

IN BRIEF

- Good behavioural management techniques are essential for providing effective child dental treatment. Currently, little is known in Britain about paediatric dentists' attitudes towards different behavioural techniques. This study provides preliminary insight into these attitudes.
- The study shows that the paediatric dentists surveyed were positively oriented to parental accompaniment of the child during treatment and generally viewed parents as useful allies in facilitating dental treatment for the child more effectively.
- Further studies, comparing the effectiveness of various behavioural management techniques, are now required.

An investigation of paediatric dentists' attitudes towards parental accompaniment and behavioural management techniques in the UK

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Objective Good behavioural management techniques are essential for treating children. Recent research has investigated parental and paediatric attitudes towards various behavioural management techniques. However, in the UK, very little is known about paediatric attitudes towards such issues. Accordingly, the aim of this investigation was to conduct a survey in order to provide insight into the current thinking of paediatric dentists across the UK.

Study design A questionnaire was developed for this study on the basis of previous surveys investigating the attitudes of paediatric dentists towards the use of various behavioural management techniques in Australia and the USA. Areas covered in the questionnaire included: attitudes towards parental accompaniment; attitudes regarding parental expectations; and attitudes towards the use of various different child management techniques. The questionnaire was sent out to all registered members of the British Society of Paediatric Dentistry ($n = 304$).

Results 245 responses (80.5%) were returned, of which 218 provided valid and useable information (72%). A majority of 80% of respondents supported parental accompaniment of the child during the course of treatment. Separate analysis of variance (ANOVA) procedures revealed significant differences between acceptability of parental accompaniment and the year in which dentists had qualified ($P < 0.05$). More recently qualified dentists were less accepting of parental accompaniment. Only a minority of dentists reported feeling pressured by parental expectations with regard to their child's treatment. However, an independent sample t -test revealed that male dentists experienced greater perceived conflict between dental and parental expectations, than female dentists ($P < 0.05$).

In terms of specific behavioural management techniques, the most favoured was 'tell-show-do' with 87% of respondents citing this as their most commonly used method. Least acceptable were 'hand over mouth' techniques, followed closely by active restraint and papoose board.

Conclusion In general, paediatric dentists in the UK favoured less 'restraining' methods of behavioural management. There was widespread support for parental accompaniment in the dental

operatory and a desire to work in participation with parents in order to facilitate the child's good behaviour and more effective dental treatment. Further studies comparing the effectiveness of various techniques used with regard to treatment time and clinical outcomes, are now required.

Good behavioural management techniques are essential for treating children. The establishment of good rapport between dentist and child has been shown to influence the success of treatment, whether in terms of the child's co-operation in undergoing treatment or in following prevention advice. In order to be successful in the treatment of children, some have argued that '*It is very important that the younger patient is not simply treated like a mini version of the older one*'.¹

Much of the existing research in this area has focussed almost exclusively on *parental* attitudes towards the use of different child behavioural management techniques.²⁻⁶ In North America and Australia, a number of surveys have expanded this research, examining and contrasting the attitudes of paediatric dentists in these two countries towards different behavioural management strategies.⁶⁻¹⁰ For instance, it has been found that the majority of dentists in Minnesota, USA, favoured the use of behavioural management techniques such as the use of physical restraints and nitrous oxide, in the belief that they result in greater degrees of productivity.⁹ By contrast, a study of Australian dentists in Victoria, found that few supported the use of such 'restraining' methods, relying instead on strategies such as setting shorter appointment sessions and teaching anxious children relaxation techniques.¹⁰ This study also found that younger dentists tended to use behavioural strategies more frequently than their older colleagues. Another US study, however, indicated wide variations in dentists' attitudes to the use of restraints and aversive techniques the presence of parents in the surgery, the use of sedation, and general anaesthesia.^{11,12}

In the UK, by contrast, there is a total paucity of research investigating the attitudes of paediatric dentists towards behavioural management techniques. The aim of this investigation was therefore to survey paediatric dentists in the UK in order to find out how they feel about these issues. The results of this investigation are presented as a means of providing insight into the current thinking of paediatric dentists across the UK. This study will be of interest to all dentists and dental students who treat children and wish to understand the extent to which various behavioural management techniques are currently used across the UK.

