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Abstract: The incidence of eating disorders has increased substantially over the last forty years. Primary care physicians and dentists share a parallel challenge for secondary prevention of anorexia nervosa and bulimia nervosa. The dentist, in particular, has a uniquely important and valuable role with respect to assessment of oral and physical manifestations, patient communication, referral, case management, and restorative care. Despite this crucial role, few dentists are engaged in eating disorder-specific secondary prevention. The purpose of this study was to explore beliefs, attitudes, and experiences of general dentists regarding eating disorder-specific secondary prevention behaviors using focus group methodology. Three ninety-minute focus groups were conducted with twenty-one general dentists (seventeen male, four female) recruited from the 2004 Academy of General Dentistry Leadership Conference. Data from the focus groups were analyzed to identify two overarching themes and associated subthemes with regard to supports and barriers to eating disorder-specific secondary prevention practices. Analysis of data revealed that training, network, and dental professional contingencies emerged as places of influence for increasing capacity among dentists with regard to secondary prevention of eating disorders. This exploratory assessment identifies leverage points where strategic interventions including curriculum development, policies, and practices can be developed to support and sustain secondary preventive clinical behaviors among dentists.

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On the whole, incidence rates of eating disorders in the United States have increased over the last four decades. Among adolescents and adult women, it is estimated that 0.5 to 1 percent meet diagnostic criteria for anorexia nervosa and 1 to 2 percent meet diagnostic criteria for bulimia nervosa. Occurring at higher rates, disordered eating behaviors such as excessive dieting or the presence of bulimic behaviors (vomiting, use of diuretics and/or laxatives, excessive exercise, etc.) are prevalent in approximately 10 percent of late adolescent and adult women. The Diagnostic and Statistical Manual, 4th edition (DSM-IV) has described this form of eating disorder (the presence of disordered eating behaviors) as partial syndrome or eating disorders not otherwise specified (EDNOS). Evidence indicating progression from engaging in disordered eating behaviors to full-syndrome bulimia nervosa suggests the importance of early detection and referral to treatment.

Eating disorder prevention can be depicted as encompassing primary, secondary, and tertiary prevention activities. Primary prevention includes all activities that prevent this health issue from occurring. Secondary prevention is comprised of activities that enable early detection of eating disorders (i.e., the detection of disordered eating behaviors, with physical and oral manifestations) and includes all actions that can modify the severity or extent of the problem (referral for care, patient-specific oral treatment, etc.). Tertiary prevention includes activities taken to
minimize disability and enable rehabilitation once the health problem has progressed (e.g., case management).⁶ Due to the oral manifestations resulting from disordered eating behaviors, the dentist and the dental hygienist have central roles in secondary prevention of eating disorders, which includes early detection, patient-specific oral treatment, and referral for care. However, recent research indicates that many dentists and dental hygienists are not engaging in eating disorder-specific secondary prevention behaviors.⁷⁻⁹

Employing a randomized cross-sectional study, DeBate et al. collected data from 350 practicing male and female dentists regarding current behaviors and behavioral beliefs with regard to secondary prevention of eating disorders.⁷ Results of this study revealed that only 42.3 percent of dentists participating in the investigation reported currently assessing patients for oral cues of eating disorders. Similarly, only 46.3 percent of dentists reported providing specific home dental care instructions for patients suspected of eating disorders. Results from this study also indicate few dentists employed secondary prevention measures. Only 26 percent of dentists reported arranging a more frequent recall program for patients with orodental manifestations of eating disorders, 25 percent reported referring patients with oral signs of eating disorders, and 19 percent reported that they communicated with the patient’s primary care physician about suspected eating disorders. The results of this current study support the previous work of others⁶⁻⁹ that describes a low level of assessment, approach, and referral of patients exhibiting oral manifestations of disordered eating behaviors.

