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ORIGINAL RESEARCH

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Conflict management in parent–dentist communication in pediatric dentistry: a qualitative study

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Abstract

Background: In pediatric dentistry, the communication process takes place within the child–parent–dentist triad, and a child's dental experience is influenced by communication between the dentist and the parent. Gaps in this communication may lead to conflict and require effective management; however, conflict management approaches between pediatric dentists and parents have not been specifically examined. This study explored pediatric dentists' approaches to conflict situations with parents and evaluated these approaches within the Thomas–Kilmann conflict management framework, which includes five styles: competing, avoiding, accommodating, compromising, and collaborating. **Methods**: A qualitative descriptive study was conducted using semi-structured interviews based on predefined conflict scenarios, which were developed based on the research team's prior professional and field experience, with 18 pediatric dentistry residents and specialists in Türkiye. The participants consisted of three experience groups (n = 6 each): early-stage residents (6–12 months), late-stage residents (30–36 months), and pediatric dentists with at least 3 years of clinical experience. Interviews were audio-recorded, transcribed verbatim, and analyzed using inductive thematic analysis, followed by code-level framework analysis based on the Thomas–Kilmann conflict management framework. Conflict management styles were then examined across conflict scenarios and experience groups. **Results**: Three main themes were identified: Approaches to Managing Parental Expectation, Approaches to Managing Parental Discourse, and Approaches to Managing Parental Criticism. Coding based on the Thomas–Kilmann conflict management framework demonstrated that the participants did not employ a fixed conflict resolution style; rather, the styles varied across scenarios and depending on professional experience. **Conclusions**: The findings contribute to increasing awareness of parent–dentist conflicts and conflict resolution styles among pediatric dentists and to a better understanding of conflict management approaches in pediatric dentistry.

Keywords

Conflict resolution; Health communication; Interpersonal relations; Parenting; Pedodontics; Qualitative research

1. Introduction

Communication is a two-way process involving speech, writing, or nonverbal methods; it aims to establish a common understanding between parties and serves as one of the fundamental functions in the healthcare sector [1]. In pediatric dentistry, communication strategies are considered among the most important tools for achieving the goal of "performing necessary dental treatment effectively and efficiently, and promoting a positive attitude towards dental treatment in children" [2].

The communication process in pediatric dentistry occurs within the child–parent–dentist triad; parents generally prefer to participate in treatment-related decisions and frequently hold particular expectations about their child's dental care experience [3–7]. However, when parents' and dentists' expectations and priorities misalign, communication breakdowns may occur. This can lead to conflict in parent–dentist communication. Conflict in interpersonal relationships is defined as disagreement between individuals that is harmful or has the potential to cause harm [1]. In a pediatric dentistry setting, conflict between a parent and a dentist may cause reduced child cooperation during treatment and negatively affect the child's dental experience [5–8].

In the conflict management literature, various theoretical frameworks, such as Rahim's conflict management model [9], the Thomas–Kilmann model [10], and Morton Deutsch's [11] theory of cooperation and competition, have been used to

examine conflict resolution [12]. The Thomas–Kilmann model [10], one of the most widely used models in healthcare conflict management research, is based on an individual's assertiveness and cooperativeness, and conceptualizes conflict resolution through two dimensions: the degree of concern for one's own interests (assertiveness) and the degree of concern for the interests of others (cooperativeness) [1]. Accordingly, depending on different levels of assertiveness and cooperativeness, the model identifies five conflict resolution styles: competing, avoiding, accommodating, compromising, and collaborating, each of which has its own strengths and weaknesses and varies in appropriateness depending on the conflict situation [10, 13].

Despite the determining effect of parent–dentist communication on a child's treatment process in pediatric dentistry, previous studies have explored parent–dentist communication concerning parents' acceptance of behavior guidance techniques, parent–dentist trust, parental cooperation, and the influence of parenting styles on children's dental experiences and dental anxiety [3, 14, 15]. However, conflicts arising during parent–dentist communication and approaches to managing these conflicts represent an underexplored area in the pediatric dentistry literature.

In examining conflict management approaches, moving beyond the identification of conflict management styles to explore the experiences, perspectives, meanings, and contextual factors that shape conflict situations may provide deeper insights into parent–dentist interactions, given the complex interpersonal nature of communication. In this regard, the nature of qualitative research enables the exploration of different perspectives and the examination of contextual factors influencing conflict situations [16]. Accordingly, this qualitative study aimed to contribute to a better understanding of conflict situations and conflict management in parent–dentist communication in pediatric dentistry. This study addressed the following research questions: (1) How do pediatric dentists approach conflict situations with parents? and (2) Which Thomas–Kilmann conflict management styles are reflected in these approaches?

Addressing these research questions may contribute to clinicians' and educators' evaluations regarding the selection and application of conflict management approaches in pediatric dentistry contexts.

2. Materials and methods

A qualitative descriptive study with an exploratory orientation, situated within a constructivist research paradigm, was conducted to gain an in-depth understanding of pediatric dentists' approaches to and interpretations of conflict situations with parents in Türkiye [16–18]. This study is reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines [19].

2.1 Participants and recruitment

The study participants consisted of 12 pediatric dentistry residents and 6 pediatric dentistry specialists. In Türkiye, pediatric dentistry specialty training covers a three-year period. Participants were identified using maximum variation and snowball sampling methods [20]. Initially, maximum variation sampling was used to recruit participants with various levels of professional experience, specialty training at different universities, and experience working in different institutions and clinical settings. Accordingly, participants were grouped into three categories based on professional experience and stage of specialty training: (1) residents with 6–12 months of pediatric dentistry specialty training, (2) residents with 30–36 months of pediatric dentistry specialty training, and (3) pediatric dentists with at least 3 years of clinical experience. The inclusion criteria were as follows: being enrolled in pediatric dentistry specialty training in Türkiye within the specified training periods or being a specialist who has completed such training in Türkiye and is actively practicing with a minimum of three years of clinical experience. To enhance maximum variation and minimize the potential influence of shared institutional practices and geographical clustering, no more than two participants from the same institution or clinical setting were included, provided that they represented different professional experience groups, and only one institution or clinical setting was included from each city. Dentists undergoing training in other specialties, those holding specialty qualifications in fields other than pediatric dentistry and general dental practitioners were excluded.

Initial contact with potential participants was established by SA and CBN via telephone. Pediatric dentists who expressed interest in participating were provided with full details regarding the study's purpose and procedures by one of the researchers. Once a dentist agreed to participate in the study, an interview appointment was scheduled. These participants were also invited to recommend other potential participants who met the study criteria, thereby expanding the sample through snowball sampling. Participant characteristics are presented in Table 1.

