

A child-oriented philosophy of dental management*

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Abstract

This article presents a child-centered philosophy for managing young dental patients. The goals of this approach are to reduce children's dental fear to a minimum and to encourage a positive, accepting attitude toward regular dental care. Interventions which focus on the young child's emotional needs in the dental setting are encouraged. The dentist uses techniques designed to help the child gradually develop more accurate perceptions, more effective coping skills, and more stress tolerance. The parent is enlisted as a valuable ally and resource in this treatment process.

Dentists who treat young children inevitably encounter intense emotional and behavioral responses in some patients which are challenging to manage. This article describes a child-centered, compassionate approach which is successful when treating difficult young patients. With few exceptions, normal healthy toddlers and preschoolers can be treated effectively using this approach. Even children who are highly anxious and disruptive can be managed without physical coercion, aversive techniques, or pharmacological intervention. The major factors limiting the success of this approach are the skills of the dentist and his willingness to respond to the needs of difficult pedodontic patients.

Goals of the Child-Centered Approach

The young child's fear or anxiety is the fundamental problem in patient management. Consequently, the pedodontist must reduce children's dental fear to a minimum and encourage a positive, accepting attitude toward regular dental care. Another goal is to help the child develop skills which will help him cope with dental stress. The primary aim of child-centered treatment is to manage the young child's emotional responses and address his psychological needs in the dental setting. These patient management strategies facilitate the long-term

goal of developing a positive, trusting relationship between dentist and child; any intervention counterproductive to this goal is avoided.

This orientation differs markedly from approaches which focus primarily on control of the child's behavioral responses. In directing energy toward control of the child's disruptive or resistive behaviors, the dentist may overlook underlying emotional needs and fears. This can predispose the dentist to use intervention strategies which provide immediate behavioral control without fully considering the long-term consequences of such interventions.

Controlling the child's behavior is an inappropriate primary focus. Use of terms such as "disruptive" and "uncooperative" to characterize the child's responses suggests that the dentist's needs predominate over the child's needs. Such labels convey a negative interpretation of the child's behavior which can foster unsympathetic management strategies. A view of the child as "bad" or "misbehaving" can legitimize coercion, force, or even punitive action to control protest behavior. Such coercive treatment creates the potential for a power struggle and inevitably establishes a power basis for the dentist-child relationship. This reinforces the child's view of the dentist as a negative, hostile, or harmful individual who should be feared. This outcome is documented by recent research demonstrating a strong relationship between coercive dentist behaviors and increased fear behavior in young dental patients.¹⁻³

Role of the Child-Centered Dentist

The child-centered approach shifts responsibility for completion of dental care from the child to the dentist. The child is not expected to be cooperative — to make it easy for the dentist to deliver efficient dental care. Rather, the dentist is expected to be a caring professional who has developed skills needed to implement a supportive approach.

All pedodontists need the confidence and ability to cope with young difficult patients. The dentist must understand what behaviors to expect from the child and

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not be threatened unduly by protest behaviors. Age-appropriate protest behavior is a normal response; therefore, the ability to tolerate it while delivering care is an essential skill. The dentist must be able to manage his stress level effectively and to control his own emotional responses to difficult child behavior. To assess young children successfully and establish realistic expectations for improvement of their coping skills, the dentist must remain aware of children's tremendous variability in developing stress tolerance.

The supportive pedodontist must be able to focus on the child's emotional problems rather than on technical difficulties in delivering dental care. He must therefore develop the skills needed to deliver dental treatment during less than ideal patient behavior. The technically competent dentist can approach fearful or resistive patients confident that the necessary treatment can be provided. He should remember that it is the child, not he, who has the problem and concentrate fully on helping the child.

Dentist-Child Interaction Using the Child-Centered Approach

Dentist-child interactions are designed to help the child develop more accurate perceptions, improved coping skills, and enhanced stress tolerance. The dentist acts in a positive, supportive manner toward the child. By understanding and assessing the youngster's needs and feelings, he determines the most effective intervention for each patient. The dentist should respect the child's feelings and acknowledge the child's right to his own perspective.

Several aspects of dentist-child interaction can be identified which assist in accomplishing the objectives of child-focused treatment.

Assessing the Child

At the outset of the dental visit, the child's anxiety level and ability to cope should be assessed. By considering the child's intellectual level and social-emotional maturity, the dentist can anticipate the kinds of responses the child is likely to exhibit. This process assists the dentist in deciding how he needs to adapt the pace of the visit and what expectations he can place on the child. It also sensitizes the dentist to behaviors which, although not optimal for a treatment situation, may be age-appropriate responses for a young child facing an unfamiliar and stressful situation.

