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THE LIVED EXPERIENCE OF DENTAL ANXIETY AMONG ADULT PATIENTS IN A CLINICAL SETTING

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Abstract

Background: Dental anxiety is an important issue with a significant proportion of adults who avoid care and have poor oral health outcomes, and is experienced as a subjective first-person perception; however, this aspect is under-explored compared to the predominantly quantitative literature on dental anxiety prevalence and correlates.

Objective: This study aimed to examine the lived experience of dental anxiety in adult patients during common dental health care situations through a phenomenologically grounded qualitative approach.

Method: High dental anxiety was defined among the adults (n = 12, P1–P12) who volunteered to participate in this study in two rounds of semi-structured interviews. Of the 12 transcripts, each had usable data, and were analyzed using Braun and Clarke's (2006) six phase reflexive thematic analysis.

Results: Six themes emerged: anticipatory anxiety before the appointment, physiological or embodied experience of anxiety, the feeling of lack of control and the desire to gain control, the role of the practitioner as a key moderator, and a personal repertoire of coping strategies, and a general wish to be believed, rather than judged, across a broad range of severity. Dental anxiety was felt not only as fear of pain per se but as a sense of a loss of control

over oneself, and the combination of sensory triggers and communication from the practitioner, which made it a great deal more manageable.

Conclusion: These findings are congruent with trauma-informed, patient-centred dental care, where it is understood that clear communication is essential, agreed stop signals are valued and patient distress is explicitly validated as part of the clinical process, not just courtesy. The implications for practice and directions for future research are discussed.

Introduction

A substantial percentage of the adult population is impacted by dental anxiety and this has been linked to non-attending for dental care and poorer oral health outcomes (Eitner et al., 2006). It is one of the most frequent reasons for not attending the dentist regularly, and affects them beyond the clinical setting, leading to poor oral health and subsequent more serious treatment requirements.

Most of the literature on dental anxiety is quantitative, using standardised rating scales that quantify the level of anxiety a person has, but not what it feels like to experience. By contrast, its subjective, embodied texture (what patients describe as thoughts in their head during therapy, clinical features that bring up discomfort in the patient, and coping strategies to mitigate discomfort) have received relatively little attention. This is where the current study comes in to fill.

The aim of the present study is to examine the lived experience of dental anxiety within the context of routine oral health procedures among adult dental patients using a phenomenologically informed qualitative approach. In line with Husserlian and hermeneutic interpretive traditions of qualitative inquiry (Groenewald, 2004; Qutoshi, 2018), the goal was to describe the structure of the experience in the description of the participant in their own terms, with the aim of understanding and informing more empathetic, patient-centred dental care (Bliss, 2016). The guiding research question was: What is the nature of an experienced profile of dental fear in adult patients during a routine dental care procedure? The five objectives were to: uncover the participants' lived experiences in relation to high dental anxiety; uncover common emotional, cognitive and physiological patterns; reveal the experience that took place in the clinical setting; document participants' coping strategies; and elicit implications for more empathetic and patient-centred dental care.

Following this, the literature on the topic is reviewed, the methodology used in the study is described, the six themes found through thematic analysis are outlined, and the interpretation of each theme is described, followed by the implications for clinical practice and suggestions of future research.

Literature Review

Dental anxiety has been consistently reported in epidemiological studies from various populations. The dental anxiety among adults was also high in South India, with evidence of anxious people postponing or avoiding dental care altogether as noted by Appukuttan et al., (2015). Peric and Tadin (2024) continued this work in their large study of adults who were surveyed online. Eitner et al. (2006) also connected dental anxiety with oral health outcomes, describing it as a psychological as well as a public health problem, rather than just an individual problem. More recently, Chidley and Burns-Nader (2024) surveyed adults aged 18 to 25 at university and reported nine different dental fears, most notably needles and pain, and observed a significant correlation between patient's confidence in their provider with the amount of fear and anxiety

experienced — which foreshadows the present study's key qualitative theme of practitioner conduct as a key moderating factor.