Participants were recruited purposively to capture perspectives from individuals with relevant experience in conflict management. Data collection and analysis occurred concurrently, allowing the research team to assess the emergence of new concepts throughout the study. After approximately 15 interviews, no substantive new codes or conceptual insights were identified, and subsequent interviews primarily reinforced existing patterns and interpretations. Data collection continued until the research team determined that sufficient conceptual depth was achieved to address the study aims. Based on this iterative process, 18 participants were considered adequate for the purposes of this qualitative inquiry [21]. No participant refusals or withdrawals occurred during the study, and the study was completed with 18 participants.

2.2 Interview guide

Semi-structured interviews built around predefined conflict scenarios were used in this study. The interview guide was developed through an iterative process informed by the research objectives, a comprehensive review of the literature, and feedback from five pediatric dentistry specialists and two qualitative research experts. The conflict scenarios were initially developed based on the research team's prior professional and field experience regarding real conflict situations

TABLE 1. The characteristics of the participants (N = 18).

Participant characteristics by professional experience level	Pseudonyms	Gender	Age (yr)	Clinical experience	Work setting
Group 1: 6–12 months of pediatric dentistry specialty training					
	Emma	Female	35	9 mon	University
	Olivia	Female	25	10 mon	University
	Charlotte	Female	25	9 mon	University
	Amelia	Female	26	9 mon	University
	Sophia	Female	25	9.5 mon	University
	Grace	Female	27	10 mon	University
Group 2: 30–36 months of pediatric dentistry specialty training					
	Lily	Female	27	30 mon	University
	Hannah	Female	28	30 mon	University
	Chloe	Female	30	30 mon	University
	Ella	Female	29	31 mon	University
	Lucy	Female	29	30 mon	University
	Mia	Female	28	30 mon	University
Group 3: At least 3 years of clinical experience					
	Emily	Female	38	8 yr	University
	Alice	Female	34	4 yr	University
	Claire	Female	31	3.5 yr	Private
	Sarah	Female	36	4 yr	Private
	Julia	Female	37	5 yr	University
	Rebecca	Female	36	8 yr	Private

encountered in pediatric dental practice and were structured according to conflict management theory [13]. To ensure the appropriateness and comprehensiveness of the scenarios, they were reviewed by five pediatric dentistry specialists for the realism of the clinical situations, content validity, and comprehensibility, and by two qualitative research experts for alignment with the qualitative research design. Pilot interviews were subsequently conducted with two pediatric dentists to assess the face validity, clarity, and comprehensibility of the interview guide and conflict scenarios. Based on the feedback obtained, the interview form was revised and finalized prior to data collection.

The first section comprised questions about sociodemographic information, including age, gender, professional experience and work setting. The second section presented five scenarios related to conflict situations with parents. Conflict scenarios were developed to reflect realistic interpersonal conflicts and to incorporate the contextual factors underlying conflict resolution theories [13]. Scenario 1 involved a situation in which, despite the child's very low level of cooperation, the parent insisted on initiating treatment with a difficult procedure as the first step. In Scenario 2, when an absent-parent approach was used, the child did not cooperate with the treatment, and the parent claimed that the child would be persuaded if the treatment were attempted again in their presence. Scenario 3 presented a situation in which the parent, in the presence of the child, used negative and misleading statements such as "there will be no injection, don't be afraid, it will be done without an injection.". In Scenario 4, the parent attributed the child's reaction to the previous dentist forcing the treatment. Scenario 5 described a situation in which the parent questioned, in an accusatory tone, whether anesthesia had been administered. The conflict scenarios are presented in Fig. 1. Detailed information regarding the development and validation process of the semi-structured interview form based on conflict scenarios is provided in **Supplementary material 1**. The conflict scenarios and the contextual factors accompanying each scenario are presented in **Supplementary material 2**.

2.3 Data collection

Semi-structured interviews were conducted to enable participants to express their views comfortably and without external influence. Interviews were conducted in Turkish via Zoom (6.2.6, Zoom Video Communications, San Jose, CA, USA) to facilitate the participation of dentists working in different cities. Data collection for the study was conducted between December 2024 and February 2025.

Interviews were conducted by the first author (SA), a female pediatric dentist and faculty member with at least five years of clinical experience, who received formal training in qualitative research. A qualitative research expert participated as an observer in each interview to monitor adherence to qualitative interviewing principles and ethical considerations

Scenario 1

What is your approach when you observe that the level of compliance of the child is extremely low, and you intend to commence with a simple procedure as the initial intervention, yet the family persistently requests that a complex procedure, such as extraction, be performed?

Scenario 2

At the commencement of treatment, the parents of the patient were instructed to remain outside. While the parent waited outside, you attempted to persuade the child for a certain period. However, the child remained uncooperative. Upon terminating the treatment and inviting the parent back inside to provide an explanation, the parent reacted by saying, "You were unable to persuade him. He would have been persuaded if I had been present; however, you would not have allowed me to enter. Allow me to go inside; let us attempt again with my presence." What is your approach to such situations?

Scenario 3

The parent was present with the child during the treatment. You are at the commencement of the treatment, and it is necessary to administer anaesthesia during that session; however, what would be your approach if, at that moment, the parent informs the child by stating, "There will be no needle; do not be afraid; it will be carried out without a needle?"

Scenario 4

The parent was present with the child during treatment. You have met the child for the first time and intend to establish rapport and conduct an examination. The child did not allow the examination and began crying. At that moment, while the child is crying, the parent states, "The previous dentist forcibly extracted his or her tooth; that is why he or she is reacting in this manner." What is your approach in this situation?

Scenario 5

At the commencement of treatment, the parents of the patient were instructed to remain outside. While the parent was waiting outside, you planned a procedure that required anaesthesia. You initiated the procedure, administered anaesthesia, verified its effectiveness, and proceeded with the treatment. At an intermediate stage of treatment, the child began to cry, and at that point, the parent was allowed to enter (or enter independently) and immediately stated, "My child is very resistant. Did you not administer anaesthesia? Did the anaesthesia not take effect? Why is he or she crying? Under normal circumstances, he or she never cries." What is your approach in this situation?

FIGURE 1. Overview of the conflict scenarios.

and to support a neutral and non-judgmental interview environment. Before each interview, participants were informed about data confidentiality, the study's aim, and the use of audio recording for data collection, and informed consent was obtained. Accordingly, all interviews were audio-recorded. Subsequently, sociodemographic information was collected, and participants were asked to share their views regarding the presented conflict scenarios. Field notes were taken to document observations and reflections related to the interview process by the first author (SA). The mean interview duration was 64 $\pm$ 15.1 minutes (range: 37–96 minutes). No repeat interviews were conducted. All interviews were transcribed verbatim by a professional transcription service, and transcripts were checked for accuracy by the interviewers. The interview recordings were anonymized by removing identifying information, and participants were assigned pseudonyms (Emma, Olivia, *etc.*). Due to participants' limited availability and time constraints, which made follow-up engagement impractical, the interviewer provided a brief summary of key points and interpretations emerging from the interview and invited participants to confirm, clarify, or correct these reflections before concluding the interview to facilitate member checking.

