

**МИНИСТЕРСТВО НАУКИ И ВЫСШЕГО ОБРАЗОВАНИЯ  
РОССИЙСКОЙ ФЕДЕРАЦИИ  
Федеральное государственное бюджетное  
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«ПЕНЗЕНСКИЙ ГОСУДАРСТВЕННЫЙ УНИВЕРСИТЕТ»**

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**Е. Е. Воробьева**

**ПСИХОЛОГИЧЕСКОЕ ВЗАИМОДЕЙСТВИЕ  
ВРАЧА И ПАЦИЕНТА  
В СТОМАТОЛОГИЧЕСКОЙ ПРАКТИКЕ**

**Учебно-методическое пособие**

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**E. E. Vorobeva**

**PSYCHOLOGICAL INTERACTION  
BETWEEN DOCTOR AND PATIENT  
IN DENTAL PRACTICE**

**Teaching manual**

**ПЕНЗА 2025**



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Издание подготовлено на кафедре «Стоматология» Медицинского института Пензенского государственного университета и предназначено для обучающихся по специальности 31.05.03 «Стоматология», а также может быть использовано для изучения раздела «Челюстно-лицевая хирургия», «Терапевтическая стоматология», «Хирургия полости рта» студентами стоматологических факультетов медицинских вузов, клиническими ординаторами и врачами-стоматологами.

The information provided in the teaching manual is necessary for the successful development of the subjects "Psychological aspects of the relationship between dentist and patient", "Psychology and pedagogy", "Propaedeutics". It contains theoretical material, control questions and a glossary.

The publication was prepared at the Department of Dentistry of the Medical Institute of Penza State University and is intended for students majoring in 31.05.03 "Dentistry" as well as can be used to study the sections "Maxillofacial surgery", "Therapeutic dentistry", "Oral surgery" by students of dental faculties of medical universities, clinical residents, and dentists.

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## INTRODUCTION

Today, the profession of a dentist is one of the most sought-after and attractive in medicine. This branch of medicine is dynamically developing and opens up new horizons and prospects for doctors. At the same time, there is a daily competitive struggle between doctors for their clients, so in addition to having professional skills, it is necessary to be able to find an approach to each patient. The doctor must earn the trust and location of his patient, purposefully build friendly relations with him, set him up for a favorable outcome of treatment. In 1947, the World Health Organization defined health as "Health is a state of complete physical, spiritual and social well-being, and not just the absence of disease and defects." Health is a dynamic process that is determined subjectively and objectively. These are the ability to take care of oneself, the integrity of the personality with the optimal functioning of the body as a whole and mental activity, adaptation to stress, as well as the processes of continuous growth and formation of personality.

The knowledge of psychology is widely used in biological and medical sciences, in order to study and identify psychological problems in humans, as well as to find their effective solution. The connection between psychology and medicine has long been proven at the level of theory and practice. The center of medicine is a person and his health. Psychology pays similar attention to a person and his health. Only, unlike medicine, psychology is engaged in the study of human mental health. However, mental health is closely related to physical health. Currently, psychological research methods and techniques are used in medicine as treatments for certain diseases. This is due to the fact that a person's physical condition and the development of psychosomatic diseases depend on their mental state.

In dentistry, where the distance of interpersonal communication is minimal, the patient's comfort will largely depend on the personal characteristics of the doctor. A modern specialist in the field of medicine must have knowledge from the field of psychology in order to provide each patient with effective and full-fledged medical care. A young specialist needs to understand that in order to become in demand in his profession, it is not enough to know only the medical aspects of dentistry, it is necessary to purposefully and competently build relationships with patients. Medicine and psychology are those sciences that provide knowledge about a person, the peculiarities of the development and functioning of his body, and his capabilities. This knowledge will be more complete only with the

interaction of psychology and medicine. The main purpose of communication in both medicine and psychology is to obtain and exchange the necessary information. Moreover, in these two areas, there is a particularly close personality-oriented interaction with the patient (client), who must entrust personal information to the specialist, while the specialist must comply with ethical standards for working with confidential information and build partnerships where the patient (client) is an equal participant in the interaction process. It is very important for students to understand that the formation of an ethical and legal culture of interaction between the main subjects of the treatment process should not be spontaneous, but directed and should be laid at the stage of studying at a medical university.

## **Topic 1. MODELS OF INTERACTION IN THE TREATMENT PROCESS**

**Motivation of the topic.** The outcome of medical care is largely determined by the quality of information exchange and interaction between the doctor and the patient. An important role belongs to the choice of a model of therapeutic interaction, on the basis of which the doctor-patient relationship is built and the general psychological background of communication is formed. Knowing the advantages and disadvantages of a particular interaction model and its informed choice will allow the doctor to form a trusting relationship, an appropriate organizational culture, which will increase the effectiveness of the interaction between the doctor and the patient.

### **The theoretical part**

Modern medical practice is a complexly differentiated system in which doctors can choose different models of social interaction. Each of these models reflects certain traditions of medical practice that exist in a given society at a particular time. To describe the various options for the relationship between medical professionals and patients, American medical ethicist Robert Veatch identified four basic models:

- 1) engineering;
- 2) pastoral (paternalistic);
- 3) collegial;
- 4) contractual (contractual).

These models are unequal in their moral significance and represent a hierarchy from the least morally sound engineering model to the most sound collegial, as well as the most acceptable in the health insurance system – contractual.

**1. The engineering model.** Within the framework of the engineering model, the doctor treats the patient as an impersonal broken mechanism. The task of healing is interpreted as correcting the "breakdown" of the mechanism caused by the action of external or internal factors. In some cases, instead of the category of breakdown, the concept of deviation of the physiological mechanism from the equilibrium position is used. Healing consists in the fact that the doctor, with the help of certain physical influences, seeks to return this mechanism to a position of balance. The engineering model is based on the idea of medical activity as a field of application of objective, value-neutral scientific knowledge, which, like science, should be "on the other side of good and evil." The benefit of the patient is restored health, which is described through a set of objective signs:

biochemical parameters, blood pressure values, gas exchange values, X-ray data, etc. R. Veatch notes that the engineering model is based on an outdated view of the nature of scientific knowledge. As modern philosophy of science convincingly demonstrates, objective knowledge is "loaded" with a significant amount of prerequisites that scientists do not realize, among which personal and group interests, as well as certain moral preferences, play an important role. In principle, criticism of the ideology of the engineering model is justified to the extent that it is a question of the moral mindset of a doctor or scientist. The modern moral standard of medical practice prescribes in the strongest possible way to prevent depersonalization of the attitude towards the patient. For centuries, healing has existed as an activity of an individual professional who personally contacts the patient, makes decisions and provides assistance. Nowadays, it is not uncommon for a patient to be treated not by an individual doctor, but by a collective entity (team). The activity of this collective subject is personified in the context of interpersonal communication with the attending physician. Everyone else is forced, by virtue of their social role and place in the system of division of labor, to perform more or less technical functions.

**2. *The pastoral or paternalistic model.*** Within the framework of the paternalistic model, the relationship between doctor and patient resembles the fatherly attitude of a father to a child or a priest to a parishioner. Actually, in the latter case, the priest is traditionally referred to as father or father, and the parishioner as son or daughter. There is significant progress in the moral transformation of the structure of the relationship between doctors and patients. This is no longer an impersonal manipulation of an object, as was observed in the engineering model. The paternalistic attitude is filled with personal content. It is motivated by the desire to help a suffering person and avoid harming them. Paternalistic healing is built as a kind of interpersonal communication. His moral principles are love for one's neighbor, charity, mercy and justice. However, individuals are in an unequal position at the same time. The doctor plays the role of a "father" who possesses certain scientific knowledge and knows how to apply it to help the patient. The patient plays the role of an ignorant child whose moral prowess lies in the disciplined fulfillment of the prescriptions and appointments of the "elder".

The paternalistic model has dominated medicine for many centuries. It is clearly expressed both in the "Hippocratic Oath" and in the "Oath of the Russian Doctor". Paternalism in dealing with patients remains the norm for a significant number of modern physicians, and not so few patients recognize a paternalistic attitude towards themselves as the most appropriate. What is the moral disadvantage of this model? According to R. Veatch, paternalism infringes on the rights of the patient as an autonomous person who

independently and freely makes vital decisions and controls his condition. There is a humiliation of the patient's personal dignity, since the attitude from "horizontal" – equal – is transformed into "vertical" – subordinate. The patient, figuratively speaking, is forced to look up at the doctor.

**3. *The collegial model.*** In the technical type model, the doctor turns into a plumber devoid of any moral qualities. In the sacred type model, the doctor's moral authority has such an impact on the patient that it suppresses his freedom and dignity. Trying to define the doctor-patient relationship more adequately, while preserving fundamental values and responsibilities, some ethicists say that a doctor and a patient should see each other as colleagues striving for a common goal – to eliminate the disease and protect the patient's health. A doctor is a patient's "friend." It is in the collegial type model that trust plays a crucial role. When two people or two groups of people really stand up for common goals, their trust is justified, and the collegial type model is adequate. This is a solidary way for colleagues to interact. There is equality here in dignity, respect, and a world of assistance that was not inherent in previous models.

However, social realism forces us to ask a difficult question: is there really any real ground for interaction, for common goals and interests, which would allow us to use the model of an unmanageable community of colleagues in a doctor-patient relationship? Some signs of a community driven by real common interests arose in the radical health movement and in free clinics, but nevertheless it must be stated that ethnic, class, economic and value differences between people turn the principle of common interests necessary for a collegial type model into an empty dream. It is necessary to create a model that is more appropriate to the conditions and allows equality between the patient and the doctor in the field of morality, without accepting the utopian premise of collegiality.

**4. *The contractual model.*** Speaking about the contractual model of the relationship between a doctor and a patient, R. Veatch means not only the legal content of the concept of "contract" (contract), but also a more general one. A contract or contract is a specific form of establishing rules for the interaction of various social actors with each other. The specifics of the contract are that these rules are freely developed by the participants, based on mutual interests. By concluding a contract, the parties distribute powers among themselves, establish mutual responsibility, determine the goals pursued and the means to achieve them.

What is the attraction of the contract model as an exemplary structure of the relationship between a doctor and a patient? According to R. Veatch, it is this model that most protects the moral values of an autonomous personality. Within the framework of the contractual model, "... individuals

and groups interact with each other in such a way that each of the parties has certain obligations and each achieves certain benefits... The basic moral principles of freedom, dignity, truthfulness, fidelity to obligations and justice are important for the implementation of contractual relations." The contractual form of the relationship avoids the disadvantages inherent in the engineering and paternalistic model. The patient voluntarily establishes a relationship with the doctor on the terms that he considers beneficial for himself. At the same time, he can delegate certain "authoritative" powers to the doctor so that he can adequately fulfill his professional obligations, having stipulated them with a medical care contract. The contract model is more realistic. It takes into account the impossibility of equality between doctors and patients, i.e. the inevitability of a "vertical" relationship of dependence. However, this dependency is established under certain conditions. If these conditions are not met, then the patient has the right to consider this contract invalid for himself and deprive the doctor of the powers that the latter received by virtue of the contract.

The basic principles of freedom, personal dignity, honesty, and fairness are necessary for a contract-type model. Its prerequisite is trust, even when it is clear that there is no complete reciprocity of interests. Social support is associated with the legitimization of this interaction and ensures its implementation in case of violation of the contract. However, it is believed that in most cases the obligations assumed will be strictly respected. Only in a contract-type model can there be a genuine separation of moral authority and responsibility. It avoids the rejection of morality on the part of the doctor, which is typical of the technical type model, and the rejection of morality on the part of the patient, which is typical of the sacred type model. It avoids false and uncontrolled equality in the collegial type model. In a contract-based relationship, the doctor recognizes that in cases of informed choice, the patient should have the freedom to manage his life. If the doctor does not agree to enter into such a relationship, then the contract is either terminated or not concluded. This means that there needs to be a deeper discussion of the moral grounds on which medical decisions are made before or as these decisions are made.

V. A. Tashlykov identifies two main types of role interaction in psychotherapeutic contact:

**1. Guide:** as an expression of the authority of a specialist, it reflects the traditional medical model of the "doctor-patient" relationship, in which the doctor dominates, takes a leading position, takes responsibility for solving the main tasks during treatment, and the patient remains subordinate, relatively inactive or passive subject of therapy.

**2. Partnership:** as a model of non-authoritarian cooperation, the therapeutic union presupposes the active participation of the patient in the psychotherapeutic process, the development of responsibility and independence, the ability to make a choice between alternative solutions. Russian medical practice has developed two main models of doctor-patient relationships: the paternalistic model – the doctor not only assumes the duties of the patient, but also independently decides how treatment will be conducted; and the autonomous model, based on the principle of patient autonomy, according to which all medical activities are based on an equal dialogue with patients. In order for the patient to make a definite decision, the doctor must inform him about the nature of the disease and the planned diagnostic and therapeutic measures.

For a long time, the paternalistic model prevailed in Russian medicine, which is now being replaced by models based on a patient – oriented approach. However, the adaptation of models of doctor-patient relationships has a number of features. Thus, the practical application of one of the most widespread models in the world practice, the contract model, has a number of features. Due to a number of cultural and historical reasons, paternalism in Russia extended not only to medicine, but also to all spheres of social activity. Therefore, it is extremely difficult to get rid of the paternalistic attitudes of public consciousness. It should be noted that each of the common models is an ideal type and, as a rule, is not implemented in its pure form, although the interaction of the doctor and the patient in one case or another is based on one of the models.

### **Control questions**

1. Explain how the relationship between medicine and psychology manifests itself?
2. How do psychological factors influence the effectiveness of the treatment process?
3. What is the evolution of the doctor-patient relationship in modern medicine?
4. What models of doctor-patient interaction do you know?
5. Which model most fully takes into account the moral – ethical standards inherent in the work of a doctor? Justify it.
6. What is the practical significance of identifying models of doctor-patient relationships?

## **Topic 2. THERAPEUTIC INTERACTION IN CLINICAL PRACTICE. THE COMMUNICATIVE COMPETENCE OF THE DOCTOR**

**Motivation of the topic.** The effectiveness of medical care is often determined by the quality of information exchange between the doctor and the patient. To build therapeutic interaction in the practice of a dentist, it is necessary to take into account the psychological factors of the treatment process and the individual characteristics of the patient. For the formation of a favorable communicative microclimate between a medical specialist and patients, such a component as communicative competence is especially important.

### **The theoretical part**

In its most general form, communicative competence can be described as the experience of interpersonal communication necessary for interacting with people in various fields. The communicative competence of a doctor presupposes the presence of a set of communication skills, as well as the presence of certain professional views and beliefs, which is especially important in the medical profession. At the moment, it has become an axiom that medical care cannot be complete if the most professional doctor does not possess moral and ethical qualities.

It is quite common to hear about the purposeful formation of communicative competence in a particular professional field. The professional activity of a doctor is associated with the development of strategies and tactics of therapeutic impact (creation of a therapeutic alliance) and, therefore, requires the ability to predict events, anticipating the development of not only the disease, but also possible complications in the relationship. The dentist needs to be able to use his communication skills in order to win over the patient, collect information about his problems, listen to his treatment suggestions, evaluate them and inform him so that he himself can make a choice based on the information received. In such circumstances, patients are more attentive to the professional recommendations of the doctor. At the same time, they are satisfied with the medical attention and care provided and, as a rule, become regular customers in the future.

The goal of forming a therapeutic alliance can be achieved only if the dentist has certain professional communication skills. To do this, in particular, he needs to be able to distinguish between factors that contribute to or hinder the formation of a therapeutic alliance.

## Positive factors determining the nature of the dentist-patient relationship

*The psychological factor*, that is, the personal typology of the patient, his emotional attitude, opinion about the state of health and consideration of wishes regarding the upcoming course of treatment. As for the dentist, for this aspect of the relationship with the patient, it is necessary to master some techniques and methods of psychotherapeutic communication with the patient, and not only at the time of examination and diagnosis of the disease, but also at all subsequent stages of the treatment process.

*The factors contributing to the exchange of information within the framework of the dentist-patient relationship* are equally important for both participants in this process. In many ways, the psychosocial component of this interaction helps them both. The dentist's ability to communicate effectively and listen attentively to the patient in the vast majority of cases mirrors the patient's willingness to speak freely and share their experiences, fears and concerns with such an attentive doctor. Understanding the nuances of the relationship between a dentist and a patient largely determines the effectiveness of his recommendations and the patient's response to them. The doctor needs to realize that the patient has the right to be afraid and fearful at a dental appointment, and it is the doctor's duty to help the patient cope with this condition. This approach inspires the patient's trust in the specialist (fig.1).

