

dental input can be facilitated for this group of children by timely and effective communication with the MDT paediatric dentist involved in their care.

L. Burbridge, Newcastle, UK

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Parental behaviour

Sir, when I suggested applying some 'caramel gel' to my apparently co-operative, low-caries-risk paediatric patient last week, he burst into tears at the thought of it.

As a foundation dentist working in a relatively low-needs practice, most of my child patients are regular attenders and familiar with the dental environment. Despite having no experience of toothache, traumatic dental procedures, or phobic parents, many of them still present with dental anxiety. I have begun to wonder why certain children feel so threatened and unable to cope at the suggestion of something new being put on their teeth. It suggests that in a patient group whose basic physical and economic needs are met, there is more space to explore underlying emotional problems and psychological determinants of behaviour. In particular, the style of parenting is revealed as problematic.

I came across a review paper which began to address this issue and articulated many thoughts I had pondered during my experience with children at dental school.¹ It summarised parental behaviours that seek to control the child, and addressed areas of developmental psychology that can be applied to dentistry. From my understanding of the paper, certain controlling parental behaviours manifest as psychological intrusions which negatively influence how the child perceives a new situation. As a result of this, they do not feel empowered to cope with the task at hand and become anxious.

I am sure many of my colleagues, both students and qualified dentists, will have witnessed examples of controlling or manipulative tactics used by parents in an attempt to make their children cooperate. To quote just a few from the aforementioned article, these include bribing, shaming or 'babying' the child.¹ These are not always obvious and can often be well-intentioned despite being coercive.

In some cases I have been able to work with the child to overcome these intrusions and encouraged them to have an explorative

experience of the dental appointment. However, others have still been difficult to manage. To me, their phobia seems reinforced by the parent's behaviour, which coalesces as inner conflict for the child, especially when it is difficult to see the child without the parent present.

Looking beyond childhood and to the implications of parental intrusions later in life, I have seen several patients with hypersensitive gag reflexes, unusual fixations about their teeth, or idiopathic facial pain symptoms. Part of me wonders whether the symptoms of these patient groups are actually unconscious manifestations of unresolved parental intrusions. The behaviours used to cope with them could be the techniques patients have developed as a way of dealing with this inner conflict.

I would encourage dentists, students and DCPs to consider reading this paper as part of the quest to comprehend the patient experience. A greater understanding of the parent-child relationship, how it affects the dental consultation, and how it can be managed in practice, may help us to better engage with and care for these anxious children.

A. Beaven, Chelmsford, UK

Reference

1. Chapman H R, Kirby-Turner N. Psychological intrusion - an overlooked aspect of dental fear. *Front Psychol* 2018; **9**: 501.

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Formula milk products

Sir, I am writing to express my concerns about the following article recently published in the *BDJ*: *A cross-country exploratory study to investigate the labelling, energy, carbohydrate and sugar content of formula milk products marketed for infants* (*BDJ* 2020; **228**: 198-212).

The title and abstract of this article refers to the sugar content of infant formula milk. The study looks at the sugar content of a wide range of products including fortified cows' milk and milk based nutritional supplements marketed at toddlers. These are not infant formulas or breastmilk substitutes as implied in the article.

Looking at the data, the sugar content of the infant formulas shows little variability and is comparable to that of breastmilk. As I understand it, this sugar content is necessary to meet the nutritional requirements of

infants who rely on infant formula as a food source. The sugar content of the range of products targeting toddlers is more variable, as the authors note.

I am concerned that by referring to a wide range of milk products as 'infant formula', the article is misleading and may cause undue anxieties about the sugar content of infant formula.

I would be grateful if your journal could amend the original article to reflect the data it contains.

R. A. Harpur, on behalf of Infant Feeding Alliance, UK

Authors Gemma Bridge, Marta Lomazzi and Raman Bedi respond: We thank the editor for the opportunity to reply to the letter from Dr Harpur. We are grateful to Dr Harpur for her letter. She raises concerns the article could be misleading and cause undue anxieties about the sugar content of formula milk amongst some parents.

We believe these anxieties are unfounded. The title of our published paper states that we investigated a range of formula milk 'products' marketed at infants, ie babies and very young children.

We found that many of the products were high in sugar and that the sugar content was not clearly stated on the products. We argue that those responsible for providing information to parents about infant feeding, including The Infant Feeding Alliance, an organisation that Dr Harpur is affiliated with, public health groups, industry and health professionals should be concerned about the sugar content of all products that are consumed by infants as there is a significant proportion of young children with early childhood caries. The risk of caries is increased by high sugar intake, especially in the first 1,000 days of life.

The purpose of our article was to describe the sugar content of a sample of infant formula products from across the world, and to assess what information is available to caregivers on the labelling of such products about the amount and type of sugar in the products. These aims were achieved. However, we recognise that this study is just the start and do strongly recommend and support the need for further research on the possible long-term health effects of a high sugar diet in infancy, and argue that sugar content and labelling regulations of formula milk products for infants under three are warranted.

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