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Dental anxiety as a hidden access barrier: prevalence, sociodemographic predictors, and service-utilization effects

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Abstract

Another major, yet significantly under-acknowledged cause of lower utilization of oral healthcare services is dental anxiety. Although there has been increased dental technology coupled with the focus on the patient, fear and anxiety are playing a role in ensuring that individuals do not get timely treatment resulting in the worsening of the oral health condition. This paper will cover the commonality of dental phobia, its sociodemographic predictors, as well as the effects of dental phobia on patterns of service uptake, especially in vulnerable groups. This study relies on a multidisciplinary literature review, thus showing how the age, gender, socioeconomic status, previous trauma, and mental health stigma augment the effects of dental fear. The article claims an oral health structural barrier is the hidden element of dental anxiety that transpires into greater oral health disparity by synthesizing international and regional data, especially with low- and middle-income situations. The results promote a universal culturally competent, and trauma-sensitive system of dental medicine, based on the trust in advance of screening and anxiety-reduction methods. Finally, the problem of dental anxiety is important not only to enhance oral health outcomes but to create equity in access to basic health services.

Keywords

Dental anxiety; oral health access; healthcare utilization; sociodemographic predictors; mental health stigma; trauma-informed care; health disparities; service avoidance; fear of dentists; public health barriers

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1. Introduction

1. *Anxiety as an Underreported Barrier to Care*

Dental anxiety can be termed as fear or fear of dental surroundings, apparatus, or procedure or even the preconception of the treatment. Although it is a known fact in the dental practice, it has been and continues to be capitalistically underreported in the public health field of planning healthcare services (Taqi et al., 2023). Most national oral health plans give more attention to institutional challenges of the shortage of workers, high taxes, or insufficient facilities, and neglect the emotional and psychological barriers such as fear or denial (Shahid, 2021).

But dental anxiety is paralyzing. Even with a moderate level of fear, patients can postpone or fail to to obtain visiting, preventive opting for health care, or employ it until it causes distress, thereby pushing routine health care to the emergency service (Schibbye et al., 2024; Osuh et al., 2023). Regrettably, such behavior patterns tend to remain unnoticed by policymakers or even clinicians themselves, as their anxiety is not always revealed by a patient either due to stigma and ignorance or even due to shame (Lincoln et al., 2017; Saint Arnault & O'Halloran, 2016). And such invisibility causes dental anxiety to be a silent epidemic that exacerbates the struggle to achieve universal oral healthcare and increase preexisting disparities in health access and outcomes.

2. *Why It is Important in terms of Public Health, and Service Delivery*

Oral diseases form some of the simplest to prevent and yet widely spread health conditions the world over. Dental anxiety directly affects the advancement of untreated caries and periodontal disease; moreover, it is also a factor who leads to complications in the appeal of higher systemic diseases, including diabetic complications and cardiovascular diseases (Osuh et al., 2023). To health systems that have already been challenged with a burden of inequality, avoidance of care driven by fear leads to lost opportunities to prevent, more emergency room visits, and greatly reduces the cost of treatment over time (Doughty et al., 2023; Osuh et al., 2023).

Moreover, dental phobia and anxiety exhibit disproportionate impacts on specific groups of people such as women, individuals with low income, past traumatic events, and people with a co-morbid mental disorder (Walker et al., 1996; Hudson et al., 2016; Sileo & Kershaw, 2020). This is closely connected with social determinants of health, such as education, employment, literacy, and neighborhood safety (Tiwari et al., 2022; Shahid, 2021). Thus, dental anxiety is more of a public health concern than an individual apprehension, and poseting it in terms of any of the said allows introducing more non-dronic and compassionate and attentive care models.

