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Substance abuse: Social stigmas and patient management

Part 2

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Substance abuse: Social stigmas and patient management

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At the conclusion of this educational activity, participants will be able to:

1. Define the effects of addiction on the brain.
2. Identify stigmas associated with drug use and addiction.
3. Initiate difficult conversations with addicted patients through basic motivational interviewing skills and empathy.
4. Recognize the difference between sympathy and empathy.

Abstract

The stigmatization of addiction can easily lead to making assumptions about patients who are drug users. Dental professionals often associate addiction with a drug-seeking patient, which can lead to a loss of empathy and proper care of the individual. Awareness of the oral and systemic effects of a variety of drugs—including alcohol, marijuana, ecstasy, methamphetamine, and opioids—may assist dental professionals in effectively communicating and providing intervention for addicted patients.

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Introduction

As drug use in America climbs, so does the responsibility of dental professionals to identify addiction, advocate for patients, show appropriate empathy, and refer to addiction professionals when necessary. Substance abuse, whether illegal or legal, has significant impact on individuals, families, and communities.[1] Dental clinicians have the opportunity to be on the front lines of this epidemic and intervene in an appropriate manner.

From the legalization of marijuana in some states to overprescribing of drugs by physicians and dentists, individuals have easier access to addictive substances. Even though addiction is now more recognized as a chronic issue that requires professional treatment, strong social stigma remains. Dental professionals trained to recognize addiction through observing behaviors and/or oral health issues have an opportunity to care for patients beyond the dental chair.

Part one of this course introduced specific drugs' effects on the body and oral cavity. This course, part two, will continue that discussion and focus on the realities of addiction, social stigmas associated with drug use, and effective communication through motivational interviewing for addicted patients.

Addiction

Merriam-Webster dictionary defines addiction as the "compulsive need for and use of a habit-forming substance (such as heroin, nicotine, or alcohol) characterized by tolerance and by well-defined physiological symptoms upon withdrawal; broadly: persistent compulsive use of a substance known by the user to be harmful."[2]

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) recently changed the diagnosis of addiction, combining substance abuse and dependence. The DSM has been revised five times since 1952 and is the standard for classifying mental disorders in the United States. DSM criteria are used in diagnosing individuals, are useful for creating treatment plans, and in research settings. New criteria for substance abuse were rewritten in the 2013 version of the DSM, renaming substance abuse and dependence as substance use disorder. The decision to combine abuse and dependence criteria was determined after studying over 200,000 participants, which raised questions about the thoroughness of the diagnosis. The new criteria, though not perfect, is more encompassing of issues surrounding addiction. It defines the use of 10 specific addictive substances. This gives mental health practitioners more defined guidelines for making clinical decisions.[3]

The DSM-5 groups substance use disorder in four major categories: impaired control, social impairment, risky use, and pharmacological criteria such as tolerance and withdrawal issues.[3]

Impaired control—A person may continue to use even when there is a strong desire to quit. He/she uses the substance longer, more frequently, and in higher quantity than intended.

Social impairment—A person continues to use despite problems with work, family, neglect of children, neglect of self-care, and social interactions. Oftentimes, individuals will give up important social activities instead of reducing or eliminating drug use.

Risky use—A drug will continue to be used even when the person knows it is causing harm to self or others. For example, someone may repeatedly drive while intoxicated without considering or caring about severe consequences.

Tolerance and withdrawal—Pharmacological indicators when the body adapts to the quantity and frequency of substance use and a person eventually requires more of the drug to achieve a high or buzz. Once the body has developed a tolerance, unpleasant symptoms are experienced when the person stops the substance.

Table 1 shows specific criteria for diagnosing substance use disorder. Mental health clinicians determine the severity of use based on the number of criteria exhibited by a client. Two to three criteria are indicative of mild substance use disorder. If a person presents with four to five of the listed criteria, moderate use is diagnosed. Six or more raises the significance of the issue to "severe."[4]

TABLE 1: Criteria for substance use disorders[4]

Substance use disorders span a wide variety of problems arising from substance use, and cover [11] different criteria:
1. Taking the substance in larger amounts or for longer than one meant to.
2. Wanting to cut down or stop using the substance but not managing to.
3. Spending a lot of time getting, using, or recovering from use of the substance.
4. Cravings and urges to use the substance.
5. Not managing to do what one should at work, home, or school because of substance use.
6. Continuing to use, even when it causes problems in relationships.
7. Giving up important social, occupational, or recreational activities because of substance use.
8. Using substances again and again, even when it puts one in danger.
9. Continuing to use, even when one knows one has a physical or psychological problem that could have been caused or made worse by the substance.
10. Needing more of the substance to get the effect wanted (tolerance).
11. Development of withdrawal symptoms, which can be relieved by taking more of the substance.

