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A psychodynamic understanding of the dentist–patient interaction

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This paper describes various elements of the dentist–patient relationship, how they interact and illustrates them with case studies.

The aim of continuous dental care is for dentists to be able to make contact with patients in an easy, accessible and acceptable manner. For patients who may be described as 'regular attenders' dentists have been able to form and maintain a 'treatment' relationship. This enables patients to accept the care which has been negotiated and offered.

For other patients it is impossible for the dentist or the dental team to contact them in either a physical or psychological way. Research suggests that these people remain non-compliant because they are too anxious, too impoverished and/or seem to be too disinterested to attend[1-3]. For whatever reason they are unable to use the dental care offered and provided by the dental team.

There are many ways in which dentists provide dental care for their patients and these techniques come under the umbrella of patient management. Methods of patient management are said to assist dentists in their work with patients by reducing stress not only in themselves but also in those individuals who form their dental teams. However despite increased awareness as to the importance of management skills, dental health professionals still experience stress, especially with patients who appear more demanding, anxious and who are sometimes described as 'difficult'. Patient management skills seem to have little bearing on the effect these patients can have upon the dental team. In fact dentists may state that even the mention of certain patients' names can lead to despondency. It would seem that some interactions with patients can stir up profound feelings. However unlike patients who have the potential to ventilate their anxieties and concerns, the dentist must keep his in check by reacting professionally within the confines of the dentist–patient relationship. In order for patient management to be successful it is important that dentists have an understanding of the ways in which patient interactions may progress.

Various models[4] have been suggested to explain the dentist–patient interaction. Some have suggested that a power differential[4–5] exists while others have formulated an explanation based upon psychodynamic ideas[6–8]. It has been suggested that using a psychodynamic model can help the clinician to appreciate that dental care is not one person working on another but a two person endeavour involving adults working together toward a common health goal. The psychodynamic model assumes that when the dentist and patient are unable to work together toward the common health goal difficulties may occur. It is proposed that an appreciation of the dynamics of the dentist–patient relationship will help to reduce occupational stress while enabling the patient to accept dental healthcare. The aim of this paper is to examine the dentist–patient relationship using a psychodynamic framework and to show its relevance for dentists and their patients in dental practice.

The psychodynamic explanation of the dentist–patient relationship

From a psychodynamic viewpoint dental healthcare is a 2-person endeavour. It is the dentist working with the patient and the patient being able to accept (use) the work (treatment) offered and provided by the dentist. It acknowledges that there is a uniqueness in the interaction for both dentist and patient while accepting the potential for inequalities within the interaction. Nevertheless it requires the health professional to remain flexible, to be able, as the need arises, to make adjustments in treatment plans thereby maximising status equality while minimising the potential for disruptions within the relationship. Benefits exist for the dental health professional when the equality between themselves and their patients is maintained. These include improved time and behavioural management skills, increased awareness of their patients' concerns and anxieties, the ability to readjust treatment plans and to provide patient-centred care.

There are three aspects of the psychodynamic model which must be considered in this regard. These are first the real relationship, secondly, the treatment alliance and thirdly, the transference.[9]

The real relationship

The real relationship is an equal and unique relationship between two adults. This is a genuine and realistic interaction in which the uniqueness of the dentist is complemented by the uniqueness of the patient. The interaction

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between them therefore has a distinction which belongs only to that specific patient who interacts with that particular dentist. Within the adult-to-adult equality of the relationship the dentist will have been chosen by the patient because of his clinical attributes and skills. The real relationship, in this regard, will remain unaffected by any anxieties or concerns the patient may have about dental treatment. Mrs W's interaction with her new dentist is a good example of the real relationship (Case 1). She experienced high dental anxiety and wished to find a dentist with good clinical as well as patient management skills. Her wish for a competent dentist was unaffected by her dental anxiety.

Case 1
Mrs W, a 25 year old woman, had recently moved to new town and was looking for a new dentist. She had been very pleased with her previous dentist with whom she had been able to manage her considerable dental anxiety. She would have continued to see him but for her new location. It was just too far to travel. She had asked about a dentist at her place of work and had been told that the dentist nearby had a good reputation. Mrs W decided to make an appointment. This was based upon the dentist's clinical reputation and patient management skills.

