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RESEARCH ARTICLE

Role of Parent in Behavior Guidance of Children in Dental Operatory: Current Trends

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Abstract

Parental factors have an important role in the behavior of the child in the dental clinic. These factors include parent-child relationship, parental dental anxiety, parental attitudes and perceptions regarding child's behavior in the dental clinic, parent's past dental experiences, parental presence in the dental operatory during treatment. Understanding the ways in which parent influences behavior will help the dentist in behavior guidance of the child during dental treatment. Parent should be a partner in the behavior guidance of the child, whose role should be guided by the dentist.

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INTRODUCTION

Lack of co-operative behavior in children is associated with anxiety and fear regarding dental treatment (Klingberg and Broberg ,2007).It is recognized as a risk factor for avoidance in seeking dental treatment thus increasing risk for untreated dental disease (Wigen et al.,2009).A child's response during dental treatment is influenced by many factors such as previous negative medical and dental experiences, social influences and personality factors (Kyritsi et al., 2009). Parents play an important role in child's behavior in general due to their style of parenting such as discipline techniques and how much freedom they allow. Dentistry is a situation in life which the child experiences because the parent has got the child to dental clinic (Wright et al., 1983). Thus parental factors also can influence the anxiety of the child and hence the behavior of the child in dental clinic.

Parental factors influencing the behavior in dental clinic:

1. Parent-Child relationship
2. Parental dental anxiety
3. Parental attitudes and perceptions regarding child's behavior
4. Parent's past dental experiences
5. Parental presence in the dental operatory

Parent-Child relationship:

The parent-child relationship forms the basis of influence of parents on children's behavior. The mother-child relationship is given more importance as mother is often the primary care giver. The type of personality of the mother influences the child's ability to cope in fear provoking situations such as dental treatment. Based on mother's personality type, 3 types of mother-child dyad are documented in literature (Freeman, 2007).

A) *Competent mother-child dyad:* characterized by nurturing interactions between the child and the mother. This encourages psychological growth of the child. The mother behaves in a consistent manner, contains her child's

anxieties, and interacts in a positive emotional manner. This encourages the child to develop independence and social skills. The child is able to cope up in stressful situations such as dental treatment.

B) *Aggressive mother-child dyad:* characterized by inconsistency and emotional detachment. The aggressive mother is unable to set clear boundaries for the child's behaviors and wavers between rejection and possessiveness of her child. They are overly attentive or inattentive and emotionally inclusive or distant. When children exhibit negative behavior, they respond in an inconsistent and aggressive manner.

C) *Anxious mother-child dyad:* Mothers behave in authoritarian manner. They are negative and punitive. There is little warmth and responsiveness to child's developmental needs. There are strict limits and controls for the child. Child's autonomy and social skills are inhibited. This results in poor child compliance and disruptive behavior.

The parent-child dyad determines the parent's capacity to respond to the child's emotional world which in turn affects the reaction of the child to dental treatment. An anxious child caught in the anxious and/ or aggressive mother-child dyad will be left to manage her dental fear which will be intensified by mother's inconsistent and ambivalent behaviors. Parents inadvertently reinforce the anxious and disruptive behavior by being overprotective while exhibiting anger and hostility (Barret et al., 1996;Freeman, 2007).

Parental anxiety

The research provides conflicting evidence about parent's effect on their child's dental fear. Some studies suggest that parents with a high level of dental anxiety struggle to prepare their children adequately for the dental visit. Some other evidence suggests that compared with other factors, parental fear may not be of significance in the etiology of child's dental fear. A meta-analysis demonstrated significant relationship between parental and child dental fear particularly in children younger than 8 years of age (Themessl-Huber et al.,2010). Mothers show significantly higher anxiety than fathers. Fathers also play a relevant role, different from mother's, in childhood anxiety. Children seem to put higher weight on father's responses than on mother's responses in the face of possible threats, whether the situation is dangerous/ to be avoided (Lara et al.,2012).