Table 1: Hidden Impacts of Dental Anxiety on Oral Health Service Access

Impact Area	Manifestation	Sources
Care Avoidance & Delay	Missed appointments; late-stage presentations	Taqi et al., 2023; Schibbye et al., 2024
Oral Health Deterioration	Progression of preventable conditions like caries and periodontitis	Osuh et al., 2023; Doughty et al., 2023
Emergency-Only Utilization	Patients presenting only when in severe pain or crisis	Osuh et al., 2023; Adeniyi & Oyapero, 2020

Widening Health Inequities	Disproportionate impact on women, low-income, and trauma-exposed groups	Hudson et al., 2016; Tiwari et al., 2022
Psychological and Social Compounding	Shame, stigma, and self-isolation exacerbating mental health burden	Lincoln et al., 2017; Saint Arnault & O'Halloran, 2016

3. *Theoretical Relevance and Gap in Research*

Although sources such as the Behavioral Model created by Andersen (Adeniyi and Oyapero, 2020) allow creating a solid reference to examine the potential mechanisms of healthcare utilization based on predisposing, enabling, and need factors, most consequences in dental practices do not directly add emotionally and psychologically restrictive factors such as anxiety. On the same note, the fact that different investigations address the reasons behind health-seeking inactivity: be it stigmatization, literacy, or cultural incompatibilities (Lincoln et al., 2017; Hanson et al., 2019), does not mean that they neglect the specific influence of fear on the choice of oral health practices.

This article closes that gap by reconstruing dental anxiety as a sociostructurally determinant of health and such consequences can be seen as real in terms of avoidance of care, delayed treatment, and inequality in systems. It is on the basis of new research which relates dental anxiety to demographic measures such as age, gender, family structure, mental health condition and mental trauma history (Kvesić et al., 2023; Hassan et al., 2022; Hagqvist et al., 2015).

This article proceeds by first reviewing the existing literature on dental anxiety, particularly its prevalence and psychological dimensions. The next section explores the sociodemographic predictors, drawing connections between fear and structural inequities. Following that, the article assesses how dental anxiety influences patterns of service utilization, with examples across countries and populations. The discussion then reflects on the policy, clinical, and public health implications, advocating for a shift toward trauma-informed and culturally competent dental services. Finally, the conclusion outlines recommendations for future research and health policy to reduce the anxiety gap in oral healthcare access.

2. Literature Review

1. Understanding Dental Anxiety2

Dental anxiety is usually described as a mental situation where an individual experiences increased nervousness, fear or anxiety to dental procedures. Its cause is commonly multifactorial, involving cognitive and behavioral reactions as well as emotional and physiological reactions to real or perceived dental treatment (Taqi et al., 2023). Avoidance behavior forms the fundamental aspect of dental anxiety where an individual voluntarily defers or defiance dental care on the basis of fear of pain, loss of control or previous traumatic events. According to Schibbye et al. (2024), this reaction is explained in terms of the approach-avoidance conflict with the interest in being treated eroding under the threat of the painful stimuli or being humiliated.

