
Good
Morning

Non pharmacological Behavior management

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INTRODUCTION:

- Behavioral dentistry is a interdisciplinary science which need to be learned, practiced and reinforced in context of clinical care and within the community oral health care delivery system.
- Objective: Develop in a dental practioner an understanding of the interpersonnel, intrapersonnel social forces that influence the patient behaivour.

Behaivior: It is defined as any change observed in the functioning of an organism.

Learning as related to behavior is a process in which past experience or practice results in relatively permanent changes in an individual's behavior.

Behavioral Pedodontics: Study of science which helps to understand development of fear & anger as it applies to child in the dental situation.

BEHAVIORAL CLASSIFICATIONS AND PATTERNS IN CHILDREN

- Wilson's classification
- Frankel's classification
- Lamp shire classification
- Wright classification
- Garcia-Godoy

Wilson classification (1933)

- Normal/bold
- Bashful/ timid
- Hysterical/ rebellious
- Nervous / fearful

Sands (1933)

- Hyper sensitive or alert
- Nervous
- Fearful
- Physically unfit
- Stubborn

Sarnet et.al (1972)

- Actively cooperative
- Passively cooperative
- Neutral or indifferent
- Opposed
- Completely uncooperative

FRANKL'S BEHAVIOR RATING SCALE (1962)

Rating 1: definitively negative(--)

1. Refusal of R_x -
2. Crying forcefully - uncontrollable
3. Extreme -ve behaivour is associated with fear

Rating 2 : negative(-)

1. Reluctant to R_x
2. Displays slight evidence of negativism- timid,whining

FRANKL'S BEHAVIOR RATING SCALE (1962)

Rating 3 : positive(+)

Accepts treatment
- but if the child has any bad experience,may become uncooperative

Rating 4 definitively positive(++)

-Unique behavior
-Good rapport with dentist
-Understand the importance of treatment
-interested in the dental procedures laughs & enjoys

Lampshire classification (1970)

1. Cooperative
2. Tense
3. Outwardly apprehensive
4. Fearful
5. Stubborn / defiant
6. Hypersensitive
7. Handicapped
8. Emotionally immature

Wright classification (1975)

1) Cooperative behaviour

2) Lacking co-operative ability

3) Potentially cooperative behavior

Potentially co-operative behaviour (-ve)

1. **Uncontrolled behavior/hysterical/incorrigible:**

- 3-6 yrs
- Temper tantrums even in the reception area.
- Tears, loud crying, physical lashing out flailing of the hands & legs
- Refuses to co operate with dentist

2. **Defiant behavior/obstinate:**

- Elementary school group.
- Stubborn or spoilt child
- Made cooperative

3. **Timid behavior:**

- Overprotective at first visit
- Shy, but cooperative
- Needs to gain self confidence

4. **Tense cooperative:**

- Border line behavior
- Does not resist treatment but the child is tensed at time

5. **Whining behavior:**

- whines through out the behavior
- Extremely frustrate to treat
- c/o pain even after repeated LA

6. **Stoic behavior:**

- Physically abused child
- Cooperative, does not talk readily
- Sits quiet, passively receives R/ including LA

Garcia – Godoy (1986)

1. Fearful
2. Timid
3. Spoiled
4. Aggressive
5. Adopted
6. Handicapped
7. Cooperative

Children attitudes towards dentistry:

- Attitude: "a readiness, inclination or tendency to act toward inner or external elements in accordance with the individuals acquaintance with them

- Mc Dermott ---- largely shaped by the emotional meaning of the event to the child & will vary according to the child's stage of emotional development

Likes:

- Interesting wait room , including comic & story books, magazines
- Background music
- The dentist to talk while working
- To be called by first name
- Explanations of dental procedure
- To watch in mirror as the dentist works
- To have a signal for the dentist to stop drilling
- To be told he / She has been a good patient
- A postoperative gift

Dislikes:

- Being kept wait
- an unattractive waiting area
- The smell of the dentist office
- Cotton rolls
- Drilling
- Operating light to the eyes
- Untruthfulness about a painful procedure
- Being made fun off
- Scold by the dentist
- Being asked questions when mouth is full
- Being compared to other children
- Uncomplimentary reports to parents

FACTORS AFFECTING CHILD'S

Under the control of dentist	Out of control of the dentist	Under control of the parents
Dental office environment	Growth and development	Maternal behaviour
Dentist's activity and attitudes	Nutritional factors	Family development and peer influence
Dentist's attire	Past dental experience	Home environment
+/- of parents in the operatory	School environment	
Presence of older siblings	socioeconomic status	

Effect of Maternal Attitude

Mother's behavior	Child's behavior
1. Over protective a. Dominant b. Overindulgent	Submissive, shy anxious, aggressive, demanding,
2. Overindulgent	Aggressive, spoiled, demanding; displays temper
3. Under affectionate	Usually well behaved, but may be unable to cooperate: shy, may cry easily
4. Rejecting	Aggressive, overactive, disobedient

ENVIRONMENT

Broken home : insecure,inferior,apathic, depressed

FAMILY DEVELOPMENT AND PEER INFLUENCE

Position of the child
Internal family conflicts
Younger children follow older sibling & family members

Home is where one starts from. - T. S. Eliot

II) UNDER THE CONTROL OF DENTIST

Effect of the dentist activity & attitude

- Data gathering and observation
- Structuring
- Externalization
- Empathy and support
- Flexible authority
- Education and training

UNDER THE CONTROL OF DENTIST

APPEARANCE OF DENTAL OFFICE

Fig. 8.2A: Colorful atmosphere of the reception eases the child's fear

- RECEPTION ROOM
  - Chairs and table
  - Books for all ages
  - simple and sturdy toys

- OPERATING ROOM
  - few pictures of children at play
  - assistant skilled in making animals or other objects from cotton rolls
  - separate door for children to enter and exit

Effect of the dentist attire

- If undue past experience with white uniforms or doctors—association of fear is more.

