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Original Research Article

The role of dental anxiety in shaping patient satisfaction with dental services among patients visiting a tertiary care hospital: a cross-sectional study

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ABSTRACT

Background: The study aimed to examine the effect of dental anxiety on patient satisfaction with dental services and whether dental anxiety influences satisfaction levels among patients visiting tertiary care hospitals.
Methods: The method was conducted among 356 dental patients at a tertiary care hospital, Nagpur. The Modified Dental Anxiety Scale (MDAS) was used to assess anxiety levels in patients. A pre-validated questionnaire was used to measure patient satisfaction with dental services.
Results: Respondents were generally satisfied, although some internal differences were observed. Of the 356 responses, 92.1% of participants reported being satisfied, while 7.9% were unsatisfied. Satisfaction level was higher among younger age groups, though this association was not statistically significant. Males reported greater satisfaction (53.4%) compared to females (46.6%). No significant association was found between satisfaction and education level. However, satisfaction was highest among patients with education levels below graduates. Dental anxiety was more prevalent in younger patients. Females experienced higher dental anxiety (18.9%) than males (7.5%). The highest levels of dental anxiety were observed among those with education below graduation.
Conclusions: Patients with higher dental anxiety reported lower satisfaction. Respondents were generally satisfied with dental services, except for waiting times. Older patients were less satisfied compared to younger ones. Males were more satisfied than Females.

Keywords: Dental anxiety, Dental health services, Dental care, Patient satisfaction, Questionnaire

INTRODUCTION

Dental anxiety affects millions of people worldwide, causing significant distress and hindering access to essential oral healthcare. Approximately 75% of adults experience some level of dental anxiety, with around 10% suffering from extreme fear. It is estimated that 6-15% of the global adult population avoids dental care due to severe dental anxiety or phobia.[1] The consequences of dental anxiety can be serious, often leading to deterioration in oral health and presenting a major epidemiologic challenge for dental professionals.[2] This study explores the relationship between dental anxiety and oral health outcomes. Dental care satisfaction refers to how content patients are with the healthcare they receive, particularly dental care and related services. Satisfaction plays a key role in evaluating the success of dental units delivering care.[3] Patient satisfaction is a vital component of dental services, as it reflects the quality and effectiveness of treatment, communication and care provided by dental professionals. Measuring satisfaction enables dental practices to identify areas for improvement and ensure that patients receive the highest standard of care.[4] Understanding Patients perceptions of their oral

health and the factors that influence those perceptions can help dental profession address barriers that patients face when accessing dental care.[5] By identifying the causes and consequences of dental anxiety, healthcare providers can design effective interventions to improve patient outcomes. Accordingly, this study aims to investigate the hypothesis that dental anxiety affects the utilization of dental services among patients visiting a Tertiary Care Hospital.

METHODS

Study design

This was a cross-sectional questionnaire-based study. Ethical clearance was obtained from the Institutional Review Board of Government Dental College and Hospital, Nagpur.

Study population

The study included patients visiting a Tertiary Care Hospital in the state of Maharashtra.

Sample size

A G power software was used to calculate the required sample size. The minimum sample size was determined to be 356 participants. Individuals aged between 16 and 75 years were included in the survey.

Study size calculation

The sample size was estimated based on published data on the prevalence of dental anxiety on Indian populations, which reported a 10% prevalence rate of dental anxiety.6 The minimum required sample size was calculated using the formula provided by Suresh KP and Chandrashekara N (2012)7 for estimating proportions in survey type studies.

$N = (Z\alpha/2)2 \times P \times (1-P) \times D\ (1.96)2 \times 0.1 \times (1-0.1) \times 1$

$E2 = (0.05)^2$

R = 0.8

Sample size = 345

Where, Z (α/2) = 95% Confidence interval = 1.96

P = 10% Prevalence of parental Anxiety = 0.1

D = Design effect - reflects sample design: for Simple random sampling = 1

E = 5% Margin Error = 0.05

R = 80% Response rate = 0.8

To account for the response rate, the final sample size was increased by 20%, resulting in a required sample size which is 414. Of these, 356 patients aged between 16 and 75 years completed the survey.