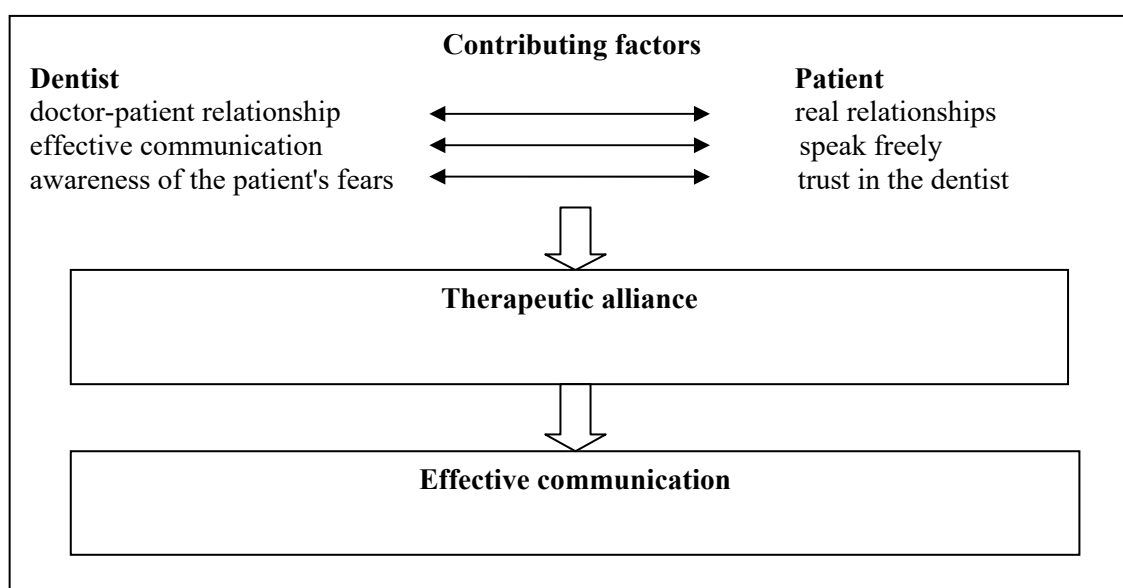


Fig. 1. Factors contributing to the formation and maintenance of a therapeutic alliance

## **The first meeting of a doctor with a patient**

A professional conversation between a dentist and a patient differs from a regular medical interview, which is characterized by a more general and abstract range of topics of discussion. The purpose of such an interview (to collect anamnesis) should be to obtain sufficient information from the patient to understand his problem and decide how to solve it. An interview can be defined as the process of obtaining information through an oral interview. It can be conducted in a free or standardized form. A free interview is a good way to achieve relaxation of the patient as a result of a detailed account of his condition. Its disadvantage is that this form of communication, as a rule, takes a lot of time and has low information content. However, it is an important form of stress relief for the patient. On the contrary, a standardized interview can be very short in time, but informative. Its disadvantages are the violation of emotional contact with the patient, the inclusion of psychological defense mechanisms. The purpose of the interview is to clarify the range of significant problems for the patient related to his personal characteristics, the course of the disease, and methods of social adaptation. Knowledge of these patient characteristics can significantly influence the choice of treatment methods.

Professional interviewing requires skills in building logic and sequencing questions, brevity and clarity, choice of expressions and formulations, voice modulations, pauses, a rich palette of response behavioral reactions, knowledge of the age, gender, educational, cultural, and social characteristics of the group of people to which the patient belongs. Questions should not contain excessive professional vocabulary. Interviews can be conducted in order to obtain information, clarify and test hypotheses, and enter information. Different techniques can be used for this: concretization (for example: when did the first symptoms appear?); verbalization of the experience (what feelings do you experience?); interpretation (if I understood you correctly?); identification of patterns (is it possible to formulate this?); causal analysis (is this a pattern or an exception?); problematization (what's the problem?).

Start the interview with two or three general questions, then move on to the patient's dental problems and their specific manifestations. It should be understood that the doctor is responsible for the content, direction and pace of such an interview, but at the same time it is necessary to avoid introducing elements of edification and moralizing. The doctor should be more interested in establishing a simple human relationship with the patient at this stage, rather than in obtaining factual information. At this

stage, the patient is still unable to speak fluently. A doctor who understands this tactfully conducts a conversation, encouraging the patient to express his opinion freely. The so-called initial questions are used to get more information about the patient, his thoughts about treatment, and previous experience with the dentist. Such questions and answers help to outline the correct treatment strategy. The patient's answers will allow the doctor to give qualified advice about the patient's previously expressed concerns.

The questions that we ask the interlocutor are conditionally divided into open and closed. An open question implies the possibility of a lengthy, free answer, while a closed one implies an accurate, unambiguous answer. At the beginning of the conversation, giving the patient the opportunity to speak out, it is preferable to use open-ended questions: "How do you feel?", "How did it start?" Closed, more directive questions aimed at clarifying specific information and limiting freedom of expression (for example, "What was the temperature in the morning?", "Did you feel worse or better?"), are necessary to clarify the complaints. But if they prevail in the collection of medical history, this can constrain the patient, deprive him of initiative and discourage cooperation. It is not uncommon for a doctor to struggle against both the disease and the person who carries it, instead of a situation of interaction, cooperation between the doctor and the patient to achieve a common goal – recovery. When collecting anamnesis, it is necessary to give the patient feedback. It is useful to briefly summarize the complaints and ask if you have understood it correctly. Then the patient will have confidence that you have heard everything he wanted to tell you, and there will also be an opportunity to correct or supplement his complaints. At the repeat appointment, with the help of feedback from the patient, you will find out how and what your recommendations he followed and what the results were. In this case, you can not only help the patient more effectively, but also learn from his example, receiving confirmation or refutation of your predictions. By controlling the process of the first meeting, the dentist can make this communication more focused. According to R. Masse and F. Legare (2001), for the successful formation of a therapeutic alliance, the initial meeting with a patient should consist of six stages.

**Stage one: creating an empathic atmosphere.** The professional activity of a dentist has a number of specific features, and its success is determined not only by professional knowledge and the ability to implement them in their activities through the development of professional qualities. One of the most important personal and professional characteristics of a dentist is the ability to understand the emotional state of

the patient. In psychology, this is called "empathic listening" – understanding the emotional state of another person and demonstrating this understanding. For example, when interviewing a patient by a doctor, showing empathy means, firstly, understanding the patient's words, feelings and gestures, and secondly, such a manifestation of this understanding that it becomes clear to the patient that the doctor is aware of his feelings. Thus, the emphasis is on the objective side of the process, and having the skill of empathy means the ability to gather information about the patient's thoughts and feelings. The purpose of such empathic listening is to make it clear to the patient that he is being listened to, and to encourage him to express his feelings more fully, which in turn will allow the doctor to form a more complete picture of the topic of the story.

The range of empathy varies quite widely: from a light emotional response to a complete immersion in the world of feelings of a communication partner. It is believed that empathy occurs due to an emotional response to perceived external, often almost imperceptible, manifestations of another person's emotional state – actions, speech, facial reactions, gestures, and so on.

*The following types of empathy are distinguished:*

1. Emotional empathy based on the mechanisms of projection and imitation of motor and affective reactions of another person.
2. Cognitive empathy is based on intellectual processes – comparison, analogy, etc.
3. Predicative empathy is manifested as a person's ability to predict another person's affective reactions in specific situations.

### **The rules of empathic listening**

– It is necessary to tune in to listening: forget about your problems for a while, get rid of your own feelings, try to get rid of ready-made attitudes and prejudices about this person. Only in this case you will be able to feel what the interlocutor feels, to see his emotion. In your reaction to your partner's words, you must accurately reflect the experience, feeling, and emotion behind his statement, but do it in such a way as to demonstrate to the other person that his feeling is not only correctly understood, but also accepted by you.

– It is necessary to keep pauses. After your answer, it is necessary to be silent. Remember that this time belongs to the interlocutor, do not occupy him with your additional considerations, clarifications, clarifications. A pause is necessary for your partner to sort out his experience.

– It must be remembered that empathic listening is not an interpretation of the hidden motives of the interlocutor's behavior. It is only

necessary to reflect the partner's feeling, but not to explain to him the reason for this feeling. Comments like: "In fact, you would like to be noticed all the time," as a rule, can cause nothing but rejection and protection. Especially if these words are spoken at the beginning of a conversation, when trust has not arisen yet.

– It makes sense to use the empathic listening technique only if the person wants to share some experiences with you. If he doesn't want to talk about it with you, but you want to discuss it with him, using empathic listening is impossible. The doctor's task is to help the patient express their complaints and concerns. With verbal and non-verbal stimuli (a glance, a smile, a gesture), he encourages his story, carefully directing the conversation in the right direction. A nod of the head, a movement towards him, a friendly request-a question at the right moment: "About this, please, in more detail", "Did I understand correctly that you have ...?" – all this encourages a person, promotes his frankness, leads him to a more accurate expression of complaints.

To create an empathic atmosphere, the dentist must provide the necessary external environment that corresponds to the atmosphere of conversation, open behavior, and understanding of the meaning of the patient's emotional reactions. Conducting interviews (surveys) in conditions that distract the patient's attention should be avoided. The environment should help the doctor to focus his attention on the patient, listen and observe him. Many dentists set aside a special room for a conversation with a new patient. This allows not only to establish the necessary background for empathic interaction, but also creates the conditions for establishing effective relationships. Such communication increases trust in the doctor and helps to overcome possible difficulties in the treatment process in the future. The time spent during the initial clinical interview is worth a lot. Therefore, if you treat the patient carefully and with interest, then a kind of reward for this will be the information that will help the doctor determine the right path and method of treatment. It is then that the therapeutic alliance begins to form.

**Stages two and three are effective communication.** Free communication is facilitated by encouraging the patient to have a frank conversation. Communication is essentially a two-way process in which the relationship of two personalities is formed: a dentist and a patient united by solving a common problem.

There are a number of key elements in this communication, the main of which are:

- be able to understand the patient without words;
- be able to listen carefully;

- encourage talking;
- be able to ask the right questions;
- be able to empathize.

The doctor should use these skills in accordance with the patient's personality and emotional state. It is important that the dentist pays attention not only to verbal communication, but also to non-verbal communication. The main thing here is to be able to listen, not just like that, but with conscious effort and attention to what is being said and what is being omitted. What the patient does not want to talk about may reflect his concerns, in particular from the experience of visiting dentists in the past and the negative consequences of past treatment or concerns about the cost of upcoming treatment.

***Non-verbal communication.*** Non-verbal communication includes the following elements:

- the speed of speech, its tonality, the interval between phrases;
- eye contact;
- fixation of gestures, body movements.

Non-verbal communication allows the dentist to understand the patient's fears, concerns, and concerns about the treatment process. Therefore, it is important that the dentist constantly maintains visual contact with the patient. The lack of eye contact, glancing at the clock, being distracted by watching recordings or talking on the phone during an interview demonstrates that the doctor is not interested in the patient. On the other hand, attentive eye contact and confirmation of the patient's statements by nodding creates a friendly atmosphere and emphasizes attentiveness and interest in the patient.

***Encouraging the patient to talk is making contact.*** The dentist's task is to help the patient relieve tension and feel free at the first visit to the clinic. This is the essence of the dentist's initial contact with the patient. It is recommended that the patient's first appointment be conducted especially carefully: to build a rhythm of conversation in a friendly tone, without abusing special medical terminology, if possible, not to be distracted by calls, phone calls, not to avoid eye contact, to show a respectful interest in the patient's information. After a certain level of mutual understanding is achieved, the patient will usually feel more relaxed and comfortable. Encouraging the patient to talk gives him the opportunity to speak freely.

The doctor should be able to divide the periods of communication with the patient into several stages: initial, substantive and final, acting appropriately at each stage.

The rules and conditions of social communication usually play the role of an interpersonal "language" at the first meeting. However, in addition to general welcoming phrases, the patient needs to make it clear that they want to help him solve his problems. Sometimes it is very important to repeat to the patient the main thing that he himself told the doctor. This technique (summary) not only indicates that the patient is being given due attention, but also helps the doctor to better evaluate the information received from the patient. It is useful to talk less and listen more, so you can learn more about the patient and establish closer contact with him.

***The ability to ask questions.*** Active listening should be used by the doctor during the interview. At the substantive stage of the conversation, the doctor can use focused questions to encourage the patient to talk in detail about their problem. Focused questions are needed for the desired therapeutic alliance. The patient's answers will clarify the issues raised at the beginning of the interview. The doctor now has the opportunity to provide explanations and advice in response to the patient's concerns. It is important that the dentist's answers are concise, accurate, without special medical terminology, with a more detailed explanation of the main points of the course of treatment, if necessary. The key factors in the clinical history of a patient with pain complaints are primary (localization, intensity, nature of pain, temporal aspects) and secondary (causes of pain increase and decrease, circumstances of pain occurrence).

Often the patient cannot clearly describe both. In this case, the dentist should help the patient, which at the same time gives the doctor the opportunity to get more information he needs. Asking the question: "Do you have a toothache when you chew?" the implied answer is yes or no (closed question). However, when you ask: "When do you feel pain?", you are asking to find out the time ranges of the disease (an open question). If the patient responds that the pain will be his in the middle of the night and absent during the day, then this information highlights the existing condition on a new scale of the problem. In other words, open-ended questions can provide information that the patient had never even thought of sharing before.

The accuracy of understanding a problem often requires clarification. For example, if a patient complains of pain in a particular tooth, he should be asked to describe in more detail the pain he is experiencing. Clarifying questions: "When do you have pain? While eating cold or hot food, or while chewing?" They not only help the dentist to understand the essence of the problem, but also provide an opportunity for the patient to open up

and feel more relaxed in the dentist's chair. Clarifying the details brings vague complaints into sharp focus. By summarizing the patient's explanations, the doctor confirms that the message has been accepted and understood. Summarizing and summarizing the details, the doctor, in turn, draws up his own conclusion about the upcoming treatment plan.

The ability to listen in this contact is the most difficult. It requires concentration of attention, a lot of internal tension and, to some extent, acting skills. During the listening process, it is important not to immediately deny, condemn, praise or comment on anything, but to encourage the patient to speak by guiding him. Try to turn off your opinion and be open to the information that the patient provides you with. Thus, the doctor's ability to actively listen helps establish effective communication with the patient, prevents hasty decisions and ensures the accuracy of diagnosis. At the same time, it is necessary that the doctor understands the importance of both verbal and non-verbal communication. Of course, it is very important to listen to what the patient is saying, but besides that, body language is also quite eloquent. So, erratic, convulsive movements, crossing of arms, clenching of fists often indicate fear, fear of the patient. Realizing this, the doctor can tactfully convey to the patient that he knows about anxiety and is ready to help overcome this condition. This is usually enough to reduce the level of discomfort and anxiety that patients often experience at the reception.

A dentist should always formulate his thoughts, considerations and suggestions clearly and clearly, taking into account the specific situation, the patient's personality and his capabilities. And, of course, confidentiality is a prerequisite for building a trusting relationship with the patient, an important factor contributing to the formation of a therapeutic alliance, which dental practitioners should never forget. Patient trust is the foundation of a therapeutic alliance. A harmonious relationship between a doctor and a patient contributes to the establishment of a state of mutual understanding and trust, and a normal working relationship. If such a relationship develops normally, the patient listens to what the doctor recommends, and he has confidence in the doctor.

The decisive factor in establishing a harmonious doctor-patient relationship is the behavior of the doctor. He needs to be able to listen to the patient without reacting to his inaccurate knowledge of medicine. The patient has the right to his point of view, to misconceptions, to delusions caused by incorrect information obtained from advertising, the Internet and other sources. The doctor's task is to support the patient in what he is right about and convince him of what he is wrong about.

If necessary, the patient should be offered a reasoned way out of a potentially conflicting situation. This position of the doctor gives the patient a signal that a certain mutual understanding has been established between them. The doctor is no longer perceived as an authoritarian threatening figure, he is just a professional who listens to the patient, gives him explanations, discusses possible treatment options. The patient begins to respect the doctor's clinical experience, the validity and expediency of the decisions recommended by him, for example, the immediate manufacture of a partially removable, rather than a bridge-like prosthesis, or, finally, can recognize the importance of home hygiene procedures for health.

**Stage four: understanding the patient's fear and anxiety.**

The doctor's ability to correctly diagnose the degree of fear and anxiety of the patient is an important factor that strengthens the patient's trust in the doctor, thereby helping to further cope with negative psychological stress during treatment. The term "negative dental experience" refers to various conditions, experiences, and unpleasant sensations caused by internal and external stimuli (influences) during dental treatment, as well as associations and memories of them. Physical discomfort experienced and unreacted by the patient is also a form of negative dental experience. Unpleasant sensations are stored in the patient's memory and are usually ready to be reproduced as soon as a similar stimulus begins to act or a thought about it arises. The doctor should not ignore the patient's fear and anxiety, he needs to find out the causes of this emotional state in order to draw up a plan that guarantees high-quality and effective treatment.

**Stage five: creating an environment of mutual understanding.**

A dentist should not dictate his decision. This behavior scares the patient away, destroys the atmosphere of mutual understanding. The doctor's task is to maintain the patient's emerging trust in the doctor, avoiding acting as a strict parent to him. Although it is not always easy to be objective in the working environment of the clinic, you need to strive for this. The doctor should always keep his feelings and emotions, such concepts as likes/dislikes, to himself, focusing on the needs of the patient. Even when the patient expresses critical considerations that the doctor does not agree with, the dentist should not actively respond to this. Be able to tolerate the patient's nervousness or passivity. It should be understood that the patient's irritation, objections, or inertia are not directly related to the dentist. More often they relate to circumstances related to the patient himself. While remaining neutral, make sure that the patient feels comfortable, then the doctor will feel in a normal working condition. Treating a patient with whom you don't feel at ease is doubly difficult.

