
Creating Peaceful Dental Clinics: Integrating Evidence-Based Environmental Design and Compassionate Communication to Reduce Dental Anxiety and Improving Patient Experience

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Abstract

Dental anxiety remains a significant barrier to timely and equitable oral healthcare worldwide. Fear of pain, loss of control, unfamiliar sensory stimuli, and uncertainty about treatment can heighten physiological arousal, reduce cooperation, and lead many patients to delay or avoid dental visits. These patterns worsen oral health outcomes and create service pressures through cancellations, interrupted procedures, and greater reliance on crisis-based care. This conceptual and practice-oriented article synthesizes evidence from dentistry, person-centred care, trauma-informed practice, healthcare environmental design, and culturally responsive wellbeing approaches to propose the Peaceful Dental Clinic Model (PDCM). The model conceptualizes patient comfort as biopsychosocial safety co-produced through four interrelated domains: interactional safety, sensory safety, spatial safety, and cultural-ethical resonance. Interactional safety emphasizes empathy, predictability, consent-sensitive communication, and shared decision-making. Sensory safety concerns the regulation of sound, light, smell, temperature, and tactile cues that may intensify distress. Spatial safety addresses privacy, wayfinding, supportive waiting experiences, and smoother transitions across the patient journey. Cultural-ethical resonance refers to inclusive, non-coercive practices that foster dignity, compassionate speech, and optional settling supports, such as brief mindfulness-based calming. The article further organizes practical recommendations into environmental, communicative, and organizational interventions and proposes staged implementation and measurable indicators, including dental anxiety scales, patient-reported experience measures, and workflow indicators. By integrating communication, design, and ethical care practices into a single actionable framework, the proposed model offers dental leaders, educators, and clinic designers a feasible strategy to reduce anxiety, improve patient experience, and strengthen trust without compromising clinical safety or operational efficiency.

Keywords: Dental Anxiety; Patient Experience; Evidence-based Design; Trauma-informed Care; Mindfulness; Compassionate Communication

Introduction

Dental anxiety is a persistent barrier to oral healthcare and a significant determinant of avoidance, delayed attendance, and poorer oral health outcomes. A systematic review and meta-analysis found that dental fear and dental anxiety remain prevalent across adult populations and are consistently associated with postponement of care, disrupted attendance patterns, and poorer subjective oral health (Silveira et al., 2021). In practice, this problem extends beyond individual distress. Patients who enter care late often present with more complex needs, while missed appointments, interrupted procedures, and heightened demand for reassurance place additional pressure on chair time, clinic workflow, and staff attention. Dental anxiety should therefore be understood not only as a psychological issue, but also as a quality-of-care, service-delivery, and public health concern.

The dental setting contains multiple cues that can intensify threat appraisal, including bright lights, high-frequency sounds, unfamiliar smells, close physical proximity, invasive touch, and limited opportunities to speak during treatment. These conditions often heighten uncertainty and reduce perceived control. As a result, the patient experience begins before the procedure itself: it begins with booking systems, reception encounters, waiting environments, and the language clinicians use to explain what will happen next. The World Dental Federation's Vision 2030 agenda positions oral healthcare within a broader person-centred and integrated health framework, underscoring that communication, trust, engagement, and equity are fundamental to quality care rather than peripheral concerns (Glick et al., 2021).

Recent evidence supports the value of nonpharmacological strategies for moderating anxiety and improving cooperation. The American Academy of Pediatric Dentistry (AAPD, 2025) continues to emphasize behaviour guidance and communication as central components of safe care, while systematic reviews show beneficial effects from sensory-adapted environments and low-risk calming interventions such as music (López-Valverde et al., 2024; Reynolds et al., 2023). At the same time, broader evidence-based design research demonstrates that environmental features such as privacy, noise control, lighting, and wayfinding influence stress, safety, and perceived quality of care (Ulrich et al., 2008). Dental-

environment studies similarly suggest that waiting rooms, treatment rooms, and circulation patterns are active contributors to patient comfort rather than neutral backdrops (Emami et al., 2024; Lundberg et al., 2024; Sarapultseva et al., 2022).

