51.6% of men had no consultation with a dentist as compared with 47.8% of women. A greater difference was suggested by a 1990 report prepared for the British Columbia College of Dental Surgeons. In this survey 51% of husbands attended less often than their wives.

The General Social Survey (Statistics Canada, 1987) reveals that the dental care seeking pattern in men and women is similar in all age groups except in the 25 to 44 and 75 and over groups, where women report a higher utilization. This phenomenon occurs even though women were found to have greater anxiety arousal than men. However, both groups experienced decreased anxiety with dentists of the same gender (Freeman, 1989, p. 316). Despite the limitations that Seeman and Molin (1976) identify regarding their research, they believe their study reflects the findings of the Swedish Institute for Opinion Investigation in 1962. These findings showed that in a study of 1,375 persons, women were the proponent persons suffering from feelings of helplessness in dental situations.

In a study by MacEntee, Stolar, Hill, and Wong (1990) of 521 independent adults over the age of 70, women were more likely to seek health care and valued appearance more than men. For men, their mouths were less problematic than other aspects of their bodies. It appears that more men avoid dental care than do women at certain times of their lives. However, there appears to be little evidence as to the specific reasons for this avoidance.

Ethnicity

Ethnicity has been named a factor in the seeking or avoiding health care. In a 1990 report prepared for the British Columbia College of Dental Surgeons, more people of ethnic background only visited a dentist when they had a problem or pain than those who did not have an ethnic background.

In a study by Kandleman and Lepage (1982) of an elderly population in Quebec, the demand for dental care was low. Less than 10% of the people they researched had visited a dentist in the past year. As many people in Quebec live in rural environments, availability of dental care may be a reason for the large numbers who do not seek dental care. Many of the people in Quebec had demonstrated a high level of satisfaction with their present dental situation. This may indicate that they undervalued their dental problems. Also French-speaking Canadian people have a higher rate of complete denture wearing than English-speaking Canadians. In Kandleman and Lepage's opinion, there is a significant relationship between ethnic origin and
educational level. People with less education, preferred prosthodontic care (use of dentures), than those with more education who often favored restorative care. In an examination of 405 older people in Quebec (Brodeur, Demers, Simard, & Kandleman, 1988), need perception was seen as the major determinant of dental health.

A comparison of dental attendance between Israel and the United States indicates that Israelis are less likely to visit their dentist for a checkup (Shuval, 1966); 20% of Israelis compared to 43% of Americans in 1959 (p. 96). In the "marginal comparison of Israeli and United States findings" (p. 125), Israelis were found to be less preventive oriented, to first visit a dentist at a later age, and appear to have more barriers to preventive dental health behaviour than their American counterparts. They report more fear of pain which may be a barrier to seeking dental care.

Dental avoidance has been examined in other Western countries such as Finland (Nyyssonen, Kerranen, & Rimpela, 1984). In examining the attendance pattern and continuity of the dental care of Finnish adults (aged 17-65) over a 5 year period, Nyyssonen et al (1984), found that only 30% of adults used dental services regularly (approximately one course of treatment per year). The researchers findings indicate that women attended more frequently than men, the numbers of treatments decreased with increasing age, and people living in urban areas availed themselves of care more frequently than those who lived in rural areas. The numbers of treatments chosen increased with increasing educational level; although they were not affected by income. Perhaps there are less differences in regard to ethnicity and dental avoidance than might have been expected. Fear has been cited as a major factor in dental avoidance. Similarities of the universal fear responses in western and non-western cultures have been have been found in Milgrom, Kleinknecht, Elliot, Hsing, and Choo-Soo's (1990) cross-cultural study of the Dental Fear Survey in South East Asia.

The research on ethnicity and dentistry does not further our understanding of the phenomenon of dental avoidance. It would appear that other factors such as education, SES, and geographical location may contribute to health-related attitudes among ethnic groups.

Long Standing Causes

Several long standing causes or barriers to seeking care have been said to impact dental avoidance. They are dental status, lack of mobility and ill health, availability, economic considerations, and past experiences.

Dental Status.

The fact that people have no teeth (edentulism) has been cited in the research as a reason for dental avoidance. In a 1986 Health Interview Survey, cited by Holtzman, Berkey, and
Mann (1990), "over 70% of edentate individuals (those with no remaining teeth) had not used dental service in five years or more" (p. 164). The numbers of people who are edentate, increases significantly with age. This may account for some of those people in the older age group who avoid dentists. In examining the 1986 National Survey of Adult Dental Health, (Berkey et al.), found that 76% of dentulous seniors (those with their teeth) had visited a dentist in the past two years; whereas, only 29% of their cohorts were edentate did. In a 1990 report of the British Columbia College of Dental Surgeons, 69% claimed to have their own teeth, 23% had some false teeth, and 8% had full dentures. Those aged 50 years or older and those not covered by dental insurance were more likely to have false teeth. Those who have dentures as well as those who wait until they are in pain, place their last dentist visit "furthest in the past" (p. 25).

The relationship of edentulism to avoidance may have been more of a factor one 100 years ago, when three-quarters of the women in America over 50 years of age, had no teeth (Dychtwald & Flower, 1990). This differs with the situation today when the average "70-year-old" (p.331) has only lost 10 teeth. That older people today retain more of their natural dentition is reflected in the statistics that 58% of elderly people have their own teeth (Schwab, & Pavlatos, 1991, p. 331). This contrasts with a 1970-1972 Nutrition Canada dental report that stated that almost half the men were edentulous, and 55.7% of women were completely edentulous (Ableson, Padden, & Strohmenger, 1983, p. 96). This Nutrition Canada dental report (1970-1972) showed 26.6% of women 19 and over being edentulous compared to 20.3% of men who had no teeth. Between the ages of 30 to 40, almost four times as many women as men were without their own teeth. Ableson et al suggest that that there is a possibility that women in this age group have chosen to have dental plates for esthetic reasons. Even though people have no teeth, preventive measures require that they have the tissues of their mouths checked for pathology on a two yearly basis.

Although edentulism may be the reason that some older people do not seek dental care, it appears to be an insufficient factor in accounting for much of the non-attending behaviour of this age group. Other factors, such as perceived need by individuals for dentistry may be a significant influence among older persons (Kiyak, 1988; Dworkin, Ference, & Giddon, 1978). In the future, as more older persons retain their own teeth, the premise of edentulism being a reason for avoidance is becoming less credible.

**Economic Constraints.**

Economic constraints have been considered a significant factor in people not seeking dental care (Bomberg & Ernst, 1986; Branch, Antczak, & Stason, 1986; Kiyak & Miller, 1982; Perich, 1986). The Health and Social Support (1985) report shows that although lower income Canadians are likely to consult a physician more frequently than those in higher levels, higher
income Canadians tend to consult a dentist at least once a year. "Nearly seven out of ten persons in the highest level quintile report at least one dentist contact, compared to three out of ten in the lowest quintile" (p. 75).

Lack of income has often been identified as a factor in dental avoidance among older people. A United States government health and human services report (1981), cited by Branch, Antczak, and Stason (1986), found that about 40% of all people aged 65 or older had seen a dentist within the past two year, in contrast with 23% of people with annual incomes below the poverty level. Ability to pay and values related to SES, such as perceived use of dental care may both be involved in the income-dental use relationship (Branch, Antczak, & Stason, 1986). Schwab and Pavlato (1991) challenge the myth of the older population being poor in their statistics that 60% of the disposable income in the United States is owned by the 50 to 65 age group (p. 331). Several researchers identify that it is perceived need rather than financial considerations that constitute a dental avoidance factor (Kiyak, 1988; Pappas, Niessen, & Chauncey, 1991). This perceived need may be influenced by SES.

The high cost of dental treatment is said to effect whether people seek dental care. In a report (Marktrend, 1990) prepared for the British Columbia College of Dental Surgeons of dental patterns throughout the province, 76% of people with insurance were likely to engage in preventive dental behaviours as compared to 53% of those without insurance. However, in a study of older people in Vancouver, British Columbia, who were independent (MacEntee, Stolar, Hill, & Wong, 1990), cost did not appear to cause much concern although 42.8% of women and 17.5% of men had incomes below $1000.

Although economic constraint is a factor in the seeking of dental care, the evidence is inconclusive that it is the major factor. The economic factor would appear to be related to health-seeking values as well as other variables.

Lack of Mobility and Ill Health.

Lack of mobility and ill health; factors that affect access to dental care have been identified as causal factors in dental avoidance (Bomberg & Ernst; 1986, Warren, 1984). As a person ages, it is likely that these factors may increase. That the well-elderly constitutes more than 75% of the total population of elderly in the United States (Marinelli, Screebny, & Kamen, 1982), suggests that there are almost 25% of the elderly who are homebound or institutionalized. Marelli et al. cite a 1979 American Dental Association report on the dental care utilization patterns of 1300 people of all ages. They deducted that for non-institutionalized people over 60, less than 33% sought regular dental care. It is difficult to determine what proportion of the other two thirds of this independent older population do no seek care because of lack of mobility and ill health or
for other reasons. Sometimes people are not able to attend because dental offices are inaccessible for those in wheelchairs or there is a lack of wheelchair assessible transportation.

Availability of Services.

Geographic factors for those living in communities far from available dental care have been identified as being relevant in statistics on dental avoidance (Bomberg & Ernst, 1986; Branch, Antczak, & Stason, 1986).

Past Experiences.

In the opinion of Milgrom, Weinstein, Kleinknecht, and Getz (1985), the most prevalent etiology of dental fears and avoidant behavior is through a "direct negative experience in the dental office" (p. 33). Experiences of pain or stress and trauma may result from such an experience. Individuals may experience intense pain or fright and/or negative interpersonal transactions between the dentist and themselves which create associations between dentistry and unpleasantness. Although experiences of pain or fear are frequently linked with avoidant behaviour in the literature, there are few references of the implications of negative interpersonal transactions between the person and the dentist.

The pain associated with dental procedures is frequently considered the cause of people avoiding dentistry. Fear of pain was identified by McNeil and Berryman (1989) as being the "most significant predictor of dental fear" (p. 233) in both men and women. Wepman (1978) questioned dental pain only being considered a physiological event. For him, pain also involved a psychological components such as "cognitive, emotional, and symbolic factors" (p. 103). In Kleinknecht, Klepac, and Alexander's (1973) study cited by Milgrom, Weinstein, Kleinknecht, and Getz (1985) 81% did not consider that pain influenced their attitudes toward seeking care. For these people it was the dentist himself or herself that had a greater impact on their fear than pain.

In the opinion of Milgrom et al. (1985), the experience of an earlier uncomfortable dental experience may automatically elicit a negative response on a future visit. For instance, if a dentist accidently injures a person's tongue with a drill, it automatically causes a fear or pain response. This automatic response can elicit a emotional response by itself, even in the absence of the original stimulus. This latter associated stimulus has the capacity to elicit an emotional response called the Conditioned Emotional Response, "causing the person to experience arousal and avoidance behaviour" (1985, p. 34). For instance, even the thought of a dentist may cause arousal.

Expectations of an experience of pain often result in overprediction of pain (Arntz, VanEck, & Heijmans, 1990; Liddell & May, 1984). Arntz et al. found that "inaccurate
expectations do not continue because anxiety causes increased pain experiences, but because experienced anxiety interferes with the change processes of subjective schemas" (p. 40).

A comparison of "avoidant dental patients" with "patients low in dental fear" (Klepac, Dowling, & Hauge, 1982, p. 293) showed that although avoidant persons were no different than the "fearless patients" (p. 297) in their tolerance for dentally-irrelevant pain, they had a lower tolerance for dental pain. The researchers question the credibility of some of their findings. It was their opinion that the avoidant people might exhibit a lower pain tolerance because of anxiety about the poor condition of their mouths.

Conditioned fear that persists when there is no justification creates a neurotic paradox. Stanfl (1991) presents a summary of Guthrie's (1938) theory about neurotic paradox proposing that "neurotic behavior never gets extinguished because the neurotic individual avoids the stimuli in the presence of which extinction might take place. Avoidance behaviour early in the sequence precludes exposure to aversive stimuli later in the sequence" (p.387). When individuals stay away from the dentist, they escape or avoid the experience. This helps to resolve the neurotic paradox. This neurotic behavior "is at one and the same time self-defeating and yet self-perpetuating, instead of self-eliminating" (Stanfl, 1991, p. 386). Thus people avoiding the dentist may experience relief from the neurotic paradox by not going but do not accomplish any improvement in their phobic behaviour.

Stimulus generalization occurs when "a person conditioned to respond to one stimulus associated with pain or trauma will also respond emotionally to a similar stimulus or situation" (Milgrom et al., p. 40). In dental situations, a person may become fearful of elements that remind them of a similar situation such as medical or surgical procedures (Borland, 1962). Individuals often have very unique reactions to fear. Rather than an increased sympathetic arousal such as increased pulse and respiration, those fearful of blood and injury may exhibit a parasympathetic response of dropped heart rate and blood pressure. Another potential source influencing stimulus generalization is that essentially all young children receive immunization inoculations. It is possible that people may generalize past experience of fear of inoculations to receiving a local dental anesthetic injection.

A review of the literature on pain and dental avoidance did not show any conclusive evidence that these two factors were the principle reasons for avoidance. Limiting understanding is the fact that the perception of pain is difficult to operationalize. In addition, as with many factors cited in dental avoidance, the interrelationship between pain and avoidance is complex and difficult to assess.

People often refer to the stress and trauma that they associate with dentistry. Neither the psychiatric definition of a traumatic event "as a stressful occurrence 'that is outside the range of usual human experience and that would be markedly distressing to almost anyone'" nor the DSM
Ill's definition of trauma as "serious threats to one's life or physical integrity" explicitly account for "the wide and subtle range of potentially traumatic situations" (Levine, 1992, p. 11) such as those that are sometimes found in the dental office.

Many individuals are able to "experience stress, even threat, in a multitude of forms, and most of the time [they] make healthy, successful responses and emerge without trauma" (p.11). Kobasa (1979) has described such individuals as exhibiting "hardiness". It is Levine's (1992) belief that many unresolved traumatic reactions become "locked in the body/mind" of individuals (p. 11). Many indirect causes of fear would not be considered "catastrophic disasters or even child abuse" but are "instead unremembered and seemingly insignificant incidents such as a fall, an illness or a childhood operation, or even a routine medical (dental) procedure" (p. 12).

The origins of trauma are found in the environment; in the mother's womb and during the birthing process; when "there is a great potential for trauma" (p. 12). In later childhood, sexual, physical, and emotional abuse contribute to the child's experience of trauma. The effects of such abuse, which often occurs in families that are "alcoholic and dysfunctional", can be devastating. "The unpredictability of these families adds eroding effects in the form of chaos and chronic stress" (p. 12). Although trauma affects everyone including those from healthy families, "not everything is traumatizing regardless of how it appears" (p. 16). An individual's copability response ("his or her ability to respond appropriately and successfully to the event") not only helps individuals to meet the challenge effectively but "also allows the nervous system to work off the energy of the activated state and return to the normal level of functioning" (p. 16).

Empirical research on the direct affects of trauma on dental avoidance appear to be lacking. It has been implicated with fear and anxiety but to date there is little conclusive evidence.

Immediate Causes of Avoidant Behaviour in Dentistry

This section, includes premises that have been postulated as possible immediate causes of avoidant behaviour in dentistry. These premises have been grouped under the following headings; Affect Associated with Oral Cavity, Negative Attitudes, and Transient Situational Aspects.

Affect Associated with Oral Cavity

Several affects have been identified as being associated with the oral cavity; fear and anxiety; shame; helplessness; and regression are among those frequently identified.
Fear and Anxiety.

In this section, fear and anxiety as well as phobia are discussed in relation to dentistry. In that the most widely acknowledged causes of dental avoidance throughout the general population are dental anxiety, fear, and phobia, it is important to review them in order to understand their relationship to dental avoidance.

Kleinknecht and Berstein (1978) state that dental fear and the subsequent avoidance of dental care is a significant health problem for an estimated 6% of the population of the United States. This estimate differs from an estimate that 12 to 15% totally avoid dental care (Kuhn, 1988) because of severe anxiety. Kuhn also cites several studies and reports that "80% of the population in the U.S. is apprehensive when contemplating a visit to the dentist". Harrison, Carlsson, and Berggren (1985) make reference to a popular magazine in stating that as many as 6 out of 10 Americans visit a dentist only if they have a toothache. Fear was cited as being the reason for avoidance in spite of the recognized benefit of regular care. Research data indicates that the majority of fears began in the pre-teen years and tends to lessen as a person has increasing maturity and experience (Milgrom, Weinstein, Kleinknecht et al., 1985). A surprising new finding showed that more adolescents than adults had not seen a dentist in a year or more. These findings may reflect the fact that teen-agers as they become independent of their parents and may see no immediate value in seeking dental treatment. The findings may also reflect Gatchel's (1980) observation that dental fear may be increasing rather than stabilizing or decreasing. In his opinion, the results highlight the need for accurate research about the incidence of dental fear and fear-motivated avoidance of dentists by people in general. Milgrom, Weinstein, Kleinknecht, and Getz (1985) state that 6 to 14% of the population experience dental phobias.

Fear of dentistry may begin at an early age (Marks, 1978). Young children may all be impacted at the first dental visit as generally the first exposure to "a totally novel situation causes anxiety in children" (p. 51). Normally a child will adapt quickly to a new situation, although the child may develop a phobia if the original traumatic experience is reinforced. In Marks opinion, children at the age of three to five years are reaching their peak of fear. In a Swedish study by Berggren and Meynert (1984) of the origin of dental fear, it was found that 85% of dental fear had started in childhood. In dental fear of early origin the dentist's professional behaviour was important; whereas in adulthood, pain was considered most important.

Fear responses to dental treatments would appear to range along a continuum with mild fear through to the extreme of "odontophobia" (dental phobia) (Borland, 1962). "Disproportionate Dental Anxiety" is a concept developed by Molin and Seeman (1969) to describe a response which lays somewhat in the middle of the continuum. This condition was widely varying in that people did not have the "fixed reality-distorting features" of a phobia yet developed anxiety.
disproportionate to the stimulus (Seeman & Molin, 1976). Agoraphobia (fear of open places often resulting in social withdrawal [Judd & Burrows, 1992]) has been identified as a distressing phobia for persons entering a dental office (Martin & Nusbacher, 1984).

Fear is an appraisal that there is an actual or possible danger in a particular situation. Anxiety, although frequently used to describe an emotional response similar to fear, is also said "to denote responses to situations in which the source of threat to the individual is ill-defined, ambiguous, or not immediately present" (Beck & Emery, 1985, p. 6). This definition alludes to the anticipation of dentistry or thought of dentistry, whereas fear is a response to an immediate threat. "Fear involves the intellectual appraisal of a threatening stimulus; anxiety involves the emotional response to that appraisal" (p. 9).

Phobia refers to a specific kind of fear. It is characterized by an "intense desire to avoid the feared situation" (p. 8). The feared situation may arise from stimuli such as specific objects, natural occurrences, or social events. Individual phobic responses may range from mild anxiety to panic. The principal aspect of a phobia is that "it involves the appraisal of a high degree of risk in a situation that is relatively safe" (p. 9). Often in human phobias, a paradoxical situation (the neurotic paradox) occurs when phobic behaviour, persists for months or years even though there is no "real justification" for this fear (Stampfl, 1991, p. 386). Memory of a single event involving a traumatic encounter with a dentist may inhibit an individual from seeking future dental care (Milgrom, Weinstein, Kleinknecht, & Getz, 1985).

Some psychosomatic dental disorders such as extreme gagging reflex, orofacial pain, rejection of a prosthesis, and glossal (tongue) symptoms may contribute to anxiety, which in turn may contribute to a person avoiding the dentist. This anxiety often causes severe problems during routine dental treatment (Kleinhauz, Eli, & Rubenstein, 1985). These researchers consider moderate dental anxiety a common occurrence which accompanies normal development in childhood experiences, such as teething and loss of primary teeth (Lowenthal, 1978). The events involve a large number of psychodynamic processes which apparently contribute to a large proportion of the population experiencing a certain amount of dental anxiety prior to any dental exposure.

Wardle (1982) disagrees with Kleinknecht and Berstein's (1978) findings that fearful persons have rated their dental treatment as more painful than non-fearful persons. In one study, she found no differences. By comparing anxiety and expected pain for a number of dental procedures, Wardle found that anticipated pain was the most common reason for fear.

An analysis of persons with an inordinate fear of dental treatment by Seeman and Molin (1976), suggested that for the majority the fear is the emotionally threatening aspects of dental treatment rather than being physically uncomfortable or painful. This fear was associated with feelings of inferiority in bodily appearance or bodily functions. Although individuals avoided dental
care, they tended to seek regular medical care. Individuals in this group appeared to be the most fearful due to feelings of "confinement or helplessness in the dental chair" or to a negative relationship with the dentist.

Previously Forsberg (1966) proffered the suggestion that the fear is fear of the dentist who is performing the treatment rather than of elements of the dental treatment itself. Emphasizing this view is Molin and Seeman's (1969) contention that it is "the recollection of the dentists who practiced these treatments that paralyzes the clients resolve to seek effective care" (p. 81). These fears fundamentally involved an "assault to a part of the body by another person" (p. 82). Borland's (1962) experience is illuminating in understanding the potency of exposure and assault on the oral cavity. He relates that although he only experienced moderate anxiety in receiving surgical procedures to many parts of his body, when he was confronted with a rather minor surgical treatment to his face, "I suddenly realized that I was frightened almost to the point of panic. As I thought about this, I realized that my feelings could be summed up rather adequately by the protest: It is just much too close to me" (p. 687).

Seeman and Molin (1976) believe that the persons, who are described as experiencing Disproportionate Dental Anxiety (Molin & Seeman, 1969), may be disturbed by the interpersonal intimacy and feel the need to "protect themselves from bodily exposure to another person, in particular an assaulting person" (p. 90). The authors go on to emphasize the severity of persons' reactions: "One can well understand their terror (a not too strong word for most of the subjects) in being confined to the dental chair, helpless victims before what they perceive as a brusque, berating, and even scornful, if not sadistic, dentist" (p. 90).

The person's feelings of helplessness or perceived lack of control over their experience in a dental office is a "psychological hardship" (Kuhn, 1988). A sense of maintaining some sense control has been found to reduce anxiety as well as to increase pain tolerance and decrease discomfort (Wepman, 1978). It would appear that perception is the relevant factor rather than actuality. Kuhn (1988) states that it is individuals' perception of the ability to escape or to control a situation that mobilizes their fear and anxiety and enables them to suppress pain. In the event that escape or control appear impossible then fear becomes part of the "noxious stimulus" (Wepman, 1978) and aggravates the pain experienced. Wepman postulates that a lack of predictability can be experienced by a person as a kind of helplessness or lack of control contributing to a state of hyperarousal or hypervigilance.

The approach-avoidance conceptualization, a classification system for determining the amount of dental fear in individuals, has been used to explain dental avoidant behaviour. When a person has two competing tendencies in relation to a single situation, an approach-avoidance conflict is said to exist (Milgrom et al., p.7). In dentistry, this dynamic occurs when persons know they need dental care in order to have healthy, attractive teeth and are motivated to achieve their
goals. At the same time, they are fearful of visiting a dentist and want to avoid it. These competing responses leave individuals confused and conflicted. In their research, Dollard and Miller (1950) found that the dispositions tended to change in strength as the person moved toward or away from the wished for but feared circumstance. The more removed one is in time or distance, the greater the approach tendency, and the closer the feared situation, the stronger the avoidance tendency.

The interrelationship of fear and dental avoidance is a complicated one. There appear to be many aspects of fear which may or may not have a direct influence upon dental avoidance. For instance, it is possible that some persons will go to a dentist with anticipatory anxiety which may in turn amplify their responses to stimulations in the dental chair. For some individuals, high anxiety and phobia may contribute to them avoiding the dental checkups and corrective and maintenance procedures necessary to maintain their dental health. In contrast, there are many individuals who, in spite of high anxiety levels, do seek care (Milgrom, Weinstein, Kleinknecht, & Getz, 1985).

In spite of frequent references in the literature to fear being the causative factor in dental avoidance, the extent and complexity of the variables would suggest that this is too simplistic a view.

Shame.

Shame or embarrassment as an element of lack of utilization of dental care is rarely discussed in the empirical research. People have expressed the importance of a fear of being belittled by dental personnel. Milgrom, Weinstein, Kleinknecht, and Getz (1985) cite Gale’s (1972) study. Gale studied the importance of 25 fear-producing qualities. Being told by the dentist “that you have bad teeth” ranked third (p. 25). In a study by Scott and Hirschman (1982), it was discovered that the most significant way that a person’s anxiety could be raised was by insults or fear of insults from the dentist (p. 30). Kleinknecht, Klepac, and Alexander (1973) report that a significant proportion of persons report fear of personal criticism by the dentist. People seeking care sometimes feel shame and guilt about the poor condition of their teeth which may reflect their inability to pursue healthful practices such as brushing, flossing, and good nutrition.

In spite of the powerful emotional response to fear of being shamed in the dental office, there would appear to be no in depth studies of the dynamics of that experience for the person in the dental chair.

Helplessness.

For some people, feelings of helplessness that are generated when they sit in a dental chair, are problematic for them as they seek care for their teeth. They may chose to avoid a
dentist rather than experience their discomfort. "(H)ow readily a person believes in his own helplessness or mastery is shaped by his experience with controllable and uncontrollable events" (Seligman, 1975, p. 137).

Reports from people in dental situations indicate that the two most common causes of anxiety are the expectation of pain and "anticipation of being helpless while unable to communicate verbally during the dental procedure" (Kuhn, 1988, p. 263). The sense of helplessness appears to be a perceived lack of control about what might happen in the dental environment and for most people may be experienced as a "psychological hardship". Kuhn maintains that if individuals are able to perceive that they are able to maintain some control over what appears to be an unpleasant situation, their anxiety is not only reduced but also their pain tolerance is increased and their level of discomfort of a "specific level of noxious stimulation" is decreased. Identification of the complex phenomenon of pain by recent theorists suggests that knowledge of the quality, intensity, location, and duration of the noxious stimulus is not sufficient. In Kuhn's (1988) opinion, "the fullest understanding of the pain experience depends, in addition, on many psychological, spiritual, and contextual or social factors" (p. 264).

Although fear is a frequent factor described in the literature about dental avoidance, it would appear that there are many exceptions to present information. For instance, Milgrom, Weinstein, Kleinknecht, and Getz (1985) caution not to assume that because people are older, they will not be fearful or that all younger persons will be fearful.

**Regression.**

The occurrence of regression in situations of dental anxiety has been noted by many authors (Epstein, 1962; Lowenthal, 1978; Schwartz, 1971; Todes, 1972; Weckstein, 1970). Regression is the natural adaptive pattern which facilitates healing and recovery. "Such a pattern is demonstrated by the dental patient who reacts by becoming more immature, more self-centred, and more childish" (Weckstein, 1970, p. 387). Contributing factors to regression in the dental chair, in addition to the possible anxiety created by the stress of dental treatment, might be the immobilization, the inability to speak, and the reclining posture of the person. Lefer (1975) enlarges this view of regression by suggesting that the patient takes on the role of an infant by being "a gurgling, salivating, helpless being with an adult over him, putting things into his mouth and taking things out" (p. 1765). Although direct references to the role of regression in serving the ego during dental treatment have been difficult to find, Moulton (1955) elaborates that "preventive dental treatment requires a good deal of maturity on the part of the patient" (p. 263).

As well as lack of control experienced while in dentists' chairs, individuals may also experience the sense of losing control over their physical reactions such as gagging or vomiting (Todes, 1972) or loss of body sensation with a general or local anaesthesia. The ether
anaesthesia of the 1940s, 50s, and early 60s for tonsillectomies or dental procedures has left some people with unidentified traumas. "Black masks were placed over their faces and they were made to breathe ether" (Levine, 1992, p. 13). This often "produced feeling of suffocation and terrifying hallucinations. Tied down and helpless, they finally pass out". These children, even though paralyzed, sometimes "experienced extreme pain, bleeding, and terror" (p. 13). Distortion of some bodily sensations, through anaesthesia or the dental experience in general, may result in ego boundaries at times being loose or indefinite (Chepin-Roen, 1982).

With the generation of regression, the person's perceptions of the dentist are increasingly important. Possible transference reactions to the dentist may be generated as the person experiences issues of trust and dominance-submission such as they present in the parent-child relationship. These reactions in turn would likely generate greater anxiety. Seeman and Molin (1976) in a study with 19 individuals who experienced extreme dental fear found that five people indicated that their relationship with their dentist was a contributory factor to their anxiety. Being criticized by the dentist, shame of being afraid, feelings of inferiority, and fear of not being valued as a person or having an inadequate explanation of pending treatment were cited.

The affects of fear and anxiety, shame, helplessness, and regression are possible influences in dental avoidance. Although Axelrod (1984) identifies difficulties in the psychoanalytic research of psychological factors and orality, she believes the value of this research is sufficient to merit attempts to overcoming the impediments.

Negative Attitudes

Implicated in the process of dental avoidance are the negative attitudes people experience from the dentist and dental personnel. Complicating this dynamic is the interrelational aspect of this communication. In this section, an overview of the attitudes of people towards dentists and dentistry and the attitudes of dentists is discussed.

Some people avoid dental care because they experience dentists as uncaring, harsh, belittling, or insulting. Sometimes people generalize when they are not treated in a way that is supportive and developing of trust. In a study of factors that contributed to peoples' choice of a dentist, quality of care (rather than cost) and elements of the dentist's personality were important criteria for selection (Barnes, 1985). The Dental Visit Satisfaction Scale, developed by Corah, O'Shea, Pace, and Seyrek in 1984, further emphasizes the importance of interpersonal qualities in the dental office, by measuring information and communication, understanding and acceptance, general satisfaction in addition to dental competence. Freeman (1989) describes the relationship between dentist and patient as being fraught with the potential for conflict and being based on strong emotional interaction between two personalities. The patient may experience feelings of anxiety about the dental treatment (Scott & Hirschman, 1982) and resentment towards
the dentist (Roskin & Rabiner, 1979), cited by Bochner. As well, the dentist may also experience anxiety (Blum, 1970a,b) "which at times of increased stress may be screened by hostility" (Freeman, 1989, p.307). In Freeman's study, using patient heart rate as a predictor for dental anxiety, patients were more relaxed when treated by less experienced operators. This may have been attributable to the newer practitioner's "high sensitivity to emotional quality of the dental situation" (p.316).

Expectations of individuals in regard to dental personnel may influence their perception of how they are cared for. In a 1980 study of 513 persons in Amsterdam, the three most important characteristics of an "ideal dentist" were professional skill, reassurance and the ability to put the patient at ease, and friendliness" (Bochner, 1988, p. 18). Overall, these respondents regarded dentists as remote and mainly interested in making money rather than helping or caring for people. This study's particular value was in discovering that a discrepancy existed "between how people expect dentists to behave (the ideal dentist) and how they actually perceive the behavior of dentists". In Bochner's opinion, the discrepancy related to "the social rather than technical skills of dentists and could be reduced by practitioners developing a more personal, caring style in relating to their patients". In a study by McKeithen (1966) of patients' images of the ideal dentist, the personality of the dentist, which included attitudes towards patients and the professional ability were those deemed most important. The interpersonal aspect of the dentist's ability to reduce fear and pain ranked third.

Rankin and Harris's (1985) study, cited by Bochner, of 258 dental clients rated eight aspects of dental treatment. People most liked "having the dentist explain the treatment fully, explain the use of equipment, explain how to act, and be truthful about the amount of discomfort to expect" (p.19). In contrast, people disliked "having a dentist start treatment without explanations, tell that a procedure that is actually painful, will not hurt, scold them for poor oral hygiene, and fail to comment on their cooperativeness" (p.19). The finding that clients prefer their dentists to be informative and truthful is supported by other studies.

Lack of confidence in the dentist affects individual's attendance patterns. When 541 people were interviewed in Melbourne by Biro and Hewson (1976), they generally had high trust in their dentists. A relationship was found between positive attitudes towards the dentist and regular attendance. The attendance of people who admired their dentist was 82%; those who had high confidence, 78%; and those who thought their dentist was interested in them 77%. Their attendance patterns differed from those people who experienced no confidence in their dentists with 24% attending and of those people who thought their dentist was rude, only 30% attended. Bochner further cites Kleinknecht, Klepac, and Alexander, who in their 1973 American study, found that personal dislike of dentists contributed to the persons' adverse reaction to dental work (p.19). These findings clearly point to the personal attributes of the dentist affecting client
attendance or avoidance. Bochner also states that when Estabrook, Zapka, and Lupin (1980) reviewed pertinent literature, they found that visits and compliance with dental advice related closely to the perceptions of the dentist and the system for delivery of care.

In addition to the expectations and attitudes of an individual toward the dentist, attendance patterns in dentistry are affected by the attitudes of the dentist toward the individual. Understanding is furthered by review of studies on the "ideal client" from the dentists' perspective. In research by O'Shea, Corah, and Ayer (1983) of 628 general practitioners, the most mentioned characteristics were "concern about oral health, respect for the dentist's opinion, and being on time for appointments" (p. 18). This would indicate that dentists value dental sophistication and compliance in their clients. Bochner states that these findings again point to the fact that if dentists want clients to be more manageable, they will need to develop interpersonal skills in addition to their technical ones.

Dentists regard their work with clients as challenging and for the most part, satisfying. Bochner cites Martin (1970) who questioned 182 dentists in a study in New South Wales, Australia. Martin found that although 85% considered dentistry "to be emotionally exhausting", they enjoyed their work (p. 20). Some of the aspects they disliked were coping with nervous adults, treating children, and clients who did not care for their teeth. They valued technical competency over "sensitivity to people and powers of persuasion". Bochner, also cites Corah, O'Shea, and Ayer (1985), who questioned 746 dentists about their management of anxious clients. Seventy-eight percent of dentists agreed that "alleviating a patient's anxiety (was) the most important factor in patient's satisfaction with a dentist and 75% agreed "that patient anxiety is the greatest barrier to people getting adequate dental care" (p. 21). A further citation by Bochner, describes Weinstein, Milgrom, Ratener, Read, and Morrison who interviewed 105 dentists in 1978 and found that although most dentists saw their clients as cooperative, they perceived difficulties in helping patients to accept and pay for optimum treatment, or to follow recommendations about home care. In general, the research indicates that although most dentists are confident about the technical aspects of dentistry, they experience a lack of confidence in the interpersonal aspects.

Transient Situational Aspects

There are several transient situational aspects that may impact an individual's behaviour in avoiding dentistry. Some of these may be ill health of a short duration; temporary unemployment; loss of financial coverage from insurance; change of residence; and the retirement of the dentist. Although these aspects are occasionally mentioned in the research literature, there has been little substantive research in dentistry.
Summary Discussion

In spite of the fact that dentistry has only recently become a profession that is highly proficient technically and endeavours to produces minimal pain, many individuals today avoid dental care. Attempts by researchers to understand the etiology of dental avoidance in individuals has resulted in a body of research literature which focusses primarily on causative factors and little on understanding the psychological dynamics of avoidance.

Contemporary psychology, being a young discipline, is said to lack the cohesion of other areas of knowledge that are more established (Bochner, 1988). Much of the research in the early part of this century came from the psychoanalytic school of psychology out of which came Freud's Theory of Personality Development but little of this material has found its way into dentistry. Although dentists may use psychoanalytic approaches as "explanations" it may have no substance for the individual (p. 73).

Although researchers have endeavoured to identify the causative aspects of dental avoidance; individuals' experience of dental avoidance and sufficient descriptions of it are absent in the literature. Causal factors have been identified which may or may not significantly impact the avoidant experience. These factors do not reveal the full richness and depth of the experience of avoidance as lived by an individual; one that "implicates the totality of life" (Van Manen, 1990, p.36). The research does not examine the context in which avoidance occurs; nor does it appraise the consequences of this phenomenon in a person's life. The literature is devoid of descriptions of the meaning of dental avoidance for an individual. Perhaps a phenomenologist, by opening the door to an understanding of the essence of dental avoidance for a person, can contribute to what is missing. With this study, the process can begin.
CHAPTER III
METHOD

Design

The design of this study is derived from field research methodology. It utilizes an multiple-case study method to obtain the personal perspectives of individuals who have experienced dental avoidance in order to answer the question: "What is the meaning of dental avoidance as it is lived over a life?". Because meaning was seminal to this research and "meanings are contextually grounded" (Mishler, 1986a, p. 117), the case study approach was chosen as an appropriate method of research for obtaining contextual information. One of the significant ways that people "make sense of and give meaning to their experiences is to organize them in narrative form" (p. 118) and the narrative form underlies the basis for the interview with respondents.

The multiple-case study method was chosen rather than a single case study design, so that the overall study would be considered "more robust" in that the evidence is "more compelling" than that of a single case design (Yin, 1989, p. 52). As each single case study is considered "whole" in itself, the choice of multiple-case studies is the choice of the "replication" logic of multiple experiments. The cases would be similar to multiple experiments "with similar results (a literal replication) or contrary results (a theoretical replication)" (p. 59).

Yin (1989) postulates four criteria for judging the quality of research design in order to establish rigour, which may be applied to this research. They are construct validity, internal validity, external validity, and reliability. Within this research, construct validity, which is involved in the construction of the appropriate operational measures, was demonstrated by the use of "multiple sources of evidence", that a "chain of evidence" was established, and that co-researchers reviewed the draft of the case narrative (p. 41). Internal validity was established during the data analysis, with pattern matching and explanation-building. External validity was built into the research design with the "replication logic" of multiple-case studies. Reliability, which is concerned with minimizing errors and bias, was tested in the data collection process; with the use of case study protocol, the development of a case study data base, and with the examination of my interview skills for accuracy and bias by reviewers with psychological education who were not associated with this research.