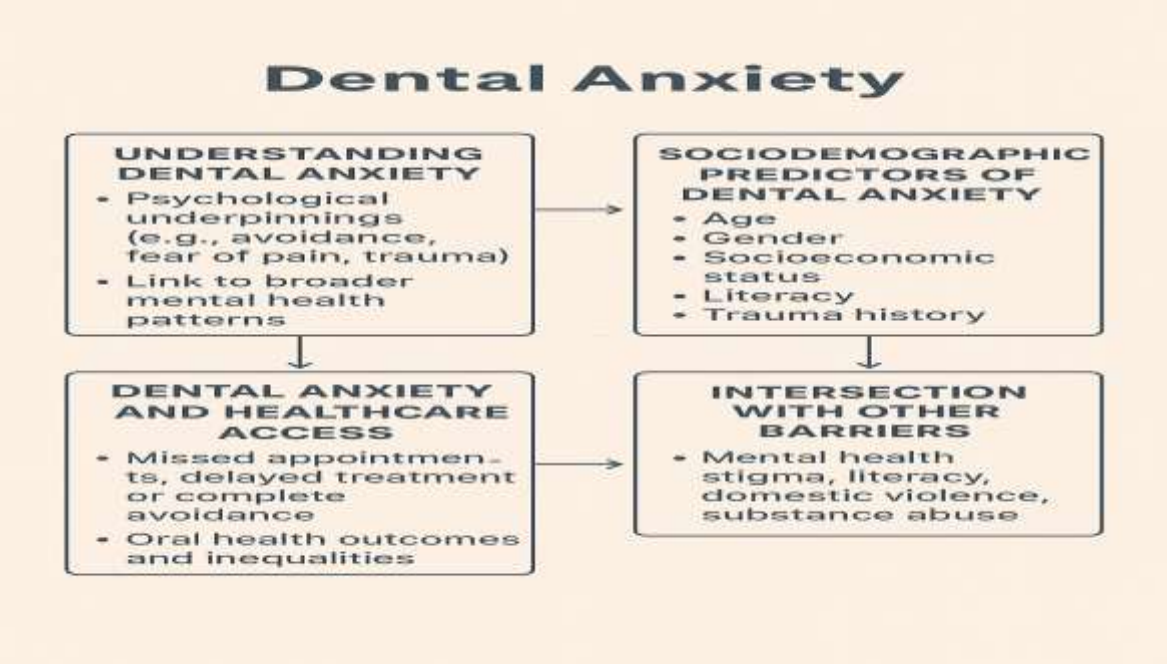
Needle phobia, dental practice, or dentist patient power relationship frequently results in anxiety that can further develop into phobia. Fear may prevail in some Lynch law victims, even after they get over any physical trauma involving their dental injury (Kvesić et al., 2023). In addition, dental phobia is not an

independent one but is often associated with mental illnesses like generalized anxiety disorder, post-traumatic stress disorder (PTSD), or depression (Lincoln et al., 2017; Sileo and Kershaw, 2020). Lack of literacy, poor health confidence may also result in anxiety as individuals may fear that instructions will be misunderstood or that they will be evaluated negatively by medical care providers (Lincoln et al., 2017). The Double Stigma Model by Lincoln et al. (2017), in particular, is particularly pertinent here when it comes to the lack of literacy combined with mental illness that constrains the extent to which the individual can engage in health seeking behavior, the impact of which is oral healthcare. It results that dental anxiety cannot be considered independently but needs to be analyzed on the basis of more philosophical psychosocial and emotional contexts.

2. Sociodemographic Predictors of Dental Anxiety

Anxiety relating to the dental disease does not occur evenly. Studies have always revealed that some sociodemographic variables are strong predictors of high levels of dental fear. One of the variables with the most extensive study is age and gender. Increases in anxiety among adolescents and young adults are mainly reported when young adults have a negative or painful experience of dental care at an early age (Taqi et al., 2023; Kvesić et al., 2023). In general, there is a propensity to female patients reporting a higher score of dental fear as compared to male patients, which is perhaps likely to happen because of a stronger chance of experiencing some sort of past trauma or abuse (Walker et al., 1996; Hudson et al., 2016).

The issue of socioeconomic status is dominant. Persons, who belong to low-income families, are less likely to receive dental education, have fewer options in providers, and more experiences in public dental systems, which do not give them empathy or privacy, all creatures that increase fear and mistrust (Osuh et al., 2023; Adeniyi and Oyapero, 2020). Another intensive variable is literacy. With low health literacy rates, patients are unable to decipher dental terms, or treatment revenue, or consent forms, which enhances anxiety based on bewilderment and powerlessness (Lincoln et al., 2017; Shahid, 2021). History of trauma-childhood abuse, family abuse, and other incidents of psychological or physical trauma- is a powerful predictor of dental anxiety. Dental setting (e.g., reclined chair, invasive procedures, the body close to each other) may cause flashbacks of trauma or may burnish the experience of being vulnerable (Hudson et al., 2016). There are also cultural aspects that are involved. In certain communities, oral health is less prioritized or even stigmatized and fear of being judged or being ashamed might not allow one to attend to anyone (Tiwari et al., 2022; Hassan et al., 2022).