Combined, these pieces of literature have proven that dental anxiety is widespread, detrimental and quantifiable, but until recently, little was known about the experience from the patient's perspective. While standardized rating scales can measure a person's level of anxiety at a specific time, they don't measure internal conversation, sensory triggers, or coping mechanisms that dictate a patient's daily experience and interaction with dental treatment. Qualitative approaches are more appropriate for this, and especially phenomenological approaches seek to describe a phenomenon as it is experienced, as opposed to being categorised beforehand (Groenewald, 2004; Qutoshi, 2018). Bliss (2016) also claims phenomenological research is appropriate for health-related experience because of the meanings that patients themselves ascribe to their health encounters, which may vary greatly from what the clinician or researcher assumes. Among the first to take a direct approach to this gap, a recent mixed-method study by Taqi et al. (2023) sought to identify themes associated with patients' physical responses to dental procedures and the nature of their relationship with their dentist with a validated fear survey questionnaire completed by 100 dental patients from Pakistan, followed by 25 qualitative interviews with fearful adult patients across dental specialties, who described their most threatening procedure as that of oral surgery. As this work demonstrates, it is possible to have a qualitative, patient-centred account of dental fear that is feasible and clinically informative, and as of yet there have not been many studies of this type that have a purely phenomenological design as opposed to a mixed methods design.

The method used for this study is reflexive thematic analysis (Braun and Clarke 2006; 2019; 2021), which conceives the process of development of themes as an interpretive process that is not mechanical, but rather researcher-designed, as it was further developed in a more recent worked example by Braun et al (2022). In contrast to procedures like inter-rater reliability that are developed in other traditions of analysis that are codebook-driven, Braun and Clarke (2021) suggest that transparency with respect to analytic decisions and the researcher's position should form the basis of judging quality in reflexive thematic analysis. Reflexive thematic analysis thus seems to be an appropriate method for a small, phenomenologically oriented study like the present one, for which the aim is a rich and defensible interpretation of a limited number of data rather than statistical generalizability.

Methodology

Design

The study adopted a qualitative design with the consequence of reflecting the participants' lived experiences, and reflexive thematic analysis (Braun & Clarke, 2006, 2019) was employed to analyse the semi-structured interviews. This orientation is employed because the research question is not aimed at

determining a prevalence or correlative factors for the subjective experience, but rather at its essence, and phenomenological approaches focus on the participants' descriptions of a phenomenon rather than categories imposed on it from the outside (Groenewald, 2004).

Participants and Data Collection

Data collection was carried out in two phases, with the same ten-phase semi-structured interview guide, which included rapport building, the sensory and emotional quality of the anxiety, its influence on everyday life, the clinical setting, the patient–practitioner relationship, coping strategies, and hopes for future care. The interviews conducted in the first round comprised ten adult participants who reported to the researchers that they had high dental anxiety; nine of the transcripts (P1–P9) contained full responses and Participant 10's transcript did not contain a response initially. In a second round, Participant 10's transcript was completed and two additional participants (P11 and P12) were interviewed with the same interview guide. Thus, the number of participants (P1–P12) was fewer than the proposed 15–20, as will be discussed in the section Limitations. The three new transcripts (P10–P12) that were added in the most recent step did not provide a candidate theme beyond the six already found in P1–P9, although they further embedded themes with additional detail.

Analytic Procedure

All twelve transcripts were analyzed using the six phase approach outlined by Braun and Clarke (2006; Braun et al., 2022): familiarization with the overall data set, initial coding of every transcript, collation of codes into candidate themes, review of themes with both the coded extracts and the data set, definition and naming of themes, and the production of the findings reported below. Coding was inductive, drawing upon the meaning given to the participants' own experiences and not from a pre-conceived coding scheme. As an illustration of this process, the extract ‘In some cases, it makes it worse to search on Google before the treatment' (P10) was coded as pre-appointment information-seeking that backfires, placed in the subtheme of ruminative, catastrophizing thought, and within Theme 1 below.

Trustworthiness and Reflexivity

Here, trustworthiness, which is more about procedures like interrater reliability, sits uneasy with the reflexive approach, but is established through transparency of the analyst's role and what can be inferred from the data.The trustworthiness here is less about procedures like interrater reliability, as these are problematic in a reflexive approach, and more about transparency of the analyst's role and what can be inferred from the data. Themes reported below are intersubjectively validated as far as conducted by only one coder while no second coder and no participant member-checking was performed, limiting the extent to which they can be described as intersubjectively validated; member-checking and peer debriefing are recommended as a next step prior to informing practice or publication. Another limitation is data integrity:

the wording of P1 and P5 is highly similar, and only partially changed in P5's transcript during the second phase of data collection. The themes reported below are grounded in the work of nine of the twelve participants for whom the accounts do not overlap with each other or with P1 and are treated as an unresolved issue that should be checked against original recordings or consent documents before using the data set further.