2.4 Data analysis

The analysis began with an inductive thematic analysis to allow patterns and meanings to emerge directly from the data without imposing a pre-existing framework. This initial stage supported an open exploration of participants' interpretations of conflict situations. Following this, the Thomas–Kilmann model was used as an interpretive lens in a second analytic stage to organize and further interpret the emergent themes in relation to an established conflict management framework. The inductive analysis ensured that findings remained grounded in participants' accounts, while the subsequent framework-informed stage enabled interpretation of these findings within a widely used theoretical model, thereby enhancing the conceptual positioning and practical relevance of the results.

2.4.1 Thematic analysis

Thematic analysis was conducted in accordance with Braun and Clarke's approach [22] to identify themes, subthemes, and codes related to the participants' conflict approaches, which were derived from the interview data without reference to any pre-existing conflict management framework. Initial codes were generated independently by two members of the research team (SA and CBN). To ensure that the themes accurately represented the data, data segments assigned to each theme were re-examined and, where necessary, refined to achieve better alignment with the emerging patterns. During this process, some themes were merged, separated, or removed as needed. Field notes and analytic memos were used to support interpretation and enhance the credibility of the findings. Throughout the thematic analysis process, three qualitative research experts provided feedback on the coding structure and thematic organization to enhance the rigor and credibility of the analysis. The themes and subthemes were then reviewed through iterative discussions among the research team. In these discussions, the principle of "seeking richer interpretations of meaning rather than attempting to reach consensus on meaning" was adopted [17–19]. Data analysis was performed manually and using MAXQDA 26 (VERBI Software GmbH, Berlin, BE, Germany). The codebook is provided in **Supplementary Table 1**.

2.4.2 Framework analysis

The resulting codes were interpreted in relation to the Thomas–Kilmann conflict management framework. The framework analysis was conducted at the code level to avoid potential overlap between conflict management styles, while the interpretation of each style was grounded in the content and context of the corresponding codes and the theme and subtheme in which the codes were embedded. The framework analysis proceeded in the following stages:

1- Each code was independently interpreted by the researchers in relation to the five Thomas–Kilmann conflict management styles based on its core orientation in terms of assertiveness and cooperativeness (see Table 2 for the Thomas–Kilmann conflict management styles and their core orientations).

TABLE 2. Core orientations and animal representations of Thomas–Kilmann conflict management styles.

Conflict management style	Animal metapho	Core orientation
Competing	Shark	High assertiveness Low cooperativeness
Avoiding	Turtle	Low assertiveness Low cooperativeness
Accommodating	Teddy bear	Low assertiveness High cooperativeness
Compromising	Fox	Moderate assertiveness Moderate cooperativeness
Collaborating	Owl	High assertiveness High cooperativeness

2- The interpretations were then compared to identify areas of disagreement. Discrepancies were identified for three codes. For these codes, the corresponding participant quotations and the context of the conflict scenarios were re-examined and discussed. Consensus on the final interpretation of each code within the Thomas–Kilmann framework was subsequently reached through discussion.

2.5 Rigor

In qualitative research, the concept of rigor refers to the credibility, consistency, transferability, and confirmability of the research process [17, 23]. In this study, trustworthiness was ensured in accordance with the principles proposed by Guba and Lincoln [24]. The measures taken to enhance rigor in the study are presented in **Supplementary material 3**.

2.6 Reflexivity

Given the interpretive nature of qualitative research, reflexivity was considered an integral component throughout the research process. Reflexivity involves acknowledging how researchers' professional backgrounds, experiences, and assumptions may influence the development of the study, data interpretation, and analytical decisions [25].

The first and second authors are female pediatric dentists and faculty members, each with at least five years of clinical experience, and both have conducted research on pediatric dental anxiety. Their professional experience, together with the existing literature, informed the development of the conflict scenarios and supported the interpretation of the findings within the clinical context. At the same time, the research team recognized that these experiences and preconceptions could influence the interpretation of participants' accounts and the analytical process.

The methodological consultation provided by external qualitative research experts offered an independent perspective throughout the research process. Their methodological guidance and critical feedback encouraged ongoing reflexive discussions within the research team. By discussing and incorporating this feedback throughout the analytical process, the research team sought to minimize the influence of potential biases on data interpretation and enhance the trustworthiness of the findings.

3. Results

The results are organized around the themes and subthemes identified through thematic analysis; the codes underlying these themes were interpreted in relation to conflict management styles using a framework analysis approach.

Three main themes emerged from the analyses: (1) Approaches to Managing Parental Expectation, (2) Approaches to Managing Parental Discourse, and (3) Approaches to Managing Parental Criticism. Each theme and its related subthemes are presented below. Subthemes, codes, and illustrative quotations are presented in Table 3. The overall conceptual representation integrating findings from thematic analysis and their interpretation in relation to conflict management styles is illustrated in Fig. 2.

TABLE 3. Overview of themes, subthemes, codes, illustrative quotations, and participant quotations on the conflict scenarios.

Subtheme	Code	Illustrative quotation
Theme 1: Approaches to Managing Parental Expectation		
Preventing Anticipatory Expectations		
	Preventing Anticipatory Expectations by Providing Information in Advance	"*We explain this to the child's parent in any event. We also explained this during the examination. In other words, we examine the child when they first present. Extraction is a procedure that causes pain; therefore, we generally perform it at the end. I explain this to the parent as well. If we were to treat deep caries or perform extraction and administer anaesthesia at the very beginning of the treatment, the child's cooperation might be disrupted. We place particular emphasis on this point.*" (Hannah/30 months/University)
	Preventing Anticipatory Expectations Through Parental Presence During the Process	"*As there is a very strong likelihood of encountering such situations, I generally have the parents of children below a certain age present with me. They attend the consultation so that they can observe what is taking place; for instance, with some children, it is apparent that they will not remain seated. In such circumstances, when something of that nature occurs, I simply ask the parent to come in.*" (Mia/30 months/University)
	Preventing Anticipatory Expectations by Involving the Parent Before Concluding the Process	"*If a child is uncooperative, before concluding the procedure, I always ask the parent to come in so that they can see for themselves that the child is not cooperating. Unless they see this, they remain unconvinced. I even allowed them approximately 5 min. I say, 'Sit down and speak with the child; if you are able to persuade them, I will continue with the procedure.'. Generally, children are not persuaded at this stage. However, at least the parent has seen that the child is not cooperating.*" (Grace/10 months/University)
Meeting Expectations		
	Unconditionally Meeting Expectations	"*To be frank, I would try again. I will make another attempt to do so. I would also ensure that the child's family is aware of this. If the child still did not consent despite the family being present, the family would have witnessed it. This is how I would conclude the treatment. In that way, they would have peace of mind, having seen it for themselves.*" (Chloe/30 months/University)
	Conditionally Meeting Expectations–Parental Attitude	"*I can sometimes be persuaded and do as they ask. That is, if they ask in a pleasant manner...*" (Rebecca/8 years/Private)
	Conditionally Meeting Expectations–Tooth Condition	"*Conversely, if the patient has a tooth that is causing significant pain, we would also wish to address that.*" (Hannah/30 months/University)
	Conditionally Meeting Expectations–Societal Context	"*To the family, I would say: 'Yes, I can do that, if that is the reason you have come, because securing an appointment is in fact somewhat difficult…* '" (Chloe/30 months/University)
Leaving Parent with the Final Decision Regarding Expectations		
	Leaving Parent with the Final Decision by Explaining the Potential Negative Outcomes	"*If the parent does not agree to this, that is, if they still insist that we perform a difficult procedure, I explain the consequences. If I see that this is not working, then of course I will begin the difficult procedure, I will carry it out.*" (Ella/31 months/University)

TABLE 3. Continued.