Lastly, there are structural factors, including scarce areas of appointment, no culturally competent staff, and distrust of the institution, which adds to dental anxiety, historically marginalized populations (Saint Arnault & O'Halloran, 2016; Muneer et al., 2022).

3. Dental Anxiety and Healthcare Access

Dental anxiety greatly diminishes both the preventive service usage and compliance to health treatment. People experiencing high nerve levels will bestow flights or hold up appointments until things deteriorate, and in many cases, involve background and emergency or invasive medical attention (Taqi et al., 2023; Osuh et al., 2023). This helps create sequential trends of fear avoidance with unfavorable results only encouraging fear. According to Adeniyi and Oyapero (2020), underutilization of services was primarily due to predisposing determinants, such as emotional distress and prior painful experience, which did not depend on enabling determinants, such as income or insurance, between adult Nigerians. Equally, accusations insinuated by Doughty et al., (2023) indicated that among populations in the Sudan whose livelihoods were jeopardized by HIV epidemic, fear of stigma and judgments aggravated dental avoidance in populations where services were physically accessible.

This avoidance has an immense long-term effect. Osuh et al. (2023) reported the observation that Nigerian slum residents treated their oral health issues only when they became uncontrollable, which frequently leads to extracting their teeth instead of performing restorative operations. This strengthens standards of oral health inequality especially in those groups that are already experiencing economic or social inequalities.

Moreover, childhood or adolescent dental neglect, which is often accompanied by parental dental phobia, may have an impact on the long-term oral health behavior (Kvesić et al., 2023; Hagqvist et al., 2015). In that way, there is not only an individual barrier of anxiety, but a transgenerational one, which produces the oral healthcare patterns of lifespan and family.

4. Intersection with Other Barriers

General psychosocial impediments tend to overlap with dental anxiety, which can have a compounding impact to a serious reduction in accessing care.

A significant point point is with mental health stigma. Ignoring externalized stigmas, people with mental health issues such as depression or anxiety disorders may be unable to persuade themselves to approach a dentist due to fear of admitting an internalized stigma (Saint Arnault & O'Halloran, 2016; Lincoln et al., 2017). In healthcare systems, there might also be stigma where mentally ill people are seen as a problem difficult to handle, and not deserving as a person of thoughtful attention (Hudson et al., 2016). Dental anxiety also overlaps with the literacy barriers. People of low health literacy can be going through shame or embarrassment when they cannot comprehend the medical terms, treatment regimes, or the insurance documents. This will promote distrust and avoidance behavior (Shahid, 2021; Lincoln et al., 2017).

Another vulnerable population is people who survived domestic violence. Walker et al., (1996) document the fact that complex trauma is often experienced by women who have discontinued the abusive relationships, as demonstrated by elevated levels of dental fear, associated with the perceived bodily invasion, control, and inability. These women will have higher chances of not seeking care on time, economical differences and will exhibit distrust in the institutional authority. Drug abuse is even added to it. Addicts using drugs have a higher rate of oral decay, and their adverse state might deter them to use dental services on the pretext of shame (Saint Arnault & O'Halloran, 2016; Hanson et al., 2019). The

psychological barrier to help seeking is frequently heightened by a lack or limited social support (Hanson et al., 2019)

These crossroads show that dental phobia cannot be addressed separately. It should be managed using multidisciplinary models, which take into consideration the issues of mental health, literacy, trauma, and structural discrimination.

3. Methodology

The integrative conceptual framework describes the character of knowledge from a broader perspective.

1. Integrative Conceptual Framework

This review adopts an integrative conceptual approach, synthesizing findings from peer-reviewed articles, theses and population-based studies rather than collecting new data. By drawing on evidence from a variety of geographic and socioeconomic contexts, it frames dental anxiety simultaneously as an individual psychological reaction and a socially patterned determinant of care.