Results and Discussion

The data set was used to develop six themes. Anxiety profiles for the participants are summarized in Table 1 and the themes and subthemes are summarized in Table 2. For each theme, a description with illustrative extracts (identified by the number of the participant) is given and interpreted based on the literature reviewed above.

Table 1

Participant Anxiety Profiles

Participant	**Anxiety Profile**	**Notable Features**
P1	Moderate–high; escalates to panic during treatment	Delayed a checkup for ~1 year; relies on step-by-step explanation and prescribed sedatives
P2	Severe; panic attacks, hyperventilation, near-syncope	Avoided care for six years, resulting in tooth loss; completed CBT; uses sedation
P3	Mild; confined to specific procedural moments	Manages anxiety largely through information-seeking
P4	Moderate–high; self-rated 9.8/10 at peak	Draws on religious coping (Qur'an recitation); raises a consent concern
P5	Moderate–high	Reports counseling as highly effective
P6	Low baseline; confined to anticipation of major procedures	Anxiety proportional to procedural severity
P7	Moderate; largely continuous	Characterizes the experience as ‘fear of the unknown’
P8	Mild–moderate	Anxiety linked to practitioner competence and demeanor

Participant	Anxiety Profile	Notable Features
P9	Moderate–high; pronounced anticipatory build-up	Explicitly requests an agreed stop-signal
P10	Moderate–high; builds sharply pre-appointment	Pre-appointment internet searching worsens anxiety
P11	Mild overall, with one severe traumatic outlier	An eight-hour jaw-dislocation surgery was singularly distressing
P12	Moderate; typical of the sample's midpoint	Anticipation sometimes worse than the procedure itself

Table 2

Overview of Themes and Subthemes

Theme	Subthemes
1. Anticipatory anxiety preceding the appointment	Ruminative, catastrophizing thought (incl. online searching); disrupted sleep; avoidance and delay of care
2. The embodied experience of anxiety	Autonomic arousal; sensory-specific triggers; concerns about hygiene and sterilization
3. Powerlessness and the struggle for control	Feeling exposed and helpless; reclaiming control through explanation, consent, stop-signals
4. The practitioner as a central moderating factor	Validation versus dismissal; trust built through communication and consistency
5. A personal repertoire of coping strategies	Self-directed strategies; clinical interventions (sedation, nitrous oxide, CBT, counseling)
6. A spectrum of severity, a shared wish to be understood	Anxiety as heterogeneous rather than uniform; the wish to be believed; hopes for future care

Theme 1: Anticipatory Anxiety Preceding the Appointment

In most participants anxiety did not just occur during the clinical encounter, but it actually started days beforehand, ruminative and catastrophizing thoughts. When an appointment was made, P1 said that she was ‘overthinking everything that could possibly go wrong’, while P2 said that she would ‘replay painful past procedures and overwhelming nausea and suffocating fear’ in anticipation. P10 reported a more specific pattern of online searching prior to an appointment, as 'seeing images and information about dental procedures can make me think that the same procedure is happening to me online. This preparatory time was often associated with disturbed sleep, mood and concentration, and in some cases with the avoidance of dental care altogether, with several participants having a total absence of dental care for six years, which led to major tooth loss in several cases. Eight of the 12 participants reported that they delayed or avoided [at least once] due to anxiety. The present findings are consistent with Eitner et al. (2006) and Appukuttan et al. (2015), who reported an association between dental anxiety and seeking avoidance of dental care at a population level; but they provided experiential texture to this association, accounting for the gradual emergence of avoidance from anticipatory rumination, rather than a single decision. The information reviewed above does not directly discuss the phenomenon of P10's feeling the anxiety of online searching, but is in conjunction with a larger body of literature on health information-seeking that may inadvertently increase anxiety.The literature reviewed above does not directly address the phenomenon of anxiety experienced by P10 when using online search engines, but occurs in parallel with the larger body of health information-seeking literature that may inadvertently increase anxiety.