Subtheme	Code	Illustrative quotation
Structuring Expectations		
	Deferring Expectations by Proposing a Solution	"*Let us keep this first session brief. We can schedule you for more extensive treatment a day or two later, but please allow us to conduct a short procedure during this first session. At the very least, let the child see that it will not hurt and that there is nothing to fear.*" (Hannah/30 months/University)
	Delayed Meeting of the Expectation	"*If you wish, wait until I have finished what I am doing now, and then we can try again.*" (Emily/8 years/University)
	Partial Meeting of the Expectation	"*If you wish, we can speak outside. What I mean is that if they are persuaded, we can bring the child back in and continue with the treatment without the parent present. However, if they are not persuaded, then I am saying that we will have to stop.*" (Rebecca/8 years/Private)
	Meeting of Expectations at the Next Appointment	"*I would have you with me at the next appointment. Let us make another attempt; we can try again at the next one.*" (Lily/30 months/University)
Not Meeting Expectations		
	Not Meeting Expectations by Guiding Toward One's Professional Approach	"*I say something like this: if we start with that procedure, we might make this already uncooperative child even more uncooperative, and although we have the potential to carry out the other procedures, we may end up not being able to perform them at all—I deliver a talk along these lines.*" (Mia/30 months/University)
	Not Meeting Expectations by Explaining Contextual Constraints	"*At that time, because we genuinely had so many dentists working, we did not allow families in at all. This statement is justified. In fact, one father said something to the effect of, 'Even when I take my car to the garage, I am allowed to go inside and watch; yet I cannot watch my own child.' However, certain rules apply. I did everything I could, you see. We were unable to let you in.*" (Rebecca/8 years/Private)
Setting Limits on Expectations		
	Setting Limits on Expectations within Professional Scope	"*What I say is this: if you do not wish to proceed, I will do it myself; I am the one making the decision. I tell them, 'If you do not wish to proceed, you may book an appointment with another dentist or go elsewhere.'*" (Sophia/9.5 months/University)
Consulting a Supervisor Regarding Expectations		
	Informing the Supervisor of the Situation	"*In such situations, as I am currently a student, I go to my supervisor because I am unable to persuade the parents…*"(Lucy/30 months/University)
Theme 2: Approaches to Managing Parental Discourse		
Preventing Anticipatory Discourse		
	Preventing Anticipatory Discourse by Providing Information in Advance	"*I discuss with the parents what we are going to do based on the X-ray, so that they know exactly what we are going to do. This procedure will take these many minutes. For this procedure, I need to numb the tooth, and the anaesthetic is administered in the same way in children as in adults. However, we do not tell the children that it is the same.*" (Claire/3.5 years/Private)

TABLE 3. Continued.

Subtheme	Code	Illustrative quotation
Correcting the Discourse		
	Correcting the Parental Discourse in the Child's Presence	"*That is why, at that point, I do not speak in a way that seeks the parents' approval. We are going to administer an injection, but this injection will hurt a little; it will hurt for approximately 10 s. After that, they will not experience pain during treatment. Therefore, I honestly tell them that they can manage the 10 s. If the patient is older, I tell the parent, 'No, mum or dad, we are going to administer an injection.' I also give the child accurate information.*" (Hannah/30 months/University)
	Correcting the Parental Discourse in the Child's Absence	"*Therefore, I take the parents aside to a place where the child cannot hear and inform them that, under normal circumstances, we need to administer anaesthesia to their child and that an injection will be given, but that I will not present it as an injection and will instead refer to it as a 'spray'.*" (Charlotte/9 months/University)
	Indirectly Correcting the Parental Discourse Through Communication with the Child	"*For instance, if I am going to extract a tooth, I begin by saying to the child straight away: 'I will not lie to you, do not worry.' I begin every conversation in this manner. 'Do not worry; I will not mislead you. Today, we will be doing these things; however, provided that you are in an environment in which you have given me permission, I will not do anything that you do not want me to do. Alternatively, I will do so only to that extent. Of course, to carry out this procedure, I will need to numb your tooth.'.*" (Emily/8 years/University)
	Subsequent Correcting the Parental Discourse in the Child's Absence	"*I would say that we do not speak to the parent in that manner either, separately from the child, once the treatment has been completed.*" (Amelia/9 months/University)
Adapting to the Discourse		
	Adapting to the Discourse to Encourage the Child's Cooperation	"*As I said, with very young children, I prefer to avoid using the word 'needle' or showing the syringe. So yes, of course, I would say, 'There is no needle; I do not use a needle, I only use a "dental vaccine",' and I would try to go along with the lie.*" (Julia/5 years/University)
Theme 3: Approaches to Managing Parental Criticism		
Preventing Anticipatory Criticism		
	Preventing Anticipatory Criticism by Providing Information in Advance	"*Therefore, to put it plainly, from the outset, once I have decided to administer anaesthesia, I would never do so without informing the parents or without their knowledge. We always ask the parents and take a medical history related to anaesthesia. I always tell the parents that I am going to sedate the child or administer anaesthesia.*" (Julia/5 years/University)
Providing Explanations for the Criticism		
	Providing Informational Clarification	"*In this situation, if I think that the anaesthetic has taken effect, I explain to the family that the child may be reacting in this way because, during the procedure, they can still perceive movement and touch, and because they are experiencing the sensation of anaesthesia for the first time.*" (Sarah/4 years/Private)
	Presenting Objective Clinical Findings	"*I sometimes demonstrate this with the probe. Look, if they could really feel it, they would feel this too.*" (Lucy/30 months/University)
	Inviting the Parent into the Treatment Process	"*I keep the parent nearby so that they can see what is happening during the procedure. They panic because they cannot see.*" (Claire/3.5 years/Private)

TABLE 3. Continued.