The acquisition of dental fear occurs by three pathways: direct conditioning, modeling, information/ instruction. Parent's dental anxiety can influence the child through modeling and information/instruction (Rachman,1977). Many adults who are afraid of dental treatment, often verbalize these dislikes and fears in front of their children and this model may serve as a model on which they base their behavior. As children are in the stages of learning behavior, they often imitate parents who are looked upto as models (Bankole et al.,2004). Parents with high dental anxiety are more likely of low socioeconomic status and more likely to have limited dental knowledge (Arnrup and Beggren, 2002).

Parental attitudes and perceptions regarding child's behavior

Parent's expectation of the behavior of the child in dental clinic is a predictor of the behavior of the child during dental treatment. When parents estimate low dental fear, children usually show co-operative behavior. This expectation is irrespective of their own fear about dental treatment (Kyritsi et al., 2009). Children of the aggressive mother child dyad choose aggressive solutions when faced with an unknown situation like dental treatment whereas children of the anxious mother child dyad choose avoidance solutions. Both of these responses can be enhanced by a negative perception of the parents regarding child behavior.

Parents attribute child's dental fear and refusal to undergo invasive and painful dental treatment experiences on their child in the past. They also attribute it to invasive health procedures in the past, child's temperament and negative dentist behavior. Very few parents think that social influences such as their own dental fear or of family members will have an impact on the child's behavior (Ten Berge et al.,2001;de Oliveira et al.,2006). Most parents of the children with high dental fear attributed child's dental fear to external factors beyond their control, while parents of children with low dental fear, especially of younger children consider themselves more important in this process. This may be due to feeling of helplessness as they are unable to help their child overcome dental fear (Ten Berge et al., 2001).

Parent's past dental experiences

A study has shown that children whose mothers have pleasant memories are more likely to show positive behavior. Improvement in behavior in later stages of treatment is also likely to occur among children on mothers with pleasant memories. Negative dental experiences increase dental anxiety and are often told to or heard by children thus resulting in conditioned dental anxiety among children. On entering the dental operatory, mothers with positive dental experience react positively (Bankole et al., 2004). Parents' own childhood dental treatment experiences have a considerable influence upon their children's dental attendance pattern. They often delay care for children until an emergency need such as tooth ache arises which needs invasive dental treatment (Smith and Freeman, 2010).

Parent's presence in the dental operatory

Margaret Mead has described three paradigms regarding parenting children. According to her, parenting in the society has undergone a transition over decades. The earlier parents were mostly post-figurative parents, where children were bound by the rules of the family and were assigned responsibilities. The parenting paradigm then shifted to configurative where post-figurative concepts began to fade and new paradigms were experimented. The current society around the world follows mostly the pre-figurative paradigm where no rules are set and parenting strategies change time to time depending on the needs of the child (Pinkham 1991; 1995). A side effect of such a parenting is a child who is not rehearsed to handling requests of adults which poses a potential problem to the dentist. This often results in attention getting behaviors not only in dental clinic, but also in day today life. This has resulted in marked increase in number of parents who want to be present in the dental operatory during their child's dental treatment (Pinkham, 1991).

The pedodontic triangle suggests the parents to be one of the factors involved during the dental treatment in children(Wright et al., 1983). Yet, whether parental presence during dental treatment helps the dentist to carry out dental treatment and instills positive behavior in the child is still controversial. Parental presence is customary in medical situations, but traditionally dentists have excluded parents from the operatory (Cox et al., 2011). The following are the reasons for excluding parents:

- Mother often talks to the child/ dentist during dental treatment. This results in attention of the dentist/ child being divided and acts as a hindrance in the development of a good rapport between the child and the dentist. Thus too many questions to the dentist or too many instructions to the child by the mother can interfere with the dental treatment (Crossley and Joshi, 2002).
- Parental anxiety transmitted to the child, thus making him more anxious and less accepting the treatment(Cox et al., 2011).
- Presence of parent makes the dentist uncomfortable and feel pressured by their expectations (Crossley and Joshi, 2002).
- Parental presence is likely to increase the child's efforts to test the limits of behavior and also compromise the dentists efforts in setting the limits (Croxton,1967).

