

Factors related to fear and anxiety in dental care in Primary Health Care

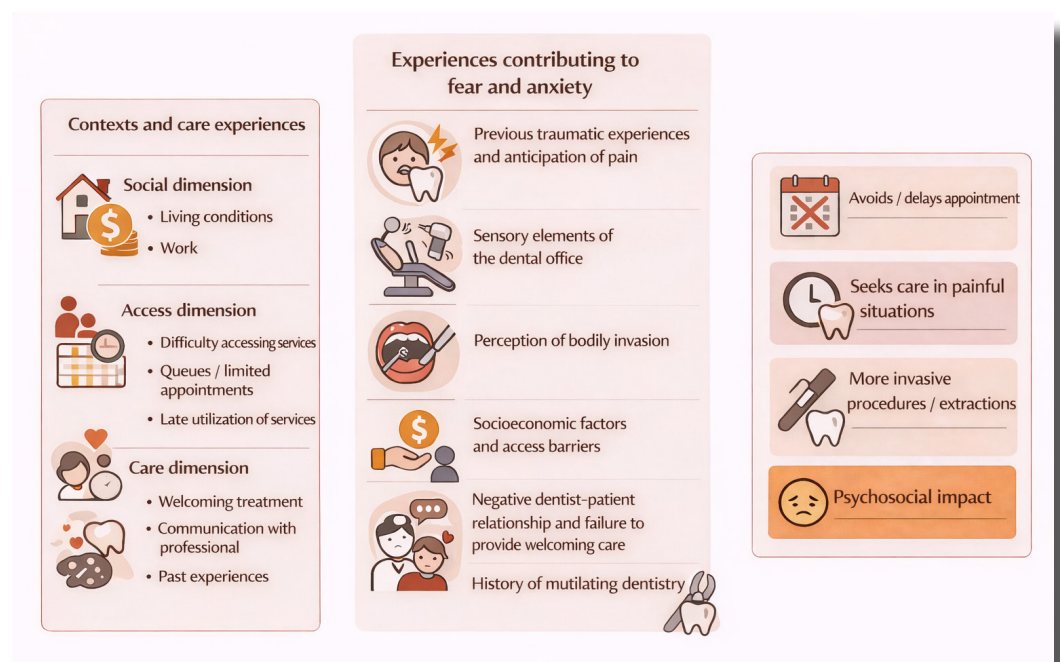
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Graphical Abstract

Highlights

- Socioeconomic factors and traumatic experiences intensify fear and anxiety in dental care.
- Limited access to oral health services contributes to late-seeking behavior and more invasive dental practices.
- Patient-centered reception and preventive dentistry are strategic approaches to reducing inequalities in Primary Health Care.



Prepared by the authors with the assistance of artificial intelligence (illustrative image).

Abstract

Dental treatment is still perceived as a traumatic procedure by many individuals, due to painful experiences or episodes that triggered fear. The scarcity of available dental services, particularly for adults, led to late-seeking behavior, making tooth extraction the primary intervention in the public health system. In addition, anxiety toward dental treatment exerts a considerable impact on psychosocial well-being, especially among users who delay dental care, resulting in serious oral health problems. This impact is even more pronounced in families with low income, low educational attainment, and limited access to preventive and curative dental care. This study aimed to analyze how socioeconomic factors relate to fear and anxiety toward dental care in Primary Health Care. This is a qualitative, exploratory-descriptive study, conducted at the Canasvieiras Health Center (HC) in the municipality of Florianópolis/SC, using semi-structured interviews with ten active users between August and September 2024, aged 23 to 66 years. Fear and anxiety in the dental office are strongly associated with traumatic experiences and socioeconomic factors, while limited access to oral health services amplifies inequalities and reinforces the need for public policies focused on equity in these services. To change this scenario, it is essential to prioritize oral health public policies, focusing on preventive dentistry, patient-centered care, and public awareness.

Keywords: Dental Care. Dental Treatment. Oral Health. Socioeconomic Factors. Anxiety.