When a patient feels a sense of trust in the dentist, it means that his opinion of the doctor has changed. The patient's feelings of fear and anxiety disappear, and the doctor ceases to be a strict parent in his eyes. The patient is ready to accept the proposed treatment plan.

**Stage six: joint decision-making on treatment tactics.** The doctor recognized the patient's complaints and concerns, while the patient recognized the professional skill, experience, and empathy of the doctor. The interview usually ends with so-called closed-ended questions. Such questions can be considered as the final tools for clarifying the most important points and problems raised earlier by the patient. Here, the dentist must make sure that the patient has correctly understood everything that was discussed with him earlier. Only then is there a joint decision-making on treatment tactics.

The doctor must be convinced that the patient understands him and agrees with the chosen treatment plan. This guarantees further interaction. By the end of the first meeting, the patient and dentist should understand each other well. The dentist's ability to involve the patient in the process of discussing and adopting a treatment plan that is created jointly is an important step towards forming a therapeutic alliance. The positive result of this process is an agreed treatment plan and the signing of an informed consent document by the patient.

Thus, a successful first meeting will establish reasonable principles of cooperation between the dentist and the patient and at the same time give the doctor the opportunity to register the patient's concerns. Together, they developed a mutually agreed treatment plan. However, this is just the initial stage of a long process. Such an alliance will be strengthened as the patient's trust in the doctor and understanding of his professional skills increase. At the same time, the dentist will become more familiar with the patient's personality and state of health. It should be borne in mind that in most cases, patients leave the dentist after the first visit with a feeling that will affect their future relationship with the doctor. Practicing dentists should keep this in mind.

### **Factors preventing the formation of a therapeutic alliance**

A professional dentist is a doctor who has experience in clinical practice, knows the skills of the profession, is able to withstand workloads, constantly improve his skills and be able to interact with patients and in a team. Such dentists can relatively easily tolerate complaints and complaints

of patients, their emotional outbursts, observing a certain emotional distance between themselves and patients. Nevertheless, some doctors still cannot withstand the psychological burden of the profession (patient complaints, administrative pressure, work and life pace, professional stress, etc.). Under stress, doctors find it difficult to adequately understand and meet the needs of their patients, and they lose the skills to communicate freely with them. As a result, the patient finds himself without the support of a doctor. This situation, of course, leads to the disintegration of the therapeutic alliance, provided, of course, it existed.

If professional skills, skillful communication between the dentist and the patient, mutual trust, goodwill and consent are the key to the formation and preservation of a therapeutic alliance, then there are factors that destroy it (fig. 2).

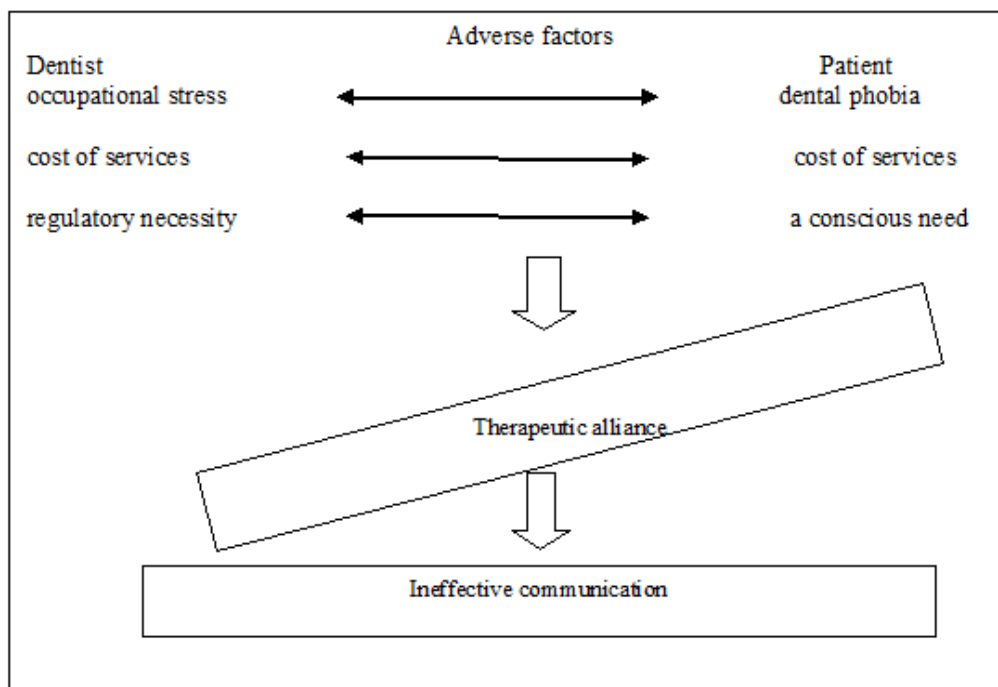


Fig. 2. Unfavorable factors threatening the therapeutic alliance

For a dentist, the inability to establish a normal interaction process is often associated with professional stress or burnout syndrome. For the patient, this is due to the persistence of fear and anxiety.

**Dentist's and patient's views on the need for treatment.** The difference in understanding of the need for dental treatment between a doctor and a patient may cause some difficulties in drawing up a treatment plan. In the dentist's view, the need for treatment is based on his professional knowledge and experience (standards, regulatory necessity); for the patient, such a need is due to past dental experience (felt necessity)

and the ability to freely express their wishes during treatment (expressed necessity). In the process of verbal communication, information is transmitted from one partner to another according to the following scheme (fig. 3).

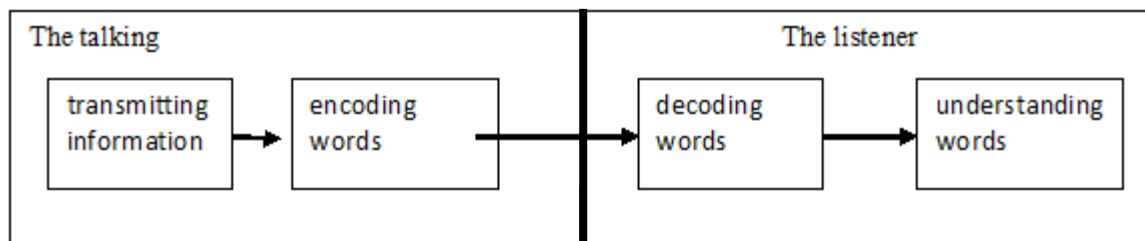


Fig. 3. The process of speech interaction

How the patient decodes the doctor's words depends on many reasons: whether the information is clearly presented; whether he is ready to receive it; whether he is interested in it; whether he trusts the speaker; which is the leading channel of perception for the doctor; which is for the patient, etc.

Feedback can be in the form of:

- 1) speech message;
- 2) non-verbal – implemented through facial expressions, gestures, postures, intonation of voice;
- 3) actions confirming understanding, approval or disapproval to another person.

The inability to use feedback significantly complicates human interaction, reducing its effectiveness. Information may be distorted or rejected by the patient (or doctor) due to barriers that arise during the conversation.

Personal traits and character traits of partners can serve as barriers. These include such qualities as egocentrism (the inability to take the position of another person), the desire for dominance, categoricalness ("There are two opinions on any issue – one is mine and the other is wrong!"), intolerance of the shortcomings of others, aggressiveness. Both overestimated and low self-esteem have an extremely negative effect on the communication process, which is sometimes found in both doctors and patients. A person with low self-esteem is touchy: they may perceive the most neutral situations as infringement of their rights, and they look for an unfavorable subtext in human relations. The apparent need to defend oneself often leads to aggressive reactions, outbursts of anger, and irritation. After all, even laughter and a smile can be interpreted as ridicule or a frivolous attitude of the interlocutor to his problem. Therefore, a smile,

a joke, a compliment – these are the most powerful tools in establishing contact and further communication – should be used carefully by doctors, since they may be faced by a person with low self-esteem, a patient in a state of depression or with a serious, incurable disease, etc.

There may be a barrier of negative emotions in communication. A person overcome with anger or full of resentment is not capable of normal interaction, he is unable to adequately perceive the interlocutor. The doctor, feeling disgust, irritation, and fear towards the patient, is unlikely to be able to understand him correctly. Meanwhile, patients who cause such feelings are found (they may be poorly dressed, untidy, not following hygiene, making unreasonable demands or accusations against the doctor, etc.). The resulting negative reaction is not always realized. Often, medical personnel are afraid of illness, deformity, and death and unconsciously try to isolate themselves and minimize contact with people who cause this feeling. Patients sometimes complain that when they enter a doctor's office, they encounter an atmosphere of hostility, as if they are preventing him from doing more important things. Having realized this fear in himself, a medical professional can and must treat this with due understanding.

There is also a perception barrier in communication. The first moment of perception largely determines the further interaction of the partners, creates an appropriate attitude, which can be either positive or negative (in the latter case, you have to spend a lot of effort to change it in the future). The following elements carry significant information about another person: general appearance, clothes, hairstyle, accessories, voice, and demeanor. Not only the surface perception is important, but also their relevance to the specific situation. The discrepancy between the doctor's appearance and the patient's expectations can negatively affect further interaction, create a sense of distrust, and vice versa. It is advisable to anticipate patients' expectations about the appearance of the doctor (medical office) and try not to shock them with anything extravagant like a short dress, stylized hairstyle or excessive jewelry. If the doctor is very tall, or the dentist is "left-handed", or the doctor is allergic to perfume odors, it is necessary to make sure that patients who have applied for the first time are properly prepared for this.

It must be remembered that non-verbal communication methods play an important role in forming the first impression, which are not always recognized by partners, but often have an impact, such as intonation and timbre of voice, posture, gestures, facial expressions, and gaze. In this case, the very first moments of communication are colored by a positive or

negative information attitude. Thus, the doctor begins to perceive the patient not on the basis of his real characteristics and characteristics, but in the light of assumptions that arose from previously received information about the patient or on the basis of social, national, religious stereotypes.

### **Control questions**

1. Describe the content, goals, and means of communication at the dental appointment.

2. How can the concept of a doctor's communicative competence be characterized?

3. What factors contribute to the creation of a therapeutic alliance between the doctor and the patient?

4. What factors prevent the creation of a therapeutic alliance between the doctor and the patient?

5. Name the stages of the initial conversation (interview) between the dentist and the patient.

6. What communication barriers prevent mutual understanding between the doctor and the patient, and what is the role of feedback in creating a therapeutic alliance?

7. How should a doctor respond correctly to the patient's fear and anxiety?

8. How and why should a dentist take into account the individual psychological characteristics of patients?

### **Topic 3. CONSIDERATION OF THE AGE CHARACTERISTICS OF PATIENTS AT A DENTAL APPOINTMENT**

**Motivation of the topic.** Effective interaction is beneficial for both patients and dentists. The choice of tactics of the dentist's behavior will largely depend on the age characteristics of the patient and situational conditions. There may be situations requiring communication with relatives, where the doctor needs to show sensitivity and competent interaction skills.

#### **The theoretical part**

##### **Age-related features of human development**

It should be borne in mind that patients of all age groups seek dental care. Age affects a person's personality traits and their manifestation. In fact, we cannot compare a patient between the ages of five and fifty in terms of physical, psychological, or social parameters. It is impossible to treat 15-year-olds and 25-year-old adults in the same way, although it is more important for the doctor to determine the psychological age of the patient, which sometimes does not coincide with the actual age. When building relationships with patients, a dentist should rely on knowledge about the age-related characteristics of personality development and take them into account when establishing contact, building conversations, and teaching therapeutic and preventive procedures. Age-related characteristics are a set of physical, intellectual, motivational, emotional, and cognitive properties characteristic of most people of the same age.

Psychological, pedagogical and medical studies have revealed a number of age-related features of human development that allow for various periodizations based on criteria specific to each approach. The most famous are the periodizations of Freud, Piaget and Erickson. The periodizations of Vygotsky and Elkonin are the most common in our country. The latter discovered the law of alternation, periodicity of various types of activities: the activity of one type of orientation in the system of relations is followed by another type of activity, in which orientation occurs in the ways of using objects. The law of alternation and periodicity in childhood development allows us to take a fresh look at the content of developmental crises.

## **Features of the doctor-patient relationship at a pediatric dental appointment**

### **Infancy and preschool age**

A child under 3 years of age finds himself alone with a doctor only in critical cases. More often, the doctor's patient will be a dyad: a child and an accompanying person. The problem of treating a child is a common problem of the child, the parents and the doctor. It will be solved most effectively by combining efforts. Interaction (collection of medical history, recommendations for treatment and care) is built both with an adult, taking into account his age, education, emotional state, and with a child. The biggest difficulties with such patients are the subjective distortion of complaints, since neither the mother nor the doctor knows exactly where and exactly how the child is hurt. They have only observation and objective research methods in their arsenal. Young children are afraid of unexpected movements, harsh sounds, and strangers. Treatment involving unusual sounds and smells, bright lights, and instruments can increase feelings of fear. Since the child's vocabulary is limited, his fear is expressed by shouting and facial expressions. And the children themselves no longer react to words, but to non-verbal characteristics of the treatment: the volume and tone of the voice, the smile or frown on the doctor's face, etc.

Especially at this age, there is a period of fear of strangers. Kids, who used to smile, were friendly and open, suddenly become timid and wary in the presence of strangers. The prospect of being alone in an unfamiliar place, even for a minute, can cause them great anxiety. At this stage of attachment, children often cry and cling to those who care for them. They only look at the doctor with great caution, studying him.

The age period from 3 to 7 years is the period of preschool childhood. The leading type of activity for children is play. The game allows the child to master adult relationships, teaches complex actions, and forces them to obey the rules. Therefore, at the reception, you can invite him to play the patient, to ride him in a dental chair. Some pediatric doctors successfully use the "collaboration" game – hold a cotton wool, a tool, tap here, tap, touch, let's look in the mirror together. Child patients differ from adults in their increased emotionality, mobility, and fatigue. During dental treatment, children of preschool (and primary school age) have pronounced motor reactions of the legs, body, arms and head. Typical movements of protection from the doctor are bringing your hands to your face and turning your head in the opposite direction from the doctor, emotional reactions may appear in the form of tears and grimaces of

protest on your face. There is increased verbal activity, which is expressed in the form of questions: "How many teeth should I treat?", "Which tooth will you treat?", "How many more times will you drill this tooth?" These questions may serve as indicators of a child's anxiety, distress, or fear of treatment, or they may be a common expression of curiosity, since this is the age of the "why". It is important to understand by intonation and other non-verbal signs whether there is anxiety and what exactly it is related to.

For example, a child of 5 years old is at the reception. What is the best way to build a relationship with him so as not to scare him, establish contact, and gain trust? After all, it is the child who will be the patient, only he knows exactly what is bothering him and where. Some doctors initially build relationships in such a way that mom, dad, or grandma act as an intermediary, translator, and performer, while the patient himself is only the object of treatment. Or, going to the other extreme, doctors don't pay attention to parents at all. Until recently, it was believed that the presence of parents during dental treatment of a child was undesirable. Yes, there are parents who are more afraid of the dentist than their child and infect their children with their anxiety. But one child at this age may have experience of being examined by a doctor without parents (regular checkups in kindergarten), and for another, the situation of being left alone with someone else's adult is new and in itself causes stress.

Dentists, psychologists and psychiatrists warn parents about the negative effect of discussing dental treatment in the presence of impressionable young children: stories and experiences passed on from adults to children can work for years as a source of their bad behavior at the reception.

Kudryavaya N. V. (2007): the textbook "Psychology for Dentists" analyzes the factors that provoke negative behavior of children, including:

- Traumatic experience of parents at the dentist.
- Inadequate preparation of the child for the visit (intimidation, lack of explanations).
- Conflicts in the family that affect the emotional state of the child.

Moods and behaviors of parents, sisters, brothers, or peers occur in the same way as the infection of a child with measles from family members or friends. The fears and anxieties of people who serve as models produce similar moods in children as in future patients, forming the foundations of non-cooperative behavior. A number of researchers note that a child attending kindergarten adapts to dental procedures faster than domestic children (J.C. Brauer). It is generally believed that a child's stay in kindergarten helps to increase his level of emotional control and

self-confidence. Gradually, the older preschooler learns moral assessments, which he considers to be the bearer of the closest adults (parents). It is the parents or their substitute family members who serve as an indisputable authority for a child of this age. Therefore, it is very important that parents are present at the examination, are maximally involved in the treatment, and understand what is happening. A detailed conversation with parents will not only calm them down, but also set them up for constructive interaction.

When carrying out preventive measures in kindergarten, you should definitely tell your parents about this at a parent-teacher meeting and try to enlist their support. In this case, the work will be more efficient. In order not to lose the child's trust, one should not say that it will not hurt if a deliberately painful procedure is to be performed. It is more correct to warn the child that it will be a little painful, but he will cope with it. And so that he can regulate his patience, arrange for the painful effect to last as long as he counts to five. If the procedure is lengthy, then it is better to perform it in stages with some children. Sometimes it is necessary to switch the child's attention. For example, if a child is afraid of injections, distracting his attention, you can ask him to squeeze his left fist very hard.

