CH. 3 NONPHARMACOLOGIC MANAGEMENT OF CHILDREN'S BEHAVIORS

McDonald, Avery, Dean. Dentistry For The Child And Adolescent, 8th Ed. Page: 33-49

Tuesday 21\10\2014
1:00 pm-2:00 pm
LECTURE OUTLINE

1. PEDIATRIC DENTAL PATIENTS:
   • Variables Influencing Children's Dental Behaviors
   • Classifying Children's Cooperative Behavior
   • The Functional Inquiry

2. PARENTS OF PEDIATRIC PATIENTS

3. STRATEGIES OF THE DENTAL TEAM:
   • Preappointment Behavior Modification
   • Fundamentals of Behavior Management
   • Communicating with Children
   • Behavior Shaping
   • Retraining
   • Aversive Conditioning
   • Practical Considerations
   • Limitations
OBJECTIVES

1. Define Behaviour Management In Treating Children
2. Define Pediatric Dentistry Treatment Triangle
3. Describe Variables Influencing Children’s Dental Behavior
4. Children Behaviours That The Student Encounters In The Office
5. List The Pedo Word Substitute For Dental Terminology (Childrenese).
6. Discuss The Strategies Of Dental Team
7. Describe Effective Communication Techniques Of Child Management In The Dental Office.
8. Describe Behaviour Shaping Model, Retraining, Aversive Conditioning, Practical Considerations And Limitations Influencing Practice Of Dentistry For Children.
A professional goal is to promote positive dental attitudes and improve dental health of society. A major difference between treatment of children and treatment of adults is relationship (pediatric dentistry treatment triangle). Recently, society has been centered in triangle. Management methods acceptable to society and influencing treatment modalities. Child is at apex of triangle and is focus of attention of both family and dental team. Dynamic relationship among corners of triangle (child, family, and dental team).
PEDIATRIC DENTISTRY TREATMENT TRIANGLE

The Child

Society

The Parents

The Dentist and Environment
Child development involves study of all areas of human development from conception through young adulthood. It involves more than physical growth, which often implies only an increase in size. Development implies a sequential unfolding that may involve changes in size, shape, function, structure, or skill.

Physical, Social, Intellectual development and Environmental influence
A fearful or anxious child who anticipates an unpleasant visit is more likely to have such an experience than is a child who has a low level of fear or anxiety. Anxiety or fearfulness affects a child's behavior and, to a large extent, determines the success of a dental appointment. The various schools of psychologic thought agree that anxiety is a personality trait, but they have various opinions concerning the origin of this trait. By the same token, dentistry has had some difficulty identifying the stimuli that lead to misbehavior in the dental office, although several variables in children's backgrounds have been related to it.

1. Maternal anxiety
2. Medical history
3. Awareness of dental problem
VARIABLES INFLUENCING CHILDREN'S DENTAL BEHAVIORS

MATERNAL ANXIETY "PARENTAL ANXIETIES"

With few exceptions, most investigations indicate a significant correlation between maternal anxiety and a child's cooperative behavior at first dental visit. High anxiety on part of parents tends to affect their children's behavior negatively, effect is greatest with those under 4 years of age.
VARIABLES INFLUENCING CHILDREN'S DENTAL BEHAVIORS

MEDICAL HISTORY

There is general agreement, however, that children who view medical experiences **POSITIVELY** are more likely to be cooperative with dentist. The **EMOTIONAL QUALITY** of past visits rather than number of visits is significant. **PAIN** experienced during previous medical visits is another consideration in a child's medical history. **PREVIOUS SURGICAL EXPERIENCES** adversely influence behavior at first dental visit, but this was not case in subsequent visits.
AWARENESS OF DENTAL PROBLEM

Some children may approach their dentist knowing that they have a dental problem. There is a tendency toward negative behavior at first dental visit when the child believes that a dental problem exists. Such behavior may be a result of apprehension transmitted to the child by a parent. Provides the dentist with a good reason for educating parents about the value of arranging a child's first dental visit before there are any dental problems.
The knowledge of these systems can be an asset to dentist in several ways:
- it can assist in directing management method,
- it can provide a means for systematically recording behaviors, and
- it can assist in evaluating validity of current research.
Wright's clinical classification:

1. COOPERATIVE
2. LACKING IN COOPERATIVE ABILITY
3. POTENTIALLY COOPERATIVE

*(NO uncooperative patient)*
WRIGHT'S CLINICAL CLASSIFICATION PLACES CHILDREN IN THREE CATEGORIES

1. COOPERATIVE

Most children are cooperate.
Children are reasonably relaxed.
They have minimal apprehension.
They may be enthusiastic.
They can be treated by a straightforward, behavior-shaping approach.
2. **LACKING IN COOPERATIVE ABILITY**

Very young children with whom communication cannot be established and of whom comprehension cannot be expected.

Those with specific debilitating or disabling conditions.

Although their treatment is accomplished, immediate major positive behavioral changes cannot be expected.
WRIGHT'S CLINICAL CLASSIFICATION PLACES CHILDREN IN THREE CATEGORIES

3. POTENTIALLY COOPERATIVE (behavior problem)

These children have capability to perform cooperatively. Child's behavior can be modified and become cooperative.
FRANKL BEHAVIORAL RATING SCALE

Rating 1: Definitely Negative. Refusal of treatment, forceful crying, fearfulness, or any other overt evidence of extreme negativism.

Rating 2: Negative. Reluctance to accept treatment, uncooperativeness, some evidence of negative attitude but not pronounced (sullen, withdrawn).

Rating 3: Positive. Acceptance of treatment; cautious behavior at times; willingness to comply with dentist, at times with reservation, but patient follows dentist's directions cooperatively.

Rating 4: Definitely Positive. Good rapport with dentist, interest in dental procedures, laughter and enjoyment.
THE FUNCTIONAL INQUIRY

Functional inquiry (medical and dental history), from a behavioral viewpoint, should be conducted. During inquiry, there are two primary goals: (1) to learn about patient and parental concerns and (2) to gather information enabling a reliable estimate of cooperative ability of child. Coupling findings from functional inquiry with clinical experience, dentist is in a much better position to meet patient's needs and to apply appropriate management strategies. Usually, functional inquiries are conducted in two ways: (1) by a paper and pencil questionnaire completed by parent and (2) by direct interview of child and parent.
<table>
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<tr>
<th>Question</th>
<th>Options</th>
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<td>How do you think your child has reacted to past medical procedures?</td>
<td>Very well, Moderately well, Moderately poorly, Very poorly</td>
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<tr>
<td>How would you rate your own anxiety (fear, nervousness) at this moment?</td>
<td>High, Moderately high, Moderately low, Low</td>
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<td>Does your child think there is anything wrong with his or her teeth, such as a chipped tooth, decayed tooth, gum boil?</td>
<td>Yes, No</td>
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<tr>
<td>How do you expect your child to react in the dental chair?</td>
<td>Very well, Moderately well, Moderately poorly, Very poorly</td>
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THE FUNCTIONAL INQUIRY

For personal interview to serve as an efficient functional inquiry tool, a structured framework. The paper and pencil questionnaire is a starting point. It provides general information or clues and helps guide personal interview. Consider following question: Do you consider your child to be (check one):
- advanced in learning?
- progressing normally?
- a slow learner?

A leading question in personal interview, "What school does your child attend?". There is no limit to depth of personal interview, but if it is to be efficient, questioning must be thoughtful.

Rewards and consequences used in home environment. These provide insight into type of behavior management techniques that would be acceptable to a parent.
PARENTS OF PEDIATRIC PATIENTS

Understanding parents' dental behaviors is not always easy. The socioeconomic status of parents. Societal changes. The dental team must recognize the individuality of parents. The necessity of gaining parental cooperation. Parents of pediatric patients require understanding and have to be led through their children's dental experiences.
STRATEGIES OF THE DENTAL TEAM

A primary objective during dental procedures is to lead children step by step so that they develop a positive attitude toward dentistry. These successes can be attributed to a number of factors, such as a child's confident personality, a parent's proper preparation of child for appointment, or a dental team's excellent communicative skills.