Parallel to understanding clinical practice is knowledge of educational underpinnings that could address change in practice behavior. A long-standing problem in oral health education is preparing clinicians, clinician educators, and students to address problems and threats to oral health that are well represented in the population but only marginally addressed in the curriculum.¹⁰⁻¹² Many dental educators contend that important public health problems that lead to significant morbidity and mortality such as smoking, domestic violence, physical abuse/neglect, substance abuse, and eating disorders are not typically covered in the curriculum or in clinical education in appropriate depth.¹³⁻¹⁸ At a minimum, the communication skills that provide the building blocks for training clinicians in these difficult and complex areas are not adequately or uniformly integrated through the behavioral sciences curriculum in dental schools.¹⁹

The purpose of this study was to expand the quantitative findings concerning eating disorder-specific secondary prevention behaviors by exploring the opinions, beliefs, attitudes, and experiences of dentists related to this area of professional practice. Knowledge gained from this qualitative study provides additional information that can help to further explain results from the previous quantitative inquiry. Triangulation of these data can provide a better understanding of this important health issue and can facilitate the identification of leverage points (i.e., places of influence where strategic interventions can be planned and implemented to affect systems of care) for increasing secondary prevention for eating disorders in clinical practice, which will ultimately decrease the progression from partial-syndrome to full-syndrome eating disorders in a growing number of patients. Data from this study will also add to our understanding of how to better define curriculum and clinical experiences to address this underdeveloped area and potentially other underdeveloped topics in dental education.

**Methods**

An exploratory assessment of eating disorder-specific secondary prevention among dental care professionals was conducted using focus group methodology. A qualitative approach was chosen for this assessment because it enabled the researchers to supplement previous quantitative research findings through in-depth exploration of opinions, beliefs, attitudes, and experiences regarding eating disorder-specific secondary prevention behaviors. Focus groups have been found to be a valuable tool in further exploration of findings from survey research.²⁰

This study is part of a larger qualitative inquiry of dental care professionals consisting of nine focus groups: three conducted with general dentists, and six conducted with dental hygienists. The results presented here describe findings with regard to the three focus groups conducted with the general dentists attending the 2004 Academy of General Dentistry’s Leadership Conference.

A structured moderator’s guide was developed for the dental care provider focus groups. The principal investigator developed the guide with input and feedback from the research team, which consisted of a behavioral scientist, dentist, and dental hygienist. Questions were developed following guidelines described by Hawe et al.,²¹ which involve the orga-
organization of questions to allow for a funneling effect. In a funneling-based focus group, the group begins with a less structured approach resulting in free discussion, moving toward a structured discussion of specific questions posed by the moderator. Table 1 depicts a sample of exploratory questions from the moderator’s guide utilized in this study.

The principal investigator, who is experienced with focus group and interview procedures, moderated all focus groups. The university’s Institutional Review Board granted approval for the study. To collect the data reported here, three 1.5-hour focus groups were conducted at the 2004 Academy of General Dentistry’s Leadership Conference (Chicago, IL). Each focus group consisted of five to twelve participants who were provided with refreshments and snacks for participation. The “rule of thumb” for focus group participants includes the use of homogeneous strangers, six to ten participants per group, and the implementation of three to five groups per project. Inclusion criteria for the focus groups included the following: a) over the age of eighteen; and b) currently practicing as a general dentist.

Prior to the focus groups, each participant was asked to read and sign a consent form; the procedures and purpose of the group were explained by the moderator; and participants were given an opportunity to ask any questions. All focus groups were audiotaped and later transcribed verbatim (with the exception of identifying information) by an experienced transcriptionist. All focus group transcriptions were reviewed to verify that the transcripts were as accurate and reflective of the interview as possible.

Two independent coders initially hand-coded all focus groups utilizing modified coding methods developed by Spradley. This initial coding explored patterns for words, perceptions, and ideas that were classified into categories. Coding was then compared, and an agreement of initial codes was reached. Focus group transcripts were then imported into NVivo where further exploration of data and detail coding was conducted and, as a result, overarching themes and subthemes emerged. Lastly, a working conceptual framework built from emerged codes was developed to assess the relationship of various factors to secondary prevention of eating disorders among dentists.