Subtheme	Code	Illustrative quotation
Internalizing the Criticism		
	Developing Bias Toward the Parent	"*I become very irritated. Naturally, I assume that they are blaming the other dentist. This implies that the child is uncooperative, but the parents are clearly unwilling to accept it. This leads me to form a preconceived view of parents. If the child will not cooperate, I frankly do not wish to carry out the procedure. After all, the consequences will also fall on me; that is how I see it.*" (Ella/31 months/University)
Addressing the Criticism with Caution		
	Assessing the Merits of the Criticism	"*Therefore, he may have exaggerated. There may be some truth to this statement. I would say, 'Let us have a look. Let us see what happened'.*" (Emma/9 months/University)
	Empathizing with a Colleague	"*In some situations, we are obliged to do so. We may have to carry out the deepest possible treatment, treat the deepest carious lesion, or, if there is an abscess or the tooth is infected, we may have to extract it.*" (Hannah/30 months/University)
Structuring the Criticism		
	Expressing Empathy for a Colleague to the Parent	"*I would tell the parent that the child may not have experienced pain during that appointment but may have behaved in that manner simply out of fear. So, instead of stating outright that the child received poor treatment, I would try to understand what had happened during the previous appointment.*" (Charlotte/9 months/University)
Focusing on the Child's Emotions Rather than the Criticism		
	Guiding the Parent Toward One's Professional Approach	"*I tell them that we need to allow some time, and that, if necessary, they may bring the child back for further review whenever they wish.*" (Alice/4 years/University)
	Employing Basic Nonpharmacological Behavior Guidance Techniques	"*However, if the child has genuinely experienced such trauma, I make sure that they have a very positive session to help restructure that memory.*" (Emily/8 years/University)
Setting Limits on the Criticism		
	Setting Limits on Expectations within Professional Scope	"*Frankly, in that situation, I may become somewhat irritated as well. I do not have much patience left for this kind of remark. 'No, Mum, we have administered the anaesthetic, the tooth is fully numb; your child is behaving in this way because they are frightened or simply do not want to.' That is how I would say it. If they still insist, saying, 'No, it is your fault,' and so on, I will not continue with the treatment.*" (Chloe/30 months/University)
Illustrative participant quotations on the conflict scenarios		
"*Yes, we experience them frequently, actually. Yes, I mean, all of the scenarios you listed—we really experience all of them in clinical practice, very often.*" (Chloe/30 months/University)		
"*I think I have experienced 99% of them. In fact, I generally tried to describe situations that I have personally encountered.*" (Rebecca/8 years/Private)		
"*I have experienced all of them. To be honest, while answering the questions, I felt the need to respond by recalling occasions when I had previously experienced those situations in the clinic. Over the past 10 years, however, I have encountered all of the situations you mentioned many times.*" (Julia/5 years/University)		

FIGURE 2. Conceptual representation of dentists' conflict management approaches. Overall conceptual representation integrating the findings of the thematic analysis with the interpretation of the corresponding codes according to the Thomas–Kilmann conflict management framework. The animal illustrations associated with each code represent the corresponding Thomas–Kilmann animal metaphors and indicate the conflict management style assigned to that code during the framework analysis. Created specifically for this study using CorelDRAW Graphics Suite.

Notably, all participants agreed that the conflict situations presented in the scenarios were frequently encountered in clinical practice. Representative participant quotations illustrating these views are presented in Table 3.

3.1 Theme 1: approaches to managing parental expectation

The Approaches to Managing Parental Expectation theme describes how participants managed parental expectations that were inconsistent with treatment realities. This theme involves seven subthemes as follows: Preventing Anticipatory Expectations, Meeting Expectations, Leaving the Final Decision Regarding Expectations to the Parent, Structuring Expectations, Not Meeting Expectations, Setting Limits on Expectations, and Consulting a Supervisor Regarding Expectations.

Under the approach termed Preventing Anticipatory Expectations, the participants sought to prevent parental expectations from arising by providing information in advance. Under the approach termed Meeting Expectations, the participants met parental expectations either directly and without imposing any conditions or subject to specific conditions. Under the approach termed Leaving the Final Decision Regarding Expectations to the Parent, the participants explained the possible adverse consequences of expectations and left the final decision to the parent. Under the approach termed Structuring Expectations, the participants restructured parental expectations by deferring them, meeting them in part, or proposing solutions instead of meeting them directly. Under the approach termed Not Meeting Expectations, the participants did not meet parental expectations and instead redirected the parents toward a professional approach. Under the approach termed Setting Limits on Expectations, the participants clearly defined their professional boundaries in response to parental expectations. Under the approach termed Consulting a Supervisor Regarding Expectations, the participants consulted a supervisor to manage the process (Table 3).

3.2 Theme 2: approaches to managing parental discourse

The Approaches to Managing Parental Discourse theme describes how the participants managed parental statements that were inconsistent with the facts of the treatment process. This theme involves three subthemes as follows: Preventing Anticipatory Discourse, Correcting the Discourse, and Adapting to the Discourse.

Under the approach termed Preventing Anticipatory Discourse, the participants sought to prevent potential statements from arising by providing advance information about the treatment process and the parent's role. Under the approach termed Correcting the Discourse, the participants corrected the parent's statements directly, whether in the presence or absence of the child. Notably, some participants preferred to correct

the parent's statements indirectly through their communication with the child, rather than addressing them directly. Under the approach termed Adapting to the Discourse, the participants adapted to the parent's statements instead of correcting them with the aim of improving the child's compliance with treatment (Table 3).

3.3 Theme 3: approaches to managing parental criticism

The Approaches to Managing Parental Criticism theme describes how the participants responded to criticism directed by the parents toward themselves or another dentist. This theme involves seven subthemes as follows: Preventing Anticipatory Criticism, Providing Explanations for the Criticism, Internalizing the Criticism, Approaching the Criticism with Caution, Structuring the Criticism, Focusing on the Child's Emotions Rather than the Criticism, and Setting Limits on the Criticism.

Under the approach termed Preventing Anticipatory Criticism, the participants sought to prevent potential criticism by providing information in advance concerning the treatment process. The participants addressed criticism directed toward them through the approach termed Providing Explanations for the Criticism, offering explanations in response to the parents' criticism, supporting those explanations with clinical findings, or involving the parent in the process. Furthermore, professional boundaries were clearly defined under the approach termed Setting Limits on the Criticism.

However, under the Internalizing the Criticism approach, when the parents criticized another dentist, the participants who internalized the criticism developed a bias against the parent. By contrast, under the Approaching the Criticism with Caution approach, they adopted a more cautious position by questioning the validity of the criticism and demonstrating empathy toward their colleague. Under the Structuring the Criticism approach, they showed empathy toward their colleague while also providing the parent with an explanation that addressed their criticism. Finally, under the Focusing on the Child's Emotions Rather than the Criticism approach, the participants redirected their focus from the parent's criticism to the child's emotions (Table 3).