Against this background, the present article offers a conceptual and practice-oriented synthesis rather than a report of original empirical research. Its purpose is threefold: first, to clarify how clinic environments, communication styles, and organizational routines shape dental anxiety; second, to propose the Peaceful Dental Clinic Model (PDCM) as an integrative framework for patient comfort and dignity; and third, to translate that framework into implementation-oriented guidance for dental settings seeking to reduce anxiety while maintaining efficiency, safety, and cultural sensitivity. The article further argues that in contexts where ethical vocabularies such as mindfulness, non-harming, and compassionate speech are culturally familiar, they may serve as locally resonant but strictly voluntary supports for humane care (Ven. Pannasara et al., 2024).

Dental anxiety as a biopsychosocial threat appraisal

Dental anxiety can be understood as a dynamic threat appraisal shaped by prior experience, expectation, perceived vulnerability, and situational cues. In dentistry, patients evaluate not only the anticipated pain of treatment but also whether the encounter feels predictable, controllable, and respectful. These appraisals are continuously updated through sensory information such as sound, vibration, smell, body position, and time pressure, as well as through social information such as tone of voice, pace, eye contact, and consent practices. When cues signal low predictability and low control, patients may interpret even routine procedures as threatening. Conversely, when clinicians explain steps clearly, invite questions, and establish pause mechanisms, the same procedure can be experienced as manageable rather than overwhelming. This point is important because it shifts the focus from a narrow understanding of anxiety as an internal patient trait to a broader understanding of anxiety as co-produced by the patient, the clinical environment, and the encounter itself.

Person-centred care, shared decision-making, and trauma-informed practice

Person-centred care is increasingly recognized as a clinical and ethical standard in dentistry. At its core, person-centred care requires that the patient's concerns, preferences, and goals shape the clinical conversation rather than being treated as barriers to technical work. Shared decision-making operationalizes this

principle by inviting patients into the treatment dialogue, presenting options with benefits and burdens, checking understanding, and making explicit room for questions. A recent overview of dentist-patient communication argues that clarity, empathy, and mutual understanding are essential components of high-quality dental care and can be trained and reinforced (Ho et al., 2025). For anxious patients, shared decision-making is not merely courteous; it is an anxiety-reduction strategy because it restores agency and mitigates the helplessness that often accompanies dental treatment.

Trauma-informed care further strengthens this perspective by treating safety, trustworthiness, collaboration, and empowerment as universal precautions rather than special accommodations reserved for disclosed trauma histories. Choi et al. (2025) argue that oral health practitioners are likely to encounter patients whose behaviour has been shaped by trauma even when trauma is not disclosed, and Kang et al. (2026) similarly conclude that trauma-informed practice should be normalized within everyday dental care. In practical terms, this means asking permission before touch, offering stop signals, avoiding shaming language, minimizing surprises, and explaining transitions before they occur. These practices are low-cost, ethically robust, and compatible with routine clinic operations.

Environmental design as a determinant of perceived safety

Evidence-based design research demonstrates that healthcare environments affect patient outcomes through pathways such as noise reduction, privacy, better lighting, improved visibility, supportive layouts, and reduced cognitive load (Ulrich et al., 2008). Although much of this literature originates in hospital and medical settings, its relevance to dentistry is direct because dental care is unusually sensory-intensive and often performed under conditions of heightened vulnerability. Dental-specific studies reinforce this conclusion. Sarapultseva et al. (2022) found that both patients and staff attend to environmental cues when evaluating the psychological comfort of dental clinics, while Emami et al. (2024) demonstrate that design features in dental waiting areas influence how patients perceive stress during the pre-treatment period. Lundberg et al. (2024) further show that waiting-room ambience and low-risk interventions during waiting can reduce physiological and self-reported stress. Together, these studies suggest that the environment is not simply decorative; it is an active clinical variable that can either amplify or attenuate threat appraisal.

Compassionate and culturally responsive care

Communication in dentistry is never purely informational. It also conveys judgment, safety, hierarchy, and emotional tone. Brief verbal encounters can either protect dignity or intensify shame, particularly for patients who have delayed care and expect criticism. Compassionate communication, therefore, functions as both a clinical skill and an ethical practice. In culturally Buddhist contexts, language around mindfulness, compassionate speech, and non-harming can offer a familiar ethical vocabulary for articulating dignity in care, provided such language is used in a nonsectarian and entirely voluntary manner. Ven. Pannasara et al. (2024) frame mindfulness and healthy living as practical disciplines of daily life rather than as abstract ideals. Applied cautiously in clinical settings, this perspective supports a humane model of care in which patients are guided without coercion, fear is acknowledged without dramatization, and emotional settling is supported without imposing belief. The important principle is not religious identity, but respect for persons through compassionate, culturally sensitive, and autonomy-preserving practice.