- Cohen - that the type of attire that a dentist wears probably is not a significant factor influencing the behavior of most children in the dental situation

Effect of another's presence in the operatory

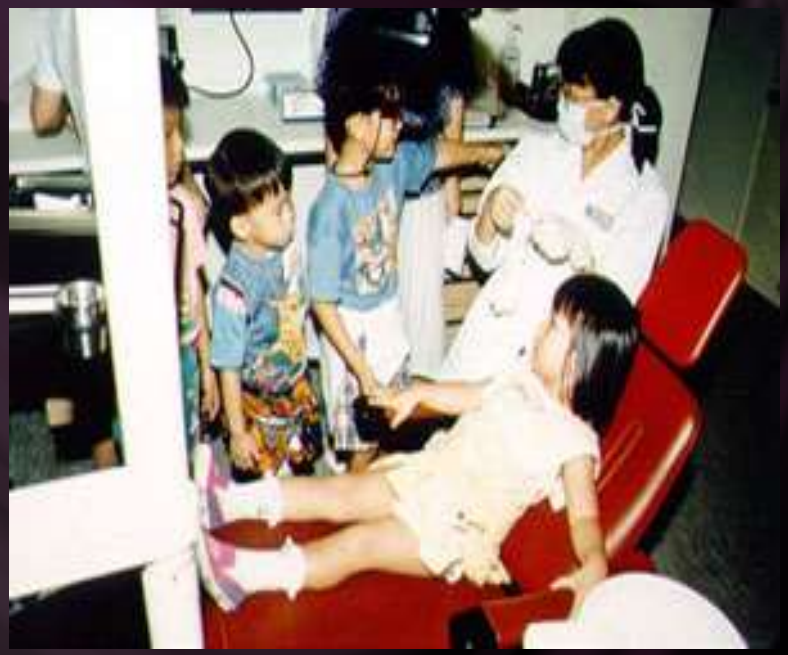
a) Mother's presence
b) An older sibling presence

An older sibling presence:

- serves as a role model.

- Ghose et al--

  Positive behavior in the younger child is accompanied by the older sibling



Other variables which are not under the control of dentist.

- Growth & development
- Nutritional factors:
- Past medical & dental experience
- School environment
- Socio economic status

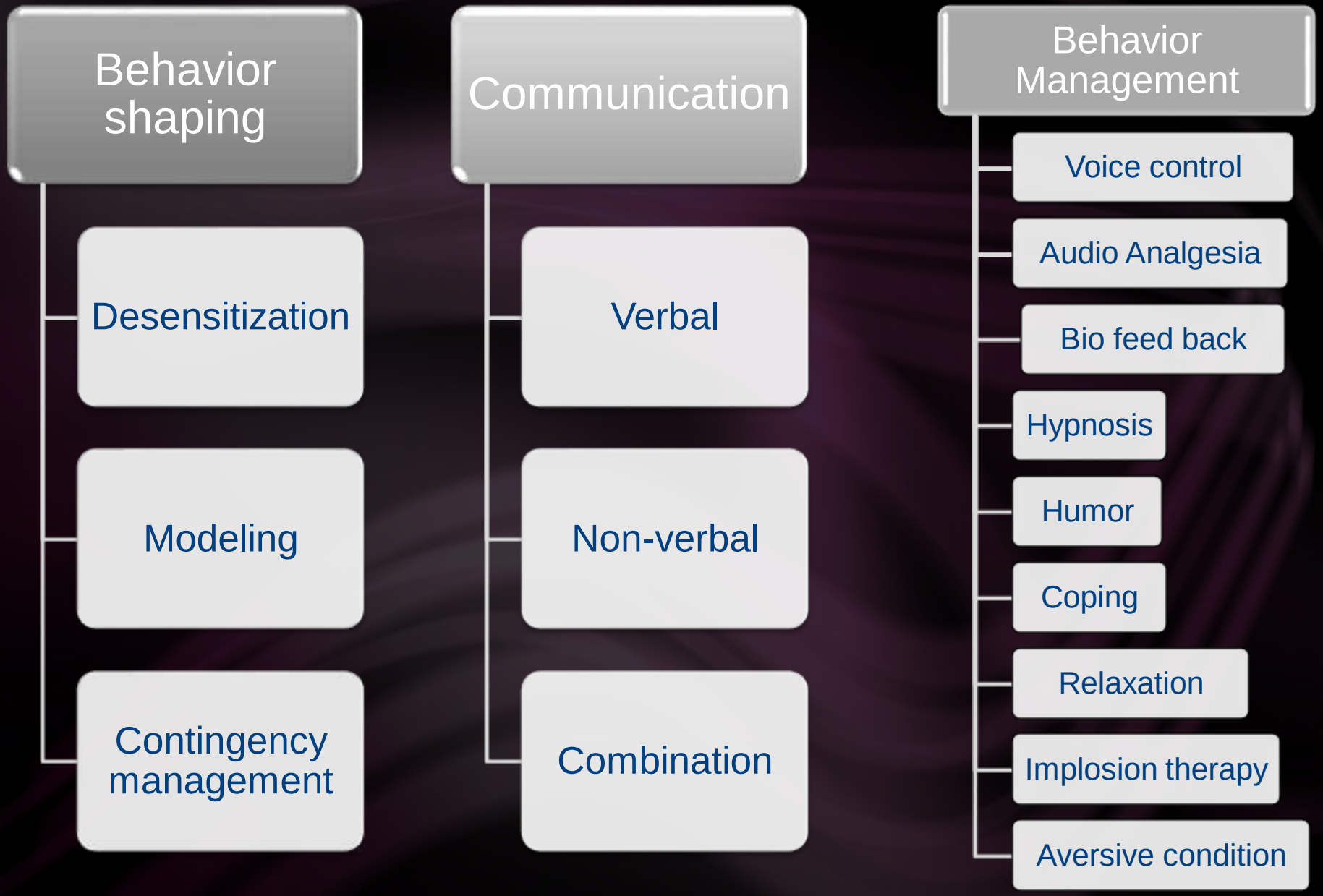
- **Behavior shaping:** Is the procedure which slowly develops behavior by reinforcing a successive approximation of the desired behavior until the desired behavior comes in to being.

- **Behavior modification:** Defined as the attempt to alter human behavior & emotion in beneficial way & in accordance with laws of learning.

- **Behavior management:** The means by which the dental health team effectively & efficiently performs dental treatment & there by instills a positive dental attitude. (Wright)

Classification of behavior management


Psychological
Communication
Behavior shaping
Behavior Management


Behavior shaping
Desensitization
Modeling
Contingency management
Communication
Verbal
Non-verbal
Combination
Behavior Management
Voice control
Audio Analgesia
Bio feed back
Hypnosis
Humor
Coping
Relaxation
Implosion therapy
Aversive condition

AAPD Guidelines: 1999

I) Traditional behaivour management :

- Voice control
- TSD
- Positive reinforcement
- Distraction
- Nonverbal communication
- Modelling

II) Adverse behaivour management

- Voice control
- Hold and go
- Restraining
- HOME

III) Pharmacological methods

- Conscious sedation
- Nitrous oxide
- General anesthesia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Non pharmacological methods of Behavior Management

COMMUNICATION

- Chambers (1976)
- Universally used in pediatric dentistry
- Establish a relationship with the child

Communication is affected by:
- Dialogue
- Tone of voice
- Facial expression
- Body language.