Attention and memory in preschool age are involuntary. The child remembers better what is of the greatest interest to him, emotionally colored. Therefore, it is necessary to have bright posters in the office, but not distracting, but helping the child to remember the recommendations. In addition, drawings of stylized (humanized) body parts or organs (heart, tooth, etc.) with different emotional states are now used to survey children in medical practice – a pictorial pain scale.

The accumulation of practical experience by the senior preschool age, a sufficient level of development of perception, memory, imagination and thinking increase the child's sense of self-confidence. This is reflected in the setting of increasingly diverse and complex goals, which are facilitated by volitional regulation of behavior. By the age of 6–7, a child can strive for a distant (including imaginary) goal. Therefore, he can already be an ally of the doctor, if he is properly attuned to this. It is useful to encourage a child's calm behavior, for example, in some children's clinics there are gifts for "excellent treatment" (a transparent box containing small children's toys from which he can choose something). When children are rewarded for results, they develop diligence. If the award ceremony does not take place in the office, but in a room where other children are waiting for an appointment, this has a positive effect on the next patient at the same time.

### **Primary school age**

The beginning of school is a turning point in a child's behavior, as they are required to learn new knowledge and rules of behavior. The child becomes less dependent on his parents, and his ties with his peers grow stronger. He already knows the world around him better, learns to understand it. He develops a sense of social responsibility and duty. The teacher's opinion becomes authoritative. A child's self-awareness is significantly influenced by successes and failures. Children begin to show willingness to cooperate with the doctor: they enter into a dialogue, understand the need for therapeutic measures and fulfill all the requirements. However, it is always necessary to prepare for a doctor's examination, and for difficult, especially unfamiliar or painful procedures. The conversation should be conducted in a language that is understandable to the child and accessible to his psychological age, otherwise even a well-mannered little patient will find himself alone with a serious problem.

A feeling of self-doubt can lead to a loss of independence and dignity, and in a stressful situation, it is possible to return to behavior typical of early childhood. These children are unable to get in touch with a doctor and understand what they came to the doctor for. A doctor's communication with unruly and disobedient children can be successful if he is able to correctly interpret various aspects of a child's behavior. Children who have had negative experiences with painful procedures or who have heard terrible stories about treatment are afraid of doctors. They require a special approach. The traditional fear of people in white coats and physical pain can be overcome through targeted preparation for treatment. The necessary treatment in this case can also be carried out with the help of sedatives, where a pediatrician's consultation is required. It is better to teach healthy lifestyles and conduct medical and preventive educational programs (for example, oral care) with primary school-age children in groups under the guidance of an experienced teacher. The children will be happy to explain to the doctor and to each other how to perform the necessary actions correctly.

### **Several types of behavior at a children's reception**

***Hysterical or uncontrollable behavior.*** This pattern is characterized by screaming, sudden movements, and other manifestations of temperament, and it is often observed with the use of local anesthesia. In such cases, the fear of treatment is exciting, which is reinforced by the people in the office. This behavior is classic for children who have learned to control their parents and achieve what they want through tantrums.

**Negative behavior.** A passive child, as a rule, sits tensely in a chair, tightly clenching his teeth, tries not to look into the doctor's eyes and ignores any attempt at communication. Typical statements at the same time: "I won't let you do anything with my teeth" or "I won't open my mouth." Most often, these are older children, so they are protected from the orders of their parents and other people involved in the treatment.

**Cowardly behavior.** The consequence of fear before the first visit to the doctor, especially in young children, may be that they become timid and cowardly. In this case, the doctor should slowly and calmly, if necessary repeating the same thing several times, explain to the patient the purpose of the treatment. If the child trusts the doctor, it will be possible to talk about cooperation. Tension, but willingness to cooperate. These children hold on tightly to the armrests of the chair, intently watching every movement of the doctor. Treatment is accepted, but it is accompanied by screaming, for example, during injection. Since the child wants to cooperate, his behavior depends entirely on the actions of the doctor, and the goal of the latter is to gain the patient's trust.

**Whiny behavior.** In this case, crying is used by the child as a compensatory reaction to fear. Sometimes the child allows the treatment, but does not stop crying. The procedure takes a lot of effort and time, and it is frustrating, because despite sufficient local anesthesia, the child complains of pain. This situation can be avoided by gaining the patient's trust and using distracting techniques.

**Stoic behavior.** Such children sit quietly and passively in a chair and do not interfere with the treatment. But they look withdrawn and sad. It deceptively seems that the doctor can relax and just do his job. This behavior is atypical for a child, so it should serve as an alarm signal. You should be very careful with such patients. It is important to adapt behavior and treatment to the emotional characteristics and reactions of the child. Some children, oddly enough, tolerate more difficult interventions well, but they may be greatly frightened by a banal action or any medical instrument. Other children are strongly influenced by praise or encouragement, some children accept cheerful treatment and jokes well, while others accept serious conversation, etc.

E. G. Kiseleva and D. A. Kuzmina identified four working styles of dentists at children's appointments:

- 1) positive;
- 2) negative;
- 3) "silent mastery";
- 4) "carrot and stick".

A positive relationship style is based on respect for the patient's personality, is most effective for forming long-term relationships between dentists and patients of any type of behavior, and is more promising for all medical institutions, but is more common, according to the authors, in private clinics. In the service sector, politeness, gentleness, foresight (prediction) of the patient's reaction to the discussed treatment plan and individual medical manipulations are necessary components of a professional communication style. The doctor's relationship with parents is changing towards a relationship aimed at obtaining informed parental consent for the therapeutic and preventive stages of treatment.

Relationships based on the "carrot and stick" method can have a short-term effect that does not involve further mutual action. This style is only applicable to small children and is not acceptable when working with teenagers and young adults. This style provokes conflicts.

The "silent mastery" style is ineffective for working in a dental office with patients who have a negative attitude towards treatment. Such patients require increased motivation for treatment, verbal psychological correction, positive information about the stages of treatment, and a guarantee of safety and painlessness of treatment. In 1959, H. K. Addelston described a technique for working with children based on the theory of learning. The technique is called "tell-show-do" (RPS). Although the RPS technique only works as an introduction to dental procedures, it is the cornerstone of managing the behavior of a small patient. This style of behavior of a doctor at a children's appointment includes psychological correction, praise and approval.

### **Teenagers or middle school age**

According to the latest World Health Organization (WHO) classification, adolescence lasts from 10 to 20 years (including adolescence and early adolescence). The rapid growth and restructuring of the body, the intermediate position in the "child-adult" system, the inadequate psychological needs of leading activities (educational) lead to a teenage crisis, which generates personal instability and mental tension. Puberty enhances sexual identification. Shyness appears. This should be taken into account when conducting an examination or other medical procedures. Coming to the reception, a teenager can behave quite audaciously, angular movements may seem cheeky. In fact, this is a manifestation of the unstable interaction of hormonal, nervous and musculoskeletal systems. Boys are more characterized by unformed facial expressions, answering questions with harsh, unformulated phrases using slang. Age-related protest can be expressed by deliberately careless, provocative clothes,

jewelry, and makeup. At the same time, a teenager may perceive your gaze as disapproval and ridicule and "bristle with needles of insolence" or withdraw from contact. The protective mechanisms of the psyche allow a teenager to force unpleasant facts out of consciousness, forget them, or help justify and justify his own unseemly act.

It must be borne in mind that a teenager's self-esteem, worldview, and behavior cannot but depend on external influences, no matter how original and independent he may try to appear. A teenager is a member of the group. Therefore, when communicating with a teenager, a doctor should take into account the social basis of such a patient's attitude to the disease and to health in general (the fashion for piercings, braces, or, conversely, the fear of ridicule from classmates). The doctor should also understand that at this age there is a restructuring of relationships with adults: teenagers begin to rebel against their previous guardianship, moralizing, and prohibitions. The course of the adolescent crisis varies in time and manifestations, therefore, when building relationships with patients aged 10–14 and their parents, it is necessary to be attentive to the teenager's self-esteem and to his family situation. When communicating with a teenage patient, keep a calm, detached tone, be friendly, attentive, but be sure to keep your distance. Do not engage in lengthy discussions, especially arguments, and avoid jargon – the patient may become uncontrollable. Take the behavior of a teenager and his appearance for granted according to his age status (even if you yourself were not like that at his age!), communicate as with an adult, but in concise, succinct phrases. Do not ostentatiously separate him from his parents: if for the baby the doctor was an extension of the parents, then for the teenager the doctor is a representative of society, exactly the sphere where the teenager aspires and which is not yet available to him.

### **Early youth**

This is the age that ends childhood. Its peculiarity is that there is a focus on the future and concern for it. At this age, the foundations of one's own worldview are laid: value orientations and moral consciousness are formed. The central question is about the meaning of life and plans for the future. Boys and girls clearly show a desire to critically comprehend everything around them, assert their independence and originality, create their own theories of the meaning of life, love, happiness, politics, etc., while they are characterized by maximalism and a peculiar egocentrism of judgments. As a rule, inadequate self-esteem corresponds to youth. Or it is overestimated: it generates groundless self-confidence, an over-critical attitude towards adults, unrealistic claims, and an overestimation of one's

capabilities. Or, on the contrary, it is underestimated: leading to difficulties in communication, tension, anxiety, isolation, painful reaction to any criticism. The same thing happens with the assessment of one's health status – from overestimating one's physical abilities to constant anxiety, hypochondriac suspicions, excessive and uncontrolled use of all kinds of advertised drugs. However, most often, as long as there are no acute problems, health as such does not serve as a subject of attention for young people, representing a rather abstract concept. An uncritical attitude towards oneself usually leads to disruption of the digestive tract (anorexia, bulimia), early alcoholism and drug use, and an over-critical attitude towards adults prevents a teenager from seeking help in a timely manner.

The need to define oneself in adulthood can lead to another age-related identity crisis caused by the contradiction between the desired personal and professional future and real achievements. This can provoke mental tension, emotional imbalance, and neurosis, and such conditions are 6 times more common in boys between the ages of 14 and 18 than in girls. In dentistry, difficulties with patients of this age arise due to their irregular or untimely visits to the doctor, careless attitude to recommendations on oral care. The main focus of the doctor should be on motivating a healthy lifestyle, based on the desire of young people to look good, be liked by the opposite sex, and be successful.

### **Parents and their influence on dental treatment**

Children learn the basic elements of daily life from their parents, this process is called "socialization", and it is constant and gradual. By the age of 4, children know many of the conventions that exist in this cultural community, male and female roles. The process of transmitting cultural information in early life is called "primary socialization." In industrialized countries, adolescents actually receive information about many aspects of life in schools and colleges rather than in families. This is called "secondary socialization." Primary, family socialization can have a profound and lasting effect. For example, the fear of dental treatment or the time when we first started brushing our teeth is often associated with family influence. Parents consciously, and often unconsciously, shape a child's attitude to their oral health, hygiene procedures, and doctor visits. With this in mind, every effort should be made to involve parents in the process when you offer dental treatment or try to change a child's oral care skills.

Involving parents in the process means that the dentist must enlist positive reinforcement, and not create a sense of guilt among parents. Parents who are accused of neglecting their child's dental health may feel offended or feel threatened by their authority. Too often, flaws in children's

dental health are caused by parents' lack of knowledge, so individual conversations and prevention programs should be carefully planned to avoid any possibility of putting parents in a position of blame. Guilt often leads parents to spend more time looking for excuses for problems than solving them. If parents are convinced that their child has a dental problem that can be solved, they usually respond positively to both the dental counselor and the prevention program itself. It helps especially if the preventive strategy includes a system of positive support elements for the child. Items such as dental cleaning schedules, diet menus, awards for excellent dental cleaning, and allocation of additional pocket money for giving up the habit of thumb sucking can be useful additions to help parents maintain their child's enthusiasm for a particular dental project.

It should be emphasized that prevention programs should be planned in such a way as to include only one main goal in each case. Parents will not be able to cope if too much is expected of them in each case. Programs that involve family involvement have a higher success rate than those that focus solely on the patient. It is interesting to note that families have a more effective effect on the level of dental concern of children. If mothers have a fear of dental appointments, then their children exhibit negative behavior in the dentist's chair. Hence, it is necessary to consider the entire family situation of the child when analyzing the causes of dental phobia or carelessness. One of the main controversial issues in pediatric dentistry is whether parents should be allowed to be present in the dentist's office during the treatment of a child. The child's family, one cannot disagree with this, can provide emotional support during treatment. Without any doubt, the medical profession supports the concept of a "parent living with a child" when a child is hospitalized. However, this issue is not absolutely clear.

The first question that needs to be answered is – Do dentists have an ethical/moral right to prohibit parents from sitting with children while they are being treated? Naturally, parents have their own opinion, and the level of concern may increase if parents feel that their rights are under threat, and the child is exposed to additional stress due to the tense relationship with the medical staff. Parents usually refer to the fact that the pediatrician, for example, always allows parents to attend a medical appointment.

The book on the problems of relationships with children summarizes the advantages of treating a child without parents:

- parents often repeat the dentist's instructions, thereby irritating both the dentist and the child patient;

- parents intercept the doctor's instructions, creating a barrier to the development of mutual understanding between the dentist and the child;
- the dentist cannot use voice intonation in the presence of parents for fear of offending them;
- the child is forced to divide his attention between his parents and the dentist;
- the dentist is forced to divide his attention between parents and the child; Dentists are likely to feel more relaxed and comfortable when parents stay in the waiting room.

A number of studies have determined the age threshold of 8,5–9 years, up to which the presence of parents can have a beneficial effect. At the same time, research shows that most often parents themselves understand whether they have a positive or negative impact on the child's behavior in the dental chair, and when given a choice, they make it right. Ultimately, at the moment it is a personal decision of the dentist, taking into account the concerns of parents and clinical experience. Therefore, the decision to find parents with their children should be made individually in each case, and not implemented as part of a "no parents allowed" policy. Patients with special needs need a high degree of parental involvement in oral health care. This is particularly required for children with educational, behavioral, and physical disabilities. For example, brushing teeth is a difficult cognitive and motor task for many children with disabilities. Parents need to be trained on how to effectively monitor the adequacy of oral hygiene and diet.

### **Features of interaction with pediatric dentistry**

McElroy's "Dentistry for children" said: "Even if the surgical dental treatment was performed brilliantly, but the child leaves in tears, the visit failed." This is the first statement in the dental literature about the criteria for the success or failure of children's admission. The possession of effective communication skills in working with children is of great value, since the ability to communicate with young patients is an important factor for successful practice. Which dentist parents choose to treat their child depends to a certain extent on the information about his professional skills received from family members and friends, but the main driving force will be well-developed interpersonal skills. An important factor worth noting is that the dentist's technical skill is usually assessed by the degree of care and sympathy for the child. This makes it even more important for the dentist to master a good "chair demeanor". Another factor that is highly appreciated and may actually affect the frequency of repeat appointments

is a leisurely conversation with the parents about how the child's treatment will proceed.

The formation of a child's behavior at a dental appointment can be defined as a means by which the staff of a pediatric dental clinic (dental team) not only successfully and cost-effectively treats a child, but at the same time forms a positive attitude towards dental treatment. The entire clinic team should be involved in this process. G. Z. Wright, P. S. Starkey described that regardless of the type of procedures performed, an important goal of the team's work is to gradually, step-by-step guide the child through dental treatment in order for him to acquire a positive attitude towards dentistry. Although the importance of a stable working relationship between a dentist and a patient is widely recognized, however, there are still certain difficulties in establishing standard characteristics of such a relationship. In pediatrics, difficulties in the relationship with the patient have always existed, since the doctor is forced to simultaneously communicate with two subjects – the child and his accompanying person, and with each of them at a certain level. And in pediatric dentistry, unlike in an adult clinic, there is a triangle concept.

The "Triangle of pediatric Dentistry" reflects the great differences that exist between the treatment of children and adults. The doctor treating the child interacts with both the child patient and his parents, that is, he works according to the "1:2" scheme. The "Triangle of pediatric dentistry" suggests another important circumstance – there is a child at the top of the "triangle". This makes the child the center of attention. The base of the "triangle" is usually adults. In the atmosphere of a clinic where children are admitted, the basic rules of the relationship between a doctor and a child should be felt: "optimism", "altruism", "distance", and the prevention of a nervous breakdown during dental treatment should begin long before it. There is a lot of literature on the behavior of children in the dental clinic, where the main idea is that effective communication is a prerequisite for establishing good contact with a child and the basis for the success of children's practice. The higher the doctor's ability to respond adequately to the behavior and problems of the patient and his parents, the more successful the interaction in the triangle of pediatric dentistry is.

The right position to work with a child includes the personal factors of the doctor and the members of the entire team, such as sincerity or interest in the patient, which can be expressed non-verbally. A pleasant smile can tell a child that an adult is sympathetic to him. The personality of the doctor himself plays an important role in communicating with children. Not every doctor can be a pediatrician. Such a doctor should love children, understand the child's world, his confusion in the face of the unknown, and

feel the need to satisfy children's emotional needs. If a pediatric dentist is a friendly, warm-hearted person, it helps to intuitively do the right thing in an unusual situation. At the same time, the doctor must have good communication skills: be able to create an atmosphere of trust, be sincere, organize interaction, be able to clearly and competently explain to the child what will happen during therapeutic manipulations in an accessible and understandable language that corresponds to the psychological age of the patient and his ability to perceive.