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METHOD

Procedure

A questionnaire was developed for this study on the basis of previous surveys investigating the attitudes of paediatric dentists towards the use of various behavioural management techniques in Australia and the USA. Areas covered in the questionnaire included attitudes towards parental accompaniment and attitudes regarding parental expectations. Individual questionnaire items in relation to both of these areas were rated by participants using a 5-point Likert scale (1 = strongly agree, 2 = agree, 3 = neutral, 4 = disagree, 5 = strongly disagree). In order to make the data more manageable, scores on each of the eight questions pertaining to attitudes towards parental accompaniment were added together to constitute an overall scale score. These resulted in an 'attitude towards parental accompaniment' scale with an internal consistency (Cronbach α) score of 0.89. This same procedure was conducted in relation to the four individual items addressing 'attitudes towards parental expectations', resulting in a scale with an α of 0.78. When comparing groups of dentists in relation to these scores (eg comparing men and women), the mean scores of the two groups were calculated and tested for statistically significant differences.

Dentists' attitudes towards the use of various different child management techniques were also sought. Socio-demographic information such as age, gender, ethnicity, place of qualification, year of qualification, amount of clinical experience and regions of practice were also surveyed. The questionnaire was pilot tested on a sample of 12 dentists engaging in the treatment of children at the Turner Dental School, Manchester University. Minor modifications to the questionnaire were made in order to improve clarity.

Participants

A questionnaire was sent out in October 2000 to members of the British Society of Paediatric Dentistry who were listed in a published 'Directory of members' ($n = 304$). In order to be listed in the directory, BSPD members needed to have completed and returned a slip indicating their willingness to be included in the directory. This listing does not therefore represent all registered members of the BSPD, just those who agreed to be listed in the directory. Nevertheless, it was considered that the directory consisted of a useful 'convenience sample' of paediatric dentists whose views could be sought in order to throw some light on the questions posed in this study. The questionnaire was sent out together with a cover letter explaining the purpose of the research and a reply paid envelope. A reminder letter was sent if reply to the questionnaire had not been received within 3 weeks.

Analysis

The results were analysed using basic descriptive statistics. Differences in dentists' attitudes were explored and analysed through the use of a mixture of parametric and non-parametric tests including independent t -test, ANOVA, χ^2 and the Mann-Whitney U test.

RESULTS

Respondents

A total of 245 responses (80.5%) were returned, of which 218 provided valid and useable information (72%). The sample included 73 (33%) men and 143 women (66%) ($n = 2$ did not give their gender – please note that when any of the following percentages do not add up to 100%, the shortfall is accounted for by respondents who failed to respond to that particular question). Respondents ranged from 30–75 years, with a mean age of 46. For the purposes of analysis, the sample was further divided into four age groups:

- 1) Between 30–40 ($n = 60$)
- 2) 41–50 ($n = 85$)
- 3) 51–60 ($n = 52$), and
- 4) 60+ ($n = 11$)

The majority of respondents were White ($n = 198$, 90%), with the remaining 10% describing themselves variously as African, Pakistani, Indian, Chinese, Eurasian and Persian. Twenty five per cent of the dentists qualified in London, 6% in Bristol, 9% in Newcastle, 8.5% in Manchester, 8% in Liverpool, 4% in Sheffield, 4% in Leeds, 19% in Scotland, 5% in Cardiff, 7.5% in Ireland and 1.5% overseas. Dentists were divided into four groups in terms of when they qualified as dentists. These included:

- 1) Between 1950 and 1970 ($n = 45$, 21%)
- 2) Between 1971–1980 ($n = 87$, 40%)
- 3) 1981–1990 ($n = 70$, 32%), and
- 4) 1991–1997 ($n = 9$, 4%)

Sixteen per cent of the respondents had been in practice for less than 10 years, 36% for 11–20 years, 31% for 21–30 years and 10% for 31–51 years. In terms of regions of practice:

Thirty one per cent were located in the North of England (including Northwest, North and Northeast); 5% in the Midlands, 16% in the South (including Southeast, South and Southwest); 12% in Scotland; 5% in Ireland; and 5% in Wales (26% did not respond to this question).

Attitudes towards parental accompaniment of child during treatment

At present, there is no official consensus amongst paediatric dentists regarding whether a parent should be permitted in the dental operatory. However, trends in this survey revealed that a majority of 80% ($n = 175$) were in support of parental accompaniment of the child during the course of treatment. Forty nine per cent ($n = 107$) of those surveyed had a policy on parental accompaniment during treatment. The most common policy used by 37% ($n = 80$) of dentists was one of allowing parents to accompany their child during treatment. A considerable 38% ($n = 84$) used a variety of other policies in accordance with individual circumstances.