### Results

Twenty-one participants were involved in the general dentist focus groups. Participants were seventeen males and four females, and years in practice ranged from four to thirty-four years. Analysis of focus group data revealed two general themes consisting of supports and barriers to engaging in eating disorders.

<table>
<thead>
<tr>
<th>Table 1. Sample focus group questions</th>
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<tr>
<td>• Let’s start off by giving me an idea of how long you have been practicing as a dentist.</td>
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<tr>
<td>• Now I would like to get your perceptions about your role in the diagnosis of systemic health problems.</td>
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<tr>
<td>o Discuss your perception of your role as a dental professional in the screening of patients for significant medical and behavioral disorders.</td>
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<td>o Describe the types of screening procedures (comprehensive medical history, vital signs, complete head and neck check, intra-oral exam) you implement with regard to secondary prevention.</td>
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<tr>
<td>• I want to focus now on secondary prevention of eating disorders.</td>
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<td>o Describe your perception of your role with regard to secondary prevention of eating disorders.</td>
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<td>o Describe what you perceive to be the oro-dental and physical manifestations of disordered eating. In other words, what would you assess on a patient that would make you suspicious of his or her eating behaviors?</td>
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<td>o Describe your experiences with assessing oro-dental manifestations that reflected signs and symptoms of health and disease.</td>
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<td>o Describe your experiences with approaching patients regarding oral manifestations perceived to be due to disordered eating behaviors.</td>
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<td>o Say you had a patient whom you suspected of disordered eating behaviors; what would you do (processes and procedures)?</td>
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<tr>
<td>o Has there been any discussion with your office colleagues about what procedures to follow if a patient is suspected of an eating disorder?</td>
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<tr>
<td>• Describe some things that can be done to improve your role with regard to secondary prevention of eating disorders.</td>
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disorder-specific secondary prevention behaviors. Also emerging from the analysis were intrapersonal and network subthemes within the support theme and intrapersonal, interpersonal, network, and professional contingencies subthemes that surfaced from the general barriers theme. Table 2 presents a summary of these general themes and subthemes. The description below presents the findings that support the general themes of supports and barriers in addition to associated subthemes.

**General Theme 1: Supports for Eating Disorder-Specific Secondary Prevention**

Participants were first asked to describe their role with regard to identification of systemic health issues via oral manifestations. Progressing toward specifics, participants were then asked to describe their role regarding secondary prevention of eating disorders. Overall, participants indicated that they had an important role with regard to identification of systemic illnesses via the presentation of oral manifestations. In addition, the overwhelming majority of participants had strong comments regarding the ethical obligation to assess, approach, and refer any patient with oral manifestations of suspected disordered eating behaviors.

The second subtheme within the general support theme can be described as network contingencies. Participants discussed the role of the dental hygienist as an important support professional who can assist with secondary prevention of eating disorders. Participants suggested that, due to the length of time the dental hygienist spends with the patient, the hygienist not only implements a thorough examination of the mouth, but also develops a strong rapport and trust with the patient.

Representative comments reflecting the two support subthemes are as follows.

_a) Intrapersonal contingencies (perceived ethical obligation)_

“[An] eighteen-year-old girl comes in. [She has] massive wear on the lingual sides of her anterior teeth from vomiting. You’re obligated to say something, or depending on her age, get her parents involved. And educate her of what she’s doing to herself and why she needs to change.”

“But bottom line is, we’re oral physicians. If you fail to disclose something that you have discovered or that you suspect, you’re not exercising your full obligation as a health care professional. The days of ‘Well, I’m only a dentist’ are long gone.”

“I think it’s our ethical obligation to refer her to somebody competent who can treat that eating disorder.”

_b) Network contingencies (assistance from dental hygienist)_

“. . . these new ones [recent dental hygiene graduates] who know what they’re looking for are maybe better able to tell patients than we are because we don’t have time to give to a patient in the five minutes that we talk to them versus they [dental hygienists] do in the extra amount of time [they spend with the patient].”