The child's behavior is influenced by the scheduling of children's appointments. At the Children's Forum, the American Society of Dentists emphasized the need to follow a schedule so that waiting periods for appointments are minimal. R.E. McDonald suggested scheduling children's appointments in the morning. The basis for such recommendations was morning vigor and lack of fatigue, both for the patient and the doctor. The importance of a child's first visit to the dentist is very important for the entire dental team. During the first visit, many things may be revealed that will allow the doctor to get into the emotional state of a small patient, understand his attitude to dental procedures and help introduce the child to the treatment process. The first visit is extremely important and can become the foundation for establishing a good relationship between the doctor and the patient. The entire dental team should be ready to make this important period of time as pleasant as possible for the patient. To help students and aspiring dentists develop patient interaction skills, we can provide a structure for a successful dental consultation. The proposed model includes six stages and is based on the work of M. B. Wanles and P. J. Holloway (1994).

***Greeting.*** The dentist greets the child, calling him by name. Avoid using typical greetings: "Hello, son! Hello, sweetheart!" because they are general in nature and are not addressed directly to this patient. If parents are present, then include them in the conversation, but do not forget that the child should be the center of attention in the development of relationships. A greeting can be spoiled by moving too quickly to an instruction rather than an invitation. For example: "Hi, Ira, jump into the chair," such an invitation, rather harsh in its form, can damage the relationship. The greeting should be used to make the child and parents feel calm before proceeding to the next stage.

***A preliminary interview.*** This stage has three goals: to find out if the patient or parents have any special problems or concerns, to determine the patient's place in the clinical environment, and to assess the patient's emotional state. The proposed conversation sequence is one of the ways to maximize its effect.

– Start the conversation with questions unrelated to dentistry. It is useful to record the necessary information about children who have already been to the reception before, such as the names of siblings, school, pets and hobbies.

– Ask an open-ended question, such as, "How are you? Do you have any problems with your teeth?" Listen to the answer and ask the next question if necessary. Too often dentists ask a question and then ignore the answer! By talking about general topics and noting what the child says, you offer a certain degree of control and reduce his level of concern and fear.

***A preliminary explanation.*** At this stage, the goal is to explain the clinical or preventive tasks set in a way that is understandable to parents and children. This is a vital part of any visit, as it determines the viability of the dentist as a person who knows what the ultimate goal of the treatment process is and is willing to spend his time and effort discussing the problem in a language that everyone understands. It should be emphasized that accurate information cannot be offered to the patient or parents until the doctor has a complete picture of the problem and a treatment plan based on reliable information. This requires the doctor to take an all-encompassing look at the patient and should not be completely focused on dental problems. It's so easy to lose the trust of parents and children if you find yourself in the position of a doctor apologizing for hastily made clinical decisions.

Thus, a preliminary conversation determines the situation before the actual clinical activity begins.

***The healing process.*** It is important to maintain verbal contact. Make sure that the patient is not experiencing pain, talk about what you are doing, address the patient by name to demonstrate personal interest, explain everything that is unclear. At the end of the treatment stage, it is useful to summarize what has been done and give preventive dental care recommendations.

***Recommendations on oral hygiene.*** Although offering advice to parents and patients is a necessary thing, in many cases dentists treat hygiene education issues carelessly.

The key ways to improve the value of the advice offered are as follows:

- make the advice specific, formulate a personal problem for the child that he needs to solve;
- provide simple and accurate information;
- do not set goals related to behavior change that the patient is unable to achieve;

- make sure that your advice is understood correctly and is not treated in any other way;
- offer your advice in such a way that the child and parents do not feel threatened or blamed;
- if you are trying to improve oral hygiene, avoid theoretical reasoning, offer a practical demonstration;
- reinforce your advice positively on repeat visits.

The final part, related to hygiene education, boils down to setting the task. The dentist defines in simple terms what the patient should try to achieve by the next visit. This implies some form of contract, and as such it helps both children and adults to have a clear understanding of how they can improve the hygienic condition of the child's oral cavity. Always try to ensure that your planned goal is well thought out and presented in a positive, friendly manner.

***Separation.*** This is the final stage of the visit. It should be clearly marked so that everyone knows that the appointment is over. The patient should be addressed by name with a clearly worded farewell. The goal is for the patient and parents to leave the hospital with as much goodwill as possible. Obviously, not all therapeutic techniques can be broken down into these six stages. However, the basic rule – giving the patient maximum attention and personal treatment – should never be forgotten.

### **Features of dental treatment for the elderly**

Due to the demographic processes taking place in the world and in Russia, there is currently a rather sharp increase in the proportion of elderly people in the total population of the country. According to WHO experts, by 2005, more than 1 billion people in the world had passed the age of 60. By 2012, the number of pensioners in Russia exceeded 38 million (that is, a quarter of the country's population). If the aging process continues at the same pace, the proportion of elderly people in our country will exceed 50 % of the total population by the middle of this century. One of the founders of Russian gerontology, I. V. Davydovsky, believed that there are no calendar dates for the onset of old age. Another well-known gerontologist, N. F. Shakhmatov, who developed an approach to the problems of aging from the perspective of biological patterns and trends, considered mental aging as a result of age-destructive changes in the higher parts of the central nervous system. He sought to prove that, although the aging process is a natural process of age-related changes in organs and systems during ontogenesis, it has a pronounced individual character. The place and time of occurrence, the predominant spread, and the rate of progression determine various forms or variants of mental

aging, as well as life expectancy. Therefore, even from a biological point of view, it is difficult to identify a certain date for the onset of old age. The term "aging", proposed by WHO, indicates the gradualness and continuity of the process.

Gerontopsychology (geronto + psychology) is a branch of gerontology and age psychology that studies the peculiarities of the psyche and behavior of elderly and senile people. Although interest in the problems of mental characteristics and changes during aging has existed for a long time, the emergence of gerontopsychology as a scientific discipline is primarily due to social reasons: an increase (absolute and relative) in the number of elderly people, problems with their working capacity and lifestyle. Gerontopsychology studies the change and interrelation of common physiological and psychophysiological characteristics during aging, as well as psychological behavioral features, personality shifts caused by changes in the nature of activities and value orientations. The task of gerontopsychology can be called the search for means of prolonging an active and fulfilling human life. According to the classification of the WHO Regional Office for Europe, aging (old age) lasts for men from 61 to 74 years, for women – from 55 to 74 years. Old age begins at the age of 75 (advanced age). The period over 90 years is longevity.

The society is trying to improve the quality of life of the aging population by increasing the number of various services that ensure the preservation of diverse opportunities for the elderly: continuing personal development, adaptation and communication in changed social conditions, maintaining an active lifestyle. Tourism programs are actively developing in Europe, and special educational programs are being developed in many countries, such as the University of the Third Age in Kaliningrad, Kazan and other cities. Therefore, the issue of maintaining health, including dental, for such a significant part of the country's population is very relevant both in the present and in the future. The dental care system should be guided by the changed demographic situation. Due to the progressive aging of the population, attitudes towards the elderly and senile in the healthcare system have begun to change in recent years. Medical professionals today clearly see that without knowledge of the inner world of the elderly, it is impossible to rationally build a strategy and tactics for the medical care they need. The dentist and all participants in the treatment process remain the key element in the process of both therapeutic treatment and communication with the elderly patient and his relatives. Therefore, when attempting to generalize observations of the elderly and

elderly people undergoing dental treatment, it is necessary to outline the main lines of behavior of the doctor when communicating with elderly patients.

Elderly patients, due to their psychological and physical characteristics, are not always able to understand their situation and assess the health-threatening risks. Many patients of the older age groups experience memory loss and a decrease in the speed of mental reactions, which, along with the burden of accumulated chronic diseases, does not contribute to the assimilation of unfamiliar medical information. Elderly people who enter a medical institution may not always realize their situation and assess the threatening risks. Today, there is an opinion that elderly patients should be considered as a vulnerable group of the population, requiring representation of their interests by third parties due to the fact that it is difficult for them to independently exercise their rights and protect their legitimate interests. In difficult cases, it is recommended to appoint guardianship in the form of patronage, since in accordance with civil legislation patronage can be established over an adult capable citizen. The use of patronage in the provision of medical care to elderly and senile patients will allow them to exercise their rights with the participation of their legal representatives and legally regulate the professional duties of medical workers.

The consent received for treatment in the older age groups of the population requires special communication from the doctor. It is important to understand aspects such as sensitivity to cultural issues and generational issues. It is necessary to be aware of the patient's prospects, attentive listening, and it is very important to encourage positive changes in the patient's condition. In oral hygiene education, advertising material with a clear and accessible presentation of information is of great help. As a person's age increases, his dental status is significantly influenced by a number of factors of the aging body and the environment, which must be taken into account during the dental examination of the patient.

The most important of them are considered to be:

- biological age-related changes;
- concomitant diseases and medications;
- nutrition features (frequency of meals, restrictions);
- bad habits (smoking, alcohol);
- behavioral habits (oral hygiene);
- availability of dentures;
- possible dry mouth;
- frequency and reasons of dental visits;
- possible physical limitations.

It is important to consider that elderly people in our country today, more than any other group, are exposed to unfavorable social factors. The sense of social insecurity has most significantly affected these most vulnerable groups in psychological and economic terms.

Moreover, according to a long-standing belief held for decades, many dentists treat patients from older age groups as individuals who are simply living out their remaining years, and providing them with qualified dental care is not seen as a priority.

Most elderly patients visit a dentist due to acute pain or for prosthetics. As a result, the dentist usually does not consider the patient's dental problems comprehensively, and in the context of a clinic setting, they often lack the time and desire for a lengthy patient interview. Instead, they limit themselves to treating the problematic tooth and providing recommendations for prosthetics. If the doctor fails to observe certain ethical considerations during the conversation, some patients may experience emergency conditions such as fainting, hypertensive crises, or allergic reactions, which could have been avoided by choosing the right communication approach.

Every elderly patient should be approached by the dentist with a comprehensive understanding of their dental issues, the development of a general treatment plan for this group, and its consistent implementation. After all, dental caries can be prevented at any age, and progressive periodontal disease can be significantly slowed down by regular professional prevention, just as progressive tooth loss can be stopped or slowed down by timely and rational treatment, and disorders of the masticatory functions of the maxillary system are restored by dental prosthetics.

As a person ages, their vision, hearing, and the functioning of all sensory organs gradually weaken. Reduced efficiency, memory, and attention are noted. Gradually, vitality and mobility diminish, and once highly active individuals become more passive. There is a decline in mental activity, a sharpening of characteristic traits, and the development of emotional instability. A lack of self-control makes a person irritable, quick-tempered, aggressive, or, conversely, insecure, depressed, and tearful. It is important to note that all of this also affects the immune system – elderly people are more susceptible to various diseases.

Elderly individuals are troubled by any life changes and easily become anxious, often over minor issues. With age, people tend to become more conservative in their judgments and actions and are prone to moralizing.

However, old age is not homogeneous, and not everyone reaches it with the same outcomes. The specific characteristics of old age include high social activity, a need for recognition, and a fear of losing health and strength, leading to dependence on others. This is particularly important for doctors working in gerontology to understand.

Tooth loss during this period often coincides with unfavorable social changes: reduced demand at work, children leaving home, the death of parents, an increase in the number of deaths among friends, and a decline in overall physical health. Lost teeth remind the patient of their physical deficiency and necessitate interactions with doctors, decision-making, and regular trips from home at specific times.

Thus, when working with elderly patients, dentists should consider certain characteristics:

- **Psychological:** slowed reaction, preoccupation with details; a tendency to focus more on subjective painful and other unpleasant sensations, a desire to report them to the doctor, increased sensitivity to stimuli, distrust in the effectiveness of treatment, and indifference to its results. Old age is sometimes accompanied by a lack of communication, which can lead to certain disorders: a person may start talking aloud, develop suspiciousness, and experience distorted perception (often auditory). In advanced age, some skills are lost, signs of losing control over emotions appear, irritability sets in, and the range of interests narrows, while memory and attention weaken.

- **Social:** concern about the cost of treatment, choosing a medical facility based on location (due to difficulty in moving around) rather than professional qualifications, and the need for assistance from relatives.

- **Physical:** the development of diseases, a decline in immune system function, and a slower metabolism. The need for orthopedic treatment increases. Changes in the digestive system increase the risk of oral diseases.

It is in old age that certain mental disorders may arise. Treatment of such patients should be carried out in close cooperation with relatives and doctors of other specialties (psychologists, therapists, psychiatrists, etc.).

During visits, a key condition for the effectiveness of verbal interaction with the patient is the dentist's compassionate and kind attitude. Conversely, provocative statements, rude jokes, and insolent remarks can undermine the entire treatment process and spoil the relationship with the patient. It is no secret that in practice, a dentist's popularity often depends not so much on their professional-technical skills but on their ability to connect with the patient and find the right approach. On the other hand, if a

doctor meets the patient in a disheveled state, unfriendly, in a non-work environment, and later makes unfortunate remarks, they will not gain trust, and the treatment or prosthetics may not yield the desired effect. It should be remembered that indifference and lack of interest are the main reasons for complaints about medical staff among elderly people.

The waiting time for the doctor is also important: long waits cause unpleasant tension. Some patients wait patiently, while others lose patience. Those waiting often exchange opinions about prosthetics, doctors, and the cost of treatment, which influences their subsequent behavior. Some encourage each other by discussing the outcomes of prosthetics. There are also patients who are skeptical about their doctor's abilities, often due to past failures in prosthetics. Such patients negatively affect the mood and emotional state of others. Pessimism and distrust can be exacerbated by careless remarks from medical staff, such as comments about the difficulties of fixing a prosthesis. Measures should also be taken to prevent "consultations" from overly talkative auxiliary staff (nurses, dental technicians, orderlies).

Individual or group work with patients waiting for an appointment is of great importance for prevention and treatment. Much depends on the room where they wait. Stands, models, the range of necessary materials, and the design of the offices should help calm patients and give them confidence that they will receive the necessary assistance here.

In the dental status of elderly patients, in addition to diseases caused by the natural aging process, the following are often present:

- multiple pathological conditions;
- non-specific manifestations of disease;
- rapid deterioration of condition if diseases are left untreated;
- high frequency of complications;
- the need for rehabilitation.

With the establishment of the International Association of Gerontology (IAG) in 1983, the concept of "gerontostomatology" became more widely adopted. This field views the science of dental care for elderly individuals primarily as a discipline within dentistry, rather than a specialized branch of gerontology. When developing strategies for dental care services, it is essential to base decisions on priorities determined by demographic trends, epidemiologically justified needs for dental care, and its effectiveness. Additionally, it is crucial to consider the attitudes of elderly individuals toward the condition of their teeth and oral cavity, their perception of dental care, and their fear of high costs.

Dental treatment for elderly patients should be comprehensive, involving collaboration among general dentists, surgeons, and orthopedists, while taking into account the patient's somatic conditions.

The dentist must develop a comprehensive treatment plan, which requires the following steps:

- ***conduct a thorough health assessment***: since systemic diseases can cause or exacerbate dental issues, the dentist should ask questions in a language the patient understands, maintaining ethical sensitivity;
- ***identify dietary factors*** negatively affecting teeth and oral mucosa;
- ***detect harmful habits*** (e.g., smoking, alcohol consumption) that increase the risk of oral mucosal diseases and worsen periodontal conditions;
- ***identify occlusal issues***, overhanging fillings, and poorly fitted crowns or prostheses;
- ***detect chronic oral sepsis*** sources, such as deep periodontal pockets or apical periodontitis;
- ***identify carious teeth*** as potential sources of oral sepsis and causes of complications like pulpitis or apical periodontitis;
- ***screen for preclinical symptoms*** of maxillofacial tumors through lymph node palpation.

One of the most challenging and pressing issues in dentistry is the adaptation of elderly patients to dental prostheses. The success of removable prosthetics largely depends on the patient's subjective attitude, which is influenced by painful reactions and the prolonged adaptation period. In 40 % of cases, difficulties in adapting to removable prostheses are linked to the patient's mental state. Prosthetic failures may result from insufficient psychological preparation or a lack of effective communication between the dentist and the patient. The orthopedic dentist's deontological approach, tailored to the patient's personality traits, can facilitate better adaptation to prostheses and prevent conflicts.

Experience from developed countries (e.g., R. E. Peterson, G. D. Slade) shows that the prevalence of chronic diseases and high disability rates among the elderly can be reduced through adequate therapeutic and preventive measures aimed at improving quality of life. Dental health is a critical component of overall health, necessitating the creation and implementation of specialized programs for elderly individuals (G. N. Pakhomov, Z. Antoloivska).

A rational treatment plan for elderly patients should include the following, based on individual indications:

- ***eliminating risk factors*** for dental diseases;

- ***educating patients*** on proper oral hygiene techniques tailored to their dental status (e.g., presence or absence of removable or fixed prostheses), including the use of additional hygiene aids;
- ***treating dental caries***, pulpitis, and apical periodontitis;
- ***extracting severely damaged or non-restorable teeth***;
- ***providing prosthetic solutions***;
- ***implementing follow-up systems***, with patients recalled for check-ups at least once a year.