Theme 2: The Embodied Experience of Anxiety

In all but two of the transcripts, anxiety is first characterized as a physiological sensation and then secondarily as an emotional or cognitive state. P1 said she would feel her heart pounding 'the moment I put my feet into the chair', while P2 said her presentation was much more intense: ‘my chest tightens, I hyperventilate, my hands get cold and sweaty and I start shaking uncontrollably and feel like I'm about to pass out in the chair’. This arousal was always related to the sensory aspects of the clinical situation such as the sound of the drill, the sight of the syringe and the feeling of being reclined in the chair. P11 asked about concern over ‘the hygiene and sterilization of dental equipment’’, indicating that perceived control over the threat of infection was an issue in this sample that had not been a focus in current dental anxiety scales, in addition to feared pain.

Theme 3: Powerlessness and the Struggle for Control

The common theme in nearly all of the accounts was the feeling of physical fragility and reliance on the actions of others, as well as an attempt to regain some control. But, but, but, P2 was clear about what she did not want: ‘I need to have full control, so I can raise my hand and stop the procedure if I want to, without

any resistance. The “letting go” strategies outlined by participants focused on information and mutual consent, rather than dramatic intervention: P1 wanted practitioners to explain ‘step-by-step what they are doing before starting it so nothing surprises me’ and P4 raised a similar but different concern about consent, where they wanted practitioners to explain ‘step-by-step’ before showing it to their practitioners. This need for information and agreed stop-signals resonates with the phenomenological premise that lived experience is best understood through the meaning participants attach to it (Groenewald, 2004; Bliss, 2016) in this case it is not pain per se, but control that organizes this experience.

Theme 4: The Practitioner as a Central Moderating Factor

The one thing that was the same in every sample was that the procedure itself, rather than the manner in which the dentist and staff performed the procedure, was the greatest determinant of whether a visit was tolerable. Some examples of what was helpful: P2's was that she was told to 'not exaggerate' this made her feel worse, but a practitioner who said 'immediately stop all work, take off your gloves, and accept that your pain and fear is real' was the most helpful response she had received. It's the same story with P11's positive side: "exceptionally calm, composed, reassuring" as a dentist, she said his manner “substantially contributes to a sense of confidence and comfort during treatment”. This dynamic was each described in a separate way by P1, P9 and P12, all of whom used the theme of trust. This is an extension of the largely quantitative literature reviewed above in that it goes beyond a mere report of increased anxiety following a negative experience, and also indicates a likely mechanism: the negative experience taught participants that they would not be listened to when they felt distressed and so this became generalised to future experiences. This role of practitioner behaviour aligns with the qualitative results from Taqi et al. (2023) who identified how patients relating to dentists was an important factor affecting the perceived threat of a procedure, indicating that this pattern is not unique to this sample.

Theme 5: A Personal Repertoire of Coping Strategies

Participants reported a variety of styles of coping, an individual style. Some used distraction – such as audiobooks, podcasts and social media – while others used breathing, self-talk or, for P4, spiritual practice: ‘I constantly tell myself to remain still and I recite the verses of the Holy Quran to give me internal peace.’ This finding is somewhat incongruent with the majority of the coping literature reviewed above, which is largely from the western tradition, and indicates that coping patterns for dental anxiety could be culturally and religiously different from what is captured in standard coping taxonomies. Six of the twelve had previously used or were currently using clinical support including sedation, nitrous oxide or cognitive behavioural therapy; the other six had not sought such support, although a supportive, communicative dentist could have a more significant impact than a particular clinical intervention, although this was not explored in this study.

Theme 6: A Spectrum of Severity, a Shared Wish to Be Understood

The anxiety experienced by participants in this sample was not necessarily extreme, but a continuum, from the unease of P3, P6 and P11, occasioned by a specific situation, to the trauma-adjacent anxiety of P2, who noted that ‘severe dental anxiety has become a psychological disorder and not a choice.’ The common theme in this range was a desire to have practitioners grasp that dental fear is not ‘dramatic exaggeration', but rather, ‘a physical involuntary panic'. P10 put it best when he said that ‘people may look calm on the outside but there is a lot of fear and anxiety on the inside’ Future-care participants reported that their care involved treating anxiety as a part of, rather than separate from, dental care.

