

Eliminating pediatric behavior management problems at the outset: inviting parents into the dental operator

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Introduction

Among the most common of iatrogenic causes of initial pediatric dental misbehavior occurs when a young or fearful child is separated from their parent and escorted by a stranger into the dental operator. While many children ages four and older can readily be separated from the parent and enter the dental operator alone without consequence, timid, moderate to severely apprehensive, and pre-cooperative children, however, can be expected to find detachment from a parent in new circumstances a highly frightening event. Not astonishingly, workplace policies that demand arbitrary or necessary separation has potential to precipitate a behavior management drawback before one need occur [1]. At this juncture, having to confront a hysterical and crying child from an otherwise content child with the comfort of their parent is avoidable from the outset.

Managing children who lack cooperative potential is a daily occurrence for many generalists and pediatric dentists alike. The question of the practicality and the useful nature of including parents within the dental operator have long been controversial. Trends over the last few decades appear in the direction that more and more parents have interest to be present to observe how their children respond to clinicians' management style in the same way more clinicians seem willing to permit the child to have a familiar face present during initial and subsequent treatment visits [2].

For some clinicians experienced or novice, comfort levels to include parent presence are entrenched in divergent directions. Some practitioners are simply not comfortable with a parent witnessing how they speak to their patients or the techniques they employ. Under these circumstances, referral may best be the appropriate course of action. Both pediatric dentists and advanced training programs even today seem to be advocates of either one school of thought or the other, permitting parents or excluding parents [3-7]. Somewhere in the middle, it might be speculated that a majority likely gravitate to a more flexible stance and defer judgment to the circumstances that present for a given child. Those favoring parent exclusion from the outset are believed authoritarian in demeanor and believe it is their responsibility to establish a rapport with the child without interruption or competition with the parent. This management style has high expectations for cooperation from their patients and many are highly successful in manipulating child behaviors in their efforts to elicit obedience; these clinicians express great pride in their ability to circumvent interfering child misbehaviors. This authoritarian style readily informs the child when behavior is unacceptable and what is expected to remain within his/ her good graces. While successful with some apprehensive or resistive children, massive confrontations can be expected to often result when two strong-willed personality types face off [2].

This orientation is generally viewed as a result of one's training and a strategy endorsed by

one's mentors. This author, on the other hand, is a product of a philosophy of "child advocacy," whose role is to guide children in the desired direction through compassion, patience, and understanding while eliciting input and insight from a parent who is acknowledged from the outset to know their child best.

In this respect, practitioners can be quite different in the extent to which their styles impact on variable child disposition and behavior. One's presence no doubt plays differently with some children, some of whom make quick recognition that this isn't a figure they "wish to find contention with" [2]. In much the same way that children in a classroom develop an immediate sense for the level of control a teacher brings be it weak or strong, children are adept at reading who the authority figure is (or isn't) in the dental office. The dentist who arbitrarily excludes the privilege of the parent wishing to be present, or the child's preference for their parent's presence, in this author's opinion does so at his/her peril. This paper seeks to elaborate on the consequences for parental inclusion vs. exclusion, from the perspective of a child, a parent and a clinician seeking to avoid unnecessary and unproductive confrontations at the outset of an initial dental visit. The global objective is to dissuade those of the older school of thinking to grasp and make use of overwhelming advantages to be gained by routinely enabling parents, both trusting and skeptics, to accompany their children in the operatory. While not a panacea, the below dialogue seeks to offer logical evidence of the merit of parental inclusion leaving the flexible clinician with numerous and viable options when confronting initial challenging child behavior.

It is not the intent of this paper to indicate bias or judgment to policies that embody or exclude parental presence. There seems to be no argument amongst clinicians that there are adequate reasons to exclude some parents. Those who are not able to refrain from display of their own negative or fearful attitudes toward dentistry, through what they convey by words or body language, or those unable to refrain

from challenging the dental team for the attention of their child can be problematic for the dentist. On the other hand, taking time to briefly counsel such parents privately may suffice to bring the parent(s) on board. In most cases, this approach can remedy a failing initial interaction.

Unlike pediatric practice, wherever uncomfortable or invasive procedures, temporary or prolonged, are performed underneath general anesthesia or sedation, the dental practitioner confronts separation anxiety of a young child on an everyday basis with expectations that uncomfortable procedures are usually undertaken with very little or no pharmacological assistance. Often the choice to include or exclude a parent isn't altogether easy. Efforts to establish and define parameters with the target of making an environment most conducive to gaining a child's attention and compliance are subject to several limitations. For all intent and purpose, skilled societies like the AAP and AAPD acknowledge wide variation among practitioner philosophy, training and knowledge additionally to a wide range of ever-evolving parental child-rearing practices, preferences, and attitudes. Guthrie [8] accurately has noticed from a historical perspective organized odontology has long preferred parental exclusion.

Over time, instances have arisen within which authority and methods used by clinicians to reform non-compliant child behaviors have been raspably scrutinized. Once considered reasonable and appropriate some have become discredited or abandoned, or at the very least, discouraged in some old-time and aversive methods. Parental preferences and patient acceptance of the practitioner to establish authority and/or give discipline for harmful behavior has lessened.