Dentists should realize that young children have a limited set of behaviors to draw upon in coping with stress. A child's coping ability varies depending on his maturity, prior dental experience, personality, and characteristic patterns of relating to adults. His behavior often is guided by the need to protest an unpleasant situation and the impulse to protect himself from perceived danger. Among the behaviors that can impede dental care are: hyperactivity, crying, resistive movement, refusing

to open the mouth, and even aggression. The child's behavior is due to the underlying problem of fear — his goal is self-protection.

Orienting the Child to the Dental Experience

By assessing the child, the dentist can understand how the youngster perceives the dental situation. He then can begin to help the child correct overly negative perceptions and develop a more positive, accepting attitude. This orientation process begins in the waiting room by positive, supportive staff behavior and continues throughout the visit to help guide the child's interpretation of the new experience.

It often is helpful to begin the orientation by addressing the parent. Information which the dentist wants to convey to the child can be shared with the parent and is phrased in a way that will be understandable and reassuring to the child. By communicating through the parent, the anxious child is not threatened. Seeing the parent respond positively to the dental personnel, the youngster is likely to begin feeling more comfortable and relaxed.

When it is time to go to the operatory, the attitude of the staff should communicate complete assurance that the dental treatment will be accomplished. If the patient becomes overly anxious and resistive at this point, the staff should realize that the parent may not know how to react. Therefore, the staff should tell the parent how to respond to the child. If the staff calmly escorts the parent into the operatory, the child likely will follow the parent. If this approach proves unsuccessful, the parent can be asked to carry the child into the operatory. Thus, the staff avoids coercive interventions which might reinforce the child's negative perceptions of the dental personnel.

If the parent proves ineffective, the dentist should pick up the child in a kind but positive manner, minimizing force or coercion. He should use gentle, comforting physical contact, a soft, calm tone of voice, and reassuring explanations. Humor often can be used to defuse tension, for example, "It's hard to carry you when you wiggle so much. Are you related to a Mexican jumping bean?" The professionals involved should demonstrate effective control of both the situation and themselves. By remaining calm, pleasant, and understanding, they can reduce the anxiety of both child and parent, and model a relaxed response. No matter how resistive the patient is, he can be placed in the chair with kindness and understanding that should demonstrate that the protest is unnecessary. But most importantly, a positive and supportive foundation has been laid and the visit can progress.

Providing a Support System to the Child

Unlike the adult patient, a young child does not visit the dentist independently. The pediatric dentist must be

prepared to deal with the parent as well as the child.⁴ The parent can be a valuable ally and resource in helping the child cope with the stress of dental care.

Separation of the young child from his parent can increase stress in an already difficult situation. A decision to separate children from their parents may reflect the dentist's own anxieties, and not be in the child's best interest. Allowing a parent in the operatory for the first time can be a source of stress to a dentist; he may be concerned about his ability to manage the child successfully or about the parent's response to certain management techniques. However, dentists must work through such anxieties. These concerns can be resolved easily as they gain experience treating children with parents present — the dentist becomes more secure in his abilities. When practitioners use a management strategy that respects the child and addresses the child's emotional needs, they will find that parents respond as favorably as youngsters to the management approach.

Parental concerns about the child's dental experience are resolved by observing and participating in the visits. The parent's relaxed feelings are communicated to the youngster who is affected positively. The parent thus becomes a valuable resource in facilitating the child's mastery of dental anxiety and developing a positive attitude toward dental visits.

When a child is particularly fearful and resistive, the parent can help reassure the child and limit his movements. The parent can sit in the operatory chair and hold the child in his lap. This allows the parent to restrict the child's movements, while simultaneously comforting the child with close physical contact. Thus, the parent can share in and contribute to the success of the child's visit (and reinforce the dentist's sense of confidence and effectiveness).

Implementing Techniques that Support the Child

The dentist must project an image of a sensitive, caring, and capable person worthy of the child's trust. The dentist-patient relationship should be based on the dentist's ability to support the child and help him respond effectively to the challenges of the dental situation. The dentist should be aware of the youngster's feelings, acknowledge them, and discuss them. Fears should be dealt with openly by helping the child to identify his concerns. Explaining procedures will help allay fears. The child can be told, "I think you're worried about what's going to happen. I am going to show you everything before I do it, so you don't have to worry so much." By telling the child what will happen, he can begin to perceive the dental situation accurately. Suggestions that will help the child cope more effectively should be made.

Force and excessive demands for behavior change are to be avoided. While aversive techniques may temporarily suppress unwanted behavior, behavior dissipates

rapidly when negative reinforcement is discontinued.⁵ Furthermore, aversive stimulation induces escape or avoidance behavior. While the dentist may be reinforced by the effectiveness of aversive techniques in immediately suppressing undesired behaviors, the child's fear and resistiveness simultaneously are reinforced. Even if the dentist applies sufficient coercion to inhibit the child's protest behavior, the child's underlying fear is not resolved and a negative perception of the dentist is reinforced. If the behavior is not changed, it may intensify and the dentist may become increasingly aversive. When aversive techniques fail to control behavior, the dentist must resort to pharmacological intervention or treatment in the operating room.