Nine respondents were chosen in order to examine a diverse group as to age and experience and to strengthen the criteria of Yin's rigour. These respondents bear no relation to the approximate 49% of Canadians who are identified in the literature as not attending a dentist within a given year (Statisc Canada, 1987). These statistics likely include those who perceive no need to seek dental care or are without teeth. Unlike those individuals identified in that research,
all of the nine respondents in this study recognized that they needed care and that their avoidant
behaviour was a problem for them.

Because nine case studies were chosen, each of these cases represented a whole study
to be compared to each of the others. In each of the nine, the protocol for the introduction and
questioning was replicated. If there is a convergence of evidence (replication of three or more)
obtained from the different sources of evidence, it will strengthen the study's external validity.

Summary of Case Study Method

A step-by-step methodology was developed that reflected the guidelines for a rigorous
approach to the case study research suggested by Yin (1989). Throughout the entire research
process, I attempted to maintain an unbiased perspective which sometimes necessitated
adapting and refining the method. In so doing I endeavoured to meet Yin's criteria of balancing
"adaptiveness with rigor" in order not to leave "unknown gaps and biases" (p. 64). The following
are the steps of this case study method:

1. Sensitization to issues in research.
2. Selection of co-researchers.
3. Development of the interview protocol.
4. Orchestration of pilot interview, preparation of transcript, and the examination of
effectiveness of my interview method.
5. Revision of interview protocol.
6. Orchestration of eight initial interviews with co-researchers.
7. Preparation of transcript from the audiotape of each initial interview.
8. Construction of narrative account.
9. Orchestration of second interview to validate the narrative account.
10. Revision of narrative accounts.
11. Review of interviews and narrative accounts by nine reviewers who were not
associated with this research. who examined the accounts for accuracy and bias.
12. Execution of pattern analysis procedure.
13. Synthesization of nine narrative accounts into "The General Story" of dental
avoidance.
Details of Case Study Method

1. Sensitization to issues in research.

In a case study approach to research, the researcher is the primary instrument in data gathering. In preparation for the interview process, I heightened my sensitivity to the issues involved in this research by exploring my past experiences in the field, examining the literature, and by speaking to dental professionals and people who had been avoiding dentists.

In my position as a nurse/counsellor in a Vancouver dental practice, I conducted approximately 200 interviews of people newly seeking care. The purpose of each of these client-centred interviews was to encourage the individual to begin a process of personal participation in his or her dental health care. During the course of each interview, I obtained dental and medical history information, information about previous dental experiences, and personal life-style; ascertained short and long-term goals; and in general oriented each person to the health-centred philosophy of the practice. During the course of these interviews, I was impressed by the profound effect that not being able to seek the care of a dentist had on several people: a few wept with relief at being able to tell someone their story; a few said they had never told anyone else; and several described feelings of helplessness, shame, violation, mistrust, and low self-esteem. When I examined the literature, I found that primarily causal factors and treatment strategies for avoidance had been researched. There appeared to be nothing that explained the profundity and complexity of the experience of dental avoidance of those I interviewed. In discussions with dental professionals, I found that they voiced assumptions that were similar to those found in the literature. My experiences with people that avoid dentistry and subsequent explorations led to a heightened sensitivity for me about the difficulty of avoidance. My sensitization continued to increase over the time of conducting this research, as I interviewed a further 100 people seeking dental care. Throughout this period of sensitization, I continually contemplated the various issues involved in examining this phenomenon.

2. Selection of co-researchers.

Participants were selected on the criterion of identifying dental avoidance as problematic for them. Each individual had not seen a dentist for one or more periods in his or her life. The duration of these periods was two years or longer. Nine participants were chosen because of their availability, approachability, and willingness to participate.

The empowerment of respondents is an essential aspect of the collaborative relationship between the researcher and respondent in case study research. Empowerment assists the
respondents by encouraging "them to find and speak in their own 'voices'" (Mishler, 1986a, p. 118). The naming of the respondents as either "research collaborators" (Mishler, 1986a,b) or "co-researchers" (Colaizzi, 1978), aids in the redistribution of power. For the purpose of this research, the word co-researcher will be used in reference to respondents. I enhanced the sense of empowerment for co-researchers by giving them a description about how the data will be utilized and later by engaging them in reviewing and offering corrections to their narrative accounts.

It was essential that the co-researchers be able to articulate clearly and fully their experience of avoidance and have a reasonable memory for related events. The role of the co-researchers was to provide information, life histories in relation to dentistry, and descriptions of their experience with dental avoidance. As the authorities on their experiences, they were responsible for the generation of revalent data and valid interpretations of information. All the co-researchers were asked to choose fictitious names which were used in order to protect their privacy and assure confidentiality (Mishler, 1986a). Although it is possible that this anonymity may have lead to more candid responses, at least three of the co-researchers were willing to use their own names. In addition to the interviews, I also had access to records in a dental practice: medical and dental histories, dental records, and the client entrance interviews of some co-researchers. All of this material served to validate and enhance the case study information. This process reflected that "the case study's unique strength is its ability to deal with a full variety of evidence" (Yin, 1989, p. 20).

The demographic information was assembled after the initial interviews with co-researchers and was not pertinent to the selection process. There were nine co-researchers, three women and six men, ranging in ages from 33 to 85. All co-researchers had wide and varied life experiences. All were Caucasians of British, European, American, and Canadian heritage.

The co-researchers were selected from among clients from the Vancouver dental practice in which I work as a nurse/counsellor, clients referred to my personal counselling practice, and people referred by dental and counselling professionals. Many people to whom I spoke offered names of selves, family, and friends who have engaged in avoidant behaviour. Their enthusiasm and expressions of anguish attest to the profound effects of avoidance.

The co-researchers were first contacted by telephone and given details of the research project. An appointment was made which was followed by a letter detailing the particulars of the research process in relation to their involvement.

3. Development of the interview protocol.

The interview protocol was developed and refined in order to set the structure of the interview and allow the fullest possible response.
4. Orchestration of a pilot interview, preparation of a transcript, and examination of the effectiveness of researcher's interview method.

One co-researcher was interviewed using the interview protocol and several open-ended questions. This was done for the purpose of modifying and refining the interview process. A transcript was then made from the audiotape of the interview and examples of questions asked by the researcher extracted. These questions were given to two thesis committee members who validated that the questions were appropriate and did not bias the person's response. It was agreed that this interview sufficiently met the criteria of rigour in case study interviewing, and that the interview could be used as the first of the case studies.

5. Revision of interview protocol.

The final thesis interview protocol was revised after the pilot interview. The protocol is as follows:

I am doing a study in order to understand the lived experience of dental avoidance over a lifetime. It appears that the reactions and meanings are different for each person. I will be asking you questions about your personal experience about not visiting a dentist for a long period of time. First, I would like you to take a moment now and think back over your dental experiences throughout your life. I would like you to tell me about your earliest recollection of going to a dentist - what you remember of the experience, what you remember of the dentist, how old you were. Then I would like you to tell me about the experiences you remember that came after that first one. As you describe these experiences I will be writing them chronologically along this line (indicate a line drawn on a piece of paper). As we continue, I will be asking you questions from time to time. I'd like you to describe the experience in as much detail as you can, as if you were telling me a story. That is, I would like to hear about your dental experiences throughout your life, your first one, what your later experiences were and what your most recent avoidant experience has been.

A modified life line approach was used by the researcher in order to enable relaxation and assist the co-researchers to focus. It appeared that use of this approach was sufficiently unstructured that it did not appear to narrow the co-researcher's ability to range widely in their descriptions of their experience. Most co-researchers, after the opening question, appeared to be unaware that I was tracking the chronology of their experience on paper.

6. Orchestration of eight initial interviews with co-researchers.

These interviews were the first of two interviews with the co-researchers. They were conducted either in the individual's home or in the researcher's office and were recorded on an audiotape. At the beginning of the first interview, some time was taken by the researcher to
develop rapport and trust in order to enhance the collaborative relationship. The co-researchers were asked about whether they had any questions and then were asked to sign the Participant Consent Form.

In order to allow the fullest expression of the co-researcher's story, an unstructured interview style was adopted (Mishler, 1986a). Care was taken to design a method to support the relationship of empowerment of the co-researchers. It was essential for me to be both respectful and inquiring in order to obtain the fullest response from each co-researcher. It was necessary that there was a reciprocity between myself and the co-researcher as partners in order to equalize the power as much as possible. Colaizzi (1978) and Mishler (1986a,b) emphasize that the efforts to empower respondents and to study their responses are closely connected. They are linked through the assumption that individuals "construct coherent and reasonable worlds of meaning", endeavour to make sense of their experiences, and organize them into narrative or story form (Mishler, 1986a, p.118).

This process also helps elicit dialogue which is richly embedded in the context of peoples' lives. I began the interviews using the interview protocol in order to set the climate for the interview. An audio-taping of each interview was made.

As the interview proceeded, some of the questions the researcher used to elicit further depth of understanding were generally as follows:

1. What is your earliest recollection of your teeth?

2. How would you describe your parents' attitude towards teeth? The attitudes of your siblings?

3. How would you describe your general health? Do you think your family influenced your attitude towards health?

4. Would you describe any surgical or medical procedures that you may have had over your lifetime?

5. Are there any other experiences and/or interactions with others that may have influenced your reluctance to visit a dentist?

6. Has your avoidant behaviour affected other areas of your life?

With progression of the interview, I asked additional questions when necessary to elicit more details and further clarify information when the general questions failed to do this.

Did the experiences that you had with the dentist influence how you felt about other professionals?

How did you feel about that?

Was there some way you felt that you didn't have much choice in the decision-making?

In what way?
Have you told others about this experience?

Throughout the interviews, it was essential for me to carefully attend to the co-researchers and their responses through a process called active listening, and to stay fully present in a natural way. In order to facilitate each co-researcher’s narration, clarify information, and deepen responses, my counseling skills were invaluable. I asked open-ended questions such as “Can you tell me more about that?”, “How was that for you?”, and “What does that mean to you?” Paraphrasing was also helpful in assisting the co-researcher to elaborate.

7. Preparation of transcript from the audiotape of each initial interview.

A transcript of each co-researcher’s interview was made from the audiotape of each interview by listening to the tape and producing by means of a computer the exact replication of the words of the interview. This replication included pauses, "umms", and exclamations which were underlined. A short example, extracted from one co-researcher’s interview is found in Appendix D.

8. Construction of narrative account.

Before constructing a narrative account, understanding of the dynamics of such a construction was necessary. Mishler (1986a) citation of Labov and Waletzky (1967) aids understanding with their definition of narrative "as one method of recapitulating past experience by matching a verbal sequence of clauses to the sequence of events which actually occurred" (p. 78). It was also necessary to ask myself the two fundamental questions that Mishler poses for all students of interview narratives: "What are the effects on the production of a narrative, the respondent's "story", of the interview as a particular context and of the interviewer as questioner listener, and coparticipant in the discourse? And how should one take into account, in theory and analysis, relations between events in the real world and these events expressed in the narrative...?" (p.82).

Polkinghorne (1988) offers further elaboration of the narrative report: "it is a retrospective gathering of events into an account that makes the ending reasonable and believable" (p. 171). Rather than the narrative account be "a mere chronicling or listing of events along a time line: it configures the events in such a way that their parts in the whole story become clear" (p. 171). Polkinghorne cites Atkinson's (1978) positive criteria for narratives to be explanatory power and intelligible. Coherence is necessary which includes "comprehensiveness with unity, nothing relevant omitted, everything irrelevant excluded" (p. 172).
From the transcript or protocol, I constructed a narrative account by writing out the stories of the co-researchers' lives as they related to their dental avoidance. An extraction from one of the co-researcher's transcript is shown in Appendix B. Each transcript from the initial interview was read many times in order for me to become very conversant with the co-researcher's responses in order to acquire of feeling sense of the phenomenon and to aid in understanding the underlying meaning. Significant phrases or sentences were underlined throughout each transcript. The construction of the narrative account was done by organizing the information from each co-researcher into a chronological sequence, bringing thematic information together, and offering interpretative links. Their experiences were narrated, using their words and deleting any redundancies. By referring back to the transcript, I checked to make sure that I had not added anything that was not present in the original interview, and also not left anything of significance out of this account. Each narrative told the story of how dental avoidance arose in a persons' life and the meaning of this avoidance as it is lived in the course of that person's life. The completed narrative account of the first interview was mailed or given to the co-researchers within a range of two weeks to three months after the interview. A letter was enclosed with the narrative account asking them to consider the following questions:

Was my story portraying your experience accurate?
Did I distort anything?
Did I add anything or leave out anything of importance? Is there anything you would like to add to or delete from this narrative account?

An interview was arranged by telephone to take place approximately two weeks later.

9. Orchestration of second interview in order to validate the narrative account.

A second interview was conducted in which the researcher asked the above questions which were in the letter. Feedback was obtained and audiotaped. As a result of co-researchers' feedback, I renegotiated with them the meanings of their experience.

10. Revision of narrative accounts.

Each narrative account was revised in accordance with the second interview with the co-researchers. For most narrative accounts, little or no revision was necessary; one co-researcher requested extensive rewriting of his narrative in order that the account more clearly describe identified themes and details of psychological dynamics in situations.
11. Review of interviews and narrative accounts by nine reviewers who were not associated with this research who examined the accounts for accuracy and bias.

The independent reviewers included a psychologist, doctoral students, and masters graduates in counselling psychology. Individuals were approached first by telephone and when they accepted arrangements were made for the delivery of research material. Each of the nine reviewers was given an audiotape of one co-researcher’s interview, the written narrative account of that interview, and a letter requesting that he or she go through the material and answer the following questions:

- Was the narrative account accurate or distorted?
- In my account did I leave out anything of significance?
- Comment on my interview style. Was it facilitative and free of bias (distortion) or did I appear to force my own views?

The independent reviewers were to note any examples of leading statements or questions, any distortion, or any way in which the researcher may have influenced the co-researcher. Subsequently, I met with each reviewer in person and audiotaped each interview with the exception of one that she interviewed on the telephone. These interviews were taped and transcribed. Extracts from the transcripts of these interviews were added to the research as an external validation of my interview technique and are found at the end of the chapter entitled Results.

12. Orchestration of pattern analysis procedure.

The pattern analysis procedure was conducted as follows:

(i) The transcripts were reread.

(ii) The underlined significant phrases or sentences in the transcript were placed on index cards. If there were the same or similar statements in the transcript they were not noted.

(iii) Meanings were formulated from the statements. Often the meanings were obvious there was no need to look for further understanding of the meaning.

"I'll go in and get my teeth done when they start to hurt."

"I guess one of my biggest fears is being out of control."
"It's not just dentists. You take your chances with anybody-physicians, whatever."

Sometimes the meaning implied in the co-researchers' statements were more difficult. Statements were examined for implied meanings while remaining true to the original statement. Colaizzi (1978) stated that to do this required "creative insight...leap from what his subjects say to what they mean" (p. 59).

"So I was determined, because I was so fearful myself, and it kept with me."

"So there is a familiarity between the two senses, kinesthetic senses of spaces, of the becoming, of the shifting shape."

"I didn't feel claustrophobic or trapped, it was that I couldn't go back and face them".

"In my case, a way of actually physically bending and mutating reality and saying things are not what they appear to be on the surface."

Meanings were formulated for each statement and written in coloured ink across the top of the index card. Wherever possible, the co-researcher's own words were used.

(iv) For each transcript, there were now index cards with meanings or themes noted across the top, with the sample statements below. Then each card was then marked with one of three words: the Beginning, Middle, or End, which represented the sections of the general story. Three columns were created on a table and all the cards placed under the appropriate column and then arranged according to themes. On three large sheets of paper, each representing one of the three parts of the general story, a process called mind-mapping (Buzan, 198) was employed. An example of one of the maps is shown in Appendix B. The process for the mapping for The Beginning began with enclosing "Beginning" in an oval shape in the centre of the paper. Fanning out from the centre and attached to the centre oval were the identified themes, commonalities, or unique experiences. Each was enclosed in an oval shape. Some of these themes were personal, family, and cultural attitudes, specific dental and medical experiences, psychological aspects, attitudes about dental professionals, non-dental experiences. Each of these themes was represented by its own colour on this map. When each of the three maps was completed, The Beginning, The Middle, and The End, a pictorial overview was available from which to construct the general story.

13. Synthesization of nine narrative accounts into The General Story of Dental Avoidance.

In order to meet the objective of this study, which was to create a substantially descriptive narrative of selected and interpreted significant aspects of the avoidant experience, a general
story was written. The synthesis of the nine narrative accounts presented a challenging dilemma. The final synthesis involved a contradiction between the scientific concern about not being sufficiently detached and the humanistic concern about not being sufficiently engaged. In studying the map of the Beginning, several aspects of the beginning dynamics of dental avoidance were identified. As one example, the aspect of Chronic Influences served as an umbrella for cultural, personal, and family values. Each of the three stages of the general story was organized in such a manner and then the general story was written describing the commonalities as well as the uniqueness of individual experience.

Upon completion of the entire research, thank you letters together with a copy of The General Story were sent to the co-researchers. Thank you letters were sent to each of the independent reviewers.

Reflexivity

The reflexive nature of qualitative research: "that is, to recognize that we are part of the social world we study" (Hammersley & Atkinson, 1983, p. 14) presented a challenge. It was important to acknowledge the dynamic of reflexivity, in order to be aware of its presence in the research process. Throughout the entire research process, there were reciprocal effects on me of being influenced by the process and new learning. As the research issues evolved, I asked new questions, struggled with new theoretical speculations. And in turn, I was shaped by this process. The process of reflexivity appeared to enhance and deepen the research process.

The interviews with the co-researchers deepened the level of my inquiry; fresh insights arising out of this new knowledge led to increased awareness for both the co-researchers and myself; which in turn, led to refinement of the questions and sent me off to look at more literature. Noting the cautions of Hammersley and Atkinson, I had to be continuously aware that there was no way for me to escape the social world in order to study it: "it is an existential fact" (p. 15). Encouragement is offered by these authors, who suggest the researcher "exploit" reflexivity rather than treating it solely as a source of bias.

The strength of the case study approach lay in the opportunities the interview method yielded for understanding the phenomenon of dental avoidance within the context of people's lives and the meaning it had for them. In this research, there is no way to avoid depending on "'common-sense' knowledge" (p. 15) or having an effect on the phenomenon being studied. Just as there is little argument for rejecting common-sense arguments there is also no reason for treating it as all "valid in its own terms": there is "no external, absolutely conclusive standard by which to judge it" (p. 15). Hammersley and Atkinson encourage the necessity of working with the knowledge we have, while at the same time "recognizing that it may be erroneous" (p. 15). They suggest that whenever there is doubt, utilize systematic inquiry.
This research affected the co-researchers as well as myself. The reciprocal nature of the research contributed to a sense of empowerment as well as a high level of commitment and cooperation for all the co-researchers. During the process of the interview, previous reactions associated with avoidance were sometimes reactivated. Increased exploration of the dynamics of this response led to them regaining composure. Co-researchers also developed a deeper understanding of the dynamics of the phenomenon of dental avoidance in their lives and several experienced powerful insights. All co-researchers were excited about the prospect that their participation might help others who are experiencing the effects of dental avoidance.
CHAPTER IV
RESULTS

Nine narrative accounts were constructed based upon qualitative evidence from the interviews with co-researchers who had all been involved in dental avoidance at some time in their lives. These nine accounts of dental avoidance constitute the results of the study. Each account was evolved from an interview. One co-researcher, Charlotte, was interviewed a second time because the initial recorded interview was inadvertently blanked from the audiotape. Each narrative account was reviewed and validated by the co-researcher originally interviewed. In addition, the audiotape and narrative account of each co-researcher was reviewed by an independent reviewer. The purpose of this chapter is to present the nine narrative accounts, the results of the co-researcher self-reviews, and the independent reviews.

Narrative Account One: Eleanor

Eleanor is 74 years old and was born in Edmonton. Her father was Irish and her mother of Irish and English descent. When she was an infant, her family moved to Vancouver. She and her younger sister were raised by her mother, as her father left the family when she was about five years old. This was an extremely difficult time financially for the family, as her mother earned little as a secretary in an insurance and real estate office. Later, during the depression her mother lost her job and they had to relinquish a house they owned. She graduated from high school with first year university standing, then worked as a telephone operator until her marriage. Her husband worked as a longshoreman until his retirement. They had two children; a son and a daughter. Although it was unusual for a woman of her time to work while raising childrens, she returned to work to augment family finances. She worked at a variety of occupations which included being a file clerk, a telephone operator, and a real estate saleswoman. She is now retired and lives an active life in White Rock, often caring for her husband and for her mother who is 95.

Eleanor's earliest recollection of her mouth was at age two, when she vividly remembers putting a hot pepper in her mouth while her mother was pickling. Although her memories about early dental experiences are "hazy", she remembers disliking cleaning her teeth when her mother would say "did you clean your teeth?" It is likely that the lack of knowledge in those times about what constituted a healthy diet and the severe financial restrictions resulted in her "being raised with a lot of starches" which may have partially contributed to her poor dental health in later years.

About the age of 12, Eleanor had her first clear memory of having dental work. The dentist did not use freezing and just kept "boring away in spite of it hurting. From there on in, it
set a pattern." She felt that her general sense of insecurity and the fact that she was a "highly sensitive" person may have attributed her fear of dentists.

Also at this time, as she entered puberty, she began to question her life and come to terms with growing up without a father. At the same time she was challenged by her relationship with her mother, who was demanding of Eleanor at times and at other times did not support her. She described her interactions with her mother as being "kind of strange but like anything you do with my mother, you accept it." She described two incidents which reflected her relationship with her mother. On one occasion, "when I was 12 or so when I had done something [that I was chastized for], I was rebellious and I felt that something hadn't been fair. But I remember thinking that it didn't matter, because I was like an apple. They could eat my outside, but they couldn't eat my core." The second incident occurred at the time of Eleanor's first experience with a doctor. The doctor, who "was not a nice man" threatened to tie her down when she resisted his attempt to do a vaginal exam in her mother's presence. Although she eventually allowed him to do the exam, she felt violated by him and angry at her mother for colluding with him and allowing the abuse. Her association with this event stayed with her into maturity. Something occurred "in my spirit about not being tied down" and as a result she hated the limitation of the work telephone operator because of "the cord [of the switchboard] tying me down."

At age 13, Eleanor cut an artery in her leg with a long steel shaving as she was skipping with it. As she was taken to the hospital in the back of a Model T car "with blood spraying" from her leg, she recalls not being frightened. She accounted for her stoicism by saying that "it didn't hurt." The intern put her face down on the operating table in order to stitch her leg and "why in God's name he did not freeze it or anything, I do not know!...I hollered a lot" and "this cute little nun" came and asked her to "please be quiet because I was disturbing everybody."

When she was 16, Eleanor had "a terrible toothache and Mom took me to Painless Parker [a dental franchise] and I had a molar pulled." The impact of her losing a tooth was evidenced as she sadly said "so that was the first." While she was there she saw "the body of a man and a chair falling past the window, I was about five stories up." So profound was her distraction with her concerns about having her tooth pulled, that the sight of the falling man appeared to have little impact on her. Since that experience, whenever she had a tooth pulled, "there was a loss." She knew that "if you didn't keep your teeth, others shifted around and your bite was off...and that added more stress to your dental [structures] and so on."

At age 25, Eleanor gave birth to her first child, a daughter. It was during the Second World War and she commented on the terrible crowding in the 16 bed ward in which she was a patient. Although she thinks her memory "is failing", she remembers having two injections in her arm and being in great pain. Until then she had lived such a "safe, secure, parochial life." By comparison to others who had more life experiences, her hospital experience was foreign and
upsetting for her. Two years later, she chose to go to a different hospital for the birth of her son because of the earlier unhappy experience.

After the birth of her children, Eleanor "was determined, because I was so fearful myself, and it [the fear of dentists] kept with me. I didn't ever get over it." She was concerned that she not pass on her fear of dentists. She took her children to a child specialist and in spite of that her daughter experienced pain when she was only four years old. She continued the hardship of travelling from North Vancouver to Vancouver by bus, with two small children in order to visit the specialist. She realized that in spite of her careful choice of a dentist for her children, that likely the fact that "I talked too much and made no secret of my feelings for dentistry; that this affected them very much." She believed that her fear of dentists is now reflected in the behaviour of her son, who at age 45, resists dental care. His behaviour contrasts with her daughter who "takes good care of her teeth" as a result of dental care now being "economically feasible."

When she was in her early 30s, she went to an older dentist, who was supposed "to be a good one." She describes him as being familiar, "he wiped his hands kind of low on the bib"; touching her breasts. While he was placing freezing her in her mouth, she experienced a really piercing pain, right up through her gum to the back of her eye. The pain continued for two to three weeks after her dental treatment and then suddenly she had a terrible toothache which hurt "unbelievably. I was really in agony." After getting the results of the x-rays, the dentist elected to pull the tooth. Later she was shocked when she overheard him say that there was nothing wrong with the tooth that he had pulled. About four weeks later, she felt something in her nose. When she blew her nose, she expelled a "pleget with the most foul smelling matter that you could believe." She was horrified and in retrospect she felt that the dentist had pierced her sinus. She was upset at his treatment of her and did not go back.

After the disturbing experience with the dentist whose practice she left, she "skipped from one dentist to another many times." Although she did not like going to the dentist she felt that "the pain drives you, so you go. It was not a pleasant time for me." She felt violated because she had trusted dentists and she felt that although many dentists were good people, she just happened to be unfortunate. She never gave up hope, however; "there must be a jewel out there." She thought that with dentists and physicians "you just took chances" and that once and a while you were "lucky" and found someone good.

At age 35, during the second of two gynecological procedures, she said "I was insulted!" when she awoke from an anaesthetic to learn that the nurses had "put a strip of adhesive tape on my forehead which said not to send patients down with nail polish on their fingers!" She described herself as feeling as if she was "a piece of meat." Two days later, a serious complication occurred. Her temperature went up and she learned that they had accidently left
packing in her vagina. She did not blame the doctor for this, feeling that it was "just a series of circumstances."

On the advice of her sister, when she was about 55, she went to a dentist whom she later realized "didn't keep up the techniques." Although several of her teeth had fallen out previously because of "pyhorrea" [disease of the gums], she felt she still had some functioning teeth. In her opinion, it was likely that this dentist did not have the capability to handle the complexity of her situation and she blamed him for taking the easy solution by extracting all of her teeth. He sent her to a specialist for her extractions and because of the extreme rudeness of his receptionist she refused to have him extract her teeth. She went back to her original dentist who extracted her remaining teeth. Although this wasn't too painful physically, it was emotionally. In retrospect, she felt so violated by this experience of the dentist, she called him "a butcher. I feel quite sure that if I had gone to another dentist who was more up to date that I probably would not have had to have the dentures."

In 1982, she went to a dentist for a problem with her dentures. She enthusiastically called him a "real specialist" although he was a general dentist. She'd had a stroke by this time and had a certain amount of pain. He was the antithesis of the other dentists, "a really nice man" and his staff was excellent. Adding to this experience which was the best experience she has had with a dentist to date, was the homelike environment of his office which was not noisy or sterile.

Eight years later, after she had had another stroke, she needed to have two teeth replaced on her denture and went to a denturist. She describes him as "incredible" and critical of dentists. He had told her "five visits and it turned out to be fifteen!" "Seven hundred and fifty dollars later, I had the new ones", which "changed the shape of my face" and affected her speech. This has been a hardship, in the past she was "loquacious" and now she does not talk as much. "It's very difficult to say 'Mississippi' but it wasn't difficult with the old ones." Another disadvantage of her dentures is her inability to eat certain foods. She now needs new dentures but when she considered the cost of new dentures, she stated that she would rather have her house fixed. As she said this she exclaimed "So there I am, priorities again!"

She felt that her teeth greatly affect her sense of well-being. The loss of teeth is more difficult than the loss of a leg. When "you lose a leg or something, well that's one thing, your body is more resilient in some ways." With "your leg you can compensate one way or another...but teeth are teeth...I never lost my leg" but I think your whole being depends on your digestion and your choice of food." She felt that "with your own teeth you could eat anything--I can't even bite a piece of bread...or eat a carrot out of the garden, not with the kind of dentures I have." Her repugnance of having her teeth extracted was amplified by her horror at meeting her father-in-law who although he had his teeth extracted, wore no dentures. "It was a crippling thing, I'd curl up
and die if I was like that. It's like instant age.- 99!” Her sister, in contrast to Eleanor, retained her own teeth until she died at age 68. Her sister's healthier teeth may have been a reflection of there being more money available for dentistry when she was growing up. Eleanor's mother, who is now 95, has lost very few teeth, and until recently has had very little difficulty with her teeth. When Eleanor was 60, she had a clear recollection of a dentist who compared her teeth unfavorably with her mother's teeth saying: "Your mother's teeth are harder than yours." Strong teeth seemed to be found in Eleanor's ancestors. Surprisingly, when her grandmother died in her 100th year she had most of her teeth.

She believes that her values influenced her decisions to use her money to purchase a car which was necessary for work rather than seeking dental care. "That was my choice" which she now questions although it was an almost impossible decision to make. Her family always lived "more or less below the poverty level" and had little money for dentistry. Her husband's work did not include insurance for dentistry. As well as her unpleasant experiences with dentists, she also had some "unbelievable" experiences with doctors. She has some ambivalence about the issue of teeth and health professionals. On one hand, she feels she has a greater trust now, on the other, she does not because she "ended up with dentures." "It does make a terrible difference [having dentures]!...I would say don't ever believe that dentures are anywhere near as competent to do the job" of real teeth.

Eleanor then went on to say "I haven't spoken to anyone about this denture thing, not another soul." To me it's a very great failure, it's one of my bete noirs." She spoke with deep sadness "I really see it as my life's sorrow." Although she still carries "a certain amount of anger" about having to have dentures, she felt that to "carry" that anger to dentists or professionals was a "useless thing." In retrospect, she feels angry at being mistreated the first time she received dental care, but "there is no way I could do anything" when he "stuffed" her mouth "unless I kicked him." She felt that to be assertive was not her way but felt helpless and powerless and knew it would do no good to tell her mother because "she wouldn't have understood or cared if I had told her that man had hurt me."

In retrospect, Eleanor knows that her avoidance was mostly "the business of money rather than the question of pain." But pain was what drove her to seek care. "When I couldn't contain the pain, ironing the clothes, or brushing my teeth, or whatever, then I would go to see a dentist" and that was always allied with a certain amount of fear. Her association of pain with her teeth and fear of dentists and her avoidance "has been a real presence" in her life and she has not wanted to talk about it to anyone. She felt a sense of shame about neglecting her teeth and attaches no blame to others, that it was a choice having to do with values and priorities. "But I would have been better advised to have had the dental work done to save my teeth." Her sense
is that she so was busy through the time her children were young that she "did the best I could; living with an alcoholic [her husband] was traumatic. At times dentistry was not high on the list."

In retrospect, she also felt that "about 50 years ago" when she was young, "there were no medical skills and that included dentistry." It was even more difficult if "you're ignorant, which I was. But I was not so ignorant that I wasn't aware of the dangers of some of the choices I made." Also the fact that she was living in a time in the culture when mothers were not supposed to work, contributed to her feeling overwhelmed and "guilty about working as well as being the decision maker in the family." Now that she is older, her realization "that I did not have permission to run male energy and as a result felt guilty" has enabled her to feel more understanding of her earlier behaviour. In conclusion, she hoped that her story will help other people realize that dentures are not "just as good" as real teeth. If you have a choice always choose to look after your teeth." She laughingly said, "So, if this knowledge will help other people to prioritize their teeth, hooray!"

**Narrative Account Two: Stan**

Stan is 38 years old and was born in Peterborough, Ontario. Both parents were born in Winnipeg; his father of Icelandic heritage, his mother, English, with a Metis grandmother. His father worked as a electrical engineer in the nuclear energy field. His mother was a homemaker, caring for the family of five children at home. Stan continued to live in Peterborough until about 1976, when he moved to Alberta. He then came to British Columbia, living for about five years in the interior and commuting to Vancouver for half of that time. He has now lived in Vancouver for three years. He has completed some university undergraduate work and is now the manager of a university bookstore.

During our conversation, although Stan did not have "any direct recollections of actually being in a dentist's chair", he remembered going to the dentist and having the image of "three kids in the family [an older brother and a younger sister] in the dentist's waiting room...I would have been maybe five or six." He experienced some satisfaction in not having any cavities like his brother. His response seemed to be related to his recollection of Crest commercials on television "Look, Mom, no cavities!"

Around that same time, he was sexually abused by a barber on at least one occasion. He now believes that there was some association between that incident and going to the dentist - the barber's chair being similar to a dental chair, and the fact that he wore a white jacket like "dentists used to wear white jackets."

Stan did not have any medical or surgical experiences which might have adversely affected his response to dental treatment. He described the attitude of his parents towards dental health as being "kind of casual." Although they made sure their children attended a dentist and
brushed their teeth he realized that they did not understand appropriate ways to care for your teeth such as flossing.

Although he had no memories, he knew he was being cared for by a dentist up until the time of his next recollection of a dental experience which occurred when he was about 14 or 15. He was taken to a new dentist because the former one, who may have been a child’s specialist, was no longer available. "The building was old, a bit dingy and the office space was not nice. The new dentist was a woman, who was "brusque, judgemental" with a kind of "very sharp manner." She discovered that he had cavities and these were the first he had ever had. He remembered her talking about cleaning teeth and being "really disgusted" with him. He thought he must have gone back to have his cavities filled. He thought it odd that he had no memory of any dentistry for the remainder of his high school years given the importance of dental health to his parents.

For the next 20 years, until 1990, Stan did not go to a dentist. After he had been in therapy dealing with issues of sexual abuse for some time, he realized that he "had to deal with this business of going to the dentist...I just hadn't been dealing with the need for dental care and had managed to avoid." In the course of his group therapy for men who had been sexually abused, he discovered that other people who had been abused had also experienced dental avoidance. One of the men referred him to Dr.G's practice which provided support for people who had avoidant behaviour.

Since resuming care in April 1991, Stan has had a brief avoidant experience even though he was highly motivated to become dentally healthy. He had been in Dr.G’s practice for about a year and the personnel had engaged with him in obtaining care at his own pace. He was then referred to a specialist for care of a root canal. Compared to the people in his new practice the people in the specialist's practice were "more focussed on the business-aspects such as payment." Adding to Stan's sense of lack of being welcomed was the fact that the receptionist was in "little glassed-in booth." He was kept waiting for an hour. "This woman [the dentist] walked in and looked in my mouth and started asking me a whole bunch of questions" for which he didn't have any context "as to what she was really trying to get with these questions." Without checking with Stan about what he knew about the health of his mouth, she stated that he had serious gum disease and questioned the care that he was receiving. "It was just an awful way to be treated!" In his new practice, he and "the people" in Dr.G's practice were comfortable with the serious condition of his gums which was slowly improving with focussed care. In the presence of this woman dentist, he felt himself struggling with the "shame and all the other stuff" that that "kind of behaviour tends to invoke" but "fortunately because of my experience in [Dr.] G's practice I knew enough to be angry rather than saying it was my fault." In the course of only about 10 to 15 minutes she came and left about three times. In addition to the sense of chaos with the
technicians and the dentist "running around like crazy" was the experience of having very little privacy because their space was divided up into so many little places." He felt disrespect from the time he walked in; the manner of the receptionist, being made to wait an hour and "not asking anything at all about what was going on in my treatment" with the referring dentist: "just making assumptions." He thought it might be significant that she was a woman and that the other previous traumatic dental experience, that he had had while in his teens, was with a woman. "So then I didn’t do anything about that tooth because I wasn’t going to go back there." He had already "come to grips with the severity of the problem" and "I was pretty clear that I did not want to go back to this person, ever again." When Stan returned to Dr.G a short time later, he was relieved to be supported in his decision not to go back.

After this experience, he found it interesting to observe himself "watching the mechanism" of avoidance: "of just not following up on it", not calling Dr. G after his encounter. "Just letting it go and just saying 'you know that tooth's going to stop hurting',...so just wait." After his unfortunate incident with the specialist, Stan felt that he did not engage in the avoidant behavior with Dr.G because he was able to appraise "the difference between being treated well and being treated poorly." At this time, Dr.G suggested that he see another specialist in the same practice as the former specialist. But still Stan did not call. He did not want to go back to that practice "At All!"

Then a new associate, who treated root canals, joined Dr.G's practice and Stan had his tooth treated by him. He was ecstatic at being able to stay where he "was being treated properly." A further validation of his increasing ability to care for himself in health situations, occurred after a recent extraction. He felt that he was able to cope with the emotional aspects of the loss of a tooth, "because I knew enough to nurture myself and I went home and slept."

Stan's analysis of the situation is that his issues around his dental avoidance "are less to do with the procedures themselves" and "much more around the sense of how I'm being treated, the sense of being judged, the sense of shame, and all that stuff. Those are the things that go along with being sexually abused; you are being totally violated and,...you're a bad kid for it. 'It's all your fault, you're awful.'" In Stan's opinion, his outward stoicism while experiencing pain in the dental chair [although inside he feels like he is "flinching"], relates to the dynamics of his earlier abuse. Being in Dr.G's practice and discovering that he was not being judged, has enabled Stan to recover from some of his issues around his abuse and criticism from dentists.