Elderly patients often experience chronic and degenerative diseases due to age-related physiological changes. In the maxillofacial region, progressive atrophy of periodontal supporting tissues is common. Kidney function in 70-year-olds is 50 % lower than in 20-year-olds, and liver function, along with associated metabolic processes, is also reduced. Impaired excretory function of the kidneys and liver can lead to slower drug elimination, resulting in higher drug concentrations and prolonged circulation in the body. Similarly, age-related decreases in drug distribution volume and plasma protein binding can lead to higher blood concentrations of medications.

When performing local anesthesia in elderly patients, dentists must exercise extreme caution, considering the following aspects:

- ***changes in the pharmacokinetics*** of local anesthetics in elderly patients;
- ***reactions to local anesthetics*** that are more common in elderly patients;
- ***interactions between local anesthetics*** and other medications.

## **Control questions**

1. What are the age-related developmental characteristics of humans?
2. What are the unique aspects of the dentist-patient relationship in pediatric dentistry?
3. What types of behavior in children during dental visits are you familiar with?
4. What role do parents play in the dental treatment of children?
5. What are the dynamics of the "pediatric dentistry triangle" (dentist – child – parent)?
6. What categories of elderly individuals are defined in the WHO classification?
7. How can and should dentists account for the individual psychological and physical characteristics of elderly patients? What are the specific considerations in dental treatment for elderly patients?

## Topic 4. CONFLICTS IN DENTISTRY AND THEIR PREVENTION

**Motivation of the topic.** Healthcare professionals of all specialties require knowledge of modern conflict theory and practice, skills in professional conduct during conflict situations, and the ability to regulate conflicts while optimizing interactions with staff and patients. These competencies help prevent misunderstandings and foster collaborative relationships.

### The theoretical part

#### Defining the concept of "conflict"

Conflicts in society are inevitable. When faced with conflict, people typically find ways to resolve it in the end. However, few reflect on the phenomenon of conflict itself: its causes, mechanisms, or resolution strategies.

Initially, scientific inquiry focused on conflicts between state authority and society, between social groups, and between individuals and authority. Later, attention shifted to socioeconomic, political, interethnic, and eventually interpersonal and group conflicts. Various disciplines – philosophy, economics, political science, psychology, and sociology – studied these conflicts. Over time, the need arose for a systematic analysis of socially significant conflicts and behavioral tactics for individuals or groups. By the mid-20th century, this led to the emergence of a dedicated field called **conflictology**.

Since multiple disciplines study conflicts, there are numerous definitions of the term. Some sociologists argue that conflict must involve a specific variable: *disagreement* (R. Derendorf). Others claim conflict arises from resolvable differences or conflicting interests (K. Thomas, R. Axelrod).

The **behaviorist approach** focused primarily on observable conflicts, such as interpersonal and intergroup disputes. This method sought connections between external stimuli and behavioral responses, summarized as the "stimulus = reaction" formula. Applied to conflicts, this became "situation = conflict behavior," implying that situational factors drive conflict.

Psychologists from other schools define conflict as a distorted state of emotions, attitudes, or relationships. Early management theorists viewed conflict as a sign of poor organization or ineffective leadership. Until the 1960s, scholars aimed to create utopian "conflict-free" models of harmony.

However, human diversity in interests, positions, and perspectives made this unrealistic. Later research highlighted the **positive functions of conflict**, such as expressing contradictions, driving progress, and filtering ideas. Consequently, conflictology shifted toward studying conflict origins and effective resolution strategies.

While definitions of conflict vary, all center on **contradiction**. We propose distinguishing between:

- **Conflict**: a conscious contradiction between individuals or groups, accompanied by attempts to resolve it amid emotional tension.

- **Conflict situation**: opposing views, positions, goals, or methods of achieving them.

Thus: **Conflict = Conflict Situation + Incident**.

Conflict is inherently social and personal. It requires subjects capable of self-awareness and recognizing the "self" and "other." Without this, conflict becomes a deadlock.

**Conflict is always accompanied by significant psychological tension, fueled by what psychology refers to as personal content.** A conflict situation escalates into a full-blown conflict when contradictions acquire personal significance. These contradictions may matter more to some, less to others, or be entirely indifferent to a third group, while appearing trivial on a universal scale. As long as there is no clash of personalities, there is no conflict – only differing opinions or judgments about the same subject.

**The subjects of a conflict** can include not only individuals but also organizations, teams, social classes, ethnic groups, and more.

**The object of a conflict** is the variable (component) that characterizes any conflict. A thorough analysis of this object is always necessary, no matter how intense the conflict may be. The subject of a conflict can be something material or spiritual, around which opposing opinions and actions form. Alongside the real subject of a conflict, there may also be a **false subject**, which masks the true cause. This false subject is often linked to the incident or trigger that provokes the conflict's development.

**A conflict situation** represents the initial, pre-conflict stage. Its indicator, or external manifestation, is the state of tension in the relationship between the subjects. Tension is a specific state of consciousness and corresponding actions of the subjects, indicating their awareness of emerging contradictions and the impending need to resolve them.

## Classification of conflicts

Conflict situations can arise from mismatches in personal values across various aspects: religious, ideological, professional, or interactions that provoke hidden resistance or irritation. Sometimes, unclear or uneven distribution of responsibilities (e.g., a part-time dentist required to perform the same workload as full-time colleagues) or failure by management to fulfill obligations can lead to conflict. Ambiguous or incomplete information (e.g., unclear grading criteria), misunderstandings, reliance on rumors or inaccurate facts, or breaches of confidentiality (e.g., disclosing a diagnosis) can also serve as conflict triggers (fig 4).

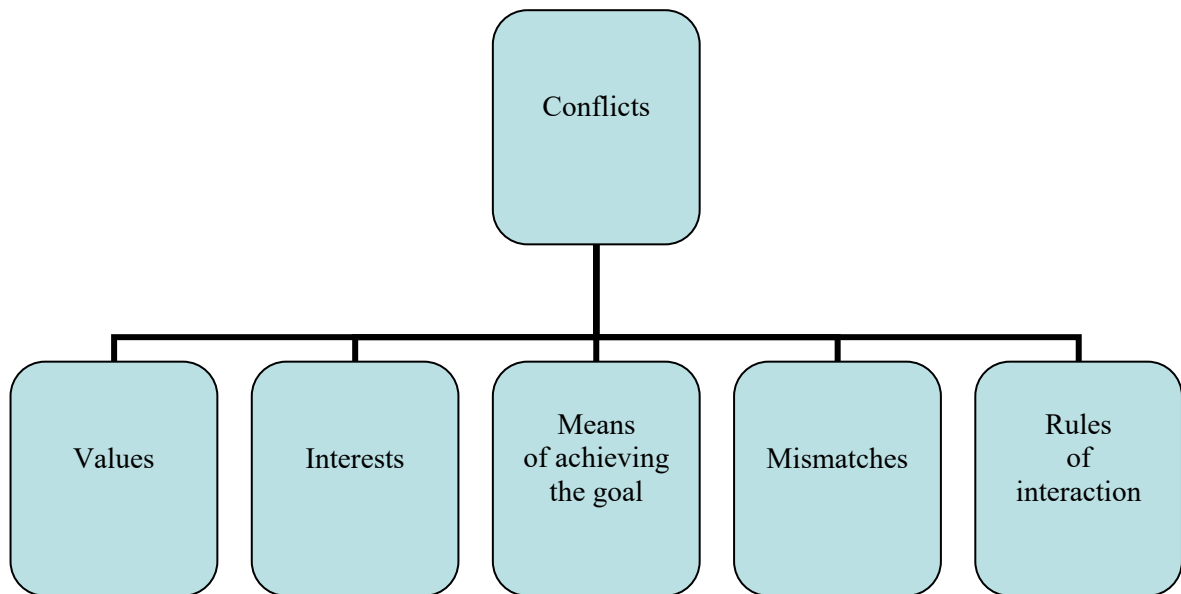


Fig. 4. Typology of conflicts

In **value conflicts**, disagreements revolve around the value-based and meaningful aspects of interaction. For example, participants may have different understandings of the purpose and goals of their shared activities. For one employee, the profession of a dentist is a true calling, driving them to work passionately, continuously improve their skills, and strive for the highest quality patient care. Another dentist, however, may lack interest in practicing as a clinician, showing no initiative despite fulfilling their required duties. Here, the contradictions touch not on behavioral norms but on the value-based and meaningful aspects of the individuals' core beliefs.

This does not mean that differing value systems inevitably lead to conflicts. People can work together successfully and maintain good relationships despite their differing values. A conflict arises only when one person begins to intrude into the value sphere of another.

In **conflicts of interests**, two scenarios are possible.

1. **Resource conflicts**: when interests align but participants compete for limited material factors – such as space, time, facilities, financial rewards, or similar resources – the conflict is termed a **resource conflict**. Each party seeks to obtain the desired resource (e.g., new equipment) or a more favorable share of it (in terms of quantity or quality). While they share the same goals, their interests clash due to resource scarcity. This category includes all situations involving distribution issues or competition for possession of something (e.g., a residency or postgraduate position).

2. **Conflicting interests**: the second scenario arises when partners have opposing interests. Through their interaction, they intentionally or unintentionally hinder each other's ability to achieve their goals. For example, part of a study group may want to move classes to a weekday evening to free up Saturdays, while students who work after classes disagree. Similarly, some clinic staff may agree to pursue professional development during non-working hours, while others refuse to sacrifice personal or family time.

Participants in an interaction may share common values and goals but differ in their approaches to achieving them. A **conflict over means** can arise even when values and goals differ. People may coexist peacefully with differing value systems, but if one person's chosen methods harm the collective effort or other participants, problems emerge. For instance, you might tolerate a colleague's indifference to their duties, but if they try to shift part of their workload onto you, a conflict situation arises.

**Conflicts of mismatches** relate to the participants' capabilities and the alignment of expectations with their abilities. These conflicts can take various forms. For example, someone may be unable to contribute adequately to a shared goal due to incompetence or physical limitations. Such situations are common: a student who fails to meet their responsibilities, performs poorly, or is consistently late may provoke dissatisfaction from the instructor, affecting the entire group. This creates problems for others and can gradually escalate into a conflict.

Another variation of these conflicts stems from significant disparities in intellectual, physical, or other capabilities among participants. Such situations arise because the overall outcome of an activity depends on the sum of individual efforts, and a "weak link" can either diminish the collective result, harm the clinic's reputation, or even obstruct certain actions.

**Conflicts of interaction rules** can arise when any participant violates accepted norms or established rules, causing harm to normal

interaction or relationships. These include situations where disagreements stem from individuals failing to fulfill their obligations to others, breaching commonly accepted etiquette or group-specific norms, overstepping their authority, and so on. Such conflicts may also emerge from attempts by one participant to revise rules and norms, redistribute power or responsibilities, increase the rights of some while reducing those of others, or change the rules within the existing system.

**Based on the number of participants**, psychological literature identifies four types of conflicts:

- *intrapersonal conflict* (within an individual);
- *interpersonal conflict* (between individuals);
- *conflict between an individual and a group*;
- *group conflict* (between groups).

**Intrapersonal conflict** arises when an individual faces a dilemma or a problem of choice. It is a clash between "want" and "cannot," "should" and "do not want," a struggle between needs and social norms, desires and limitations, necessity and possibilities. Should you stay late at work, as required by professional demands, or rush to the institute where your presence is needed? Should you take a job that pays well but fills you with disgust? If the pros and cons seem equally balanced and making a choice feels overwhelming, you are experiencing an intrapersonal conflict.

**Causes of intrapersonal conflicts** may include:

- *Loss of ability to work* due to injury or severe illness, leading to a growing mismatch between needs and diminished capabilities. Failure to resolve intrapersonal conflicts can result in heightened emotional tension. The individual may either lash out at others (turning the conflict into an interpersonal one) or retreat into illness.

- *Conflicting instructions* given to a nurse by the head nurse, doctor, and department head simultaneously can cause emotional strain.

- *Contradictory demands from parents* can contribute to the development of neurosis in a child.

**Interpersonal Conflict** is a conflict between two, or less commonly, three or more individuals (where each acts in their own interest). It typically arises when people have differing value orientations, interests, potential capabilities, views on means to achieve goals, or rules of interaction, as well as when personal relationships between partners change.

- *Vertical conflicts* are interpersonal conflicts where the parties are at different levels of a hierarchy, meaning they have different rights and authority.

– **Horizontal conflicts** involve contradictions between individuals of equal status.

Interpersonal conflicts unfold differently depending on the relationship between the parties. If the conflicting parties have a positive attitude toward each other, both sides strive to find a way out of the conflict. If one partner has an ambiguous or negative attitude toward the other, the relationship may remain unresolved for a long time. If one partner feels positively toward the other while the other feels negatively, this creates a **conflict of hopelessness**. Their relationship will remain in a state of incompatibility. Psychologically, the side receiving negative treatment perceives the conflict more acutely, though the other side also experiences significant emotional tension.

There are also situations where the same person evokes both positive and negative feelings simultaneously. Any attempt to get closer to them is quickly halted, as closeness intensifies the desire to distance oneself and break off the relationship.

**The dynamics of interpersonal relationships in a healthcare setting is shown in the fig. 5.**

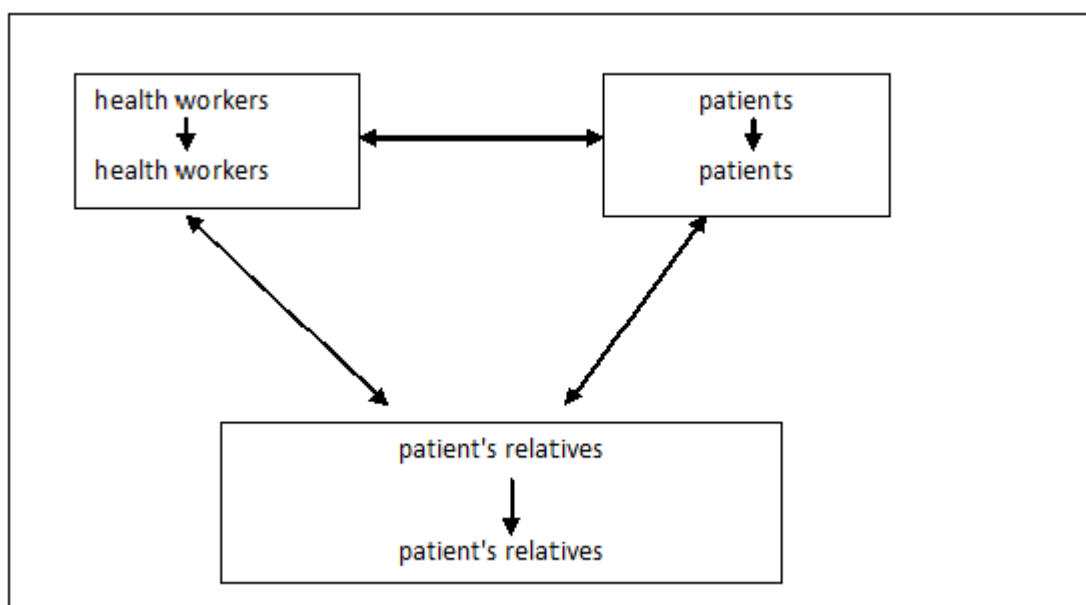


Fig. 5. The scheme of interpersonal relationships in Medical Institution

If an interpersonal conflict remains unresolved, the participants may seek support from others, and the conflict escalates into an **intergroup conflict** or a **conflict between an individual and a group**.

**Conflict Between an individual and a group** can arise as a consequence of an interpersonal conflict when one party gains support for their

position. Examples include conflicts between a teacher and a group of students, a patient and medical staff, a doctor and a patient's relatives, and so on.

This type of conflict can also occur when an individual rejects the group's values, fails to adhere to its behavioral norms, or does not meet the group's social expectations – essentially, when someone brings their own rules into an established group.

A common cause of such conflicts is the mistake of transferring old habits into a new environment, such as a new employee insisting, "But this is how we were taught!" or "Your methods are outdated!"

It can also manifest as a conflict between a leader and subordinates when the leader adopts an authoritarian stance, disregarding the opinions, desires, or needs of the team.

Additionally, this type of conflict may arise between a creative individual and society.

**Group conflict** can range from everyday disputes (between neighbors) to international wars, from momentary arguments (a quarrel in a queue) to eternal conflicts (like the generational clash between "fathers and sons"). These include religious and ethnic conflicts, as well as disputes between scientific schools or departments within a hospital. **Intergroup conflict** occurs between groups or subgroups within a single collective. It can arise between formal groups (e.g., the day shift accusing the night shift of poor patient care), between formal and informal groups (e.g., hospital staff believing the administration is unfair and resisting its directives), or between informal groups.

### **Dynamics of conflict**

Based on the intensity of contradictions, conflicts can be categorized as follows:

- 1) discontent;
- 2) disagreement;
- 3) confrontation;
- 4) dispute;
- 5) quarrel;
- 6) strife;
- 7) altercation;
- 8) clash;
- 9) argument;
- 10) scandal;
- 11) hostility;
- 12) war (physical fight).