Positive noncoercive contact often can be employed effectively. It should communicate gentleness, concern, empathy, and understanding; at the same time, it reinforces the dentist's presence and commitment to accomplish the treatment. This comforting contact also limits the child's range of movements and obviates the need for coercive restraint.

The dentist's approach emphasizes supportiveness but avoids time-consuming requests for cooperation. The approach communicates low-keyed, effective control of the situation. His concern, quiet confidence, and positive mastery of the situation thereby become evident to the child. These positive cues have a quieting effect on the child and elicit trust. The child will not confuse concern and empathy with weakness or undue permissiveness.

The need for pharmacological intervention should be evaluated on an individual basis. In selected cases, a light dose of drugs or nitrous oxide may be used to help a highly anxious child relax and to support his coping efforts. Patient management skills must be used in conjunction with medication to help the child develop a more relaxed and positive attitude toward dental care. Medications should be used primarily to help a child manage fears — medication should never be used as a form of behavior control. It is never a substitute for interacting with the child and managing behavior, but on occasion can serve as an adjunct to primary supportive interventions. By keeping dosage low, the child remains aware, is available for supportive interaction, and can acquire positive learning experiences that will facilitate an eventual adaptation to dental care.

Implementing a supportive technique involves sensitivity to the child's needs, awareness of parental concerns, and effective communication with both child and parent. The dentist approaches the child in a gradual, non-threatening manner, establishing positive verbal and visual interaction before making physical contact. He addresses the child in simple language and asks questions the child can answer easily. The youngster is given simple choices to help him experience some control and mastery in a frightening situation. Again, physical contact is made in a gentle, supportive manner that conveys

the caring qualities of the dentist.

Developing Expectations that Allow the Child to Experience Success

Throughout the visit the practitioner helps the child to experience success at whatever level the youngster can achieve. The dentist must remain sensitive to the child's developmental level and point of view. From the young child's perspective, protest and resistance often are reasonable and realistic responses. Crying may be a functional coping response; it enables the child to ventilate feelings, thereby reducing other emotional arousal. Crying enables him to tolerate a difficult situation. Therefore, at least initially, it is inadvisable to deny such responses. As the youngster's anxiety is reduced, such behavior frequently resolves itself. The patient's need to express distress is reduced when the dentist demonstrates that he understands the child's message.

By tolerating the child's age-appropriate coping efforts, the dentist avoids making unrealistic, excessive demands. Because complex developmental, personality, and experiential factors affect each child's coping strategies and skills,^{6,7} it is unrealistic to expect all children to conform immediately to a predetermined standard of behavior. Therefore, statements such as "Stop crying; we do not allow crying in this office!" should never be used.

Such unreasonable demands lead to loss of treatment time, failure experiences for the child, and an image of the dentist that is unnecessarily unsympathetic, hostile, and coercive. Unfortunately, the assumption often has been made that efficient dental treatment requires cooperative behavior and that dentists must be able to ensure cooperation in their patients. These assumptions lead to a view of the child as the problem. This brings about an inappropriate focus on the child's resistive behavior and lends critical overtone to the dentist-child-parent relationship. Consequently, dentists place unrealistic demands on themselves, creating unnecessary emotional, physical, and psychological stress.

Emphasizing Positive Aspects of the Child's Behavior

The dentist must be attuned to the child's need for adult approval. Positive feedback from adult figures guides him in learning social expectations and appropriate behaviors, while lack of attention tends to weaken undesirable responses. Feedback supporting a positive self-image facilitates the child's efforts to display behaviors consistent with that image.

For these reasons, the dentist uses language that conveys acceptance of the child and he comments favorably on positive aspects of the youngster's behavior. The dentist selectively focuses on behaviors which reflect the child's competence or effective coping efforts; less desirable responses are de-emphasized or ignored. For example, if a crying child succeeds in sitting still in the

operatory chair, this success is commented on, and the crying is ignored. When little can be observed in the child's behavior that is worthy of praise, the dentist should be creative in his efforts to be positive, perhaps commenting, "You tried very hard to be helpful," or "You did better than the last time." As the dentist gains experience, he develops confidence that even active physical resistance can be managed using this positive approach. The dentist maintains a positive, supportive image and avoids an interpretation of the child as deliberately uncooperative or hostile, accomplishing the procedure while preserving and enhancing the child's self-esteem.