Stan experienced his sexual abuse as being one of the most powerful factors affecting his life. The "way that impact gets played out in particular has a lot to do around memory and denial and repression." His capacity to forget or hide his memories of sexual abuse almost as soon as they arose was "quite phenomenal." Retrieving his memories has been "almost a detective story of knowing there was something there and then going back and having to find
what it is and getting little bits of it." It was more than "hunting them down and coaxing the memories back." Stan's lack of memory about going to the dentist may have been associated with his "fight to get any little memories of the sexual abuse." It was "creating a safe enough climate inside myself or in my emotional life" so that it was alright for these parts to come out. During the period of abuse, it was easy for Stan to "totally forget and totally hide from myself this stuff that was going on" because of his family's [and in particular, his mother's] ability to ignore: "out of sight, out of mind."

In retrospect, his lack of previous cavities probably reinforced his thinking that he "could get away with thinking everything was okay." He described the horror of "that haunted feeling of always knowing that something is wrong, something is terribly wrong, but not knowing what it is and interpreting it always as being 'there is something wrong with me.'" He associated the fact that he became involved in heavy drug usage as a teenager as "a way of actually physically bending reality and mutating reality, saying things are not what they appear to be on the surface." The hallucinogen LSD "takes reality and breaks it in little pieces and says there's something behind it, when for me, in my life...that was a physical metaphor of the fact that this nice little family life on the surface reality is indeed not what it appears to be." By taking drugs he also hid his anxiety and pain and tried "to fill up the holes." He now sees his capacity to totally avoid going to a dentist in the same light as his capacity to totally repress the experiences of being sexually abused. It was not as if he "ever consciously thought "Oh, I need to go to a dentist" and that there was some kind of fear reaction or conscious avoidance of going. "It's just like I didn't even think about it and wasn't even really aware that I was avoiding that." He felt that it was remarkable that something like this could happen.

The experience of being sexually abused also affected Stan's personality. This abuse continued as much as he could determine for at least two years and as long as four or five. He continuously had a high level anxiety and experienced "not liking myself, not trusting myself, not trusting others, and being afraid of much of the world. My sexual abuse experience occurred not only in the home, very close to me [by his grandfather], but also outside in some place like a barber shop, that you're supposed to be able to go to, that everyone goes to normally." With his sense of the lack of safety in either domain: "the whole world became unsafe for me." At least with the use of drugs at least he "could escape internally." Since he started meditating in recent years he found that meditating is better than drugs in that it is not an escape but it is safe and internal.

Stan drew a parallel between dentistry and going to the barber by describing an experience in which his grandfather took him to the barber shop. He remembered being brought out of this back room which was curtained off and being put back in the barber chair. "I was crying; crying my head off" and was "given a sucker: the barber used to give suckers to kids who
were good kids." So "the whole thing about suckers and teeth and sweets", the barber in a white coat like a dentist, and the barber's chair being like a dental chair may "have something to do with avoiding dentists."

Another way that his sexual abuse experience has affected his life is that he would have extremely powerful anxiety attacks whenever he would approach a barber shop in order to have his hair cut. As he would approach a barber shop, his heart would pound, he would have tunnel vision and he would start to sweat. After thinking "oh, no-no, I can't go in that place!" he would then walk around the street spending as long as two to three hours walking from "barber shop to barber shop in total state of anxiety and not getting a haircut." He blamed himself, always thinking he "was just fucked up."

There were other areas of his life besides dentistry, where Stan would engage in avoidant behaviour such as not submitting income tax forms and not getting haircuts. In addition to recognizing the patterns in his avoidant behaviour, he now feels "quite strongly that I've not fulfilled the potential that I have." He sees it as being related "in the sense that all has to do with self-image and liking yourself" and other questions such as "Do you deserve to take care of yourself? 'Do you deserve an education?' and 'do you deserve da-ta-da-ta-da, all those things?'" In addition to the things Stan had lost in his life, "a whole lot more of it was how I would see myself as well." His change in his dental behaviour is "part of the whole change of being more comfortable with [himself], healthier, and taking better care of self." It is likely that his avoidance has affected others more than he "realized." He knows it "affected his partner, although I'm not sure I know exactly how except that she had to apply pressure in order to get me to deal with my dental problems."

Upon reflection, Stan sees his original reasons for avoiding dentistry had to do with his sexual abuse and had nothing to do with dentists. These reasons "contrasted" with his dislike of the way he was treated by subsequent dentists. "Although the results were the same, the causes were different." There was a startling contrast for him between the specialist's office where he was treated impersonally and the office where he felt acknowledged and supported.

His advice to others with problems with dental avoidance would be to find a practice that has respect for people and is non-judgemental. Other criteria for this practice would be to involve the client in the process and sharing information; that practitioners have an awareness of issues that the client might have; that practitioners state and talk openly about these issues; and that they proceed with treatment at the pace the client is comfortable with. Other qualities that would be desirable would be that of having "a counsellor or someone with counsellor skills attached to the practice, and that the client be introduced to the practice and practitioners" before having any work done. Stan also suggested that it would be useful "to set up an information network for
psychologists who deal with sexual abuse" in order to disseminate the knowledge that sexual abuse sometimes results in people avoiding seeking dental care.

Stan described the significance of his teeth as being "kind of metaphoric. The metaphor is as much my self-image as my actual condition." The process of recognizing that he had a serious difficulty and needed to go to a dentist and "beginning healing stuff around [his] teeth" is now "metaphoric of my whole life and the issues around sexual abuse." There is a "kind of permanent damage", "there are the teeth that are gone and its like those parts of me and my experiences that are gone." For him, the meaning of his avoidance is that "it’s one of the sadder results of being sexually abused and all that stuff." Stan felt that as an adult, he has to live with the consequences of what happened to "me as a little kid" but "at the same time healing is definitely taking place and it’s a process over which I have a lot of control and participation and ownership." Although it now bothers him that he cannot chew as well as he would like to, he optimistically states that "as we continue to work on my teeth and do bridges so that some of the holes are gone, that will change."

Narrative Account Three: Larissa

Larissa is 45 years old and was born in Great Britain just after the Second World War. Her father had served as a doctor in the Canadian Medical Corps during the war and her mother, who had completed her training as a teacher, joined him in Britain after the war. Her mother was of English and Irish heritage and her father’s family was principally English with some Danish extraction. Before she was two years old she and her parents moved to a Vancouver Island city, living there for a few months before moving to a small coastal town. She has a younger brother and sister who were born in Canada. When she graduated from high school she moved to Vancouver. She has had 18 years of schooling with two years of post-graduate work and is now working as an anthropologist.

Larissa’s earliest recollections in regard to her teeth and mouth were about laughing a lot as a little child. She did not walk until about 18 months and her mother described her as being "like a Buddha sitting there, you would laugh a lot, your face was very, very expressive." I had a "body remembering of that, being very expressive in the face" but that closed down when she started school, shifting to being more serious and less expressive. She loves making sounds now and feels that this is reflective of herself "as a kid making all kinds of sounds and playing with them." Although she is unable to be specific about what happened at this time of starting school she does have a memory of a sense of "deadness" that came down through her cheeks to her chin. At times when she has felt depressed, it was as if the depression resided in her mouth and cheeks. There was an "extra sagging of the cheeks" where she felt "something unknown."
Larissa felt that while growing up she had a sense of shyness or hiding about her mouth, in expressing, "smiling, showing teeth, barring teeth, even braying with teeth." She found herself keeping her mouth more closed and particularly during puberty she found herself frequently putting her hands over her mouth. Since she recently became more conscious of these dynamics, she feels she is hiding less.

Larissa's first memory of going to a dentist's office, which was located in the junior high school, occurred when she was about eight years old. Everything felt "absolutely enormous and overwhelming,...terrifying, too." As far as she remembered she went by herself to this place that was "huge and cavernous, feeling very small and intimidated." It reminds her of the experiences she used to have in her bedroom with the "room shifting shape and becoming really enormous." When she did some recent work with her therapist "there was a whole thing that came up around some sexual material with my Dad [when she was about eight years old], and that...I would try to get out and the room would shift shape." She found there was "a familiarity between the two senses, the kinesthetic senses of the space and...of [the image of ] the shifting shape." During some recent therapeutic work she was able to trace the sensation of the space in her room changing back to an incident with her father. She was able to go up to the corner of the room from where she could safely renegotiate with her father. As a small child she was unable to do that and instead "the room just shifted shape."

At this first dental office, she was particularly aware of the sound of the drills. She felt as if "my whole being was going to shatter," particularly with the low speed drill and "the grinding away." Her initial experience of being in the dental chair was "holding and freezing and pulling in tight and this whole thing...of seeing this monstrous arm and this needle." She was terrified of the needle and felt like she was going out of control but once the needle was in "it was all right." At the same time she was experiencing the terror, "the little scientist" in her was intrigued with "medicine and body" which was mysterious in that there was "this whole thing of repairing something inside." This sense of intrigue was heightened by going on medical rounds with her father at the hospital.

The attitude in Larissa's family was not "an environment of health promotion, [admonitions about health] were more likely given to prevent you from going wrong in some way" rather than there being a sense of "you've got to take care of your health 'cause this is all you have." This led to Larissa as a child "always feeling a bit guilty" for not brushing, which seems to relate to other aspects of her life. In her family there was this pervading sense of "You should be doing such and such" and "if you're not, well, you're bad." There were the charts in the dentist's office that added to that pervasive sense. The charts had which "these huge teeth...and carrots" had admonishments "of what we were supposed to do and eat." In addition a pervasive sense of guilt about "not doing something properly or not doing enough of [something]", was the guilt of
having cavities. Self-reproach was perpetrated by comparisons between her brother and sister and herself, with the one having the least cavities being praised. "If you had fewer cavities--you were just much better about being a human being." There was also a "mystery" about how you got cavities. Adding to the confusion for Larissa, was the fact that her parents appeared not to care for their own teeth. She never saw her mother taking care of her teeth and never saw caring for teeth as part of a regular family health regime other than "go brush your teeth before you go to bed!" Taking care of your teeth was "invisible in our family" and was reflected in her father also having trouble with his teeth, he now has dentures. Larissa felt that there was a general family attitude about health problems that could be traced to her father who was a doctor and did not like sick people. He viewed most as hypochondriacs. Permeating the family was the sense of "being guilty for being sick" and being considered needy and weak so Larissa was careful "If I hurt myself,...there was no way I'd show it." She experienced a sense of being alone with her pain, of having to be "very stoic" because she would not get any sympathy. Her father's attitude of impatience with illness created confusion for Larissa in that it contrasted with his attentiveness to her when she was sick. With dental cavities she experienced more exposure as she couldn't cover them up like she could physical injuries.

Shortly after attending the clinic in the junior high school, Larissa changed to a dentist in a clinic that her father had started. In that this dentist was in a clinic where the office was smaller than the one in the school. "It didn't have that oppressive space feeling at all." However, going to that dentist seemed like a joyless chore, she would look out the window and "space out." Her sense of guilt about "being wrong" prevailed.

During Larissa's teens, there was nothing that stood out specifically about dentistry although likely "all the things that were going on in my body" regarding puberty were related. She had two operations and "again it was a mystery that I didn't know and somebody else was the authority, and certain actions were taken that I just had to go along with." When she was 14, her father discovered a cyst in her neck that worried him although he did speak about his concern. At 16, a cancer specialist removed the cyst which was found to be benign. This surgery was done with no discussion between Larissa and her father, or Larissa and other medical people. At age 18, she had another experience with someone else being in control of her body. While she was working at a resort in the summer, she had a surprise call from her father. He informed her that she needed to return home ahead of time in order to have the breast reduction surgery that he had arranged for her without her knowledge. Looking back now, she was amazed that she just went along with it, turning over her authority to her father. Although she had been self conscious about the size of her breasts and "not comfortable in her body", she was shocked at the impact of having such surgery. As well as not knowing cosmetic breast surgery existed, she would never have chosen to have such invasive surgery. At the beginning of the procedure she remembers
being under anaesthetic and woke up to "a guy who I had never met before marking on my breasts with a pen." "So there was a sense of feeling violated" by medical personnel and her father and "being under anaesthetic and being out of control. She has since done a considerable amount of therapeutic work "on the whole thing with my breasts" and her sense of being out of control while under the general anaesthetic administered for this surgery.

There are similar elements of lack of control and transgression by health personnel in the events that marked the beginning of Larissa's avoidant experience. This occurred when she was about 35 and lasted until she was almost 45. She had a root canal done by dental specialist who gave her an anaesthetic. She had a hard time coming out of the anaesthetic and the staff were "quite short with me" and not very sympathetic. "Again, the whole feeling that you've done something wrong. I was very, very affected by the anesthetic", and when she reported back to her dentist later "he just brushed it off." That experience reflected back to her the similarity of "being under anaesthetic for my breasts and being out of control" and "being under somebody else's charge and medical experts and not feeling very taken care of." She realizes in thinking back on this situation that she did not participate, "didn't include myself." She "just sort of went along" and it was part of the history she had with her father. "I didn't demand that this was wrong behavior to be treated this way." After her regular dentist brushed off her report of inconsiderate care, she did not seek dental care for the next 10 years.

The factors in Larissa's dental avoidance as she sees them, relate to lack of finances, guilt, and early sexual material. During her avoidant period, Larissa realizes that although she did not have much money she would always make other things a priority, "I'll do that later." She felt she could ignore and deny the necessity of paying attention to her mouth, that it was invisible, inside "where I couldn't see it and nobody had to know." She knows of "several things with my Dad around touching and there's something about the mouth." Larissa did not know whether there was anything specifically about her mouth in these experiences with her father but "there is the whole thing of being invaded,...my space being invaded that may affect...my not going to the dentist." Her sense of boundaries being violated had also affected her relationships with other people in her life. Although she become very expressive in some ways, in other ways, she has remained very private, controlling the degree of her vulnerability, particularly in respect to intimacy. Authority figures such as teachers, dentists, or doctors present a different challenge for her in that she has to develop trust before she's willing to participate. She takes really good care of her boundaries, "where I'll keep them out, and I run the show" so that she can control her vulnerability. She realized looking back over "a lot of areas of my life" that she missed some opportunities with this behaviour but presently felt accepting of herself.

Larissa's attitude to her dental avoidance changed when she learned that from me that dental avoidance was an identified phenomenon. Until that time she "thought I was all alone, it
wasn't something I would ever talk about... I just said it's something that is unique to me" and she did not even identify her avoidance as a problem. She just thought that "it's just something I'll deal with later but I don't have to share that." This new idea that there was something called "dental avoidance" and that a number of people have it" was "really helpful." It "freed me up. I just knew it was getting to a point that I had to do something." Having more money available to her also made a difference as well as recognizing, as she worked therapeutically with her experiences of sexual abuse, that these experiences affected her behaviour in relation to dentistry. The fact that she achieved some resolution of "the whole thing of violation of boundaries" freed her up to face her avoidant behaviour. About that time she also found Dr.R's dental practice. In this practice, there was an empathic approach, and she found herself able to let go of her feelings of guilt about her avoidant behaviour.

Larissa felt that "this whole dental thing" runs in her family and has become alarmed at her mother, who at age 75, is having a "terrible time with her teeth" as well as grinding them. Larissa's mother always had a "oh, I'll take care of it tomorrow" attitude around health. Her mother's serious problems with her teeth and the fact that she and her mother have the same kind of patterns around denial and their teeth have heightened her resolve to take care of her teeth. "I've got to do this now or I'll have nothing left at 75!" Her brother, in contrast, has been very attentive in caring for his teeth. It is likely that her sister has also taken better care of her teeth than Larissa.

Larissa feels that her values are reflective of her "tendency generally in my life to set certain priorities that aren't necessarily like taking care of home and business." She now is more gentle and accepting of herself and her health. "There was a certain rigidity around 'what my body should be', 'what I should do' and 'I'm wrong' or 'there's something wrong with me if I'm not healthy'." She always felt these admonitions in relation to her body shape.

An event which influenced Larissa's avoidant behaviour, occurred when she overheard two women talking about their dental avoidance. They each had a two hour visit in advance of their dental treatment so that they could prepare for their treatment. This enabled her to acknowledge and stop denying her own avoidance. As she worked with immigrant women this past winter she began to be aware that one woman she was counselling required dental care in order to be presentable in a job interview. She realized that unlike this woman, she had the finances and the ability to seek dental care and yet was refusing to. In her work with immigrant women, she has observed that family influences rather than ethnic origin determine health seeking behaviour.

Larissa felt that her mouth and teeth have been significant in her life because there has been "the whole thing of biting through and biting, grabbing onto and grabbing onto life and grabbing onto my life." In the past she had "stayed hidden behind and tried to be soft with it, not
wanted to create any abrasiveness, I want things to stay nice, to be nice with my mouth and not too hard-edged. Looking back she realizes that she should have "bitten through." She looks back on her surgeries and other incidents in her life and now asks "Where was I?...Why wasn't I wanting to know or wanting to be a participant in all of that? Why do I live it with so few questions?" It's like somehow I sort of lost the ability to bite through." She did not have the confidence to stand up for herself and say "See, this is mine!...It felt like I was in somebody else's space [and my body belonged to some one else] and didn't know I had space of my own and boundaries." She lost the sense of who she was and felt very symbiotic with others as she was easily able to enter their spaces. The sensation of this experience felt very sticky,"like being in a marshmallow." Particularly difficult were the spaces involving authority, particularly medical authorities, "like my Father", with whom she lost her sense of her own space. Looking at life from this perspective has given her unique view of her life. She laughingly said "When I view the whole part with the mouth, its a lot about feeling mealy-mouthed."

In retrospect, Larissa felt anger about what happened to her but at this present time, she feels "very firm in my life...that's all sort of my story, and it's led me to where I am and it's...also my gift." As she reflected over her avoidant period, she appreciated that she did a "lot of meandering" as she worked on her Master's degree, developed her abilities to teach creative dance, and was involved in psychotherapy. In the past she did a "lot of tasting" describing her mouth as not being "totally formed and biting off chunks." Now things are "coming to form." The work that she does with women now comes out of the richness of her past experiences.

During her avoidant period she was aware that she was living in her mind and not her body and avoiding things with the body. For instance that although in the past she had "dealt in the emotional realm for years and years on the breast surgery" she "stayed away from the emotional and material realm" of dental avoidance. At this time she was into this thinking, intellectual space but "there was a lot of body stuff that I didn't take care of. In thinking about her teeth, Larissa felt rather embarrassed and judgemental and blames herself for being "weak" in not taking care of them. "Yeah, it's hard just to be human!" As a result of telling her story, she felt agitated and less accepting of herself than she was before talking about her avoidance but at the same time realized that it has helped her to talk about it. In the past two years, with the help of therapy, she has been in the process of reclaiming her body and "this [the mouth] may be one of the last areas that I have reclaimed."

In conclusion, Larissa has found talking about her avoidance and the recognition of it as "a phenomena that happens" with many issues involved, to be very beneficial. She now knows that many people have either specific or non-specific sexual issues which "connect up with the teeth." For her, boundaries and medical personnel that are "into my space and me being out of control under anaesthetic" all "ties in somehow." She was curious to see what evolves out of her
recent "threading" together of these elements. She's aware now that "as soon as I put my hands over my mouth [a thinking posture], I start becoming more aware." She now feels very comfortable with that sense of spaciousness as long as she is the one that sets it up and is in control. "So by not biting through, there's openness, there's space for newness to come in or ideas to ferment." Larissa was excited when she realized that her ten year period of dental abstension had afforded her the time in which to gestate new forms--"now I've got this incredible eclectic experience of [dance, therapy, anthropology, and mythology] that I'm bringing forward....It's so metaphoric! Oooohh!" As she begins to take action and reclaim her body, she exclaimed "I feel like I'm now beginning to really bite through my life, I'm turning forty-five, I mean it's my life!"

Narrative Account Four: Herschel

Herschel is 48 years old and describes himself as being of Celtic descent. His mother was a Cornish woman and his father was of Scottish and Cornish descent. He lived in a rural area of Cornwall, completing 11 years of schooling. His step-father worked as a rigger for the government and his mother as a housewife and later as a nurses' aide. After training as a merchant navy seaman, he travelled extensively, coming to Canada at the age of 22. After living in a small city in the Okanagan area of British Columbia, he came to Vancouver where he worked as a part-time marine attendant on call for four years until a permanent position became available.

Herschel's earliest recollection of a dental experience was, at the age of four or five, going to Dr. H, whose office in a Victorian building was very dark with dark furnishings. Dr. H was near retirement age, and "he smelled a lot of tobacco and it sometimes irritated me." He remembered his antiquated equipment, and the sound of the drill vividly. In those days he was given a general anaesthetic instead of freezing. "Coming through that, feeling very sick, I had some weird dreams whilst under the influence of anaesthetic." Herschel remembered a rubber mask "that smelt like a tunnel. There was a piece of rope going over your ear and they hold the mask to you and hold you down to make it effective. That was absolutely frightening!" In retrospect, he realized that it was likely a dangerous procedure for a dentist to be administering anaesthetic in his office.

This experience occurred after the Second World War and although Herschel knows now that the times were hard, as a child he did not think so. He remembered discussions with his older brother and sister and as they would joke about dentistry, the pain and the general anaesthetic "they would get more angry and frightened." They shared common experiences such as "whether they threw up." His brother and sister drew attention to his two prominent front teeth
by teasing him with the nickname--"Tombstone." His family was poor and "I can remember we
were lucky to have a a toothbrush each." His father would sometimes brush his teeth with soot
from the chimney. "I'm sure he even still has all his own teeth." After his parents divorced when
he was the age of four, his mother remarried. When he was six, Dr.H suggested to Herschel's
mother that he would need braces on his front teeth. Although they were on the National Health
Plan, he "kind of fell through the cracks" and never had his teeth straightened. His mother's "aim
at the time was to keep the peace [with his step-father] and just keep the lid on things" for the
family because of her husband's serious drinking problem. Even though she was interested in
Herschel having his work done, she didn't follow through. "So dentistry or anything like that was a
very low priority. Unless you were absolutely screaming, you wouldn't get to go." In retrospect,
Herschel has been able to understand his parents's behaviour at that time, realizing that their
attitudes reflected the generalized attitude of many people in Cornwall at that time. It is likely that
his attitude about dentistry not being important was influenced by them. He wished that he had
known when he was a child that "life wasn't as hopeless as they portrayed it."

Herschel did not remember anything else about his dental experiences until just before
he came to Canada when he was 22. At that time, he went to a dentist who happened to be from
Vancouver, and "there was a total, a very distinct difference between him and anybody else I'd
ever been to....He actually talked to me and asked my name and where I was born!" Until then
he felt that dentistry was nothing "other then the necessary evil." After that he remembered little
except getting "a couple of fillings in the first three or four years" of being in Canada. "I just went
to a dentist, and that was it....Clinical, in and out, 'thank you!'" Later he went to a dentist because
his girlfriend had worked for this dentist. It was "this very tacky office" with the dentist just running
between his four rooms. "It wasn't very personal, I really remember the feeling, just like one of a
number....'Like pick a number - next!!'...That kind of really put me off."

About two years after that experience, Herschel met a dentist who was a client at the
hotel where he was working. This dentist asked if he would crew for him on his sailboat. He said
"I would love to but I've got a toothache. He [the dentist] said I'll fix you up and we'll go sailing."
He went regularly to his office for dental care for a while. Even though he thought he "really liked
the man....he was a very good dentist and a good person, too", this dentist was very busy.
"There was never anything that was very personal about this kind of care." Even though he had a
friendship with this dentist, Herschel always felt that he was "still one of a number."

Herschel was then out of work and had "no money for quite some time", and a friend,
who worked as a dental hygienist for the same dentist, asked him to come to a study session to
have work done without a fee. "Even though it was a study session, I was sitting in the chair and
it was like I wasn't even there." "Like I wasn't even there! I was not part of this except for 'open
your mouth!'" There wasn't any 'Okay, Herschel, this is what we're going to do, and really you
should be doing this'. ..There was none of that. You know, they should have taken a skull and worked on it 'cause that's all it was." Later his hygienist friend told him that he needed "to have a lot of work done" or he would lose his teeth. She made an appointment for him with Dr. J, a periodontist (specialist in gum disease). When he arrived at Dr. J's, "it was again 'open the mouth' and 'okay, make an appointment and let us know'. They were going to cut the gum back and do all that scraping. There was no conversation between he and I." Herschel had the feeling that Dr. J was "looking down his nose at me." Further complicating his decision about whether he would seek treatment was his lack of finances. "I didn't follow through with it, "much to my chagrin and regret at this particular time" because he believed that this dentist had a very good reputation. In retrospect, he thinks that if Dr. J. had been "really human then, and said 'you've got to get this done', ...just that alone, I would have said 'yeah, sure!' That alone!" If there had been "some kind of communication there, such as, 'if you don't care for your gums you're going to lose your teeth'."

It was at this time, that Herschel was working part-time as a marine attendant and was on call "24 hours a day, 365 days a year." He lived under enormous stress for about four years. He had "to beg just to get a couple of days off together" and found it "pretty rough" having immediate superiors with a "1920's style of management." He "was right at the end of [his] tether" when his name came up for a permanent position.

For a period of about 9 to 10 years, from the time Herschel left Dr. J's office until January of 1992, he did not seek dental care. Throughout this period, he experienced a sense of hopelessness. "I'm going to lose my teeth anyway [some of his teeth were "obviously very loose"], so why seek care, you know I'm just going to prolong it." Herschel knew he was prolonging the inevitable. It "was very much like being in a hole.-.going deeper and deeper." He describes a turning point occurring as a result of attending a weekend training program in which participants work at developing their abilities of personal expression and becoming more active in their lives. Near the conclusion of the workshop, he developed a list of things he was willing to commit to and at the "head of my list was going to a dentist. I mean that's how big it was for me!" He met a woman at this workshop who was a hygienist and she referred him to Dr. R's practice. Within a week he made an appointment, experiencing "a lot of relief." "It wasn't just making an appointment, it was a lot of other things in my life, too, that I was able to do. That was just one of them. Everything started to fall in place a lot better." He just "started taking charge and just not letting things not happen." He described his sense of himself as "I was a lot bigger. It freed me up a lot...with no end to my options."

Herschel credits subsequent changes in his life to being "pretty big' since coming to the new dental practice. When he came in January, 1992, he felt seen for who he was, "not just a number", Everyone is a person....It's done very professionally! and it's a very comforting place to
be." He feels it will be his permanent place to receive care. "It's totally different!" He describes the qualities of the associate dentist as being "a true professional and he's really fun and obviously he likes people a lot." He liked that there was "no B.S. with him, just the straight goods." Herschel felt very much included by the associate's "how's this working? Hey, try this!"

After a recent extraction of his four front teeth which was very traumatic, he experienced "a bleak sense of loss." With his dentist's encouragement, he acknowledged his sadness and was able go through his grieving fairly quickly. After his dental restoration was adjusted, he felt ecstatic about how healed and natural his mouth felt.

Herschel views his decision to seek dental care was "one of the big ones [steps]" in all the new ones he has taken in his life. He has also stopped smoking over a year ago and his general health has improved "dramatically."

For most of Herschel's life he had "had these problems with professionals" and that has affected his responses to dentists. He felt that it likely had come from his background of British attitudes of "a straight British class state." He had a sense that doctors regarded themselves as "Dr. Gods" and an example of a person's interaction with them was "Dr God, please speak to me'; 'I'll tell you what you need to know'." He said that "I've always had a problem with that. It's something other people have I'm sure." He also hated going to doctors and avoided them for the same nine or ten years he avoided dentists. He did not remember having a bad experience with a doctor and recalls his childhood doctor as being a "pretty taciturn man, a Scottish man...but a very nice man." He regarded his experiences of dental and medical avoidance as parallel. He did not know "the reason why I didn't go, apart from never feeling sick."

Herschel felt his avoidant behaviour has "tremendously" affected his life. He knew that he was also avoiding a lot of other things in his life. For example, he avoided relationships, "I always had ports of call, but I never had a destination. I always avoided anything that was strictly long term, there were never any plans." From his earliest childhood, the fact that nothing seemed permanent to him was possibly influenced by him having a stepfather and then going to sea as a young teenager. "I was never in one place for any length of time and for years....I always lived out of suitcases. So it didn't matter if I avoided things, because I was away the next week anyway. For years and years I avoided everybody and just lived for today, the moment." Now things have "shifted" and he is making long term plans; going for regular check-ups to his doctor and thinking about retirement. Looking back, he realized that "just about everybody had been doing it all their lives" but "they didn't do some of the things I did." Although it was always easy for him to pick up and move on, "you can always run, but you can't hide." Now that he has a different perspective, "there's no point in hiding. It's great" although "in some ways it's hard. I hate like hell, now, to leave things."
Now Herschel realizes that health care is "number one" on his list of important things. He feels that his values around money were also reflected in his avoidant behaviour. "I've made a lot of money, I'd waste it a lot because I've always avoided doing anything with it by doing silly things" and never had anything afterwards. He realizes that he could have had a good time on much less money. In recognizing his former behaviour, he does not feel judgemental of his upbringing and accepts that "was just the way it was." He realizes that he "never had instruction from his parents, such as this is how you look after money, and this is what you do with this and this is how you do this'."

Herschel's principle reasons for avoidance he attributed to "a little bit of arrogance of youth." There was also "the feeling of can I really believe what's going on here? Because no dentists were really conversing with me" and there seemed to be different opinions from different dentists. He felt that his dental situation was a big lesson that "appertains to life" which was "to keep searching for the right way to go in anything, and not to let that kind of thing put you off all the time." It is "to persist with whatever you are believing in" and that there are certain things "I can't let slide, I have to seek further. This applies not only to dentistry but to my life, period. I just can't be influenced by this kind of thing anymore." In retrospect, Herschel recognizes that prior to coming to the new practice and taking action that "I was prepared to let things slide or go because they didn't meet my expectations and standards, certainly expectations. Now I view it a little differently", in the past,"my standards were not quite realistic."

For Herschel, the meaning of his avoidance is fraught with regrets. As he thought back on his earlier behaviour he felt a sense of embarrassment, shame and guilt. It was likely that as he engaged in avoidant behaviour, the fact that he was" not one-hundred percent trustworthy [in other areas] had consequences to others." He now feels hopeful of his future, he has "several long term goals in place with more coming." He also feels "more confident and definite about things in [his] life." For Herschel, his changes are "amazing" and he continues "to work through the new changes a lot of the time." He knows now that the condition of his "mouth is almost like a bell weather", if his gums are unhealthy then his "general health is not good." His advice to others is not to let their attitudes get in the way of any health care but to persist until they find what they need.

Narrative Account Five: Kevin

Kevin is 37 years old and was born in Regina. His mother was of English and German descent and his father, of Scottish descent. His mother was a stenographer and an acting sargeant in the reserve army. His father was involved in the plumbing supply business. His stepfather, whom his mother married when Kevin was about eight years old, was a military field
engineer, who later retired as sergeant major. At the age of about nine, his family moved to a small city in the Fraser Valley of British Columbia. Kevin had a brother, sister and step-brother. When Kevin was in his teens, the family spent two years in London, England. He graduated from university with a Bachelor in Education, and spent six years as a part-time graduate student in adult education. At present time he works as a personnel officer.

Kevin's early remembrance of dentistry likely occurred before he was eight years old. He had six to ten adult teeth removed for his small and "crowded mouth." At that time he had general anaesthetic which was likely gas and the physical remembering of that time was of "a real sense of suffocation, panic." There was also "a bad smell" when the mask was placed on his face and he seemed to remember it "hissing" and having "a very foul taste to it, something toxic."

When he was about 10 or 11, Kevin had his first clear remembrance of dentistry. This was of a male dentist who was "extremely rough. It wasn't a pleasant experience." He experienced an emotionally painful time in regard to a medical condition, when he was about 12 years old. He developed a swelling in his neck which his doctor chose not to treat. Two weeks later it became grossly swollen. "I could look down past my chubby little cheeks and I could see my neck protruding past my chin. It was big!...and it hurt like the devil." His mother, unhappy with Kevin's care, found a new doctor. He was then hospitalized and found the intermuscular injections in his buttocks "degrading. These injections of "pain killers and antibiotics" would "for a while take me out of the pain in my throat." Although he found these injections painful he did not react. Everyone said he was "a good little patient" and he was amazed that no one could see how much it hurt. He found this experience very frightening because "the adults were walking around and nobody was doing anything....It was nuts!" and very much reminded him of the previous "torture [the sexual abuse] I went through before." It was "something to endure...everybody commented on how stoic and tough I was." When he was about two or three years old, he had made a promise to himself, that "Nobody else gets control of my body!" In a desperate effort to assert some control over his body, he went two to three days without urinating. He then felt a further violation when the orderly, lifted up the sheet without saying a word, and pushed down on his bladder with his finger. His terror of his hospitalization experience was further exacerbated by being placed on a ward and "watching a lot of chronic smokers die." He also described how "religious trash [was] shoved in your face" by people who 'had got Religion'....So the whole thing was just a nightmare...I basically dealt with it quite superficially at the time."

In terms of family attitude, the only thing Kevin remembered about teeth was his great-grandmother's using a toothbrush and salt or Pepsodent powder to clean her teeth. "She was the only person....Nobody ever talked about teeth...nothing." Although teeth were never talked about he remembered that "there were dentures everywhere!" This was reflective of the attitude of "a heavy dose of denial about a lot of things in my family....where my mother's sex instruction was to..."
leave a pamphlet amongst the towels." In spite of the fact that his "grandmother was a major violent drunk", it was amazing to him that no one ever spoke about the fact that "this woman was nuts!...Were they crazy or what?" He had to endure alone his grandmother's assaults on him which were focussed on his head. She would smother or choke him to get him to submit to her sexual advances. At that time, "a lot of my behaviour was focussed on protecting my younger brother." As far as he knew, he was the only one she assaulted. The fact that no one ever confirmed his experience by talking about it, was traumatic and bewildering for him. Within his family, "there were no confidences: all were secrets."

Looking back, he now feels that this and other promises he made while very young probably relate to the sexual abuse that he experienced which started when he was about 18 months and continued until he was about six. As he gathered memories "like a blind man putting together the puzzle", he felt that there may have been one other person, besides his grandmother, who abused him. He knows now that it is likely the difficulties he has around his head and his mouth stem from those experiences. "I don't like having people grab my throat, funny enough!...I have have difficulties with having moisture across my face."

Kevin had a reoccurring nightmare which began in his childhood. It "was this feeling of being separated from my body and falling inside while everything else around my body shoots up." Another description of this same feeling: "there's this part of me that's collapsing inside my body, while the outside of my body expands and then just the sense of everything outside of me is just expanding....Everything get larger while I'm dropping. It's the strangest, strangest feeling. It's a very powerful one for me and I have a real sense of panic." At times he could bring it on by just sitting and thinking of a particular image. "I had an image in my head of this standing on the outside of this golfball-like thing and buildings shooting up by me, me dropping down." When he was around 9 or 10 years old he used to do it as a game to amuse himself. "The older I got the harder it's been to do it" and it's very difficult now for him to bring it on. Although in the past this experience had sometimes spontaneously occurred to him when he has been in the dental chair, the nightmares probably stopped sometime in his early teens. Reoccurrences of these nightmares began during the period which preceded him seeking therapy and lasted for about five years. The nightmare would begin just as his body was relaxing with sleep at night, and he would wake everyone up with his shouting.

Later, while attending school in Britain at the ages of 13 and 14, Kevin recalls that "sitting in the chair...and having fillings done without the freezing was not fun." He felt like "I was a human slab....So if he [the dentist] tried to do that to me again I think I would fight back. That was an assault!"

As far as his siblings' dental health attitudes, Kevin describes his younger brother as being very different that him in personality and that this is reflected in him having all of his teeth.
"If I'm Oscar Madison, he's Felix Unger....He would vacuum the bedroom daily and I would give him cause to!" His sister made a conscious decision, because her teeth "were rotting on her" at the age of 29, to have all of her teeth extracted. "It was a great relief to her." Kevin felt his sister's teeth were reflective of those of his mother who had "the very soft teeth that came in this form." Kevin's mother recounted to him the story of the loss of her teeth. The dentist just "pulled her teeth and 'jammed' the dentures in."

Although Kevin's family's behaviour "sometimes makes him nuts", they consider him the odd one in the family. In the past he has gone through periods of "hypochondria" in which he knew he had to take care of himself although he was not sure how to do that. He would be the one in his family that would "get the books on how to take care of your body." Sometimes he would get to the point where he "would obsessively eat or not eat, or exercise or not exercise." To the chagrin of his stepfather, he "ended up in the Ed Faculty instead of something harder in terms of physical theory. I'm the people person of the bunch." Although his family appears to be thankful for it, "they don't know how to cope with it...I was able to parent the other kids, better than my parents could." It was not that his mother was neglectful, it was that he was "always able to relate to my siblings and deal with their needs a lot better than an adult could." He now realizes that although he was an important person in his family's upbringing that this "was out of place."

At age 19 or 20, prior to graduating from university, Kevin had to have his newly erupting wisdom teeth removed by a dental surgeon. Eventually he went back to the same referring dentist for dental treatment when "the pain got so bad that I just couldn't stand it anymore." "It was at the point where I couldn't function. It'd be so bad I'd just have to go in or I couldn't walk around." During a period of four years, he probably saw this dentist about four times.