The Peaceful Dental Clinic Model

To operationalize the synthesis above, this article proposes the Peaceful Dental Clinic Model (PDCM), an integrative framework that treats patient comfort as biopsychosocial safety co-produced through four domains: interactional safety, sensory safety, spatial safety, and cultural-ethical resonance. The model is designed to be conceptually coherent and practically adoptable. It assumes that leadership commitment, staff training, environmental audit, and patient feedback serve as enabling inputs; that communication routines, sensory moderation, privacy protection, and supportive workflow are the core activities; and that the mechanism of improvement is the reduction of uncertainty, shame, and overload together with the strengthening of predictability, control, and trust. These mechanisms are expected to yield lower anxiety, better cooperation, improved patient experience, fewer cancellations, and safer procedures.

Interactional safety concerns the relational conditions that help patients feel respected, heard, and informed. It includes greeting rituals, eye-level explanations, anticipatory guidance, explicit permission before touch, and meaningful pause options. Interactional safety is especially important because patients often interpret staff behaviour as a signal of whether their distress will be taken seriously. A hurried or dismissive tone can increase arousal even when the

clinical procedure is technically excellent. By contrast, structured empathy and predictable communication reduce uncertainty and normalize questions without trivializing fear.

Sensory safety concerns the modulation of the sensory environment. Dentistry is unusually intense from a sensory perspective because it concentrates bright lighting, mechanical sound, water spray, suction, taste cues, and close bodily proximity. Sensory safety, therefore, includes the strategic control of noise, lighting, smell, temperature, and tactile intrusiveness. The aim is not to eliminate all stimulation, which is impossible, but to avoid unnecessary overload, provide a realistic preview of sensations, and introduce calming counter-cues where feasible. Evidence for music-based anxiety reduction and sensory-adapted environments suggests that even modest interventions can reduce pre-treatment stress and improve cooperation (López-Valverde et al., 2024; Reynolds et al., 2023).

Spatial safety refers to the experience of layout, movement, privacy, and transition. Patients enter clinics already evaluating cleanliness, order, privacy, and whether they know where to go next. Confusing navigation, overheard conversations, crowded waiting zones, and abrupt transitions between spaces all increase stress by reducing perceived competence and predictability. Spatial safety, therefore, emphasizes intuitive wayfinding, privacy-sensitive reception processes, supportive waiting environments, uncluttered treatment spaces, and calm handoffs between zones. In this framework, the waiting period is not administrative downtime but part of the treatment encounter.

Cultural-ethical resonance refers to the way organizational values become tangible in everyday practice. It includes dignity-preserving language, non-blaming explanations, inclusivity, and optional settling supports such as guided breathing, silent pause, or patient-selected music. In some settings, a vocabulary of mindfulness or compassionate speech may be culturally resonant and helpful, but the model insists that these supports remain voluntary, nonsectarian, and subordinate to patient preference. Cultural-ethical resonance matters because patients not only interpret technical competence; they also interpret moral tone. A clinic that communicates patience, non-harming, and respect is more likely to be trusted, especially by patients who already expect embarrassment or judgment.

Table 1: Peaceful Dental Clinic Model (PDCM): domains, mechanisms, and practice indicators

Domain	Core Focus	Primary Mechanism	Illustrative Practice Indicators
Interactional safety	Respectful, predictable, consent-sensitive communication	Reduces uncertainty and restores perceived control	Greeting and orientation; explain-before-doing; stop-signal protocol; teach-back; shared decision-making
Sensory safety	Modulation of sound, light, smell, temperature, and tactile load	Reduces overload and anticipatory arousal	Noise buffering; sensory preview; music option; glare control; minimize avoidable odours
Spatial safety	Privacy, wayfinding, supportive transitions, and calm layout	Strengthens trust cues and lowers cognitive load	Private check-in; clear signage; organized waiting zones; smoother movement to treatment rooms
Cultural-ethical resonance	Dignity, inclusivity, compassionate norms, and optional settling supports	Reduces shame and improves relational safety	Non-blaming language; voluntary breathing pause; patient-selected coping support; respectful cultural sensitivity