3.4 Representation of conflict management styles

When the conflict management styles used by the participants were examined based on the relationship between the identified codes and conflict management styles (see Fig. 2), all five styles were identified. However, examination of the breadth of participant coverage, representation within the coded dataset, and representation across conflict scenarios revealed differences among the identified styles, with collaborating showing the broadest overall representation. Detailed information regarding the interpretation of all codes is provided in **Supplementary Table 2** (Code–Conflict Management Style Framework), which includes each code, its interpretation within the Thomas–Kilmann conflict management framework, and the rationale underlying that interpretation. Illustrative examples of this interpretive process from Theme 1, Theme 2, and Theme 3 are presented below.

• Within Theme 1, the code Setting Limits on Expectations within Professional Scope was interpreted as reflecting a competing style because the participant set limits on the expectations expressed by the parent within a professional framework without attempting to establish cooperation. This approach reflected low cooperativeness toward parents but high assertiveness in maintaining a professional stance.

• Within Theme 2, the code Correcting the Parental Discourse in the Child's Absence was interpreted as reflecting a collaborating style because the participant directly corrected parental statements that did not align with the facts in a setting separate from the child. This approach reflected both high assertiveness and high cooperativeness, as the clinician maintained their professional position while also considering the parent's role in communicating with the child.

• Within Theme 3, the code Employing Basic Nonpharmacological Behavior Guidance Techniques by Focusing on the Child's Emotions Rather than the Criticism was interpreted as reflecting an avoiding style because, instead of directly engaging with the parent's criticism of another dentist, the participant redirected attention to the child's emotions and focused on their own approach to supporting the child, thereby moving away from the center of the conflict. This approach reflected low assertiveness and low cooperativeness.

When analyzed on a scenario-by-scenario basis, variation in the representation of conflict management styles was observed. Collaborating showed the broadest representation in Scenario 1, whereas avoiding showed the broadest representation in Scenario 4. In Scenarios 2 and 3, no single conflict management style showed a broader representation than the others. Furthermore, accommodating was not identified in Scenario 4, while neither avoiding nor accommodating was identified in Scenario 5 (see Fig. 3). These findings suggest that participants draw on different conflict management styles depending on the conflict situation.

When considered in relation to professional experience, all five conflict management styles were represented across all experience levels; however, differences in their patterns of representation were observed. The representation of collaborating was more evident among participants at the end of their specialty training, whereas avoiding appeared more evident among specialists. In contrast, competing showed more limited representation among participants at the beginning of their specialty training. Accommodating and compromising displayed relatively similar patterns of representation across the different experience levels (see Fig. 4).

4. Discussion

The purpose of this study was to examine the approaches adopted by pediatric dentists in managing conflict situations with parents and to explore these approaches within the Thomas–Kilmann conflict management framework. The findings demonstrate that the participating dentists did not adopt a single uniform approach to conflicts with parents; rather, they appeared to employ different approaches depending on the circumstances. These findings provide a noteworthy point of departure for examining parent–dentist communication [7, 8]. Furthermore, to the best of our

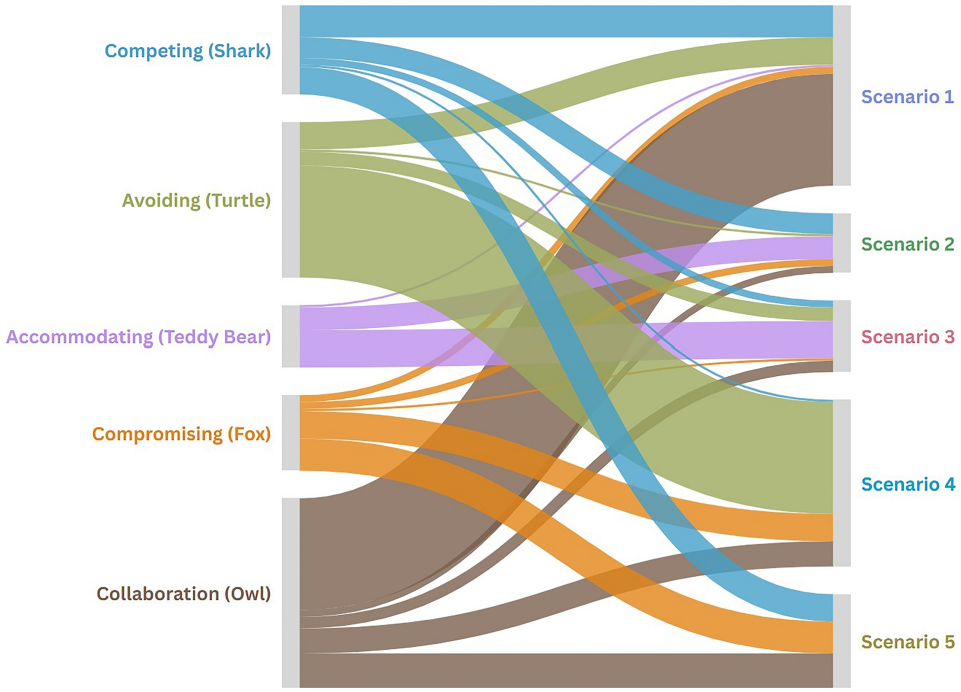

FIGURE 3. Sankey diagram of conflict management styles across clinical scenarios. Relational flows between Thomas–Kilmann conflict management styles identified through framework analysis and clinical scenarios. Flow widths reflect the relative representation of the codes associated with each conflict management style within the coded dataset and are intended to provide a visual illustration of style representation across clinical scenarios. Generated from the study data using the Flourish data visualization platform.