Then began Kevin's first avoidant period, which lasted approximately seven years, from age 22 to 29. During this time, "I didn't know why [I avoided],...but it was pretty well a conscious decision every day not to deal with it." Then it got to the point, by this time he was married, when he was not able to sleep at night because of his pain and anxiety over losing his teeth. His behaviour would wake up his wife. "I was basically getting hysterical by then." This anxiety related to the fear he had of being like his family. He associated his possible loss with the fact that his mother, his grandparents and sister had all "lost their teeth. It was a frightening fear, because I didn't understand it although I do now." Some of it was reaction to "just the physical pain of having untended teeth." The intensity of this experience was partially associated with a promise he had made to himself when he was three or four years old when "I promised myself not to be like the people around me." In addition to this promise was the fact that "I have a lot of issues about my mouth and stuff and having control of my mouth and that sort of thing is really important to me. So the thought of being without my teeth was really debilitating!" The whole
situation was exacerbated by "just being in a lot of pain. I can live with pain but it was probably the two things together."

This period of avoidance ended when Kevin asked his wife to find him another dentist "because I basically said I can't deal with this." She found "a Dr.T" and Kevin was attracted to him because he experienced this dentist as being more trustworthy than previous dentists. Although this dentist did excellent work, Kevin felt "betrayed" by him. He used hypnosis, when in Kevin's opinion, it was an inappropriate intervention given the severity of his fear. He felt disappointed when this dentist "did not understand me...He is fooling himself if he thinks he's doing hypnosis on people" because "he wasn't doing what he thought he was doing." Kevin feels that his appraisal of Dr.T's hypnotic technique was perhaps unfair because he had "been able to do things in and out of his body" previous to this hypnotic experience. "As soon as I sat in the chair I was out of my body and I was gone. I don't know what he was hypnotizing. I wasn't there." The dentist would say "I don't know why you think you have problems... Look at you, you just lay there!" Over a year and a half period, he went three times in order to complete all the work that he needed done. "It was difficulty for me to go back, I had difficulty facing him again." Although everything looked fine with Kevin on the outside, "usually I'm barren inside....I'm gone. And I don't want to go through life not inside my body anymore."

Kevin then began another period of avoidance when he was 30. The duration of this period was approximately six years. His avoidance related to a pattern that occurred with his seeking care with each of these two dentists; "It was difficult to go. It was difficult to make appointments. It was just difficult to get back. And its a feeling I've had in other situations in my life" such as when "It was extremely difficult to go to class." His options were that he either had to "go to all classes or to none." If he missed one or two classes, it was almost impossible for him to go back. Fortunately he was bright enough that he "could wing it, write exams without attending classes." He did not feel claustrophobic or trapped but "couldn't go back and 'face them', that's the phrase...'face them', I couldn't let people see me again." He had this experience with most of his professors. "Without any pressure to go in, it was easier to avoid going in than facing it." Kevin really wanted help at this time but he was not sure how to get it. It felt like a double bind to him. On one hand, he did not want to be found out, and on the other, he "did not know what it was that [he] did not want to be found out about." There was "a lot of embarrassment, shame, and real feelings of inadequacy, of not being good enough." At that time, he had "no one to let me know that I'm not crazy." It is only recently that he has the ability to do his own "reality check. Then it never dawned on me to ask for help."

The formidableness of "facing" someone was also reflected in Kevin's behaviour towards himself. When he is 'looking at myself in mirrors." "I have difficulty facing myself. I'm dealing with a lot of shame, and things that make me uncomfortable, and looking at parts of myself I've
not wanted to even acknowledge." Because he has been the recipient of violent behaviour in his family, he is fearful of being an offender himself. "I can't look at myself." He found "the thought is just nauseating. He fears that he will not be a decent parent, will not be able "to hold it together long enough and just not being good enough." In his experience, adults have not been too reliable and in his therapy he is beginning "to learn that you can have adult emotions and still be reliable." He found that "you have to admit to that shadow stuff." He finds now that "I'm starting to bring it together, but I don't know about accepting [parts of himself]." He has felt such revulsion as he retrieves early memories that he "want[s] to have a shower after."

Kevin said that his pattern of avoidance began changing at age thirty-one. Nine months after the birth of his first son, he re-entered "a starvation-exercise" phase which was followed by "a binge eating-anxiety" phase. He realized the severity of his difficulty and sought psychiatric help. This was unsuccessful. He felt that the use of drugs to solve his problem was not helpful. He knew "something was wrong and what I had been experiencing previously, just wasn't right." Until that time, he had had a life theme which was "'On or Off'. A lot me was designed for survival from my family."

In addition to the difficulty he was having attending classes, he also was having difficulty in concentrating. In his fourth and fifth year "I was close to being booked into the Psych Hospital, just for observation, because I had the shakes." He would have cycles of depression, withdrawal, and isolation accompanied by headaches. Because it was what Kevin was used to, "it didn't dawn on me there was any other way of doing things." About this time, he and his wife had a second child, a daughter. He realized that he could not parent children and handle his difficulties at the same time. It took him a while to find a therapist that he could be with long enough to trust and for the past two and-a-half years he has been seeing his present therapist. During "the process of giving up secrets", the secret of his dental avoidance came up and his therapist referred him to me for counselling for his difficulty in seeking care for his teeth. After two counselling sessions, he decided to go to Dr. S's practice. From there "it took that level" where he was "trying to change some of the promises I'd made to myself [as a child]. So I'm starting to make new ones that try and replace the old ones...with some adult promises."

Even though Kevin was satisfied with his present dentist, a third avoidant period began for him over a seven month period in 1992, when he began to uncover more details of his childhood experience of sexual abuse. This period was similar to his other two periods of dental avoidance with patterns of behaviour repeating themselves. During these periods, he said that "I can't even take care of my mouth. There's a cluster of things. Part of it's the mouth. I have difficulty, I tend to wear the same clothes, eat the same foods, my weight fluctuates." He has learned to connect with his "emotions and spirit", but he still struggles with being "back in [his] body" which makes it difficult for him to care for his body. When he is self-abusive now, he asks
himself: “who am I trying to destroy?” He has become aware that his “dental avoidance has been caught up in this. Normally I would get quite depressed, which hasn't been happening, that's something that has changed.” He now experiences a great deal of anxiety instead “which I suppose is better, but things are slowly unthawing, so that's happening.”

Kevin has found that as he goes through therapy uncovering the patterns of abuse in his life, that "I don’t have clear pictures of it, but my body seems to remember, and so being in a certain position in the dental chair and...if I don’t disassociate from myself and if I’m in a certain position in the chair and if my face or neck are touched in a certain way, it really causes me a lot of discomfort." He is beginning to retrieve memories of smells. During a recent appointment with a woman barber, the smell of her body odour triggered old aversions. This was a stronger aversion than he feels when he is having his teeth cleaned. In July, 1992, he had an appointment with the hygienist for cleaning and in order to prepare himself in advance sought counselling for his anxiety. When contemplating the hygiene appointment he realized that "I did not want to sit in that chair and lay back in it....It was my body reacting, I was having a great deal of difficulty, I really felt a lot of anxiety." He had a "real fear reaction" in which his heart pounded. "I cried all the way [to the office] in the car. I was just about hysterical." As he spoke about this he began to cry saying “so even now it leaps at me sometimes.” On his way to the dental office, he alternated between coming and not coming, but rationalized to himself that "now I've committed to come and I've got a safe place." In the past his fear of dentistry has never prevented him from keeping an appointment: "usually once I make a commitment, [I] always follow through."

One of his biggest fears is being out of control, "I don't like things to be out of control, least of all myself. So the thought of panicking in the chair and and getting up and walking out is really, really disgusting to me and to have people witness that would really bother me a lot." He realized that in Dr.S’s practice he can give himself permission to be out of control. "I'm feeling a lot more comfortable with letting myself, if that happens, it happens, and I can come back and face it." His improved interpersonal skills combined with being acknowledged by his new dentist, has led to him being able to relate to people better. He now feels comfortable with Dr.S as his dentist, because "I can now look up and see a human face."

The impetus to overcome his avoidance has come also from Kevin's desire to provide modelling for his children around their "dental hygiene and their relationship with their dentist" in a way that was lacking for him. His parenting skills have come through observation of others, "I've seen how other people have done it and I'm choosing to do it a different way." He emphasizes that it is not enough to disagree with others but that he needs to take action in order to be a responsible parent - "I also have to commit to it and do it!" which means that "I gotta deal with the rest of the shit!" He began to cry as he struggled with the emotional impact of this situation.
At present time Kevin is going through a "really disturbing period" as he changes the "traditional way" he has acted in the past and "it's scaring the hell out of my mother." He felt that he cannot take a lot of her pain and loneliness about the recent death of his stepfather. He just doesn't "know how to have a relationship with my mother right now because of that." Now he knows that she has had an even more violent situation growing up than he did but he is not prepared to "deal with somebody else's denial right now. I have enough trouble with my own." He felt that if he should disclose to her what he knows about the past, it might be traumatic: "if I hold up the mirror, its not the mirror that's going to be broken, it's gonna be me. I think she really believes that nothing did happen."

In relation to dental treatment, the drill does not bother Kevin nor does "the burning decay material smell." Although the dam has bothered him a little, he realized that part of it was the invasion of "people looking in my mouth, having their hands in my mouth, laying back and letting people do that, coming in and facing people....there is a degree of intimacy to it that I wasn't comfortable with....at least in the past there was a point that I probably would have died before I would have been intimate. And it came close to that...the fear of intimacy."

As he looked over his seeking of health care, Kevin recognized that he used to go to physicians looking for help "and not knowing what the help was. I now know what it is I was probably looking for but I never went to a dentist for it...which strikes me as odd." In his opinion, his high pain threshold relates to his "unwillingness to do something" about what is causing his pain. There appeared to be a hierarchy of health seeking behaviour with him rarely seeking help for things relating to his head such as painful teeth or even migraines. He would get "quite desperate before I sought help with these."

Since attempting to come to terms with his avoidant behaviour, Kevin is feeling less fearful and more connected to his family-of-origin. "I'm not as fearful I put my own family's experience into perspective. Having dentures isn't quiet the debilitating fear it was. I know I'll probably be okay. [Laughing] I might survive the rest of my life! As far as my teeth are concerned I'm more hopeful." In general now he feels he is less isolated from his wife and children. "Usually when I have periods of avoidance, generally I withdraw from my family. It's not as much now because I'm really aware of it. I still have periods where I lose my focus and I withdraw completely but it's not like it was. I'm now more of a partner than I was before."

Kevin's advice to others was to "Be persistent. Seek out people that make sense of their experience as opposed to those who buy into cultural messages that keep you from seeking help. Dental avoidance can't be separated from how you experience life in society. Some suffer abuse; some are neglected by society when they are told: 'you are not a good little boy, or good little girl. You're bad.' Then there's often no place to go with your experience of shame."
Kevin felt that his avoidant behaviour is tied into his self-esteem. "I have a lot of shame about my mouth" and although the avoidance may not have caused that he feels that it may be connected. When he is able to take care of his dental health "it's a great sense of comfort...it's a way of taking care of myself, and that's what I'm trying to learn to do. And if my mouth is healthy, I feel better about myself. If it's not healthy, it's one more reminder that I'm not good enough." He has found that when he takes care of his teeth then he is usually taking better care of himself generally. For him, there's "a cluster of things" such as bingeing that appear to be connected and what he is "trying to do is not to have and On-Off switch, but a dimmer switch. I want to be a little more 'green' in the use of my energy here. Yeah, I'm trying to moderate most of the things that I'm doing in dental hygiene. Usually if I'm taking care of my teeth I'm flossing once a day and brushing three times and at the same time I'm probably over-exercising, being too careful with the diet...So I'm trying to be less obsessive about things and find a happy medium." He laughingly said "and the period of the pendulum is less every time, so, in another eighty years!"

For Kevin, "dental avoidance is a barometer. If I'm avoiding, and I am right now, I know that I'm in a period of personal change when the past is catching up with me. My esteem is bad. What I'm using now is a marker and I know I'll get through it, then it's a matter of turning it back on track and trying to be persistent. It used to be to take care of teeth was a behavioral thing that I could teach my self, and there's still an element of that. But now I appreciate how strongly tied my emotions are to my self-esteem and how I care for myself. Dental avoidance is tied in with how I care for my body. In an avoidance period, I try to avoid myself as much as possible. I have difficulty looking in mirrors. If you have a bad experience [such as the 'emotional flooding' he has been experiencing recently], you have to care for yourself afterwards and there's just not enough energy." As he reflected on the past, he became aware that he "had never pictured myself in tomorrow." With that perspective, he became involved in activities which were extremely risky. He knows now that his compulsive behaviour was an attempt to numb, smother, and repress his reoccurring feeling that "something [ominous] was going to happen." In the past, when "a moment was so painful" that he could "not see self in future", he contemplated suicide. So vehement is he about "not being like my family", that he declared he would "kill myself before being like them." At one time, he used to feel "there was never an end" to his sense of being overwhelmed as emotions surface. In spite of his anguish over the painful process of healing from his abuse, Kevin has a keen sense of humour which has greatly helped him to keep things in balance.

He is now feeling a greater sense of self-assurance, knowing he "can get back on track." He now feels more hopeful at this point in his life than he has in a long time and he has taken a great deal, especially his psychotherapy, on the "faith that I would get through it." Kevin is now entering a new phase as he begins work with a new therapist. He recognized how much he had
changed as he works at planning for the future and finding a balance between "pushing the body stuff and not traumatizing" himself. "I want to have moderate possession of my faculties. I want to do it differently this time [in his present dental practice]." Although he found describing some aspects of his avoidance painful, he laughingly said: "It beats donating my brain. At least I can read the thesis and still appreciate it!"

Narrative Account Six: George

George was born in Winnipeg 85 years ago. His father was Scottish and his mother was from a Pennsylvania Dutch family of German extraction. His father was a buyer for a major dry goods firm and his mother, who had attended university, taught school for a short time. George's parents, in their concern for his education, sent him to Upper Canada College in Ontario, at the age of fourteen. Upon graduation from high school, he studied at a university for five years. During his lifetime, he has been a minister, pastoral counsellor, columnist, and in his retirement continues to live vigorously. He travels to visit friends, writes, and hosts celebratory musical events.

Although George cannot remember anything specific about dentistry in his early years he does "remember a general dislike for it...a general abhorrence of the idea of putting myself in the hands of a dentist." A strong memory of himself as a boy of eight or older was evoked as George considered his fears. He had a very vivid image of a partial plate of his father's: "I can see that plate, right now, just as clear as a bell." His father used to put this partial plate out at night. "He was careful about it, he wasn't brash about it at all." He remembers having "an awful feeling...a feeling of revulsion about that." This plate would have come out of his father's mouth and he related it to the fact that "it was done by the dentist!" and he feels that this may be associated to his early experience of not liking to go to a dentist. "That's the only thing I can think of that might be related at all....that this may have been the start of it because that had something to do with the dentist." George deducted that he had likely only received dental care for emergencies up until the age of 14. At this age, he went away to a boy's college and did not seek care until he was 23. For the next 47 years, George only sought care on an emergency basis.

At age 70, he realized that he needed some more extensive work done and sought help from a dentist. At that time, the dentist gave him "a shot for a filling or something or other, then feeling afraid because I had a feeling, I suppose in my heart, and the dentist said to me 'are you all right?'...and the nurse came and somebody else came and they all wanted to know if I was all right and they said 'Well, you just lie here for a while and see how you feel' and then then went out of the room and left me for what seemed to be about 10 minutes and then my heart gradually got better and then they went ahead with the work." As he was sitting in the chair he thought to
himself that "perhaps I'm not alone, they are just around the corner watching me....surely they
wouldn't go away if there was anything serious, but I guess I was afraid." Even though George did
not know whether "this heart thing was heart or whether it was just something the shot did to me",
it is likely that he had had heart palpitations as a reaction to the dental anaesthetic.

For the following 12 years, George entered an avoidant period when he only went once
for dental care. He had a vivid and unpleasant experience as a result of the attitude and
behaviour of the hygienist who was cleaning his teeth and "discovering what the doctor would
later need to know." She was "unfeeling and almost rough...I don't imagine she was but it felt that
way to me, that she didn't care when it hurt or when it bothered me." She was in a hurry "and
was going to get this done, now, quickly." Although the atmosphere of this office appeared to him
as "dark and miserable" he was not sure whether that was because of the hygienist's treatment of
him or that the office was actually that way.

George's avoidant period continued until 1988, when he briefly sought counselling with
me in an effort to allay his fears regarding dentists. Before he had completed his counselling, as
a result of a painful tooth he sought emergency help with Dr.K. Dr.K "graciously offered" to see
him out of office hours and he is not sure whether he pulled or treated a tooth: "that was a
lifesaver for me." Dr.K, when I had to come back to him because the former treatment was
temporary "very thoughtfully and kindly put me in the hands of a hygienist" and explained to her
my discomfort with dentistry. She was altogether different from that other experience I had. She
was kind and sensitive and careful and in no hurry, and kept saying to me 'now if you want to quit,
we can finish this again some other time'." So although he had a good feeling about this
experience and felt that Dr.K had gone out of his way to treat him "carefully and acknowledge the
fact that it was difficult for me....When I finished [my restorative work] with him, I vowed I'd never
go back again. It isn't because of any way Dr.K treated me or his hygienist treated me--it was
perfect."

He found this response "a very strange thing" and does not know "what the deuce it is,
because it isn't a fear of being hurt. There is nothing that hurts me particularly." He did not like
"the drilling much" but has no fear of needles. "It's simply I don't want to be touched in the
mouth!" He still experiences a dislike for brushing his teeth which goes back as far as he can
remember. "It wasn't a terrible thing, but I just didn't want to ....but I [as a child] was sort of tickled"
when I forgot, to wash, to brush my teeth. I was glad that I didn't."

During this time George was seeing Dr.K he was referred to a dental surgeon and found
this experience disconcerting. At the beginning the doctor was going to give him a general
anaesthetic, "and then he decided because of my age or something, he hadn't better, and he
explained this after I was down on the chair already. I was expecting to have a general
anaesthetic. That was the arrangement. And he just casually told me that he wanted to give me
a local anaesthetic and went ahead with it." In retrospect, George was glad that the specialist did not give him an anaesthetic because it turned out fine....But I don't want to have another one like that either." He later had to go back to the specialist because he felt "a sort of hard thing coming out of the gum from the place where he had taken" the tooth away. The doctor just felt in there and said "oh, its nothing, just wait, it'll look after itself. Now, I didn't think he gave me enough time to understand that." George felt "that he didn't give me any credit for that at all." Rather than be dismissed by this dentist, he would have liked to have had him explain what was happening in such a way that he could have understood. In the past, he has never felt having a tooth extracted was "much of a turmoil for me" until this disturbing experience with this dentist.

His mother had healthy teeth throughout her life. When she died at the age of 89 she had all her own teeth and only one filling. His parents neither taught him to brush his teeth nor "bullied" him into brushing. His parents just "thought that I always brushed them." He remembered very little about his parents attitudes to health, although he was aware that his father "made himself sick at times, when he didn't want to do something.....I don't know whether it was true or not, I just had that feeling....And he would spend mornings in bed, and didn't want anyone to know it, and would give instructions to Mother and to me what to say if anybody phoned." He felt his father was very afraid of health problems whereas "Mother wasn't...She was relatively very healthy....But my father, he bothered me in the health area." George did not know what health difficulties his father had. As far as he knew his parents were not "interested in health in any positive sort of way. They just put up with things if there was trouble." His father coped "in a more childish sort of way" but he's not sure whether they ever talked about the value of George looking after his health. In contrast to his parents, he describes himself as "mildly interested in being well. That is I'm miles from being fanatical about it." He felt that "in this day and age when everybody's feeling more interested in health, that must sound stupid."

George's behaviour around his dental avoidance were "a mystery" to him. The meaning of his avoidance to him, may relate to the fact that he may "feel a bit badly about myself because I have fear. I have every reason to believe I could be rid of it. It is a defeat, but I don't stay awake and worry about it. I got to wondering if there was anything else vaguely like this in my life. And I don't think there is. The only thing that comes within a mile of it is I don't like being in high places and looking down when there isn't a big fence or a banister in front of me." He feels that this is likely not related because he is not afraid of flying or going up in an elevator. "I thought of all sorts of fear I might have" but there is nothing he can relate this to. When considering his sensitivity in relation to others, he feels that he has had "a rather healthy sensitivity in regards to relationships.

George cited a medical experience which occurred in his teens when he was at Upper Canada College. He had rheumatism which started in the big toe on his right foot and which he
describes as "the funniest darn thing." He "had to make up some wild story" about dropping a drawer on his toe in order to persuade the nurse to admit him to the sick room. To his chagrin, two days later the rheumatism shifted to his left foot and gradually progressed throughout his body before dissappating.

When George was about 40, a medical experience occurred which he feels "certainly takes the medal for the big one. I had shingles of the middle ear" of which he exclaimed "I feel perfectly justified in saying it was terrifying because I don't know how anyone could have gone through it without being scared to death. It was awful!" One day he felt a "little funny feeling, almost like a movement in the top of my head." The next day he woke up to find he was dizzy and even lying still there everything was going around and around in circle and then the bed went up to the ceiling. And I was hanging onto the bed to keep from falling down. Oh, gee, I was scared!" His wife called the ambulance, and when the ambulance drivers arrived, "I was going to say they got me down off the ceiling! Isn't that funny! That's how real it was, though." When they put him onto the stretcher, "oh, that terrified me! because I didn't feel like I was safe on it." As they carried him out and placed him in the ambulance the movement was "awful!" Over a period of weeks "it gradually got better." His condition was so serious that during that time he had seven doctors. His "doctor who was my specialist for ears...told me that there was no reason in the world why I had any hearing at all...and the doctor that was a specialist for eyes...said he didn't know how my eyes lasted."

In September of 1990 during a lengthy hospitalization for heart and lung complications, George's doctor inserted a urinary "catheter--that drove me batty too! [similar to having someone work in his mouth]." Physically it was a bit painful but it was more the idea of it. "I don't think that's the connection with the dentist thing...although in one way it's a similar kind of fear. I'd hate to have to go back to that guy [the doctor] even though he's good and I know him." He agreed that it might be his response rather than the actual procedure that was so frightening.

When considering the meaning that his avoidant dental behaviour has had for him he remarked "ordinarily you'd think a person would be sort of ashamed of that kind of fear, or even ashamed of not going into it even if you are afraid....But I don't, I feel sort of good that I'm that way. Anything to keep from going and doing it, you see? So I suppose I've buried some sort of courage and good sense that I really have because I don't like the discomfort of using those things....the courage and the wisdom." He feels that his dental health has not suffered from his avoidance although he concedes that "probably Dr.K would think so." His observation that he gets "little twinges about twice a year" but he thinks that "probably it has nothing to do with teeth" may be reflective of the possibility that he has less sensitivity in his mouth now that he is older. Although he did not think that his fear of dentistry had affected his daughters' attitudes towards dentistry, he suggested that I check with one of his daughters who arrived after our second
interview. His daughter exclaimed emphatically that his attitude had severely affected both her and her sister's attitudes towards dentists. She had gone through an avoidant period several years before and as a result had been told by two specialists that she would lose all of her teeth. Unwilling to concede to such a dismal prospect, she found a dentist who was willing to work with her. Under her dentist's gentle and reassuring care she was able to save all but three of her teeth and overcome her fear of dentistry. She had recently admonished her sister who has been avoiding dentists for the past 10 years that she needs to seek care immediately.

In conclusion, George stated that "I'd like to underline the business of it being a mystery to me because, I really feel like I'm pretty well able to face up to and handle almost anything, and do pretty well, even things like financial things, or family things, or whatever. But I can't handle this And I'm not struggling at it though....I've sort of agreed to put it off....Agreed with myself that I don't need to punish myself by doing something about it. I know otherwise, but that's what I feel. Yeah, mystery is the big word. I can't understand it. But I don't want to." He describes his telling of his story as "I've felt my way....I obviously didn't have anything made up to say, I just gave you my feelings as truthfully as I could. In connection with my father, I feel too that I had an unhappy feeling towards him....And so, with this unhappy feeling between us, those teeth [the partial plate] meant more still."

Narrative Account Seven: Kim

Kim is 33 years old and was born in Calgary. His mother is Canadian; of English and Scottish descent and his father; Canadian, of Irish and English descent. His father was a land surveyor; his mother worked as a homemaker, teacher, receptionist-office manager. When he was seven years old, he and his family moved to a small city in the Okanagan area of British Columbia where they lived for four years. Subsequently, they moved to a city in the interior of British Columbia where they lived for five years with his parents.

Kim had no recollection "of being a kid." He assumed early responsibility in his family as the eldest of four children who were very close in age. During his teens, he was very active in athletics. "I was good at everything I played" which included hockey, football, soccer, rugby, baseball through which he picked up enough skills to compete in track and field. He was offered opportunities to become a professional in several fields. "When I look back on it I'm really glad that I did all the things I did, but I also really regret the fact that I never focussed on anything. I was very good at everything, but not exceptional at anything." In spite of his successes, "even in high school, I knew there was something missing, that wasn't quite right." Although he thinks that he had a fairly powerful singing voice during his developing years, he became discouraged by others' responses. "So I began to believe I couldn't sing" and did not pursue his inclination until
this past year. Until recently, Kim performed for audiences as a storyteller. His abilities were reflected as he told his story of dental avoidance.

Kim’s first dentist was a Dr. M in Calgary and he "had nothing but good feelings about this man." Kim’s family considered him a friend of the family that they respected for his personal and professional abilities. Although Kim did not look forward to going to him, he cannot "remember being hurt by him. It was a really good experience and I didn’t grow up being afraid of dentists or anything." Most of the time when Kim went it was to wait in the office while his brother's teeth were being cared for. They had to go frequently as his brother had been "premature and had lousy teeth."

Later when he went to the Okanagan, he remembered that "the thing I hated most about going to the dentist was the freezing." He hated "the length of time it stays in, the feeling of being numb, and that it hurts as it's leaving." So this dentist once tried "to do the work without freezing to try to accommodate me and that semi-worked." Although he described himself as sensitive to what is occurring in his mouth, surprisingly he has been able to tolerate high levels of pain. It had been only recently that he was able to tolerate rubber dams. "No one ever told me why or who it was for. I'm not a big fan of needles, find it uncomfortable to swallow fluid in mouth, and don't like the tastes. Anyone who tells you they like the sound of drills is lying." On more than one occasion he was driven "up the wall" when the dentist's assistant would not let him cross his arms. Charitably he suggested that during her training "someone must have told her that you would not get relaxation with arms crossed." This experience may contributed to his subsequent distrust of professionals.

When he moved to the interior city, he liked his new dentist as a person despite his "ultra-authoritarian" manner which made it difficult for him to keep staff. At one time, Kim suggested that if this dentist wished to share his practice, he would be interested in going into dentistry. In retrospect, he believes that this dentist did some unnecessary work. "I remember one occasion in particular where...I was brushing things under the gums and they started to swell up. My Mom was really worried about it and she phoned the dentist and said my teeth were abscessing....and so he made room for us." The dentist said that "this is not an abscess,....it looks to me like you're brushing things under your gum." He cleaned it out and went ahead and filled something anyway. And to this day I'm not sure that it needed to be done. A number of years later the filling fell out." Kim left that tooth for more than 10 years before having it repaired. "What needed to happen was that somebody needed to spend some time showing me how to brush my teeth so that the swelling didn't happen again rather than filling it and doing the dental work....I guess my feeling was that, now that I'm in the office and he's made the time for me, he's going to do something rather than looking at it and deciding whether something really needs to be done." So
great was his sense of betrayal because of this one experience with his dentist, Kim developed a deep mistrust of professionals.

From the time Kim was 18 until he was 24, his dental attending habits became inconsistent. He sought help only "a few times" during the next few years, on the occasions when he would be visiting his parents. This was the beginning of a nine year period during which he rarely sought help for his dental needs. In addition to the issue of trust with regard to dentists, another factor was that he was no longer on his parents dental insurance. At this time he was developing his "own sense of responsibility." Now "it wasn't just going and having the checkup" but he asked himself "Why am I doing this?...I don't need to go here for his [the dentist's] benefit. What am I getting out of it? Since my finances were tight anyway, if my teeth weren't bothering me, then why go in? And then, when my teeth did start to bother me, it seemed like when I went back in that the things performed didn't solve the problem anyway." His inability to have dentists alleviate his problems, in addition to his previous issues about not trusting them to only do necessary work, exacerbated his resistance to seeking dental care. In order to "make do" with the problems with his teeth and to stay away from dentists, "it was easier to chew differently", adjusting his bite to the condition of his mouth. This "has been more successful than having somebody go in and try and fix the problem." In reflecting on where his stoicism may have come from, he laughingly suggested it might "have something to do with being born in Calgary."

Kim's life "changed drastically" after high school. When he was 18, as a recipient of a Rotary exchange scholarship he spent a year in the Phillipines completing his first year of university. "When I went and lived in a country where I was being hosted by people of incredible wealth and surrounded with just abject poverty of the worst kind, it just blew me away!....It was also the first time that I had to live as a minority." This was the first time that he got "to the point where I questioned some of my parents values and...some of our societal values and ideals, but I had never seen them from the outside. So I had a real collapse of faith...in the goals and ideals I'd grown up with....I was supposedly on a fast track somewhere. I was off to University to get a business degree and might have taken over Dad's business, but something happened on my exchange that I spent a lot of time in tears, a lot of times; very, very lonely. It was a very, very traumatic year. I had some emotionally ecstatic times and some just emotionally crushing times. And I haven't looked at the world in the same way since then."

Kim returned to Vancouver from the Phillipines in order to attend university where he later completed an honour's degree in economics. "[W]hen I was down at the Coast, again I got the sense that what was being proposed wasn't really necessary. And I went back home a couple of time when I was still on my parent's insurance and had some work done." When Kim broke a "cusp" off his molar, "they attempted to build it up and...it broke off twice - It got crushed out and
then rather than going back to get it fixed, I just broke off the little pins that they put in there and just went on and it lasted...for over 10 years."

Kim’s distrust of professionals continued to grow. This distrust may have been exacerbated by his strong need to be in control. Later, when he took economics, his distrust was validated by theory. Kim found out that "the classic example of this phenomenon [of performing unnecessary procedures] was physicians and appendectomies. The concentration of physicians goes up and the number of appendectomies in the population goes up....In my mind now I feel the same way about going to doctors as I do about going to dentists. You go there and they find something wrong and fix it, rather than giving me some sense of what needs to be done and satisfying that need....I only went to the dentist because you go to the dentist regularly."

For an 18 month period, when he was 24, he and a friend went on a cycling trip in Australia and New Zealand and while overseas he experienced his first period of dental avoidance. After returning to Canada and competing in a triathalon in the summer of 1986, he entered a physical education program at a university. At that time he sought help for his broken cusp at the university dental school, only to discover that there was a year’s waiting list. Exasperated he said, "Forget it! And then I saw an ad that dentists from out of country put up when they have to do their dental board exams. So I got some work done with them, but again it was [like the former dentists] - they would look through my teeth and find something that they could work on, rather than looking at my teeth and giving me some sense of what I needed for good dental health." Subsequently, a gold filling that one of the qualifying dentists had inserted, fell out. So not only did he feel unseen, but now he also could not trust dentists’ ability to do his dental work well. He became even more disheartened and mistrustful. "My attitude was 'you'll put it in and it'll crush out too'."

This experience further discouraged him and as a result he did not go to a dentist’s office for five years. During that time he had difficulty eating popcorn, not being able to chew on one side. He felt that he "never got to the point of understanding or being able to make the link between what dentists do" for him being good for him. His attitude about his ten year period of almost entire dental avoidance is expressed in the statement: "At one point I had this broken crown and three fillings that had fallen out and my mouth didn't feel any worse for wear than when they were all in there , so why bother going to get them fixed?"

In considering his dental health values, Kim found it difficult to distinguish what values he "picked up from my Mom as opposed to my Dad. My Dad is a typical stoic....I like to think that if something’s bothering me, that I’ll go and get it checked out. My Father isn’t into that, you can count the number of times that he’s been to the doctor and dentist on one hand. But Mother, on the other hand...tends to somatize some things....We always went to the dentist, once or twice a year, we went for physicals regularly....I never wanted for anything in a health care sense. My
parents were really good about making sure that all of the things happened that we needed whether it be physicians or dentists or physiotherapists or chiropractors....I'm sure I went to the dentist at least once a year for the first 18 years of my life." This was a very familiar habit, "an externally set mode of operation and it was something you did 'cause your parents asked you to do it....there was no internal sense of what was going on." Looking back at the behaviour of his father and mother, he realized that they "spent their whole life trying to provide for the family...it's just that they forgot to do the things that they wanted to." He feels sad about this and at the same time, this realization gives him "a degree of motivation now that I never had before."

His avoidance may have partially reflected his father's values of only seeking care when necessary as he had not been able to make the connection between regular care seeking and good dental health. As he was growing up "I had always lived with the impression you have to see your dentist regularly and if you don't see your dentist regularly, then all your teeth are going to fall out. Well, I didn't see my dentist regularly and my teeth did not fall out." He realizes now that "it was a very short term perspective. It wasn't long term at all."

Kim's assessment of the reasons he ended his dental avoidance was that "three things brought me to a dentist; that I met somebody that I thought I could trust; that I could see that if I was pursuing my voice seriously that in 10 years my dental health was going to be important to me for a lot of external and internal reasons; and then the immediate thing was, 'this is ridiculous, you should be able to eat popcorn and potato chips without having to be so damn careful'." His first awareness, that perhaps he could trust a dentist again, had occurred two years before he sought dental care. Kim met a Dr.L and C, who was a dental student at that time, at a workshop. He felt that he could trust these two men. "And I joked with C, I said 'well, by the time you graduate, I'm sure that your first Mercedes is in my mouth'." So when the time came to seek help, he had already "known for some time who I was going to come to, if they would take me." A second awareness occurred when he had been watching tapes of Metropolitan Opera as part of his recent voice training. "Anytime there was a special on TV with Pavarotti, my voice teacher would phone me....They would always have these close-ups going into people's mouths, and so I started watching mouths a lot. And I began to think, my mouth is not in a great state of repair and if I ever become even known in this city as a vocalist, let alone internationally, then that's going to be me with the cameras focussing on my mouth. All these young vocalists are going to see how my mouth moves and I don't want a bunch of dental decay spread out across the screen....I think that in ten years with this vocal career, I'm going to want healthy teeth - not just healthy teeth, but a healthy jaw and a healthy throat and healthy tonsils." Shortly after this realization about the health of his mouth, Kim had a third awareness. He remembered "sitting around eating junk food and I took a bite of something. My mouth was full enough that I couldn't adapt my bite the way I usually did and it hurt everywhere!" He then began to recognize the extent of his denial. Until
this time he had continued to adapt his eating behaviour to accommodate the discomfort of his teeth. "And then I started admitting to myself that I only brushed my teeth with warm water, rather than cold water [because of their sensitivity]." This new awareness alerted him to the other difficulties he was having with his mouth. "I couldn't eat steak for dinner without having dental floss there" because of the gaps in his teeth. "What's happened here is, with not getting this cusp looked after; my teeth are starting to gap and move around, and the fillings that are in there aren't able to keep up with the movement of the teeth....Things are starting to get loose. So it's time to get something done."

Kim felt that to a certain extent his present attitude toward his teeth has changed because "now I can make the link between something that I want and the service that can be provided to me. I'm not sure that I have made the link of 'you see your dentist regularly because your teeth deteriorate without seeing them'." Even after resuming care there has been some initial difficulty as he had to readapt to his jaw being in its normal position. After some recent dental work with Dr C, "we spent a lot of time trying to figure out where the bumps and lumps and whatnot were, my jaw was uncomfortable in its new position. But after two weeks then things had kind of shifted " and he was comfortable again.

The attitude he had constructed while avoiding dentists was "I'll go in and get my teeth done when they start to hurt" which was similar to his attitude towards doctors. "It just didn't seem right to be going into a dentist just like I don't go to the doctor regularly." This point of view did not prevent him from being "vigorous and not neglectful about my health." So, if I've got aches and pains, I have a pretty good sense of my body and what's going on with it, and I adapt to it, exercise around it, or do things that bring it back." He has gone to the doctor fairly often in the past, but its always been for a "busted ankle, or dislocated...or separated shoulder, or broken neck, it's not been the regular sort of physical checkups and stuff." Kim felt that if there was something "mysterious" happening "that I was concerned about, that I didn't think that I had the expertise in, then I'd go and find somebody to give me some answers. Once I had some heart palpations, irregular rhythms, and pain when I was working out, so I went and checked that out because it didn't make sense to me what was going on." He went to "check them out and found that I have an irregular heartbeat. It happens to some people. So that's good to know.....if I ever go into a medical situation where they could be monitoring my heart, I can tell them not to be worried about this, this is something we've know about for a long time, and there's a history with it."

Recently Kim started seeing the doctor again, "somewhat regularly....I felt that a physician might need to see me....if we had any changes going on in my throat that they would be able to have seen what's happening over a long period of time, but up to that point, why bother?" He felt that in the past until he "could find a reason for being there" there was no point in going. "I
didn't feel it was important to go in and see a doctor regularly just to have him say, 'you're healthy'. With dentists I have a slightly more malicious attitude, because I was going to go there and they were going to find something to do to my teeth, regardless of whether it needed doing or not."

Kim reported that coming off his parent's medical and dental insurance contributed to his decision not to seek dental care. He seemed to realize that may not have been an accurate assumption by his statement "even though I still have medical coverage I don't go to the doctor regularly." He related this to the fact that "when I was younger, your mother packs up up and sends you off to the doctor to see that you get a physical." When he was on his own "I would choose to do what I wanted to. And I suspect that a lot of my own ideals got in the way...I can't justify going and taxing the medicare system, when it isn't something that needs to be done."