Abuse and addiction to alcohol, nicotine, and illicit and prescription drugs cost Americans more than $700 billion a year in health costs, crime, and loss of productivity. Drugs and alcohol contribute to the death of more than 90,000 Americans per year. In addition, tobacco is linked to an estimated 480,000 deaths per year.[5] With these staggering statistics, it is imperative that dental professionals are not only educated on the oral implications of drug use, but also have an understanding of addiction, the brain's response, and associated stigmatization.

Social stigmas

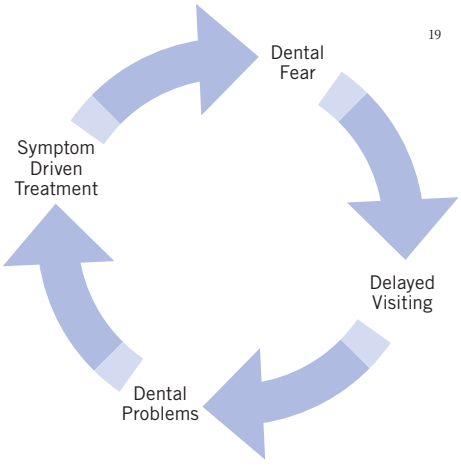
A stigma is a "mark of disgrace associated with a particular circumstance, quality, or

person."[6] Many times stigmas about addiction deflect the reality of the brain's function and reaction to drugs. Some addicted people may be viewed as lazy, social deviants, having a lack of morals, or simply just hanging out with the wrong crowd. Once individuals experience the euphoria associated with substances, the addiction becomes a matter of brain science rather than a person's will, choice of friends, or self-control.[7] Other social beliefs about addicted individuals may presumptuously label the person as poor or uneducated. Common sense leads one to believe that most people do not aspire to abandon their responsibilities or opportunities to the loyalty of a drug.

Addiction has no boundaries and makes any brain that does not have damaged pleasure centers susceptible to dependence on a substance.[8] When a mood-altering substance is consumed, the neurotransmitter dopamine floods the central nervous system (CNS), activating the pleasure centers. The pleasure experienced triggers repeated-use behavior in an effort to replicate the euphoria. Increased amounts must be used over time to achieve the same high. Experimentation or casual use becomes addiction when the person uses even when he/she does not want to, experiences impaired control, social impairment, risky use, and tolerance and withdrawal issues as stated previously.[1] The power of the substance on the pleasure circuit of the brain makes it conceivable how any person without defective pleasure centers is not immune to addiction.[7] Despite these known physiological problems, substance use disorder is still one of the most stigmatized conditions in the world, leaving its victims to experience social segregation and discrimination.[9]

Dental professionals may not be aware of the extreme dental anxiety one may experience when in need of dental treatment. Addicted persons deal with many psychological, social, and medical problems that overshadow dental health needs. Individuals are often unaware of the systemic/oral relationship and may not realize that improved oral health can lead to decreased medical problems.[10] One study revealed that increasing access to dental care and education for a homeless population with alcohol and drug addiction was helpful in reducing disease.[10]

There is a high incidence of periodontal disease, missing teeth, and caries among persons addicted to one or more substances. Many patients will go to the dentist only when severe pain has manifested.[10] It is common for patients to put off treatment as long as possible in order to avoid embarrassment or confrontation. Many addicted



[19]

persons get caught in the vicious cycle of dental anxiety, which is the avoidance of preventive dental appointments until pain is intolerable and an appointment becomes necessary. This ongoing avoidance leads to embarrassment about the condition of their teeth and may manifest as aggressive or exaggerated behavior in the dental chair. Dental professionals have been trained to identify drug-seeking patients and may not be empathetic toward a patient who is suffering due to long-time drug use. The stigmas and perceptions of the addict may cloud the patient/clinician relationship and lead to further vicious cycle behavior.