The treatment alliance

The treatment alliance is an equal relationship between two adults. However, while it possesses the same status equality of the real relationship, it differs. The treatment alliance is not only a development of the real relationship but is affected by the patient's anxieties and concerns with regard to accepting dental treatment. For the first time in the dentist–patient relationship the patient's concerns and anxiety about dental treatment seem to merge with the dentist's clinical and patient management skills. It is suggested that barriers to compliance, such as dental phobia, costs and so forth, act within the treatment alliance to distort the relationship between the dentist and patient. The intensity of anxiety, for instance, may render it impossible for the patient to depend upon, or align himself with, the dentist. The patient is unable to accept or use the treatment offered by the dentist.

Case 2
Laura, a 25-year-old woman attended for dental treatment. She was anxious and delayed the start of treatment by using every means available to her. Despite being implored by the dentist and the nurse she finally refused to have any treatment at all, becoming distressed and tearful. After Laura left the dentist complained 'difficult patients!'. However on reflection he acknowledged how uncomfortable he felt in response to the intensity of Laura's anxiety. When she came for the next visit he talked to her about her fears and concerns and Laura admitted that her anxiety had led to her being unable to sleep for nights. The dentist discussed with her why she was so anxious and subsequently by working together a treatment alliance was formed and together they were able to formulate a treatment plan.

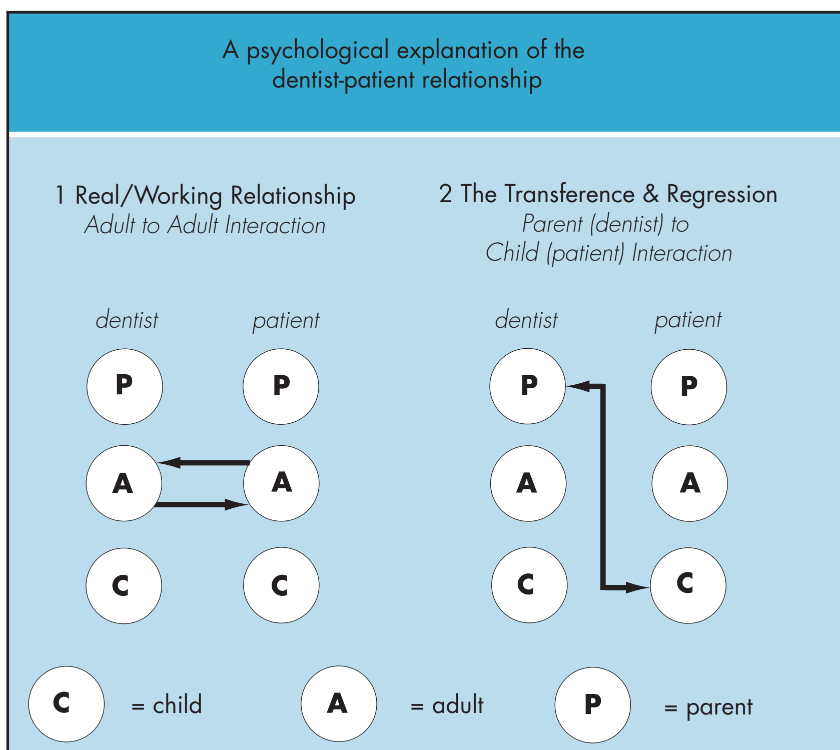

Fig. 1A psychological explanation of the dentist–patient relationship

The example of Laura (Case 2)shows how the intensity of the patient's anxiety can make the achievement of a treatment alliance difficult for both patient and dentist. Laura's anxiety was so intense that she was unable to depend upon the dentist (align herself with him) or use the dental care he was providing for her. However Laura's anxiety also affected the dentist. He too became unable to function within the treatment alliance, describing her as 'difficult'. Only after a realisation as to the inappropriateness of his reaction to the patient was he able to make adjustments and re-formulate his treatment plans in accordance to Laura's psychological and dental needs.