In some ways he has no regrets about his avoidance. "I don't know whether this is a flawed way of looking at things, but when I had my mouth looked at eight years ago they said 'Well, there's about a thousand dollars of dental work to be done'...I said 'I'll think about it.' I come back and get my teeth done eight to ten years later and it was about a thousand dollars worth of dental work, but in my mind I've saved at least a thousand dollars because I did it in 1992 dollars and not in 1982 dollars!" He felt that his attitude is reflective of the pragmatic values of his father who is the only land surveyor that Kim knows that tells people "you don't need that" or when a person that comes in that cannot afford it. "Dad looks at them and says 'you need a lot more than that. This is what you need and this is why you need to do it.' And then he finds some way of getting it to them even if they can't afford it. I just don't see that level of integrity in the professions."

Reflecting on how his avoidant behaviour may have affected other parts of his life, Kim was amused by the fact that "authority and I don't get along too well." For him, the need to be in control has been a major issue in his life. "My avoidant behaviour involves setting up authority figures as trying to control my life in a way I don't want it to be controlled, so I blow up the system rather than find some way to compromise." Some of the difficulties he has had with authority have occurred in the past, while both a student and an employee. He recognizes that this has been a repeating "classic" pattern for him. "The interesting part for me is going to be what happens to my voice." He has already seen this in a minor way when recently confronted by a choir director who wanted him to sing in lower key than his voice instructor wanted him to sing. He resisted his temptation to once again say "Screw you! I don't need this!" He knows that he "will have to keep wrestling with it. The common denominator here in all of these things is that I know I'm right. The problem is, I don't handle it properly. I blow the situation up." He wants to get what he wants without escalating things. "And that's the trick: staying in the system. This is tough for me, even when it is to my advantage to find a way." He became aware that he may
also be challenged in staying with the development of his voice because in the past he always lost interest in things after about two years.

Kim acknowledged that he is "incredibly cynical - professionalism drives me nuts!" He has gone through experiences with physicians, dentists, and with voice coaches who have the sense of "'I'm the expert and you're not, so you just listen to me, because I know what's best for you.' So my response to dentists is 'Bullshit! You get your hands out of my mouth!'" He knows that this goes a step further because the guys in my men's group say I have a lot of control issues, but I say in general a lot of people have a lack of control issues. Why would you give your body over to somebody? Why? I don't understand that?" If he was given options for solutions then he could decide on time priorities "Why today? Why not two years from now?"

What he felt he missed in some of his experiences with dentists was a sense of connecting with them, not that he was wasting their time.

When considering whether he will leave the new dental practice where he is, "I don't know. I think the biggest difference and the reason why I'm here in the first place,...I have respect for the individuals involved, partially because I know them outside of the practice so I have a sense of what they stand for as people. And I get a sense that the office is interested in me and what I stand for as a person and I think that will be the key to the difference. I also think that the other key difference is that I have a greater degree of personal motivation to make things work and I think that I will operate in the system to that level. And I won't be at all surprised if, at some point, I say, 'I don't want to have that work done' but I think that'll be okay in this system'." He feels he will not have to confront and leave. "But there's also the added dynamic that in this system when something's suggested, I have more of a sense that it's being suggested because of a certain dental necessity, rather than a certain mortgage payment necessity. I'd hate to come back to that. I really am jaded when it comes to professionals. Really jaded!"

In terms of advice to others, he is not sure that he has any. In his view "each situation is so different that you have to take each one on a personal level. 'It is not a good idea to take anything, or any aspect of your health for granted or it will get you!'" For him it is also important to have the perspective that "professionals are not 'god-like' and never will be." Dental avoidance must "have had some cause because I kept doing it." It may have been a way for Kim to exercise "some control" over himself. "I'm not sure of the meaning, but it may end up being a symbol of me coasting through life rather than deciding on a course of action. I wrested control of my mouth away from dentists and dentistry and did not do anything about it."

The fact that he "always had perfect teeth" in his childhood was a metaphor of the wealth of other endowments in his life. Although he had cavities, others often commented that he must have had orthodontia [his teeth straightened], as they observed his teeth which appeared "perfect" on the outside. As a child he went through a spell of "thinking if there was just
something wrong with me, something I had to overcome, that things would be a lot better....then I
would have developed a sense of fortitude, because everything I did just came easily. People
who had something to overcome had a degree of determination that I didn't....I've never had to
work at my teeth, they've always been great, by everybody else's standards...and it's only recently
that I have not been able to use my mouth the way that I wanted to." Also related to this problem
of his "perfect teeth", was Kim's realization that in a job he had held at a centre for adolescents
that are emotionally disturbed, he was unable to teach them how to establish relationships. "My
biggest problem in working with these kids was that at their age I couldn't go and approach
people that I'd like to have a relationship with--what I did was become captain of the soccer team,
so that I was in a position [sigh], in an admirable position that people would want to come and get
to know me....But I never really went out and established healthy relationships with people."

At the present time, he does part-time work as a seminar leader in order to support
himself while he pursues a two year commitment to develop his voice in order to pursue his
dream of becoming a professional singer. In his passionate commitment to pursue his voice
training, he's now "trying to get more and more focussed. I've given up an awful lot of things,
things I'd like to be doing." In the past "it was easier to do things that people recognized that I
was good at. Then I'd get to a certain level and then there wasn't that inner sort of drive to push
me over the obstacles that come in pursuing anything. I've already found out that trying to sing is
not easy. It's not going to be easy in the future." His transition of moving from being a generalist
in his activities to becoming very focussed on singing has been an incredibly powerful transition
for him, with repercussions throughout his life.

Narrative Account Eight: Mark

Mark is 45 years old. He was born in Pittsburgh and raised in the Jewish tradition. His
ancestors came from mid-Europe and southern Russia. His father is an independent business
owner in the building supply industry. His mother has been a homemaker throughout her married
life. Mark completed four years of university training and presently works as a computer
consultant.

Upon reflection, Mark's connects his early childhood "will struggles" with his mouth. A
story told to him by his mother was that at a very early age he would hold his breath until he
would "turn blue and black and then pass out." She was "very freaked out by that" and the family
physician advised her to "just let him pass out." Mark believed that before he could talk, he also
received "pre-verbal oral damage" as a result of his mother force feeding him. He could
remember her "Feeding me and feeding me and feeding me" and he objected by holding the food
in his mouth. "I was labelled a poor eater." This led to future "will struggles" with his father. He
could remember a situation sitting at the dinner table with his father and just not wanting anymore food. His father had said: "Well, you either sit here and finish your peas or you can't go out" to which Mark replied: "Okay, I won't go out!" And I sat there until the sun went down." This dialogue serves to illustrate Mark's strong belief that his dental avoidance pattern is tied into the energy of his "will struggles." "For me, there's more going on in my mouth than just some white teeth and gums that don't bleed."

In relation to family attitudes about teeth, Mark believed that his mother was afraid of dentists because of her poor teeth. His father always gave her conscious emotional support in encouraging her to seek care. From a dental point of view, "the apple does not fall far from the tree" in that Mark felt that he inherited his mother's poor teeth and her attitudes. He described his father as being "good looking and straight-toothed." He remembered the parental admonitions of "put on your jammies and brush your teeth" as being part of his early training. This likely reflected his father's values of taking good care of oneself.

"My primary experiences as a child were to link dentists and pain - going to the dentist always meant a lot of pain." The family dentist was Dr.D. D was the family choice because he was an uncle "not because of the quality of his work." Between the ages 8 to 12, my mother would take me downtown and would sit out in the waiting room. Mark remembered the gurgling of the water aspirator, sitting in that big black chair, and waiting for the pain of the drilling. "I was unable to control the situation." A feeling he had when he thought of that time was that "of not having a lot of choices in the matter." This view of not having much choice was further heightened by the dentist's behaviour in "basically ignoring my complaints. Not that he was sadistic, it was just that my complaints would have no effect on him."

Around the age of 13, Mark changed dentists. His family moved to a new neighbourhood and began to see Dr.J, a gentle dentist whose practice was just down the street from their new home. This move to a new dentist appeared to be part of "my mother taking more control over the upbringing of her kids, rather than them being influenced by Uncle Morris" from whom they had rented their previous house. Mark experienced Dr.J as a kindly older man and although he still had a lot of fear he would go there on his own "and just be very nervous. The whole thought of the needles was just so overpowering" that he chose to have the work done without needles in spite of the trauma of pain. He continued to go to Dr.J for about 10 years and all the while it was "a disagreeable experience."

During adolescence, he began to experience problems eating. This was caused by tooth crowding, rotation of his incisors, and a severe overbite. This required orthodontic work. "There was a fair amount of heavy duty stuff going on in my mouth....It wasn't filled with torturous pain" but weekly or biweekly the orthodontist would "tighten the gizmos and then my teeth would ache for two days." He wore a harness at night and would wake up in the morning with a sore mouth.
At one point he had two molars pulled under nitrous oxide. Although the condition of his mouth improved, his experience with his orthodontia was extremely negative.

During the interview, Mark identified four phases in his life which he regarded as struggles rather than accomplishments. He named them fear and pain; denial; increasing responsibility; and conscious self esteem. These phases were also reflected in his dental behaviour. He regarded the time before he left home as the phase of "fear and pain."

When he was 23, Mark left Pittsburgh. He lived in Ottawa for about a year and a half and then moved to small coastal city in British Columbia where he "bush lived" for two and a half years. Thus began the second phase of his life: the psychological phase of denial. During this time he manifested "a lot of parental resistance and disconnection" by not going to dentists and not taking care of his teeth. "Not taking care of my teeth is the same thing as letting my hair grow or not adhering to a family dress code. He did not "have any difficulty if I 'forgot' to brush my teeth for five days or with the fact that my mouth was yucky." The fact that his "breath was bad" during his avoidant periods, may have affected his relationships with others. During this five year period before he moved to Vancouver, he only went once to a dentist in response to a severe tooth ache. The tooth was extracted and he was so relieved to be free of the pain, he had no sense of loss. Throughout this time he felt a sense of "real disconnection."

After three years of living in the "B.C. bush", Mark felt that his "life was going nowhere." Thus began his increasing responsibility phase. He moved to Vancouver and began living in an itinerant manner, "crashing in peoples' basements for another year before I got a kind of trip together." This phase which he feels he is still in at present time was also reflected in his life in general as he attempted to "keep my trucks running and keep my bills paid."

At that time "essentially some dental event occurred" which necessitated him seeking dental help with Dr.L. "I realized that I needed to be totally in charge of what was going on in my mouth and needed to take responsibility for that and just do it." When he first went to Dr.L his teeth were a mess. He felt that he continued to experience dental difficulties because he had not separated from his parents consciously by taking over the responsibilities for himself.

Some aspects of Mark's experience with Dr.L were very positive. Dr L "was so gentle that I overcame my fear of needles: not to fear them other than in the moment. I was able to close my eyes and just let them do whatever they needed to do. He was the first dentist that I allowed novacaine in my mouth." During this phase, Mark felt he used his sense of his internal father in order to become dentally motivated rather than acting from his personal sense of self-esteem. Although Mark felt safer with Dr L than he had with any other dentist, he realized that he had formed an internal negative image of him.

His first disenchantment with this practice began with him feeling "that I didn't have enough control over my dental situation with Dr.L. Now this is a perceived situation, not
necessarily real. I rationalized some of that by feeling he was just too expensive for my blood. The second had to do with receiving information after the fact and not feeling that I had any choices." For example, once while Dr.L was drilling away preparing Mark's bridge work he asked Mark: "Well, what do you want, white or gold?" Mark hurriedly answered "Well, white, you know, I would really like white" and Dr.L said "Well, that's another hundred dollars', and I said 'Well, I wished I'd have known about that before hand.'" Although "a hundred dollars was a lot of money" to Mark, it was not really "the hundred dollars so much, as that this detail was not made clear to me on the front end....And I would have transferred money into my account, and because of the kind of personality I am, I was expecting to pay 445 and had balanced my month...So there was this feeling...I wasn't given the opportunity to think this thing through." He saw the money as a kind of rationalization because "in reality, I think, if it had been discussed at the front end, there would have been no problem....A hundred dollars doesn't means anything in the big picture of my life." He feels that this lack of opportunity to be involved in decision making in advance of treatment had occurred on more than one occasion with Dr.L.

After eight years with Dr.L, Mark experienced an "emotional crisis point" while at a local community college. "There were finals and I was not holding up to my own intellectual self-image" so he called and cancelled his quarterly dental appointment with Dr.L. In his opinion, this was a time of personal confusion. It appeared that Dr.L became negatively associated "somewhere in me, to this crisis of computers, college finals, and my own self-image, and my father." To Mark, because Dr.L was a dentist, he also became associated with Mark's negative relationship to the "history of dentists in my mouth." Mark explained his understanding of the psychological aspects of this confusing reaction by saying that he had projected a negative father image onto Dr.L. He then felt that he had an fatherly obligation to Dr.L that he couldn't live up to. When Mark did not live up to his own perceived expectations, he felt that he had failed himself and his father, he exclaimed "I never went back."

During this second avoidant period, Mark knew he was in psychological difficulty around dentistry. He recognized that his feelings were "coming from two different psychic sources." The first was his struggle to disconnect his father projections from dentists. The second was what he called an "existential struggle". During this time as his teeth deteriorated, he strove to cope with his fear and sense of low self-esteem.

His avoidant period ended in 1991, when he felt trusting enough to seek dental care in the practice of Dr.C. His increasing maturity in contrast to his earlier denial was demonstrated as he worked "consciously hard to psychologically respect dentists" and to change his "status image" of dentists. It was helpful for him to regard dentists as delivering technological services. "They're businessmen, their dental hygienists have done a lot of training." He had met Dr.C, a dentist, through a men's group and formed a "positive projection" onto him. "So my actual
psychic construct of Dr. C is somebody I know in a men's group who happens to be a dentist." This incident appeared to be pivotal for him in changing his denial pattern. As Mark feels a greater sense of control in this new practice, his former attitude towards dental professionals is shifting. An example of this is his relationship with his new dental hygienist. Her approaching him in an empathetic and human way, rather than with a professional-client approach has enabled him to experience a sense of trust and bonding with her. This connection has proved helpful to him in motivating him to return for future care.

Mark's dislike of his mouth is also "an existentially based struggle", linked to his sense of identity. Regarding to his struggle, he felt "Why would God punish me with unstraight teeth? Why don't I have better teeth?" Mark realized that his dislike of his mouth has kept him from seeking dental care. He recognized that he was carrying "an idealized image of smaller teeth." He also had an personal image of the "the mouth being dirty" which led him to questioning the motives of dental professionals. "Who would want to pick around in somebody else's dirty mouth?...which would mean somewhere in my psychology the asshole and the mouth are connected." Although Mark has offered his present insights about the dynamics of his dental avoidance he feels that now he has discussed one layer and that other layers could be revealed with further discussion. For instance, he is still "medically in denial" as he avoids going to doctors. He rationalizes that this likely relates to his fear of death and knows that in the future he will "probably just have to tackle that fear."

In relating his teeth to his sense of well-being and maturity, Mark entered his fourth phase: conscious self-esteem. He was now aware of the extent of his denial, and with his increasing sense of self-esteem began to value the importance of caring for his teeth. In describing his behaviour prior to this phase, Mark used the analogy of running out of gas in his car. "I didn't notice anything until I was out of gas." He attitude toward his teeth was "very much like that, I'd go along fine and then some negative event occurs and my well-being crumbles."

As he approaches mid-life, Mel now recognizes that his dental avoidance behaviour appears to be very connected to "self-esteem events" which effect his emotional well-being. Even though he has made a conscious effort to seek care and has found a dental practice where he now feels comfortable, he continues to struggle. He recognized recently that he had entered a minor period of avoidance by not following through with planned reconstructive treatment. This appears connected with his amnesia that arose, as it had in the past, when confronted by emotional crisis. He tracks that "right down to the major self-esteem crisis in my life;...a mid-life crisis. My relationship of ten years is ended; I'm moving out of my community." His present "amnesia" around his goals to keep his mouth healthy is "part of a protection pattern" and he is surprised at how completely he had forgotten about carrying through the next phase of his dentistry. The amnesia showed him that he's in an area "that's not exactly under conscious
control....So, basically my self-esteem has been really plunged back to early childhood places by the traumas of current events." So he attributed this reaction to "zero self-esteem. I realized the other day I haven't even begun to deal with the loss of the relationship:...the loss of a love." He now knows that the pain of his grief and loss, although under conscious observation, is "not under control." The struggle Mark is experiencing in caring for his teeth appeared to be between his "conscious self-esteem" and his "protective amnesia." Consequently he has been experiencing minor periods of avoidance when he forgets his "game plan."

The meaning dental avoidance has had for Mark is that "I see dental health as my gateway to personal mental health....[It's an example] that I'm trying to take more responsibility and control for my flaws....I'm doing the best that I can, I'm accepting the gifts that I've been given and these are my limits and I work at not forgetting and my teeth...anchor me in that. Sometimes I don't brush my teeth in the morning...and I go 'stop what you are doing and go brush your teeth...don't let it be a convenience'." He now likes to keep his tooth brushing as part of his "morning ritual." It is difficult for Mark to say how his new behaviour in relation to dentistry has affected his life. At the present time, his "life is in such turmoil, dentistry is small by comparison."

For him, the meaning of his dental avoidance is connected to "parental rejection and the unconscious parts of [his] self-esteem." His separation from his parents resulted in the loss of a "father image." "I had no one to tell me to brush my teeth and go to the dentist." He now feels he has a "more adult view" which involves not projecting onto dentists any responsibility for his teeth. With his present dentist, he has lowered his expectations. For others with difficulties with avoidant behaviour, Mark prefers: "Find a dentist who you like and trust." His overview of his dental consciousness is that he has moved from the "magic universe" of childhood, through parental consciousness, to arrive at his present adult consciousness.

Narrative Account Nine: Charlotte

Charlotte was born in Edmonton 45 years ago. When she was about four years old, she moved with her family to Vancouver. Her parents were of British and Scottish descent. Her father was a medical doctor and her mother a homemaker. Charlotte attended school in Vancouver, graduating with a masters degree in Counselling Psychology. She is married and the mother of two grown children. She is now a psychotherapist in private practice.

Throughout her childhood there was a high level of health consciousness in Charlotte's family. In that her father was a doctor, she grew up in a world surrounded by dentists and doctors as family friends. "It was an unarticulated truth in the house that you went to the dentist on a regular basis because that was something that needed to be tended to on a regular basis, that you couldn't do yourself. It was part of the fabric. It didn't stand out positively or negatively in any
particular way, it was like you put your underwear on in the morning; you went to the dentist every six months. Period." Although they did not have the usual "admonishments, it was really clear what we were expected to do. And we did it." The children were "checked" by their mother physically when they were small and verbally as they grew older. "In my family it was Mom who did everything, which is probably partially [the] fifties" way. Her mother would arrange dental appointments as she did other family activities. Charlotte did not make a connection between the theory of brushing her teeth regularly and having fewer cavities, because she always had cavities. "So, it was mechanical, I did it I probably got a 'B'. I could have got an 'A'. But it didn't make much difference....There wasn't a high correlation." There was a consistency in the family, her parents "didn't tell us to do something that they weren't doing."

Charlotte had a fairly uneventful childhood as far as dentistry was concerned although she had the sense of "spending most of my Easter breaks and school holidays going to the dentist, like everyone seemed to in those days....It was part of the normal routine." Although she did not remember being at the dentist "as being a horror, I know I didn't like being there." Time would seem interminable as she watched the digital clock in the dentist's office flip and she would think "there's one more minute gone." She would become very perturbed if the dentist was behind which was often the case because of the lack of support staff for the dentist. She was also uncomfortable in the waiting room, sometimes pacing if the dentist was late. "So I think that's a reflection of obviously some major discomfort. But it didn't stop me from going." This was puzzling because she did not "remember pain being an issue" although she certainly did not "like the invasiveness of the treatment", she felt her response was not anymore or any less "than anyone else's." In spite of the dentist being a "a cohort and a peer" of her father, she had a sense of him being disembodied as "he was a pair of hands" to her. As well, she regarded him as a technician who was at the end of the continuum of "barely being appropriate." This appeared to coincide with his personal view of himself as a technician. He "delivered good service, in the years that have come I've never heard anyone saying about him: 'jeez, who worked on these teeth, they're a mess'." In addition to ongoing treatment for dental decay, Charlotte had "orthodonture" to straighten her teeth when she was about 11.

"The real turning point for me was the effect on me, of my mother being pushed into dental care when she was terminally ill." Charlotte was 19 at the time, the eldest of three children. "The circumstances were; that there was an assumption made, by the treating doctor, who was my Dad's best pal that 'Mom will eat better if she gets her teeth fixed'....I can remember thinking 'That doesn't compute, that does not make sense, that it's like trying to fix a mosquito bite on your arm, when your leg is broken'." Although she disagreed, she said nothing. "There were two levels of authority I couldn't 'mess with.' The parental and medical authority that were both vested in my dad. So I was, being the eldest, designated to be the driver to take my mother back
and forth. Back to the same dentist who we all went to." She never thought much about it "beyond 'it doesn't make sense' until I took Mom down there the first day. And by then she was looking ill, looking terminally ill. And we got out of the parking lot in the medical building, and she hid behind me. And I realized 'this is an office building that's filled with all of the friends they [her parents] socialize with, all of my Dad's peers"and that she had to go and needed Charlotte to protect her was "mortifying; it's just mortifying!" "And it's happening again, it's really depressing [crying]. And that did it!. I'm sure I went back several times with her but my real memory is that moment." Even now, she has a sense of outrage and abhorrence "of it being really inhumane" as she considered how severely her mother's dignity was offended by her having to have her teeth cared for as her disease progressed and as she became increasingly incapacitated. "Oh! She was very compliant, she was doing what she was told to do but she was mortified--mortified! I think she would have preferred to be dead, than to go through that....And it was just body language, more than anything. You know, her head went down and she just cowered. It was awful!" Charlotte was angry that her father, her mother's doctor, and dentist had insisted that her mother have her teeth completely reconstructed even though she was dying. It greatly shamed her mother and violated her privacy. After the trauma of her mother's death, Charlotte "just divorced dentists. Period. Full stop. The End! Why should I go there. I couldn't find any reason." So Charlotte began a seven or eight year period of dental avoidance from the age of about 19 to 26 or 27. Also, this period appeared to be associated with her determination to be independent.

During this avoidant period, she began to have nightmares and "I got so phobic that if there was even a Colgate ad on the TV, I would leave the room. So it began to eat me. You know dentists, drills, and machinery coming at me in my nightmares." By now she had a young daughter and a son, and one day, "I, God knows how, plucked my courage up and made a phone call and set up a dental appointment. And they said 'if we get a cancellation we'll call you earlier' - which they did, and I wouldn't go. So I went to my regularly scheduled appointment." Shortly afterwards the staff in the dental office informed her that she was going to have gum problems and needed to see a specialist. "We'll set up the appointment up and call you. And essentially, I left my phone off the hook for over three months during business hours, which would probably give you some idea of my level of anxiety." In spite of the severity of her reaction, she looks back on that time with some gratitude as it has been very useful in her professional life in increasing her understanding when working with people with anxieties. She felt so overwhelmed that she would never want to experience that degree of anxiety again. So that she would not "pollute" her children with her fear, her husband took complete responsibility for their dental care; taking them to the same dentist she attended. This strategy was successful in that "the good news is that they are healthy dental patients. Because I got the hell out of the way!. There was nothing I
could do that was constructive in terms of attitude, so I just backed off." For the next four or five years she continued to see that dentist until she and her husband separated and she had "absolutely nothing that was not routine care....I absolutely hated it. My first real memory was dropping the kids off at a friend's house in order to go to the dentist, always first thing in the morning, and coming back about nine-thirty in the morning, and this friend was standing at the front door, with a glass of Scotch. Which I don't even like!. But on 'dental days' that's all I did. My job was: I go to the dentist. Nothing else. Kept it absolutely together. And I was just high as a kite when I'd get back because 'now I've got six months of dental-free days'."

On what was probably her last visit to this dentist, Charlotte went for the removal of a disintegrating wisdom tooth. "For some reason, it wasn't a first thing in the morning appointment. So he put the freezing in, and I obviously needed more freezing. They always gave me twice as much 'cause I just wear it off. So he kept coming back, and I could really feel what he was doing." He appeared to become agitated and kept looking at his watch. "The message was 'this is my time; it's lunch hour; what are you still doing here?' It really crushed me. I think it took away the little bit of confidence I had about being there....It was not verbal messages, it was his body which was making all these strong signals. So I never went back to him." She described this dentist, who was the second of the three dentists that she has gone to in her life, as being "young and keen. Externally it looked like he was doing all the right things. A good support staff and you know a sense of team and community....There was a sense they were trying to do that. It probably worked for everybody else, but it sure didn't work for me." She did not intend to malign him because she realized that he was doing the best he could. "I'm sure the days that someone like me came in, he just went--'ohhh, it's not my favorite patient!' Because I needed--I guess that one would know instinctively in a dental office, that I needed extra care, and they may know that but they may not know how to deliver that care" which resulted in them feeling inadequate. "And then they would be (inadequate) - which was what I don't need, because I'm already anxious. 'I don't need your inadequacy, at all! There's no room! So I left. Whhht! gone!"

The effect of her sense of this dentist's impatience profoundly affected her. "So then I went underground again."

This new avoidant period began when she was about 31, although because these memories were "suppressed or repressed" it was difficult to "get a perfect chronology." She continued to avoid seeking care for about five years, until the spring of 1983, when she was 36. "When I was in Graduate School, I was writing a paper...and I was chewing on a carrot and half a tooth - it felt like - fell out on a Friday afternoon." So great was Charlotte's fear that she felt that "I would rather be dead than deal with what I'm now having to deal with. I used to think that one of the good things about Heaven is that there won't be any dentists up there. Great, eh? This is healthy thinking?" She felt "frozen" and knew that she could not "get through the night and the
weekend, so I have no choice, that I will give myself a heart attack if I don't do something about it." Overwhelmed by her inner turmoil and with no one at home to support her she started phoning contemporaries in order to get names of dentists. She started phoning getting "passed around" to several dentists "all of whom I'm thinking, on four o'clock on a Friday afternoon, don't need this! I'm sure they could hear it in my voice! The anxiety. And finally ended up connecting with Dr.O." She was greatly reassured by Dr.O's secretary. Although "I don't remember what she said 'cause the words weren't so important, but I knew, this is where I belong. I knew it and I said, 'I will hire a helicopter, if I have to, to get down there. I'm prepared to come right now and I'm prepared to stand in your waiting room until the dentist can see me'. And that's exactly what I did." She "just got in the car and went down there. And that was the turning point for me."

In retrospect, she recognizes that it was the personal qualities of this woman dentist that enabled Charlotte to feel safe. She was young and fresh and did not have a lot of support staff. It was "not just her gentleness in terms of persona and style but also her gentleness in terms of treatment; each time she cleaned my teeth in those early days...she did a little bit more. You know? The message being, you are toughening up, you can handle this." As well as supporting Charlotte by matching her progress, Dr.O "wanted to know, very early on, why I was this way. And she's probably the only person I've ever talked at any length with. It's not that it's a big secret, but it's not something I talk a lot about. But I was very comfortable yapping with Dr.O."

The result of being so supported and understood has been that she has been going to Dr.O for almost 10 years - "every three months!" Charlotte has created a ritual of going "Friday at eight o'clock in the morning. The appointment is made before I leave [the office at the time of my previous appointment]. They are not allowed to call me to remind me. If they call me to remind me, I will not come. They give me so much control!" Around her appointments, Charlotte and the people in Dr.O's practice have created further ritual to enhance her sense of control. They take her immediately and "When I'm in having my teeth cleaned, no one else is allowed in the room. So, if the assistant has to get in Dr.O's office, she's not allowed to come through. I just put my purse up and I barricade. The hygienist is not allowed to leave. When Dr.O comes in to check, she's got three minutes, starting now!" Charlotte keeps track of the time, telling the dentist when the time is up. "They are phenomenal in terms of allowing me as much control as they can give me, without it getting in the way. Not only is care not compromised, but they now have a body in there that occasionally remembers to breathe. Occasionally. I mean I'm not here to say I'm over this! But...I am managing it. But it's only because it's being co-managed. And that's absolutely the key for me. Absolutely. The key for me. They are splendid in terms of seeming instinctively to know how to deal with people, because I hear it around me, when I'm there. but I don't think it's just instinctive. I think they do a lot of work. Together, as a group. I get a strong feeling that they work on more than on our teeth. We are more than our teeth. And that's made all the
difference!” When she first started going to Dr. O’s practice, “they sent lovely cards telling me what a star I was! I left with balloons one day and was proud of them. So there’s a tremendous level of play! And humour. But, it seems to be acknowledged how important that is, around dealing with anxiety. It’s not humour for the sake of humour.” Things are taken “absolutely” seriously.

After finding Dr. O, an incident with her son necessitated Charlotte calling her previous dentist. She felt that the dentist had been inappropriate in giving her son, who was only about 14, a choice in whether or not he wanted freezing for repair of a cavity. As her son told her about it “what I heard was that Martin really hadn’t been given a choice. All the words were there, but he was actually led to saying ‘yeah, I’d prefer to do it without freezing. My hit being, it’s faster for the dentist,...but I could be dead wrong....I mean, I guess that my assumptions around dentistry are dead wrong. So I stewed for a couple of days, and then I thought that’s not okay. So I wrote Dr. W a note saying ‘here’s how I see what happened. This is my issue: my son’s just fine. He’s not the problem. But I think you put someone in a decision-making situation where they were not capable of making that decision. And given my experience, I think you should tread lightly in situations like that.” Later the dentist called her which she gave “him credit for.” But “the very act of having him on the phone, I really was not able to say what I wanted to. He called to explain. I didn’t need an explanation, particularly. And, as I was fumbling around trying to reiterate what I really wanted him to hear, and couldn’t because I was off balance, he wanted to talk to me about my teeth. And that made me angry, because that was not why I was calling. So, it was not an ugly phone call, at all. It was just sort of another example to me of ‘you guys are on another planet!” They don’t get it! Guys is the operative word.” This was reminiscent of the lack of sensivitivy and the authoritative manner of men in the medical and dental professions that Charlotte had experienced in her earlier experience with her mother. “I really thought, he’s on Mars! He’s on Mars!” The only reason she had the confidence to face Dr. W was that she was already successfully attending another dentist. “Otherwise, this would never have happened. Oh! Not in a million years!”

Charlotte knows that if in the future she has to go to a specialist that “I’m gonna get unglued again.” Although it will be difficult, she knows that she will “do what needs to be done.” In order to cope, she will “use any drug in order to get some sleep the night before. It’s not the being there that’s tough, it’s the anticipatory anxiety that is the killer.” But with the assurance of her experience with Dr. O she knows that she will develop “a bunch of rituals about getting there. And including, not doing anything else for the rest of the day and spending as much time as I can the day I’ve been to the dentist, telling everybody who doesn’t want to hear, how wonderful I am.” She also knows she will “go ballistic again” and then her story “will be a different story” if her present dentist decides to retire “because I don’t do change well with this kind of anxiety.”
Perhaps she would be able to use the experiences she has had in her present office to carefully plan a transition. For instance, her present hygienist has been "fantastic" if Charlotte requires another person to care for her. The team members "first of all have let me know what's coming and then, subsequent to that they have made sure that the person that they are going to connect me to gets a lot of information about me in front of me, which I really appreciate." Her current hygienist will "actually say things to me like 'now I'm taking holidays in about four months, but I haven't booked them yet and I want to book them in a way that your appointment isn't screwed up'. It's profoundly important to me."

Charlotte's family also participates in her pre and post-dental rituals, supporting her in a humorous way. Her husband teases her "it's the one time on a Friday morning that he can get me 'Ohhh, I can get you calm before you go to the dentist!' so there's a great joke about it, and another ritual." One time when she and her husband returned home after being away, her children put a wine glass on her husband's pillow and on her pillow was "the toothpicks and my tooth [cleaning apparatus]! I thought, 'do they know me! I was really touched. And they are very good at humouring me when I'm back from the dentist, telling everyone how wonderful I am, and 'your mother has clean teeth' and blah-blah-blah...Their eyeballs roll, but they are very good at humouring me. So that's a gift. That contributes. It's part of the ritual." Although Charlotte knows that each of these things by themselves are insignificant, "the ritual I've developed allows me to take care of myself until I get there, and then there's sort of mutual management." If she "had a problem with a tooth now, I wouldn't wait ten seconds, I'd pick up the phone and call."

In terms of understanding the psychological aspects of how she has managed her anxiety around her dental care, she feels that "It is about trust but that's just a given. But it's, for me, in terms of my anxiety, it's around need for control" and that the people in her present office respect her need for that. "And I couldn't ask for anything more. The only way it would be better is if I had a general anaesthetic." So profound is her anxiety that she would even prefer childbirth to the experience of going to the dentist. It is "over, done!" whereas she has to anticipate visits to the dentist. There is also "a nice reciprocity of respect. Respect more than trust" although "trust is implicit. Some nice reciprocal trust there. And then the respect."

At the present time, Charlotte does not regard herself as "a healthy dental patient, but I would certainly call myself a co-operative and engaged dental patient, and for me that's eleven out of ten. My goal is not to love this, believe me." She knows that it is in her best interests to take care of her teeth, because the more she does the less time she has to spends in a dentist's office. "And if my goal is to avoid the very thing that makes me anxious, obviously I'm going to participate in it. That cycle's real clear to me." In order to maintain her dental care she works very consistently at prevention. When considering the significance of her mouth, her teeth, and her dental care she responded that "I do it because I have no choice. Period. Full stop."
In Charlotte's opinion, her experience of dental avoidance has not affected other areas such as the seeking of medical care, because "it's a high anxiety, specifically located." The question of the meaning of her avoidance is "a profound question" to her. It was difficult to understand the full portent of it as she was giving "really speedy responses, but I think, if I chew on it, there will be more." "What stands out is my understanding of the need for the really important fit between the client or patient and the professional. And that it has as much balance and equality as you can give it. I think that's the real issue for me. When I think about how it's translated for me professionally, it's the lack of balance. The recognition of the issues of power and the importance of acknowledging them. Overtly. Verbally acknowledging them and looking at how we can manage them....They are easier to manage if they are articulated."

Another "playout of the experience" occurs when she thinks about what "this has done for me, it's when I do retrospective memories of the medical community, what I thought then and what I see now in retrospect, are two very different things. And that's just a function of being from a medical family, and the medical big shots sending Mom into a place where she had no need to be and that the whole sense of them being the 'big boss'. So again, I'm really referring to the same thing, in a different way. So that jades, or alters, some of my memories of some of these players." She wondered how people could countenance such an incredibly inappropriate decision regarding her mother's care. "I certainly have my moments when I can look with some empathy at particularly the internist, who was our neighbour....and I can get glimpses of his pain during that time, but I don't spend a lot of time dwelling on it." What continues to be the overriding consideration for her was that her mother was subjected to needless indignity and suffering by the inappropriate behaviour of others.

The profound effects of that experience still echo for Charlotte: "To this day I won't see dental people in my office. I won't have dentists in my home. I just won't do it." Although she has treated one hygienist in her practice, "a dentist will never darken my door. I've had one [to my home], only because I couldn't avoid it, because we had a wedding here. But I behaved very well. He was very nice but it wouldn't have been my choice. So I'm very rigourous in that way and I realize that the rigour has an element of ridiculousness to it. And I don't care." Her behaviour reflects another way that she protects herself from needless anxiety. "If one of my kids marries a dentist, I'll deal with it then."

Charlotte's advice to others who have difficulties with avoidance was "to never see the avoidance as the bad guy that you want to get rid of. To try to find a way to create a partnership with the avoidance so that it has its air time, but not always. That's usually how I do it." When working with someone in her practice she gives that person "the affirmation that the anxiety is real, and I'm not going to minimize it, so you don't need to. I think is the first big step. And everything can follow from there. But my goal for someone and with them would not be total
elimination of anxiety. I think that that can sabotage, in my opinion. So it’s a constant
acknowledgment and then an ability to start feeling in charge of it, to some degree. That’s how I
use my own anxieties and when I’m working professionally that how I try to deal with it, in a
nutshell. As long as they are not dental anxieties from other people. I don’t do those." She
knows that if she did "how unfair it would be! I’d keep getting in my own way. Right."

In conclusion, when Charlotte received a call for a second initial interview because of
damage to the previous audiotape, she remarked: "when I thought about you coming again, I
wondered about how real this would be, and it has been just as real. It has been very similar, but
it has also been different. And I think what I want to say the most is how surprised I am that the
emotions so immediately returned. Somehow, I think my sense was that there was some
cleansing from the last time, but the well is still real full. So I’m a bit surprised....but I’m not upset
by that." She would have thought that if the interview had been in a year’s time that the image
"would have triggered quite quickly. But when I get into the images of my Mom, even as I say it
now, I can feel the tears inside. So it’s the provoking of that image which is the central piece
here. Without question. And I didn’t even know that until right now when I said it to you. So
that’s sort of the ‘Aha!’ for me; which is probably why I don’t talk endlessly about it with people,
because it provokes that image. So that’s sort of the other insight here." With this touching into
her sense of loss and grief around her mother, Charlotte felt that "I've truly given you my story.
So I don't feel like there's a lot of big pieces missing."

Validation

Co-researcher's Self-reviews

The co-researchers were each sent a copy of of their narrative accounts and a letter
asking them to validate their account by considering its accuracy and completeness (Appendix A).
In the follow-up interview approximately two weeks later, the narratives were reviewed, checked
for accuracy, and additions and deletions made. An audiotape recording was made of this
interview.