Three Nigerian investigations illuminate how poverty, limited insurance cover and fear converge to suppress routine attendance (Adeniyi & Oyapero, 2020; Osuh et al., 2023). Qualitative work on oral-health-related stigma shows that shame and anticipated judgement are universal drivers of avoidance, regardless of setting (Doughty et al., 2023). U.S. studies add depth: one documents the double stigma created by limited literacy and mental illness (Lincoln et al., 2017); another demonstrates how experiences of domestic violence heighten dental fear and avoidance (Walker et al., 1996); and a third details the role of masculine norms in men's reluctance to disclose anxiety (Hudson et al., 2016). Together these culturally diverse sources form the foundation for a cross-disciplinary explanation of dental anxiety—as a complex, context-dependent cause of oral-health disparities that is most visible among already vulnerable populations.

2. Application of Andersen's Behavioral Model of Health Services Use

To base this conceptual synthesis on a theoretical framework, the paper utilizes the Behavioral Model of Health Services Use as a theoretical framework explaining the chosen studies. It is a model that has been developed during the 1960s and increased over the decades, and its developers distinguish the drivers of healthcare utilization into three broad components:

a) Predisposing factors (e.g., demography, beliefs, psychological characteristics)
b) Facilitating conditions (e.g., financial and logistical resources)
c) Need (e.g., perceived and clinically assessed health needs) factors

Mainstream traditionally stays out of this scenario--dental anxiety inspected as a trivial psychological concern, as opposed to service determinant. This paper re-positioned dental anxiety as an innate characteristic within all three domains of the Andersen model hence enhancing its application and predictive powers in the study of oral health.

Table 2. Repositioning Dental Anxiety Within Andersen's Behavioral Model

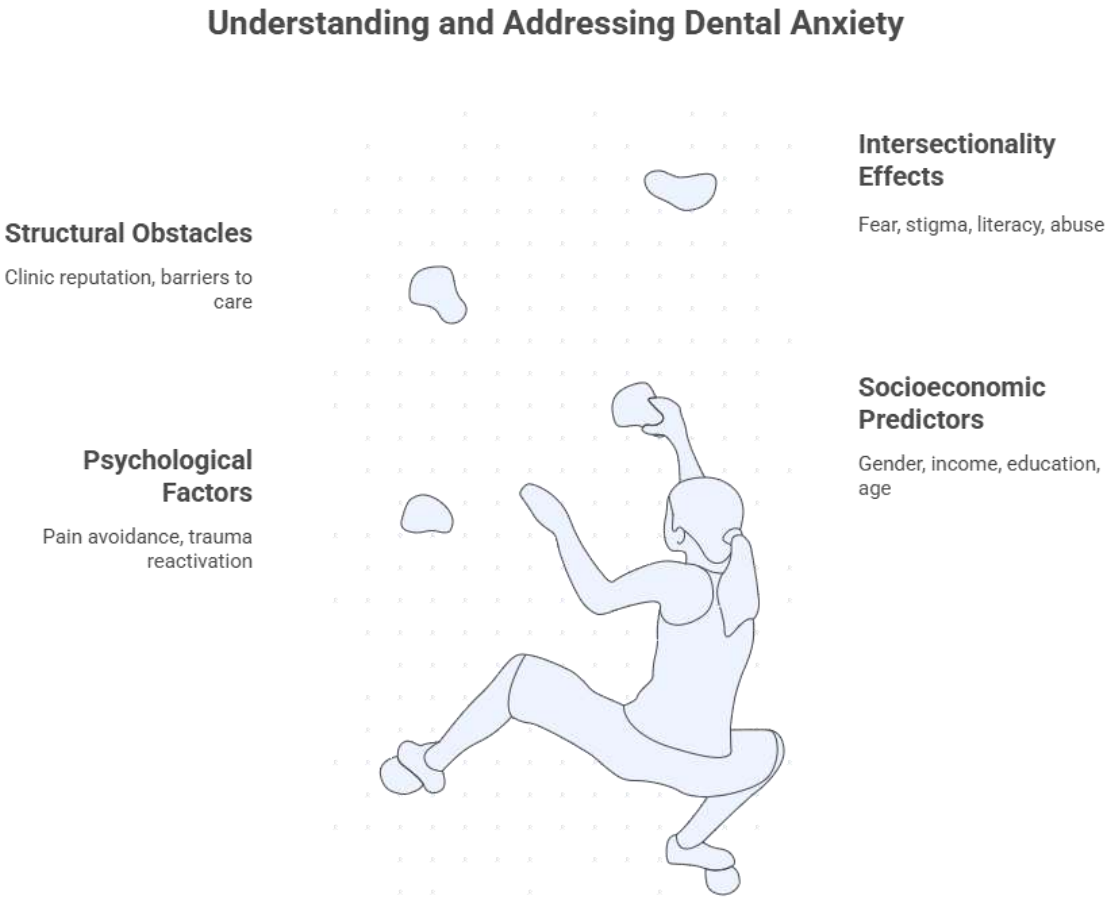
Andersen Component	Typical Variables	Dental Anxiety-Specific Manifestation	Example Sources
Predisposing	Age, gender, beliefs, education	Gendered fear response, early trauma, cultural norms about pain and health, oral health literacy	Kvesić et al. (2023); Shahid (2021); Hudson et al., (2016)
Enabling	Income, transportation, health insurance	Fear of public clinics, perceived rudeness, stigma in provider interactions, lack of trauma-informed care	Adeniyi & Oyapero (2020); Osuh et al. (2023)
Need	Symptoms, disease severity, perception of urgency	Avoidance despite pain, normalization of discomfort, internalized stigma, fear of judgment or poor outcomes	AHRQ, (2024); Walker et al., (1996); Doughty et al., (2023)