Inclusion criteria

Participants were included in the study if they met the following criteria.

Patients who had completed at least one dental appointment. Patients aged between 16 and 75 years. Patients who were willing to participate. Patients who are intellectually and physically capable of responses.

Exclusion criteria

Participants were excluded from the study if they met any of the following conditions.

Patients visiting for the first time or those without any dental treatment experience. Patients below 16 years of age. Patients who did not provide consent for clinical examination. Patients suffering from neurological or systemic diseases, experiencing acute pain or with any medically compromised conditions.

Study tool

The MDAS, developed by Humphries G, Morrison T and Lindsay SJE, BMC Oral Health was used to measure dental anxiety in the patients.[7] It is a brief, self-administered questionnaire consisting of five questions each with a 5-category rating scale, ranging from ‘not anxious’ (scoring-1) to ‘extremely anxious’ (scoring-5). To assess patient satisfaction with dental services, a pre-validated questionnaire developed by was used.[9]

The MDAS scale has proven to be reliable and valid tool for measuring dental anxiety, with proven cross-cultural applicability. Validation studies have been conducted in the UK, Ireland, Middle East (Dubai), South America (Brazil), Europe (Turkey), North America (United States).

Greek translations of the MDAS and DFS demonstrated satisfactory internal consistency and test-retest reliability, as evidenced by research conducted by T. Coolidge.[3] There remains a critical need for rigorous scientific evaluation of dental anxiety management practices, especially to quantify their effectiveness. Given the diversity of individual experiences, flexible and personalized approaches are essential to address unique patient needs and concerns.[4]

Data collection

The cross-sectional, questionnaire-based study, was conducted between March and August 2022. Ethical clearance was obtained from Institutional Ethical

committee. Written Informed consent was secured from patients who had completed at least one dental treatment session. Patients visiting the Tertiary Care hospital in state of Maharashtra were approached for participation. A Simple random sampling technique was employed. Using the Survey Monkey platform, a survey link was distributed via WhatsApp. The survey was designed so that only one response submitted per device.

The data collection was done by using a customized questionnaire divided into three sections.

Part 1 recording demographic profiles of the participants, including age, gender and education level. Part 2 (Que1-5). The MDAS was used to assess anxiety levels among patients.[8] The questionnaire included one item specifically assessing the patient's anxiety level during treatment. Responses were rated on a 5-point scale ranging from "Not anxious" to "extremely anxious". Scores from all five items were summed to generate a total score ranging from 5 to 25. Part 3 (Que6-18) a pre-validated questionnaire was used to assess patient' satisfaction with dental services. Responses were rated on a 5-point Likert-type scale ranging from "strongly satisfied" to "strongly dissatisfied".

Validity and reliability of study tool

Face and content validation were conducted with the help of two subject matter experts, along with a focused group discussion involving a small representative sample of 10 study subjects. Internal consistency and homogeneity of the questionnaire were evaluated using Cronbach's alpha which yielded a value of 0.909, indicating high reliability. None of the items showed improvement upon deletion, so all the items were retained in the final questionnaire. Test-retest reliability was conducted to assess external consistency. This was evaluated on group of 30 study participants with a two-week interval between the two assessments. The correlation coefficient was 0.9, indicating strong reproducibility and high reliability of the questionnaire.

Statistical analysis

After collecting all demographic data from participants, the responses were entered into an Excel worksheet. The data extracted from the completed questionnaires were analysed using the statistical package for social sciences (SPSS), IBM version 23.0, a commercially available statistical software. Estimated prevalence rates were presented with a 95% confidence interval (95% CI). Statistical significance was determined at a p value less than 0.05. Descriptive statistics were used to calculate frequencies, means and standard deviations for variables considered in the study. The chi-square test was applied to compare categorical variables.