The vicious cycle positively correlates with negative stigmas of substance use disorder. Internal or external characteristics such as illness, ethnicity, religion, intelligence, and behaviors can categorize someone in a stigmatized population. Many times, people in certain groups will begin to take on negative characteristics of that population after learning of societal views. This is called internalized stigma or self-stigma. Self-stigma contributes to low self-esteem, depression, hopelessness, guilt, anxiety, and self-devaluation. Research shows that health-care professionals have a general dissatisfaction and low regard for working with patients who struggle with substance abuse, making it more difficult to seek treatment. da Silveira et al. state, "Stigmatizing attitudes of health professionals toward people with substance use problems may negatively affect health care delivery and could result in treatment avoidance or interruption during relapse."[9] A patient who is socially and internally stigmatized, in combination with an apathetic health-care worker, is a recipe for further decline in health, self-worth, and continued drug use.

Dental clinicians have a unique opportunity to intervene in a nonjudgmental and positive way, whether with a one-time patient caught in the vicious cycle or a long-standing patient who displays signs and symptoms of use. Clinicians build trusting relationships and friendships with patients over time. Often, patients spend more time with dental personnel than any other medical professional. Dental professionals who are well versed in addiction and how to communicate with the patient are more likely to build trust that will encourage the patient to return for preventive measures and refer for the proper mental health professional for intervention.[11]

Managing the addicted patient

Even hygienists and dentists with the best patient communication may find it challenging or uncomfortable to have difficult conversations when addiction is admitted or suspected. Generally, hygienists spend more time with patients than any other team member and can build trusting relationships over time, which may open the door to candid conversations about addiction.[12]

Adult patients have varying reasons as to why drug use or addiction has become a problem. The Harm Reduction Coalition, an advocacy group that works to promote health and dignity for individuals affected by drug use, emphasizes that destigmatizing addiction is the first step in providing help.[13] The World Health Organization states, "Stigma is a major cause of discrimination and exclusion: it affects people's self-esteem, helps disrupt their family relationships, and limits their ability to socialize and obtain housing and jobs. It hampers the prevention of mental health disorders,

the promotion of mental well-being, and the provision of effective treatment and care. It also contributes to the abuse of human rights."[14]

Among surveyed dentists, one-third do not question patients about drug use during health history assessment. Even if asked, patients may be hesitant to admit drug use due to attached stigmas, judgment, shame, and fear of confrontation. Hygienists and dentists have an ethical duty to screen patients for substance abuse and offer referrals to mental health professionals for proper intervention.[12] A sound practice for dental offices is to build relationships with two or three local substance abuse counselors and offer literature and contact information to patients in need. This process can happen with minimal resistance when clinicians remove stigmas, communicate without judgment, and help the patient feel understood.

Patient communication

Many dental clinicians have shifted patient communication to the motivational interviewing (MI) model, developed by psychologists and counselors, in order to remove stigmas and begin collaborative relationships with patients around behavior change issues and treatment planning. Motivational interviewing is a "collaborative conversation style for strengthening a person's own motivation and commitment to change." It allows patients to join with the hygienist in decision-making by allowing the patient to trust his/her own wisdom.[15] MI removes the element of lecturing and/or broaching subjects the patient is uncomfortable discussing and promotes "change talk" by implementing four core skills called OARS:[16]

Four Basic Skills in Motivational Interviewing[20]

- **O**pen-ended questions
- **A**ffirmations
- **R**eflective Listening
- **S**ummary Statements

Open-ended questions—Beginning conversations with open-ended questions makes space for the patient to divulge as much or as little information as he/she wishes. It also allows for more information to be gathered. For example, "What are some things you can think of that could be causing the issues I am seeing in your mouth today?" This opens a path of communication. It is a remarkable contrast to questions that elicit a "yes" or "no" answer, such as "Do you use marijuana, methamphetamine, etc?" This could result in resistance from the patient.

Affirming—Affirming highlights patients' positive statements with encouragement and support. An example of affirming is: "You say you haven't been to the dentist in a long time because you were embarrassed. Well, you are here today, and that is a brave step." A positive affirmation leaves the patient feeling encouraged about making a healthy decision.