This conceptual frame indicates the manner of the interaction of dental anxiety as a mediating and increasing effect on the classic determinants of healthcare access. As an example, a woman, who has been victimized by domestic abuse might show considerable dental fear, which will influence her perception of her symptoms as emergency issues, even in situations, where a clinical need is evident.

3. Narrative Synthesis and Thematic Focus

The literature was organized using a narrative synthesis approach that has created inter-relating themes that mirror both systems and individual levels of dental phobia. Instead of summing the numerical data, this approach makes qualitative and conceptual analogies in a wide variety of populations and situations. Major themes include:

a) Psychological foundations of fear (e.g., pain avoidance, reactivation of traumas)
b) Socioeconomic predictors (e.g., gender, income, education, age)
c) Structural obstacles (e.g., the reputation of clinics, barriers to the general care)
d) Intersectionality (e.g. the effects of fear on stigma, literacy or history of abuse)



Research including Lincoln et al. (2017) and Saint Arnault & O'Halloran, 2016 demonstrates the multiplication of anxiety among populations with numerous examples of vulnerability and Osuh et al. (2023) emphasizes geographic and socioeconomic stratification of the fear in the context of the healthcare setting. This set of theme clusters can be used to make the cause-effect broader and show how individual fear issues can turn out to be health debts in society when not addressed.

4. Ethical Considerations and Research Implications

Being a conceptual study using published data, the article does not imply any direct contact with human subjects so there is no need of formal ethical clearance. The reference to vulnerable populations (survivors of domestic violence, mentally-ill people, children exposed to trauma, etc.) have been approached with great care, though. It is shown that all studies that were reviewed adhered to the ethical standards in their research procedures.

This research methodology also provides the basis of subsequent empirical studies. By accommodating dental anxiety into the framework of Anderson, scholars and policymakers are able to create quantitative models (either agent-based simulation or structural equation model) that are better explained as predicting oral health behavior in the presence of fear. Besides, this framework can be adopted in qualitative research

of lived experiences of dental avoidance, and can be applied to interviews and focus groups to articulate such experiences.

Overall, this research method is the combination of theory and narrative evidence of how dental anxiety which may be considered as an individual problem is, in reality, a behavioral determinant, a complicated concept within the wider health systems. In the manner in which the article has been revised and in its narrative synthesis, the article offers a practical but subtle roadmap towards identifying, quantifying, and ultimately addressing access gap due to dental fear.