Helping the Child Develop Coping Skills

In the child-centered approach, the dentist realizes that the young child experiences stress and anxiety during initial dental visits. He accepts protest behavior and focuses on helping the child develop stress tolerance and coping skills. Over a series of visits, he can help the child acquire more effective coping skills and adjust behaviorally to the dental situation.

Emotional and behavioral changes occur slowly over a series of visits; the more anxious the child, the slower behavioral improvement is achieved. The dentist should realize that increasingly negative behavior often appears before improvement is made.⁸ The child may need to exhaust all available coping tactics before becoming convinced that they will not produce results. Only then will he try new, positive strategies for coping with the stress. Understanding this process helps the dentist avoid becoming prematurely discouraged, conclude that the child is being traumatized, and resort to pharmacological or coercive interventions.

Inappropriate responses are resolved as the child is helped to view the threats inherent in the dental situation in a less exaggerated and distorted way. The practitioner's consistent, caring manner dispels the child's original view of the dentist as a hostile, threatening figure. The dentist uses every opportunity to discuss and diminish unrealistic fears and to redefine dental procedures in a more accurate way. By maintaining a supportive approach, he fosters the gradual development of a positive attitude toward dentistry and dental personnel. As the child's anxiety is resolved, he becomes more able to use appropriate coping resources effectively.

Maladaptive behaviors can be weakened by suggesting ways that the child can cope. The child can be taught anxiety-reducing behaviors such as slow, deep breathing and relaxation. Verbal communication skills can be fostered by the dentist's sensitivity to the child's cues. Appropriate ways to signal discomfort also can be demonstrated, raising the child's trust level and stress tolerance. The patient can be taught that appropriate positioning and lack of movement enables the dentist to minimize both the duration and discomfort of dental procedures.

Over several visits, gradual improvement in response occurs through the dentist's support of the child's efforts and reinforcement of appropriate behaviors. Positive feedback on the youngster's progress helps him feel successful and consolidates new coping skills.

Choosing Patients for the Child-Centered Approach

This method is appropriate for healthy children, two years of age or older, who are in the normal range of intellectual functioning and social-emotional development. Very fearful children, including those who resort to physical resistance and extreme vocal protest, especially will benefit from this approach. Other good candidates are children who have limited experience dealing with stress and controlling their behavioral responses, for example, children who often are labeled "spoiled."

This method can be adapted or supplemented with other techniques to treat patients with special needs. Children lacking the intellectual skills and social awareness to deal with the dental environment will not benefit fully from this approach. This group includes many children younger than two years, handicapped children who have major intellectual deficits, and children with severe developmental disorders such as autism. Children whose communication skills are limited or who do not speak the same language will not benefit fully from verbally-mediated interventions, but still will respond positively to the nonverbal aspects of supportive communication. Children with major medical problems such as hemophilia will require an individual evaluation to determine whether treatment in the operating room is indicated. Finally, older children who have an extreme fear may require systematic desensitization and/or anxiety-reducing pharmacological intervention.

Economic Feasibility of the Child-Centered Approach

Because the child's behavior changes slowly and gradually, dentists may conclude inaccurately that this method is time-consuming and costly. This concern is not valid. The dentist spends the same time implementing a supportive or a coercive technique; he simply uses the time differently. Practitioners using a coercive approach try to interrupt or prevent the child's resistive behavior and can expend considerable time dealing with a persistent child. Because the child-centered approach accepts some protest behavior and does not try to alter it directly, the dentist can provide the needed dental care more quickly. Time isn't wasted unrealistically pursuing immediate behavioral change.

Conclusions

In summary, the child-centered approach focuses on

the child's needs rather than the dentist's needs. It defines effective management as the dentist's ability to accept and support the child and to provide care at the child's level of functioning and coping skills. The dentist exhibits tolerance for the young child's behavior and is willing to deliver care under less than ideal patient conditions. Behavioral cues such as cessation of crying or absence of movement, are not used as criteria for successful child management. Instead, the dentist establishes realistic goals for gradual behavioral change over several visits. These goals enable both dentist and child to experience success.

Throughout this approach, the dentist's challenge is to guide the child toward a realistic perception of dental treatment. The dentist provides support and reduces fear, so that the child no longer feels the need to protest or resist. The process requires patience and varying amounts of time for different youngsters. It also requires a sensitive, careful assessment of each child's stress tolerance so that realistic behavioral expectations can be established. Such sensitivity and concern help the child view the dentist and the dental experience more positively. The child's coping efforts are not hampered by excessive anxiety, thus he can respond to the challenges of the dental situation to the best of his ability. The child's protest and resistance gradually diminish, but not because he has been forced to behave cooperatively; behavior improves because the patient has been helped to master an unrealistic fear of the dental setting, to acquire a more accurate, accepting view of dental care, and to develop the coping skills needed to deal with dental stress.

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