RESULTS

A total of 356 patients participated in this study with a mean age was 35.8 years (SD 13.9). The majority belonged to the 35-55 age group (51.9%). Male participants and those with education below graduation level were slightly predominant in the sample. Overall, satisfaction with the dental services was very high, with 92.1% of participants reporting satisfaction. Only 7.9% reported being either dissatisfied or less satisfied (Table 1).

Table 2 presents satisfaction ratings across various participant characteristics. Satisfaction was higher among younger age groups, although this association was not statistically significant. Males reported higher satisfaction than females, (p=0.286). Education level did not show a statistically significant with satisfaction either, although the highest satisfaction was reported among those with education below graduation level (p=0.508). In the low anxiety group, 66.8% participants were satisfied, whereas in the high anxiety group, only 7.6% were satisfied. These results suggest a discernible correlation between increased anxiety levels and lower satisfaction, indicating that increased dental anxiety is associated with reduced satisfaction rates (Table 2).

Table 1: Socioeconomic characteristics of the respondents.

Variable		Male	%	Female	%
Age (in years)	16-35	108	53.5	94	46.5
	36-55	52	48.1	56	51.9
	56-75	26	56.5	20	43.5
Education	Below graduate	82	44.1	104	55.9
	Graduate	76	54.3	64	45.7
	Post graduate	28	93.3	2	6.7
Satisfaction with dental services	Yes	175	53.4	153	46.6
	No	12	42.9	16	57.1

As shown in Table 3, all variables of patient satisfaction were significantly associated with different levels of dental anxiety except for waiting time. Others influencing factors such as the number of dentists, availability of the appointments, seating in the waiting area, receptionist behavior, speed of response to complaints were found to

be significantly related to dental anxiety levels. This table also shows a significant association between satisfaction with dental services and dental anxiety, (p=0.003) (Table 3). Table 4 outlines the most commonly cited reasons for satisfaction with dental services. The highest satisfaction attributed to the dentist listening empathetically to patients, with 91.6% agreement. This was followed closely by satisfaction with the dentist ability to provide clear explanations about treatment and post treatment instructions with 91%.

Other reasons for satisfaction included a warm welcome at the reception (90.4%), availability of the dentist (89.9%), speed of response (89.9%), treatment results (89.3%), prompt service in emergencies (89.3%). Additional contributing factors were interior décor (88.8%), sterilization and hygiene (88.2%), availability of seats in the waiting area (86.5%). Satisfaction was also reported for the suitability of appointment dates (84.8%), clinical competence (83.7%). The least satisfactory factor, with only 72.5% satisfaction, was related to the waiting time before seeing the doctor on the day of appointment (Table 4).

Table 2: Satisfaction with dentist by Socio-demographic characteristics of the respondents.

Variable		Satisfied	%	Unsatisfied	%	P value
Age (in years)	16-35	188	57.3	14	50.0	0.560
	36-55	97	29.6	11	39.3	
	56-75	43	13.1	3	10.7	
Gender	Male	175	53.4	12	42.9	0.286
	Female	153	46.6	16	57.1	
Education	Below graduate	174	53	14	50	0.508
	Graduate	128	39	10	35.7	
	Post graduate	26	7.9	4	14.3	
Anxiety group	Low (1-10)	219	66.8	12	42.9	0.003
	Moderate (11-18)	84	25.6	9	32.1	
	High (19-25)	25	7.6	7	25	

Table 3: Reasons for satisfaction with dentist by different levels of dental anxiety.