4. Discussion

1. Implications for Service Delivery

Dental anxiety is a real issue affecting the provision and the use of oral services and generally conducts silently in clinical as well as in the community health setting. Those with a moderate to severe fear experience might postpone intervention until oral health issues turn into emergencies, making it a further contributor to poor clinical outcomes, an increase in the long-term cost, and patient dissatisfaction (Taqi et al., 2023; Osuh et al., 2023). People may see a lack of appointment attendance or non-compliance as lack of responsibility, instead of treating this as an effect of anxiety and distress (Schibbye et al., 2024). The result of such disconnection is the lack of opportunity to provide trauma-informed care. The intervention of introducing a behavioral conceptualization of dental fear in service provision has the potential of changing models of dental care. Dentists and hygienists, or front-line clinicians, must be taught to detect some of the non-verbal signs of anxiety, pre-appointment screening, and employ pre-operation communication, such as the use of non-threatening words, joint decision-making, and discussing the options to overcome the feeling of fear (Walker et al., 1996; Hudson et al., 2016).

Additionally, avoidance due to fear is overrepresented in the case of populations that have been marginalized, which is likely to be the case: they do not typically have access to culturally competent or empathetic care (Osuh et al., 2023; Doughty et al., 2023). This indicates a system-wide blind spot, as those who render the services are in many times oblivious as to the psychological barriers that take place prior to even the initial visit to the dentist. Subsequently, dental phobia has been contributing to the distance gap between clinical accessibility and practice.

2. Cultural and Demographic Sensitivity in Dental Care

The creation and experience of dental anxiety is influenced by cultural beliefs, gender norms and family structures. As an example, women have a higher likelihood to report fear because they have previously experienced traumatic events or more susceptible to bodily vulnerability when treatment is provided (Hudson et al., 2016). In the meantime, fear can be underreported among men because of the masculine status that frowns upon emotional susceptibility and results in clandestine avoidance and unaddressed oral issues (Sileo and Kershaw, 2020). Beliefs regarding dental pain and treatment may be different in the patients in multicultural settings than that of biomedical models. There are those who might view dental procedures as being harmful in itself, and others who will usually only turn to care when in crises (Tiwari et al., 2022; Hassan et al., 2022). Providers fail to recognize such beliefs, thus leading patients to feel judged, misunderstood, or unsafe, which contributes to avoiding it.

These barriers are enhanced by low health literacy. Not just in fear, patients are free to miss appointments because they are not able to comprehend treatment plans or to find their way through insurance processes (Lincoln et al., 2017; Shahid, 2021). This particularly applies in environments that have low formal education levels or in health care systems that are not comfortable in language sense (Tiwari et al., 2022; Hassan et al., 2022). In response to this, dental practices need to be culturally safe, linguistically and literacy-sensitive. Clinicians can be trained on cross-cultural communication, bringing family/community service providers in, and giving out translated materials to the hospital and patients, which can greatly decrease fear and enhance trust, particularly with vulnerable populations.

3. Policy and Public Health Perspectives

Dental anxiety is an invisible determinant of oral health inequalities in terms of the public health perspective. Affordability and availability are most frequently considered in the policies of national and regional policies of oral health, but the psychological and emotional aspects of care avoidance are rarely factored into the policies (Adeniyi & Oyapero, 2020; Osuh et al., 2023). It is such a limited frame that it does not recognize the fact of structural access without emotional access.

In epidemiological surveys, fear is not always recorded and reported and thus anxiety related avoidance is often missed in public health systems. As an example, when patients fail to attend appointments, they will typically be wiped off the radar, creating selection bias and underrepresenting7women who are most anxious (Lincoln et al., 2017).

Plans to reform policy ought to include:

1) Dental fear screening in the community clinics which is obligatory.
2) Dental Anxiety indicators should be included in national health surveys.
3) Stake in dental mental health partnerships, at least with high-risk groups.

Also, special community outreach will be able to change the ultimate opinion regarding dental treatment, lessen the stigma, and legitimize discussions concerned with anxiety. Similarly to the situation with models of behavioral health referrals in underserved populations (Muneer et al., 2022), community-based health workers must be crucial in bridging between committed people who are anxious and those receiving supportive services.