In comparison with female dentists, male dentists were significantly more likely to have an explicit policy on parental accompaniment (64% compared with 41%, $\chi^2 = 10.34$, $df = 1$, $P < 0.001$). There were also age differences: dentists in the 60+ age group were significantly more likely to have an explicit policy on parental accompaniment (73%), than those in any of the other age groups, for instance 51–60 (56%), 41–50 (54%) and 30–40 (32%) ($\chi^2 = 11.54$, $df = 3$, $P < 0.01$). Consistent with these results are the fact that dentists who qualified in 1950–1970 were significantly more likely to have an explicit policy on parental accompaniment (60%) than those qualifying in 1971–1980 (53%), 1981–1990 (39%) and 1991–1997 (22%) ($\chi^2 = 8.3$, $df = 3$, $P < 0.05$).

Eighty six per cent ($n = 188$) of those surveyed felt comfortable managing a child with the parent present during treatment. Sixty one per cent ($n = 131$) favoured parental accompaniment because the parent helped reduce the child's anxiety. Likewise, 60% ($n = 129$) believed that a child's anxiety increased when separated from the parent. A large majority (89%, $n = 194$) of dentists believed that a child under the age of 3 behaved better when a parent was present. Similarly, 58% ($n = 128$) believed that a child over the age of 3 behaved better when a parent was present. Only 7% ($n = 16$) of respondents regarded parental accompaniment as counter-productive, and only 13% ($n = 28$) preferred parents to stay in the reception room whilst treating the child. Although 84% of respondents believed that there were some parents who increased the child's anxiety during the course of dental treatment, it was evident that most parents were perceived as being helpful rather than counter-productive.

The results indicated that 87% of dentists surveyed believed that the majority of the parents wanted to accompany their child during dental treatment. When asked why they thought parents

wanted to be in attendance during treatment, 75% believed that the parent felt the need to protect the child, 61% thought that the parent had a strong emotional bond with the child, and 54% assumed that the parent felt the child would behave better. However, less than 17% believed that it was because the parent did not trust the dentist in treating her or his child.

Attitude towards parental accompaniment scale

In order to make more sense of this data, an attitude towards parental accompaniment scale was constructed. This consisted of the eight statements listed in Table 1, each response being scored in terms of a 5-point scale where 1 = strongly agree and 5 = strongly disagree. Items 6 and 8 were reverse keyed to eliminate any effects of acquiescence response sets. Ratings ranged from 8 to 40, with lower scores indicating greater acceptance of parental accompaniment. The scale had an internal consistency (Cronbach α) score of 0.89. The mean score in this sample was 16.4.

Attitude towards parental accompaniment and associations with socio-demographic variables

Separate analysis of variance (ANOVA) procedures were used to examine the relationship between attitudes towards parental accompaniment and variables such as age and the year in which the dentist qualified. Although no significant difference in attitudes was revealed in terms of age, the year in which dentists qualified was significant ($F = 1.7$, $df = 26$, $P < 0.05$). Exploring this relationship further it was found that those dentists who qualified between 1991 and 1997 had significantly higher scores (and therefore were less accepting of parental accompaniment) than dentists in any of the other groups ($t = 3.49$, $df = 198$, $P < 0.001$, see Table 2). There were no significant differences between attitude to parental accompaniment scores and gender.

Attitudes towards parental expectations

The survey also investigated paediatric dentists' perceptions of parental expectations. Results revealed that 22% ($n = 48$) of respondents often felt pressured by parental expectations of the child's treatment. Twenty per cent ($n = 44$) felt that this pressure was increasing. Twenty nine per cent ($n = 63$) felt that some parents had unrealistically high expectations of their child's dental treatment. However, only a small minority (15%) of dentists felt that parents did not trust them.

The research also examined whether paediatric dentists thought that parental level of education affected parents' expectations of treatment. A substantial 48% ($n = 107$) of respondents believed parental level of education affected parents' perception of the acceptability of various behavioural management techniques. However, only 28% believed that parents with less education were more accepting of the dentists' clinical opinion. Likewise, only 25% believed that parents with less education were less likely to express dissatisfaction with the clinical procedure.

Attitude towards parental expectations scale

In order to make further sense of this data, an attitude towards parental expectations scale was constructed. This consisted of the 4 statements listed in Table 3, each response being scored in terms of a five point scale where 1 = strongly agree and 5 = strongly disagree. Ratings ranged from 4 to 20 with lower scores indicating greater perceived conflict between dental and parental expectations. The scale had an internal consistency (Cronbach α) score of 0.78. The mean score in this sample was 13.8.