Environmental Design Implications for Peaceful Dental Clinics

Reception and arrival are the first regulatory moments

Arrival is a stress-sensitive moment because patients actively scan for cues of threat and safety. Reception design should therefore reduce exposure, noise, and ambiguity. Privacy-sensitive check-in procedures, clear visual order, and a calm tone at the front desk prevent the first interaction from becoming an additional stressor. Staff should avoid discussing sensitive information in others' earshot and use short, predictable phrases to orient patients to the next step. Even basic environmental features such as uncluttered counters, visible appointment flow, and comfortable seating distances can improve perceived safety by reducing both embarrassment and uncertainty.

Waiting areas as active components of care

The waiting area should be understood as part of the treatment environment rather than as a neutral holding space. Evidence indicates that waiting-room

ambience can influence stress and anxiety before treatment (Emami et al., 2024; Lundberg et al., 2024). A peaceful waiting area is quiet without feeling empty, visually legible without being sterile, and comforting without appearing infantilizing. Useful design principles include moderate sensory load, acoustic buffering, reduced television noise, supportive lighting, predictable waiting information, and simple access to water or tissues. Where resources permit, clinics may incorporate positive distraction such as patient-selected music, nature imagery, or other nonintrusive calming stimuli. The aim is to transform anticipatory waiting from passive exposure to stress into supported preparation.

Wayfinding, signage, and transition management

Poor wayfinding increases cognitive load and can undermine dignity by forcing repeated requests for help. Clear and humane signage reduces stress by confirming that patients are in the right place and know what happens next. Transition management is equally important. The movement from the waiting room to the treatment room is often abrupt and may intensify anticipatory fear. Staff can reduce this effect by narrating transitions in simple, calm language and by ensuring that circulation paths are uncluttered and visually coherent. Small environmental cues such as directional markers, room numbers, and brief reassurance signs can be especially helpful for first-time patients, older patients, or highly anxious patients.

Treatment rooms: balancing technical demands with calm

Treatment rooms must meet infection-control and procedural-efficiency requirements, yet they can still be designed to preserve calm. Glare should be controlled where possible; unnecessary noise should be minimized; instruments not immediately required should be kept visually contained; and odour sources should be managed carefully. Patients benefit when clinicians introduce key sensations honestly and briefly before they occur. This sensory preview can be supported by the room environment itself: visible organization, a prepared chair area, and a sense that the room is ready rather than chaotic. Privacy also remains crucial. Patients who fear judgment are acutely sensitive to overheard comments and to being exposed, so screens, doors, and sound management should be used deliberately to protect dignity.

Staff areas and organizational climate

A peaceful clinic cannot be sustained if the work environment continually overwhelms staff. Stress contagion is real: hurried, overloaded clinicians are more likely to communicate abruptness, impatience, or inattentiveness. Staff

areas therefore matter indirectly to patient comfort because they shape the emotional regulation capacity of the care team. Quiet zones for documentation, structured handoff spaces, and realistic workflow pacing support more consistent communication and reduce avoidable relational friction. In this sense, environmental design for patients and for staff should not be separated too sharply; both contribute to the overall atmosphere of safety and trust.

Compassionate Communication and Behavioural Micro-Skills

Predictive explanation and stop-signal protocols

High-quality communication in dentistry should be brief, structured, and anticipatory. Patients do not need long technical lectures during stressful moments; they need concise explanations that clarify what they are likely to hear, feel, and experience, how long a sensation will last, and what options they have if discomfort becomes too great. Predictive explanation reduces uncertainty, which is one of the strongest amplifiers of anxiety. A universal stop-signal protocol is particularly valuable because it formalizes patient agency. Before treatment begins, the clinician can explain a simple hand signal that will pause treatment immediately. This protocol demonstrates respect for control, reassures anxious patients that they are not trapped, and is consistent with trauma-informed principles of safety and empowerment (Choi et al., 2025; Kang et al., 2026).