Reflective listening—Reflective statements may be the most important skill because they validate responses by mirroring patients' emotions. Reflective listening can be used to help patients feel understood and seen. If a patient appears anxious during assessment or treatment, but does not vocalize it, an example of a reflective listening statement is, "It seems like you are anxious to be here today." This could lead to another open-ended question: "What can I do to make this easier?" This puts the proverbial ball in the patient's court. At this point, the patient has the opportunity to agree that he/she is anxious or correct the reflection with the proper emotion. Reflection helps the patient feel understood and not judged, which is a crucial step in destigmatization.

Summarizing—Summarizing links the conversation together and offers opportunities for patients to correct or add any pertinent information. The hygienist could summarize the conversation and ask the patient if anything was missed or misunderstood. This allows for further discussion, clarification, and validation.[16]

When used effectively, OARS skills guide the patient to be open to receiving education or recommendations from the clinician without feeling lectured. Nonjudgmental communication also builds trust for future possibilities of difficult conversations if the patient is not ready to disclose substance abuse.

Motivational interviewing is vaster than the above four skills. It involves a number of proficiencies that require practice over time. For more information on honing MI skills, a wealth of information exists through an organization called MINT at https://motivationalinterviewing.org.[17]

Empathy

Empathy is the ability to place oneself in the situation of another in an attempt to truly understand the other's feelings and experience. Approaching patients with a sense of curiosity instead of judgment evokes empathy. For example, a hygienist may shift his/her thinking from "this person is messed up, bad, etc." to "I wonder how this person ended up in this situation." This softens feelings of judgment and brings forth empathy, which is likely to result in a more positive appointment for both clinician and patient. Tapping into empathy creates long-lasting and trusting relationships with patients.[18]

Empathy is not to be confused with sympathy. Even the most educated professionals confuse these two skills at times, leaving patients feeling misunderstood. Sympathy is defined as "feelings of pity or sorrow for someone's misfortune."[6] Though this may seem compassionate, sympathy does not allow the clinician to "join the patient" in an understanding way. Sympathy keeps the practitioner and patient on separate emotional levels as the practitioner looks at the patient with pity rather than true understanding. This may leave patients feeling alone or even guilty.

An example of sympathy versus empathy may occur when a patient displays or verbalizes anxiety about the appointment. Sympathy is expressed, as "Oh! It's okay, you poor thing. This won't take long." In contrast, empathy is related to reflective listening. For example, "Yes, I can tell that you feel anxious. Can you help me understand the reasons for your anxiety? Maybe I can help reduce it." The latter response is more likely to evoke feelings of comfort and nonjudgment for the patient. These steps in building trust can lead to patient disclosure about substance abuse and the need for intervention, giving the hygienist or dentist the opportunity to refer to the proper professional.[18]

Conclusion

It is important for dental clinicians to be well versed in issues related to substance abuse. If a clinician not only detects oral complications of drug use, but also the mental, emotional, and social issues, he/she can play an important role in patients' lives. Knowing when and in what manner to approach a patient about drug use or any risky behavior is a skill that can be developed with awareness and practice. Using empathy and OARS skills builds long-lasting trust and relieves patients' internal stigmas. A clinician who can identify his/her own prejudices of an addicted person can not only provide the patient with a high standard of care, but also have better self-understanding of feelings and beliefs. Dental professionals have a unique opportunity to serve as more than oral health providers. When aware of patients' clinical and emotional needs, dental practitioners can also offer optimum overall health care.

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Notes

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QUESTIONS

1. According to Merriam-Webster dictionary, what is defined as the "compulsive need for and use of a habit-forming substance (such as heroin, nicotine, or alcohol) characterized by tolerance and by well-defined physiological symptoms upon withdrawal"?
   A. Addiction
   B. Abuse
   C. Withdrawal
   D. Dependence

2. What is the standard for classifying mental disorders in the United States?
   A. CAGE-AID questionnaire
   B. Rorschach test
   C. Diagnostic Statistical Manual of Mental Disorders
   D. Ink blot test

3. What are the DSM criteria used for?
   A. Diagnosing individuals
   B. Creating treatment plans
   C. Research settings
   D. All of the above