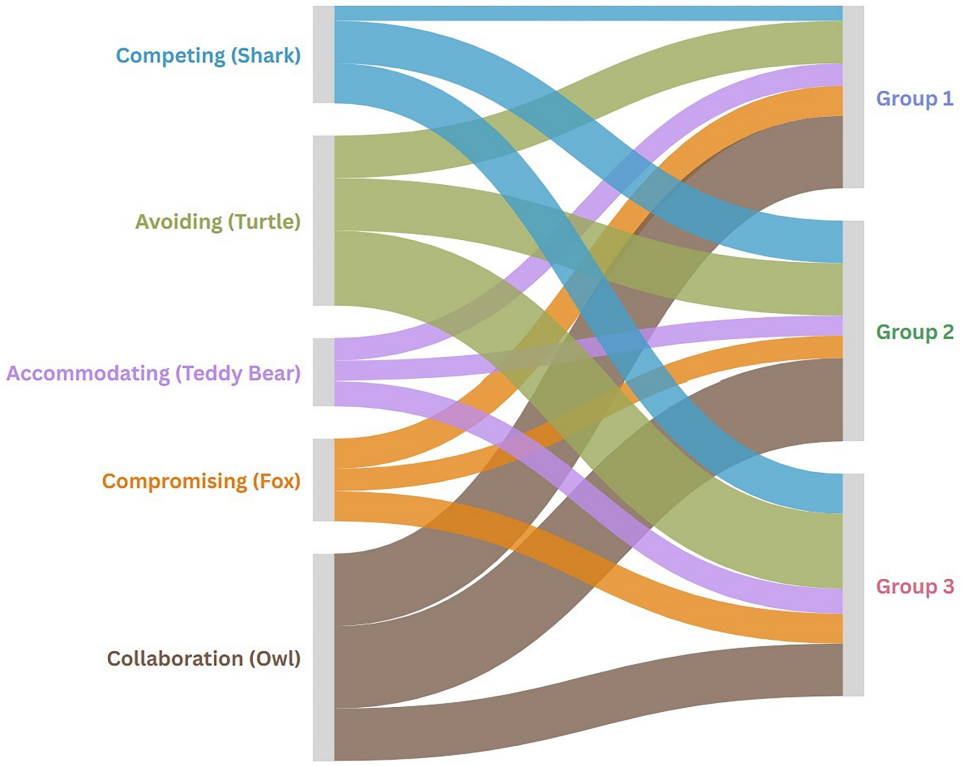

FIGURE 4. Sankey diagram of conflict management styles among participant groups. Relational flows between Thomas–Kilmann conflict management styles identified through framework analysis and participant groups. Flow widths reflect the relative representation of the codes associated with each conflict management style within the coded dataset and are intended to provide a visual illustration of style representation among participant groups. Generated from the study data using the Flourish data visualization platform.

knowledge, no study has previously examined dentist–parent communication within the framework of conflict management. Accordingly, given the lack of directly comparable evidence, the findings were interpreted by drawing on the broader literature on communication in pediatric dentistry and conflict management.

The themes of expectations, discourse, and criticism identified in the conflict scenarios represent key factors shaping conflict in pediatric dentist–parent interactions, consistent with the existing literature. Regarding parents' expectations that are disconnected from treatment realities, Crossley *et al*. [3] reported that dentists experienced pressure arising from parental expectations and that parents sometimes held unrealistic expectations concerning treatment. Similarly, many of the dentists who participated in this study perceived such expectations as barriers to successful treatment and as factors that could undermine the child's trust. Together, these findings suggest that unrealistic parental expectations may constitute an important source of conflict in pediatric dental care across different sociocultural contexts.

Tahani *et al*. [4] qualitatively examined the first dental experience of children aged 7–8 and found that they recalled the statements made by the accompanying adults and that these statements formed an active part of the experience. Jasbi *et al*. [26] reported that adolescents did not respond favorably to the misleading statements made by the parents and that this resulted in a loss of trust. Consistent with these findings, the American Academy of Pediatric Dentistry [27] recommends that parents avoid negative statements that may increase children's anxiety. Parents' statements may thus become a source of conflict that influences the child's dental experience by increasing anxiety, reducing cooperation, and undermining trust in the dentist–child relationship.

Many of the dentists who participated in this study appeared to be negatively affected by parental criticism, particularly when it reflected distrust toward the dentist or the proposed treatment. Consistent with our findings, the Parental Cooperation Scale developed by Kupietzky *et al*. [7] classifies parents who approach dentistry with distrust, continually question treatment necessity, and express skepticism toward the dentist within its most negative category of parental cooperation. From the patient's perspective, trust is regarded as a multidimensional construct that is strongly shaped by interpersonal experiences and communication [28–30]. Although evidence on dentists' perspectives remains limited, the available evidence and our findings suggest that the distrust underlying parental criticism may negatively influence both the dentist and the treatment process [31]. Taken together, these findings suggest that communication gaps may undermine trust, a key component of interpersonal relationships, and increase the likelihood of conflict [32, 33].

Armfield *et al*. [30] also found that a negative experience with the most recently visited dentist could reduce an individual's overall trust in the dental profession. Similarly, in the present study, approaches to distrust toward a colleague and the accompanying criticism ranged from showing empathy toward the colleague to developing prejudice against the parent. Given dentists' professional responsibility to act fairly and respectfully toward colleagues [34], criticism directed toward colleagues thus carries clear potential for conflict, as it may require balancing the dentist's relationship with both the colleague and the parent.

While the themes of expectations, discourse, and criticism provide insight into the issues underlying conflict in parent–dentist interactions, they also reveal the approaches adopted by dentists in response to these conflict situations. Interpretation of these approaches within the Thomas–Kilmann conflict management framework indicated that different conflict management styles were adopted both across and within scenarios, suggesting that the dentists who participated in this study did not rely on a single conflict management style. These findings are consistent with conflict management theories proposing that the appropriateness of different conflict management styles depends on the context and the individuals involved [35, 36].

Within this qualitative sample, some exploratory patterns suggested that professional experience may have been associated with the approaches adopted in particular conflict situations. Regarding a parent's expectation concerning a difficult procedure, an early-career participant adopted an avoiding style by informing the supervisor of the situation, whereas an experienced participant adopted a collaborating style by conditionally meeting the parent's expectation based on the clinical condition of the tooth. Similarly, parental criticism regarding the administration of local anesthesia appeared to be managed differently depending on professional experience. The least experienced participants rarely adopted a competing style by setting limits on parental expectations within the boundaries of professional responsibility, whereas all of them adopted a collaborating style by addressing the criticism through objective clinical findings. Taken together, these observations may suggest that the need to explain clinical decisions and seek support in conflict situations may be associated with professional experience. Another noteworthy observation was that, in scenarios involving parental criticism directed at another dentist and parental intervention detached from treatment realities, the competing style was adopted only by participants with intermediate levels of professional experience. This observation may suggest that the adoption of highly assertive conflict management styles did not follow a clear pattern across levels of professional experience. In contrast, no discernible pattern related to professional experience was observed in responses to parents' negative discourse concerning the treatment. One possible explanation is that this conflict situation involves communication with the child, and therefore may be shaped by communication and behavior guidance principles that are shared across different levels of professional experience [27].

In addition to professional experience, some observations within this qualitative sample suggested that workplace setting and sociocultural context may also have been associated with the approaches adopted in particular conflict situations. Among the participants working in private practice, expectations about reattempting treatment in the presence of the parent did not emerge as a situation requiring conflict management, as parental presence during treatment constituted a routine part of clinical practice. In contrast, participants working in university settings indicated that parental presence

during treatment was not always feasible because of institutional routines and clinical conditions. As a result, this expectation more often emerged as a situation requiring the adoption of a conflict management style. In addition, many of the participants who adopted an accommodating style through unconditionally meeting this expectation stated that they did so not because they expected parents to contribute to behavior guidance, but rather because they felt that parents were unlikely to be convinced without directly observing their child's behavior during treatment. The perceptions among the dentists who participated in this study that direct observation may be more convincing to parents than professional explanation may reflect sociocultural influences shaping parent–dentist interactions.

Taken together, these observations may suggest that professional experience, clinical setting, and sociocultural context were among the contextual and individual influences associated with the approaches adopted by the dentists who participated in this study in particular conflict situations. However, given the qualitative nature of the study and the limited number of participants within each experience group, these interpretations should be considered exploratory, and the adoption of particular conflict management styles should not be assumed to be explained solely by these influences.

