The Functional Inquiry

Before the dentist treats a child, medical, dental, and social histories are essential. However, a functional inquiry, from a behavioral viewpoint, should also be conducted. During the inquiry, there are two primary goals:
(1) to learn about patient and parental concerns
(2) to gather information to enable a reliable estimate of the cooperative ability of the child.

Coupling the findings from the functional inquiry with the clinical experience, the dentist is in a much better position to meet the patient’s needs and to apply appropriate behavior guidance strategies to treat individual pediatric patients than by simply proceeding inadequately informed.

Parents and their influence on dental treatment

From the moment of their children’s birth, parents shape children’s behaviors by selective encouragement and discouragement of particular behaviors, by their disciplinary techniques and by the amount of freedom they allow. Children learn the basic aspects of everyday life from their parents. This process is termed socialization, and is ongoing and gradual. By the age of 4 years children know many of the conventions current in their culture, such as male and female roles. The process of transmitting cultural information early in life is called primary socialization. In industrialized countries, obtaining information on many aspects of life is gained formally in schools and colleges rather than from the family. This is termed secondary socialization.

In early years, at least historically, it is mainly from parents that children learn what they are supposed to do and what behavior is forbidden. Unfortunately societal changes in recent years have created dynamics that can indirectly affect the behavior of children in dental offices.

When providing dental care for children, it is important that dentists understand parents’ expectancies. As with any health issue the social class background of the respondent’s influences attitudes and beliefs. For example, parents of high socioeconomic status are more interested in professional competence
and gaining information, whereas parents from poorer areas want a dentist to reassure and be friendly to their child.

**STRATEGIES OF THE DENTAL TEAM**

A primary objective during dental procedures is to lead children step by step so that they develop a positive attitude toward dentistry. Fortunately, most children progress easily and pleasantly through their dental visits, without undue pressure on themselves or the dental team. These successes can be attributed to several factors, such as a child’s confident personality, a parent’s proper preparation of the child for the appointment, or a dental team’s excellent communicative skills. In contrast, some children’s dental office experiences cause anxiety and the beginning of a negative dental attitude. Sometimes these controllable but apprehensive children are managed without medication, as long as appropriate nonpharmacologic psychologic techniques are used.

Because behavior guidance techniques are used daily and come naturally to many persons, their importance sometimes is overlooked or taken for granted. This increases the potential for avoidable behavior problems. However, a full understanding and conscious implementation of strategies can lead to recognizable improvements in child management skills (which is a complex problem) that requires a team effort involving the parent, the dental staff and sometimes even the teacher.

Principles of behavior management technique is as following:
1. Anticipation: Explaining the child regarding the procedure and answering the question regarding dentistry and procedures. This can be done through Tell Show Do approach, Good communication etc.
2. Diversion: Diverting the child’s attention away from fear producing situation may calm the child and allow the dentist to perform the treatment without disturbance i.e. Audio analgesia, etc.
3. Substitution: It involves substituting unwanted behavior by an accepted behavior. This can be done by contingency management, modeling etc.
4. Restriction: Restricting a child from exhibiting unwanted behavior. This can be achieved through physical restraints or pharmacological behavior management technique.

Behavior management can be achieved by basically two methods
1. Nonpharmacological methods
2. Pharmacological methods

**Nonpharmacological Management Methods**

Psychologists have developed many techniques for modifying patients’ behaviors by using the principles of learning theory. These techniques are called behavior modification. Usually they are thought about in conjunction with dentist-patient intra operatory relationships. Various techniques are present:

1. **Preappointment behavior modification**
2. **Behaviour modification techniques**: can be classified as follows:
   A) **Communicative management**
      Voice control
      Non-verbal communication
      Desensitization
      Tell-Show-Do
      Modelling
      Contingency management (positive and negative reinforcement)
      Distraction
   B) **Hand-Over-Mouth (HOM/Aversive conditioning)**
   C) **Patient immobilization**
      Immobilization by dentist/staff/parents
      Physical restraints with immobilization devices

**Pharmacological Management Methods**

- General anesthesia
- Nitrous oxide/oxygen inhalation sedation
- Conscious sedation

**Preappointment Behavior Modification**

It is aimed at preparing the child for a dental visit so it refers to anything that is said or done to have a positive influence on the child’s behavior before the child enters a dental operatory. The merit of this strategy is that it prepares the pediatric patient and eases the introduction to dentistry. It has received a great deal of attention because the first dental visit is crucial in the formation of the child’s
attitude toward dentistry. If the first visit is pleasant, it paves the road for future successes.

Various methods used for pre appointment behavior modification includes audiovisual aids, letters, films and videotapes. Children cure explained the importance of maintaining the teeth in health. Video clipping may include other children undergoing dental treatment so that the child will feel the similarity and reproduce the behavior exhibited by the model. Preappointment behavior modification can also be performed with live patient as models such as siblings, other children or parents.