**Discontent** – a feeling of dissatisfaction – is the first sign of an emerging conflict. It manifests through facial expressions, gestures, tone of voice, and sometimes verbal remarks. Discontent is not yet a conflict, as the individual may not fully understand its cause – the underlying contradictions remain on the periphery of consciousness. Discontent indicates that a contradiction has arisen between the parties. If left unresolved and allowed to accumulate, it becomes more defined and turns into **disagreement**.

**Disagreement** – a divergence in opinions or views that hold personal significance for the parties. Disagreements are recognized and voiced by one or all parties involved. If the parties fail to resolve their differences, the conflict escalates to **confrontation**. At this stage, the parties have fully grasped the contradictions, and each knows (or believes they know) what they want. The desire to achieve their goals intensifies. If no constructive solution is found, **confrontation** turns into **conflict**. This may involve constant arguments, mutual grievances (justified or not), broken relationships, verbal abuse, scandals, or even physical altercations. Resolving such conflicts is difficult, as the focus shifts to specific words and actions, overshadowing the original conflict. This is a destructive (dead-end) approach, as each party defends their own interests without considering the others. The initial conflict may remain unresolved, and the relationship reaches an impasse. Time or skilled mediators may help in such cases.

**Constructive conflict resolution** leads to a positive outcome, as both parties reach a new, higher level of understanding by learning to consider each other's interests.

### **Strategies of behavior in conflict situations**

To describe how people behave in conflicts, K. Thomas proposed a two-dimensional model of conflict management. The two key dimensions are:

1. **Cooperativeness** – focusing on the interests of others involved in the conflict.
2. **Assertiveness** – emphasizing the defense of one's own interests.

Based on these dimensions, K. Thomas identified five strategies of conflict behavior (fig. 6).

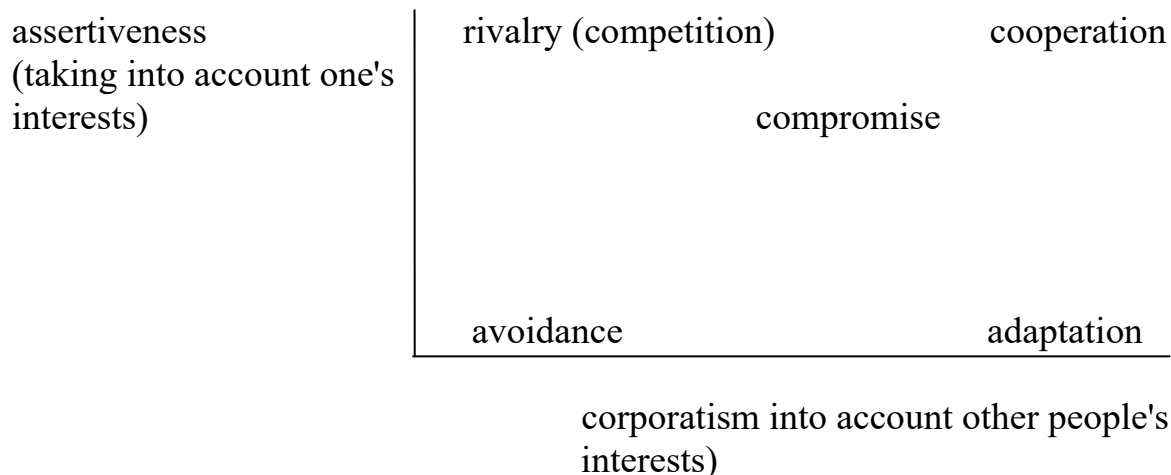


Fig. 6. Strategies of the behavior in conflict

Historical and cultural stereotypes can lead to the choice of an ineffective strategy. The harsh ideological standards of our past were more focused on intolerance, struggle, and uncompromising (remember the battles for crops, the conquest of nature, etc.), and, on the contrary, the mention of a tendency to compromise actually sounded like an accusation of unscrupulousness. These ideas have undoubtedly left their mark on the spread of rigid strategies of behavior in conflict situations, straightforward polemics, and negotiation. "Retreat without a fight" is a behavior that, if not condemned, is often regarded as a sign of weakness. Everyone wants to be strong, authoritative, and cool, and if society sees strength not in the ability to cooperate intelligently or compromise, but in fighting to the end, then people will choose confrontation.

When you are in a conflict situation, to solve a problem more effectively, look at it from the outside and consciously choose a strategy for your behavior. At the same time, one should take into account one's own style, the behavior of other people involved in the conflict, as well as the nature of the conflict itself.

**Avoidance** (withdrawal) is a behavior in a conflict situation that is expressed in self-withdrawal, ignoring or actually denying the conflict. The forms of avoiding solving a problem can be different: you remain silent, shutting out the discussion of the issue, defiantly retire or resentfully leave with a complete rejection of further friendly and business relations with the "guilty" party, sarcastically making remarks about opponents behind their backs, etc.

The reason for choosing this strategy may be:

- self-doubt and self-reliance, fear of losing;
- uncertainty of one's own position on this conflict issue;

- the desire to gain additional time for serious preparation for participation in the conflict;
- the lack of authority, finances, and time;
- the fear of losing something.

If you choose avoidance as your behavior strategy, then you can save time and nerve cells, but further eliminate the influence on the course of events.

The conflict will either be resolved without taking your interests into account, or it will not be resolved and will grow and deepen. Avoidance, however, can be useful in a situation that does not directly affect your interests, or when your involvement in resolving a conflict situation does not affect its development. It is likely that if you try to ignore the conflict, not show your attitude towards it and change the subject, leave the room or do something that will delay the showdown, the problem may eventually resolve itself. If not, then you can deal with this problem later when you are ready for it.

**Adaptation** is behavior that manifests itself in changing one's actions and attitudes under real or imagined pressure from the opposite side, sometimes to the detriment of one's own interests. It looks like this: you pretend that everything is fine, even if something hurts you very much, you prefer to put up with what is happening so as not to spoil the relationship, at first you silently agree, and then you harbor resentment or plan revenge or try to find workarounds to achieve your goal.

A strategy of adaptation is resorted to if:

- the conflict situation does not affect vital goals;
- maintaining a relationship is more important than defending one's interests;
- the outcome is much more important to the other person;
- they realize that the opponent is right;
- there are more important interests at the moment;
- the other has more power;
- they believe that the other person can learn a useful lesson from this situation;
- they can achieve the goal in a roundabout way;
- brute force or authority is used.

Adjustment and conflict resolution may be a reasonable strategy if a dispute over minor differences can ruin a relationship.

There are cases when conflicts resolve themselves during the normalization of friendly relations. However, in the event of a serious conflict, the adjustment strategy prevents the resolution of the dispute, as it does not change the situation and does not give the partner the opportunity

to find out the real reason for your dissatisfaction (irritation). It is better to use this style when you feel that by giving in a little, you will lose little. If you feel that you are giving in to something important for yourself and feel dissatisfied with it, then an adjustment strategy is unacceptable. It is also not suitable if you see that the other person may not appreciate what you have done and is not going to sacrifice something in turn.

The strategy of adaptation is a bit like withdrawal (avoiding conflict), because it can be used to delay the resolution of a problem. The main difference is that you act together with the other person, participate in the situation, and agree to do what the other person wants. If you choose an avoidance strategy, you are not doing anything to satisfy the other person's interests. You just push the problem away from you, walk away from it. Rivalry is one of the strategies of behavior in a conflict situation, characterized by the achievement of individual or group goals in a confrontation with partners.

**Rivalry** (or competition) is usually characterized by your strong involvement in the struggle, activating all your potential capabilities while completely ignoring the interests of your opponent. The basic principle of this strategy is: "In order for me to win, you must lose!", "We will not stand for the price!"

In behavior, rivalry is manifested in the fact that you (or a colleague, boss, patient, etc.) strive at all costs to prove your case, resort to pressure on the opponent (try to convince, argue, use authority, authority, or even physical force), demand unconditional consent and obedience, call for help allies who strengthen your position. Very often, people see only one way out of a conflict situation: the partner must abandon his position and accept their point of view, admitting his wrongdoing or even guilt. If this seems to be the only acceptable way out of the situation for a person, then he will stubbornly defend his position, impose his point of view on his partner, and deny his arguments. In fact, he is not looking for a solution to the problem, there is only one possible solution for him – his own. Sometimes a person believes that he is absolutely right, and does not understand why others do not see it. Sometimes he is prevented from listening to the arguments of another person by the habit of always gaining the upper hand in an argument, dominating, and wanting to be the first. In some situations, it may be that the partner causes an emotional protest and a desire to disagree because of the tone he has chosen unsuccessfully in this situation, a harsh, inappropriate joke or negative experience of a past relationship.

Thus, the reasons for choosing this strategy of behavior in a conflict situation may be:

- the need to protect their interests: life, image, professional, family, etc.;
- the desire to set a priority, striving for leadership;
- distrust of people in general, including opponents, attributing negative motivation to the partner's actions;
- egocentrism, inability to look at the problem objectively;
- critical situation that requires an immediate solution.

A rivalry strategy is justified if you take control into your own hands in order to protect people from violence or reckless actions. This can be effective when you have a certain amount of power, you know that your decision in this situation is the most correct one, and you have the opportunity to insist on it. Especially if the decision-making time is limited, and irreparable events may occur during a long discussion. When you take all power into your own hands, ignoring other opinions, your authority may drop somewhat, but you will gain supporters if you quickly get a positive result. However, this strategy rarely yields long-term results - the losing side may not support a decision made against its will, sabotage its implementation, or secretly or explicitly put a stick in the wheel (any oppression provokes protest). A company that unnecessarily harshly exploits its employees may suffer from a strike or the departure of the best specialists. A marriage in which one side suppresses the other usually ends in complete collapse. Parents who demand complete obedience from their children often face deception.

**Compromise** is the resolution of a conflict situation through mutual concessions. Each party reasonably lowers their level of demands. Compromise can take various forms: you and your partner may yield to each other to maintain friendly relations, or your strengths may be equal, leaving no option but to divide the desired object (or unwanted responsibilities) equally. In this case, both parties seek a fair outcome from the very beginning.

Typically, a compromise is chosen for the following reasons:

- the desire to achieve at least a partial win;
- recognition of the values and interests of others;
- the desire to be objective;
- when negotiations have reached a deadlock, and compromise is the only way out.

The compromise strategy can be useful in situations where both parties have equal power and mutually exclusive interests. Compromise may sometimes be the last opportunity to reach a solution that allows you to preserve the relationship and gain some benefit. You may choose this strategy from the outset, especially if you want to reach an agreement quickly.

However, compromise requires certain negotiation skills to ensure that each participant gains something. Equal division is often a fair solution: if we cannot increase the size of the item being divided (a bonus, a computer, or space), equal access to the available resources is already an achievement.

If a compromise is reached without thoroughly analyzing other possible solutions or on unequal terms, it may not be the optimal outcome of the negotiations. Neither party will be satisfied with the decision.

**Collaboration** is a behavior strategy that prioritizes finding a solution to a specific conflict situation while satisfying the interests of all parties involved. Collaboration operates under the motto: "I want everyone to win!" It involves finding ways to engage all interested parties in the conflict resolution process and striving for mutual benefit for everyone collectively and individually.

This strategy requires more time than other approaches of conflict. You need to spend time identifying the hidden interests and needs of the parties, listening to each other, and then developing various solutions to the problem.

The collaboration strategy is most effective when:

- the solution to the problem is very important to both parties, and neither wants to completely withdraw from it;
- there is time to work on the problem;
- the parties are able to articulate their interests and listen to each other;
- the participants have equal power or are willing to ignore differences in status to seek a solution on equal terms.

The goal of collaboration is to develop a long-term, mutually beneficial solution.

Conflict resolution experts believe that in **avoidance (withdrawal)**, neither party succeeds; in **rivalry**, **accommodation**, or **compromise** – one wins and the other loses, or both lose. Only in **collaboration** – both parties emerge as winners.

### **Methods of conflict prevention**

When analyzing any type of conflict, both objective and subjective causes of its occurrence can be identified. In some cases, an individual's perception of a situation may be far from reality (e.g., due to incomplete or unverified information), but their reaction will be based on their perception. Conflict is always a subjective-objective relationship (interaction) that occurs in a social environment. Since it exists both in reality and in the minds of the subjects, the causes of conflict and

behavioral strategies are formed not outside this interaction but within it, perceived and evaluated differently by the subjects from their own perspectives.

For example, an analysis of conflicts in one of the dental clinics in Kherson showed that the ratio of complaints about the low professional level of doctors to complaints about tactless behavior toward patients was 1:8. The dominance of personal grievances is due, on the one hand, to the emotional tension of patients, and on the other, to the low communicative competence of doctors and their lack of attention to the process of interacting with patients. Doctors also feel the pressure of conflicts. A survey of Moscow dentists with over five years of experience revealed that 24 % of respondents "often feel that they have unresolved conflicts with colleagues," and 36.5 % agreed with the statement that "conflicts or disagreements with patients or colleagues take a lot of energy and emotions."

While focusing on objective causes and conditions, it would be a mistake to underestimate the role of intra-subjective factors, including irrational ones: self-esteem, attitudes, emotional state, traditions, mentality, and even instincts.

### **Behavior in conflict**

Conflict behavior is characterized by high levels of physical and psychological tension, as even a hidden confrontation requires concentration of energy and significant mental and emotional resources to resolve the situation. The more complex and significant the conflict, the more energy it demands. If we cannot handle the tension, we may lose control, violate accepted communication boundaries, and later regret our actions, blaming ourselves for losing control or others for provoking the outburst. Sometimes, a person cannot calm down, repeatedly replaying the situation in their mind, revisiting what was said, and searching for alternative reactions. Even when they understand the need to let go of a minor incident, they persistently return to it in their thoughts. Negative emotions arising from the conflict can quickly shift from the problem to the opponent's personality, adding a personal dimension to the conflict.

There are various ways to help oneself (or others) reduce emotional tension when dealing with conflict. While there is no standard algorithm, there is a set of methods from which one can choose the most suitable for a specific person and situation.

#### ***Individual methods for managing conflicts:***

– *Analysis of the situation and selection of optimal behavioral strategies.*

- *Three-position assessment of the situation.*
- *Emotional release:* autogenic training, pedagogical pause, fitness, etc.
- *Visualization:* working with mental imagery.
- *"I" renaming:* reframing one's perspective.
- *Psychological cushioning:* adapting to the partner's state and expectations.

### **Types of conflict-prone personalities in dental practice**

Psychologists identify five types of conflict-prone personalities you may encounter in a dental setting:

#### **1. *Demonstrative conflict-prone personality:***

- seeks to be the center of attention;
  - wants to look good in the eyes of others;
  - relationships with others depend on how they treat them;
  - enjoys superficial conflicts and admires their own suffering and resilience;
  - rational behavior is weak; emotional behavior dominates;
  - plans activities situationally and struggles to implement them;
  - does not avoid conflicts and feels comfortable in conflict situations;
  - often the source of conflict but does not see themselves as such;
- Strategy:* provide maximum attention, and if a conflict arises, manage it rather than avoid it.

#### **2. *Rigid conflict-prone personality:***

- has an inflated self-esteem;
  - constantly seeks confirmation of their importance;
  - fails to account for changes in situations or circumstances;
  - straightforward and inflexible;
  - struggles to accept the doctor's point of view and disregards their opinion;
  - takes expressions of respect for granted;
  - perceives hostility from others as an insult;
  - lacks self-criticism regarding their actions;
  - highly sensitive to perceived or real injustices.
- Strategy:* show maximum patience and attention to their opinion, and speak and act authoritatively.

#### **3. *Unmanageable conflict-prone personality:***

- impulsive and lacks self-control;
- their behavior is unpredictable;
- acts provocatively and aggressively;

- often ignores social norms in the heat of the moment;
- has a high level of entitlement;
- lacks self-criticism;
- tends to blame others for failures or troubles;
- struggles to plan activities or implement plans consistently;
- learns little from past experiences, even negative ones.

*Strategy:* avoid discussions or arguments with them, and do not try to convince them of your point of view. Act confidently but be prepared for potential issues.

#### **4. *Overly precise conflict-prone personality:***

- meticulous about everything;
- sets high standards for themselves and others, often making people feel criticized;
- highly anxious and overly sensitive to details;
- tends to overreact to others' comments;
- may suddenly cut off relationships if they feel offended;
- suffers internally, dwelling on their mistakes and failures, sometimes leading to health issues (insomnia, headaches, etc.);
- lacks strong willpower;
- does not deeply consider the consequences of their actions or the motives of others.

*Strategy:* be extremely attentive and polite.

#### **5. *Conflict-Avoidant Personality:***

- unstable in their evaluations and opinions;
- easily influenced by others;
- internally contradictory and somewhat inconsistent in behavior;
- focuses on immediate success in situations;
- lacks a clear vision of the future;
- highly dependent on others' opinions, especially those of leaders;
- excessively seeks compromise;
- lacks strong willpower;
- does not deeply consider the consequences of their actions or the motives of others;
- easily persuaded but may feel deceived after leaving the room and listening to others.

*Strategy:* patiently convince them that the choice made together with you is the most correct one.

### **Preventing Objective Causes of Conflict**

To address objective causes of conflicts, management methods can be used:

- Clear formulation of requirements, rules, and evaluation criteria for behavior.
- A well-defined hierarchical structure and the use of coordinating management mechanisms.
- Identification of main goals and the formation of shared values.
- A balanced reward system that prevents clashes between departments or employees.