- The 1st objective in successful management is to establish communication by involving the child in conversation .
- The fear and natural instinct curiosity of the child demands explanations it should be given for each and every step of dental treatment.
- Effective vocabulary is important.
- Relaxed tone of voice is used.
- Honesty of approach.

- The important aspect in communication is getting the child to respond to dentist.
- Positive languages should be used.

Verbal

Non verbal

Both

Speech

Body language

Smiling

Eye contact

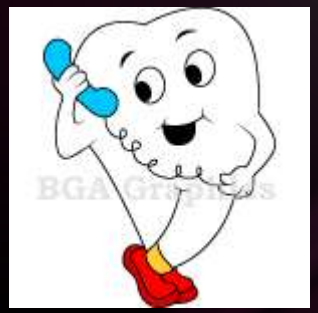
Expression of feelings without speaking

Showing concern

Touching the Child

A pat

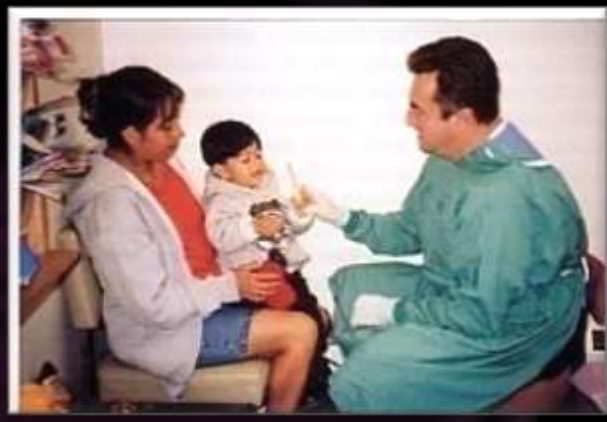
A hug



SMILE IS A CURVE THAT SETS EVERYTHING STRAIGHT

HOW TO COMMUNICATE:

- We should use words that express pleasantness , friendly and concern.
- Constant and gentle voice
- Conversation –name, age, class.etc.
- Prefers to be addressed by name.
- Ask questions about likes/dislikes.
- We have to phrase requests in a manner that encourages compliance and gives the child choices when possible.
- We should be truthful.



USE OF SECOND LANGUAGE : EUPHEMISM

- They are substitute words which can be used in presence of child.
- Address the child in his or her level of comprehension.
- Inoffensive or mild expressions must be substituted that suggest unpleasantness or are fear promoting.
- The word substitutes are most effectively used with preschool children.
- Like spraying sleepy water on a tooth is much offensive than saying or promoting fear like" I am going to give you a shot on your gum".

EUPHEMISM

DENTAL TERMINOLOGY	WORD SUBSTITUTE
Air	Wind
Impression material	Pudding
Anesthetic	Sleepy medicine
Bur	Brush
Caries	Brown spot
Explorer	Tooth counter
Evacuator	Vacuum cleaner
X-ray	Camera
Hand piece	Whistling train
Rubber dam	Raincoat

Multisensory communication:

- Focus on what to say or how to say.
- Body contact- Placing a hand on child's shoulder- feeling of warmth, friendship
- Sitting and speaking at eye level – friendlier, less authoritative communication.
- Avoidance of Eye contact– child is not prepared to cooperate.

Communication environment

- Friendly atmosphere sets the mood
- Welcoming smile of the receptionist
- Decor of the room
- Homely atmosphere

Behavior Shaping

Modeling

Desensitization

Contingency Management

DESENSITIZATION

1915-1997

Joseph Wolpe (1975)

- Therapeutic technique that pairs an anxiety evoking stimulus with a response inhibitory to anxiety.

- Pre-established fears and uncooperative behavior.

- Wolpe used relaxation as a inhibitor of anxiety visual imaginary of anxiety provoking stimuli with a patient maintaining profound muscle relaxation.

- Joseph Wolpe was a South African psychiatrist, one of the most influential figures in Behavior Therapy. He grew up in South Africa, attending Parktown Boys' High School and obtaining his M.D. from the University of the Witwatersrand.

- Born: April 20, 1915, Johannesburg, South Africa

- Died: December 4, 1997, Los Angeles, California, United States

- Books: The practice of behavior therapy, Our useless fears

- One of the most influential experiences in Wolpe's life was when he enlisted in the South African army as a medical officer.
- Wolpe was entrusted to treat soldiers who were diagnosed with what was then called "war neurosis" but today is known as post traumatic stress disorder.
- The mainstream treatment of the time for soldiers was drug therapy.
- Doctors would use a type of "truth serum" to get soldiers to talk about their experiences.
- It was believed that by having the soldiers talk about their experiences openly it would effectively cure their neurosis.

- Systematic desensitization is when the patient is exposed to the anxiety-producing stimulus at a low level, and once no anxiety is present a stronger version of the anxiety-producing stimulus is given.

- This continues until the individual no longer feels any anxiety towards the stimulus.

- There are three main steps in using systematic desensitization.

- The first step is to teach the patient relaxation techniques.

- The second step is for the patient and the therapist to create a hierarchy of anxieties.
- The therapist normally has the patient make a list of all the things that produce anxiety in all its different forms.
- Then together, with the therapist, the patient makes a hierarchy, starting with what produces the lowest level of anxiety to what produces the most anxiety.
- Next is to have the patient be fully relaxed while imaging the anxiety producing stimulus.
- Depending on what their reaction is, whether they feel no anxiety or a great amount of anxiety, the stimulus will then be changed to a stronger or weaker one.

- Systematic desensitization, though successful, has flaws as well.
- The patient may give misleading hierarchies, have trouble relaxing or not be able to adequately imagine the scenarios.
- Despite this possible flaw, it seems to be most successful.

Preventive Desensitization:

Imaginary scenes are presented to the patients in a graduated fashion so that scenes provoking only minimal anxiety are initially described and gradually more stressful situations are presented.

It is possible for child during the 1st dental visit.

- Tell show do
- Easy procedures.
- Ex- examination, oral prophylaxis, fluoride treatment, brushing instructions.