Variable		Low	%	Moderate	%	High	%	P value
Enough dentist in institution	Satisfied	219	68.4	81	25.3	20	6.2	0.000
	Dissatisfies	12	33.3	12	33.3	12	33.3	
Ability to listen to patients	Satisfied	219	67.2	85	26.1	22	6.7	0.001
	Dissatisfies	12	40	8	26.7	10	33.3	
Providing clear explanation	Satisfied	221	68.2	83	25.6	20	6.2	0.001
	Dissatisfies	10	31.2	10	31.2	12	37.5	
Clinical competence	Satisfied	193	64.8	83	27.9	22	7.4	0.025
	Dissatisfies	38	65.5	10	17.2	10	17.2	
Suiff date for appointment	Satisfied	201	66.6	81	26.8	20	6.6	0.001
	Dissatisfies	30	55.6	12	22.2	12	22.2	
Waiting time	Satisfied	163	63.2	73	28.3	22	8.5	0.311
	Dissatisfies	68	69.4	20	20.4	10	10.2	
Enough seats in waiting area	Satisfied	211	68.5	77	25	20	6.5	0.000
	Dissatisfies	20	41.7	16	33.3	12	25.0	
Interior design	Satisfied	211	66.8	83	26.3	22	7	0.001
	Dissatisfies	20	50	10	25	10	25	
Welcome at reception	Satisfied	217	67.4	85	26.4	20	6.2	0.000
	Dissatisfies	14	41.2	8	23.5	12	35.3	
Speed of response of patient complaint	Satisfied	213	66.6	85	26.6	22	6.9	0.000
	Dissatisfies	18	50	8	22.2	10	27.8	
Patient satisfaction to treatment results	Satisfied	217	68.2	81	25.5	20	6.3	0.000
	Dissatisfies	14	36.8	12	31.6	12	31.6	
Fast service	Satisfied	211	64.4	85	26.7	22	6.9	0.000
	Dissatisfies	20	52.6	8	21.1	10	26.3	
Sterilization and Hygiene	Satisfied	207	65.9	85	27.1	22	7	0.001
	Dissatisfies	22	55	8	20	10	25	

Table 4: The most common reasons for satisfaction of dental services among patients were that.

S. no.	Most common reasons	%
1	The dentist listen to the patients and empathize with them	91.6
2	The dentist provide clear explanation to patient before treatment and give post treatment instructions	91
3	They were welcomed at reception	90.4
4	They were satisfied with enough availability of dentists in the institution.	89.9
5	They were satisfied with the speed of response of patient's complaint.	89.9
6	They were satisfied with the treatment results.	89.3
7	They were satisfied getting the fast service in case of emergencies.	89.3
8	They were satisfied with the interior design/décor of the centre.	88.8
9	They were satisfied with the sterilization and hygiene in the centre.	88.2
10	They were satisfied with enough availability of seats in the waiting area.	86.5
11	They were satisfied with obtaining a suiff date for appointments easily.	84.8
12	They were satisfied with dentist's clinical competence in performing the dental procedure at the designated time frame.	83.7
13	They were satisfied with the waiting time before seeing the doctor on the day of appointment.	72.5

DISCUSSION

A comprehensive understanding of health service utilization patterns and the factors influencing such behaviour is essential for optimizing oral health outcomes.[5] This study offered a means of evaluating the impact of dental anxiety on patient satisfaction with dental services and presented data that correlated various factors, including socio-demographic characteristics. Our study showed a high level of satisfaction with dental services with 92.1% of participants reporting positive experiences, consistent with findings from other studies.[10,11]

The primary reasons for satisfaction with dental care were largely associated with the interpersonal qualities of both the dentist and the supporting staff. Although higher levels of dental fear were linked to increased dissatisfaction, studies have shown that even among fearful individuals in Switzerland, satisfaction with dental care remains relatively high.[12] This reinforces the importance of communication skills in dental practice. Education on effective communication has been shown to independently contribute to improved well-being and long-term satisfaction.[13] However, the rapid growth of dental colleges in India has not resulted in proportional improvements in patient satisfaction, which contributes to be notably low. Factors such as high patient volume and cost-related concerns remain critical variables affecting patient experience.