Given the direct influence of parent–dentist communication on the child's treatment process in pediatric dentistry, the findings may offer several practical considerations for clinical practice [5–8, 15]. In conflicts arising from parental expectations regarding difficult procedures, it may be important to determine the most appropriate approach based on considerations such as the clinical condition of the tooth, the prevailing clinical circumstances, and professional judgment. In conflicts arising from parental expectations regarding parental presence during treatment, it may be important to determine the most appropriate approach for each child based on considerations such as the child's right to be accompanied by a legal representative during the examination, parenting style, parental compliance, and parent–child interaction [5–8, 15, 37]. In situations involving parental discourse concerning treatment, particular attention may be given to communicating with the child in a clear, honest, and age-appropriate manner [27, 38, 39]. In situations involving parental criticism and distrust, it may be important to recognize that trust is both multidimensional and dynamic [29, 32, 40]. Accordingly, the most appropriate approach may depend on the current state of trust within the parent–dentist relationship, including whether trust is established, weakened, or damaged. What matters, therefore, is not finding a single "one-size-fits-all" approach, but identifying the one best suited to the specific conflict situation and clinical context.

Beyond selecting appropriate conflict management approaches once conflict has emerged, preventing conflict in the first place is equally important. Providing clear and sufficient information about the treatment process in advance, and involving the parent in the process when necessary, may minimize communication gaps between the dentist and the parent and help prevent the emergence of conflict. Even with preventive efforts, conflict situations may still occur and require the use of appropriate conflict management approaches.

In addition, observations related to clinical setting and sociocultural context may suggest influences beyond the individual dentist in some conflict situations. In light of these observations, both the literature and the patterns observed across the interviews may provide insight into areas where educational and systemic approaches could support conflict management [29, 31, 40, 41]. Approaches aimed at strengthening communication within healthcare systems, supporting dentist–parent trust, raising public awareness of oral health, and fostering clinical environments that facilitate effective communication between dentists and parents may be beneficial. Likewise, incorporating communication and conflict management skills into specialist training curricula, and reinforcing these skills through supervision and feedback in clinical practice, may help prepare pediatric dentists for managing challenging interactions with parents. Such training may include structured reflection on conflict scenarios, simulation-based communication training, and use of the Thomas–Kilmann framework as a reflective tool for discussing clinician–parent–child interactions.

One of this study's strengths is that it goes beyond a thematic presentation of pediatric dentists' approaches to conflicts with parents, evaluating those approaches within the Thomas–Kilmann conflict management framework. This highlighted potential communication gaps, revealed conflict resolution styles, and illustrated that there is no single "one-size-fits-all solution". Furthermore, the fact that the scenarios were derived from real-life situations enhances the applicability of the findings to clinical practice.

The study has some limitations. First, as the scenarios were grounded in the clinical and sociocultural context of Türkiye, the findings should be interpreted within this specific context, and their transferability to other societies and healthcare systems may be limited. Second, all participants were female. Although male dentists were invited to participate, participation could not be achieved due to the relatively small number of male pediatric dentists and pediatric dentistry residents in the profession, together with difficulties in meeting the inclusion criteria (*e.g.*, a minimum of three years of professional experience), willingness to participate, and availability constraints within the recruitment timeframe. While the exclusively female sample broadly reflects the demographic characteristics of pediatric dentistry in Türkiye, perspectives on communication and conflict management with parents that might have emerged from male dentists may not be fully represented in the findings of this study, as these processes may also be shaped by individual experiences and interpersonal interactions. Accordingly, the transferability of the findings to the broader pediatric dentistry population should be considered with caution. Third, the absence of age-group classification in the scenario contexts limited the exploration of potential age-related differences in communication. Fourth, we had a limited number of participants within each group, which should be considered when interpreting the findings. Fifth, although maximum variation sampling was used, participants in the early and late stages of specialist training were necessarily recruited from university settings because pediatric dentistry residency programs in Türkiye are conducted within universities.

In addition, some specialists were recruited from university settings to capture the perspectives of specialists involved in the education and supervision of pediatric dentistry residents. This should be considered when interpreting the findings, as perspectives associated with university-based practice may have been more strongly represented, potentially limiting the transferability of the findings to pediatric dentists working primarily in private practice or other non-academic clinical settings. Sixth, the translation of the interviews from Turkish into English may have influenced how certain meanings and nuances were represented. Seventh, although the conflict scenarios were based on real clinical situations, participants' responses may not fully reflect their real-time behaviors in complex clinical encounters. In addition, the possibility of social desirability bias cannot be excluded. Finally, the exclusive focus on the perspectives of dentists meant that the views of children and parents were not represented.

Future research involving a broader and more diverse range of participants may help explore additional perspectives and contexts and enhance the transferability of the findings. In addition, incorporating the perspectives of children and parents may provide a more comprehensive understanding of conflict management in pediatric dentistry. Studies involving direct observation of real clinical interactions could provide further insight into how conflict management approaches are enacted in practice, whereas mixed methods research may offer a more comprehensive understanding by integrating qualitative and quantitative findings. Finally, evaluation of educational interventions designed to strengthen communication and conflict management skills in pediatric dentistry may provide valuable insights.

5. Conclusions

Effective dental treatment for children is inseparable from effective communication with parents. In this context, this study revealed three key domains shaping conflict in pediatric dentist–parent interactions: parental expectations, parental discourse, and parental criticism. It also showed that the conflict resolution styles of the pediatric dentists who participated in this study varied depending on the scenario and level of experience, and that there is no single "one-size-fits-all approach".

These findings may provide a basis for recommendations regarding future educational initiatives and system-level strategies aimed at supporting effective parent–dentist communication. Educational initiatives may focus on strengthening communication and conflict management skills during specialist training and clinical practice, and may incorporate the Thomas–Kilmann conflict management framework to facilitate the discussion and analysis of the conflict situations encountered in clinical practice. System-level efforts may support dentist–parent trust, communication within healthcare settings, and public awareness of oral health.

AVAILABILITY OF DATA AND MATERIALS

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

AUTHOR CONTRIBUTIONS

SA—conceived the study; collected the data; drafted the manuscript. CBN—critically revised the manuscript for important intellectual content. SA and CBN—developed the research design; analyzed and interpreted the data; read and approved the final version of the manuscript and agreed to be accountable for all aspects of the work.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

Ethical approval was obtained from the Ethics Committee of Kütahya Health Sciences University (reference no. 2024/13-29). Before each interview, participants were informed about data confidentiality, the study's aim, and the use of audio recording for data collection, and informed consent was obtained.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

SUPPLEMENTARY MATERIAL

Supplementary material associated with this article can be found, in the online version, at https://oss.jocpd.com/files/article/2095420555588976640/attachment/Supplementary%20material.docx.

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