Each of the co-researchers was enthusiastically involved in this self review. In general
during their self-reviews, the co-researchers were positive in their evaluation and in their
enjoyment of participation. For one person, the interview was "a magnificent experience." The
co-researchers felt that the narratives accurately reflected their avoidant experiences. Charlotte
exclaimed "you get eleven out of ten!...The narrative says it all. The essence was completely
captured." Mark found that although he felt his narrative was accurate, it was "so choppy" that
he did not get the "intellectual flow of what was happening" so assisted the researcher in rewriting
it. Kim, although he felt the narrative was accurate, encouraged the researcher to use her intuition more in the interpretation.

Stan felt that all the salient elements were captured. The narrative highlighted that his original avoidance did not have anything to do with dentists. A comparison for him between the situation when he did like the way he was treated by a dentist and the new practice he went to "was startling." For Kim, a subsequent rereading underlined for him that all his dental decisions have been ego driven.

Some co-researchers clarified the minor concerns that they had regarding specific details. For every point questioned, however subtle, the narrative was adjusted to concur with the co-researchers' concern for exactitude.

Several spoke of the profound emotional responses they had to reading their interviews. Charlotte exclaimed: "I had a strong reaction. Each of the three times I read it, I cried!" For two co-researchers, reading the narrative brought up strong feelings of guilt. Eleanor commented that the process of the interview and reading the narrative "has been such a trip. It has brought me back to thinking about things that I did not want to think about. I thought I was better than that, I feel a sense of failure." George said that "I may feel a bit badly about myself because I have fear. I have every reason to believe I could be rid of it. It's a defeat not to stay awake and work on it."

Larissa spoke about her feeling of vulnerability upon seeing her dental avoidant experience "written down that way." She realized that this narrative represented only "a chunk of [her] life." She felt that the story of her avoidance is still unravelling and would have liked the researcher to track her avoidance in a year's time. She stated that she had been affected by participating in this research "much like a person is affected when interviewed by an anthropologist."

For several, reading the narrative brought their avoidant experience into sharper focus. Some felt self-conscious and others a small degree of judgement towards themselves. Co-researchers were excited about recognizing dental avoidance as a complex and evolving process. Larissa commented on the richness of looking forward to seeing what lies ahead in avoidance research. Kevin felt relief at reading the narrative and gained the perspective that his fear was not as debilitating as it had been. He knows that "I'm going to be okay! I'm going to survive the rest of my life!"

**Independent Reviewers Appraisal**

The independent reviewers were each given the audiotape of their original interview and a copy of the narrative account of that co-researcher. The independent reviewers were asked questions regarding style, bias, accuracy, and omission, in an accompanying letter (Appendix A).
Within a few weeks time of the distribution of the tape and narrative, a follow-up interview was
done and taped.

For the independent reviewers, the experience of reading the narrative was very engaging. Remarks such as "the narrative was great" and "the narrative speaks to the quality of the interview, there was rich material coming through" reflect characteristics of the narratives and the vividness of the co-researchers' experience. One reviewer found the narrative "fascinating" and that "between you and him, a sense how this [the avoidance] had impacted and evolved and continued to shape and interact with how he lived his life was nicely fleshed out in the interview." Another found that "the pulling together of the narrative, I really think was very unbiased and did what you set out to do."

The reviewers felt that I had been respectful of the co-researchers and facilitative of their process during the interviews. A reviewer said that what impressed her most that "it was very respectful, particularly in areas where you made her comfortable because quite a lot of things were things for her generation that you just didn't talk about." Another said that "it was unbiased, very Rogerian in its style, your energy matched his very well." Another commented: "The client spoke so freely and easily and told so much of his story." One reviewer felt that the use of humour "broke the tension and made him feel a little more comfortable." Patience was identified as a factor in allowing the co-researcher "to go deeper with it [the subject]."

One reviewer remarked that she was aware of how well the researcher followed the co-researcher and assisted in opening him to the next level. In her opinion, there were many times that the interviewer was helpful in refining "the general to the specific." One independent reviewer felt that the researcher met the challenge of successfully keeping the co-researcher "focussed in" by asking "can you give me an example?" There were times when allowing the co-researcher not to focus and to go into different areas was also considered facilitative by an independent reviewer. "It was effective that you allowed him to go into different areas that perhaps were only tangential to what your main focus was." A reviewer felt that although one co-researcher seemed to lead herself, the researcher would "add a clarifying question or supportive statement."

The independent reviewers were unanimous in their appraisal that the interviews were free of bias, congruent, and that the researcher did not lead the co-researcher. One remarked "if you were forcing a pet theory I don't know what it was." Another reviewer said "you were, in a focussed way, sampling some different aspects [of dental avoidance], but I didn't feel like you were pushing him into any particular theorizing about it." "You did a really good job of staying out of the way of leading him or jumping to conclusion."
Generally, nothing of importance was left out and there was no distortion noted. Most of the reviewers reflected the view of one "in listening [to the interview], I felt very privileged in being able to hear about her story and about the impact of her dental experience."
CHAPTER V
THE GENERAL STORY OF DENTAL AVOIDANCE

The general story encompasses the unique and diverse experiences of nine individuals' experiences of dental avoidance within the context of their lives. The objective of the general story is to offer a synthesis of the nine individual stories into a collective story of dental avoidance. A story is a life drama or "symbolized account of actions of human beings "which has "a beginning, a middle, and an ending " (Sarbin, 1986, p.3). This concept is expanded by Cochran (1986):

The basic organizing principle of a story is a gap between two poles... Scholars have used various terms to describe the beginning, such as disequilibrium, problem, disturbance, or upset. The path toward resolution of difficulty is the middle of the story. And the story ends when the initiating disturbance is calmed (p.13).

The sense of coherence of a story is created by "recognizable patterns of events called plots" to which "human predicaments and attempted resolutions" (Sarbin, 1986, p.3) are central. Patterns that grew out of the synthesis of the nine narratives were organized into three portions: the beginning, the middle, and the end. The beginning of the story considers the influences, emotions, and beliefs leading up to avoidant episodes. The growth of avoidance, precipitating events or influences, the avoidant experience, and the shattering of avoidant defenses, compose the middle. The ending incorporates the seeking of dental care, results of reappraisal and new values, the enlistment of help from others to continue seeking care, and the meaning of dental avoidance. This story is confined to the experiences of the co-researchers rather than proposing a generalization to other individuals who may have difficulties with dental avoidance.

A brief overview of the personal experience of dental avoidance serves as a prologue to the general story. There is a greater degree of complexity of the phenomenon of dental avoidance as demonstrated by the nine co-researchers than the causal reasons generally identified. Dental fear, socioeconomic status, gender, ethnicity, economic constraints, age, and dental status, are among the most widely replicated reasons. Although dental fear was a factor in many instances it appeared often to be linked less with dental procedures and more to do with lack of support; lack of being acknowledged by the dentist; lack of having choices in the dental office. Often experiences other than those related specifically to dentistry had powerful consequences which became generalized to include the seeking of dental care. The effects of early childhood traumas for a very specific population were a result of experiences such as sexual abuse, accidents, surgeries, and medical interventions. Orality issues such as the interruption of the gratification of early needs, the force feeding of infants, and the violation of the oral cavity in
sexual abuse (audiotaped interview with Hanley and Jacobs, 1992), are all less easily recognized as reasons for this avoidant behaviour.

The inability of some people to seek care for their teeth has profound effects on their sense of themselves as well as affecting their behaviour in other areas of their lives. Many speak of the feelings of lowered self-esteem, lack of self-efficacy, deep shame, guilt, and fear of the unexpected while in their avoidant phase. These feelings may be linked to a person's sense of agency (Laub, 1991, p. 14) in being able to follow through in general behaviours in their lives. It is difficult to ascertain whether a person's sense of agency is the cause of avoidance or a result of the effect of avoidant behaviour. In addition to the shame of visibly decaying teeth and an overwhelming sense of helplessness in not being able to take action, some people that engage in avoidant behaviour often feel the shadow of something inexplicable. In retrospect, after the avoidant period is over, there is a recognition of the denial which enabled them to live with the effects of their deteriorating dental health. This denial also relates to avoidant behaviours in other parts of their lives such as avoiding relationships and commitments, being fiscally irresponsible, and avoiding medical care.

The Beginning

The story begins with the experiences and difficulties which precede and possibly precipitate the avoidant behaviour. There is a considerable range of elements which impact the development of avoidant behaviour. As in all stories, there is an interweaving of these elements. No one aspect stands alone but is a strand in the complex tapestry reflective of the personal experience of avoidance in dentistry. These elements develop from various chronic and acute influences. Personal, family, and cultural values and attitudes constitute the chronic influences. Acute influences evolve from traumatic episodes of direct dental experiences or of non-dental experiences that have been generalized to dentistry. Arising from these influences are emotions and beliefs which determine the decisions a person makes prior to taking action to either avoid or seek dental care.

Chronic Influences

The elements of chronic influences derive from the unique characteristics of an individual as well as the impact of personal values and the values of family and culture.

Cultural Values

The time in history when a co-researcher was born may have influenced their cultural values, the quality of their dental care, and economic considerations. A brief description of the history of the culture of dentistry within which the co-researchers have lived will establish a
cultural backdrop against which to view this story. The early dental experiences of the older co-researchers took place in the early years of this century. At that time dentistry had progressed from the care by "a band of itinerant tooth-drawers" Davis (1980, p. 13) to a primitive version of care when compared to the sophistication that people find in dental offices today.

Cultural and family values and economic factors of today form a very different backdrop against which the avoidant experience took place. George and Eleanor were children in the early part of this century. This was a time when dentistry was in its infancy. Dental procedures were often painful and little was understood about preventive care. Some family attitudes about dental health were casual, George did not "even remember them teaching me or telling me I should brush them. It wasn't that I was bullied into doing it and resented it....I think they always thought I brushed them." Neither his mother nor father was interested in health "in a positive way", and today he can "take it or leave it about health."

Personal and Family Values

Little was elicited from the co-researchers about developmental aspects of their mouths. It may be that because oral development takes place at a preverbal age, they had little conscious recall. It is also possible that lack of memory or information from parents or the amnesia which occurred as a result of traumatic events (Levine, 1992) contributed to this lack of recall. Mark spoke of his "preverbal oral damage" and being considered "a poor eater." He associated some of this damage with his mother forcefeeding him when he was still in his high chair. He feels that his mother's action was also responsible for some of his early will struggles which included holding his breath until he passed out. Several co-researchers reflected Erikson's (1963) developmental phase of challenging parental or societal values when they did not seek dental care after leaving their families of origin, possibly in oppositions to parental values about care.

In addition to parental influences in early developmental stages, parental attitudes toward dental and medical health have also affected young children's aversion to dentistry. Although in families, mothers most often took responsibility for making appointments with the dentist when the children were young, the co-researchers were often influenced by their fathers' attitudes. In Larissa's family, her father showed a lack of sympathy for admitting pain or being ill: "we didn't dare get sick." His attitude created a double bind for her dentally. How could she seek care for the pain of her cavity? Not only was she "wrong for having got a cavity" but she was also "wrong for asking for help." Mark recalls his mother being so afraid of the dentist that his father had to emotionally support her in order for her to go for care. His father also fostered in Mark the importance of the general care of oneself. Kim had the example of his father, as a "macho male", going to the doctor and dentist so seldom in his life that "you could count the times on one hand."
George felt that the malingering behaviour of his father was used to avoid responsibilities: "he made himself sick at times, when he didn't want to do something."

There were vivid first memories of tooth related events: Kevin's of his great-grandmother being the only one in his family that brushed her teeth; Herschel's of his father brushing his teeth with soot; Eleanor's of the unexpected shock of putting a red pepper in her mouth while her mother was pickling.

In spite of preventive dental health values changing, in many families there was little knowledge of health habits being related to having a healthy mouth. Even if there was an awareness of this relationship for parents, children were often unaware of the connection. Several had similar experiences to Mark, brushing teeth "was just something you did, like putting on your jammies." For other families such as Kim's, regular attendance at the dentist was just "something you did" and was externally imposed and not internalized as a habit. Charlotte's family had a high level of health consciousness, and attending the dentist on a regular basis was just "part of the fabric." She never made the connection between brushing and preventing cavities because she always had cavities. In Larissa's family, although her father was a doctor, "it was not an attitude of health promotion, but "something to prevent you from going wrong." In some families there was a lack of instruction, Stan did not know that there was "a right way" to brush. Some families reflected Kevin's experience; "there was a heavy dose of denial in my family." No one ever talked about teeth; you were left to discover" for yourself." This lack of acknowledgement of the importance of teeth was reflected in Kevin's sex instruction when "she would leave a pamphlet in amongst the towels in the towel cupboard."

It is likely that the formation of these early attitudes towards dentistry was associated with the formation of health attitudes in general. Kim "only sought care" when he had sports' injuries; George felt that he is "more accepting of anything that happens to me [healthwise] than my parents....and I'm mildly interested in being well." Often children followed family values, but there were individual differences. For instance, Kevin was "the odd one in my family" in that he was the only one who sought self care. Others like Eleanor, had a low pain threshold. "I wasn't a very secure person, I was highly sensitive."

There were also genetic differences which related to people's experiences of comparisons." Mark describes his unaligned teeth as reflecting his mother's teeth unlike his father's "good looking straight toothed" look. Between siblings, there were also contrasts, Stan remembers triumphantly leaving the dentist's office with no cavities, at a time when his brother had decay, with the popular Crest jingle "Look Ma, no cavities!" ringing in his ears. That he had "perfect teeth" in relationship to his brother's soft and decaying teeth, was noteworthy for Kim.

Some families experienced financial hardship when the children were young so that dental health values were of low priority. In Herschel's family there was so little money that the
children felt they were lucky to have a tooth brush. Later when his mother sought the advice of a
dentist about Herschel's unaligned teeth, she was so consumed with struggles at "keeping the
peace" between her children and the step-father that she never followed through even though
they had financial coverage under a national health plan. As the child of a single mother, Eleanor
recalls eating "a lot of starches" in order to stretch the food budget. At that time, she was not
aware that her high starch diet was conducive to creating cavities.

Personal values grew out of early family influences. These values affected the co-
researchers priorities in their adult life. Even though financial reasons for avoidance as adults
were voiced, these co-reseachers recognized that caring for one's teeth was often a matter of
values. Kim, when he was no longer on his parents dental plan, identified lack of insurance as
only a contributing factor to his avoidant behaviour. Mark realized that his concern for the cost of
a particular dental procedure was a rationalization rather than that he could not afford it. On one
occasion his dentist had stopped in the middle of a procedure and asked him if he wanted a
procedure that would cost one hundred dollars more than expected. Mark felt very disturbed by
this lack of involvement in the pre-planning decision. If the dentist had discussed the cost of this
procedure in advance of beginning treatment, there would have been no problem for Mark in
agreeing to pay for it. "A hundred dollars, well that doesn't mean anything in the big picture of my
life."

**Acute Influences**

For many co-researchers early experiences left a profound impression. Some of these
experiences related directly to dentistry such as the attitude of dentists, general anaesthetics,
freezing, drilling, and the environment. The experiences of others were more oblique. Many had
aversions to dentistry even though they had never had a direct episode of pain or a negative
personal encounter. These may have been a result of an early traumatic experience such as a
medical procedure or sexual abuse.

**Direct Experiences With Dentistry**

Many spoke about the association of fear and pain with dentistry. In the forties and fifties,
when Herschel was young, going to the dentist for him was traumatic and unpleasant. For some
the drill is particularly objectionable. Both the vibration and the sound cause discomfort for many.
The sound of the drill affected Larissa more than anything. One day when her dentist was drilling
in her mouth, she felt "like my whole being was going to shatter."

Body modifications such as the application of braces, partial dentures and full dentures
were mentioned by the co-researchers. The application of braces was described by Mark as
"being a negative experience all around the block." First, he recalls the trauma having had two
molars removed under a nitrous oxide. His recollection of his braces was "a lot of ache and pain as every two weeks the orthodontist "would tighten the gizmos and then my teeth would ache for two days. I'd wear a harness and wake up in the morning with a sore mouth...So I just have a lot of negative recollections around my mouth at the physical level."

George had a powerful episode when he was about eight that has remained with him: he remembered his father putting a partial denture plate out at night. Almost eighty years later, he can still see the image of that partial. "I remember having a feeling of revulsion about that, and that may have had something to do with (not liking to go to the dentist). And [the partial] was something done by a dentist!" He had further insight into the association of his father's partial with his early dental aversion, when he spoke about his father who "rubbed me the wrong way. And so with this unhappy feeling between us, those teeth [the partial] there meant more still."

In addition to the trauma of the loss of teeth by extraction, dentures may cause difficulties for the wearer as Eleanor's experience shows. Wearing dentures for her was the "bête noir" of her life. For her losing her teeth, was worse than losing a leg. With the loss of a leg, "you can compensate one way or another....I think your whole being depends on your digestion and your choice of food."

Many of the direct experiences with dentistry were often traumatic and left powerful memories of specific incidents. Many years later, these recollections were painful to recall.

**Generalized Non-dental Experiences**

Although people may have never had a negative dental experience they may have had upsetting experiences with doctors and other health professionals. Difficult medical experiences can become generalized and affect the seeking of dental care. Negative associations may occur as a result of injections for routine immunizations or medical anaesthesia as well as lack of anaesthetic for painful incidents. It is likely that preverbal experiences of infants with routine immunizations has influenced the way the child in later years may respond when in situations requiring injections.

The aspect of being unable to truthfully acknowledge what you were really feeling appeared to also be a dynamic, encouragement was given to "keep a stiff upper lip." When she was 13, Eleanor cut an artery in her leg while skipping with a long metal shaving and was not frightened although blood was spurting out. However, when she went to emergency, experienced pain in the context of no support. The "intern sewed it up and why in God's name he did not freeze it or anything....I hollered a lot!. The nun ordered me to please be quiet." When George was in his teens and was boarding at Upper Canada College, he remembers having rheumatism in his left big toe. He "had to make up some wild story [that he dropped a drawer on his toe]...so
that she let me into the infirmary... I can't go down there to the nurse and say I have a sore toe but I couldn't walk at all Then two days later it was round to the other toe!"

A horrifying experience which had elements of being encouraged to deny any problems, left a lasting impression on Kevin which has persisted since he was 12. He had had a swelling in his neck which "hurt like the devil" and went untreated by his doctor for two weeks. He was later hospitalized and for three or four weeks had "just a lot of pain....The adults were just walking around and I mean nobody was doing anything! It was nuts! It felt much like the torture I went through (earlier when his sexual abuse being denied)....Everybody was commenting on how stoic and tough I was." This experience was further complicated by him being on "a cancer ward for old men" and feeling invaded by strangers giving him religious tracts. In spite of feeling that he had dealt with this experience superficially at the time; "The whole thing was a nightmare!"

An experience of being disrespected by medical personnel was described by Eleanor. When she was returned to her room after surgery, the nurses discovered that "the operating crew had put a strip of adhesive tape on my forehead which said not to send patients down with nail polish on their fingers. I was insulted!" She felt like she was "a piece of meat, a thing!"

Experiences with serious medical implications were profoundly effecting. When George describes the following episode which occurred when he was 30: "I had shingles of the middle ear and it was a terrifying experience and I feel perfectly justified it was terrifying cause I don't know how anybody could have gone through it without being scared to death...It was awful!" His specialists told him that "there was no reason in the world why I had any hearing at all and the eye doctor said he didn't know how my eyes lasted." He describes that experience as taking "the medal for the big one" medically in his life. Although George knows that his aversion to dentistry had begun before this experience, it is possible that his present dislike of drilling may relate to that experience with his middle ear, rendering him more susceptible to noises within his mouth.

In addition to traumatic medical experiences in childhood that are generalizable to dentistry, physical and sexual abuse experiences also appear to be implicated in dental avoidance in later life. Four of the co-researchers report memories of sexual abuse in their early childhood, some by family members and others by a dentist, a doctor, and a barber. The trauma of the abuse may influence retrieval of memory and account for some episodes of amnesia about early dental experiences. Stan relates that his first experience of going to the dentist "would have occurred just before the sexual abuse stuff started happening and that's maybe why its my only memory."

In families where sexual abuse occurred, there was a strong sense of denial which was very confusing to the children. For Kevin; there was the craziness of the denial of his grandmother's drunkenness and violent behaviour. For Stan; the knowledge that his "family was not this nice little family" they seemed to be. The circumstances around the abuse may have
resulted in generalization to dentistry in relation to abuse experienced by the co-researchers by a dentist, a physician, and a barber. In the situation of the sexual abuse and cruelty by her dentist, Eleanor felt more helpless in knowing that she would not receive any empathy from her mother.

In the situation of abuse by the barber, Stan feels that his experience may have had something to do with his later dental aversion, that in addition to his psychological trauma, the barber's white smock and chair may have influenced future dental situations. That his grandfather who was also abusing him took him to this barber contributed to the profound effects of his abuse. He experienced a high level of anxiety all the time, found that he did not like or trust himself, "not trusting and being afraid of much of the world because my sexual abuse experiences (occurred) not only in the home very close to me...but also outside in some place like the barber shop, that you're just supposed to be able to go quite normally, so it was like the whole world became unsafe for me." Up until two or three years ago whenever he had to go to have his haircut, he would have "totally powerful anxiety attacks" when his heart would pound, his eyes would having tunnel vision, and he would perspire in anticipation of going. He would have to go to several shops before finally entering. All this time his avoidant behaviour around dentists and barbers was "Incredible! I always thought that I was the one fucked up." He describes his sexual abuse as being "one of the most powerful factors affecting his life (getting) played out in particular around memory, denial, and repression, and my capacity to accomplish things it was quite phenomenal."

Sexual abuse is also a factor in a person's ability to set boundaries that sometimes becomes problematic for people when they are in the dental chair. For Larissa, "it felt like I was in somebody else's space and I didn't know that I had a space of my own and boundaries....I didn't know who I was and was very symbiotic....I felt like a marshmallow....But there were certain spaces where there was authority, particularly a medical authority like my father, that I lost the sense of having my own space. Why did I live it with so few questions?" She didn't remember anything specific about her mouth but she knows that "the whole thing of being invaded, my space being invaded that may affect not going to the dentist." On one of her first visits to a dentist she had a frightening experience of the space expanding. In her work with a therapist, she was able to "trace back one incident where the space changed and I ended up going to the corner of the room and that was a safe place to be and I could renegotiate with Dad. But as a kid I couldn't do that and it was like the room just shifted shape." Larissa speaks of keeping "the boundaries pretty tight in terms of intimacy and relationships", in spite of being very expressive in certain areas. "I have to develop trust around authority figures [teachers, dentists, doctors] and then certain things can be accomplished." With authority figures she really controls her vulnerability by taking "good care of my boundaries to the point where I'll keep them out and this way I run the show."
Feelings of body spatial shifts occurred also for Kevin, who had a reoccurring nightmare "which was this feeling of being separated from my body and falling inside while everything else around shoots up. And that sometimes occurs in the chair. There's this part of me that's collapsing inside my body while the outside of my body [and everything outside of me] expands. It's the strangest, strangest feeling. It's a very powerful one for me and I have a real sense of panic." He had a image of this experience represented "by this golf ball-like thing with buildings shooting up past me, me just dropping down" that he used to play a game by thinking about the image and bringing this experience on. People that have been sexually abused often have some discomfort with intimacy or an aversion to touching, particularly their head, mouth, throat or moisture across their faces. Kevin emphasizes this: "the drill does not bother me, the burning smell does not bother me, the dam bothers me but part of it (the fear) was having people looking in my mouth, having their hands in my mouth, laying back and having people do that. There is a degree of intimacy to it (that) I wasn't comfortable with. There was...in the past, a point where I would have probably died before I was intimate. And it came close to that, fear of intimacy, and a lot of it." Whenever he goes to a dentist he is always considered "a good patient." His experience is that he just lies there and "usually I'm barren inside, I'm gone." Difficulties with intimacy extend often to include intimate others as well as authority figures.

Traumatic memories are not just confined to dentistry. Childhood experiences such as difficult medical experiences as well as sexual abuse can be generalized and result in an avoidance of dental care.

**Emotions and Beliefs Arising From Influences**

Growing out of earlier influences or experiences, either dental or non-dental, were several emotions that affected the individual's beliefs in regard to their dental health. Some of the most powerful emotions were those of fear and anxiety, shame and guilt, powerlessness, and the sense of depersonalization.

**Fear and Anxiety**

Fear and anxiety can arise from direct experiences in a dental office or may be generalized from some non-dental episode. In addition to general associations, people may have had with relating emotions of fear and pain with dentistry, there were many other emotions that arose as a results of the specifics of dental care such as elements of the office environment, general and local anaesthetics, drilling, and body modification with braces and dentures.

Memories of visiting the dental office, were vividly described by co-researchers. Herschel felt oppressed by the Victorian building of his dentist with its dark furnishings and antiquated equipment and by his dentist who smelled irritatingly of tobacco. Some described the heaviness
of the atmosphere of older buildings. One high school where the dentist's office was was a place where everything for Larissa, when she was about eight years old, was "absolutely enormous, everything seemed huge and terrifying, cavernous...and I was by myself." She felt "very small and intimidated" and was reminded of an experience she used to have at home in which the bedroom shifted shape and became "enormous." There was a familiarity between this situation and one which occurred for her around "some sexual stuff with my Dad... I would try to get out and the room would shift shape, so there is a familiarity between the two senses; a kinesthetic sense of the spaces,... of the shifting shape." Sometimes dental offices appeared unwelcoming. The "little glassed in box" of the receptionist in one specialist's office contributed to Stan's experience of being unwelcome.

The effects of early encounters with general and local anaesthetics elicited strong memories. Herschel's first dentist gave general anaesthetics for all his dental procedures and he remembers "that rubber mask smelling like a tunnel... and there was a piece of rope going over your ear and they hold it to you. That was absolutely frightening." When Kevin was eight years old he had teeth removed because of his crowded mouth. When they applied the general anaesthetic there was "a real sense of suffocation, panic, the bad smell. I remember things physically....I remember hissing, it had a very foul smell to it, something toxic."

For some there were stories of drilling without freezing. Herschel remembers sitting in a chair and having fillings without freezing. "That was not fun! If he tried to do that again, I would fight back." He was tearful at the memory; "That was an assault!" In order to accommodate Kim's hatred of freezing, his dentist tried to drill without freezing and "it semi-worked."

Sometimes people have aversions to needles. Larissa spoke of being "terrified of needles and once they were in it was okay." She vividly recalled "the whole thing of this needle coming into my mouth....(I) see this monstrous arm and this needle... and feeling like I'm going out of control." She had conflicting emotions. Even though she was terrified, "the little scientist in me was quite intrigued with it all."

When George was about seventy, he had an anxiety producing experience in a dental office. He remembered an experience of been given an injection prior to the dentist filling his tooth; "and then feeling afraid" because he had palpitations in his heart. "The dentist said to me 'are you alright?'") The nurse came in and also inquired about his welfare. During the time the dental personnel were absent, ["it seemed like ten minutes"], George reassured himself by thinking: "Perhaps I'm not alone....surely they wouldn't go away if there was anything serious" but he was frightened because he didn't know whether "this heart thing was heart or whether it was just something the shot did to me." It is possible that this situation did have something to do with George's heart, because when he was hospitalized several years later, he experienced heart failure while in hospital.
Although the literature identifies fear and anxiety as the principle reasons for avoidance (Gatchel, 1980; Harrison, Carlsson, & Berggren, 1985; Kleinknecht & Berstein, 1978; Kuhn, 1988; Milgrom, Weinstein, Kleinknecht, & Getz, 1985), it would appear that in individuals' personal experience the relationship is complex.

Shame and Guilt

Co-researchers were aware of feelings of guilt, shame, and embarrassment around their mouths and teeth. There was guilt for having cavities; guilt for not brushing your teeth or brushing your teeth incorrectly; guilt because your teeth were not "perfect"; or just an inexplicable feeling such as Larissa's experience of "a prevalent sense of guilt about having something wrong with me." In her family there was the comparison between her and her sister and brother: "whoever had the least cavities was praised. If you had fewer cavities you were just a much better human being. It was always my teeth that were not the best in the family. A subtle comparison, somehow you were guilty if you had cavities." For her there was a confounding of the shame because there was always a "mystery" for her about how she developed cavities.

Sometimes co-researchers felt shamed by their dentist. Stan as a teen-ager going to a new dentist, felt the dentist's disgust about him having cavities and not cleaning his teeth well enough. For him, that was "awful" and he felt "the shame of being wrong."

For Kevin, his embarrassment or "difficulty facing" related not only to dental situations when "it's difficult to get back" but also "it's a feeling I've had in other situations in my life." such as being an undergraduate at university. At this time it was extremely difficult for Kevin to go to class. "If I missed a class it was almost impossible for me to go back sometimes. I was bright enough that I could wing it. [For the most part] I could write exams without attending class....I didn't understand then what was going on. I barely do now....Didn't feel claustrophobic or trapped. It was I couldn't go back and 'face them', that's the phrase."

Some people are sensitive to the esthetics of their teeth and have a sense of shame that they are not more "perfect." For some, their sense of self-image is affected by their feeling that their teeth are too big or too small. Herschel's older sister and brother nicknamed him "Tombstone" because he had two prominent teeth in front. Mark speaks of his understanding of his unhappiness with his teeth: "I feel I have big teeth which means somewhere I have an idealized image with smaller teeth....Obviously, I'm unhappy with my teeth....They're too big. Why would God punish me with unstraight teeth?...Why don't I have better teeth? So there's a lot of existentially based struggles around my teeth."
Powerlessness

Feelings of being powerless constitute a major difficulty for persons with avoidant behaviour. Often this sense of powerlessness was related to lack of choice and perceived violation of boundaries. Many spoke of having no choices as to having dentistry; having their complaints ignored by dentists; and having a sense that others were in control. Parents' demanded their children's compliance with tooth brushing; dentists often did not discuss the possibilities of choice; did not engage individuals' in understanding procedures in advance of treatment. As non-participants in the process of the dental treatment, people often felt powerless and felt that they could not assert their needs.

Eleanor's lack of assurance manifested itself in her never questioning "any kind of authority from Mother, teachers, professionals." She felt that she "didn't have what it took to say the way I felt" and to request that dentists do something differently. Her sense of powerlessness, prevented her from protesting a physical violation of her boundaries. "If I had had more assurance I could have told that old man [her dentist] to keep his hands off my breasts.... I just accepted this." Her inability to protest was further heightened by the fact that "my mother would not have understood or cared'. She found herself angry at the dentist's mistreatment the first time but accepted that."anger was just a fact of life." She felt resigned to her sense of lack of control; "What could I do? No way I could do anything. You know, [he was] stuffing your mouth, unless I kicked him or something, but that was not my method." She felt that inspite of the fact she had a certain amount of anger she was resigned: "was a useless thing. Am I going to carry anger to dentists or professionals?" About the age of twelve or thirteen, she was able to respond more assertively in relation to authority figures in her life. At that time, "I was rebellious and felt something was not fair....I felt like an apple, they [my Mother, authorities] could eat my outside but they couldn't eat my core!" She felt her lack of confidence also affected her ability later on to obtain what she needed in order to have a healthy mouth.

Often a deepening sense of powerlessness occurs during dental avoidance, as the state of a person's mouth deteriorates. For individuals who have to have teeth extracted, there is often a sense of powerlessness in terms of being unable to control the state of their mouths. The loss of one's teeth is a very profound experience accompanied by sadness and loss. The sense of powerlessness in being able to intervene in preventing the loss of teeth is mirrored in Eleanor's deep sadness. "Everytime I lost a tooth there was a loss. I was aware that if you didn't keep your teeth others shifted around and your bite was off and that added more stress to your dental [system]."

There was also the interface with the developmental issues of developing self-responsibility and the difficulties inherent. Eleanor's felt that she had a "too soon maturity, I felt out of control" of things in her life. Larissa's experience with surgery for breast reduction is a vivid
illustration of the sense of having no control. The first she knew of the this surgery was when her father called her at the place she was working for the summer and told her to come home early because he had arranged the surgery. "And I, at eighteen, just went along with it--it amazes me!" She felt that she had turned over her authority "a sense of being violated by the medical profession....and the whole thing about being under anaesthetic and being out of control." She remembers "waking up and this guy I had never met before marking on my breasts with a pen." Previous to this experience, her father had arranged without her knowledge for surgery to remove a cyst from her neck. She associated both these experiences with "a mystery that I didn't know and somebody else was the authority and certain actions were taken that I just had to go along with." She feels this feeling of being under anaesthetic and out of control is also connected to her experiences with dentists.

The importance of maintaining control at any cost was demonstrated by Kevin during his hospitalization for his neck infection when he withheld his urine for two to three days as a way of taking control. "That was one of the promises I made [when he was about three or four years old] that nobody else gets control of my body. So it's difficult to come in [to the dental office] and let somebody else control my body. I mean Nobody gets the body!"

Depersonalization

Some people feel unacknowledged when they are in a dental office. They may experience a sense of powerlessness because of their perception of a lack of control while in the chair because they regard the dentist as an authority figure. Part of the lack of personal acknowledgement that people experience, comes from feeling rushed; being treated in such a way they felt like a "number"; or feeling unsupported when the dentist leaves the room abruptly and frequently. Often people speak of feeling unseen or unheard by dental personnel when they are preoccupied with their work. Once Herschel felt particularly unseen by a dentist--"he even looked down his nose at me." Dentists are not the only ones singled out for criticism. Several instances of insensitive responses from other dental personnel were cited such as the rudeness of receptionists, dental personnel, and specialists and their staffs were mentioned several times. Being kept waiting and not being informed was another instance of not being seen. One evening while volunteering as a client in a study session for hygienists, Herschel "was sitting in a chair and it was like I wasn't even there! I wasn't part of this, except 'open your mouth!'" He was shocked that no one even mentioned his name. "They should have taken a skull and worked on it!"

Beginning of Disequilibrium

In the story of dental avoidance, a "disequilibrium, problem, disturbance, or upset" (Cochran, 1986, p.13) occurs that begins to unbalance the formerly held position by a person in
relation to maintaining the care of their teeth. Sometimes this imbalance occurs as a result of the accumulation of the results of chronic and acute influences. From these influences arise certain emotions and beliefs which begin to impact dental health behaviour. For some persons, a single violation or perhaps series of violations create a disturbance in formerly held positions. For others, the problem may emerge from a growing mistrust of the dentist and dentistry.

Violation

Most of the co-researchers had experiences in which they felt violated while in a dental office. Many people have a sense of vulnerability even before beginning treatment. Compounding their vulnerability, was that they experienced being touched in their mouths as an invasion of privacy.

For Eleanor, two experiences stand out as being ones of being violated in a dental office. On one occasion, she experienced "a really piercing pain, right up my gum, then right up to the back of my eye", when her dentist had given her an injection to freeze her teeth. She thought that he punctured her sinus, because about four weeks later she was horrified when she blew her nose and expelled "the most foul smelling matter you could believe." Because of her sense of being violated emotionally, Eleanor described her dentist when she had her teeth extracted as "a butcher."

Stan marks the time of the beginning of his avoidant behaviour to the negative attitude of a new dentist. He was about fifteen and he had always been under the care of a children’s dentist. Up until this time he had had no cavities. "I would describe her as brusque, judgemental. The tone of her voice and the things she was saying....and I remember then having cavities and that was the first time in my life that I had cavities....her talking about cleaning teeth and being really disgusted." He had these cavities filled and that was "the last time I went to a dentist until I came to a new dentist approximately twenty years later." Later, after becoming established in a practice that he felt comfortable in, Stan was referred to a specialist. He felt unwelcome in the office because of the impersonal manner of the receptionist and being kept waiting an hour to see the dentist. He was then seated in a dental cubicle which had little privacy "and and the place was so chaotic." When he finally saw the dentist, he felt unnerved as she was "running around like crazy" and came in and out of his cubicle several times within a fifteen minute period. Without asking for information about his condition and care, she started to question the quality of the care he was receiving from the other dentist. He felt violated by her; "it was just an awful way to be treated." Her judgement of him might have evoked shame in the past, but fortunately, because of his recent positive experiences in his new dentist's office, he "knew enough to be angry, rather than saying it was my fault." He decided not to go back for his necessary treatment.
and may have begun another avoidant period had he not found a dental practice in which he felt safe.

Mistrust of Dentists

The dynamics of trust appear to be complex. Mistrust has been associated with the dentist's interpersonal skills and attitudes, with questions of the dentist's competence; and with negative projections onto the dentist by an individual. Sometimes a dentist's lack of ability to really acknowledge the person in the chair has resulted in the dentist's professional abilities being called into question. Herschel had been in an office where he felt a lack of interpersonal communication with the dentist. "How can I believe what's going on here when no one is conversing with me." Sometimes unpleasant experiences became associated with anaesthetics. After having a general anaesthetic for a root canal in a specialist's office, Larissa had a really hard time coming out of it. "They were quite short with me and not very sympathetic....you know, again, that whole feeling that you've done something wrong." When she reported her difficulty to her dentist, he just brushed it off. This incident occurred just before Larissa began her ten year avoidant period.

Issues of trust also appear to be related to finances, it appeared that if trust was lacking then lack of finances became a reason for not seeking care. For Herschel, an avoidant period began during a time when his financial situation was difficult. The periodontist "was a pretty good dentist and had a good name....they were going to cut the gum back and do all that scraping....I didn't follow through with it . If he had been really human then and said 'you've got to get this done'--you know, just that alone, I would have said 'yeah, sure!' that alone!"