- Howitt & Stricker address the hierarchy of anxiety in children in dental clinic as :

Prophylaxis < Hand instruments < rubber dam < dental drill < exposure to dental environment < injection

- Disadvantage :

slower than other methods

"Tell-Show-Do"

- Developed by Addleston in 1959.
- Popularly used for modifying behavior by desensitization in children.
- The classical model for communicating the child and favorably conditioning the child

1. Dentist should say what is going to be done.

2. Demonstrate the child about the procedure

3.Perform the procedure.

TELL

- Explain exactly what you are going to do.
- Tell before ,after , while.
- Voice- soft, firm,confident and consistent.
- Be trustful to child.
- Distraction can be used.

SHOW:

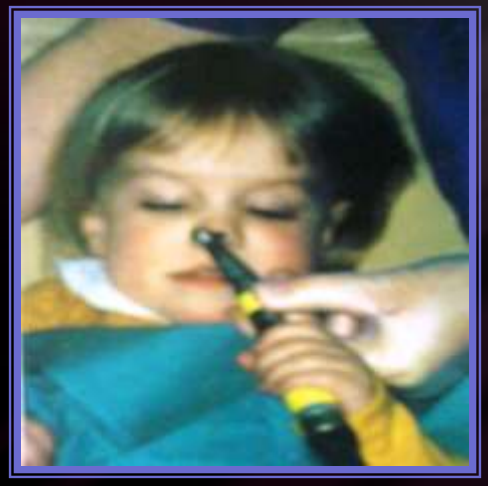
- Demonstrate the child of the visual , auditory, olfactory and tactile aspect of the procedure in a carefully defined non threatening setting.
- Demonstrate what, how and with what the procedure will happen and Demonstrate on himself or inanimate object.
- Although showing the child is a basic guideline it is better to avoid showing fear promoting instruments.
- Bringing equipment from behind is preferred.

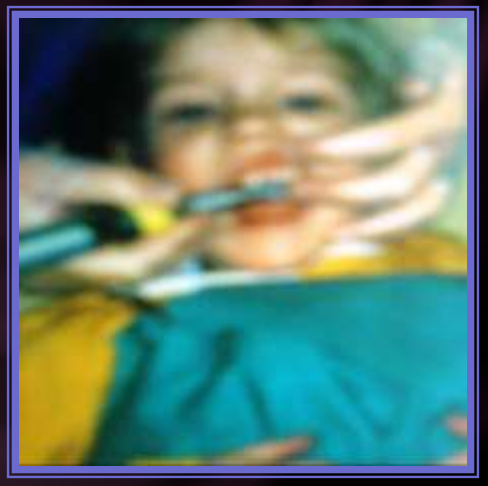
DO

- Without deviating from explanation proceed directly to perform the previewed operation.
- In doing , do what you said you would do.
- Use the same tone of voice in telling what you are doing as you are doing it.

Tell It!

Show It!





Do It!

Objectives :

1. Teach the patient important aspects of the dental visit & familiarize the patient with the dental setting.

2. Shape the patient's response to procedures

Indications:

- 1st visit
- Subsequent visits when introducing new dental procedure.
- Fearful child
- Apprehensive child

MODIFICATIONS FOR TELL SHOW DO

- Tell touch do
- Show touch do
- Tell touch smell
- Show touch smell
- Touch taste smell

Visually impaired children can we show some light. Prashant chowdary et.al. The journal of Ahmadabad dental college -2011.

MODELING

Social learning theory which says that ones learning occurs through suitable model performing a behavior.

Modeling of behavior begins with imitation and continues throughout life.

ALBERT BANDURA (1967)

Allowing a patient to observe one or more individuals who demonstrate appropriate behavior.

Imitation, Observational Learning, Identification, Internalization, Introjections, Coping , Social Facilitations, Contagion and Role Taking.

- It is a type of behavior modification technique whereby a young patient can learn about the dental experience by viewing other children receiving treatment
- This technique improves the behavior of apprehensive patients who have no previous dental experience.
- The child is made to come in and observe the treatment of an older sibling.

- Many pedodontists apply modeling techniques by utilizing open bay operatories so that treatment of several children is visible from any chair.
- Other technique is by making them view a video tape.

Modeling:

- Live models
- Filmed models
- Posters
- Audio visual aids

- It is useful in producing behavioral changes in situations requiring Cooperation, aggressive behavior, language developments and moral judgments.

Johnson and Machen:

- 12min video tape- Examination , Radiographs, LA Administration and Restorative Treatment.
- More positive behavior
- If the model is same age group –the effect is more pronounced.

Barbara G. Melamed, Donald Weistein, Roland Hawes

They found that the Filmed modeling , just before actual dental work was found to be more effective.

- **Machen BJ & Ronald Johnson**

  Compared Modeling & Desensitization along with control (3-5 yr old)

  No significant difference between the two Behavior Management techniques

- **Strokes & Kennedy**

  They have done a study on Live modeling.

  They found that ,children simply being observed by peers during more invasive procedures has a decreased level of disruptive behavior

Ghose et al :

- Have done a study on 75 children of 3-5 yrs age.

- Children who saw their older sibling exhibited more positive behavior than who did not.

- Children with exposure to modeling had + ^{ve} behavior even in the 2nd appointment where in actual R_x procedure conducted, including LA.

CONTINGENCY MANAGEMENT

- Is a method of modifying the behavior of children by presentation or withdrawal of reinforces.
- Involves successful approximations in achieving a goal with intermediate steps.

Positive Reinforcer

Contingent presentation increases frequency of behavior

Negative Reinforcer

Contingent withdrawal increases the frequency of behavior

POSITIVE REINFORCEMENT:

- It is way to recognize the cooperation of the child patient and to reward it.
- It is most effective when it is specific to behavior that is cooperative.
- Patient will be pleased by the comment " you are being such a great patient today" and "thank you for sitting so still and opening your mouth so still".
- Rewards such as toy or sticker provide positive reinforcement.
- The child can take these home and show them off as a source of pride in their accomplishment.

REINFORCERS

Material

- Candies
- Gums
- Cookies
- Toys

Social

- Praise
- Facial expressions
- Nearness
- Physical contact

Activity

- TV
- Music

Activity reinforcers:

- Involve the opportunity or privilege of participating in a preferred activity after performance of a less preferred behavior

- Little Application in operatory dentistry

- Successful in the home programs like plaque control, habit breaking therapies.

GIFTS FOR CHILDREN

- Gift giving can serve as a reward.
- Something can always be found for which to praise a child.
- If the gift can have a dental significance it is better.
- The gift can be used as reinforcement for dental health.
- The gifts should be used as a token of affection for children not as bribe.
- Bribes rarely achieve results or provide a lasting good dentist relation ship.