Shared decision-making and teach-back

Shared decision-making should be visible in the encounter rather than merely implied by professional goodwill. A useful structure is to ask about the patient's main concern, explain the options in plain language, and then check understanding through teach-back or a concise summary from the patient. Teach-back is particularly important because anxious patients may appear to agree while misunderstanding the procedure, aftercare, or implications of delay. Ho et al. (2025) emphasize that mutual understanding is central to quality dental care, and in the present framework, teach-back also functions as a dignity practice: it signals that the patient's comprehension matters and that informed agreement is more important than passive compliance.

Dignity-preserving language

Language can either protect dignity or intensify shame. Patients who have postponed care often anticipate blame about oral hygiene, attendance, or treatment complexity. For this reason, clinicians should replace judgment-laden phrases with supportive and future-oriented language. Rather than saying, "You

should have come earlier," a clinician might say, "We can work from where things are now and make the next steps manageable." Rather than saying, "You need to be less nervous," a clinician might say, "Many people feel tense here; let us slow down and go step by step." Compassionate speech does not require excessive sentimentality. It requires precision, calm, and the deliberate avoidance of language that humiliates or pressures the patient.

Optional settling practices

Some patients benefit from brief, noncoercive settling practices before injections, drilling, or other high-intensity moments. These may include one or two guided breaths, a short silent pause, patient-selected music, or grounding language such as, "Feel your feet on the floor; we will go one step at a time." Such supports should always be offered, never imposed, and should be framed as practical coping options rather than moral obligations to be calm. In culturally Buddhist settings, a simple vocabulary of mindfulness or steady attention may feel familiar and acceptable; however, any such language must remain pluralistic and responsive to the patient's wishes. The goal is not spiritual instruction but momentary reduction of physiological arousal so that the patient can re-enter the procedure with more stability.

Team communication and continuity

Anxiety increases when patients must repeatedly retell their concerns or when handoffs feel abrupt and disjointed. Team continuity can be improved through brief verbal handoffs that identify both the clinical plan and the patient's comfort needs. For example, a receptionist may note that the patient prefers step-by-step explanation, and the dental assistant can confirm that preference before the dentist begins treatment. This continuity communicates that the clinic has listened and that comfort is a legitimate part of care rather than a private burden the patient must manage alone.

Implementation and Evaluation

Because the PDCM is intended as a practice-oriented framework, implementation should proceed through staged quality improvement rather than through one-time redesign. The first requirement is governance. Clinics should designate a person responsible for coordinating patient comfort initiatives across reception, treatment rooms, and follow-up communication. This role does not

need to sit at the top of the formal hierarchy, but it should have sufficient visibility to gather feedback, organize training, and monitor whether agreed practices are actually used.

The second requirement is a structured environmental and workflow audit. A 45- to 60-minute walk-through can be conducted from three perspectives: the first-time patient, the highly anxious patient, and the staff member moving under time pressure. The audit should identify where noise rises, where privacy is compromised, where navigation becomes confusing, where explanations are missing, and where transitions feel abrupt. This kind of audit is valuable because it reveals barriers that staff often normalize yet remain highly salient to patients.

The third requirement is the establishment of standard comfort protocols. These protocols should be short, observable, and embedded in routine care. Examples include: orienting the patient at the first point of contact, confirming the stop signal before treatment, providing sensory preview before high-intensity steps, using teach-back for consent and aftercare, and closing the encounter with a brief summary of what was done and what to expect next. Standardization reduces variability and helps ensure that compassionate care is not dependent on individual personality alone.

Training should be brief, frequent, and behaviourally specific. Micro-training formats work well: short demonstrations, scripted rehearsal, peer observation, and rapid debriefs after difficult encounters. Communication skills can degrade under time pressure unless they are revisited repeatedly. For that reason, training should be treated as an ongoing feature of service quality rather than a one-off workshop. Clinics may also benefit from incorporating comfort protocols into new-staff orientation so that the desired relational culture is introduced from the outset.