4. Which of the following are major categories of substance use disorder?
   A. Impaired control
   B. Social impairment
   C. Risky use
   D. All of the above

5. Which term is associated with a person who continues to use despite problems with work, family, neglect of children, neglect of self-care, and social interactions?
   A. Impaired control
   B. Social impairment
   C. Risky use
   D. None of the above

6. Someone who repeatedly drives while intoxicated without considering or caring about severe consequences would fall under which category of substance use disorder?
   A. Risky use
   B. Tolerance and withdrawal
   C. Social impairment
   D. Impaired control

7. Which of the following is NOT a criterion for substance use disorder?
   A. Giving up important social, occupational, or recreational activities because of substance abuse
   B. Having cravings and urges to use that substance
   C. Using only when with friends or attending parties
   D. Spending a lot of time getting, using, or recovering from use of the substance

8. If a person presents with four or five of the listed criteria for substance use disorder, what severity is diagnosed?
   A. Recreational
   B. Mild
   C. Moderate
   D. Severe

9. How much does abuse and addiction to alcohol, nicotine, and illicit and prescription drugs cost Americans a year in health costs, crime, and loss of productivity?
   A. More than $500 million
   B. More than $4 billion
   C. More than $700 billion
   D. More than $8.3 million

10. Drugs and alcohol contribute to the death of how many Americans annually?
    A. 50,000
    B. 160,000
    C. 90,000
    D. 23,000

11. When a mood-altering substance is consumed, what neurotransmitter floods the CNS activating the pleasure centers of the brain?
    A. Dopamine
    B. Serotonin
    C. Acetylcholine
    D. Oxytocin

12. Experimentation or casual use becomes addiction when:
    A. The person uses even when he/she does not want to
    B. The person experiences impaired control
    C. Social impairment occurs
    D. All of the above

13. When the patient experiences unpleasant symptoms upon stopping the substance, which DSM-5 category of substance use disorder are they experiencing?
    A. Impaired control
    B. Social impairment
    C. Tolerance and withdrawal
    D. Risky use

14. The avoidance of preventive dental appointments until pain is not tolerable is termed:
    A. Dental paranoia
    B. Dental fear
    C. Vicious cycle of dental anxiety
    D. Nervousness

15. What term is associated with a "mark of disgrace associated with a particular circumstance, quality, or person"?
    A. Stigma
    B. Stereotype
    C. Criticism
    D. Prejudice

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QUESTIONS

16. There is a high incidence of which of the following among persons addicted to one or more substances?
    A. Gingival inflammation, bleeding on probing
    B. Missing teeth, periodontal disease
    C. Caries, halitosis
    D. Halitosis, periodontal disease

17. What is self-stigma?
    A. Hating oneself due to certain characteristics of one's personality
    B. Taking on negative characteristics of a particular population after learning of societal views
    C. Causing oneself emotional pain due to ideas of what one should be
    D. Pretending to be something one is not

18. What does self-stigma contribute to?
    A. Low-self esteem
    B. Depression
    C. Guilt
    D. All of the above

19. Among surveyed dentists, how many do not question patients about drug use during the health history assessment?
    A. 1/4
    B. 1/3
    C. 1/2
    D. 3/4

20. What is a group mentioned in the article that works to promote health and dignity for individuals affected by drug use?
    A. Alcoholics Anonymous
    B. Dual Recovery Anonymous
    C. Suicide Prevention Lifeline
    D. Harm Reduction Coalition

21. What is a sound practice for dental offices to adopt?
    A. Building relationships with two or three local substance abuse counselors
    B. Lecturing all patients on negative effects of substance use
    C. Offering candy as the patient leaves the appointment
    D. Staying quiet in order to avoid an embarrassing situation for the patient

22. What is motivational interviewing?
    A. Asking patients how they are doing in their home care
    B. Collaborative conversation style for strengthening a person's own motivation and commitment to change
    C. Offering encouraging advice to patients in regard to their chief complaint and acting as their cheerleader
    D. Praising patients for good home care so they will keep doing it

23. What is the first step in the four main motivational interviewing model skills?
    A. Open-ended questions
    B. Reflective listening
    C. Affirming
    D. Summarizing

24. What type of communication builds trust for future possibilities of difficult conversations?
    A. Open-ended
    B. Nonjudgmental
    C. Sympathetic
    D. Judgmental

25. What is an example of an open-ended question?
    A. "Did you check in with the front desk?"
    B. "Do you know that you have a cavity?"
    C. "What are some things you can think of that could be causing the issues I am seeing in your mouth today?"
    D. "Do you use illicit drugs or abuse alcohol?"