Many dentists allow young children into the operatory with parents to preview the dental experience. Because the observing child likely will be initiated into dental care with a dental examination, a parent’s recall visit offers an excellent modeling opportunity. On these occasions, many young children climb into the dental chair after their parents’ appointments. These previews should be selected carefully. Young children are sometimes frightened by loud noises, as from a highspeed handpiece. The merits of modeling procedures, commonly involving audiovisual or live models, are recognized by psychologists. Summarized them as follows:

1. Stimulation of new behaviors,
2. Facilitation of behavior in a more appropriate manner,
3. Disinhibition of inappropriate behavior due to fear,

These procedures offer the practicing dentist some interesting ways to modify children’s behavior before their dental visit.

Another behavior modification method involves preappointment parental education via mailings, prerecorded messages, or customized web pages. Mails can be sent addressed to the child that provides brief information regarding the procedure. It is called as pre appointment mailing. Parents can also be given advice for preparing the child for their first dental visit.

Precontact with the parent can provide directions for preparing the child for an initial dental visit, explain office procedures, and answer questions. Setting expectations for the first visit can increase the likelihood of a successful appointment. Almost all parents understood the letter’s contents, acknowledged the dentist’s thoughtfulness, and welcomed the concern for the proper presentation to their children. Dentists using preappointment educational materials should be selective. Overpreparation could confuse a parent or provoke unnecessary anxiety.
FUNDAMENTALS OF BEHAVIOR GUIDANCE

Behavior guidance is the means by which the dental health team effectively and efficiently performs treatment for a child and, at the same time, instills a positive dental attitude. Effectively in this definition refers to the provision of high-quality dental care. Efficient treatment is a necessity in private practice today. Quadrant dentistry, or perhaps half-mouth dentistry, utilizing auxiliary personnel is vital in the delivery of efficient service to children. Finally, the development of a pediatric patient’s positive attitude is an integral part of this definition. In the past, many practitioners have considered “getting the job done” to be behavior management. The current definition suggests a great deal more.

Although various methods in managing pediatric dental patients have evolved over the years, certain practices and concepts remain fundamental (principle) to successful behavior guidance. These are basic to the establishment of good dental team–pediatric patient relationships. These practices increase the chances for success in the provision of care for children.

The success of behavior management is based on the attitude and integrity of entire dental team. Dental office and dental personnel must have the following quality:

1. The positive approach:
   There is general agreement that the attitude or expectation of the dentist can affect the outcome of a dental appointment. Thus, positive statement increases the chances of success with children.

2. The team attitude:
   Personality factors of the dental team play an important role in the success of behavior management. For example, warmth welcomes with interest that can be conveyed without a spoken word are critical when dealing with children. A pleasant smile tells a child that an adult cares. Children respond best to a natural and friendly attitude. Often this can be conveyed immediately to the pediatric patient through a casual greeting. Children also can be made to feel comfortable in the dental office by the use of nicknames, which can be placed on a patient’s record. Noting school accomplishments or extracurricular activities such as scouting, baseball, gymnastics,
or other hobbies helps in initiating future conversations and demonstrates a friendly, caring attitude to a pediatric patient.

3. **Organization:**

   Pediatric dental clinic must be well organized. Each dental staff must train for his specialized work. For example, if a child creates disturbance in the reception area who will manage with the problem? Each dental office must devise its own contingency plans, and the entire office staff must know in advance what is expected of them and what is to be done. Also, a well written plan has to be available for the dental office team. Such plans are key features of many pediatric dental offices because they increase efficiency and contribute to successful dental staff–pediatric patient relationships. Also, a well-organized, written treatment plan must be available for the dental office team. Delays and indecisiveness can build apprehension in young patients.

4. **Truthfulness:**

   The truthfulness of dental team is extremely important in building trust; it is a fundamental rule for dealing with children. Unlike adults, most children see things as either “black” or “white.” The shades between are difficult for them to discern. To youngsters, the dental health team is either truthful or not. Because truthfulness is extremely important in building trust, it is a fundamental principle in caring for children. Recognizing and acknowledging a patient’s fear and anxiety can strengthen that trust. Empathizing with, rather than denying, such emotions helps provide assurance that the dentist appreciates the patient as an individual.

5. **Tolerance:**

   It refers to the dentist ability to rationally cope with misbehaviors while maintaining composure (state of being calm and in control of your feeling or behaviors). Recognizing individual tolerance level is especially important when dealing with children. Different individual showed different tolerance level (Tolerance level varies from person to person). For example, an upsetting experience at home can affect the clinician mood in the dental office. High tolerance level prevents loss of self-control.

   Some people are in a better frame of mind early in the morning, whereas the coping abilities of others improve as the day progresses. Thus afternoon people should instruct receptionists not to book children with behavior problems the first
thing in the morning. Learning to recognize factors that overtax tolerance levels is another fundamental because it prevents loss of self-control.

6. **Flexibility:**

Because children lack maturity, the dental team has to be flexible and prepared to change its plans at the time of treatment as situations demand. A child may begin fretting or squirming in the dental chair after half an hour, and the treatment intended for that day may have to be divided into multiple appointments. On the other hand, a dentist may plan a step-wise indirect pulp treatment, but because the child is difficult, the indirect pulp procedure may have to be completed during a single session. Treatment of small children may demand a change in operating position. Thus the dental team must be as flexible as the situation demands.