



The Evolution and Changing Patterns of Behavioral Management of Challenging Childhood Dental Anxiety: A Crossroad

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Introduction

The last several decades has witnessed significant change in the attitudes and perceptions of both parents and Pediatric Dental Specialists toward what constitutes acceptable and appropriate strategies for managing challenging children's dental anxiety and behaviors. Changing parental childrearing practices and attitudes have no doubt influenced pediatric dentists to modify their approaches and perceptions toward both non-pharmacological and pharmacological techniques. Greater parental involvement and interest to take a more active role in the decision process has become the norm rather than the exception.

Behavioral Management of Challenging Childhood Dental Anxiety

Over the course of nearly four decades of academics and private practice this clinician has observed considerable change in the way in which we approach behavioral guidance of children in the dental setting. Looking backward, there was a time when the dentist and specialist were universally regarded by parents as the experts to best select the methods appropriate for their child. Discipline was largely and willingly allocated to the dentist to overcome or repel uncooperative and resistive child behavior. Today, such a stance might better be viewed as somewhat rare. Understandably, parents choose to take a more active role in decision making as it relates to how their child is to be spoken to and treated. For the pediatric specialist, called upon to remedy a developing management problem, parental reticence if not skepticism not uncommonly prevails, particularly under circumstances where a child's previous experience deteriorated. Parental preferences and patent acceptance of the practitioner's need to establish authority and in some cases provide discipline for certain misbehaviors has lessened. Parents today appear to show increasing interest and involvement to witness the clinician's management style and participate in the decision process as to which techniques are to be instituted.

While behavioral objectives remain essentially similar, to ultimately facilitate and foster a child's positive attitude toward care, encourage and enhance cooperation, eliminate or circumvent fearful responses, methods and parental expectations appear to be reshaping how pediatric dentists make use of various conventional (or mainstream) techniques as well as pharmacological (advanced) approaches [1,2].

One aspect remaining controversial amongst pediatric dental specialists is whether to include or exclude parents from the dental treatment room. Historically, a notion that parent presence interfered with a dentist's ability to establish a rapport with a child, or that their presence limited productivity is gradually being replaced by both

parent demand to be present, and changing dentists' perception of the inherent benefits of parent inclusion to elicit more favorable child behavior while in a new environment with a familiar face. Some practitioners are simply uncomfortable managing a challenging child in a parent's presence. Some may be reticent to permit a parent to witness how they manage difficult child behavior in the parent's presence. In any case, consensus this day appears in the direction of readily permitting parent presence to aid and intercept a negative child response which occurs when a young or timid child is arbitrarily separated from their parent well before opportunity to introduce the child to a new setting [3].

There are notable exceptions to this scenario upon which both dentists and parents do not disagree. Parents unable to refrain from overt displays of their own dental anxiety, through verbalization or fearful body language in their child's presence, can serve to nullify the benefits of parent inclusion. Most clinicians, however, believe that taking a few moments to positively counsel such a parent to guide one's emotions and demeanor in their child's presence can remedy this potential downside [3]. It is noteworthy that not until 1996 the American Academy of Pediatric Dentistry formally recognized the usefulness of having a parent present as a specific management technique to gain patients' attention and compliance, avert negative or avoidance behaviors, and to enable the dentist to establish authority for treatment [3].

While the vast majority of children possess cooperative potential and coping skills to accept invasive or unpleasant dental treatment using conventional or mainstream communication techniques, there are those for whom non-pharmacological approaches prove inadequate or inappropriate. Pre-cooperative and severely apprehensive children have immature cognitive abilities, a restricted range of coping skills, brief or negligible attention spans, and virtually no experience coping with stress [3]. For such cases, more advanced techniques including pharmacological (both conscious and unconscious) approaches may become warranted. The decision to abandon communication strategies, however, is often not clear cut. Clinician variability in training and experience impact on the selection, efficacy, and safety of pharmacological approaches. While some lack proficiency and comfort level in selection and use of pharmacologic adjuncts, others have considerable expertise with sedative modalities and successfully minimize or eliminate the need for restraints. The last several decades has observed heated arguments and diverse opinions as to the appropriateness of aversive techniques (voice control, hand-over-mouth, physical restraints or what is termed, protective immobilization) vs the use of various sedative agents and combinations to terminate and circumvent interfering child behavior. Use of what was once considered a viable and powerfully effective management tool, hand-over-mouth, fell into disfavor by

virtue of a propensity for misuse by clinicians unable to control their emotions and apply and make use of the technique as originally described and proposed.

Recent reports [4-6] have explored parental perspectives of various management options and techniques; general consensus appears in the direction of preferences toward pharmacological management over immobilization/physical restraint, and other aversive techniques. Wide variability today exists with respect to what advanced training programs consider appropriate techniques or viable pharmacologic agents and dosing [7]. Regrettably, reports of adverse reactions and catastrophic outcomes have and continue to occur on a national basis [8]. With virtually no exception, evidence of cause and effect for these mishaps and unacceptable outcomes appear based on poor clinician judgment, use of inappropriate dosing, gross deviation and departure following existing safety guidelines, failure to appropriately monitor patients, inadequate facility preparation and proficiency in recognizing and managing a medical emergency, and excessive use of local anesthesia grossly exceeding maximum allowable dosing [8]. Despite the availability of sedation guidelines from numerous health care disciplines since 1985, clinician compliance remains unexplainable and short of universal. In response, numerous state and institutional constraints imposed by virtue of obligations to protect the public from improper use have narrowed the armamentarium of agents available, regardless of lengthy and extensive safety track records of time-tested agents (chloral hydrate, meperidine, diazepam) when used properly.

A troubling finding of recent research reports a prevalence among teaching programs and their directors to limit teaching and experience to a single agent, midazolam, for their use and that of students [7]. While possessing a wide range of safety, desirable amnesic effects, and a capacity for reversal, midazolam is not however without considerable limitations. These include significant concerns related to an inadequate duration of action (for all but short and ultrashort procedures) and limitation of dosing schedules that fall short of therapeutic effectiveness. All of which such shortcomings contribute to increased reliance (and necessity) on physical restraint to overcome heightened anxiety and uncooperative behavior. From the perspective of these clinicians, need for exposure and experience to include a broad arsenal of agents does not currently seem a priority. Such shortsightedness and bias seem to have set progress in a backward spiral, let alone a crossroad for advancement of behavior guidance options for difficult children [9]. Today, there appears no general consensus among paediatric dentists as to what constitutes successful patient management when deployment of physical restraints becomes necessary.

Behavioral management of children in the dental environment remains in a dynamic state of flux. Standards for teaching curricula of both non-pharmacologic and pharmacological management in advanced training programs are under constant revision. Requirements for expanded sedation training experience are under exploration. Needed is prospective and retrospective research that explores the safety and efficacy of various techniques to elucidate a common ground between what parents and practitioners consider acceptable. What becomes clear, however, is that current directions neither define what constitutes clinical success, nor endeavors to expand current pharmacologic safety and efficacy protocols in the future interests of children. In the final analysis, parents and society will likely determine which crossroads to follow in the refinement of behavior management strategies, with and without pharmacological adjuncts, to help apprehensive children cope with dental treatment. Hopefully, both educational institutions and various paediatric organizations will take the leadership role in formulating policies in the best interests of helping children accept and cope with treatment in the least stressful manner possible.

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