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INTRODUCTION

Dental treatment is still frequently perceived as a potentially traumatic experience by many users, mainly due to prior experiences associated with pain or situations that trigger fear. This feeling may be understood as a response to stimuli interpreted as threatening, in anticipation of suffering^{1,2}. In the context of oral health care, fear and anxiety are complex phenomena that are not restricted to the individual dimension but are permeated by social, historical, and cultural experiences³.

The constitution of these experiences in Brazil is directly related to how oral health care has been historically organized. Prior to the creation of the Unified Health System (SUS), oral health care in Brazil was structured under an exclusionary care model, characterized by low population coverage, strong segmentation of access, and a focus on specific groups - particularly schoolchildren - through top-down programs with restricted preventive scope⁴. In this context, practices centered on curative and mutilating interventions predominated, with tooth extractions as the primary response to accumulated demands, highlighting the low resolutive capacity and the logic of late care. Furthermore, service organization was characterized by fragmented care, dissociating preventive, curative, and rehabilitative actions, thereby contributing to care discontinuity and the persistence of high rates of oral disease in the population. This configuration reinforced a social representation of dentistry associated with pain, tooth loss, and suffering, particularly among groups historically excluded from regular access to health services^{5,6}.

This historical configuration of oral health care is directly linked to the social determinants of health, given that conditions such as income, educational attainment, labor market integration, and access to public policies influence both the occurrence of oral health problems and patterns of service utilization⁷. The exclusion from dental care over time has produced persistent inequalities, expressed in the greater disease burden among socially vulnerable populations and in the construction of negative experiences associated with dental attendance⁸. Thus, fear and anxiety toward dental care cannot be understood merely as individual phenomena, but as socially determined constructions, permeated by life trajectories marked by access barriers, insufficiently humanized practices, and limited comprehensiveness of care. In this regard, the expansion of access promoted by the SUS still coexists with the challenge of overcoming this historical legacy and reconfiguring oral health care practices from the perspective of equity and comprehensiveness⁹.

Although the expansion of access promoted by the SUS has produced advances, challenges remain regarding the comprehensiveness of care and the overcoming of procedure-centered practices¹⁰. In this context, prior negative experiences, associated with precarious access and the historically low resolutive capacity of services, continue to influence how users perceive and experience dental care, potentially assigning to the dental office a meaning of suffering and threat^{1,6}.

Manifestations of fear and anxiety toward dental care can express themselves through behaviors and physiological signs, such as restlessness, sweating, pallor, tachycardia, elevated blood pressure, and verbal complaints^{11,12}. Such responses vary among individuals and may constitute significant barriers to access and continuity of care¹³. From a conceptual standpoint, fear is a fundamental emotion related to self-preservation, while anxiety may be understood as an anticipation of this fear in the face of situations perceived as threatening¹⁴. Although these dimensions are frequently approached from an individual psychological perspective, their occurrence is profoundly intertwined with the concrete living conditions of individuals.

Anxiety may be understood as a form of anticipated fear¹⁵. It is a stress state that manifests in a multidimensional manner, encompassing emotional, physiological, and cognitive components, which influence the individual's perception of the environment. It also constitutes an adaptive biological response, activated upon perception of danger or threat. Different life experiences, both positive and negative, can modulate its expression, contributing to the association of anxiety with situations assessed as aversive in daily life¹⁶.

Anxiety exerts a considerable impact on psychosocial well-being, particularly among users who delay dental treatment, resulting in serious oral health problems such as tooth loss and diminished self-esteem. This may lead to feelings of shame, difficulties in social interaction, and obstacles in the labor market. This effect is even more pronounced in families with low income, low educational attainment, and limited access to preventive and curative dental care. These conditions are associated with a high prevalence of severe oral diseases, which profoundly affect the health and quality of life of children and adolescents^{11,17}.