Parental presence seems to be more crucial in decreasing the anxiety of the child only in the first dental visit. Even in the preschool age group, where separation anxiety is presumed, children are less anxious and more co-operative regardless of the parental presence (Venham et al,1977). However some studies have reported beneficial effect of presence of mother as they feel a sense of security and enhance the coping behavior (Fenlon et al., 1993; Freeman, 1999).This difference in the outcome is due to other factors influencing the behavior of the child such as child's coping ability, personality characteristics, mother's anxiety and behavior management approach of the dentist (Cox et al., 2011).

When given a choice, parents wish to see their children during dental treatment (Fenlon et al., 1993; Cox et al., 2011). Parents of younger children want to be present in the dental operatory than that of older children. Parents who want to be present think that they give a sense of security to the child and enhance coping abilities. Some parents also want to see what is being done to the child which is the reflection of their own anxiety. On the other hand, parents who do not wish to be in the operatory have confidence in their child's coping abilities (Arathi and Ashwini, 1999).

Dentists perceive that child's anxiety increases in the presence of parents (Cox et al., 2011). In children with behavior management problems, dentists use behavior management techniques such as effective communication, positive reinforcement of the desired behavior. Parental presence may act as a hindrance for effective communication. Frequently, parental expectations for the child's behavior (eg. no tears) are unrealistic, while expectations for the dentist who guides their behavior are great. Some parents may even try to dictate treatment, although their understanding of the procedure is lacking(Sheller,2004; AAPD guidelines, 2005-2006).

Parental/ Absence in Behavior Guidance: A Paradigm Shift

The American Academy of Pediatric Dentistry has recognized parental presence/absence as a behavior guidance technique (AAPD guidelines, 2005-2006). The need for the dentist to recognize the parental role arises because parental involvement in their children's health care has changed dramatically in recent years (Long, 2004). It is imperative that the dentist recognizes that parents' desire to be present during their child's treatment does not mean they intellectually distrust the dentist. It might mean they are uncomfortable if they visually cannot verify their child's safety. It is important to understand the changing emotional needs of present day parents as they have a latent but natural sense to be protective of their children (Pinkham,1991).Practitioners should become accustomed to this added

involvement of parents. Thus there is a paradigm shift from the traditional thinking where in the parent is considered a hindrance to have a good rapport with the child and compromises dentists efforts in setting limits for the child and hence exclude them from dental operatory, to modern thinking where parent is considered a valuable ally and resource in treatment process (Freeman, 1993). Effective communication with parent is considered as vital as effective communication with child (Pinkham,1995; AAPD guidelines, 2005-2006). Parent should be guided regarding his role in behavior management (Feigel, 2001).

Steps:

Step 1: Parent should be interviewed for factors that influence the child behavior. Parent's anxiety and dental fear should be measured. Ask for past dental experiences of the parent. Parent should be made to estimate the child's dental fear and predict the behavior of the child during treatment. The attitude and knowledge of parent towards oral heath can be determined asking a standard set of questions or through a written questionnaire. The mother-child dyad should also be determined during the interview

Step 2: Guiding the parent and setting the "rules of the game"

The case of the child should be presented and treatment plan explained before initiating treatment (Wrigth,1983).Tell the parent about the anticipated behavior of the child and the behavior management techniques that will be applied. The role of parent in dental clinic should be explained and the do's and don'ts should be told. In other words, set the rules of the game (Pinkham, 1995) such as:

- Be a silent observer
- Be empathetic to the child
- Ignore minor disruptive behavior of the child. Allow the dentist to take care of it
- Refrain from coaxing. Do not also plead the child
- Stay calm and accept the dental treatment.
- Parent should answer questions about dental appointment frankly and honestly at home. Dental treatment should not be used as a threat
- Do not promise rewards for going to the dentist

Parent should also to be told about the course of behavior management if the child becomes uncooperative. In such a scenario, parental presence may negatively reinforce misbehavior and hinder dentist-patient communication. Parent is asked to exit operatory, so that a communication between dentist and child is started. Parent returns as soon as the communication improves and behavior becomes co-operative. Parent's return serves as a positive reinforcement for co-operative behavior. This early and empathetic way of parental presence/ absence technique (PPA) has shown to be effective (Kotsanos et al.,2009). Informed consent for PPA technique as well as for other aversive behavior guidance technique such as HOME and protective stabilization should be obtained (Pinkham,1991;AAPD guidelines, 2005-2006). These techniques are less used by the dentists currently due to lack of parental preference (Adair,2004).