### **Eliminating Subjective Conflict-Causing Factors**

To address subjective causes of conflicts, it is necessary to:

- possess skills for friendly communication with others, especially difficult or conflict-prone individuals, minimizing the risk of provoking conflict;
- be able to overcome one's own negative attitudes toward situations in interpersonal communication.

### **Constructive methods of resolving conflicts**

The primary task of a dentist is not to avoid conflict, which is potentially possible in all social relationships and situations of internal choice, but to recognize and manage it to achieve the best outcome. To analyze a specific conflict and its dynamics, it is important to identify all parties involved, as well as the party initiating the conflict and the one dominating it. These are not always the same individuals. The person who provokes confrontation is often not the leader but the follower. Only by fully understanding the situation can one begin to resolve it.

It is easier to resolve a conflict situation than a full-blown conflict. If you are ready to act constructively before emotions escalate and true contradictions are hidden behind personal insults and past grievances, then:

- analyze the specific situation;
- choose an appropriate strategy, evaluate its possible outcomes and consequences;
- decide on a procedure for resolving the conflict and begin implementing it.

The chosen strategy depends on the importance of the decision, the assessment of the needs and desires of all parties, the stage of the conflict, and the nature of the emotions involved. Serious conflicts always involve the emotions of the participants. Thus, one of the first steps in resolving an ongoing conflict is to reduce the negative emotions it generates, both your own and those of others.

To improve conflict resolution and prevention, you can use the rules of conflict-free behavior outlined by O. N. Gromova:

– **Evaluate your actions and those of your opponent objectively**, avoiding false perceptions such as the "illusion of your own nobility," "searching for a speck in someone else's eye," or double standards.

– **Look at the situation from the opponent's perspective** to understand (though not necessarily accept) their point of view.

– **Avoid making judgmental statements** about the opponent's actions or words to prevent aggressive reactions.

– **Involve even less competent opponents** in discussions to show that their position is respected, they are equal participants in finding a solution, and they share responsibility for it.

– **Personally inform the opponent** about your position and interests to prevent them from relying on distorted or false information and to avoid misunderstandings.

– **Avoid expressing negative emotions** in communication. If you lose control of your emotions, pause the discussion until you regain composure to prevent triggering similar emotional reactions from the opponent.

The strategy of resolving conflicts through collaboration requires the following four steps:

1. Identify the needs behind the desires (claims) of both parties.
2. Determine how the differences can complement each other (sometimes the problem resolves itself at this stage).
3. Promote joint problem-solving ("not opponents, but partners").
4. Develop new solutions that best satisfy the needs of each party.

Collaboration does not always lead to success, but if you start resolving the conflict this way, you are more likely to achieve better results.

The Australian Conflict Resolution Organization, established in 1986, develops and promotes skills to shift from confrontational thinking to collaboration. Some of these skills include:

– **Do I want to resolve the conflict?** (Be ready to solve the problem.)

– **Am I seeing the whole picture or just my corner?** (Look broader!)

– **What are the needs and concerns of others?** (Describe them objectively.)

– **What could an objective solution be?** (Generate as many options as possible. Select those that best meet the needs of all parties.)

– **Can we solve this together?** (Let's work as equals.)

- **What am I feeling?** (Are you too emotional? Can you: look at the facts; let emotions cool; share your feelings?)
- **What do I want to change?** (Be honest. Attack the problem, not the person.)
- **What new opportunities are opening up for me?** (Focus on the positives, not the negatives.)
- **How would I feel in their place?** (Let the opponent know you understand them.)
- **Do we need a neutral mediator?** (Could a third party help us understand each other better and reach acceptable solutions?)
- **How can we both win?** (Seek solutions that consider the needs of all parties.)

Sometimes, tension in relationships escalates to the point where communication, let alone conflict resolution, seems impossible. Each side begins to threaten, coerce, and retaliate. Such actions provoke counteractions, leading to conflict escalation. In such situations, attempts to propose collaboration are often perceived as weakness and exploited.

If the opponent takes steps toward reconciliation, respond enthusiastically. "Tit for tat" (or rather, "concession for concession") is an attempt to collaborate and forget grievances while not allowing oneself to be exploited.

The collaboration strategy loses effectiveness in situations where the conflict ceases to be a means to an end and becomes an end in itself. This happens when open confrontation is preceded by long-accumulated tension or hostility. In such cases, the conflict becomes a means of expressing these emotions. For the participants, the opportunity to express accumulated hostility and emotions becomes more important than the actual subject of the conflict.

## **Control questions**

1. What is the difference between a conflict and a conflict situation?
2. What is most often the object of conflict in dental practice?
3. What are the typical causes of conflicts?
4. What conflict resolution strategies does K. Thomas identify? What are their pros and cons?
5. What are the main differences in the collaboration strategy?
6. What is conflict prevention?
7. What are constructive methods of conflict resolution?

## CONCLUSION

This teaching manual is recommended to a dentists in connection with the specifics of their work:

- the dentist works in a confined space with people experiencing health problems and in a state of emotional discomfort (tension, fear, fear, etc.);

- the doctor is in close proximity to the patient, in an intimate area communication, which contributes to involuntary resistance, tension, and a number of psychological defenses;

- the doctor has to cooperate with a diverse group of patients (with children and their parents, adolescents, the elderly), taking into account psychological characteristics will help the doctor in daily clinical practice;

- the dentist constantly interacts with a person who is expecting or experiencing pain, is negatively emotionally inclined, experiencing fear, which also affects the psychological well-being of the doctor himself.

The specific conditions of the dentist's activity impose special requirements on the level of his general psychological culture, on his psychological competence, in particular, in the field of communicative communication. Labor efficiency can be called a derivative not only of professional knowledge and skills themselves, but also of the ability to balance a set of mutually psychological relationships: dentist-patient, as well as to implement them qualitatively in their practical activities.

## GLOSSARY

**Authoritarianism** is a person's tendency to overpower other people, suppress their initiative, and use coercive measures.

**Aggressiveness** (hostility) is a person's behavior towards other people, which is characterized by a desire to cause trouble, harm.

**Autoaggression** is a type of aggressive behavior in which hostile actions for some reason (mainly social – when the object that caused the aggression is inaccessible, too strong, or somehow invulnerable) cannot be directed at an annoying object and are directed by a person at himself.

**Autoaggression** manifests itself in a tendency to self-abasement, self-blame, sometimes in self-inflicted physical injury (nail biting, hair pulling), in particularly severe cases – in suicide attempts (suicide).

**Adaptation** is the adaptation of the sensory organs to the peculiarities of the stimuli acting on them in order to best perceive them and protect the receptors from excessive overload.

**Altruism** is a character trait that motivates a person to selflessly come to the rescue.

**Ambivalence of feelings** is a contradictory emotional experience associated with an ambivalent attitude towards a person, an object, or a phenomenon. Simultaneous manifestation of sympathy and antipathy, love and hate, attachment and disgust, acceptance and rejection.

**Apathy** is a state of emotional indifference, indifference, and inactivity.

**Attraction** is the attraction of people to each other, which is the basis of affection, friendly feelings, and love.

**Authenticity** is the identity of a person to himself.

**Autism** is a violation of the normal course of thinking under the influence of illness, psychotropic or other means; a person's departure from reality into the world of fantasies and dreams. It is found in its most pronounced form in preschool children and in patients with schizophrenia. The term was introduced by psychiatrist E. Bleuler.

**Attraction** is the desire or need to do something that motivates a person to take appropriate action. Attention is a state of psychological concentration, concentration on an object.

**Age-related characteristics** are a set of physical, intellectual, motivational, emotional, and cognitive properties characteristic of most people of the same age.

**Anxiety** – a person's tendency to experience heightened unease, fear, and worry in specific social situations.

**Attitude** – readiness or predisposition to certain actions or reactions to specific stimuli.

**Aspiration** – The desire and readiness to act in a certain way

**Cognitive** – a psychological term referring to cognitive processes, distinguishing them from emotional processes.

**Cognitive style** – relatively stable individual characteristics of a person's cognitive activity, manifested in the cognitive strategies they use.

**Collective** – a highly developed small group of people whose relationships are based on positive moral norms. A collective demonstrates increased work efficiency, often in the form of a super additive effect.

**Communication** – contacts, interaction, exchange of information, and communication between people.

**Communicativeness** – the ability to easily establish social contacts; sociability.

**Conflict** – a psychological phenomenon involving the clash of opposing actions, views, interests, aspirations, plans, or opinions among different people. It is perceived as a difficult-to-resolve contradiction associated with intense emotional experiences.

**Conformity** – the tendency of a person to change their behavior under the influence of others to align with the opinions of the majority; the desire to adapt to the demands of the group.

**Communication** – interaction between individuals or social groups involving the direct exchange of experiences, skills, abilities, and information, satisfying a person's need for contact with others.

**Compatibility** – the ability of people to coexist, successfully solve tasks requiring coordinated actions, and achieve good mutual understanding.

**Concentration** – the focus of a person's attention on a specific object or activity.

**Collaboration** – a person's desire to work in harmony with others; readiness to support and assist them. The opposite of rivalry.

**Conviction** – a person's confidence in their correctness, supported by relevant arguments and facts.

**Character** – the set of personality traits that determine typical ways of responding to life circumstances, formed throughout a person's life.

**Choleric** – a person with a choleric temperament, characterized by quickness, impulsiveness, and the ability to devote themselves to a task

with exceptional passion, but lacking balance and prone to intense emotional outbursts (affects) and sudden mood swings.

**Character accentuation** is a concept that means the excessive expression of individual character traits and their combination; it represents extreme variants of the norm bordering on psychopathy. It manifests itself in the vulnerability of a person to certain life situations, influences, experiences and neuropsychological stresses with good and even increased resistance to others.

**Empathy** – the alignment of one's emotional state with that of another person or social group; experiencing the same feelings and emotions as those around them (see also empathy).

**Extraversion** – a personality characteristic described by Swiss psychiatrist and psychologist C. Jung in 1910. According to this, a person is an extrovert if their primary interests lie in the external, objective world, which they see as the highest value. Extraversion thus implies a preference for social and practical aspects of life, as opposed to immersion in the world of imagination and introspection.

**Emotions** – elementary experiences that arise in a person under the influence of the general state of the body and the process of satisfying current needs.

**Emotionality** – a personality characteristic manifested in the frequency of experiencing various emotions and feelings.

**Empathy** – awareness of another person's emotional state and the ability to share their experience; understanding and experiencing another person's emotional state.

**Expectation** – anticipation of future events by an individual.

**Facial expressions** – the combination of movements of facial features that express a person's state or attitude toward what they perceive (imagine, think about, recall, etc.).

**Feedback** – the process of obtaining information about the state of a communication partner to improve interaction and achieve desired outcomes.

**Fatigue** – a state of tiredness accompanied by reduced performance.

**Frustration** – an emotionally distressing experience of failure, accompanied by feelings of hopelessness and the collapse of hopes for achieving a desired goal.

**Gender differences** are social and psychological differences between a man and a woman.

**Humanistic psychology** is a branch of psychology in which a person is viewed as a higher spiritual being who sets himself the goal of self-improvement and strives to achieve it. Humanistic psychology emerged in the first half of the 20th century. The founders are considered to be American scientists G. Allport, A. Maslow and K. Rogers.

**Intrapersonal conflict** – a state of dissatisfaction with certain life circumstances, arising from conflicting interests, aspirations, or needs within an individual, leading to emotional distress and stress.

**Interpersonal conflict** – a difficult-to-resolve contradiction between individuals caused by differences in their views, interests, goals, or needs.

**Inference** – the process of logically deriving a specific conclusion from certain reliable statements – premises.

**Melancholic** – a person with a melancholic temperament, characterized by slow reactions to stimuli, as well as slow speech, thought, and motor processes. A melancholic is someone who is easily hurt, prone to deeply experiencing even minor failures, but outwardly reacting passively to their surroundings.

**Mobility** – readiness for quick reactions and rapid engagement in activities.

**Monotony** – a mental state caused by prolonged exposure to a monotonous stimulus, leading to reduced attention, drowsiness, fatigue, and a decline in mental activity.

**Motivation** – a dynamic process of internal, psychological, and physiological regulation of behavior, including its initiation, direction, organization, and maintenance.

**Need** – a state of necessity in an organism, individual, or person for something required for normal existence.

**Negativism** – demonstrative opposition to others, rejection of reasonable advice from others. Often observed in children during age-related crises.

**Personality questionnaire** – a method of studying personality based on a system of written or oral, pre-planned questions addressed to a person whose psychological characteristics are being examined.

**Pantomime** – a system of expressive movements performed using the body.

**Perception** – the process of sensing through the organs of perception.

**Practical thinking** – a type of thinking aimed at solving practical problems.

**Psychodiagnostics** – a field of research related to the quantitative assessment and precise qualitative analysis of psychological properties and states of a person using scientifically validated methods that provide reliable information about them.

**Psychological compatibility** – the ability of individuals to find mutual understanding, establish business and personal contacts, and collaborate with each other.

**Psychological climate** – the qualitative aspect of interpersonal relationships, manifested as a set of psychological conditions that either facilitate or hinder productive joint activities and the comprehensive development of individuals within a group.

**Predisposition** – an inclination or tendency toward something.

**Personal meaning** – the significance that an object, event, fact, or word acquires for an individual as a result of their personal life experience. The concept was introduced by A. N. Leontiev.

**Phlegmatic** – a person with a phlegmatic temperament, characterized by slowness, calmness, stable aspirations, and a more or less constant mood, with weak external expression of emotional states.

**Phobias** – obsessive states of irrational fear toward specific objects or situations, often posing no real threat (e.g., fear of blushing, fear of open spaces, fear of death, fear of school, etc.). These develop in certain psychoses.

**Personality Trait** – a stable characteristic of a person that determines their typical behavior and thinking.

**Psychological barrier** is an internal obstacle of a psychological nature (unwillingness, fear, insecurity, etc.) that prevents a person from successfully performing an action. It often occurs in people's business and personal relationships and prevents them from establishing open and trusting relationships.

**Rivalry** – a person's desire to compete with others, to surpass them, to win, or to excel.

**Relaxation** – a state of relaxation.

**Reference group** – a group of people who are attractive to an individual in some way; a group source of individual values, judgments, actions, norms, and rules of behavior.

**Reflex** – an automatic response of the body to an internal or external stimulus.

**Reflection** – the ability of consciousness to recognize one's own thoughts, feelings, causes, and consequences of actions. Self-analysis, self-knowledge, and the turning of consciousness to its own premises.

**Social adaptation** is the process of an individual's active adaptation to the conditions of the social environment; the type of interaction of a person or a social group with the social environment; the result of the harmonization of relations between the subject and the social environment.

**Suggestibility** is a person's malleability to the effect of suggestion.

**Social norms** – rules of behavior accepted in a given society or group, regulating interpersonal relationships.

**Social perception** – the perception, understanding, and evaluation of various social objects, events, and other people by individuals.

**Speech** – a system of sound signals, written signs, and symbols used by humans to represent, process, store, and transmit information.

**Self-actualization** – the use and development of a person's innate potential, transforming it into abilities. The pursuit of personal self-improvement.

**Self-control** – the ability of a person to maintain inner calm and act rationally and thoughtfully in challenging life situations.

**Self-awareness** – the awareness of oneself as an individual; reflection on one's mental qualities, feelings, motives, values, ideals, strengths, and weaknesses.

**Self-esteem** – a person's evaluation of their own qualities, strengths, and weaknesses.

**Sanguine** – a person with a sanguine temperament, characterized by energy, high efficiency, and quick reactions. A sanguine person responds quickly to surrounding events and experiences failures and setbacks relatively easily.

**Sympathy** – a feeling of emotional predisposition toward a person, increased interest, and attraction to them.

**Socialization** – the process and result of a child assimilating social experience. Through socialization, a child becomes a cultured, educated, and well-mannered individual.

**Social situation of development** – the system of social conditions that determine a person's psychological development.

**Stress** – a nonspecific reaction of the body that develops under the influence of various intense or novel stimuli (pain, cold, excessive physical exertion, psychoemotional trauma, etc.).

**Stressor** (synonym: stress factor) – a strong or extremely strong external or internal influence that causes stress.

**Skill** – the ability to perform specific actions with high quality and to successfully handle activities involving these actions.

**Thinking** – a psychological process of cognition associated with the discovery of subjectively new knowledge, problem-solving, and the creative transformation of reality.

**Temperament** (from Latin *temperamentum* – proportion, moderation) – a natural combination of stable individual characteristics of a person that describe various aspects of the dynamics of mental activity and behavior. The concept of "temperament" originated from the teachings of the ancient Greek scientist and physician Hippocrates (6th century BC). Different combinations of interrelated temperamental properties are called types of temperament. In psychology, Hippocrates' classification is commonly used: sanguine, choleric, phlegmatic, and melancholic.

**Unconscious** is a characteristic of psychological properties, processes and states of a person that are outside the sphere of his consciousness, but have the same effect on his behavior as consciousness.

**Verbal** – refers to the sound of human speech.

**Values** – what a person particularly values in life, to which they attribute special, positive life meaning.

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