The transference

The transference is quite distinct in its relationship characteristics but nevertheless inextricably linked to other aspects of the psychodynamic model. Like the treatment alliance the transference develops with time but unlike the real relationship or the treatment alliance this is not an interaction between adults. The transference represents the past. It is a repetition of previously emotionally important relationships which are inappropriately imposed by the patient upon the dentist. Therefore, as the transference represents the past, it sometimes

becomes intrinsically associated with regression. Regression simply describes the psychological state of the patients as they change from being in an emotionally controlled to a less well controlled emotional state. Regression is associated with a change in relationship status. The interaction is no longer one of equality between adults but one between the dentist as 'parent' and patient as 'child' (fig. 1). Within the transference the adult patient will re-experience childhood memories and fears, which since they have become distorted with time are experienced as occurring in the present. The dentist may, therefore, be perceived as a caring parent whereas for other patients the dentist may be a powerful adult with the ability to cause fear or to harm.

The transference is particularly important in the management of dentally anxious patients since for them previous dental experiences are relived as if they were occurring in the here and now. The example of Mr B is illustrative (Case 3).

Case 3
Mr B was 55 years old. He was successful in his professional life and was considered to be assertive and impartial in his dealings with colleagues. Mr B was a regular dental attender despite being very frightened by the thought of dental treatment. While he remained assertive in his dealings outside the dental surgery, inside he admitted to such anxiety that he felt helpless like the little boy he once was. He openly talked of how he relived a childhood dental experience expecting each filling to be as painful as in the past.

In this case, Mr B regressed from an emotionally controlled state outside the dental surgery to a less well controlled emotional state inside the dental surgery. The dentist's awareness of Mr B's feelings about dental treatment helped Mr B ventilate his concerns and anxieties. This was achieved because of the treatment alliance which existed, outside the transference. Mr B was able to use the information exchange with the dentist, together with the care offered by the dentist, as a result of the treatment alliance. The dentist had restored the adult-to-adult equality status in the dentist–patient relationship.

Applying the psychodynamic model to general practice

In order to illustrate the application of the psychodynamic model to general practice three basic models (Table 1) of the clinician–patient interaction proposed by Szasz and Hollender[6] will be explored. These models will be described separately. When they are brought together they provide an overall psychodynamic explanation of the dentist–patient interaction at different stages of the treatment encounter. Three general practice encounters will be used to illustrate how the dynamics of the dentist-patient relationship change with and within 'treatment' sessions.

The dental check-up visit: an example of the guidance–cooperation model

In the guidance–cooperation formulation of the dental check-up visit, Szasz and Hollender[6] described the relationship between the dentist and the patient not as one between two adults but one in which the dentist is the caring parent and the patient the cared-for child. While the guidance–cooperation model may explain the transference dimension of the check-up visit it ignores the treatment alliance and the real relationship. The attendance of the patient reflects the real relationship and treatment alliance. The patient re-attends because of the care afforded to her by the dentist. This is a reflection of the real relationship between dentist and patient. Since the patient has been able to use the dentist's care by attending it also illustrates that the treatment alliance is operative. This reflects the adult-to-adult aspect of the guidance-cooperation formulation. Coleman and Burton have stated that when a patient attends for their check-up visit 'the patient knows something; dentist knows something'.[10]

In Case 4 Mrs R attended for her routine

Three basic models of the dentist–patient interaction

Model	Dentist's role	Patient's role	Clinical application	Prototype of model
Activity–passivity	does something to the patient	receives the treatment	operative dental treatment	parent to child
Guidance–cooperation	tells the patient what to do	obeys accordingly	dental check-up appointment	parent to child
Mutual–participation	advises and negotiates with patient	patient in equal partner care	negotiation treatment or preventive plans	adult to adult

Table 1 Three basic model of the dentist–patient interaction

1 Nuttall N. Review of attendance behaviour *Dental Update* 1997; **24**:111-113.
2 Adams T, Freeman R, Gelbier S, Gibson B. Accessing primary dental care in three London boroughs. *Community Dental Health* 1997; **14**: 108-112.
3 Finch H, Keegan J, Ward K, Sen BB. *Barriers to the receipt of dental care. A qualitative study*. London: Social and Community Planning Research. 1988.
4 Sondell K, Soderfeldt B. Dentist-patient communication: a review of relevant models. *Acta Odontol Scand* 1997; **55**: 116-126.
5 ter Horst G., de Wit C.A. Review of behavioural research in dentistry 1987-1992: dental anxiety, dentist-patient relationship, compliance and dental attendance. *International Dental Journal* 1993; **43**: 265-278.
6 Szasz T.S. Hollender M.H. A contribution to the philosophy of medicine. *Arch Int Med* 1956; **97**: 582-592.
7 Freeman R. Communication, body language and dental anxiety. *Dental Update* 1992; **19**: 307-309
8 Burke FTJ, Freeman R. Psychological aspects of patient management in dental practice. *Dental Update* 1994; **21**: 148-151.
9 Greenson R.R. *The technique and practice of psycho-analysis*. London: Hogarth Press, 1989.
10 Coleman H., Burton J. Aspects of control on the dentist-patient relationship. *Int Soc. Lang* 1985; **51**: 75-104.