Attitude towards parental expectations and associations with socio-demographic variables

Male dentists had significantly lower scores on this scale in comparison with women dentists (indicating higher perceived conflict

Table 1 Items on the parental accompaniment scale

Items
1. In general, children under the age of 3 behave better when one of their parents is present during the course of the treatment
2. In general, children over the age of 3 behave better when one of their parents is present during the course of treatment
3. In general, separating children from their parents when dental treatment commences simply increases the child's anxiety
4. In most cases, parental accompaniment of the child assists the dentist because it reduces the child's anxiety
5. In general, I support parent accompaniment of the child during the course of treatment.
6. I think parental accompaniment of the child during treatment is counter-productive
7. In general, I feel comfortable managing a child when the parent is present during treatment
8. I prefer parents to stay in the reception room whilst I am treating the child

Table 2 Comparative scores on the attitudes towards parental accompaniment scale (NB Higher scores indicate less positive orientation towards parental accompaniment).

Year qualified	Parental accompaniment score
1950-1970	15.3
1971-1980	15.9
1981-1990	16.7
1991-1997	22.8

Table 3 Items on the parental expectations scale

Items
1. Many parents have unrealistically high expectations of their child's treatment
2. I often feel pressured by parental expectations of their child's treatment
3. I feel increasingly pressured by parental expectations
4. I sometimes feel that parents do not trust me in treating their child

between dental and parental expectations, $t = -2.17$, $df = 208$, $P < 0.05$). However, there were no significant differences in terms of age, year qualified or years practicing as a paediatric dentist (see Table 4).

Behavioural management techniques

The most popular cited technique for managing children was tell-show-do; this technique was listed by 87% of respondents as their most commonly used behavioural management strategy. When asked to list their second most common strategy, 40% listed voice control, 15% nitrous oxide, 13% dentist spending time in waiting room with child prior to treatment, and 11% live modelling. The technique dentists were least comfortable with was hand-over-mouth; 73% of respondents reported feeling uncomfortable with hand over mouth techniques, followed by 69% for active restraint and 61% with the papoose board. Table 5 illustrates how respondents felt about each behavioural technique. Although 55% of respondents agreed that the goal of behavioural management techniques was to achieve compliance of the pre-school child, only 27% ($n = 59$) believed it was necessary to do this by establishing authority over the child.

Overall, 67% of respondents reported that they did not feel constrained in the methods used to manage children, whether pharmacological or non-pharmacological. Fifty three per cent were in agreement that there was currently sufficient information on techniques for managing children's anxiety in the dental situation.

There were, however, some interesting gender differences in terms of the popularity and acceptability of various behavioural

Table 4 Mean scores on the Parental Expectations Scale

	Mean score	Significant differences within groups
Gender:		
Male	13.2	Yes
Female	14.2	
Age:		
30–40	14.1	No
41–50	13.9	
51–60	13.4	
60+	13.6	
Year qualified:		
1950–1970	12.8	No
1971–1980	13.8	
1981–1990	14.6	
1991–1997	13.9	
Years practicing as a dentist:		
Below 10	14.6	No
11–20	13.9	
21–30	14.0	
31–51	12.7	

Table 5 Proportion of dentists feeling 'totally comfortable' or 'comfortable' with each behavioural management technique

Behavioural management technique	Responses (n)	Responses (%)
Tell show do	213	93
Nitrous oxide	159	73
Papoose board	5	2
Voice control	149	69
Hand over mouth	7	3
Oral pre-medication	48	22
Active restraint	9	4
General Anaesthesia	98	45
Dentist spending time in waiting room prior to treatment	141	64
Dental assistant spending time in waiting room prior to treatment	145	67
Live modelling	140	64
Video modelling	65	30

management techniques. For instance, although female dentists indicated less discomfort than men with the use of voice control methods ($U = 4013$, $P < 0.05$), they were less comfortable than male dentists in terms of use of oral pre-medication ($U = 4175$, $P < 0.05$) and use of active restraint ($U = 4116$, $P < 0.01$). Likewise, there were interesting differences in terms of acceptance of particular techniques and the age of dentists. For instance, dentists aged over 60+ were most uncomfortable with the use of nitrous oxide, whereas the youngest age group (30–40), were the most accepting of it ($\chi^2 = 10.5$, $df = 3$, $P < 0.01$). This was also reflected in the fact that acceptability of the use of nitrous oxide techniques was inversely related to the amount of years practising as a paediatric dentist, with those practicing for 31–51 years being far less accepting than those practicing between 4–10 years ($\chi^2 = 10.1$, $df = 3$, $P < 0.01$). Also interesting was the fact that the group of dentists most recently qualifying (1991–1997), found the technique of voice control more acceptable than dentists qualifying in all other cohorts. The differences were particularly marked between the 1991–1997 cohort and the 1950–1970 cohort, with the latter being far less accepting of voice control than the former ($\chi^2 = 14.4$, $df = 3$, $P < 0.01$).

