Psychological Safety in Pediatric Dentistry

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Oft-hidden challenges to child cooperation, such as past psychological traumas, effects of early childhood deprivation, and undiagnosed behavioral conditions can frustrate practitioners, and aren't typically solicited on health histories. Dr. Friedman's perspective on less-considered factors affecting a child's in-office behavior is one of several addressing emerging and little known behavioral, physical, and pharmacologic aspects of pediatric dentistry.

The National Council for Mental Wellbeing found that at least 70 percent of people in the United States have experienced some type of traumatic event in their lifetimes.[1] A history of trauma changes the way a child experiences a dental visit and includes potential for re-traumatization. Relatively minor changes to a health care provider's physical, social, and emotional environment can reduce the likelihood of re-traumatization and improve a patient's feeling of safety.

Trauma can be defined as "any lasting emotional response that results from living through a distressing event."[2] In its original Greek, trauma means "wound." How one copes with woundedness will dictate ways of thinking and shape the experience of one's interactions within one's environment.[3] A traumatic event can harm a person's sense of safety, sense of self, and their ability to regulate emotions and navigate relationships. Long after the original "wound" occurs, people with trauma may feel shame, helplessness, powerlessness, and intense fear due to the imprint of the traumatic event that remains in the body.

According to the CDC[4], some examples of traumatic events that could occur in the lives of children include:

- Parental separation
- Experiencing violence, abuse, or neglect
- Witnessing violence in the home or community
- Experiencing homelessness
- Experiencing discrimination
- Observing substance use

Little "t" traumas can occur as well through emotional withholding from a child or increased vocalization directed at a child. Pediatric dentists can look beyond the normal definition above. Seemingly benign activities – such as being reclined in a dental chair or the smell of a dental operatory – can reactivate that negative body memory. In instances where previous oral abuse has occurred, any touch in the oral region could be a trigger. These stimuli engage the sympathetic nervous system, initiating a flight or fight response. In that state of hyperarousal, panic, fear, anxiety, frustration, and anger can present. Physiological signs of hyperarousal might include an increase in blood pressure and heart rate and a reduction in ability to relate.

A "freeze response," or hypoarousal, is also possible. This is when an individual appears to disengage from their physical body. It is as if the person has returned to the scene of the original trauma without knowing why.[5] A child in a freeze state may become dissociated, shut down, feel helpless, and even display an increased pain threshold. This is a difficult state to detect, as it may appear that the child is willingly cooperating. Physiological signs of hypoarousal include decreased heart rate, blood pressure, depth of breath, and lack of responsiveness to the human voice.

When a child is in the state of either hypo or hyperarousal – caused by the sympathetic nervous system – then the parasympathetic nervous system **(PNS)** needs to be activated to positively reengage that child. If not done, the child will not feel safe and traditional behavioral interventions are less likely to work. Physiological signs that the PNS is engaged include restoration of circulation, feelings of safety, curiosity, and calmness in connection, and reorientation to the present environment.

Reengaging the PNS can be accomplished in the moment by helping both parent and child adopt different modes of breathing. Encouraging them to slow down exhalation, for example, is easy and non-invasive. You might say: "Let's see how long you can hold your breath. Let's see if you can do it to the count of ten and then very slowly begin to let your breath out. If you need to make a noise while doing that – great! Let's try that together."

If you notice that your patient is not successfully shifting from a hypo/hyperaroused state, it will be time to stop treatment. Alternative treatment modes or settings like sedation or general anesthesia might be indicated for the long-term physical and psychological health of the child. The last thing we want to do as dentists is retraumatize a patient; it could have dire consequences on their ongoing dental care, oral health, and overall health.

Dentists – like all health care providers – have an obligation to be familiar with and recognize physiological signs of trauma and prevent re-traumatization.

Here are some tips on how your practice can create safe spaces for your patients:

1. Incorporate items like these into your intake or screening questionnaire:
    - What are you and your child expecting us to do at your appointment today and in the future?
    - Is there anything that makes the dental experience scary for your child?
    - Is there anything we can do to make your child feel more comfortable or safe?

Sympathetic Nervous System (SNS) activation		**Parasympathetic Nervous System (PNS) activation**
Hyperarousal	**Hypoarousal**	**Relaxed**
increased blood pressure	decreased heart rate	restoration of circulation
increased heart rate	decreased blood pressure	sense of safety
reduction in ability to relate	decreased depth of breath	reoriented to the environment calm
	lack of responsiveness to the human	

2. Inquire with parents at the beginning of an appointment how their child self-regulates when stressed.[6]

3. Consider how office smells might trigger a traumatic event. Perfumes, chemicals, and cleaning materials are all abundant in many offices, but the impact can be minimized with adapted cleaning practices and scent policies.

4. Try breathing exercises with your patients when you identify they could be in a state of stress-induced hypo- or hyperarousal.

5. Round out your referral network to include a child psychologist or psychiatrist so you are prepared when a child might need additional care that they are not already receiving, or to turn to for interprofessional guidance.

Pediatric dentists and their teams should be ready to identify, prevent, and manage psychological events experienced by their patients. A single technique or checklist will not necessarily make the dental environment a safe space. This work requires compassion, sensitivity, and perhaps even a shift in the team culture.

Visit the AAPD Safety Corner for more articles on contemporary safety issues in pediatric dentistry.

References

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4. *Fast Facts: Preventing Adverse Childhood Experiences. National Center for Injury Prevention and Control, Division of Violence Prevention. Reviewed June 29, 2023. Available at https://www.cdc.gov/violenceprevention/aces/fastfact.html.*

5. *Working with the Freeze Response in the Treatment of Trauma with Stephen Porges PhD. National Institute for the Clinical Application of Behavioral Medicine. Available at https://www.nicabm.com/stephen-porges-on-the-freeze-response/.*

6. *Pre-Visit Questionnaire. Available at https://www.cda-adc.ca/_files/oral_health/cfyt/special_needs/SNB_Form_EN_VFillable.pdf.*

AAPD ANNOUNCES NEW PROMOTIONS

The American Academy of Pediatric Dentistry is pleased to announce several key promotions within its staff, effective July 1, 2024. These appointments underscore the organization's commitment to excellence and leadership within the field of pediatric dentistry.

Paul Amundsen has been promoted to Senior Vice President, Foundation and Integrated Marketing. With his extensive experience and innovative approach, Amundsen is poised to drive the Foundation's strategic initiatives and enhance its marketing efforts.

Kristi Casale steps into the role of Senior Vice President, Meetings and Continuing Education. Her leadership will be instrumental in shaping the AAPD's educational programs and events, ensuring they meet the highest standards of quality and relevance.

Tim Huggenberger has been elevated to Administrative Coordinator. In this capacity, Huggenberger will play a crucial role in streamlining administrative processes and supporting the organization's operational efficiency.

Camryn Schreiner has been promoted to Senior Web and Social Media Coordinator. Schreiner's expertise in digital communications will be key in advancing the AAPD's online presence and engagement.

Adriana Loiaiza has been promoted to Director, Publications. She ensures quality production of AAPD's two scholarly journals and the *Reference Manual*.

These promotions reflect the AAPD's dedication to fostering talent and advancing its mission to promote optimal oral health for children. Congratulations to all on their well-deserved advancements!