Who's been a *good boy* today then?

Christine MacLeavy* addresses the tricky business of managing child patients in dental practice, and recommends some strategies for approaching them.

We all know that treating children is a very exacting form of dentistry which can be both challenging and rewarding. Coping with difficult child patients can be a major cause of stress: imagine treating a frightened three-year-old at one appointment and a moody, uncommunicative teenager at the next.

How we handle this depends on our personality, because we are all unique and have our own ideas, experiences, backgrounds and beliefs that make up what and who we are.

If you were to ask the average parent how they would like their child to be treated in the dental surgery, they might say that they would like someone who is friendly, reassuring and gentle, someone who explains procedures in a way that the child understands, is caring, sympathetic and keeps pain to a minimum. Then they usually ask, 'can all the treatment be done in one visit please?'

Some clinicians have a natural ability to put young patients at their ease, but unfortunately there are many who find treating children difficult and stressful. However, failure to empathise and communicate well with children can result in disappointed patients, disappointed parents and an unsuccessful career. People will tell seven people about a bad experience and only one about a positive experience. The good news is that behaviour management strategies and communication skills can be learnt.

It is important to have some basic understanding of child development before going on to discuss management and communication strategies.

Psychology of child development

The phases of child development may differ from child to child; however, there seem to be major psychological signposts that we should be aware of.

Motor development

Most children are walking by the age of two although children with Down syndrome, for example, have a slower motor development. Around this time hand-eye coordination becomes more precise and elaborate, and the dominance of one hand has emerged. By the

communication

age of seven most children have sufficient coordination to brush their own teeth reasonably well. Under that age many areas will be missed and there is a tendency to swallow the toothpaste, so supervision by the parent is imperative and oral hygiene techniques should therefore be directed at the parent.

Cognitive development

There are four broad stages of cognitive development:

Sensorimotor – lasts until the child is about two. The child begins to think of things as permanent even when they are not there.

Pre-operational thought – from approximately two years to seven. The child can predict the outcomes of behaviour. Language development facilitates these changes although they cannot understand another's point of view and are inflexible.

Concrete operations – this stage of thinking stretches from seven years to about 11.

Children are able to apply logical reasoning and can now consider another person's point of view.

Formal operations – this is the last stage in the transition to adult thinking. It begins at 11 and results in abstract thinking so that different possibilities for action may be considered.

Perceptual development

It is difficult to discover what babies are experiencing perceptually so research has

concentrated on eye movements. With increasing age scanning becomes broader. Compared with adults, six-year-olds cover less of an object and gain less information. By the age of seven they are beginning to make decisions on what deserves their attention and what can be ignored. Concentration skills improve. Some dental advice may be offered at this stage but as mentioned before, the parents should be the main focus of oral health information or diet advice. By the age of nine they are efficient at discriminating between different visual patterns and have reached adult proficiency. There is a huge growth of knowledge at this time.

Language development

By the age of five years the average child has a vocabulary of about 5,000 words. Dentistry has highly specialised language and loads of jargon. The key to successful communication with kids is to 'pitch' your advice or instructions at the right level for each age group.

Social development

Between the ages of eight months and five years many children have a fear of strangers and suffer from separation anxiety, although this tends to decline once the child starts school. This has implications for the dental surgery and it is unlikely that a child of this age will want to be in the surgery alone.

Adolescence

This is the final stage of development. Parental influence is waning. Although they appear to be moody, oversensitive and miserable for no apparent reason, they need support and reassurance but not criticism. It is important to remember that not all teenagers are rebellious and non-conformist. They are going through a stage of becoming increasingly

self-sufficient and independent and although health may not be a major concern for many, appearance might be.

Anxiety, fear and phobia

What are the differences between anxiety, fear and phobia?

Anxiety – reaction to an unknown, ill-defined or not immediately present danger.

Fear – reaction to a known or perceived threat or danger. Leads to activation of the fight or flight response.

Phobia – marked and persistent fear of a specific situation or object that is excessive or unreasonable, leading to **avoidance** of the anxiety producing situation, causing significant distress or interfering with normal functioning.

It is highly unlikely that children with little or no previous dental experience will be phobic.

Causes of dental anxiety in children

A child is more likely to be anxious if they perceive something is wrong or are in pain. However, the primary cause of all patients' fears and anxieties are negative, previous dental and medical experiences. Peer pressure and the media also have an influence on how a child perceives dentistry. Their own level of understanding, age, stage of development, and whether or not they have learning difficulties also have an impact.

The dental environment can be very frightening for a small child, especially the smells

*Christine (pictured left) began her dental career as a dental nurse in the Women's Royal Naval Service (WRNS). She went on to qualify as a Dental Therapist and currently works clinically in the CDS, GDS and private practice. She is an Assessor and Internal Verifier for the NVQ III Oral Healthcare. Christine completed both the Further and Adult Education Certificate (FAETC), and Post Graduate Certificate in Education (PGCE) specialising in post-compulsory education. Since

1998 she has been teaching part-time at the Eastman School of Dental Hygiene and Dental Therapy. She is a Licensed Practitioner in Neuro-Linguistic Programming, has a Diploma in Performance Coaching and has recently achieved a Post Graduate Diploma in Hypnosis Applied to Dentistry at University College London. Christine is currently undertaking a Master Practitioner course in NLP.