Eleanor found it hard to trust dentists for their professional or personal abilities as a result of her "unbelievable" experiences with dentists. The first dentist she remembers as a child was "cruel. he just kept drilling away with no freezing." She said that although she trusted dentists "many were good people...but I was unfortunate, not just with dentists. You take your chances with anybody--physicians, etc.. It's human nature and every now and then you're lucky."

Others described some dentists' behaviour as "extremely rough, brusque, judgemental." Not all dentists were described in negative ways, Kim talks about having nothing but good feelings for his dentist who was a kind of a friend of the family as well as a professional. Sometimes the positive qualities of a dentist stand out in stark relief against previous distasteful ones, Herschel speaks about the first time he met a dentist who "was a very nice young man. There was a total and very distinct difference between he and anybody else I've ever been to. He actually talked to me, and asked my name and where I was born." This was this first time that he ever felt a dentist was "other than a necessary evil." George described one hygienist as
"unfeeling and almost rough, I don't imagine she was but it felt that way to me that she didn't care when it hurt."

Sometimes there was nothing specific about the dentist that could be identified. George had an abhorrence for dentists "nothing specific, just a general dislike." It would appear that if a person experiences pain and fear with one dentist then those feelings and lack of trust carries to the next. Just after his Bar Mitzvah, when he was thirteen, Mark went to a new dentist, who although gentler than his first, still engendered fear.

The competence of some dentists was questioned: some thought their teeth were filled or pulled sometimes unnecessarily. Eleanor thought that many dentists did not keep up with improving their skills and developments in the field. Eleanor relates the necessity of having to have dentures to the incompetence of a dentist who did not keep up professionally. Kim speaks of the beginning of mistrust with his dentist. "I was brushing things under my gums and it started to swell up and my mother was really worried about it....So the dentist made room for us and looked at my tooth and said 'this is not an abscess' cleaned it out, and then went ahead and filled something anyway, and to this day I'm not sure that it needed to be done." His feelings of mistrust were further compounded when his filling fell out a number of years later. He felt that he needed to have some understanding of the dynamics which had occurred in his mouth so that he could prevent it happening again. "I think that probably what needed to happen was that somebody needed to spend some time showing me how to brush my teeth so that it didn't happen again rather than filling it." He relates that as a result of this experience and that "there was a lot brewing" in his late teens, his mistrust grew. This was the beginning of his questioning authority, family, and societal values. Attending his dentist was a habit, "just something you do regularly. Every time you go they find something."

Also associated with trust issues and dentists, are subtler elements such as the images that people project onto dentists. Mark's description of the dynamics of this phenomenon is elucidating. In one dentist's gentle care, he had been able to overcome his fear of needles sufficiently that he could close his eyes and receive an injection. He had been going to this dentist for ten years but was beginning to lose trust in him because of several experiences where he was consulted in the middle of a procedure rather than before. He "was at some emotional crisis point: there were finals [exams], I was not holding up to my own intellectual image of myself" and he phoned into his dentist's office to cancel a dental hygiene appointment and "I never went back! So this dentist got emotionally attached, somewhere in me to this crisis....and my own self-image and he...got swept into that pot." He describes his sense of guilt. In addition to his personal experiences with that dentist, Mark felt that he had associated him "psychically to a history of dentists in my mouth." He feels that he has projected "a negative father image" onto this dentist and links him to feelings such as "I don't feel I have control, it's costing too much
money, I have an obligation [to him], I...didn't live up to." He contrasts this with his experience with his present dentist. He first had a personal connection with this man, outside of the context of dentistry. He feels safer in this new office because he felt that he has "a positive father projection" on his present dentist.

For some persons, the view that they have of the status of dentistry in our culture affects the amount of trust a person has for a dentist. Mark realizes that the negative status image of dentists that he carried probably increased his mistrust. Dentists "are dealing with the garbage can of the body. Basically, who would want to pick around in some else's dirty mouth. Somewhere in my psychology the asshole and the mouth are connected." Difficulties with relating to professionals as authority figures was a problem for some. Herschel admits to his working class bias as he describes the British attitude to approaching dentists and doctors as "Dr. Gods, Dr. God, please speak to me!" and them saying "'I'll tell you if you need to know or if you don't!'"

Middle

The middle of the story encompasses the growth of dental avoidance; precipitating events or influences; what happens as a result of events, beliefs, and emotions; individuals' coping styles; the avoidance cycle; and interruption in the avoidance cycle.

Growth of Dental Avoidance

Dental avoidant behaviour grew out of the disequilibrium experienced by individuals. This behaviour does not always develop in a steady, incremental way. Sometimes a person will begin an avoidant period, and then find that they have to go back to a dentist for relief of pain. For some, chronic and acute influences lead to a gradual change in dental-related behaviour. Others may have been gradually influenced by these forces, but abruptly halt seeking dental care as the result of a single incident.

The co-researchers have followed several patterns in the growth of their avoidant behaviour. Some have avoided dentists over a lifetime, never having a regular pattern of attendance. They will only go to a dentist for the relief of pain. Some, although they had attended dentists regularly as a result of parental encouragement throughout their growing years, ceased attending when they left home or when they were in their early twenties. Reasons cited were lack of economic resources, travel, opposition to parental values. Others who may have begun their avoidance as a result of a single incident, may begin to attend again. Another negative dental event may cycle them into avoidance again.

Individuals sometimes would begin to avoid seeking dental care, but extreme pain would drive them to the dentist. For Eleanor, "it was always the question of pain. And when I couldn't
contain the pain, ironing clothes or brushing my teeth... then I would go and see a dentist. It was always allied with a certain amount of fear. Kevin would go on avoiding the dentist "until the pain got so bad, that I couldn’t stand it any more." His cavities would be so painful, it was "at the point where I couldn’t function. It’d be so bad I’d just have to go in or I couldn’t walk around." So great has been George’s "general abhorrence" for putting himself in the hands of a dentist, that he hoped "I would have the good luck to end my life before I had to go back to a dentist!"

Precipitating Events or Influences

Precipitating events or influences arose which contributed to the earlier beginning of disequilibrium. These events or influences appeared to be different for different people. For each person, this experience was different. Some made sudden decisions based on a single episode which may have been the "trigger" which "tipped" their behaviour into avoidance. Prior to this episode, they had been acquiring a lifetime of experience from which they formed beliefs and emotions associated with dental care. For many, their decision to avoid dentists was the culmination of years of slowly developing beliefs and emotions around their mouth and dentistry. Often there was no identifiable event.

Although for some co-researchers the avoidant experience was a singular episode lasting for a maximum period of 20 years, for five it has been part of a repeating cycle of "avoiding-attending-avoiding." Sometimes the avoidant behaviour appears to be triggered by a single event, an identifiable reason, for others it may have been developmental issues or a combination of developmental, dental and/or medical events. Some have an understanding as to the dynamics of their avoidance while for others it is inexplicable and confounding. Although other factors such as his sexual abuse contributed to Stans’s dislike of dentistry, the harsh and critical treatment by his second dentist doubtless precipitated the beginning of his avoidance. For Charlotte, her aversion to dentists did not grow out of any personal dental experiences but rather out of the horror of watching the indignity of her mother being treated by a dentist during a period when she was very ill and dying. For Larissa and Kevin there was an element of reclaiming, taking charge of their bodies. Kim, Charlotte, Stan, and Mark felt a sense of being free of parental constraints and making their own decisions.

Some people speak of negative experiences that they have had with dentists. Stan had a powerfully invalidating experience with the first dentist he went to after leaving his childhood pedodontist (children's dentist). This dentist upon finding his first cavities, angrily berated him for his negligence. To his knowledge, after having the few necessary fillings he stopped seeking care for the next twenty years. After finding a practice where he experiences support, Stan was referred to a specialist. While at this specialist, he found himself again being berated for the
condition of his mouth. "It may be significant here that she's a woman and that the other bad experience was also with a woman."

For Larissa, her avoidant period began just after she had a general anaesthetic for a root canal when she was about thirty-five. She had a hard time coming out of her anaesthetic, and the staff in the specialist office were "quite short with me about that" and she had the feeling that they acted as if "you've done something wrong....What's wrong with you?" When she reported this behaviour to her regular dentist, she was very disturbed by him "just brushing it off." She then began a ten year avoidant period. She felt her avoidance was combination of factors besides her dentists disregard, financial constraints, guilt, and possibly the unconscious associations with her childhood sexual abuse.

George and Eleanor, whose early dental experiences began in the early 1900's, appeared to avoid out of their abhorrence of dentistry. For them, avoidance behaviours were the norm. They only went when they had to because of pain or when someone told them to go. For both of them, there were events that changed their intermittent patterns of attending to extended periods of avoidance of ten years. George had an experience of anxiety and heart palpitations after a dentist gave him an anaesthetic. During most of the time of his reaction, the dental staff left him alone. He then entered a "solid" avoidant period of about ten years which was only broken by one visit to a hygienist. He perceived this hygienist as being unfeeling and "almost rough" and so went back to his avoidance. Although four years ago he found someone he could trust, so great was his anxiety that he has only gone about five times, mostly for emergency measures. Eleanor, although she has mainly a "spotty" pattern of avoidance, identified events that occurred that resulted in her making conscious decisions never to return to that dentist. One involved a dentist who had perforated her sinus while injecting freezing. This later resulted in a "foul smelling matter" forming in her nose. Since Eleanor received dentures almost twenty years ago she has only sought dental care twice; once from a dentist, once from a denturist.

Herschel's early dentist reflected an intermittent avoidance pattern. In addition to family values, his terrifying experiences with general anaesthetic for his dental treatments, and feeling unseen by his dentists, likely contributed to his dislike of dentistry. After coming to Canada he began fairly regular attendance, until he began to feel depersonalized by his experiences with several dental professionals. With one dentist, although he knew him outside of the office, in the office this dentist was impersonal and Herschel felt like he "was just a number." He then stopped going to this office. Later, a friend who was a hygienist invited him to a study club session, and once again he felt dehumanized. The hygienists paid so little attention to him that they could have worked on a "skull" rather than having him there. On a third occasion, he sought care from a periodontist (specialist concerned with gum disease). By this time he was sensitized to being ignored in dental situations, and when this dentist did not engage him in discussion about the
severe condition of his gums he did not go back for care. "If the periodontist had been more human, just that alone, I would have followed through on my care."

Extreme phobic responses to dentists were identified by the co-researchers. Kevin's earliest recollection of childhood experiences with dentistry was with a dentist who was "extremely rough." His next clear recollection was of attending a dentist in Britain, who did work without anaesthetic. He regarded this dentist's behaviour towards him as an "assault." He developed a phobic-like response towards dentists. During recent therapeutic work he has begun to make a connection between his early experiences with sexual abuse and his dental aversion. Although he was able to force himself to seek care for his teeth, he was only able to visit a particular dentist about three times, after which his anxiety over having to return and "face" that dentist would become so intense that he was unable to go.

Although Charlotte's did not like going to the dentist as a child, "it was not a horror." Her phobic responses to dentists, appeared to arise from a non-dental experience which was generalized to dentistry. When she was nineteen, as the eldest in her family, she was responsible for taking her mother, who was dying at the time, on several occasions to the dentist in order for her mother to have the cavities in her teeth restored. She knew this was a "mortifying" and unnecessary experience for her mother. Charlotte became incensed at her physician father's collusion with other "medical authorities" in submitting her mother to such an indignity. She experienced a profound sense of powerlessness and an aversion to dentists. A regular attender until she was nineteen, she then "divorced" dentists, beginning an eight year avoidant period. The severity of her tooth problems led her to seeking care and resuming regular visits. One day, after attending this dental office for four or five years, she was sitting in the chair and the dentist kept looking at his watch throughout the extended time the anaesthetic took to take effect. The non-verbal message she received from the dentist was "this is my time; it's lunch hour; what are you still doing here?" This really "crushed" her, taking away the little confidence she had about being there. That was the last time she went to that dentist and she entered a five year avoidant period.

Kim had regular attendance until he left home at the age of nineteen. He had sporadic attendance until he was was twenty-four. During some experiences in his teen years he began to question the honesty of dentists after believing that dentists had sometimes filled his teeth unnecessarily. He did not think during his maturing that he had ever understood the "link" between not going to a dentist and having "all your teeth...fall out." The reasons for his avoidance during that time he related to developing a sense of his own responsibility; lack of money; and a general sense of mistrust of professionals. For three years he avoided dentists, only seeking care once because of acute problems. This time he sought treatment "from dentists from out the country" who were writing their board exams. Again he became disillusioned, "as they would look
through my teeth and find something that they could work on, rather than looking at my teeth and
giving me some sense of what I needed for good dental health." He then began a five year
avoidant period.

Mark had regular dental care throughout his maturing years, until he left home. In his
earlier years he had a deep fear of needles and associated dentistry with pain. When he had
major orthodontic work to straighten his teeth he recalled "a lot of ache and pain." As a young
man, he moved to Canada from the United States. For the next five years, he essentially avoided
dentists. He described this as his "denial phase." His teeth were "very connected to a lot of
parental control; so my not taking care of my teeth is the same as letting my hair grow." In
response to problems with his teeth, he sought care with a gentle, supportive dentist. After about
ten years of care with this dentist, Mark began to become disillusioned with him because he
would not discuss treatment with him in advance of the procedure. One day, in the middle of a
preparation for a crown for his tooth, the dentist asked him would he like "white or gold" and when
Mark said "white", the dentist said, "that's another hundred dollars." Although Mark knew that one
hundred dollars did not "mean anything in the big picture of my life"; he then left this dentist and
entered an eight year avoidant phase. In retrospect, Mark attributed his leaving this dentist to his
rationalization that he "was just too rich for my blood" and to the fact that he "perceived" that he
received "information after the fact" and felt as if he did not have enough control over his dental
situation.

What Happens as a Result of Experiences, Emotions, and Beliefs,

As a result of the experiences, emotions, and beliefs experienced by the co-researchers,
they began to move into avoidant behaviour. During avoidant periods many emotions and
reactions surface. Co-researchers spoke of their feelings of inadequacy, shame, guilt,
vulnerability, denial, lowered self-esteem, mistrust, hopelessness, and despair. With shame there
was often a discomfort of sharing concerns with others. People felt guilt over not going, of other
things being a priority.

Kim felt some sense of "stupidity" over his problems because in the past he "never had to
work on his teeth." For some denial played a large part in their avoidant behaviour. Denial was
present in their families as they were growing up. For Stan "It was a haunted feeling of alway
knowing that something is wrong, something is terribly wrong but not knowing what it is but
always interpreting as something is wrong with me." He felt that his use of drugs as a teenager
was a way of dealing with the pain of this denial: "a way of physically bending...and mutating
reality, saying things are not what they appear to be on the surface." For George his fear of
dentistry is so powerful he has said to friends as a joke "that I hoped I would die before I had to
 go back to the dentist again."
Mark was "living in the bush" during one of his avoidant periods. For him at that time, caring for his teeth was "not an automatic habit pattern" so he did not have any difficulties if he "forgot" to brush his teeth for five days. "There is a real disconnection. I don't have any difficulty with that or feel my mouth yucky." He connects his denial as associated with his vulnerability and his teeth being "very connected to parental control-not taking care of my teeth is the same as letting my hair grow, wearing torn jeans." For Larissa her denial was "a hidden denial place....I don't have to pay attention to my mouth. It was inside where you couldn't see it, so nobody had to know. A mixture of financial and something I thought I could ignore." During his last avoidant period, Herschel had "a feeling of almost hopelessness, like I'm going to lose my teeth anyway [some were very loose] so...I'm just going to prolong it....prolonging (finding out about) the inevitable [by not going to the dentist],....very much like being in a hole. Deeper and deeper."

During his denial phase that included dental avoidance, Mark worked hard to change his attitudes about dentists and to develop a respect for them. He had been "fairly critical of how they are in my mouth" so he looked at them as businessmen. He looked for ways to acknowledge their abilities in an honest way. He would say to himself, that they were engaged in the delivery of services and he respected their training. For Kim, his avoidance was partially a result of becoming more self-responsible, developing values different from his parents and asking "why am I doing this [going to a dentist]? For the dentist's good or mine?" He looked after himself medically for sports' injuries and "I know what's going on in my mouth."

Co-researchers spoke of being self-judgemental. Larissa wonders "how could I have been so weak? I should take care of them, I should do this, do that, Yeah, it's hard to be human." Kevin realized that in his hierarchy of health values his head always came last. "I think it's odd that I used to go to physicians looking for help and not knowing what help was. I know now what it is I was probably looking for, but I never went to a dentist for. I would go [for help from a doctor] for migraines. Normally with teeth I would tough it out. Even with the migraines I was quite desperate before I sought help."

Many co-researchers were aware of how much their avoidant behaviour in relation to dentistry affected other areas of their lives. Herschel's experience is that his avoidant experience effected his life "tremendously." He "was also avoiding other things" in his life. "[In] relationships, I always had ports of call, but I never had a destination....So I always avoided anything that was strictly long term...My earliest childhood didn't seem permanent....Tomorrow never came....Then as a young teen-ager going to sea, I was never in one place for any length of time. So it didn't matter if I avoided things, because I was away the next week anyway."

There was avoidance that was associated with financial considerations. For some, even though there may have been money available, short term values prevailed. Stan "was also really poor for a long time" so the pattern of not being able to afford things "put the same behaviour
around avoidance. If you don't actually fill out income tax forms you don't actually owe the government any money!" In Herschel's opinion: "you avoid finances, I made a lot of money, I'd waste it a lot because I've avoided doing anything with it."

Larissa recognizes that she's missed some opportunities because of her avoidance "I've seen how I've done that in a lot of areas of my life; [in order] to control the degree of vulnerability." Kim speaks of "my avoidant behaviour involves setting up authority figures as trying to control my life in a way I don't want it controlled so I blow up the system rather than find some way to compromise it." He cited several instances in his life which reflected this behaviour.

After Kevin married, he would be awake with the pain at night and sometimes hysterical with the possibility of the loss of his teeth. His behaviour was disturbing to his wife. The extreme degree of his anxiety partially related to the fact that all his family members had lost their teeth and he vehemently did not want to be like them. He also had shame around his mouth. George regards his dental avoidance as quite a separate thing from the rest of his life, although while in hospital about two years ago had "the insertion of a cathetur and that drove me batty....It hurt physically a bit but more the idea of it....but I don't think that's the connection with the dentist thing. I don't see it if it is, although in one way it's a similar kind of fear."

The Avoidant Period

The dental health of the individual engaged in avoidant behaviour often deteriorates. People are challenged to cope as cavities develop; fillings fall out; crowns break, gums become swollen and bleed; teeth become loose or become so decayed that they require extraction. Often individuals experience extremes of pain or have difficulty chewing their food because of decayed or missing teeth. For individuals in the avoidant period, there appears to be two ways of coping with the increasing deterioration of their teeth. Coping in either an active or passive way enables individuals to maintain their avoidant behaviour. Some people cope by adopting one of these styles throughout their avoidant period.

Others may engage in an avoidant cycle within which there are both active and a passive styles of coping. In the active stage of the avoidant cycle: people will take action by denying the gravity of their situation; by pretending [acting as if everything is alright] by using distraction [emersing themselves in enjoyable events]; or by accommodating to the effects of their decaying teeth.

Some individuals who engage in active behaviour, may deny the gravity of their situation. This may be true of George who does not experience pain, even though he has not completed suggested restorative work. Although he has only "little twinges now and then, he thinks that "probably has nothing to do with teeth." Some people deny by caring for their teeth compulsively
while avoiding dental care. Others neglect and ignore in order to be able to cope with the results of the avoidance.

Accommodation was one way of actively coping with dental avoidance. In referring to his avoidant period, Kim described how he coped with the deterioration of his teeth. "You can imagine in a ten year period that a few fillings would fall out. So at one point I had this broken crown and three fillings that had fallen out. My mouth didn't feel any worse for wear than when they were all in there so why bother? And it was a very short term perspective. It wasn't long term at all." Kim accommodated to these problems with his teeth, by breaking off the pins of his broken crown and adapting his bite.

In the passive stage, the person copes by remaining inactive and not taking any action. They may sink into their despair; feel overwhelmed by their helplessness; or feel such a sense of shame that they are unable to overcome the inertia of their inability to seek care. Despair sometimes led to procrastination when people were fearful about finding out how bad their dental situation might be. For Herschel, it was better to avoid care rather than seek care and "find out the worst."

During avoidant periods, individuals will feel so overwhelmed that they passively endure the pain and only seeking emergency treatment when their pain is severe. As Eleanor grew up, she experienced despair and sadness because she lost teeth; a sense of helplessness at feeling unable to change things; and a sense of shame because she had not looked after her teeth well enough and they were decaying. For her, there always "a question of pain. And when I couldn't contain the pain, ironing clothes or brushing teeth or whatever then I would go and see a dentist. It was always allied with a certain amount of fear." Having to have an extraction under such circumstances was fraught with fear and pain which added to the trauma of the avoidant experience. Eleanor's description of her experience in which she relates her avoidant behaviour to the decay of her teeth and having to have dentures, elucidates the profound effect of losing teeth. Although she now knows that her present dentures are seriously effecting her lifestyle, she finds that she has other priorities in her life.

When people maintain their avoidance in an active way, they may find their actions are no longer working and their behaviour may cycle into a passive mode of coping. These coping strategies are an attempt by the the person to successfully avoid seeking care for their teeth. Although some people find their way out of this cycle permanently or for long periods of time, others may leave it only to seek emergency care in order to relieve their pain. The extent of Kevin's phobia rendered him unable to seek care for his deteriorating teeth. This contributed to him having serious nightmares and being awake at night with the pain. He would only go to a dentist if the pain kept him from his other activities.
Avoidant Defenses Shattered

It becomes increasingly difficult to adjust to the worsening of one's dental health. Ways of accommodating by refusing to smile or adjusting one's bite no longer seem to be sufficient. Things begin to happen that begin to shatter one's shield of defense or safety. Gradual awareness of the seriousness of one's situation begins to seep in. The density of this shield is penetrated in the form of reminders. Emotions penetrate. One looks in the mirror and feels anguish at the evidence that gums are bleeding and teeth are decaying. There appears to be more cycling towards anguish, greater swings to defense. People are less able to hold together the fabric that they had constructed in order to maintain the denial.

For some, the decision to seek dental care happened as the result of a specific event or realization; for others the change occurred as the result of a process which had been ongoing. Herschel had taken a weekend workshop for personal expression and creativity. At the end of the workshop he was to write down a number of things that he was to commit to in the following year. "And at the head of my list was going to the dentist!...I mean that's how big it was for me." At the workshop, he met a woman who was a hygienist and so he took her card and made the appointment the next week. After making the appointment he experienced "a lot of relief. It wasn't just making an appointment, it was a lot of other things in my life, too, that I was able to do. Everything started to fall into place." In his new practice, he feels "really seen in a personal way and it's very professional. Everybody is a person....it's a very comforting place to be."

For Kevin, the birth of his first son was the precipitating event that led to him seeking help for his dental avoidance, he was referred to me for counselling by his therapist and shortly after that chose to see a dentist. Mark was able to overcome his avoidance because he had developed an increased sense of reponsibility and self-esteem. At the same time he met a dentist socially that he liked upon whom he projected "a positive father image" so felt safe in seeking care from him.

Kim describes the three things that contributed to the end of his avoidance: that I met a dentist that I thought I could trust; I could see if I was pursing my voice [his previously unfulfilled dream] seriously that in ten years my dental health was going to be very important to me for a lot of external and internal reasons; the immediate thing was "this is ridiculous, you should be able to eat popcorn and potato chips with out being so damn careful! Then I started admitting to myself that I only brushed my teeth with warm water rather than cold water. And I started recognizing all the things I was doing. I couldn't have a steak for dinner without having dental floss there because there were enough gaps between my teeth that it was incredibly uncomfortable."

One of his external reasons stemmed from part of his voice training which was to watch video tapes of the Metropolitan Opera or Pavarotti on televisions. "So I started watching mouths a lot and I began to think, my mouth is not in a great state of repair". If he ever became known as
a singer "that's going to be me with all the cameras focussing on my mouth and all these young vocalists are going to see how my mouth moves and I don't want a bunch of dental decay spread out across the screen." He is now prepared to make sacrifices and is setting new priorities for himself that serve his preparation of his life for a singing career that would be concomitant with increasing qualities such as self-responsibility and self-esteem.

The naming of the phenomenon of dental avoidance was a turning point for Larissa in addition to having more financial resources and observing that her mother is now having a terrible time with her teeth. "She's been another one who says, 'I can take care of it tomorrow', but at seventy-five it's caught up to her and she's having to have plates put in and teeth taken out and she cracked a tooth at dinner one night... and I never saw her taking care of her teeth."

For Charlotte, the end of her avoidance occurred when she was eating a carrot and what seemed to be half of a tooth fell out. Although it was Friday afternoon, she was able to find a dentist who would see her after frantically phoning the dentists suggested by her friends. She was able to find a dentist with whom she immediately developed rapport. Through this dentist's gentle and supportive care, Charlotte has been able to maintain an active preventive program of care, in spite of her continuing phobic inclinations.

The End

The end of the story of dental avoidance grows out of people developing self-awareness about the effects of avoidant behaviour on their lives, or experiencing an event which shatters their defences. With this self-awareness, there is a recognition that one has a choice to either actively seek care or to continue the avoidant pattern. Three of the co-researchers appear fairly solidly ensconced in regular attendant patterns. Four carefully manage their behaviour so as to be able to continue care; three of these noting the reoccurrence of minor avoidance inclinations. Two of the co-researchers continue their avoidant behaviour even though they have looked at their behaviour and understand the consequences of not caring for their mouth.

This section of the general story presents the results of appraisal and new values, how individuals seek the help in others in maintaining their new dental health-seeking behaviour, offer suggestions to others, and name their interaction with their avoidance as a metaphor for their lives.

Results of Appraisal and New Values

The end of avoidance developed from an increased sense of self-awareness. This self-awareness enabled individuals to overcome their resistance about staying in avoidance and to seek care. Several people attribute their developing awareness of themselves as contributing to their ability to overcome their avoidant behaviour with the increase of qualities such as self-
responsibility and self-esteem. Three people were able to seek dental care as an aftermath of the
counselling process they were in for their sexual abuse experiences. As a result of taking action
to end their avoidant behaviour, people develop an increasing sense of self-esteem, and self-
efficacy. Some people experienced regrets over lost opportunities.

Herschel exhuberantly described how "everything fell into place" after he sought dental
care. "my sense of myself is I was a lot bigger." He now has a greater sense of freedom, has
been "taking charge of my life...and dentistry is one of the big ones." At present he feels he has
no end to options in his life, for the first time in his life he is making long range plans including
retirement plans. He feels a sense of permanence that he had never experienced in his life
before. "You know you can always run but your can't hide!" His new approach to life is "great"
although challenging in someways.

Kim had adapted his bite to his dental problems during his avoidant period. Upon
beginning care, he had a new crown and fillings replaced and then had to readjust his bite so that
his jaw could return to its normal position. He also laughingly described the money his avoidant
behaviour has saved him. "Don't know if this is a flawed way of looking at things but when I had
my mouth looked at eight to ten years ago they said 'well, there about a thousand dollars worth
of dental work to be done' I said 'that's fine, I'll think about it'. I come back to get my teeth
repaired eight to ten years later and it was about a thousand dollars worth of dental work. But in
my mind I've saved a least one thousand dollars because I did it in 1992 dollars and not 1982
dollars!"

Co-researchers have noted changes in their values regarding the seeking of dental health
care. Since changing his avoidant behaviour, Herschel now rates health which includes "dentistry
as number one." He has stopped smoking and his asthma has drastically improved to the point
that over the last eight months he had hardly touched any drugs. His words reflect his optimism "I
would say in another two or three years I don't think I'll be suffering with asthma....I'm almost
convinced of that, 'cause now I feel the difference."

With their increasing awareness, co-researchers strove to make sense of their
experiences of avoidance. For Stan, the issues had less to do with the procedures themselves.
"Issues are much more around the sense of how I'm being treated, the sense of being judged, the
sense of shame. These are the things that go along with being sexually abused because you are
being totally violated, you are a bad kid for it, it's all your fault, your awful...so that the issues are
for me more than in the practices themselves."

Larissa realized that "I have been living in my mind and not my body", She had been
"dealing a lot with the emotional realms of [her sexual abuse and breast surgery] but always
staying away from the emotional realm of dental avoidance...Maybe this is one of the last realms
I'm claiming." Her sense of her avoidance was that she had "wrested control from medical
authority figures" and then did nothing about it. Although Mark has sought dental care, he is "medically in denial, I don't go to doctors, so we're still in the denial phase as far as that goes. Now I can rationalize [his medical denial] as probably fear of death."

George's feelings are ambivalent: "[My avoidance of dentistry] is a dark mystery, I wish for me that I could unravel that. There's this double thing. It's a mystery and it seems like this unfathomable thing and on the other hand I'd just as soon leave it as a mystery....Got to wonder about anything else in my life that is vaguely like that. Don't think there is, although...I'm pretty well able to face up to most things in my life, finances, family, but I can't handle this." He goes on to say that he does not want to punish himself by trying to overcome his fear. "Someday I'll just decide to get over it but I don't think I want to." Perhaps because of the serious reaction of his heart to a dental experience and his age (85), George's response of not seeking care is a healthy one for him. About two years ago, he had about five sessions, with two dentists and a hygienist. Even though he was carefully treated by the general dentist, he "vowed I'd never go back again, even though it was fine. I don't know what the deuce it is because it isn't the fear of being hurt...I don't mind needles, I don't like drilling much. It's simply I don't want to be touched in the mouth."

Eleanor thought "even though I was ignorant I wasn't so ignorant that I wasn't aware of the dangers of some of my choices." She was "so fearful myself (about avoidance) it kept with me and I didn't ever get over it." When considering her values around dental care, she said that at present "I need new dentures, but the house needs fixing, so here I am priorities again!" She was startled when she recalled that her present values are similar to the ones when she was in her twenties when she "drove a car because I needed to use a car to get to work. My choice, but I would have been better advised to get my dental work done to save my teeth." She realized that having to wear dentures has seriously impaired her lifestyle. In addition to having difficulty chewing, wearing dentures can also affect one's ability to speak, particularly if they are poorly fitting like Eleanor's. For her having dentures, "makes a terrible difference." She describes herself as "less loquacious" now than she was. Individuals often have a sense of shame and sorrow around having dentures. "I haven't talked to anyone about this denture thing, not another soul. To me it's a very great failure. It's one of my 'bete noirs'. I see it as my life's sorrow."

Even though seven of the co-researchers are now settled in dental practices, what are the possibilities of avoidant behaviour reoccurring? Klm feels that likely he will be able to stay with this practice because he "knows what the professionals stand for as people" and trusts them. There may be an occasion at some time in the future when he may not want the dental work his dentist suggests. Rather than having to confront and leave the practice he has "more of sense that it's been suggested because of a certain dental necessity rather than a certain mortgage payment necessity....I'm really jaded when it comes to professionals."
Although Kevin was happy with his new dentist, his avoidant behaviour resurfaced as a result of his work with his therapist when he had some new memory retrievals about his sexual abuse. He sought counselling in order to support himself in continuing his dental health care. He described himself as "being fearful [but ] once I make an appointment, I always follow through."

Had Stan not had a follow-up appointment with his general dentist, he likely would have retreated to his avoidant patterns. He had been referred to an endodontist by his dentist for treatment of a root canal. After being kept waiting for an hour and being treated in an impersonal way, the dentist came in. "It may be significant here that's she's a woman and that other bad experience was also with a woman [when he first began his avoidant behaviour it was the result of an unpleasant experience with a woman dentist]. This dentist started asking him questions and "I didn't have any context for knowing what information she was really trying get from these questions." She told him that he had severe gum disease "which I knew already and had been working with a hygienist on and she was saying 'you know that's not specialist, that is just the hygienist in his practice. She was questioning the care that I was getting from my dentist. It was just an awful way to be treated. I felt angry." He struggled "with that and all the other kinds of behaviour tends to evoke...judgemental stuff, shame... but because of my experiences in his new dentist's practice I knew enough to be angry rather than saying 'this is my fault'." He felt a lack of respect "from walking in to the way the receptionists were, to being made to wait an hour and that the dentist did not ask "anything at all about what was going on in my treatment with that another dentist and making assumptions. So then I didn't do anything about that tooth because I wasn't going to go back there." Later he talked to his general dentist who suggested he see another endodontist in the same office as the other but "I didn't want to go back to that practice at all! So I just kept putting it off and eventually my dentist had a new associate who was able to do his root canal. He said that "it was surprising to experience that and then watch myself. It was interesting for me to experience that not just from having a comparison with (my new dentist) but just to watch the mechanism in myself. Because I had been going to a dentist now for a year and had come to grips with the severity of the problem. I probably would not be going to a dentist now unless somebody managed to hit me on the head with the absolute necessity of it." Mark's "zero self-esteem" as a result of a long term relationship ending and having to move out of his community has contributed to him beginning a minor avoidant behaviour in not following through with having work done that he had intended.

Network of Support for Non-avoidant Behaviour

Perhaps it is helpful to people to be supported in their new dental health care-seeking behaviour. A few individuals who have had avoidant behaviour found it beneficial to be supported
by others in their attempts to maintain non-avoidant dental care. Support may come from family members, dental and medical professionals, and counsellors.

In order to cope with her phobic responses to dentistry, Charlotte, together with her family and dental professionals, has created several rituals in order to feel that she is fully in control of her dental experiences. She has creatively developed rituals for pre-dental preparation, for the time she is in the office, and rituals for her post-treatment time. She attributed her success with maintaining her dental care with the gentleness, understanding, and ability of her dentist to pace her behaviour.

Others cite the sensitivity and caring of their new dentist and personnel as being important to the reinforcing of their new behaviour. Herschel felt that the people in his new practice see him for who he is, and are sensitive, careful, and "true professionals." Kim felt trustful in his new practice because he knows what the professionals stand for as people. He was also aware that there may be a time in the future when he refuses care but he has a sense that it will be alright in his new practice.

**Suggestions to Others**

The co-researchers, as a result of their personal experience with dental avoidance, had some suggestions both for people who are not able to seek dental care and for dental professionals. Their intent was to help both these groups understand the complexity of dental avoidance and the necessity of interventions. Some of their suggestions were: that is important to give people the knowledge to help them prioritize their teeth, to tell people that it is a phenomenon, to inform people about sexual issues and the mouth, to seek help with a counsellor; to keep searching until "you find the help that you need"; that people be told their options; and be taught the connection between prevention and the health of the mouth.

Eleanor hoped her story would help others be aware that dentures are not "just as good as real teeth" and that if a person has a choice "always choose to look after your teeth." She believed that professionals should give people information about how to attain healthy teeth and should help them prioritize the values in their lives as they relate to health-seeking behaviours.

Some advice involved finding a dental practice in which a person felt confident. For others with difficulty with their avoidant behaviour, Mark suggests: "find a dentist who you like and trust." Stan's advice to people with avoidant problems would be to find a practice that has respect for people and is non-judgemental. His other criteria for this practice would be that of involving the client in the process and sharing of information; that practitioners have an awareness of issues that the client might have; that practitioners state and talk openly about these issues; and that they proceed with treatment at the pace that the clients are comfortable with. Other qualities that would be desirable would be that of having "a counsellor or someone with counselling skills
attached to the practice, and that the client be introduced to the practice and practitioners before having any work done.

Two of the co-researchers echoed the importance of being persistent in trying to obtain support for avoidant behaviour. Herschel urges others not to let their attitudes get in the way of any health care. For him, his dental avoidance was a big lesson that "appertains to life" that was "to keep searching for the right way to go in anything, and not let that kind of thing put you off all the time." Kevin's suggestion to others was to "be persistent." It is important to "seek out people that make sense of their experience as opposed to those who buy into cultural messages that keep you from seeking help. Dental avoidance can't be separated from how you experience life in society. Some suffer abuse. Some are neglected by society when they are told: 'you are not a good little boy, or good little girl. You're bad' Then there is no place to go with your experience of shame."

Larissa felt that it would be important for those with avoidant behaviour to know that dental avoidance was a phenomenon and not a personal aberration. She also felt that it would be important for individuals and professionals to be aware of sexual issues and the mouth. Kim was reluctant to profer advice to others. In his opinion, "each situation is so different that you have to take each one on a personal level." In his opinion, it was "not a good idea to take anything or any aspect of your health for granted or it will get you!" It is also important to have the perspective that "professionals are not 'god-like'."

It was important that avoidance not be considered in a negative way. Charlotte's suggestion was "to never see avoidance as the bad guy you want to get rid of. To try to find a way to create a partnership with avoidance so that it has its air time, but not always." When she is working with someone in her psychotherapy practice who has anxiety, she gives that person "the affirmation that 'the anxiety is real', and I'm not going to minimize it so you don't need to. I think that is the first big step. And everything can follow from there. But my goal for someone would not be total elimination of anxiety...that can sabotage, in my opinion."

Interaction with Teeth and Avoidance as a Metaphor for Life

For the co-researchers, their dental avoidance had profound consequences physically, emotionally, behaviourally, cognitively, and spiritually. As a result of grappling with the effects of their avoidant experience and considering its meaning, the co-researchers upon reflection discovered that their teeth had become "a metaphor for life."

For Stan, the significance of his teeth was "kind of metaphorical" of the fact that he had not fulfilled his potential. "The metaphor is as much as my self-image as my actual condition." The process of recognizing that he had a serious difficulties and needed to go to a dentist and "beginning healing stuff around my teeth" is now "metaphoric of my whole life and the issues
around sexual abuse." There is a "kind of permanent damage....there are the teeth that are gone and it's like those parts of me and my experiences that are gone." The meaning of his avoidance for him is that "it's one of the sadder results of being sexually abused and all that stuff." Stan felt that as an adult, he has to live with the consequences of what happened "to me as a little kid" but "at the same time healing is definitely taking place and it's a process over which I have a lot of control and participation and ownership."