Evaluation is essential because a peaceful clinic should be demonstrably better, not merely more aesthetically pleasing. Anxiety and distress can be measured through validated dental anxiety scales administered before or after visits. Patient-reported experience measures can assess perceived respect, clarity, autonomy, environmental comfort, and overall satisfaction. Operational indicators such as missed appointments, early termination of procedures, escalation to pharmacological management, and complaint patterns may provide additional evidence of impact. Cross-sector work on PREM instruments illustrates the usefulness of short, structured experience measures for routine

quality monitoring (Tint et al., 2025). Together, these tools allow clinics to judge whether comfort interventions are improving patient experience and workflow rather than simply appearing well-intentioned.

Table 2: Suggested measurement framework for peaceful dental clinics

Domain of evaluation	Example indicator	Data source	Managerial use
Anxiety and distress	Pre/post dental anxiety rating; self-reported distress during visit	Brief patient questionnaire	Track whether interventions reduce anticipatory and procedural anxiety
Patient experience	Respect, clarity, autonomy, environment, overall visit rating	Short PREM survey or digital follow-up	Identify weak points in communication and the environment
Workflow and operations	No-show rate, cancelled procedures, and procedure interruption frequency	Scheduling and clinic logs	Estimate efficiency gains and implementation return
Safety and quality	Adverse events, sedation escalation, complaint patterns, and consent comprehension	Clinical audit and incident review	Ensure comfort strategies align with safety and informed care

Ethical and Cultural Safeguards

The PDCM is intentionally patient-centred, but its ethical integrity depends on several safeguards. First, all calming supports must remain voluntary. Patients should never be pressured to listen to music, practise breathing, use mindfulness language, or disclose emotional histories in order to receive care. The purpose of these supports is to expand coping options, not to shift responsibility for distress onto the patient. Second, cultural sensitivity should be pluralistic. Even when mindfulness or compassionate speech resonates with local culture, such language must remain inclusive and adaptable to patients with different beliefs, preferences, literacy levels, or prior negative experiences.

Third, peaceful-care discourse should not be instrumentalized into a branding exercise detached from equity. The most important interventions in this framework are often inexpensive: private check-in phrasing, stop signals, clearer explanations, reduced clutter, better signage, and more respectful handoffs. If comfort design is framed only as a premium aesthetic service, it risks widening inequalities and missing the populations who may benefit most. Fourth, staff should work within professional boundaries. Communication training, settling scripts, and trauma-informed awareness are appropriate; psychotherapy, spiritual direction, or coercive disclosure are not. The clinic's task is to create conditions in which patients can feel safer and more respected, not to redefine the dental visit as a therapeutic or religious encounter.

Finally, the framework should be understood as adaptable rather than rigid. Different clinic types, patient populations, and resource levels will require different combinations of environmental and communicative interventions. The goal is not perfect environmental calm at all times, which may be unrealistic in busy clinical settings, but a consistent organizational commitment to predictability, dignity, and humane care.

Conclusion

Dental anxiety is sustained not only by fear of pain but also by uncertainty, loss of control, sensory overload, and fear of judgment. These mechanisms are shaped by environments, workflows, and communication norms as much as by individual disposition. The Peaceful Dental Clinic Model responds to this reality by reframing patient comfort as biopsychosocial safety co-produced through four interrelated domains: interactional safety, sensory safety, spatial safety, and cultural-ethical resonance. In doing so, it moves the discussion beyond isolated tips for anxious patients and toward an integrated understanding of clinic design, staff behaviour, and organizational culture.

The contribution of this article is therefore both conceptual and practical. Conceptually, it positions a peaceful dental clinic as a measurable environment of dignity, predictability, and trust rather than as a purely symbolic ideal. Practically, it translates that vision into implementable actions such as stop-signal protocols, sensory preview, private check-in procedures, supportive waiting-room design, dignity-preserving language, and staged quality-improvement processes. These interventions matter because many of them are low cost, compatible with routine outpatient care, and aligned with both trauma-informed and person-centred principles.

The broader implication is that patient comfort should be treated as part of clinical quality, safety, and equity. Dental leaders can use the framework to strengthen service design, educators can integrate these competencies into training, and clinic teams can adapt the model to different cultural and organizational contexts. Future research should test the framework across diverse dental settings and identify which bundles of environmental and communicative interventions yield the greatest gains in anxiety reduction, cooperation, and patient-reported experiences. Even so, current evidence is sufficient to justify action: when dentistry is organized around predictability, autonomy, and compassion, care becomes not only more efficient but also more humane.