Synthesis and Clinical Implications

These six themes combine to indicate that dental anxiety in these participants is not just fear of pain but fear of losing control in a situation where they cannot see, stop or communicate what is happening. Rumination (Theme 1) filled with thoughts that occurred days prior and, as physiological sensation (Theme 2), became engrained in the body and was repeatedly cued by aspects of the clinical setting. The practitioner's response was more important than severity at baseline, and was linked to the maintenance of manageable distress (Theme 4): explained and taken seriously, distress remained manageable, even for those who were already calm; dismissed or rushed, distress even exacerbated for otherwise calm participants. Theme 5 described most of the coping strategies that participants discussed, and most of these statements were based on two similar underlying requests, stated in various ways throughout the sample: to be informed of what is happening prior to occurrence; and to be believed when someone seeks assistance to stop.

From a practical perspective, there are several implications that can be made that are tentative because of the possible limitations of the samples. Every practitioner action was requested in a specific way, and explaining each step before doing it was the most consistent. This is directly related to the experience of losing control, which is central to Theme 3. An agreed stop signal, one that was always followed without question, was reported by more than one participant as the condition that made it possible to treat at all. Dismissive language was specifically recognized as the most harmful practitioner response and explicit validation of pain and fear was the most supportive. Out of the sample that was brief, half reported significant distress without seeking sedation or counselling, suggesting that short-term screening for anxiety could bridge this gap between need and access. These implications are congruent with the trauma-informed care (TIC) recommendations that have been recently recommended in the dental literature, which prioritize active listening, transparent communication, and non-retraumatizing care as important clinical skills, rather than add-on features (Heaton & Cheung, 2024; Xu et al., 2024).

Limitations and Suggestions

The findings of this study should be interpreted within the context of a few limitations. The participants used in the final study are still limited, only twelve, not as many as fifteen to twenty participants as originally proposed, so the analysis should be interpreted as a preliminary study of the phenomenon. The degree of overlap in the wording of P1 and P5 was only partially reduced across the two rounds of data collection, and is an outstanding data-integrity issue that needs to be verified against the original recordings or consent documentation before it can be used further in this data set. The analysis was done from written transcripts by one coder, who did not have access to audio recordings, tone, and/or non-verbal cues, and who had no second coder or respondent member check to insure inter-rater or respondent validation.

Another limitation—closely related to the above—is interpretative, as with all reflexive thematic analysis, the boundaries of the six themes reported here are drawn by one analyst, who might have drawn them differently had he found different meaning in the data set, in this case with respect to Theme 6, which is more of a cross-cutting synthesis than a specific domain.

Member-checking and peer debriefing should be done to further validate the themes cited on this data set, and the overlapping transcripts should be compared against pre-existing audiorecordings before additional conclusions are drawn from the data to support the themes. A more extensive and varied sample would enable more confident statements of thematic saturation of the fifteen-to-twenty age group originally suggested. There were also some interesting but under-explored threads in this data set, such as P4's incidental privacy and consent concerns and P10's pre-appointment information-seeking pattern, which could be explored further in future interview guides.

Conclusion

The purpose of this study was to examine the lived experience of dental anxiety by means of a phenomenologically oriented thematic analysis of 12 interview transcripts with adult patients. The six themes identified collectively indicated that for these participants dental anxiety is experienced as a sense of losing control over their own body, which starts to develop before their appointment, continues throughout that appointment with particular sensory cues and is significantly influenced by the behaviour of the health care provider. The results are consistent with previous quantitative and qualitative studies that found a relationship between dental anxiety and avoidance, previous bad experiences and quality of practitioner interaction (Appukuttan et al., 2015; Chidley & Burns-Nader, 2024; Eitner et al., 2006; Peric & Tadin, 2024; Taqi et al., 2023), providing greater detail into how such association could work. Despite the study's limitations, the results add to the continued advocacy for the use of trauma-informed, patient-centered approaches in routine dental care, in which clear communication, agreed stop signs and explicit

validation of patient distress are treated as part of the clinical routine of dental care and not just "good manners" (Heaton & Cheung, 2024; Xu et al., 2024).

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