Parental presence in the operatory has a number of advantages:(Feigal, 2001)

- Parents can view the quality of dental care given to the child
- Parents can appreciate the hard work and caring approach of the dentist
- Parents feel that they are part of decision making and care
- Health care messages can be delivered simultaneously as parent can better understand dental problems faced by the child. This sets them up to be reinforcers of these messages at home.
- Dentist can better understand and perceive parent's attitude towards dental care
- Very young children can get appropriate physical and psychological support
- Patient behavior improves and anxiety is reduced in the presence of parent

Today's practitioners are divided regarding inviting the parent to the dental operatory. Among practitioners who accept presence of parents in the operatory, the reasons for doing so were parent's insistence/ preference and ability to consult parents during the procedure (Adair et al, 2004). In today's society, parents are less likely to set limits and give physical punishment. They are overprotective and do not wish to see their children suffer during dental treatment (Long, 2004). In general, parents are unsure of their role of their parents due to stress of daily life and changing family life scenario from a joint family system to nuclear family, due to which they have less emotional support (Harper and D'Alessandro, 2004). Parents often spend most of their time in fulfilling the materialistic needs of children than emotional needs. In such a scenario, the dentist should recognize that parents are often confused about the way to manage their child in dental clinic and hence require guidance. Use of reasoning and reinforcement should be done more often by the dentist as child is more used to this type of rearing (Long, 2004). Aversive behavior management techniques should be less used and more of pharmacological management should be used in case of uncooperative or pre-cooperative child (Sheller, 2004).

Conclusion

Parent should be a partner in the behavior guidance of the child, whose role should be guided by the dentist. In order to do this the dentist should recognize the ways in which the parent influences the child's behavior and customize the guidance for the parent. The dentist should keep in mind that parents often have increasingly lower expectations for their children and higher expectations from the dentist.

References:

