EFFECTIVE COMMUNICATION AND NONPHARMACOLOGIC BEHAVIOR MANAGEMENT

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Dentistry...is an intense communication experience built on requests and promises...

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Reasons parents/children experience anxiety regarding dental visit

dentist’s manner
general atmosphere
past experiences
fear of needles
fear of extractions
fear of tooth preparation
existing problem
fear that a child with cavities means they are a bad parent

Attitudes of children towards dentistry

Like

interesting waiting room
background music/ TV
dentist talking while working
watching in mirror
explanation of treatment
giving a signal to stop work

Dislike

waiting
unattractive/hostile room
drilling
operating light in eyes
lying about a painful procedure
being compared to other children
<table>
<thead>
<tr>
<th>Age</th>
<th>Characteristics</th>
<th>Implications</th>
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</table>
| 0-2  | Sit/crawl/babble/express single words/ Point to few body parts/ follow simple commands/ listen to simple stories or songs | Child in stroller  
Knee to knee exam  
Remember their mouths are everything |
| 2-3  | Toilet training/ “terrible two’s”/ separation anxiety/ vocab of 5-200 words/ Attention span of 1-5 min/ understand differences in meanings  
3 yr old likes to please | Talk in short sentences  
Simple vocabulary  
Unintimidating words |
| 3-4  | Attn span 4-8 min/ can count to ten/ vocab 800-900 words/ learning abc’s        | Simple instructions  
Child in dental chair independently |
| 4-5  | Tell fanciful/ long stories/ clearer sentences/ know abc’s/ capable of pretending an object symbolizes another | Independent in chair  
Carry on conversation  
Appropriate descriptive words  
Egocentrism is a limitation |
| 5-7  | Attn span 12-25 min/ speak more fluently/ interact with many people outside the home | Need to dispel myths of others  
Tend to believe everything they hear |
| 7-12 | Influence of peers and outside interests  
Developing ability to think abstractly | Talk on their level  
Talk about their interests  
Explain reasons for necessity of TX |
| 12-17| Problematic period/ strong need for control and independence/ appearance of teeth and mouth important/ arrogant/ disrespectful/ distrustful of authority | Allow time for pt to adjust  
Allow them as much control as possible  
Let know you are aware they are doing the work  
Provide choices whenever possible |
TEMPERMENT

One’s personal style and way of interacting with or responding to the environment they are in

Patient; provider and parent temperament play a role
CHARACTERISTICS OF TEMPERAMENT

ACTIVITY LEVEL
BIOLOGICAL RYTHMS
APPROACH/WITHDRAWL
ADAPTABILITY
MOOD
INTENSITY OF REACTION
DISTRACTION
PERSISTENCE
<table>
<thead>
<tr>
<th>FLEXIBLE/EASY</th>
<th>FEARFUL/CAUTIOUS</th>
<th>FEISTY/DIFFICULT</th>
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</thead>
<tbody>
<tr>
<td>REGULAR RYTHMS</td>
<td>SLOW TO ADAPT</td>
<td>ACTIVE</td>
</tr>
<tr>
<td>ADAPT QUICKLY</td>
<td>WILL WITHDRAW/ BE SHY</td>
<td>INTENSE IN THEIR RXNS</td>
</tr>
<tr>
<td>GENERALLY (+) MOOD</td>
<td>CAUTIOUS IN NEW SITUATIONS</td>
<td>DISTRACTIBLE</td>
</tr>
<tr>
<td>LOW SENSITIVITY</td>
<td>MAY OFTEN SEEK OUT CAREGIVER</td>
<td>SENSITIVE</td>
</tr>
<tr>
<td>LOW INTENSITY IN RXNS</td>
<td>NEED SECURITY OF PROXIMITY OF CAREGIVER</td>
<td>IRREGULAR BIOLOGIC RYTHMS</td>
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<td>MORE TIME TO WARM UP TO NEW SETTINGS</td>
<td>MOODY</td>
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<td>OFTEN EXERT A STRONG INFLUENCE ON THEIR CAREGIVER AND ENVIRONMENT</td>
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BASIC 3 C’s
EFFECTIVE COMMUNICATION
WITH THE PEDIATRIC PATIENT

• **Concise**
  – Simple vocabulary
  – Short message
  – Limit number of instructions or rules
  – Be clear about acceptable behavior

• **Commanding**: speak directly to child
  – Be child focused
  – Get eye contact
  – Commands better at starting than stopping behavior

• **Concrete**
  – Say what you mean
  – Don’t ask questions if there isn’t a choice
APPROPRIATE VERBAL COMMUNICATION

• Coming into maturity in language by way of conversation occurs between 2 – 4 years of age

• Receptive language
  – Sounds, vocabulary, concepts, grammar
  – 24 mo – follows simple commands
  – 36 mo – object, function, spatial relation

• Words and phrases that instill self-confidence, self respect and thoughtfulness;
  – Please, Thank you
  – Tell me more
  – You can do it
  – Great job
  – Let’s all pitch in
FUNDAMENTALS OF COMMUNICATION