- A bribe is promise to induce good behavior.
- A reward is recognition of good behavior after completion of the operation without any previously implied promise.
- Many children who seem tired or tense following operative procedures suddenly perk up upon completion and scurry for a gift.
- These gifts provide a pleasant reminder of appointment.

Behavior Modification Techniques

BEHAVIOR MODIFICATION:

- Audio analgesia
- Voice control
- Hypnosis
- Humor
- Assimilation and coping
- Relaxation
- Implosion therapy

AUDIO ANALGESIA:

- Is a method of reducing pain.
- This technique consists of providing a sound stimulus of such intensity that the patient finds it difficult to attend to anything else.
- Auditory music has been used to reduce the stress reaction to pain.

1959 by Gardner and Licklider

Effect –

Stimulus distraction, Displacement of attention & a Positive feeling on the part of the dentist.

Gardner et al :

concluded that audio analgesia is completely effective in 65% of 1,000 patients who previously required nitrous oxide to accomplish comparable procedures.

VOICE CONTROL

- It is the method of regaining the child's attention for effective communication.
- It is the modification of the intensity and pitch of one's voice in an attempt to dominate the interaction between dentist and child.
- For instance, a child who is resisting in placement of fluoride trays Is firmly told "Sit up an open your mouth".
- Sudden and firm commands are used to get the child's attention and stop the child from current activity.

- Instructions should be firm, definite and convincing.
- Typically the practitioner of voice control will make a request in normal positive tone, if this is not honored then firm tone should be used and the volume may become louder.
- The command should be repeated slowly and clearly."I need you to sit still and open wide " may be replaced by "stop moving your arms now".
- This technique is most acceptable when it is followed by positive reinforcement.

- Once the dentist gains the child's attention , he may speak softer adjusting his voice to the activity of the child.
- Used in conjunction with some form of physical restrains
- Change in tone from gentle to firm is effective in gaining the child's attention and reminding him that the dentist is an authority.

Pinkham & Paterson

- Child's ability to see the dentist's face is important.
- Facial expression communicates even when there is a language barrier .

Objectives:

- Patient attention.
- To avoid negative or avoidance behavior.
- To establish authority.

Indications:

- Uncooperative and inattentive patients

Contraindication:

- Mental or emotional immaturity.

Humor

- Helps to elevate the mood of the patient.

Functions as:-

- Social – forming & maintaining the relationship
- Emotional – providing anxiety relief in child, parent and doctor
- Informative – transmits essential information in non threatening way
- Motivation – increases interest & involvement of child
- Cognitive – distraction from fearful stimuli

OBJECTIVES

- To gain attention
- To avoid negative or avoidance behavior
- To establish authority

INDICATIONS

- Un cooperative & un attentive patients

CONTRAINDICATIONS

Hearing disability

Mental or emotional immaturity who are unable to understand

ASSIMILATION AND COPING

Stress can act to increase pain perception while coping decrease it by process called assimilation.

COPING

Defined as the cognitive & behavioral efforts made by an individual to tolerate or reduce stressful situations

2types:

a) Behavioral: include physical & verbal activities

b) Cognitive: silent & thinking in mind to keep calm

it involves manipulations of emotions.

Cognitive coping can enable children to:

- Maintain realistic perspective on the events at hand
- Perceive the situation as less threatening
- Calms and assures them that everything will be alright

Relaxation

- Effective in reducing immediate anxiety and fear
- Involves series of basic exercises which may take several months to learn & practice

Bobey and Davidson:

Compared subjects receiving either brief relaxation training, anxiety arousal, cognitive rehearsal, or control treatment in their reactions to radiant heat and pressure stimulation.

Results: The relaxation group showed the highest pain tolerance scores.

Paul et.al : Compared the relative effectiveness of brief relaxation training, hypnosis, and a control treatment in reducing subjective stress, distress, and physiologic arousal and found that both relaxation training and hypnosis were effective.

HYPNOSIS

- Franz A. Mesmer (1773)
- One of the most effective non-pharmacologic therapies.
- Hypnosis + dentistry = Hypnodontics (term given by Richardson 1980)
- It is a process producing a state of altered consciousness without the use of pharmacological agents.
- Children are more easily hypnotized
- Eg: Telling to relax, reassuring, Establishing monotony . calming, self talk.

Uses

- To reduce nervousness and apprehension
- To eliminate defense mechanisms that pts use to postpone dental work
- To control functional and psychosomatic gapping
- To induce anesthesia

TECHNIQUE:

- Patient preparation
- Hypnotic induction
  - Subjects attention
  - Relaxation and comfort
  - Focusing and suggestion
- Deepening
- Post hypnotic suggestion
- Altering patient after therapy

PARENTAL PRESENCE OR ABSENCE

Some dentists prefer to work in presence of parent and some like to keep them in waiting area.

Objectives –

- To gain patient's attention
- To avert avoidance behavior
- To establish authority

Advantages of parental presence	Advantages of parental absence
Supporting & communicating with the child	Overcoming parental conditioning
Very young patients	Avoiding communication interference
	Avoiding parental interference

RETRAINING :

- Technique similar to behavior shaping designed to fabricate positive values and to replace negative behavior in children.
- Dentist should try to build a new relation with the child so that the child is able to forget his previous thought process of dental clinic.

Indications –

- Who had a previous bad experience
- Who exhibits negativism due to improper parental & peer influence

Approaches –

- Avoidance
- De – emphasis & substitution
- Distraction

Hand over Mouth Exercise (HOME)

- This involves placing a hand over child's mouth to extinguish an unacceptable response to the dental situation.
- Once the child has calmed himself the removal of punishment is followed by words of praise.

- Karmer (1973)- Aversion
- Wright and Feasby (1972)- Restraint Discipline
- Lampshire (1970)- Emotional surprise therapy
- Levitas (1974) -Hand Over Mouth Technique

BY DR. EVANGELINE JORDAN (1920)

Evangeline Jordan -If a normal child will not listen but continues to cry and struggle…. Hold a folded napkin over the child's mouth…and gently but firmly hold his mouth shut.

Mc Donald – If the child is definitely demonstrating a temper tantrum, then the dentist must demonstrate his authority and mastery of the situation.

Craig:- The purpose of the technique is to gain the attention of the child so that communication can be established and his cooperation obtained for a safe course of treatment

Objectives

- To gain the attention
- To eliminate inappropriate behavior
- Gain control over the child's behavior
- It enables the dentist to establish communication so that the child can be taught the appropriate responses and expectations.