<table>
<thead>
<tr>
<th>Table 2. Overarching themes and subthemes</th>
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<td><strong>Subthemes</strong></td>
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| Intrapersonal | • Perceived ethical obligation | | • Fear of offending patient  
| | | | • Fear of misdiagnosis  
| Interpersonal | • Dental hygienist | | • Uneasiness with patient approach  
| | | | • Lack of training in patient approach  
| Network | | | • Lack of practice protocol  
| | | | • Lack of interdisciplinary communication  
| Professional | | | • Professional dissonance regarding role in secondary prevention  
| | | | • Lack of policy  

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“They [dental hygienists] are dentist extenders if you will, and eating disorders is just one of the many oral manifestations of systemic diseases. They can pick up on things that sometimes somebody else would not have an opportunity to pick up on. So they need to be as much a part of this and you’re reaching out to the hygienist from that perspective.”

“Even though I think I have a great relationship with most of my patients, they still have this idea that, you know, I can’t be spoken to. I can’t be talked to. But the hygienist is right there and they’re on my level and you can talk to them.”

“Yeah, but if you’re not using your hygienist as an extra pair of hands to help you find things and an extra pair of eyes. I mean, every time I walk into the room that hygienist has been over that mouth thoroughly. She knows those teeth better than I do. And I mean I’m coming in and unless I’m doing a comprehensive exam, I’m not spending more time in there than the hygienist is. She’s been there for three-quarters of an hour. She’s looked at everything. And unless she meets me up the hall with something that’s really bad, it’s written on post-it notes next to the chart.”

“The social stigma is that it is a bad disorder. That it is a psychological problem, you know. But if she doesn’t have it, I think that could be maybe a little bit insulting to her.”

“Like personally, I feel like I have to tell them right away. You know, you’re trying to build your practice at the same time and you don’t want to, you know, offend someone or bring it out in the wrong way, but you do have to tell them the truth too.”

“We’re fearing they will leave the practice because they get their feelings hurt. And to know that a patient would just walk because you said something that they do not agree with can be fearful.”

b) Intrapersonal contingencies (fear of misdiagnosis)

“I didn’t want to be wrong and hurt that person’s self-esteem in any way.”

“But I don’t feel comfortable enough to say, ‘You know, this is a symptom of an eating disorder. Therefore you need a referral to a psychologist or psychiatrist to fix your eating disorder.’ It’s kind of a big stretch and like I said in the past I’ve been wrong and, you know, dentists don’t like being wrong. We just don’t like misdiagnosing someone that way.”

“Oh, it is very awkward. Because you don’t want to be accusing someone of having some sort of problem and then they don’t.”

Also materializing within the general theme of barriers was an interpersonal contingency subtheme. Interpersonal barriers included a sense of uneasiness with regard to approaching a patient with oral manifestations suspected to be a result of disordered eating behaviors. The following are examples of participant comments.

c) Interpersonal contingencies (uneasiness with patient approach)

“I was okay with asking her if she drank too much soda pop. I was okay with talking about her that maybe she had a problem with GERD. But I was not okay with talking about that maybe she had bulimia. That I felt a little maybe sketchy, little uncomfortable.”

General Theme 2: Barriers to Engaging in Eating Disorder-Specific Secondary Prevention Behaviors

The second overall theme that emerged from the data represents barriers to participating in eating disorder-specific secondary prevention. Further analysis of data within the general theme revealed more specific subthemes including intrapersonal, interpersonal, network, and professional barriers. For example, intrapersonal barriers pertaining to approaching a patient suspected of engaging in disordered eating behaviors included fears of offending patients and misdiagnosing patients.

Representative comments with regard to the intrapersonal subtheme are as follows.

a) Intrapersonal contingencies (fear of offending patients)
“But again if it was the opposite situation where the person was obese or had an eating disorder, in that regard I think that would be a bit more uncomfortable addressing.”