In Larissa's experience, her teeth became a metaphor for her life during her 10 year avoidant period and the period that followed her receiving dental care again. She realized that her 10 year dental abstension had afforded her the time in which to gestate new forms. "I was beginning to feel things and do things but it/I wasn't formed yet. So there was something about the mouth not totally formed and biting off chunks. I was tasting things but now it's coming to form....So by not biting through" there was an "openness,...a space for newness to come in, or for ideas to ferment." She excitedly exclaimed "now I've got this incredible eclectic experience [of dance, therapy, anthropology, and mythology] that I'm bring forward....It's so metaphoric! Oooohh!" As Larissa began to take action and reclaim her body, she felt "like I'm now beginning to really bite through my life, I'm turning 45, I mean it's my life!" Larissa speaks of the significance of the mouth in life: "in expresssion, smiling, showing teeth, baring teeth even braying with teeth." She recognizes that she had some "shyness about mouth....keeping mouth more closed....so a lot of stuff with hands over mouth, especially puberty on....a hiding behind but that's shifting now."

The health of one's teeth can become a metaphor of a person's self-esteem and well-being. For Kevin, "dental avoidance is a barometer" and when he is avoiding, it's a matter for him of "turning it back on track and trying to be persistent." If he is avoiding, his self-esteem is bad. Kevin stated that "when I'm able to take care of my teeth, it's a great source of comfort. I feel good, its a way of taking care of myself....And if my mouth is healthy I feel better about myself. If it's not healthy its one more reminder that I'm not good enough....And so the thought of being without my teeth was really debilitating....the pain never bothered me. I can live with pain but it was probably the two things together." For Herschel, the condition of his "mouth is almost like a bell-weather", if his gums are unhealthy, then his "general health is not good." Mark saw "dental health as my gateway to personal mental health.....it's an [example] that I'm trying to take more responsibility and control for my flaws....I'm doing the best that I can, I'm accepting the gifts that I've been given and these are my limits and I work at not forgetting and my teeth...anchor me in that."

For Eleanor, the value of losing her teeth as a result of dental avoidance was more profound then losing a leg. "If you lose a leg, that's one thing. Your body's more resilient and you can compensate but if you lose a tooth I think your whole being depends upon digestion and
choice of food. With your own teeth you can do anything within reason. I can't even bite a piece of bread, seedy foods, or a carrot out of the garden with the dentures I have."

The circumstance of Kim having "perfect teeth" during his childhood, became a metaphor for the wealth of other endowments in his life which prevented him from developing "that inner sort of drive to push me over the obstacles that come in pursuing anything." In spite of the fact that he had cavities, others often commented on the fact that he must have had his teeth straightened as they observed his teeth which appeared "perfect" on the outside. As a child, he went through a spell of "thinking if there was just something wrong with me, something I had to overcome, that things would be a lot better....then I would have developed a sense of fortitude, because everything I did just came easily. People who had something to overcome had a degree of determination that I didn't....I've never had to work at my teeth, they have always been great, by everybody else's standards." He discovered that he did not know how to establish relationships as a result of never having to go out and establish "healthy relationships with people."

Summary

The experiences of nine individuals, who have engaged in dental avoidant behaviour for periods of two or more years in their lives, has been portrayed in a general story. The time in the history of dentistry that individuals received their early dentistry creates a backdrop upon which the person's dental seeking behaviour is enacted. The individual plots vary according to each person's unique personality, experiences, and ways of viewing the world. As well, family and cultural values influence a person's dental health-related behaviour. During the avoidant period, individuals struggle to understand their experience at the same time they are having difficulties with disturbing psychological reactions and deteriorating dental health. The effects of avoidance do not appear to be confined to dental health but also affect other areas of people's lives. This story encompasses the time prior to avoidance, the avoidant experience, and the implications of ending avoidance.

The general story begins with the aspects that influence the decision, either conscious or unconscious, to avoid dentists and dental care. Chronic influences are personal, family, and cultural values. Acute influences are experiences that a person has in a dental offices or non-dental experiences that a person generalizes to dentistry. With the increasing accumulation of negative emotions and beliefs surrounding dentistry, people struggle to maintain their care seeking behaviour. A beginning of disequilibrium in this behaviour that grows out of an increasing sense of violation to oneself by dental and medical authorities and a mistrust of dental personnel. This disequilibrium bridges to the middle of the story.
The middle of the story encompasses the avoidant phase. As the tendency towards avoidance grows, refusal to seek dental care may be the result of increasing negative events or emotions or may be precipitated by a single event or influence. Often avoidant behaviour does not arise until a person leaves home because individuals who experience traumatic events in their early years often have little choice in decisions regarding their health. Upon leaving home, people question parental and societal values and strive to take charge of their lives. The avoidant phase is extremely challenging as the person strives to cope with the results of deteriorating teeth as well as resultant strong emotional responses. In order to maintain their avoidance, some people cope in either an active or passive way with avoidance. Some cope actively by pretending and denying, by adjusting their way of chewing, or by distracting themselves. Others cope passively by dropping into emotions of despair, helplessness, shame. Still others cycle between the two cycles in order to sustain their avoidant behaviour. For some the phenomenon of avoidance has been with them so long the prospects of change feel so overwhelming. The avoidance continues until the person’s defense is shattered by increasing self-awareness or it may occur as the result of a single event or revelation. The avoidant cycle is interrupted, and at this point the individual makes a decision to seek dental care.

The story ends with persons seeking care for their mouth or choosing not to seek care. (A graph summarizing the avoidance patterns of co-researchers is found in Appendix B). Those that end their avoidance often experience tremendous relief and increased energy. This new behaviour results in a reappraisal of their lives, out of which arise new values. Their interaction with their teeth and their avoidance becomes a "metaphor" for their lives. Changes of behaviour in areas other than dentistry of their lives occur. They feel empowered and experience a greater sense of freedom as well as permanence. They become proactive in caring for their bodies. They have taken control in other areas of their lives and have begun to make plans for their future. The question of the possible reoccurrence of this dreaded phenomenon is often with them. Sometimes they enter short periods of avoidance even though committed to maintaining the health of their teeth. This new avoidance may be triggered by another unpleasant dental event or by a crisis in some other area of their life. Perhaps the benefits of personal counselling at an earlier stage in their avoidance may have changed their story. People are generally hopeful about their futures and have used their understanding of their avoidance to take charge of their health.

Epilogue

There are many ways to tell a...story. You can tell it from the viewpoint of each of the (participants); you can tell it through the eyes of a partial or impartial observer; you can tell it omnisciently as if through the mind of God; you can study it anthropologically with regard to evolution or species survival; you can interpret it sociologically in terms of
the mating habits of a particular culture at a particular time; you can analyze it psychologically from the premises of any number of a dozen schools of thought. All of these approaches produce their own truths, even though some may seem contradictory. Each version becomes a lie only when it masquerades as the only way of telling the story, the only truth (Fraser, 1987, p.190).

This story is a synthesis of the narratives told by nine persons about their experiences of dental avoidance with inclusions of my own observations, information from my background of dental experience, and information from dental and counselling records. Although the diversity and uniqueness of each person’s story suggests that there are other stories to be told, the story appears to be a reasonably credible portrayal of the general experience of the avoidance of dental care by men and women in our culture.
Although each person's experience with dental avoidance was unique, for the most part, a common flow or pattern emerged in response to this avoidance in a person's life. In particular, this flow can be conservatively organized into three parts: a beginning, a middle, and an end. This organization of the patterns of the story of dental avoidance was chosen to reflect Sarbin's (1986) view that a story is a life drama or "symbolized account of the actions of human beings which has "a beginning, a middle, and an ending " (p.3).

In the beginning, individuals tend to be born into situations that support the development of dental avoidance. Personal values arise from the foundation of family and cultural values. The avoidance grows against the backdrop of family, financial, and social considerations. Influences, such as negative experiences with dentists, deepen avoidant responses. As well, other life experiences are generalized by some to dentistry. As a result of these experiences, perceptions of violation and mistrust frequently develop.

In the pattern that marked the middle phase, tendencies toward avoidance grow and often an event or developing influence culminates in avoidance behaviour. A cycle of approach-avoid may occur. Within the avoidant phase, fluctuations within an active-passive cycle sometimes results as individuals endeavour to control the tension generated by their avoidance.

The end of dental avoidance occurs after an appraisal. As a result of this appraisal, the person may chose to seek dental care or to remain in avoidance. For those seeking care, avoidant defenses are shattered and new values and behaviours emerge. The choice of remaining in avoidance may be an adaptive response for those who consider the risk of attending too great. Some of those who chose to attend elicit help from family and friends in order to maintain their new behaviour of care-seeking. Retrospectively, individuals endeavour to understand the meaning of their avoidant experience and frequently regard their interaction with their avoidance as a metaphor for their lives.

The most significant aspects of dental avoidance found in this study are summarized as follows:

1. The pain and fear of dental treatment are not the most important factors in dental avoidance; rather it is the emotionally traumatizing way in which individuals are treated by dentists and dental personnel.

2. Interpersonal relationships with dental care givers that are helpful to people seeking help with dental avoidance are those that are empowering and build trust and respect.
3. Abuse as a result of dental and non-dental experience is implicated in dental avoidance. Abuse which occurs outside of the dental office is generalizable to dentistry.

4. The phenomenon of dental avoidance is so profound for some people that their interaction with their avoidance becomes a metaphor for their lives.

5. Dental avoidance is a complex, cyclical process, wherein people struggle to cope with their emotional responses to their behaviour.

6. The ability to deny the effects of deteriorating dental health is so strong for some individuals that they may not recognize a problem.

7. Even when a person begins to seek care after an avoidant period, he or she can avoid dentistry again. Events may trigger earlier emotional responses and lead to a repeat of the avoidant behaviour. It is often the anticipatory anxiety of a dental experience that leads to avoidance.

8. Some of the issues associated with dental avoidance are: power versus helplessness, integrity versus violation, confidence versus fear, acceptance versus denial, trust versus mistrust, and worthiness versus shame.

Limitations of the Study

An evaluation of this study points to several limitations. With this self-report method, the capability and selectivity of people as they report is influenced by factors such as memory and culture. For those who have suffered either dental or non-dental abuse in childhood, there may be amnesia about early events. Because of the complexity of the avoidant process, the influence of other experiences, and profoundity of its implications, it is also possible that some aspects were not within conscious recall. Moreover, each narrative account represents the co-researcher’s interpretation of dental avoidance as it relates to his or her particular life.

This sample of participants does not represent any particular group. With the small number of co-researchers, the findings cannot be extrapolated to the general population as a whole. In addition, the co-researchers, although from varying ethnic backgrounds, were all Caucasians and thus the findings might be quite different within other ethnic groups. Missing also were the voices of people within the age groups of the twenties, fifties, and sixties.

In that all of the co-researchers, with the exception of two, had sought dental care within the last two years, it is possible that the stories of persons in active avoidance might yield
different portraits. Another limitation of this study, may be that of the nine co-researchers, five had been in counselling situations. Two of these five people had specifically sought short-term counselling in order to change or alleviate their avoidant responses. As well, of the seven people still attending dentists, six were from one dental practice. It is possible that the outcome of changing avoidant care might have been different had these individuals come from several different practices or from practices in a rural rather than urban setting.

Another limitation may be that the selection of a general story approach may have restricted other forms of stories from emerging. There were times that the linearity of having a beginning, a middle, and an end appeared limiting during the organization of the research. Riessman (1991) suggests that there is "an inevitable connection between reduction-our need to simplify and order-and representation-our dependence on words and images to stand for what we see and feel" (p.41). She suggests that as we amplify our models of listening and analysis, perhaps other narrative genres will evolve. Perhaps by tracking a person's narrative in a circuitous rather than linear fashion, other genres may have presented. As a result of this research, in addition to the general story of avoidance, suggestions of themes for other stories emerged: trauma and abuse, boundaries, interpersonal relationships with care givers, non-dental avoidance, and phobias. Despite the limitations of this study, several significant insights have been discovered.

Theoretical Implications

Dental avoidance emerges as a unique and complex life process that deeply implodes on people's lives. Consequently, this study encourages an emphasis on contextual considerations rather than analytical, causal approaches. As the applicability of theory to the co-researcher's experience of avoidance was examined, each narrative account tested how adequately theories support the experience of the individual by being examined in relation to existant theories. As well, each of the accounts was compared to the health-related behaviour models. A model of dental avoidance, utilizing the findings of this study, was developed from an adaptation of Lazarus's (1990) model of stress, appraisal, and coping (Appendix C).

In general, this research supports the contention in the literature that many of the previously identified sources of a tendency towards dental avoidance such as fear, pain, and economic constraints are related to dental avoidance. However, this study questions the contention in the literature that dental avoidance is the result of a direct causal relationship. It would appear that there are many implicating factors. The literature's citation of past experiences of pain, and stress and trauma as principal factors in dental avoidance has been challenged by this study which suggests that this view is too narrow. The co-researchers generally reflected the fact that it was not the pain and trauma of dental treatment that was the important factor, but
rather the emotionally traumatizing way in which they were treated by dentists and personnel. For some, the sense of lack of support or of being violated in the dental office, triggered emotional responses from former traumatic events. Some felt unheard and unseen; this dynamic contributed to their sense of powerlessness and despair. This study shows that in the lives of individuals, there are multiple contributions that influence the significance of their mouths and health care during their childhood development. Either chronic and acute influences, or a combination of both, have been identified as the principle precipitating influences in dental avoidance.

This study did not produce any evidence to support psychoanalytic theory that people who avoid dentistry are stagnated in the oral stage of development. Although it is possible that the psychological aspects of the mouth are implicated in dental avoidance, it is beyond the scope of the present study to verify this effect. Although little is mentioned in the literature in regard to developmental issues, this study indicates that Erikson's (1963) stage of the questioning of familial and societal values is present in the behaviour of several individuals, who began non-attendant patterns after leaving home. This study also demonstrates that Janis and Mann's (1977) hypothesis of "defensive avoidance" (minimizing or denying the importance of the threat of the results of avoidance) is a factor in dental avoidance.

This study shows that the development of dental avoidance arises as the result of a pattern that grows over time, followed by a subsequent violation. An individual's response to violation emerges from a background of cultural values. For a person, dental avoidance is not just the loss of control, but a situation in which one's worst fears are realized: increasing pain and deterioration of teeth, diminishing self-esteem, developing sense of shame, and fear of an unknown future.

This study supports the literature's contention that there are several affects are associated with the oral cavity. Some of these are fear and anxiety, shame, helplessness, and regression. But it extends earlier research by the discovery that people can often manage these affects if they sense the dentist acknowledging and genuinely caring for them. Also, if they are given opportunities to participate in decision-making, they feel empowered and more capable of coping. Moreover, this study extends the research by demonstrating that negative attitudes of the dentist may be one of the principal factors in precipitating avoidance. One of the issues rarely identified in the literature, but illustrated in this study, is that many clients seeking treatment in dental offices, have issues with personal boundaries that may be problematic in treatment.

Three of the models, Becker's (1974) Health Belief Model (HBM), Antonovsky's (1979) Salutogenic Model of Health, and Lazarus and Folkman's (1984, 1990) stress, appraisal, and coping theory, that have been currently developed to account for health care-seeking patterns, were compared to the findings of this study. The patterns of this study supported the models'
supposition that health-related behaviour in dental avoidance is an interactive process rather than a linear, causal one.

In comparing the pattern of this study to the patterns suggested by the HBM, this study supports HBM's premise of individuals' perceptions of susceptibility, severity, threat, benefits, and barriers as being factors in the seeking of health care. This research suggests that it would be difficult to operationalize these key variables of the HBM. This study also shows that the HBM neglects the factor that health-seeking behaviour is a phenomenon in a person's life with roots arising out of early childhood: personal, family, and cultural influences.

The results of this study support, in part, Antonovsky's Salutogenic Model of Health. Antonovsky's generalized resistance resources that develop, reinforce, and maintain a sense of coherence in a person's life were present in the stories of the co-researchers in this research. This study supports the Salutogenic Model of Health's inclusion of socio-cultural and historical context. Also, in contrast to Antonovsky's approach, this research shows that a single pattern of beliefs is not sufficient to explain the fact that people often struggle with contradictory beliefs at the same time. The present research echoes Lazarus and Folkman's (1984) contention that "belief systems are too complex, rich, and contradictory to be massed into a simple unidimensional concept" (p. 68).

This study supports Lazarus and Folkman's (1984) assertion that a person's approach to distress rather than being linear and unidirectional, is transactional. This study also supports Lazarus and Folkman's view that coping is a process, reflecting what people actually think and do, what they think and do within specific contexts, and the shifting process of coping. Also supported was this model's supposition that some people cognitively appraise their situation with regard to what was at stake (primary appraisal) and consider coping resources and options (secondary appraisal). In the cases portrayed in this study, not everyone seemed able to engage in the cognitive process of appraisal. Some appeared to be unable to examine the seriousness their avoidant behaviour. For others, their need to deny that the avoidance was not a problem was so great that their coping took the form of active or passive efforts in order to maintain their avoidance. When they were in the active phase, they likely engaged in secondary appraisal, but when they were in the passive stage, they were unable to consciously appraise their deteriorating situation and identify options. This study indicates that Lazarus' approach is oversimplistic. Lazarus's research of the dynamics of appraising and coping behaviour, while useful in understanding the elements of the dynamics of stress, does little to show the complexity and richness of the experience of a person living with the challenge of dental avoidance that are evident in this study.

Although this study demonstrates several commonalities with these current models, it challenges the simplistic view of their theories. It goes beyond these theoretical contentions by
demonstrating that a person is not just avoiding, but is also locked in daily struggles, tensions, and hopes that profoundly affect this person during the avoidance. The models do not clearly reflect the immense importance to the individual of his or her interpersonal relationship with the dentist as shown by this study. Of major importance to individuals in the dental chair is that personal boundaries are not violated, that the dentist acknowledges them, and that they feel listened to and empowered by the dentist.

Implications for Counselling Practice

A key implication of this study for counselling is the necessity for counsellors to assist dentists in developing communication skills and an appreciation of the importance of their role as caregivers in the health field. It is important for dentists to know that they are in a unique position to enable their clients to live more fulfilled lives in relation to their physical and psychological health by empowering their clients. In addition to the development of effective communication skills such as rapport, sensitivity, and empathy, it is important that dentists and dental personnel develop an understanding of the complex phenomenon of the avoidant process.

Another implication is the importance of counsellors developing knowledge about the phenomenon of dental avoidance in order to counsel people who have been involved in avoidant behaviour. Goals for counselling interventions might include knowledge of the number of issues involved. Some of these might be: identifying and naming of the avoidance, determining where in the cycle of avoidance the avoidance occurred, ascertaining the extent of the experience of trauma or violation, difficulties with boundaries, degree of self-esteem, degree of associated shame, fear, and powerlessness.

Dental professionals might assess the environment of their offices for warmth and client satisfaction. Client's could be questioned as to their perceptions of how welcomed and supported they felt while in the presence of each person in the office: the receptionist, dentist, hygienist, and assistant.

A further implication would be the dissemination of information regarding the issues surrounding dental avoidance to dentists, counsellors and concerned others. Some of the issues identified in this study are: power versus helplessness, integrity versus violation, confidence versus fear, acceptance versus denial, trust versus mistrust, worthiness versus shame. In order to give clients more information and to assist their sense of empowerment, the development of a pamphlet outlining the rights of a dental client in light of the issues identified in this study, would be useful.

There are implications for the field of health promotion in the results of this study. More attention could be given in schools' guidance programs throughout Kindergarten to Grade 12 for the problem of the empowerment of dental clients. In dental health promotion, the identification of
avoidance as a phenomenon and proposals for future action, would further understanding and possibly lead to future health seeking. Publication of articles in popular health magazines, identifying the issues in dental avoidance, might reach people who do not seek care.

**Implications for Future Research**

The method of obtaining narrative accounts from individuals about their personal perspectives has yielded fresh insights and a rich body of information. This study is only a beginning of a narrative approach to the study of dental avoidance. In order to further understanding of the phenomenon of dental avoidance, several possible areas for future inquiry are suggested.

First, it would be desirable to replicate and extend this study by adding a quantitative dimension such as Corah's (1969) Dental Anxiety Scale, in addition to a qualitative one. Second, by using the same methodology, an examination the avoidant experiences of cohorts in different age groups; of women and men; of people in different ethnic populations; people in different socioeconomic groups; of people who have experienced sexual abuse; of people who are still avoiding dental care would be useful.

Third, practical insights support the development of pragmatic programs that unite dentistry and counselling. The creation of a questionnaire survey for first year dental students regarding their own dental history might enable them to identify the values they bring to their interactions with clients. The development an empathy skill training module for teaching dental students as well as practicing dentists would assist them in becoming skilled communicators. Within dental practices, an interview for new clients that included questions of inclinations towards dental avoidance, boundary issues, potential present for violation, knowledge of the cycles of avoidance: approach-avoidance, and active-passive might enable dentists in becoming sensitive to the issues that clients bring to the dental office. The creation of a co-management model to enable the dentist and client to co-manage the issues that arise as a result of the client's avoidance tendencies. Another, the development of an exit questionnaire would enable dental professionals to receive feedback about treatment from clients as they leave the office after treatment.

Fourth, the creation and field testing of questionnaires, surveys, and interventions for implementation by counsellors and health professionals would be useful. These could include: a questionnaire for persons who experienced avoidance in order to identify the pivotal issues identified in the study; a survey instrument to determine degree of avoidant inclinations; interventions for dental avoidant behaviour; a survey instruments to determine the effect of dental environments. The findings of this study suggest that counselling for some people that avoid dentistry include the use of current interventions in the areas of development, stress and trauma,
abuse, and phobia when appropriate. It is likely that strategies for the development of boundaries would also be useful.

Fifth, a qualitative study to explore the metaphors that teeth, the mouth, and dental health represent for people.

Summary

A case study approach was used to investigate the life narratives of nine individuals in relation to their dental avoidance. The participants were three women and six men who had periods of 2 to 20 years duration when they avoided dentists. Of the nine participants or co-researchers, two are still in avoidant patterns. These two people differed from the others in that they both received their childhood dental care early in this century. At that time dentistry was primitive compared to present standards; little was understood about the role of prevention, and individuals often felt traumatized by the effects of dental treatment. In order to understand the circumstances which led the individual to avoid dental care and perhaps jeopardize oral health, I examined their personal experiences within the context of their lives. After interviews with each of the persons, detailed accounts were constructed. From these accounts, a common story was composed called the general story.

The beginning of the general story of dental avoidance often has its origins in individuals’ formative years. Chronic influences on the development of avoidant behaviour, such as personal and family values, arise out of the historical and cultural milieu in which individuals find themselves. Acute influences from dental or non-dental experiences also effect avoidant behaviour. Growing out of these influences are emotions and beliefs which become associated with dentistry. If a person experiences violation or mistrust within a dental setting, a disequilibrium begins which unbalances the person’s ability to seek care.

In the middle of the general story, tendencies towards avoidance grow. For some, these tendencies are a result of slowly developing responses to dental care, for others, a single event may provide the precipitating event that triggers the beginning of an avoidant episode. As individuals struggle with the external events of pain and deteriorating teeth and gums as well as the increasing emotional responses, their lives become increasingly difficult. They may defend their avoidant behaviour in active or passive ways. In addition to resorting to defensive behaviour, people coped by seeking emergency care for the short term relief of pain. Interruption in the avoidant cycle occurs when the person’s defences are shattered. The suspension of avoidance may occur as a result of an event, either dental or non-dental, or as a result of a growing awareness of the severity of the situation.
The end of the story occurred as a consequence of individuals seeking help for their dental distress. With this help, they appraised their previous values and developed new ones. They also experienced improvements in their lives that were more far reaching than their immediate dental relief. For two people, the story ended differently as they chose not to seek help as a way of avoiding the greater discomfort of entering a dental office. For several individuals, the avoidant experience has been so profound that they felt that the condition of their teeth had become a metaphor for their lives.

Although previous research has identified several causal factors as the reason in dental avoidance, this narrative study, by examining dental avoidance in the context of people's lives, indicates that it is a decidedly more complex phenomenon. For example, the co-researchers agreed that the issues have less to do with the procedures and more to do with how the dental professionals treat them. Three models of dental health-related behaviour, Becker's (1974) Health Belief Model, Antonovsky's (1979) Salutogenic Model of Health, and Lazarus and Folkman's (1984) stress, appraisal and coping theory, were examined. This study supports the transactional nature of the three models. As well, this study demonstrates many of the health-related behaviours identified by these model. However, it suggests that these models are simplistic in that they do not take into account the richness and complexity of the avoidant experience within a person's life. Moreover, they do not clearly identify the importance of the interpersonal relationship with the dentist for the individual.

The practical implications of the study suggest the viability of the general story as a model in the study of dental avoidance. In order to affect the outcome of dental avoidant behaviour within the dental setting, this story suggests that it is essential that the dentist and dental personnel have an awareness of the issues of dental avoidance for an individual, have sufficient interpersonal skills to relay their empathy and understanding of the seriousness of this phenomenon for this person, and be skilled in empowering each person who seeks their care.
Your know, you can always run,
but you can't hide. So there's no point in hiding.
    It's great!
Then in some ways it's hard and
in other ways it isn't.
I hate like hell, now to leave things.
Number one, would be health care
which includes dentistry
and everything else.

Herschell
Co-Researcher

It is only by going down into the abyss
that we recover the treasures of life.
Where you stumble,
there lies your treasure.
The very cave you are afraid to enter
turns to be the source of
what you were looking for.

Joseph Campbell
The Joseph Campbell Companion:
Reflections on the Art of Living
REFERENCES


APPENDIX A
Dear

I am a M.A. student in the Department of Counselling Psychology at UBC. One part of my degree requirement is a Master's thesis, supervised by Dr. Larry Cochran. I am hoping to receive your assistance in my research.

I am interested in understanding the experience of dental avoidance in persons for whom this has had significance. If you consent to participate in this project, you would be asked to describe in detail such an experience and to share some of your thoughts, feelings, and actions associated with dental experiences throughout your life.

By participating in this research, you will have the opportunity to learn about dental avoidance and its meaning for you. In addition, you may be providing information helpful to counsellors and to people working in the field of health care.

There will be two interviews approximately one to one and a half hours each, for a maximum of about three hours. These interviews will be tape-recorded and transcribed. The transcriptions will have any identifying information deleted and the tape erased. All the information you give me will be strictly confidential. You have the right to refuse to answer any question and to withdraw from the study at any time without prejudice of any kind.

I will be contacting you by telephone to discuss the study with you the week prior to our appointment on August 7th. In the meantime, please feel free to ask me any questions. Thank you for your interest.

Yours sincerely,

E. Diane Marshall
M.A. Candidate
Tel: 224-7166
PARTICIPANT CONSENT FORM

Title of Project:

A PHENOMENOLOGICAL STUDY OF THE EXPERIENCE OF DENTAL AVOIDANCE AND ITS MEANING FOR THE INDEPENDENT ADULT

Principal Investigator: E. Diane Marshall

I am doing an M.A. study in order to understand more fully the experience of dental avoidance and its meaning in adults. I will be asking you to describe in detail dental experiences which have been personally significant for you. I will also be asking you to describe your thoughts, feelings, and behaviours about these experiences.

There will be two interviews each lasting approximately one to one and a half hours for a total of not more than three hours. The information you give to me will be strictly confidential. Confidentiality will be obtained by omitting any personal references and using only the first initial of your first name (omitting your surname) on the transcript. Once the project is concluded, the taped interview will be erased.

Your participation is voluntary. You have the right to refuse to answer any question and to withdraw from the study at any time without prejudice of any kind.

I HAVE READ AND UNDERSTOOD THE ABOVE AND CONSENT TO BE A PARTICIPANT IN THIS RESEARCH.

I ACKNOWLEDGE THE RECEIPT OF THE CONSENT FORM

Name of Participant:

Signature:

Researcher: Tel: 224-7166

Date:
Dear

Hello! Now we are entering the final phase of your active involvement in this study of the phenomenon of dental avoidance. Would you kindly read this narrative account of your experience and consider the following questions:

Was my story portraying your experience accurate?

Did I distort anything?

Did I add anything or leave out anything of importance?

Now that you have had some time since our interview to think about dental avoidance, is there anything you would like to add to this narrative account? Is there anything that you would like deleted?

I will be calling you shortly to arrange a meeting with you in order to receive your feedback. At that time I will be taping your answers to the above questions, perhaps clarifying some aspects of the narrative with you, and inviting any other comments you may have. Again my thanks for your support in this research, I look forward to us having a fuller understanding of this phenomenon.

Sincerely,

Diane Marshall
Dear Independent Reviewer,

Thank you for consenting to assist me in assuring the quality of my research methodology by reviewing the enclosed narrative account of a person who has experienced dental avoidance. I have enclosed the tape of the original interview and the narrative account. The narrative account is a compilation of the information received from the initial interview which has been purused for accuracy by the co-researcher (interviewee). In some cases, the co-researcher chose to add additional information during a second interview. In the narrative, the name of the person has been changed in order to respect confidentiality. Please review this account of the co-researcher's story and compare it with the audiotape of the original interview and consider the following questions:

Was the narrative account accurate or distorted?

In my account did I leave anything out of significance?

Please comment on my interview style. In your opinion was it facilitative and free of bias or did I force a pet theory?

I will be phoning you to arrange a follow-up interview and be taping your comments. Thank you for your support.

Yours sincerely,


Work: 224-7166 (Tues - Thur)
Dear

My thesis investigating dental avoidance is complete! I wanted to thank you for your generous contribution to this research. In the time since we last met, I have been documenting the results and completing the writing. I have enclosed a copy of The General Story of Dental Avoidance, which the compilation of all stories of the people who participated. May you enjoy the larger story to which your story significantly contributes.

It was a privilege to have met with you and to have you share so thoughtfully and openly. It is my intention make the results of this thesis available to others with the hope that those with avoidant difficulties or those who are working in the dental health field will have new information about the phenomenon of dental avoidance.

With the completion of my thesis, I will be graduating in May. My gratitude to you for your part in my successful completion. May you have a delightful spring!

Sincerely,
April 27, 1993.

Dear

My thesis investigating dental avoidance is complete! I wanted to thank you for your generous contribution to this research. In the time since we met, I have been documenting the results and completing the writing.

It was a privilege to have met with you and to have you share so generously and thoughtfully. Your participation as an independent reviewer added considerably to the reliability of my research method. This study has yielded some surprising results. I have enclosed a copy of the Discussion for your information. It is my intention make the findings of this thesis available to others with the hope that those with avoidant difficulties or those who are working in the dental health field will have new information about the phenomenon of dental avoidance.

With the completion of my thesis, I will be graduating in May. My gratitude to you for your part in my successful completion. May you have a delightful spring!

Sincerely,
EXTRACT FROM CO-RESEARCHER'S INTERVIEW

Diane: So that when you didn't floss or brush enough you felt that: this admonition from somewhere.

Larissa: Somewhere. Yes. And there was a guilt for having cavities. And there was kind of a comparison between my brother and sister and I, and, uh it was like whoever had the least was, uh, praised and there was a sort of thing about if you had fewer cavities - you were just much better about being a human being. And it was always my teeth were not the best in the family for sure.

Diane: So there was a subtle comparison.

Larissa: Yes, a subtle comparison and, um somehow you were guilty if you had cavities, you know. And it was just a mystery.

Diane: Yes. So how did you get those?

Larissa: Yes, and if you have a chocolate bar or something, "oh my God!", you know.

Diane: So that was like it was present in your life in a kind of haunting way.

Larissa: Yes, well, yes. Yes, and my father was a doctor, so there was a lot of stuff. He used to come home and complain about patients, so - he really didn't like sick people. It was like they were guilty. It was something about being guilty for being sick, you know? Like, they are weak, about being weak if you are sick. And, uh, if you are needy, in a medical way. So there was that kind of feeling sometimes at home and, I mean, if I hurt myself, I mean there was no way I'd show it.

Diane: To some way show that you were

Larissa: I'm weak.

Diane: Similar - similar to having cavities, some way you were deficient.

Larissa: Yeah. Yeah, in some way deficient. So, um, yeah, I hadn't thought of it in quite that way but there was that sort of pervasive attitude at home - very stoic and you didn't show pain, and if you had something wrong, I mean there was a sense of being alone with it, too, 'cause you didn't get any sympathy. It was like "What's wrong with you!"
AVOIDANCE PATTERNS OF CO-RESEARCHERS

ATTENDANCE
INTERMITTANT ATTENDANCE
AVOIDANCE

George - 85

Eleanor - 74

Herschel - 48

Larissa - 45

Mark - 45

Charlotte - 45

Stan - 38

Kevin - 37

Kim - 33

YEAR
Key Components of the Health Belief Model, 1989.

I. Threat
   A. Perceived susceptibility to an ill-health condition (or acceptance of a diagnosis)
   B. Perceived seriousness of the condition

II. Outcome expectations
   A. Perceived benefits of specified action
   B. Perceived barriers to taking that action

III. Efficacy expectations: conviction about one's ability to carry out the recommended action (self-efficacy)

Note: Sociodemographic factors such as education, age, sex, race, ethnicity, and income are believed to influence behavior indirectly by affecting perceived threat, outcome expectations, and efficacy expectations.
The Salutogenic Model of Health

Key to Figure 1

Arrow A: Life experiences shape the sense of coherence.
Arrow B: Stressors affect the generalized resistance resources at one's disposal.
Line C: By definition, a GRR provides one with sets of meaningful, coherent life experiences.
Arrow D: A strong sense of coherence mobilizes the GRRs and SRRs at one's disposal.
Arrows E: Childrearing patterns, social role complexes, idiosyncratic factors, and chance build up GRRs.
Arrow F: The sources of GRRs also create stressors.
Arrow G: Traumatic physical and biochemical stressors affect health status directly; health status affects extent of exposure to psychosocial stressors.
Arrow H: Physical and biochemical stressors interact with endogenic pathogens and "weak links" and with stress to affect health status.
Arrow I: Public and private health measures avoid or neutralize stressors.
Line J: A strong sense of coherence, mobilizing GRRs and SRRs, avoids stressors.

Line K: A strong sense of coherence, mobilizing GRRs and SRRs, defines stimuli as nonstressors.
Arrow L: Ubiquitous stressors create a state of tension.
Arrow M: The mobilized GRRs (and SRRs) interact with the state of tension and manage a holding action and the overcoming of stressors.
Arrow N: Successful tension management strengthens the sense of coherence.
Arrow O: Successful tension management maintains one's place on the health ease/dis-ease continuum.
Arrow P: Interaction between the state of stress and pathogens and "weak links" negatively affects health status.
Arrow Q: Stress is a general precursor that interacts with the existing potential endogenic and exogenic pathogens and "weak links."°
Arrow R: Good health status facilitates the acquisition of other GRRs.

Note: The statements in bold type represent the core of the salutogenic model.
Lazarus's Illustrative System Variables for the Stress and Emotion Process

<table>
<thead>
<tr>
<th>Causal Antecedent</th>
<th>Mediating Process</th>
<th>Immediate Effect</th>
<th>Long-Term Effect</th>
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<tr>
<td>Person Variables</td>
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<tr>
<td>Values, Commitments, and Goals</td>
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<tr>
<td>General Beliefs, Such as:</td>
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<td>Self-Esteem</td>
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<td>Mastery</td>
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<td>Sense of Control</td>
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<td>Interpersonal Trust</td>
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<td>Existential Beliefs</td>
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<tr>
<td>Environmental Variables</td>
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<td>Demands</td>
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<td>Resources (e.g., Social Support Network)</td>
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<tr>
<td>Constraints</td>
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<tr>
<td>Temporal Aspects</td>
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<tr>
<td>Encounter 1 . . . 2 . . . 3 . . . n</td>
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<tr>
<td>Within an encounter</td>
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<tr>
<td>Time 1 . . . 2 . . . 3 . . . n</td>
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<tr>
<td>Primary Appraisal (Stakes)</td>
<td>Affect</td>
<td>Psychological Well-Being</td>
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<tr>
<td>Secondary Appraisal (Coping Options)</td>
<td>Physiological Changes</td>
<td>Somatic Health/Illness</td>
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<tr>
<td>Coping (Including Use of Social Support)</td>
<td>Quality of Encounter Outcome</td>
<td>Social Functioning</td>
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<td>Problem-Focused Forms</td>
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<tr>
<td>Emotion-Focused Forms</td>
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Notes: Although not shown here, the model is recursive. Also, note parallelism between short-term and long-term effects.
MODEL OF DENTAL AVOIDANCE
(adapted from Lazarus's Stress and Emotional Process Model)

Chronic Influences
- Cultural Values
- Family Values
- Personal Variables
  - Values
  - Commitments
  - Goals
  - General Beliefs
- Environmental Variables
  - Demands
  - Resources
  - Constraints
  - Temporal Aspects

Acute Influences
- Direct Dental Experiences
- Generalized Non-dental Experiences

Mediating Process
- Appraisal Process (internal)
  - Primary (stakes)
  - Secondary (coping options)
    - Fear and Anxiety
    - Shame
    - Powerlessness
    - Lower Self-esteem
- Coping Strategies (active/passive)
  - Problem-Focused
    - Formation of Plan
    - Planning Support
    - Find Supportive Office
  - Emotion-Focused
    - Denial
    - Procrastination
    - Accommodation
    - Distraction

Long-term Effects
- Short-Term Effects