4. Strategies for Mitigating Anxiety Barriers

The minimization of dental anxiety should be achieved through a multi-level intervention, such as individual, provider, and community and systemic. Cognitive-behavioral therapy (CBT), guided relaxation, and sedation dentistry can also be achieved through evidence at the individual level to overcome moderately high and severe fear (Taqi et al., 2023; Schibbye et al., 2024). Access to such is however usually limited to private practices. On the provider level, one should establish trust by using loving speech. Practitioners should be educated to directly inquire about fear, not seize judgement, and provide more control to the patient during a procedure (e.g., agreed-upon hand signals, short pauses and certainty about what they should anticipate/not anticipate). From trauma-informed care already applied in domestic violence and childhood traumatic survivors, dentistry needs to be translated (Walker et al., 1996; Hudson et al., 2016).

At the community evidential, the disadvantages of fear can be de-stigmatized by kick-stating peer support models and patient education workshops, and prompting intervention earlier. They should include programs that aim at prevention and treatment of the disease and make people understand that being afraid to take care aggravates the condition with time.

Lastly, system level policy innovation plays a special role. It involves the integration of behavioural risk factors into the electronic dental records, the investments in mental health relationships in the dental clinic, and the building of anxiety-reducing schedules (e.g., longer schedules, low-stimulation waiting rooms), dental anxiety is not just a social construction inside the spaces of a behavior but a vital point of access that is part of the social and structural inequity. The practice of neglecting it will negatively affect the oral healthcare system and suggest inequality. To deal with it requires thoughtful service designs, culturally sensitive care, and courageous public health policies that put fear on an equivalent basis of consideration with cost, coverage or clinical necessity.

5. Conclusion

One of the most undervalued, but prevalent obstacles to balanced access to oral healthcare is the issue of dental anxiety. Although its existence has long been a recognized fact within clinical literature, its larger effect on health-seeking behavior, patterns of service use, and overall effects on public health are commonly lost beneath the systemic emphasis on structural and financial barriers per se. This article has redefined dental anxiety as no longer a personal emotional problem, but rather a socially patterned determinant of health, which is dependent on trauma, sex, socioeconomic status, literacy, and stigma. As a guiding framework, the present study has demonstrated that dental anxiety functions in all four domains of health service access, which are predisposing, enabling and need-associated, so that dental anxiety should be included in health systems research, health planning, reform. There is a large body of evidence of different cultural and clinical conditions indicating that the fear of avoidance is prevalent and problematic, especially among women, low-income earners, the mentally sick, and victims of domestic violence or childhood neglect. Having dental anxiety as invisible to policy and practice discredits enhancing the oral health equity. In the event of its non-recognition and treatment, patients disengage, postpone care, and turn up in later disease-related stages at an increased burden to healthcare systems, as well as increase the current disparities. Long-standing models of dental care that require emotional preparedness and trust have to be transformed into emotionally intelligent and trauma-informed models that consider fear as one of the main determinants of the decision.

A multi-level response is needed to make a progress. Clinicians need to be sensitised to learn to respond to anxiety with grace and dignity. Fear being an indicator of public health programs will need to be reported, and the settings of the services will need reorganizing to recreate the security of an occupationally tense patient. The combination of the screening of anxiety tools, community-centered schooling and culturally adjusted treatment plans should be required by the policies. More work is also required. Predictive accuracy using oral health outcomes can be enhanced by quantitative models utilizing fear as a mediator/moderator of healthcare utilization. Qualitative research may provide the voice to the silent victims of fear, and mixed methods may help see more subtle trends among groups of people. Simply put, addressing dental anxiety is not about assisting individuals to overcome their fears- but offering a more inclusive, responsive, more just oral health system. It is only through making the invisible visible that healthcare professionals, policymakers and researchers can start bridging the access divide so that oral health can be more than merely available but made to truly be without boundaries.

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