In Primary Health Care, guidelines direct the work process of health professionals, including the reception of users, which presupposes qualified listening to needs across all actions, providing humanized care and fostering the therapeutic

relationship¹⁸. The dental surgeon who adopts this practice comes to understand the user in a comprehensive manner, identifying their needs, anxieties, and fears regarding care, which contributes to the establishment of a therapeutic relationship and

to better physical and mental health outcomes, in addition to improving the quality of care provided.

This study therefore aims to analyze how socioeconomic factors relate to fear and anxiety toward dental care in Primary Health Care.

METHODOLOGY

The present study employs a qualitative, exploratory-descriptive approach. Qualitative research is grounded in the dynamic and inseparable relationship between the objective world and the subjectivity of the individual, taking the natural environment as a direct source of data for the interpretation and attribution of meaning to phenomena¹⁹. This method allows for the investigation of how life contexts and socioeconomic factors are integrated into the reality of these individuals, directly influencing their experiences and behaviors in Primary Health Care.

The research was conducted at the Canasvieiras Health Center (HC), the designation used for the Family Health Strategy (FHS), in the municipality of Florianópolis/SC. The population profile was composed of residents, influenced by seasonal variations associated with tourism, resulting in heterogeneous socioeconomic characteristics. The service provides dental care through a multidisciplinary team, constituting the setting for the analysis of experiences related to fear and anxiety in the context of dental care.

Active users of the unit participated in the study, including those who had undergone dental treatment with a dental surgeon at the HC throughout 2024. Non-probability convenience sampling was employed, including participants who were in attendance during the data collection period. Ten individuals of both sexes, aged 18 years or older, participated in the study.

The number of participants was defined based on the criterion of theoretical saturation, understood as the point at which interviews began to present repetition of information without the relevant addition of new elements for the construction of analytical categories, indicating sufficient density for understanding the investigated phenomenon.

The inclusion criteria were: users under dental follow-up at the Canasvieiras HC; age equal to or greater than 18 years; and capacity for verbal communication and comprehension to participate in the interview. The exclusion criteria were: individuals not under dental follow-up during the data collection period; individuals with limitations pre-

venting the conduct of the interview at the time of collection, such as inability to communicate verbally or cognitive difficulties compromising comprehension.

Data collection was performed through face-to-face individual interviews, using a semi-structured interview guide developed on the basis of the scientific literature on fear and anxiety in the dental context. The guide was organized around thematic axes, including: sociodemographic characteristics; access to dental services; lived experiences in oral health care; and narratives of fear and/or anxiety in dental care.

It should be noted that no pre-test (pilot study) of the instrument was conducted. Nevertheless, its adequacy was sought through grounding in the literature and the prior construction of the thematic axes, aligned with the research objectives.

Following the dental appointment, participants were informed about the study and invited to participate voluntarily. The interviews were audio-recorded and transcribed in detail for subsequent reference, and were conducted by the researcher herself in a private environment within the health service, ensuring participant privacy, with an average duration of 20 to 30 minutes.

For data processing, the technique of Content Analysis in its thematic modality was employed, developed in three stages: (I) pre-analysis, consisting of the analytical synthesis of each transcribed interview, the compilation and organization of data into a textual corpus, and floating reading; (II) material exploration, in which analytical categories are established based on information present in the text and the research objectives; (III) data analysis and interpretation, involving inferences that highlight the meanings of participants' statements²⁰.

The project was submitted for evaluation by the Research Ethics Committee Involving Human Subjects da Universidade Federal de Santa Catarina (CEPSH-UFSC) com o Opinion No. 7,020,878, and by the Health Research Projects Monitoring Commission (CAPPs) of the Florianópolis/SC Municipal Health Department.

RESULTS AND DISCUSSION

Between August and September 2024, adult participants, men and women, aged between 23 and 66 years took part in the study. Regarding housing conditions, shared arrangements predominated, with participants residing with two or three individuals. Situations of greater household density, with several cohabitants, were also identified, as were cases of solo residence. Concerning property tenure, rented housing was more prevalent, coexisting with owner-occupied dwellings and arrangements of provided accommodation.