DISCUSSION

This paper has reported on one of the first attempts to investigate the attitudes of paediatric dentists in the UK towards different behavioural management techniques.

A friendly relationship between the paediatric dentist and the child is important for effective and efficient treatment. Establishing a strong rapport on the child's first visit helps to create a comfortable atmosphere in which the child does not feel threatened.

Parental accompaniment can significantly affect the atmosphere surrounding the dental visit and dental treatment. Obviously, parental accompaniment can sometimes enhance and sometimes hinder the progress of the child's treatment. The majority of dentists surveyed in this study shared the view that some parents certainly do increase the child's anxiety levels during treatment. Having said that, however, parental accompaniment in general was not considered counter-productive and was, in fact, actively favoured by the majority of paediatric dentists. Accordingly, there was a general perception that parental accompaniment usually contributes towards successful behaviour management. Only a small minority of respondents felt pressured by parental expectations and preferred to perform dental treatment in their absence. It was interesting to note, however, that male dentists were more likely to experience pressure and conflict between dental practice and parental expectations, than female dentists (as revealed on the 'attitude towards parent expectations' scale).

This study revealed that paediatric dentists most favoured behavioural management technique was tell-show-do. Other frequently used techniques were spending time in the waiting room with the child prior to treatment, use of voice control and nitrous oxide. Procedures such as tell-show-do and voice control can be employed readily in minimally disruptive clinical situations and are accepted by parents.^{5,13–14}

By contrast, most of the dentists (73%) surveyed did not feel comfortable with the hand-over-mouth technique. This proportion was almost identical to respondents in Australia claiming never to use the 'hand-over-mouth' technique.^{10–11} These results are in contrast to surveys in the USA which indicate greater use of the 'hand-over-mouth' technique.⁶ Although the hand-over-mouth technique is an effective method in gaining a disruptive child's attention and can be successful in selected cases, it is associated with professional controversy and poor parental acceptance.^{5,13–15} The difference in attitudes between dentists in different countries is probably caused by differences in training and social acceptance. Like their Australian colleagues, it appears that the paediatric dentists in the UK use restraining methods less often than their North American colleagues.¹¹ Although 55% of respondents agreed that the goal of behavioural management techniques was to achieve compliance of the pre-school child, only 27% believed it was necessary to do this by establishing authority over the child.

Also interesting in this respect, are differences in acceptability of behavioural management techniques within different age cohorts of dentists. One Australian study found that younger dentists were less 'authoritarian' in their management strategies than their older colleagues.¹⁰ These findings were not replicated in this investigation. Although it was found that younger dentists found the less authoritarian 'voice control' technique more acceptable than older dentists, it was also the case that acceptance of nitrous oxide procedures varied inversely with the amount of years in practice as a paediatric dentist (the longer, the less accepting). In addition, it was found that the more newly qualified dentists were less accepting of a policy of parental accompaniment than those who had qualified in the earlier cohorts. One potentially controversial interpretation of these findings is that, as dentistry becomes increasingly technologised, younger dentists are actually becoming

ing less positively oriented towards basic behavioural management techniques.

Consistent with previous studies¹⁰ was the finding that, when compared with male dentists, female dentists were more comfortable with 'non-restraining' methods such as voice control. Female dentists were also more likely to feel uncomfortable with behavioural management techniques such as oral pre-medication and active restraint.

CONCLUSION

This investigation explored the attitudes of UK paediatric dentists towards parental accompaniment, parental expectations and different behavioural management techniques, providing insight into their views and opinions on the treatment of children. As with all investigations of attitudes, however, this study is unable to comment on the extent to which such self-reported attitudes translate into actual behaviour and clinical practice. In addition, it should be borne in mind that the survey results presented in this paper were taken from a sub-sample of registered members of the BSPD (those listed in the directory) and may not represent the views of those members as a whole.

On the basis of the above results, however, it can be concluded that the majority of UK paediatric dentists surveyed were positively oriented to parental accompaniment of the child during treatment and did not experience great conflict between the demands of clinical practice and parental expectations. By contrast, parents were perceived as useful allies in facilitating the child's good behaviour and thereby ensuring more pleasant, efficient and effective dental treatment for the child. Paediatric dentists in the UK tended to favour less restraining behavioural management methods, although there were some interesting gender and age differences in the acceptability of various techniques.

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