appointment. She thought as the dentist thought that there would be nothing to do. She also knew that something had to be done with her eye. Mrs R's response to her dentist's concern may be explained using the guidance-cooperation formulation. While acknowledging that she overcame a great anxiety she was, nevertheless, able to act on the dentist's guidance by cooperating and attending the eye department. She was able to do so because of the treatment alliance and her ability to use the information and care provided by the dentist.

Case 4
Mrs R attended for her usual check-up visit. She had assumed that nothing was wrong and was pleased when the dentist suggested that they should meet again in 12 months time. However, the dentist noticed that a cyst at the corner of Mrs R's eye had become much larger since they had last met and mentioned his concerns. Mrs R got very angry. Nevertheless she phoned the surgery about 4 weeks later to thank the dentist. She had acted upon his advice and attended the eye department as an emergency. They had removed the lesion which was subsequently shown to be a lachrymal cyst. Mrs R had been very worried about it and was now reassured. She thanked the dentist for his interest in her general health.

The treatment session: an example of the activity–passivity model

The observation that during operative dental treatment the patient is passive and the dentist is active may be explained by the activity–passivity model: the patient must be passive and the dentist active so that dental treatment is possible. While the activity–passivity interaction is an example of the transference and regression it also contains aspects of the treatment alliance. If the treatment alliance were not in operation the patient would be unable to accept dental care as in the case of Laura. In the Case 5 a woman patient attended for continuous dental care. Although having been a dental therapist, she felt it was as if she knew nothing of the dental procedure and the dentist knew everything.[10] Despite her disappointment in the dentist's patient management skills she remained a practice patient because of the real relationship and the treatment alliance.

This vignette shows how the treatment session interaction between dentist and patient is never static. Although Ms Z felt like a 'phantom head' (passive) when the dentist was preparing (active) the crown she nevertheless valued the dentist's clinical skills (the real relationship), the dentist ability to care for her (transference) and, as she was able to use the treatment offered, remained a patient of the dentist (treatment alliance).

Case 5
Ms Z was having a crown prepared on an upper premolar. The dentist, who was known to her, gave the local anaesthetic and said little. After inquiring that the tooth was numb, the dentist started to work. Ms Z had not expected the dentist to explain the procedure but had been surprised by a sarcastic comment when she found the temporary crown high to bite on. She felt she was like a 'phantom head' just lying there. Ms Z acknowledged that patients 'don't go to her [*this dentist*] for her tact and diplomacy but for her considerable clinical skills'.

Negotiating preventive health goals: an example of the mutual-participation model

In the mutual-participation formulation two adults are working together for common dental health goals. This describes the negotiation of dental health goals suggesting that preventive dental care must be a two-person endeavour between adults.

The dentist, by recognising the potential for transference and the patient's wish to be cared for, acts to reinforce the treatment alliance within this mutual-participation formulation. This is achieved by encouraging the patient to be active and to use the information exchange to help her to participate as well as enabling her to take responsibility for her own dental health. In order to help the patient in this regard the dental health professional must be both active (providing information, advice) and passive (listening), making adjustments in order to maintain the treatment alliance. Techniques such as motivational interviewing and the stages of change model (see Part 9 of this series) may be used by the dental health professional to negotiate health goals. These techniques rely on the dentist and patient mutually participating in a joint venture to promote dental health.

Conclusions

Dental healthcare which acknowledges the role of the real relationship, the treatment alliance and the transference within a dynamic framework, will maintain the equality of the dentist-patient relationship. It is by an appreciation of the complexities of the dentist–patient interaction that the dental health professional will be able to enable patients not only to accept dental care but also to empower them to take responsibility for their own oral health.