Regarding family educational background, the accounts indicate trajectories marked by low educational attainment among parents, predominantly incomplete primary education. To a lesser extent, references were made to the completion of higher educational levels, as well as situations involving no formal schooling or in which participants were unable to provide information. Concerning the interviewees' own educational background, a diversity of trajectories was observed, ranging from incomplete primary education to higher education and postgraduate training, with greater concentration at intermediate levels of schooling.

Regarding income, participants were situated predominantly in lower income brackets, although higher incomes were also present. Labor market participation was also heterogeneous, with some participants engaged in paid employment while others were unemployed at the time of the study.

The analysis of the narratives allowed the construction of two thematic categories: (I) fear and anxiety in the dental office and (II) socioeconomic factors related to access and the dentist-user relationship.

Fear and anxiety in the dental office: between sensory experience and anticipation of pain

Participants' accounts indicate that fear and anxiety in the dental context are recurring experiences, associated both with concrete elements of dental care and with subjective constructions related to pain and bodily invasion. Among the experiences shared during the interviews, fear of anesthesia, dental instruments, engine noise, and experiencing pain were recurrent. Determining elements of fear and anxiety in the dental office have been identified, including local anesthesia, surgical procedures, and the vibrations and sounds of high- and low-speed handpieces²¹.

User 01 reported:

"We feel afraid of having something extracted, of

getting a needle, even more so when that little drill comes... the tooth, my God, what torture. If there is no anesthesia, I won't go."

User 03, in their account, demonstrates becoming apprehensive when any instrument comes into contact with their mouth:

"It gives me a little shock in my teeth. And then I think, my God, it's going to break everything."

These accounts are consistent with studies on the subject, which describe dental fear as one of the most common and intensely experienced fears, not only due to aversive treatment-related factors such as equipment and instruments, but also due to the sensation of bodily invasion²². This perception may cause the user to perceive the situation as a threat, increasing the likelihood of avoidance or escape behaviors during treatment²³.

One of the main factors influencing the behavior of many users who seek dental care is the belief that they will be subjected to some form of discomfort or pain during treatment, as well as contact with the dental office environment, including the dental chair, instruments, and high- and low-speed handpieces^{3,24}.

Despite technological advances, anxiety arises in response to the noise of the high-speed handpiece, anesthesia, or invasive procedures, given that the sight of a needle or the sound of drilling can trigger the sensation of fear^{1,25}.

Still within this theme, accounts of anxiety signs before and during dental care were reported, such as racing heart, cold hands, sweating, and trembling. Studies show that dental anxiety triggers responses in the user's physiological and psychological systems, with respiratory alterations, increased blood pressure and heart rate, being responsible for a considerable number of dental office emergencies¹. Furthermore, the expression of fear may manifest in the body through sensations of suffocation, dry mouth, sweating, and trembling^{3,26,27}.

In this regard, fear in the dental office is not reduced to the technical procedure, but expresses a broader corporeal and symbolic experience, in which memory, anticipation of pain, and perception of invasion are articulated, configuring care as a moment of vulnerability.

Socioeconomic factors, access, and the dentist-user relationship: between inequalities and care production

The second category shows that experiences of fear and anxiety cannot be dissociated from

the social and economic conditions of the participants, which influenced both access and the way in which care is experienced. The results indicate that participants are predominantly situated in contexts of greater social vulnerability, with trajectories marked by income and educational limitations. In this scenario, access to dental services occurs irregularly, frequently conditioned by factors such as treatment cost and availability of time.

User 01 recounted that, due to lack of time because of work commitments, they had not visited the dentist for more than two years and had stopped dental treatment in the private sector due to lack of funds. This account highlights the high costs of dental treatment in Brazil, historically structured around an individual and predominantly curative model⁴. Although the SUS offers dental services, these are unable to fully meet the population's needs, leading many users to resort to the private sector.

User 8, when asked about the frequency of dental appointments, stated:

"Only when I have a problem."