26. Which of the OARS skills highlights patients' positive statements with encouragement and support?
    A. Open-ended questions
    B. Affirming
    C. Reflective listening
    D. Summarizing

27. To evoke empathy rather than judgment, we should approach patients with which of the following?
    A. Curiosity
    B. Eagerness
    C. Compassion
    D. Disgust

28. Empathy on the part of the health-care professional is not to be confused with:
    A. Compassion
    B. Curiosity
    C. Sympathy
    D. Apathy

29. Responding to an anxious patient with "Oh, I'm sorry you feel that way. This will be over soon" is an example of:
    A. Empathy
    B. Understanding
    C. Sympathy
    D. Compassion

30. Using what two skills will allow the health-care professional to build long-lasting trust and relieve patients' internal stigmas?
    A. Compassion and empathy
    B. Curiosity and motivational interviewing
    C. Empathy and OARS skills
    D. Honesty and intellect

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CITY: STATE: ZIP: COUNTRY:

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REQUIREMENTS FOR OBTAINING CE CREDITS BY MAIL/FAX: 1) Read entire course. 2) Complete info above. 3) Complete test by marking one answer per question. 4) Complete course evaluation. 5) Complete credit card info or write check payable to Endeavor Business Media. 6) Mail/fax this page to DACE. A score of 70% is required for CE credit. **FOR QUESTIONS, CALL (800) 633-1681. COURSE MAY ALSO BE COMPLETED AT DENTALACADEMYOFCE.COM.**

Educational Objectives

1. Define the effects of addiction on the brain.
2. Identify stigmas associated with drug use and addiction.
3. Initiate difficult conversations with addicted patients through basic motivational interviewing skills and empathy.
4. Recognize the difference between sympathy and empathy.

Course Evaluation

1. Were the individual course objectives met?

   Objective #1: Yes No Objective #3: Yes No

   Objective #2: Yes No Objective #4: Yes No

Please evaluate this course by responding to the following statements, using a scale of Excellent = 5 to Poor = 0.

2. To what extent were the course objectives accomplished overall? 5 4 3 2 1 0
3. Please rate your personal mastery of the course objectives. 5 4 3 2 1 0
4. How would you rate the objectives and educational methods? 5 4 3 2 1 0
5. How do you rate the author's grasp of the topic? 5 4 3 2 1 0
6. Please rate the instructor's effectiveness. 5 4 3 2 1 0
7. Was the overall administration of the course effective? 5 4 3 2 1 0
8. Please rate the usefulness and clinical applicability of this course. 5 4 3 2 1 0
9. Please rate the usefulness of the supplemental webliography. 5 4 3 2 1 0
10. Do you feel that the references were adequate? Yes No
11. Would you participate in a similar program on a different topic? Yes No
12. If any of the continuing education questions were unclear or ambiguous, please list them.

    _____

13. Was there any subject matter you found confusing? Please describe.

    _____

14. How long did it take you to complete this course?

    _____

15. What additional continuing dental education topics would you like to see?

    _____

    _____

    _____

Mail/fax completed answer sheet to:

Endeavor Business Media
Attn: Dental Division
7666 E. 61st St. Suite 230, Tulsa, OK 74133
Fax: (918) 831-9804

☐ Payment of $59 is enclosed.
Make check payable to Endeavor Business Media

If paying by credit card, please complete the following:

☐ MC ☐ Visa ☐ AmEx ☐ Discover

Acct. number: _____

Exp. date: _____ CVC #: _____

Billing address: _____

_____

Charges on your statement will show up as Endeavor.