References

- American Academy of Pediatric Dentistry. (2025). *The reference manual of pediatric dentistry: 2025–2026*. American Academy of Pediatric Dentistry.
- Bodhisatirawaranggoora, D. P., Thepa, P. C. A., Sutthirat, M. N., & Promchin, C. (2024). Mindfulness practices in the Thai society context. *Journal of Dhamma for Life*, 30(1), 96–113. <https://doi.org/10.14456/jdl.2024.9>
- Choi, K. S., Sohn, W., & Leadbeatter, D. (2025). Safe haven – a trauma-informed care model for oral health practitioners: A commentary. *British Dental Journal*, 239(10), 717–721. <https://doi.org/10.1038/s41415-025-8862-5>
- Emami, M., Pazhouhanfar, M., & Stoltz, J. (2024). Evaluating patients' preferences for dental clinic waiting area design and the impact on perceived stress. *Buildings*, 14(10), 3160. <https://doi.org/10.3390/buildings14103160>
- Glick, M., Williams, D. M., Ben Yahya, I., Bondioni, E., Cheung, W. W. M., Clark, P., Jagait, C. K., Listl, S., Mathur, M. R., Mossey, P., Ogawa, H., Seeberger, G. K., Sereny, M., & Séverin, T. (2021). *Vision 2030: Delivering optimal oral health for all*. FDI World Dental Federation.
- Ho, J. C. Y., Chai, H. H., Luo, B. W., Lo, E. C. M., Huang, M. Z., & Chu, C. H. (2025). An overview of dentist-patient communication in quality dental care. *Dentistry Journal*, 13(1), Article 31. <https://doi.org/10.3390/dj13010031>
- Kang, K. S., Choi, K. S., Sohn, W., & Leadbeatter, D. (2026). Trauma-informed care practice for dental practitioners: A scoping review. *Australian*

- Dental Journal*. Advance online publication. <https://doi.org/10.1111/adj.70043>
- Lundberg, A., Hillebrecht, A.-L., & Srinivasan, M. (2024). Effect of waiting room ambience on the stress and anxiety of patients undergoing medical treatment: A systematic review and meta-analysis. *Advances in Integrative Medicine*, 11, 47–68. <https://doi.org/10.1016/j.aimed.2024.04.004>
- López-Valverde, N., López-Valverde, A., Macedo de Sousa, B., & Blanco Rueda, J. A. (2024). Efficacy of music therapy on stress and anxiety prior to dental treatment: A systematic review and meta-analysis of randomized clinical trials. *Frontiers in Psychiatry*, 15, 1352817. <https://doi.org/10.3389/fpsyt.2024.1352817>
- Ven. Pannasara, Mahatthanadull, S., & Phramaha Nantakorn Piyabhani. (2024). Buddhist ways of healthy living for people in the information technological era. *The Journal of International Buddhist Studies College*, 10(1–2), 267–282.
- Sarapultseva, M., Zolotareva, A., Nasretdinova, N., & Sarapultsev, A. (2022). The healing environment of dental clinics through the eyes of patients and healthcare professionals: A pilot study. *International Journal of Environmental Research and Public Health*, 19(20), 13516. <https://doi.org/10.3390/ijerph192013516>
- Silveira, E. R., Cademartori, M. G., Schuch, H. S., Armfield, J. A., & Demarco, F. F. (2021). Estimated prevalence of dental fear in adults: A systematic review and meta-analysis. *Journal of Dentistry*, 108, 103632. <https://doi.org/10.1016/j.jdent.2021.103632>
- Tint, S. S., Oo, M. Z., Buawangpong, N., et al. (2025). Instruments for assessing patient-reported experience measures among patients with diabetes mellitus: A scoping review. *Journal of Patient-Reported Outcomes*, 9, 16. <https://doi.org/10.1186/s41687-025-00848-7>
- Ulrich, R. S., Zimring, C., Zhu, X., DuBose, J., Seo, H.-B., Choi, Y.-S., Quan, X., & Joseph, A. (2008). A review of the research literature on evidence-based healthcare design. *HERD: Health Environments Research & Design Journal*, 1(3), 61–125. <https://doi.org/10.1177/193758670800100306>

