Factors Affecting Children’s Behaviour in the Dental Office

ABSTRACT

Most of the children willfully accept dental treatment when approached in a positive and supportive manner. However, dental personnel routinely encounter many children who exhibit considerable anxiety or problematic behaviour in the clinical settings. For some of these children, especially those who are relatively young or have had negative prior experiences, providing even “routine” dental procedures requires considerable effort and patience. Some require special management considerations because of their extensive dental treatment needs, poor health conditions or behavioural issues. Lack of cooperation of a child not only affects the successful completion and quality of necessary dental procedures but also raises some degree of stress in the dentist. Some children do not always accommodate to plans designed for them as there are many factors which can influence the behaviour of children in the dental situation. There are many factors which influence the behaviour of children in the dental office. Some of them are activity, attitude and attire of dentist, length or time of appointment, general factors such as growth and development of child, nutritional status, school environment, presence of another sibling in the operatory and mother’s behaviour. Though some factors are not under the control of a clinician but knowledge of certain aspects and influences on child’s behaviour can be of major help in the clinical practice. Some of the factors can be modified by dentist to help the child through the dental appointments. It is important that the knowledge and practice of behaviour management should be incorporated in a continuous learning process or education for all dental practitioners. Furthermore, the dental team as a whole, including auxiliary personnel, should be trained in the knowledge and practice of various techniques, so that all children may be given quality dental care.

KEYWORDS dental office, children’s behaviour

INTRODUCTION

The management of children with non-cooperative and disruptive behaviour in the dental clinic continues to be a major challenge to the dental practitioners. Lack of cooperation in a child not only affects the successful completion and quality of necessary dental procedures but also raises some degree of stress in the dentist. Some children do not always accommodate to plans designed for them as there are many factors which can influence the behaviour of children in the dental situation. Though some factors are not under the control of a clinician but knowledge of certain aspects and influences on child’s behaviour can be of major help in the clinical practice. There are many factors which a dentist can modify to help the child through the dental appointments.

FACTORS UNDER THE CONTROL OF DENTIST

Effect of dental office environment

- Dental clinic environment should be warm and homely. Healthy communication with the child should be established. A pleasant environment helps the children to be relieved of anxiety about the dental situation.
- The operating environment should be made colorful and lively with posters, TV and videogames, toys, story books and comics.
- It should have a separate entry and an exit door. Dental auxiliary should be kind to the children and should greet them with a smile.
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The dentist explains to the child, in language that the child can understand, the purpose to the dental treatment.

The dentist prepares the child for each phase of treatment by describing it in advance.

The dentist separates each procedure into stages. The procedure is described, and the child is told when a stage is completed. Thus, during an operative procedure, phases to be described could include placement of the rubber dam, cavity preparation, removal of decay, placement of a matrix, condensing, carving and so on.

The dentist prepares the child for each change in sensation before experiencing it. This includes altering of chair position, the possible pain and subsequent numbness associated with the local anaesthetic, the vibration of the slow-speed hand piece and the whine of the high-speed hand piece.

The dentist informs the child when the next appointment has been scheduled for and what will be done then.

c. Externalisation

Externalisation is a process by which the child’s attention is focused away from the sensations associated with the dental treatment.

The local injection procedure is an example of when externalisation is often required:

- During this procedure children tend to focus their entire attention, perception and sensation on the site of injection.
- Their eyes may be closed, their mouths wide and their bodies rigid as they withdraw from all other stimuli.
- There are two methods of externalising the patient’s attention: first, involve them in verbal activity; and second, involve them in the dental activity.
- The first method is appropriate during the injection procedure and could be accomplished in the following manner. Before the injection is given, the dentist can tell the child that he will slowly count to 10 and that when the counting is finished the procedure will be over.
- The dentist then begins the injection and starts to count, taking about 60 seconds to do so. As he counts, he asks the child to count with him.
- This simple procedure accomplishes several things. First, it distracts the child from the injection itself as he will have to concentrate on counting. It also involves the child because he has to concentrate on counting. It also involves the child because he has to concentrate on counting. It also involves the child because he has to concentrate on counting. It also involves the child because he has to concentrate on counting.
- Additionally, it will indicate to the child exactly when this phase of therapy is completed, and it is thus also a form of structuring.
- Another approach involves finding out the child’s interests beforehand. Then, as the injection is given, the dentist very expressively converses with the child about his chief interest and asks the child questions requiring “yes” or “no” response.
- As the appointment progresses, the dentist can engage the child in conversation about the child’s hobbies, his pets or his favourite television programmes.
- The conversation may often be one-sided, since the child with dental instruments in his mouth will be unable to reply verbally. He can, however, nod his head and show other signs of participating in the conversation.

Appointment time should always be short, i.e., less than 30 minutes. Early morning appointments are preferable for younger children. Children should not be kept waiting for too long in the waiting area because they tend to become restless.