1.	Ⓐ	Ⓑ	Ⓒ	Ⓓ		16.	Ⓐ	Ⓑ	Ⓒ	Ⓓ
2.	Ⓐ	Ⓑ	Ⓒ	Ⓓ		17.	Ⓐ	Ⓑ	Ⓒ	Ⓓ
3.	Ⓐ	Ⓑ	Ⓒ	Ⓓ		18.	Ⓐ	Ⓑ	Ⓒ	Ⓓ
4.	Ⓐ	Ⓑ	Ⓒ	Ⓓ		19.	Ⓐ	Ⓑ	Ⓒ	Ⓓ
5.	Ⓐ	Ⓑ	Ⓒ	Ⓓ		20.	Ⓐ	Ⓑ	Ⓒ	Ⓓ
6.	Ⓐ	Ⓑ	Ⓒ	Ⓓ		21.	Ⓐ	Ⓑ	Ⓒ	Ⓓ
7.	Ⓐ	Ⓑ	Ⓒ	Ⓓ		22.	Ⓐ	Ⓑ	Ⓒ	Ⓓ
8.	Ⓐ	Ⓑ	Ⓒ	Ⓓ		23.	Ⓐ	Ⓑ	Ⓒ	Ⓓ
9.	Ⓐ	Ⓑ	Ⓒ	Ⓓ		24.	Ⓐ	Ⓑ	Ⓒ	Ⓓ
10.	Ⓐ	Ⓑ	Ⓒ	Ⓓ		25.	Ⓐ	Ⓑ	Ⓒ	Ⓓ
11.	Ⓐ	Ⓑ	Ⓒ	Ⓓ		26.	Ⓐ	Ⓑ	Ⓒ	Ⓓ
12.	Ⓐ	Ⓑ	Ⓒ	Ⓓ		27.	Ⓐ	Ⓑ	Ⓒ	Ⓓ
13.	Ⓐ	Ⓑ	Ⓒ	Ⓓ		28.	Ⓐ	Ⓑ	Ⓒ	Ⓓ
14.	Ⓐ	Ⓑ	Ⓒ	Ⓓ		29.	Ⓐ	Ⓑ	Ⓒ	Ⓓ
15.	Ⓐ	Ⓑ	Ⓒ	Ⓓ		30.	Ⓐ	Ⓑ	Ⓒ	Ⓓ

AGD Code 344

INSTRUCTIONS
All questions have only one answer. Grading of this examination is done manually. Participants will receive confirmation of passing by receipt of a verification form. Verification of Participation forms will be mailed within two weeks after taking an examination.

COURSE EVALUATION AND FEEDBACK
We encourage participant feedback. Complete the survey above and e-mail feedback to Aileen Gunter (agunter@endeavorb2b.com) and Laura Winfield (lwinfield@endeavorb2b.com).

COURSE CREDITS AND COST
All participants scoring at least 70% on the examination will receive a verification form for three CE credits. The formal CE program of this sponsor is accepted by the AGD for fellowship and mastership credit. Please contact Endeavor for current term of acceptance. Participants are urged to contact their state dental boards for continuing education requirements. Endeavor is a California CE provider. The California provider number is 4527. The cost for courses ranges from $20 to $110.

PROVIDER INFORMATION
Endeavor Business Media is an ADA CERP–recognized Provider. ADA CERP is a service of the American Dental Association to assist dental professionals in identifying quality providers of continuing dental education. ADA CERP neither approves nor endorses individual courses or instructors, nor does it imply acceptance of credit hours by boards of dentistry. Concerns about a CE provider may be directed to the provider or to ADA CERP at ada.org/gotocerp/.

Endeavor Business Media, Nationally Approved PACE Program. Provider for FAGD/MAGD credit. Approval does not imply acceptance by any regulatory authority or AGD endorsement. 11/1/2019 to 10/31/2022. Provider ID# 320452

RECORD KEEPING
Endeavor maintains records of your successful completion of any exam for a minimum of six years. Please contact our offices for a copy of your CE credits report. This report, which will list all credits earned to date, will be generated and mailed to you within five business days of receipt.

EDUCATIONAL DISCLAIMER
Completing a single CE course should not provide enough information to give participants the feeling that they are experts in the field related to the course topic. It is a combination of many educational courses and clinical experience that allows the participant to develop skills and expertise.

CANCELLATION AND REFUND POLICY
Any participant who is not 100% satisfied with this course can request a full refund by contacting Endeavor in writing.

IMAGE AUTHENTICITY
The images provided and included in this course have not been altered.

CUSTOMER SERVICE | CALL (800) 633-1681