“You don’t know how to bring it up exactly other than cut to the chase so to speak. But yet you know that there are other issues going on with a lot of these people. If you bring it up in the wrong way it can be detrimental.”

A third subtheme that emerged regarding barriers to secondary prevention practices included network contingencies. For example, when participants were probed further as to reasons they perceived as influencing the uneasiness and fear with regard to patient approach, they discussed their lack of training to identify oral manifestations of disordered eating behaviors, patient approach, and patient referral. Also representing network contingencies were intra- and interorganizational issues including lack of practice protocol and lack of interorganizational communication. Generally speaking, the majority of participants stated that they have witnessed oral manifestations among patients that they believe were the result of disordered eating behaviors. When participants were asked to describe the secondary prevention protocol that was followed when faced with that situation, the overwhelming majority indicated that their office did not have a protocol in place. The following represent participant statements regarding network contingencies.

a) Network contingencies (lack of training in patient approach)

“I guess my point was there’s a difference between noticing enamel loss and diagnosing an eating disorder. That’s a big, that’s a huge step. And I don’t know if we have the training behind us.”

“That’s what we’re saying: we don’t have enough information to make a diagnosis.”

“And I don’t know if we’re secure enough in our ability to diagnose in those different areas because of almost a lack of training but more of a lack of interest in those areas.”

“Perhaps that’s why you might, you know, feel more comfortable approaching other things because you see it frequently. You’ve done it many times. You know what to expect with this issue.”

b) Network contingencies (lack of practice protocol)

“You know, I talk big about getting a protocol in place but I didn’t know what to do. I didn’t know where to send them, you know, other than their family physician, who were willing to deal with it. I think there are help groups and things like that available. I should probably check in to those.”

“But as far as eating disorders I’ve only seen a couple of them and I have a small practice, so it’s just I dealt with it when it came up.”

In addition to lack of a protocol within dental practices, participants discussed the lack of interdisciplinary communication between the dental profession and the medical profession that created barriers for providing care.

c) Network contingencies (lack of interdisciplinary communication)

“My experience has been in the past that we’ve referred a patient, a young girl, to her physician and the physician told the mother, ‘I wish these dentists would stop diagnosing bulimia with all the patients.’ The patient left the office; they were frustrated with us because we had recommended. Maybe there are some concerns that maybe you should see a physician, and they [the physician] just dismissed it that it wasn’t a problem.”

“There are too many doctors out there that just say, ‘Oh well, the dentist does not know what they’re talking about.’ And they don’t regard us as physicians.”

The fourth subtheme that emerged concerning barriers to secondary prevention of eating disorders among dentists in this study involved professional contingencies. This subtheme included the lack of policy with regard to patient disclosure of a suspected eating disorder and dissonance within the profession with regard to the role of the dentist in secondary prevention. Concerning lack of policy, participants discussed issues related to patient confidentiality and disclosure of findings to the parent.

Also described within professional contingencies were statements reflecting dissonance among the profession regarding the dentist’s role in secondary
prevention. For example, although participants indicated that they perceived an ethical obligation to engage in secondary prevention of eating disorders, it was also revealed that there may be dissonance within the dental profession regarding the role of the dentist in identification of systemic health issues.

Representative comments with regard to professional contingencies are described as follows.

a) Professional contingencies (lack of policy)

“Do we have an obligation, and I think we do, to consult with the parent and to what extent does that violate the patient’s confidence in us in terms of confidentiality?”

“I just wonder to what extent do we have an obligation in a case of a minor who we have some suspicions of, to go to one of the parents, normally the mother, and in my practice maybe she’s out in the waiting room.”

“I think you’re obligated to tell the parent of a minor.”

“In my case I talked to a parent and suggested that they consult with their family physician and that they observe their child very closely.”

“I kind of think with a minor it’s a good idea to talk to the parent and maybe you can even convince a parent to maybe have them do a physical with their primary care physician or pediatrician. I think I’d probably go that route.”