Indications:

- children who are momentarily hysterical, belligerent or defiant
- 1st office visit
- Child with Uncontrolled behaivour
- 3-6 yrs old
- Child who can understands simple verbal commands

Contra indications:

- Very young
- immature
- frightened
- child with serious physical, mental or emotional handicap.

Mandatory

This technique only be used on children with sufficient maturity to understand simple verbal commands

Purpose:

- Gain control over the child's behavior
- So that it enables the dentist to establish communication so that the child can be taught the appropriate responses and expectations.

CONTROVERSY OVER THIS TECHNIQUE:

- They have contended that this method is unscientific and may cause psychological trauma to the child patient (Daves and King,1961)
- But the psychiatrists support the use of this technique.
- 2nd issue is legal one , but when properly explained to the parent it should not be a concern.

- 80% of pedodontists use HOME

(Association of pedodontic diplomates,1972)

- In a questionnaire conducted by Craig, 28 out of 35 used this technique.

- So this procedure is accepted by the majority of professionals.

TECHNIQUE:

- The dentist firmly places his hand over the child's mouth.
- Behavioral expectations are calmly explained close to the child's ear.
- Remove the hand when child indicates willingness to co-operate.

LEVITAS TECHNIQUE(1974):

- I place my hand over the child's mouth to muffle the noise .
- I bring my face close to him and talk directly into his ear, "If you want me to take my hand away, you must stop screaming and listen to me".
- "I only want to talk to you and look at your teeth." After a few seconds, this is repeated, and I add, "Are you ready for me to remove my hand?".
- Almost invariably there is a nodding of the head. With a final word of caution to be quiet, the hand is removed

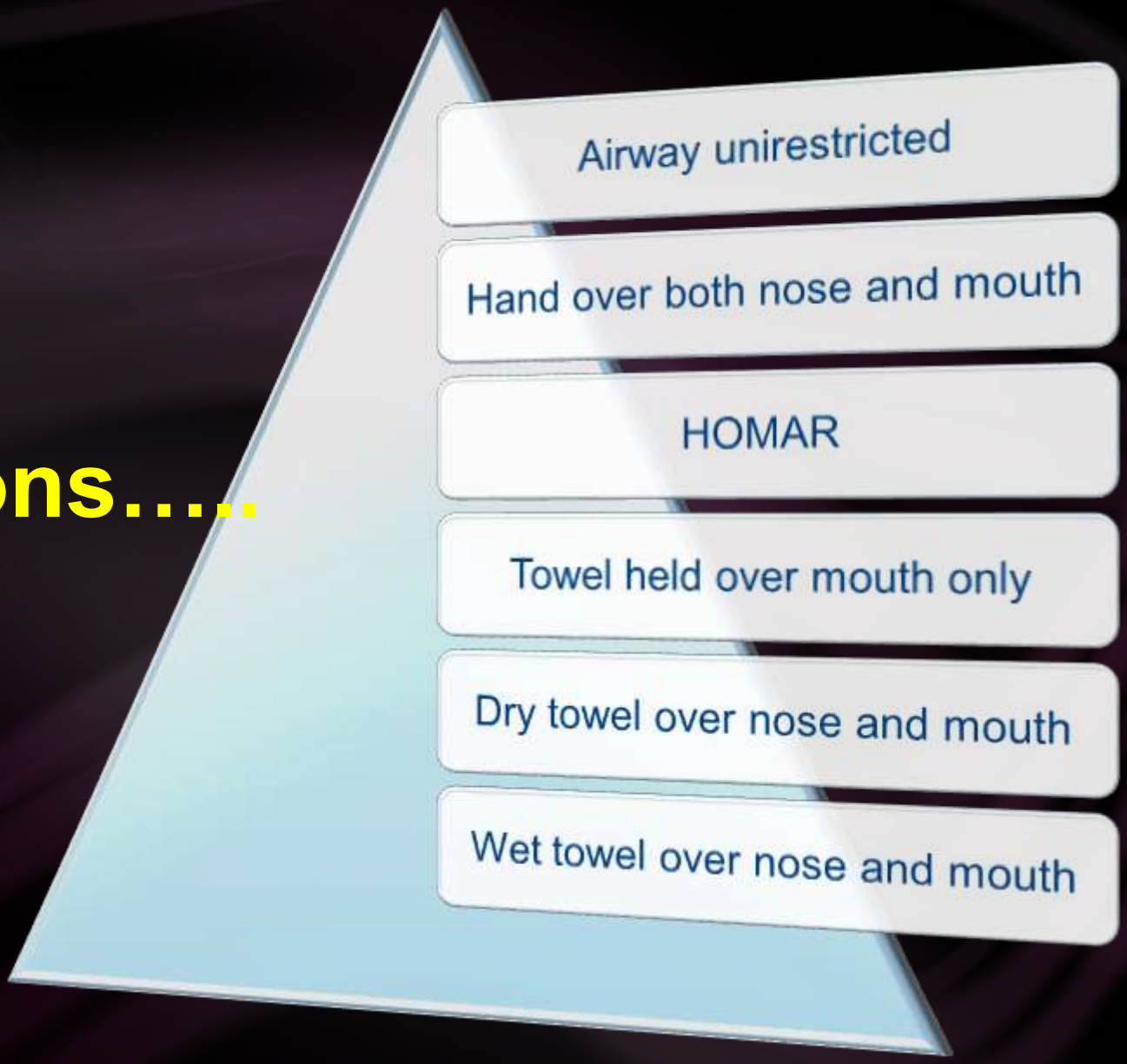
- As it leaves the face there may be another wail with a garbled request," I want my mummy".

- Immediately the hand is replaced, the admonition to stop screaming is repeated and I add, "You want your Mommy?"once again the head nods and I say , " All right but you must be quiet and I will bring her in as soon as I am finished".

- Again the nod and the hand is slowly lowered.

- While the child is composing himself he begins to talk about his clothes , friends, pets.
- If there is an attempt on the part of the child to start again, a gentle but firm remainder that the band will be replaced is usually enough to make him reconsider.

Variations…..


Airway unirestricted
Hand over both nose and mouth
HOMAR
Towel held over mouth only
Dry towel over nose and mouth
Wet towel over nose and mouth

Physical restraints

Defn – are devices, wraps or other individuals assisting in dental operatory, that are designed to prevent patients from causing harm to themselves & to the dental personnel

Objectives :

- To reduce / eliminate the untoward movement
- To protect the dental staff, patient from the injury
- To render the quality dental treatment in these patients.