1. Adair S.M., Waller, J.L., Schafer, T.E., Rockman, R.A. (2004): A survey of members of the American Academy of Pediatric Dentistry on their use of behavior management techniques. Pediatr Dent. 26(2):159-166.
2. American Academy of Pediatric Dentistry Clinical Affairs Committee--Behavior Management Subcomittee; American Academy of Pediatric Dentistry Council on Clinical Affairs--Committee on Behavior Guidance. Guideline on Behavior Guidance for the Pediatric Dental Patient. (2005-2006): PediatrDent ,27(7 Suppl):92-100.
3. Arathi, R. and Ashwini, R. (1999): Parental presence in the dental operatory-parent's point of view. J Indian Soc Pedod Prev Dent, 17(4):150–155.
4. Arnrup, K. and Berggren, U. (2002): Attitudes to dental care among parents of uncooperative vs cooperative child dental patients. Eur J Oral Sci., 110 (2):75–82.
5. Bankole, O.O., Denloye, O.O. and Aderinokun, G.A. (2004): The Effect of Mother's Past Dental Experience on The Behaviour of some Nigerian children during dental treatment. African J Biomed Res., 7:113–118.
6. Barrett, P.M., Rapee, R.M., Dadds, M.M. and Ryan S.M. (1996): Family enhancement of cognitive style in anxious and aggressive children. J Abnorm Child Psychol., 24(2):187–203.
7. Cox, I.C., Krikken, J.B. and Veerkamp, J.S. (2011): Influence of parental presence on the child's perception of, and behaviour, during dental treatment. Eur Arch Paediatr Dent., 12(4):200–204.
8. Crossley, M.L. and Joshi, G. (2002): An investigation of paediatric dentists' attitudes towards parental accompaniment and behavioural management techniques in the UK. Br Dent J., 192(9):517-521.
9. Croxton, W.L. (1967): Child behavior and the dental experience. J Dent Child. 34(4):212–218.
10. de Oliveira, V.J., da Costa, L.R., Marcelo, V.C. and Lima, A.R. (2006): Mothers' perceptions of children's refusal to undergo dental treatment : an exploratory qualitative study. Eur J Oral Sci., 114 (6):471–477.
11. Feigal, R.J. (2001): Guiding and Managing the Child Dental Patient : A Fresh Look at Old Pedagogy Management in Children J Dent Educ., 65(12):1369-1377.
12. Fenlon, W.L., Dabbs, A.R.., Curzon, M.E. and Dobbs, A.R. (1993): Parental presence during treatment of the child patient: a study with British parents. Br Dent J. 174(1):23–28.
13. Freeman, R. (2007). A fearful child attends: a psychoanalytic explanation of children's responses to dental treatment. Int J Paediatr Dent 17(6):407–18.
14. Freeman, R. The case for mother in the surgery. Br Dent J. 1999 Jun 26;186 (12):610-613.
15. Harper, D.C. and D'Alessandro, D.M. (2004): The child's voice: understanding the contexts of children and families today. Pediatr Dent., 26(2):114-120.
16. Klingberg, G. and Broberg, A.G. (2007): Dental fear/anxiety and dental behaviour management problems in children and adolescents: a review of prevalence and concomitant psychological factors. Int J Paediatr Dent., 17(6):391–406.
17. Kotsanos, N., Coolidge, T., Velonis, D. and Arapostathis, K.N. (2009): A form of "parental presence / absence" (PPA) technique for the child patient with dental behaviour management problems. Eur Arch Pediatr Dent.,10(2):90–93.
18. Kyritsi, M.A, Dimou, G. and Lygidakis, N.A. (2009): Parental attitudes and perceptions affecting children's dental behaviour in Greek population: A clinical study. Eur Arch Pediatr Dent.,10(1):29-32.
19. Lara, A., Crego, A. and Romero-Maroto, M. (2012): Emotional contagion of dental fear to children: the fathers' mediating role in parental transfer of fear. Int J Paediatr Dent., 22(5):324–330.
20. Long, N. (2004): The changing nature of parenting in America.Pediatr Dent., 26(2):121-124.
21. Pinkham, J.R. (1991): An analysis of the phenomenon of increased parental participation during the child's dental experience. ASDC J Dent Child., 58(6):458–463.
22. Pinkham, J.R. Personality development (1995): Managing behavior of the cooperative preschool child. Dent Clin North Am., 39(4):771–787.
23. Rachman, S. (1977) The conditioning theory of fear-acquisition: a critical examination. Behav Res Ther., 15(5):375–387.
24. Sheller, B. (2004): Challenges of managing child behavior in the 21st century dental setting. Pediatr Dent., 26(2):111-113.

25. Smith, P.A. and Freeman, R. (2010): Remembering and repeating childhood dental treatment experiences: parents, their children, and barriers to dental care. Int J Paediatr Dent., 20(1):50–58.
26. Ten Berge, M., Veerkamp, J.S., Hoogstraten, J .and Prins, P.J. (2001). Parental beliefs on the origins of child dental fear in The Netherlands. ASDC J Dent Child., 68(1):51–54.
27. Themess-Huber M., Freeman R., Humphris, G., MacGillivray, S. and Terzi, N. (2010): Empirical evidence of the relationship between parental and child dental fear: a structured review and meta-analysis. Int J Paediatr Dent., 20(2):83–101.
28. Venham, L., Bengston, D. and Cipes M (1977): Children's response to sequential dental visits. J Dent Res., 56(5):454–459.
29. Wigen, T.I, Skaret, E. and Wang, N.J. (2009): Dental avoidance behaviour in parent and child as risk indicators for caries in 5-year-old children. Int J Paediatr Dent., 19(6):431–437.
30. Wright, G.Z., Starkey, P.E. and Gardner, D.E. (1983): Managing children's behavior in the dental office. St. Louis: CV Mosby Company. pp 42-74.