This account highlights the predominance of a curative logic, in which care is activated only in the presence of pain or established problems, consistent with the historical trajectory of oral health services in Brazil, marked by mutilating practices, low coverage, and limited impact^{28,29}. Prior to the creation of the "Brazil Smiling" program in 2004, access was even more restricted^{4,30}.

The scarcity of services, particularly for adults, contributes to late-seeking behavior, making tooth extraction a frequent intervention in public services^{6,31}. Consequently, the dental office becomes associated, for some individuals, with suffering¹.

Still with regard to access, accounts point to concrete difficulties in everyday service use, as reported by User 01:

"...it was almost five o'clock in the morning and there were no more appointment slots."

This type of barrier highlights that, despite advances, access to oral health services remains marked by social and regional inequalities^{32,33}. In contrast, User 04, who was pregnant, highlighted that facilitated access positively impacted her care: before pregnancy she reported difficulty accessing services, whereas during pregnancy, having priority access, she began attending appointments more frequently and taking better care of her oral health. This finding demonstrates how prioritization policies can produce concrete effects in expanding care.

Another relevant aspect concerns the dentist-user relationship, which emerges as a central element in the care experience. Some accounts indicate

fear of judgment and relationships marked by power asymmetries.

○ USU 01 relatou "told off". This perception may be understood in light of relationships in which the professional assumes a dominant, powerful position, defining what is considered a health need³⁴. Even in the face of feelings of distress, users seek the service in the expectation of resolving their problems, reinforcing the centrality of cure in care.

Furthermore, negative care experiences were reported, such as lack of listening and patient-centered reception. One interviewee recounted an episode of possible allergic reaction to the anesthetic, in which the professional did not take her symptoms into consideration, describing him as "rude." Also mentioned were procedures performed without anesthesia, communication failures, and differences between public and private care.

For successful treatment, communication between the dental professional and the user is essential and should be associated with technical competence³⁵. Users expect, above all, to be treated with empathy³⁶. Nesse contexto, a valorização de humanized care may be understood as a response to a history in which dental care was strongly associated with pain. Qualities such as solidarity and respect prove fundamental to transforming the care experience and reducing the negative image associated with dental treatment³⁶.

The findings indicate that oral health care is produced at the intersection of corporeal experiences of fear and pain, socioeconomic conditions, and service organization. Fear and anxiety are not configured merely as individual responses, but as expressions of social, historical, and relational trajectories that shape how individuals access and experience care.

Thus, the dental office is configured not only as a technical space, but as a symbolic territory in which suffering, memory, inequality, and possibilities of care are intertwined. The qualification of oral health practices, therefore, requires the incorporation of approaches that consider these multiple dimensions, promoting not only access, but also more welcoming, equitable, and experientially sensitive care relationships.

As a study limitation, it should be noted that data collection and analysis were conducted by a single researcher, without the participation of a second evaluator or investigator triangulation, and in the absence of another researcher during the conduct of the interviews. This condition may increase the possibility of bias in both data collection and interpretation. On the other hand, individual conduct of the interviews may have contributed to

the creation of an environment of greater proximity with the participants, fostering the development of

rapport and enabling a more consistent deepening of accounts and shared experiences.

CONCLUSION

It is concluded, therefore, that socioeconomic factors exert a significant influence on users' fear and anxiety in the dental office, particularly in Primary Health Care. However, this subject is complex and multifaceted and cannot be discussed on the basis of a single cause alone. The insufficient provision of dental services by the SUS to the most vulnerable populations, late-seeking behavior, and a curative-centered vision of dentistry results in more traumatic experiences in dental offices and more users who are afraid to visit the dentist. According to

2021 data from the Global Burden of Disease (GBD) study, Brazil is the third country in the world with the highest number of edentulous individuals; what was done in the past produced the current scenario, and in order for this indicator to change in the future, oral health must cease to be a secondary element in public policy, and family health dentists present in health units must fulfill their role in raising population awareness about the importance of oral health, prioritizing preventive dentistry and patient-centered reception for every individual.

CRedit author statement

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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