“We can’t divulge health information to any other soul when they’re over 18 without that patient’s consent. So you have to go to the 18-year-old or 19-year-old and say, ‘Look I’m gonna talk to your mom about your health conditions, is that okay with you?’ And if they agree and they consent to it, then you go to the parent and say something to them. Most of them do.”

b) Professional contingencies (dissonance within profession regarding secondary prevention of eating disorders)

“I think I said something like that but I think that as a dental profession we, and I don’t necessarily want to paint the profession with one paintbrush, but a lot of dentists often don’t look at the patient as, you know, they address the one broken tooth. They don’t [develop] comprehensive treatment plans for the patient for maybe the overall health, oral health of the patient.”

“So I would say no, there isn’t that level of commitment that’s pervasive throughout the dental community.”

“I must say that I don’t believe that any of us have done a survey to note how many dentists feel this way or don’t feel this way. I’ve been involved in looking at some practices for other particular situations, and it is obvious to me in some of those practices that the dentist is very narrowly focused. They are just more narrowly focused than the people who believe that dental care is part of the overall health care and we believe we have a responsibility to the patient, not just to the teeth and the supporting structures.”

Discussion

One goal of qualitative analysis is to develop a framework for communication of observed themes and subthemes. As depicted in Table 2 and described via representative statements, the results from this study indicate both supports and barriers to secondary prevention of eating disorders among dentists. Moreover, these supports and barriers are comprised of intrapersonal, interpersonal, network, and professional contingencies. When viewed as a whole, it is evident that the identified subthemes (both among supports and barriers) that emerged reflect the identification of behavioral-ecologic leverage points for influencing the system of care among dentists in providing secondary prevention of eating disorders (Figure 1).

The behavioral-ecologic model suggests that adoption of behaviors is contingent upon individual, local network, community, and societal factors. Individual factors include knowledge, attitudes, beliefs, and skill with regard to the behavior. Local network contingencies include support and reinforcement from friends and coworkers. Community contingencies include laws and policies that reinforce the behavior. Lastly, societal contingencies include cultural-specific factors influencing adoption of the behavior.
Figure 1 represents the identified subtheme expressed as behavioral-ecologic contingencies. Analysis of the focus group data led to the identification of three contingencies as possible leverage points for increasing the likelihood of eating disorder-specific secondary prevention among dentists. These include training, network, and dental profession contingencies. These three contingency dimensions can be viewed as foundation conditions that define structures, policies, and practices that support and sustain the secondary prevention clinical behaviors listed on the right side of Figure 1. Similar dimensions for clinician behavior change were found in qualitative research conducted by Lewis et al.\textsuperscript{26} In work designed to understand diffusion and adoption of a caries prevention practice in primary care pediatrics, a conceptual model was described that contextualized practice behaviors in relation to communications among physicians, their staff, and patient families; practice setting logistics; and a complex of pre-existing factors related to attitudes, beliefs about scope of practice, and prior experiences.

In our study, training contingencies comprise knowledge, attitudes, beliefs, and skill with regard to secondary prevention of eating disorders. Current results indicate that dentists believe they have an ethical obligation to participate in secondary prevention of eating disorders. This is an important first step that serves as reinforcement for further training in secondary prevention clinical practices. As revealed in our study, perceived barriers to patient approach included fear of offending and/or misdiagnosing their patients.

**Training Contingencies**
- Perceive an ethical obligation to provide eating disorder-specific secondary prevention
- Knowledge of oral and physical manifestations of eating disorders
- Knowledge of types and characteristics of eating disorders
- Skill in patient approach
- Awareness of referral services

**Network Contingencies**
- Dental practice protocol
- Collaboration between dentist and dental hygienist
- Communication and collaboration between oral, mental, and medical professionals

**Dental Profession Contingencies**
- Policy regarding disclosure of suspicion of eating disorder to parent/guardian
- Professional position statement regarding role of dental professional in secondary prevention of eating disorders

**Eating Disorder-Specific Secondary Prevention:**
- Assessment of oral manifestations of disordered eating behaviors
- Patient approach
- Oral treatment
- Patient referral
- Case management with treatment team (health care provider, nutritionist, mental health care provider)

Figure 1. Contingencies for secondary prevention of eating disorders
and uneasiness with approaching patients who they suspect have disordered eating behaviors. When further probed, the dentists in this study reported that they did not receive enough training with regard to eating disorders. More specifically, they described not being knowledgeable with regard to oral and physical manifestations of eating disorders, patient communication involving sensitive topics, and local referral agencies.