Parents today are different than in the past. In earlier decades, parents might best be characterized as having vocalized universal acceptance of the clinician's judgment and recommendations as to how to best manage a given child. Parents of these days show increasing interest and involvement to witness

the clinician's style and actively participate in choices on techniques considered appropriate for his or her child. Some require explanation at length; some despite reasonable discussion stay skeptical if not mistrusting. Still others, specifically wherever their presence is excluded, seem to have no problem in having the dentist confirm the appropriateness of their presence. Regardless of whether or not a practitioner chooses to incorporate or deny parental access, their obligation to secure patient cooperation with full informed consent remains intact.

In the dental profession, resistance to parental presence in healthcare is not limited. Presence of family or parent is prohibited in many hospitals in emergency, operating room, and recovery room settings. Reasons enlisted include, space limitations, the invasive nature and painfulness of the procedures, acute illness and life threatening situations [2]. Alternately in the last decade there are some pediatric surgical center and hospital settings moving toward giving parents the choice of their presence throughout induction of anesthesia; some claim need for pre-op medication is lessened or eliminated with less recovery and quicker discharge. Observations of this author include parents (and O.R. personnel) having mixed emotions, feeling their presence will be helpful, yet find themselves being escorted out in tears or distressed by the experience. No studies have been conducted which explore parent assessment of these interactions. While anesthesiologists acknowledge the potential benefit of parent presence to achieve the afore mentioned, it might be hypothesized by their reactions that they would prefer to avoid having their personnel direct attention away from the child to a parent (some experiencing syncope).

In development for children 10-24 months, separation anxiety is considered a normal component and necessary adaptation [8]. In the presence of anxiety, however, the interpretation of what constitutes age applicable behaviors becomes ambiguous and not clear. Young children have a restricted range of coping abilities, limited cognitive skills

and limited maturity coping with stress. In anxiety provoking situations, they can be particularly vulnerable to maladaptive responses. Under this status, there are no age limits by which one might consider separation anxiety from a parent to no longer be questionable [1].

The merit of parent presence with regard to the development of coping skills among the young child are examined prospectively a few dental studies [9,10]. Other reports are either subjective surveys or anecdotal. Including the ADA many dental institutions were early advocates of child separation years ago. For encouragement of children to enter the operatory alone, subtle and less than subtle campaigns were promoted. Prospective information to assess the appropriateness of such was required and despite substantial demonstration that this was basically unsound for apprehensive youngsters, teaching philosophies weren't dramatically altered to inspire and foster parental presence. During this era, it had been acknowledged that the general public had very little problem in allowing the clinician to best determine how to shape their child's behavior and acceptance of care. It is noteworthy that not till 1996 the AAPD formally recognized the utility of having a parent present as a particular management technique to address the child's attention and compliance, and avoid negative techniques [11].

Presence of parent can be used as a technique to effectively and calmly circumvent initial displays of severely uncooperative or resistant child behavior.

Among the distinct advantages offered by parental inclusion is to provide an opportunity for dialogue between dentist and parent to jointly observe and determine a child's capacity for cooperation. Together, both dentist and parent can witness the extent by which behavior manifests a challenge; the dentist can identify the plusses and minuses associated with viable treatment modality options, and the parent is provided opportunity for questions and feedback. The dentist may consider a technique which makes use of the

parent presence as a reward and positive reinforcement. Under circumstances where child behavior proves refractory to all reasonable efforts to secure the child's attention, the technique [2, 12,13] initially involves clarification to the parent on how they wish to use the parent's presence to shape the child's behavior.

While this could be time overwhelming, time taken to explain the technique has potential to speedily re-direct the child's unwillingness to concentrate and cooperate to one of compliance. If having the parent present is desired by the child, it may have an almost immediate result. In some instances, mention of Mom being asked to leave the treatment space is sufficient to induce acceptable child behavior; different times, the sight of the parent starting up to go away can induce a change in behavior for the better. Typically the parent might have to leave the area, return upon a desired change in child behavior, and so leave again as negative behavior recurs, and come many times till the child realizes he/she will have to mind the dentist if he/she wants the parent to remain. Behavior can be expected to enhance after 2-3 trials. If this continues 2-3 times to no avail, the dentist and parent may need to re- assess their options. Recalcitrant youngsters might currently need a non-mainstream modality if urgent treatment needs are identified. Regardless, all efforts by parent and dentist are expended to give the child a selection and that their feelings are considered to be meaningful. Voices and demeanor are never raised or harshly offered. In this manner, the child has some control, and self-esteem remains intact. Similarly, the choices given remain acceptable to the dentist. At this juncture, chance for parent and dentist to jointly review future exploits will stay healthy and intact. Years of observations of this author concerning this technique realize even a reticent parent to become a robust advocate and referral source for the dentist's experience and compassionate management skills for his/her considerateness, calm demeanor that shows no alarm to initial displays of their child's negative behavior and for his or her systematic and soft approach.

Arbitrary or mandatory parent exclusion may serve to remove this potentially effective tool from one's arsenal of positive reinforcement tools to redirect initial uncooperative behaviors (some of which may originate from parent-child separation at the outset.

Lastly, an extra profit to parent presence, when mutually agreed upon, includes chance for the dental team to be assured of in progress parental approval and consent. This allows the dental practitioner to stay alert for changes in parental expression, body language or verbal cues to signal approval/ disapproval of the direction of applied approaches being taken. From the vantage of practice management, allowing parents within the dental operator has potential to permit chance to not miss what the dental practitioner is in a position to accomplish with their child.

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