- PREAPPOINTMENT BEHAVIOR MODIFICATION
- FUNDAMENTALS OF BEHAVIOR MANAGEMENT
- COMMUNICATING WITH CHILDREN
- BEHAVIOR SHAPING
- RETRAINING
- AVERSIVE CONDITIONING
- PRACTICAL CONSIDERATIONS
- LIMITATIONS
Behavior modification is techniques for modifying patients' behaviors by using principles of learning theory. Preappointment behavior modification, refers to anything that is said or done to POSITIVELY influence child's behavior before child enters a dental operatory. First dental visit is crucial, if visit is pleasant, it paves road for future successes. Films or videotapes a model for young patient. Live patient models such as siblings, other children, or parents. Mailings (Precontact with parent can provide directions for preparing child and increase likelihood of a successful first appointment).
Letter currently used in clinical practice to assist parents in preparing children for first dental visit.

Dear Parent: Children who have pleasant dental appointments when they are very young are likely to have a favorable outlook toward dental care throughout life. The first appointment is very important in this attitude formation. That is the reason I am writing to you. At our first appointment we will examine your child's teeth and gums and take any necessary x-ray films. For most children this will be an interesting and even happy occasion. All the people on our staff enjoy children and know how to work with them, but you, parents, play an important role in getting children started with a good attitude toward dental care. One of the useful things that you can do is to be completely natural and easygoing when you tell your child about the appointment with the dentist. This approach enables children to view their dental visit as an opportunity to meet some new people who want to help them stay healthy. Your cooperation is appreciated. Remember, good general health depends partly on the development of good habits, such as sensible eating, sleeping routines, and exercise. Dental health also depends on good habits, such as proper toothbrushing, regular dental visits, and a good diet. We will have a chance to further discuss these points during your child's appointment.

Sincerely,
DEFINITION OF BEHAVIOR MANAGEMENT

Behavior management is the means by which the dental health team EFFECTIVELY and EFFICIENTLY performs treatment for a child and, at the same time, instills a positive dental attitude.

Effectively means providing high-quality dental care.
Efficient means utilizing the principles of quadrant dentistry, half-mouth dentistry, and using auxiliary personnel (team working).
Finally, development of a pediatric patient's positive attitude.

There is no mention of any specific techniques or modalities of treatment.
FUNDAMENTALS OF BEHAVIOR MANAGEMENT

1. The positive approach
2. The team attitude
3. Organization
4. Truthfulness
5. Tolerance
6. Flexibility
BEHAVIOR MANAGEMENT CAN BE DEFINED AS THE MEANS BY WHICH THE DENTAL TEAM EFFECTIVELY AND EFFICIENTLY PERFORMS TREATMENT TO THE CHILD INSTILLS A POSITIVE DENTAL ATTITUDE IN THE CHILD FOR THE FUTURE. EFFICIENT HERE MEANS:

A. Utilizing the principle of quadrant dentistry
B. Providing high quality dental care
C. Working in the team as one unit
D. All of the above
E. A and C only
WRIGHT’S CLINICAL CLASSIFICATION OF CHILDREN’S BEHAVIOR DIVIDED CHILDREN INTO MANY CATEGORIES:

A. Two  
B. Three  
C. Four  
D. Depends on the clinician’s ability to express opinion  
E. None of the above is true
RATING 1 (DEFINITELY NEGATIVE - - -) IN FRANKL BEHAVIORAL RATING SCALE MEANS:

A. Reluctant to accept treatment, uncooperative with some evidence of negative attitude.
B. Acceptance of treatment with cautions.
C. Good rapport with the dentist, interested in the dental procedure.
D. Refusal of treatment, crying forcefully, very fearful.
E. Cooperative children are relaxed with little apprehension, and can be treated by straightforward behavior shaping approach mostly dental office experience affect child behavior in dental clinic.
TREATING CHILDREN INVOLVES:

A. A one to two relationship
B. A one to one relationship
C. A two to one relationship
D. A one to three relationship
E. No relationship