Before implementing any anxiety management strategy, it is essential to assess the individual characteristics of a person's dental anxiety and fear, as these significantly influence treatment outcomes. Research indicates that direct negative dental experiences are a primary contributor to dental anxiety.[14] Several studies have emphasized the influence of cognitive and emotional factors in dentist-patient interactions on patient adherence to clinical recommendations and follow-up appointments.[15] For instance, using the Dental Patient Questionnaire (DPQ), a study conducted in a centrally located Romanian city assessed patient satisfaction with both public and private dental services. The findings highlighted the need for both sectors to implement targeted strategies that improve patient engagement and offer comprehensive treatment approaches that lead to high levels of patient satisfaction.[16]

The tendency to pursue symptom-oriented treatment, often driven by dental fear, creates a harmful cycle of avoidance, increased treatment requirements and persistent anxiety.[17] A study conducted in Malaysia identified a significant correlation between patient-dentist interaction and patient satisfaction, underscoring the importance of the need for policymakers to develop evidence-based strategies that foster positive interactions and improve oral healthcare quality.[18] A study outcome by Dena et al highlights the need for further improvements in the accessibility and physical appearance of the dental centres.[9] Additionally, interventions focused on improving accessibility, particularly when scheduling appointments are necessary.

There is evidence that inherent psychological and physiological differences between males and females influence their perceptions and attitudes toward various services, emphasizing the need for a gender-sensitive approach to service evaluation.[19] In our study, males reported greater satisfaction than females, with 53.4% of males being very satisfied compared to 46.6% of females. However, a study done by Armfield et al in Switzerland found contrasting results, with females expressing greater satisfaction than males.[12] A similar trend was noted in a study conducted in Western Cape, South Africa, where female patients reported higher satisfaction levels than their male counterparts.[20]

The findings of study indicate that patients older than 36 years were less satisfied with their dental care services

than younger patients. This finding is similar to the study conducted by Ali et al in Kuwait where the patients older than 39 years of age were less satisfied with their dental care services than younger patients.[9] The elderly patients were less satisfied than the younger ones by 41.08% in Saudi Arabia.[21] Also, our finding was not in accordance with the study done by Armfield et al in Switzerland, where satisfaction was higher across older age groups.[12]

According to our study, highly educated patients were less satisfied with dental services (7.9%) compared to those with less education (53%). This finding is consistent with a study by Ali et al in Kuwait, where highly educated patients reported lower satisfaction with dental services.[9] Patel similarly found that educated individuals expressed lower satisfaction levels compared to those with limited education.[22] This discrepancy may stem from better understanding of treatment options, increased health literacy and more informed expectations among the highly educated. These results are consistent with those of Zastowny et al study.[23]

The findings indicated that while satisfaction with dental care was generally high across most common domains, waiting time was a common concern. In line with Dena A. Ali (2016) findings, our study observed that in Kuwait, satisfaction was high across all tested service areas except for the accessibility and physicals of the reception/waiting area and waiting time.[9] Given the current surge in dental education and competitive pressures, dental institutions may need to re-evaluate their service delivery approach.[24] Dr. Nagappan's study conducted in India also showed that 89% of patients were satisfied with the medical care provided. However, the primary cause of dissatisfaction among other patients was the prolonged waiting time for consultations and treatments.[22]

Dentists should prioritize comprehensive explanations of treatment options to ensure high satisfaction levels.[15] Various factors contribute to dental service utilization, including family income and parental anxiety which have shown a significant association with patient behaviour. The study further recommends implementing targeted programs to improve oral health awareness and reduce dental anxiety in parents and children.[25] Educational programs should also be developed for less educated and older individuals to set clear expectations about dental care, thereby reducing disparities in access.[26]

This study has several limitations. Firstly, a large sample size would have strengthened the findings, especially if a more balanced representation of both public and private rehabilitation settings had been included. As a cross-sectional study, the results reflect participants' experiences at only one point in time. Additionally, participants' perceptions may change after undergoing multiple appointments or a complete treatment cycle. Therefore, future research could consider modifying the inclusion criteria to require the completion of at least one full treatment cycle, rather than just a single appointment.

CONCLUSION

Respondents reported high satisfaction with dental care services except regarding waiting times. Individuals with dental anxiety were less satisfied with their dental treatment. Patients with low anxiety showed higher satisfaction. Older patients were less satisfied with dental services compared to younger patients. Additionally, males were more satisfied with dental care services than females.

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