Taken together, the findings from this study and from previous work of DeBate et al. demonstrate low levels of knowledge among dentists and dental hygienists about the oral manifestations of eating disorders and physical cues of both anorexia nervosa and bulimia nervosa, as well as weak reports of incorporation into clinical practice. These results also reinforce findings of the National Association of Anorexia Nervosa and Associated Disorders that many health care professionals have not been trained to recognize signs and symptoms of eating disorders. Moreover, although focused on domestic violence-specific secondary prevention among dentists, these findings also support the work of Love et al. who revealed similar barriers with regard to perceived lack of training in identifying domestic violence and concern about offending their patients.

Network contingencies revealed in this study include the lack of dental practice protocol with respect to secondary prevention for eating disorders in addition to the lack of communication and collaboration among health service providers. Dentists in this study indicated that they did not have a set protocol for providing patient-specific home dental care, requesting patient recall, referral, and case management for patients with suspected eating disorders. Our study also revealed that the dental hygienist was viewed as a support person in providing secondary prevention of eating disorders. It is important that this support mechanism should be maintained and strengthened. As such, it is crucial that the role of the dental assistant and dental hygienist with regard to secondary prevention of eating disorders be discussed as part of established protocol. Furthermore, all members of the dental treatment team should be aware of other health care providers in their area who treat eating disorders.

In addition to establishing practice protocol, it is also essential that communication between providers be initiated to ensure proper case management of the patient. It is essential that the dental care provider be part of the treatment team in order to ensure comprehensive treatment while increasing the quality of life of the patient. The research on secondary prevention for domestic violence by Love et al. revealed similar findings to this study in that many dentists indicated that they did not know referral sources for patients and/or did not have practice protocols in place for secondary prevention of domestic violence.

For over a decade, since the release of the Institute of Medicine report Dental Education at the Crossroads, the curriculum has been a persistent topic of discussion. However, the discussion continues on contemporary curriculum needs, such as those related to complex issues in human behavior, social problems, and mental health. The importance and value of connections with the behavioral and social sciences, yet to be accomplished, is underscored by the narrative of practitioners represented in the results of this study. Integration of topics for discussion and examination and clinical exposure to cases can be designed to create greater capacity and facility among the newest graduates. Parallel programs in continuing education should also be examined. Connections to specialty programs, like orthodontics and pediatric dentistry, where these problems are likely seen with some regularity, would also advance approaches to clinical care. Clearly, the educational adage “what is taught is practiced” applies here and in other areas where oral conditions are linked to social and psychological conditions.

Conclusions

This qualitative study explored perceptions, beliefs, and attitudes regarding the role of the dentist in secondary prevention of eating disorders. Limitations to the study include the lack of generalizability of findings (i.e., participants were general dentists attending a conference, which may not be representative of all practicing dentists). However, it must be recognized that focus group data are not intended to be generalized.

The findings of this study combined with previous quantitative assessments provide a greater understanding of the support/barriers and contingencies needed to increase the provision of secondary prevention among dentists. It is evident from the results of this study that although dentists regard secondary prevention of eating disorders as an ethical obligation, they perceive the work of the dental hygienist as a support mechanism in the provision of care, and the training, network, and professional
contingencies in dentistry have been identified as barriers to practice.

This study provides a first step in identifying behavioral ecologic leverage points necessary for increasing the number of dentists who engage in secondary prevention of eating disorders. Further, these findings add to our understanding of how to better define curriculum, practice protocol, and policy and serve as valuable guides for continuing education programs, dental education curriculum, and policy development.

Acknowledgment

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