Effect of dentist’s activity and attitudes

While the dental experience can evoke anxiety in some children, a child’s basic ability to cope will determine whether the child will be considered a “good” dental patient. A dentist’s attitude can support a child in their attempt to establish proper behaviour.

Jenks (1964) described six categories of activities by which dentists can foster or enhance cooperative behaviour in children. These activities are:

a. Data gathering and observation

- Data gathering involves collecting the type of information about a child and his/her parents that can be obtained by a formal or informal office interview or by a written questionnaire.
- Observation involves perceiving overt and subtle behavioral characteristics of a child which provide clues as to how he should be approached by the dentist and his staff.
- Observation begins with noting the waiting room behaviour of the child, including the interaction with the parent.
- The child’s attitude when he is separated from his parent and his behaviour upon first contact with the dentist should be noted.
- Once in the operatory and during treatment, the child’s response to the new sights, sounds, and smells of the dental office and his manner when responding to directions from the dentist should also be observed.

Observation should be a continuous activity. At each appointment, the dentist should be prepared to modify their approach to a child as the child’s behaviour changes and/or as the dentist’s perception of it is changed.

b. Structuring

Structuring refers to the establishment of guidelines of behaviour which are communicated by the dentist and his staff to the child. With proper structuring, children should know what to expect and how to react during the dental experience.

Jenks describes several ways in which the dentist may provide structure to the dental appointment:

- The dentist explains to the child, in language that the child can understand, the purpose to the dental treatment.
- The dentist prepares the child for each phase of treatment by describing it in advance.
- The dentist separates each procedure into stages. The procedure is described, and the child is told when a stage is completed. Thus, during an
d. Empathy and support

Empathy is the capacity to understand and to experience the feelings of another without losing one’s objectivity. Dentists must have the sensitivity and capacity to respond to children’s feelings.

Several ways in which dentists can provide this kind of support include:

- Permitting children to express their feelings of fear or anger, and their desires, without rejecting them. Communicating to children that their reactions are understood.
- Comforting children when it is appropriate. This can be done by careful choice of words, by the tone of the voice or by touching the child and giving a reassuring pat or hug.
- Encouraging children when they show acceptable behaviour. Listening to children’s comments when they wish to talk.

e. Flexible authority

- Dentist’s authority must be tempered with a degree of flexibility or compromise in order to meet the needs of the particular patient or situation.
- The dentist must consider whether the behaviour is due to the child’s personality or lack of maturity, or whether he himself has contributed to the situation by his approach to the child. If the latter is the cause, the dentist’s attitude should be sufficiently flexible to allow him to modify his tactics at the same or at future visits.

f. Education and training

- Any dentist who treats children should implement a programme which both educates children and their parents as to what constitutes good dental health and stimulates them to make the behavioural changes necessary to achieve these goals.
- For example, when dentists give dietary advice, they should recommend non-cariogenic snack substitutes such as popcorn, potato chips, peanuts or sucrose-free chewing gum. This type of recommendation is more likely to be followed than in one which demands the complete elimination of snacks from the diet.

Effect of the dentist’s attire

The attire worn by dentists varies from a surgical gown or white clinic jacket to a shirt and tie or open-necked shirt.

So far no study has attempted to evaluate the specific effect of the dentist’s attire on children’s behaviour, although it has been stated that if a child has previously experienced a stressful situation which included the presence of someone in white attire – such as a physician – the mere appearance of a white-clothed individual would be sufficient to evoke negative behaviour.

Cohen (1973) compiled the preferences of 300 children regarding the types of attire they thought dentists should wear. His findings appear to indicate that the type of attire that a dentist wears probably is not a significant factor influencing the behaviour of most children in the dental situation; however, it is possible that certain children who have associative fears may be unduly influenced by what the dentist wears.

Effect of the length and the time of day of the appointment

The earlier dental literature has stressed that appointments for children should be short, possibly because of the short attention span of children. However, with the advent of high-speed instrumentation and subsequent increased efficiency, the length of a typical appointment has been extended in order to perform quadrant or complete treatment in a single visit.

Lenchner (1966) has evaluated the effect of appointment length on children in his private practice. The children ranged in age from 3 years 1 month to 11 years 4 months. A short appointment was considered to be 30 minutes or less and a long appointment was 45 minutes or more. No significant difference was found between children’s behaviour during long or short appointments. There was, however, a trend toward deterioration of behaviour during long appointment.

The generalisation has been made that early morning appointments are preferable for young children because they are more rested and cooperative then. In the afternoon they may be tired or cranky from missing a nap.

Effect of another’s presence in the operatory

a. The mother’s presence

Frankl et al. (1962) have established that the presence of the mother as a passive observer in the operatory contributes to a greater frequency of positive behaviour in preschool children.