Indications:

- cannot co-operate due to lack of maturity
- mental/ physical handicap
- When other behavior management technique have been failed
- When the safety of dental staff & or patient would be at risk without the use of protective restraints

- Active: Restrains performed by dentists , staff or parent.

- Passive: With the aid of restraining device

TYPES

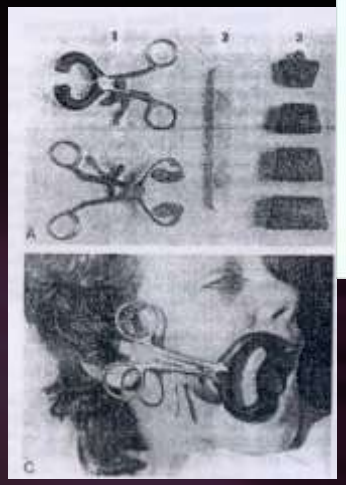

Body
Papoose board
Triangular sheet
Pedi wrap
Bean Bag
Safety belt
Extremities
Posey straps
Velco straps
Towel & Tape
Extra assistant
Head
Forearm support
Plastic bowl
Head positioner
Extra assistant
Mouth
Tongue blades
Mouth Prop
Bite blocks

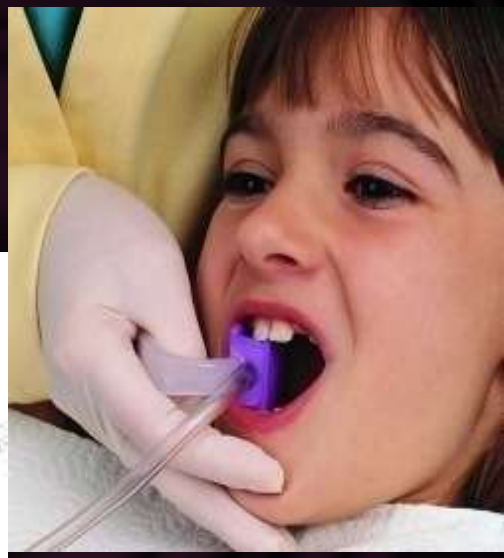
Oral :

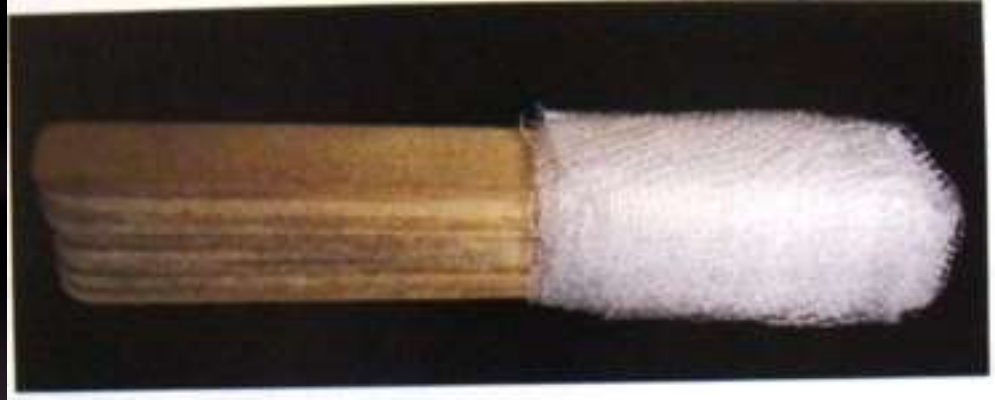
At the time of injection

- For stubborn child/ defiant child
- Mentally handicapped child
- Very young child who cannot keep their mouth open for extended period of time.

- NOT IN APREHENSIVE CHILD---↑ HIS FEARS







3.10: Ice cream sticks wrapped with gauze ca
used as restrain for the mouth

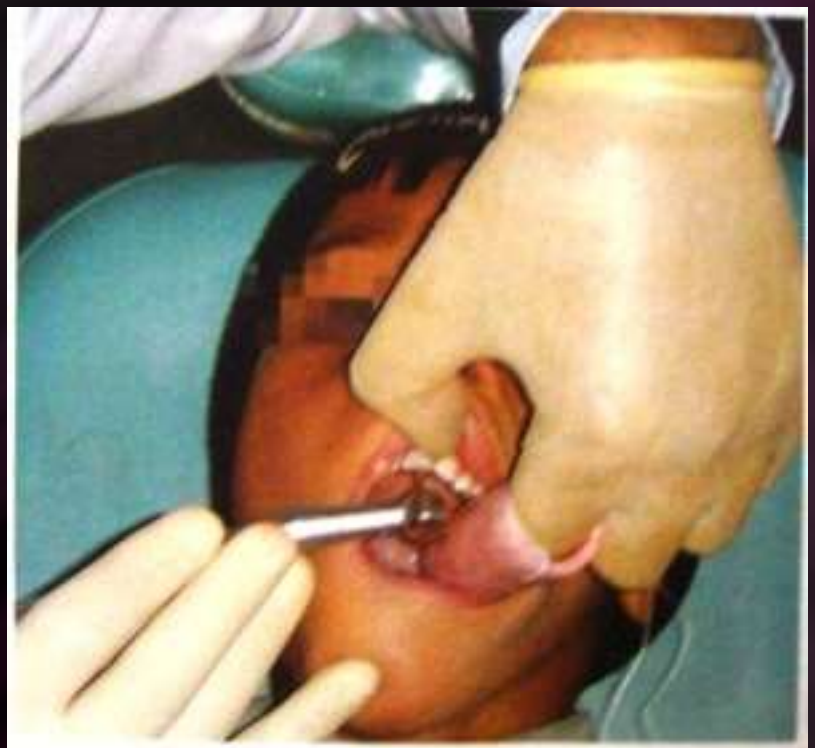


Fig. 21.20: Finger guard

Body:

- Restrict the pt movements

- Used frequently in pt < 2yrs of age


Bean bag

Types:

- Papoose board
- Triangular sheet
- Pedi wrap
- Bean bag dental chair insert
- Safety belt
- Extra assistant


Papoose board


Small
Infants -
24 Months
Regular
2 - 6
Years
Large
6 - 12
Years
Extra-Large
13 Years
to Adult

Extremities:

- Attached to the dental unit , restraints pt at the chest, waist, legs.

- To control the activity of the mentally / physically handicapped pt who cannot control his own movements.