Email: chris@macleavy.freeserve.co.uk

and sounds. Not all dental surgeries are child friendly. The appearance and attitude of the team are vital. Are their uniforms very clinical or just clean and professional? Does the language they use frighten or sooth? Is there too much jargon or is language adapted to the age and understanding of the child? Are the team friendly, and approachable?

The time of day of the appointment may affect some children as does the length of time they are kept waiting.

Parental presence? – More on that later!

It is important to understand that children's anxiety levels increase if they are criticised, ridiculed or put down, and surprisingly, when they are given too much reassurance (especially when unsolicited). Chatting to the parent/nurse or indulging in non-dental chat whilst you are working is also unnerving for the child. The child must be kept central to any communication. If you have to make unfavourable comments make sure that they are directed at the child's behaviour and not the child.

Parents in/out of the surgery?

In my experience it is impossible to keep them out. It is important to have them around when discussing cleaning teeth and diet anyway, and the attitude and level of fear or anxiety displayed by the parent is an excellent indicator of the attitude and likely behaviour of the child.

Regardless, it is important to always get the parent on your side! So look beyond the child. The main problems caused by having parents in the surgery when treating children are:

- parent intercepts – answers for the child
- child divides attention between operator and parent
- operator divides attention between parent and child
- operator unable to use voice intonation
- operator more relaxed when parent not there
- parent repeats everything.

All stand in the way of the operator formulating a working relationship with the child. The important thing is not to distress the child, so be flexible. I have often found that the mother's prediction of their child's behaviour and level of acceptance of treatment is often quite accurate.

The following studies into the relationship between child behaviour/anxiety and parental anxiety: Lewis and Law (1958), Allen and

Structure of a visit

1. Greeting

Greet child by name preferably in the waiting room

Introduce yourself

Include parents in conversation

Keep child central to developing relationship

Put child and parents at ease

2. Settle patient into the clinical environment

Assess worries the parent/child might have

Assess patient's emotional state

Use open questions 'Are you having any problems with your teeth?'

Listen to the answer!

3. State what the objectives are, clinically or preventative, in terms the patient and parent can understand ie 'Today we are going to'

Involve the patient in the planning

4. Business

The patient is now a passive object so maintain verbal contact at all times, tell them what you are doing and let them have short rests from time to time.

Use their name rather than 'pet' or 'sweetie' and offer reassurance and praise.

Summarise what's been done at the end of the visit and offer praise – 'well done you've been very grown up', sensible, clever (never 'brave'). Give positive reinforcement/feedback – especially about their behaviour. After treatment is the time for advice – postoperative instructions, health education etc. But keep it simple, non-threatening, precise and specific.

Check it is understood by asking questions and set goals for the next visit. The child will be much less anxious if they know what they can expect and what is expected of them.

5. End of visit

Make it clear it is the end of the visit and give the child a sticker if appropriate. As mentioned before, always personalise comments and address the patient by name.

Evans (1968), Venham *et al.* (1978), Pfefferle *et al.* (1982), Fenlon (1990), all failed to demonstrate that parental presence influences behaviour. Parents can offer enormous emotional support to the child. If you don't get the parent on your side, it is unlikely that you will win over the child.

Techniques for behaviour management

Behaviour shaping

This is based on a planned introduction of procedures so that the child is gradually trained to accept treatment in a relaxed and cooperative manner. This may involve starting with the easiest restorations first, or quadrant dentistry.

Positive reinforcement

Positive reinforcement involves rewarding good behaviour in order to increase the likelihood of that behaviour being displayed in the future. The operator's approval is essential to reinforce good behaviour and should be shown throughout. This can be in a verbal form, although smiling or nodding is just as acceptable. Never ignore good behaviour.

Desensitisation

Commonly used by psychologists dealing

with phobias. Classically involves three stages: teaching relaxation, developing a hierarchy of fear producing stimuli and then introducing each stimulus in the hierarchy in turn to the relaxed patient. Hypnosis is often used to help the patient relax. Children between the ages of eight and 12 years are particularly hypnotisable mainly because of their ability to become absorbed in fantasy and imagery.

Modelling

This involves watching friends or an older sibling in the chair. Hopefully the anxious child will imitate the relaxed cooperative behaviour of the 'model'.

Psychological preparation

This technique involves the parents preparing the child psychologically in preparation for their dental visit. The success of this technique depends hugely on parental attitude to dentistry and in my opinion is best not encouraged.

Tell, show, do

Explaining, then showing and then carrying out the procedure. Praise is necessary at every stage.