This was observed during an initial visit which included an examination, prophylaxis and radiographic series, and during a second visit in which local anaesthesia was given an operative procedure performed. The presence of the mother did not appear to enhance the cooperative behaviour of slightly older children, but neither was it found to be deleterious.

The mother is usually seated in front and to the right of the dental chair facing the child. This is a good location, since it will usually allow the child an unobstructed view of the mother.

b. An older sibling’s presence

It has been suggested that if an older sibling serves as a role model in the dental situation, the younger child’s behaviour can be improved.
Ghose et al. (1969) evaluated this hypothesis and also influence of the age of the younger sibling on the reaction to the presence of an older sibling. The results had shown that:

- The presence of an older sibling had little influence on the behaviour of 3-year-old patients. This age group exhibited similar frequencies of positive or negative behaviour whether or not an older brother or sister present.
- Five-year-olds were exceedingly cooperative, irrespective of the presence or absence of an older sibling.
- The effect of the presence of an older sibling was most noticeable however, among 4-year-olds.

FACTORS OUT OF THE CONTROL OF THE DENTIST

Growth and development

- If there is a deficiency in physical growth and development or congenital malformations, e.g., cleft lip, as awareness of the deformity increases it leads to psychological trauma due to rejection by the society.
- Mental retardation, epilepsy, cerebral palsy etc., make the child mentally handicapped. Here, the child cannot react to the requirements of the mother and expectations of the society. Hence, there is a failure of cognitive development and therefore variations in the behaviour are encountered.
- Also, a very young child reacts very differently and the same response may be transformed to a positive behaviour, as the child grows older. Thus the intellectual age of 3 years seems to be that point in developmental progress that signifies a maturational readiness to accept dental treatment.

Nutritional factors

- Studies have shown that an increased intake of sugar causes an irritable behaviour.
- Hypoglycemia causes a criminal behaviour.
- Skipping breakfast leads to an impaired performance.
- Nutritional deficiency also affects the milestones of biological and cognitive development.

Past medical and dental experiences

Any past unpleasant dental experience, prior hospitalisation, surgical intervention, sickness etc., are associated with a higher degree of uncooperative behaviour. Therefore the emotional quality of past visits rather than the number of visits is significant.

Genetics

- It plays a very important role in psychological development.

FACTORS UNDER THE CONTROL OF THE PARENTS

Home environment

- The home is the first school where a child learns to behave. All the individuals at home influence the child’s behaviour but none so much as the mother, e.g., in case of a broken home, the child may feel insecure, inferior, apathetic and depressed. Mother-child relationship has been described as one-tailed.
- Postnatal behaviour of the child depends on the prenatal emotional status of the mother.

Family development and peer influences

- Position and status of the child in the family and parental attitudes can influence the child’s behaviour. Overindulgence by parents can lead to a spoil behaviour in the child who may show sudden outbursts and temper tantrums.
- Internal family conflicts affect children’s behaviour. The child can sense disharmony in the family and this can emotionally frustrate the child.
- The younger child always tries to follow the model of the older sibling and family members, thus showing the same behaviour of siblings.

School environment

- Fifty per cent of the child’s development is affected by the school and the remaining 50% by the home environment.
- In school, teachers and peers help to influence the behaviour of the younger children. Also, seniors become role models to the juniors.

Socioeconomic status

- High socioeconomic status child may develop normally because the family can provide all the necessary requirements to aid in a normal psychological development. On the other hand, this child may also become spoilt if he always gets what he wants.
- A low socioeconomic status child develops resentment and is tensed as the child gets little attention and is often neglected. It can also directly affect the child’s attitude towards the value of the dental health.
Maternal behaviour

Prenatal influence

- Maternal influence on the children’s mental, physical and emotional development begins even before birth.
- Somatic development of the fetus depends on the nutritional status of the mother.
- Neurohormonal system of mother transfers emotions to the fetus.
- Postnatal behaviour of the child is linked to prenatal emotional status of the expectant mother, e.g., emotional stress during pregnancy can lead to an excessively active and irritable infant.
- Agents such as alcohol, smoking and keratogenic/totipotent drugs affect the child’s development if consumed during the pregnancy.

Postnatal influence

The pattern of the mother-child relationship during early childhood exerts a profound influence on the development of the personality of the child and affects the way the child will respond to new or demanding situations.

Acceptance (love) vs. rejection (hostility), and autonomy vs. control are regarded by some as the two most significant attitudinal considerations of the relationship between a mother and child. Between these behavioural poles fall several gradations of mother-child interaction. Those which are important in relations to the dental situation include overprotection, overindulgence, under affection, rejection and authoritarianism.

Maternal anxiety appears to be a primary factor influencing a child’s anxiety in the dental office. In fact, the subjective impressions the child garners from the family appear to arouse more fear than the dental experience itself.

For young children, who still retain some of their innate fears and are emotionally immature, the presence of the mother in the operatory can have a salutary influence on behaviour during treatment.

REFERENCES