- Prevent the pt from getting injured himself

- Prevent from interfering in the dental procedure.

- Posey straps
- Velcro straps
- Towel & tape

Fig. 21.23: Pediwraps immobilizing different extremities


Fig. 21.26: Head positioner

Head:

- Supports the head
- Protects the pt from getting injured himself

Types:

- Fore body support
- Head protector
- Plastic bowl
- Extra assistant

Consequences

- Physical or psychological harm
- Loss of dignity
- Violation of a patient's rights

Careful, continuous monitoring of the patient is mandatory during protective stabilization.

IMPLOSION THERAPY

- Sudden flooding with a barrage of stimulus which have affected him adversely and child has no other choice but to face the stimulus until negative response disappears

- Consists of HOME,VOICE CONTROL,PHYSICAL RESTRAINT

DISTRACTION

- The patient is distracted from the sounds/ sight of dental treatment thereby reducing the anxiety.
- Proper distraction techniques can help take the child minds off of the unpleasant aspects of treatment and redirect to a more pleasant place.
- Basic form of distraction is conversation with the dentist.

Objective –

- To decrease perception of unpleasantness
- To interest & involve children

Types –

- Audio – distraction
- Audio – visual distraction

"*White noise / audio analgesia*" : playing pleasant music to reduce the stress & the reaction to pain.

METHODS:

- Use stories and fairy tales.
- Slow instrumental music
- Video games
- Child watching TV will have multi sensory distraction.

ESCAPE

- Escape gives the child the ability to take a break from the demands of dental visit.
- Escape is a cessation of activity in the mouth, not getting up from the chair.
- Contingent and non contingent

Contingent:

- It is given when a child complies with a request or exhibits cooperative behavior.
- "if u can hold still until I count 1-10 we can take a break".
- Used in preschool age in disruptive children(Allen and associates)
- Advantage: non-aversive.

No contingent escape:

- It is given regardless of behavior.
- It is granted at predetermined level.
- It is very difficult to carry out consistently ,but the concept of breaks is very important in children.

Placebo

- The placebo effect as one which is not due to the specific pharmacologic properties of an administered substance.
- Involves suggestion, expectation to successful outcome & anxiety relief

• with hypnotic technique,placebos are generally more effective

Summary of the Behavior Management Techniques Based on the Individual Behavior

Cooperative Behavior:

- Engages in conversation and reasonably relaxed
- Understand the procedures by minimal apprehension
- Following directions and enthusiastic

Management:

- TSD
- They offer a reasonable level of cooperation which allows the dentist to function effectively and efficiently.

Lacking Cooperative Ability:

Very young patients:

- Communication cannot be established and comprehension cannot be expected.
- They lack cooperative abilities.
- It's a temporary period in their development.

Handicapped children:

- These children are unable to cooperate in the usual manner.

MANAGEMENT:

- Special behaivour management techniques have to be employed.
- The behavioral changes cannot be expected.
- Management varies with individual situations.
- Best accomplished with pharmacological procedures.

Potentially Cooperative Behaivour:

- Behaivoural problem
- Child may be healthy or handicapped.
- Capability to perform cooperatively

UNCONTROLLED BEHAIVOUR:

- 3-6 years
- Tantrum may start in the reception area.
- Tears
- Loud crying
- Physical lashing of hands and legs
- This behavior is rare in older children as school age children tend to model their behavior after adults.

MANGEMENT:

- Child must be removed from reception area as soon as possible.
- Flaining should be subdued to prevent injury to him.
- Line of communication must be established with the patient.

Defiant Behaivour:

- Seen in public school age group
- It can be:
  - Active resistance
  - Passive resistance

ACTIVE RESISTANT:

- stuborn or spoilt
- Shouts and screams
- Perform similarly in their home surroundings.

Management:

- Straight forward firm approach is necessary.
- After the cooperation is obtained, their behavior should be goal directed and definite guideline for their behavior is established
- Once won these children are highly cooperative.

PASSIVE RESISTANCE:

- Solemnly slumps in the dental chair.
- Does not respond verbally.
- Failure of communication.
- Clenches his teeth during intra oral examination
- Grips the chair tightly
- Eye contact avoided
- Seen in older children approaching adoloscence

MANAGEMENT:

- Firmness
- Try to understand them
- Be honest
- Struggling avoided because it is too old and too big for any approach
- If they express dislike towards dentistry, explain to them that dentistry is not inheritantly pleasant.

TIMID BEHAIVOR:

- Milder form of negativism
- Shields behind parents
- Do not offer great physical resistance to the separation procedure.
- May hesitate when given directions
- May whimper but do not cry hysterically

Reason:

- Over protective
- Coming from isolated rural area and has little contact with strangers.
- Child may be awaed by strange surroundings.

Management:

- Childs need to gain confidence in himself and the dentist
- Carefully lead to his first experience(TSD)

TENSE COOPERATIVE BEHAIVOUR:

- Lampshire in (1970)
- Borderline between positive and negative.
- Accept treatment as is provided.
- Do not exhibit violent, physical misbehavour.
- Extremely tense.
- Tremor when they speak
- Body may vibrate
- Perspire on palms
- Eyes follws the movements of dentist

Management:

- They are easily mismanaged as they accept the treatment the dentist fails to see a problem.
- So, various behavior management modification techniques may be used.

Whinning bahaivour:

- Allows the dentist to proceed but whines throughout the procedure.
- Frequently complains of pain even after repeated administrations of LA.
- Apprehension lowers their pain treshold
- Cry is not particularly loud, controlled and constant.
- The child does not shed any tears.
- Elsbach characterised whinning as compensatory cry- child uses it to vent his anxiety.
- Great patience is required as eventually child will grow out of this as their self confidence and confidence in the dentist increases.

STOIC BEHAVIOR

- The child might generally be considered.
- He sits quietly and passively and accepts all dental treatment including the injection without any protest or any sign of discomfort.
- He does not talk readily and may appear taciturn if not sad.
- Special attention is required to this behavior pattern because it is characteristic of children who have been physically abused.
- Special care should be taken with love and affection.

Behavior techniques based on the age:

Infant /toddler:

- Examination takes place on the parents lap in the "knee to knee" position using gentle active restraint from the dentist and parent.

Preschooler:

- Communication
- Tell show do
- Positive reinforcements
- Appointments should be short.

School aged children:

Communication

Conclusion

There is no mysterious formulas or secret approach to child management.

Successful handling of children is based on the Knowledgde , common sense and experience.....

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THANK YOU……