Distraction

This involves diverting the child's attention.

This can be by getting them to breathe through their nose, or lifting a leg when taking impressions or pulling the lip during LA administration.²

Control

Allowing the child some control. Twenty percent of dental needle phobia stems from poor handling of needle procedures, or being restrained during injection.

Give the child permission to signal by raising their left hand if they need a rest or a rinse.

Hand over mouth/restraint

This is generally regarded as extreme in this country. In the USA, 'partial or complete immobilisation sometimes is necessary to protect the patient, practitioner and/or dental staff from injury while providing dental care' (AAPD Guidelines 2002/2003).

However, the GDC guidelines Maintaining standards (2001) state:

3.10 There can be no justification for intimidation or, other than in the most exceptional circumstances, for the use of physical restraint in dealing with a difficult patient.

When faced with a child who is uncontrollable for whatever reason, the dentist should consider ceasing treatment, making an appropriate explanation to the parent or

representative and arranging necessary future treatment for the child, rather than continuing in these circumstances.

Complementary/alternative management strategies

In dental school, we are usually taught to use open-ended questions to encourage communication with our patients. This is fine for non-fearful patients. Coaching and Neuro-Linguistic Programming (NLP) models³ encourage us to use solution focused questioning (SFQs) when attempting to communicate with anxious people. Unfortunately anxious people are locked in a negative frame of mind, which is difficult to overcome. SFQs orient the patient away from the problem and towards change. For example:

‘When do you find you are less anxious?’

‘When do you find you do not have this problem?’

‘Suppose I had a magic wand and..... how would you feel different?’

NLP techniques can also be used to create rapport with patients through matching, pacing and leading. They are easy to learn and work excellently with children, as they are gentle, subtle and create a feeling of comfort and trust. Another language technique that might be useful is ‘the illusion of choice’. This involves asking the child questions such

as ‘would you like to sit in the chair now or after you’ve taken your coat off?’ The question presupposes that the child will sit in the chair regardless of the ‘choice’ made.

A helpful technique for reluctant children I learnt when studying hypnosis is something called the ‘Yes Set’. The clinician asks the patient a series of questions to which the answer will be ‘Yes’. Such as, ‘Have you been to school today?’ (child is wearing school uniform), ‘Is it still sunny/raining/snowing outside?’ (you know it is), and so on. Then when you ask the child if they would like to sit in the chair, the answer will invariably and almost automatically, be ‘Yes’. This technique can be used as a hypnotic induction for older children and adults.¹

Management of local anaesthetics - should we show the child the syringe?

If the child desires to see the syringe, studies show there is no detriment in showing it; it is whatever the operator feels comfortable with.

If showing the syringe produces a negative response, identifying this before attempting LA may be an advantage. Since studying dental and needle phobia as part of my Postgraduate Diploma in Hypnosis Applied to Dentistry I have no qualms about showing children the needle. I prefer the disposable system marketed by Septodont, and try to make the child’s first local an infiltration wherever possible. An extra short needle is perfect if you are considering showing it to the patient as they have usually imagined it to be huge – long and thick – and are amazed at how tiny the needle actually is.

Management techniques

- Good technique – use topical (20% benzocaine is best), keep surrounding tissues taut on penetration, use warm solution, slow administration
- Use distraction at point of penetration – if the patient has their eyes closed, I ask them to open their eyes at this point. Their visual sense is flooded with input distracting them from their internal sensations
- Talk to the patient throughout delivery – pace
- Explain sensations of local anaesthetic and how long it will last ie a funny, fat feeling is more acceptable than ‘numb’ to most children
- Give lots of feedback on behaviour – clever, sensible

- Count down from 10-1 when nearly finished.

Summary

Gain the trust and cooperation of the child. Time spent on acclimatisation is never wasted. Use language that’s suitable for the age and understanding of the child. Always use the patient’s name or whatever they prefer to be called and don’t keep them waiting too long. Bear in mind the time of day. Small children are likely to be more tired and irritable therefore less cooperative in the afternoons.

Make an accurate diagnosis and devise a treatment plan appropriate to the child’s needs.

Comprehensive preventive care

Deliver care in a manner that the child finds acceptable, using treatments and techniques which produce effective and long lasting results. Use appropriate humour and stop signals where appropriate. Avoid words like pain, hurt, or brave. Show children respect and involve them in their treatment.

Never forget to reward good behaviour!

1. Heap M, Aravind K K. *Hartland’s medical and dental hypnosis*, 4th ed. Edinburgh: Churchill Livingstone, 2002.
2. Melzack R, Wall P. Pain mechanisms: a new theory. *Science* 1965; **50**: 971-979.
3. O’Connor J. *NLP workbook: a practical guide to achieving the results you want*. London: Harper Collins, 2001.

Further reading

Welbury R. *Paediatric dentistry*, 2nd ed. Oxford: Oxford University Press, 2001.