- POSITIVE APPROACH
- TEAM ATTITUDE
- ORGANIZATION
- TRUTHFULNESS
- TOLERANCE
- FLEXIBILITY
GOALS OF EFFECTIVE BEHAVIOR MANAGEMENT

• Establish rapport, trust and communication
• Alleviate fear and anxiety
• Build a positive and trusting relationship

• Promote positive attitudes towards oral health
• Deliver quality dental care
THIS IS NOT ALWAYS EASY!
Prefigurative Parents

- Raise their children outside of any consistent tradition
  - Moment by moment adjustments in their guidance of their child
  - Few limits and less discipline
- Evolved from mobile societies and hurried lifestyles
- Intrasocietal distrust and a trend towards parental protection

Prefigurative Children

- Children are not well rehearsed in handling the requests of adults
- Misdirected behaviors
  - Undue attention
  - Manipulative behavior
  - Struggle for power
  - Retaliation and revenge
  - Inadequacy
PARENTAL ATTENDANCE DURING THE DENTAL VISIT

- safer approach legally
- parents unsure of their role, they expect to be co-decision makers
- parent education improves their role in behavior management
  - parent as the silent/passive observer
  - parent empowerment of the dentist
JUSTIFICATION FOR PARENTAL ABSENCE

- Parent often repeats orders, which creates an annoyance for both the dentist and pediatric patient.
- Parent injects orders, becoming a barrier to development of a rapport between the dentist and the child.
- Dentist unable to use voice intonation in the presence of the parent because he or she may be offended.
- Child divides attention between the parent and dentist.
- Dentist divides attention between the parent and child.
PARENTAL ABSENCE

- Most dentists more relaxed; not performing for an audience
- More relaxed manner makes their actions more likely to have a positive effect on behavior
- Most children under 3 benefit from parental presence
- Dentists must explain reasons for policy to parents
- Decision made on patient to patient basis
- May be used as an in/out situation to
PARENT PRESENCE/ABSENCE

- must be age appropriate
- children’s responses to their parents presence or absence can be beneficial or detrimental
  - child takes on the role of the victim
- Open door policy / informed consent

- Objective:
  - gain the child’s attention and compliance
  - avert negative or avoidance behavior
  - establish appropriate adult/child roles
  - enhance communication
PARENT COMMUNICATION: BUILDING A RELATIONSHIP

Essential Elements in Communication

- Open the discussion
- Gather information
- Understand the parent / patient perspective
- Share information
- Reach agreements on problems and plans
- Provide closure

Keep in Mind...

- Friendly professional attitude
- Limit dental jargon
- Caring, commanding and concise
- Not overly casual
- Ask the parents
  - About the child’s temperament
  - what they do at home when the child is behaving and not behaving
- Make parent repeat the role you give them and ask if they are comfortable with their role
RISK FACTORS

- Past medical history
- Patient diagnosis (disability)
- Patient anxiety level, past dental experiences, Dental IQ
- Patient temperament maturity/age
- Parent anxiety level and Dental IQ
- Parent/Advocate perceptions and desires
- Social/family status
- Insurance coverage and finances
- Distance traveled
- Cultural issues
- Complete list of treatment needs
- Technical demands of treatment
- Staff/equipment
PREAPPOINTMENT BEHAVIOR MODIFICATION

ANYTHING SAID OR DONE TO POSITIVELY INFLUENCE THE CHILD’S BEHAVIOR BEFORE THE CHILD ENTERS THE OPERATORY

PREAPPOINTMENT MAILINGS
VIDEO
MODELING (SIBLING)
INTRODUCTION TO DR.
NONPHARMACOLOGIC BEHAVIOR MANAGEMENT TECHNIQUES

I. Positive reinforcement
II. Tell, show do/ behavior shaping
III. Distraction
IV. Nonverbal communication
V. Voice control/HOM (adverse conditioning)
VI. Immobilization
VII. Preteaching and Behavior Modification
I. REINFORCEMENT

**POSITIVE**

- The presentation of a stimulus immediately following the target behavior that results in an increase in the future occurrence of that behavior
  - when the child has done something right or better than before

**NEGATIVE**

- The removal of an adverse stimulus immediately following target behavior which results in the future likelihood of that behavior
  - tantrum after a request and parent removes request
  - child feigns stomach ache on exam day and gets to stay home

NOTE: Most children receive Positive Reinforcement weekly And Negative Reinforcement multiple times on a daily basis
**PRAISE**

- Powerful positive reinforcer that helps children learn
- Tell them what they can do!
  - model, demonstrate
- Verbal
- Nonverbal
  - Visual, auditory, touch (ie. high five)
- All people react favorably especially children
  - Encourage parents to praise any behavior that the child should repeat
  - Be specific

**REWARDS**

- Closely tied to a performance criteria
- Rewards are tangible
- Behavior cannot already be occurring
- Use clear and specific criteria for reinforcement
- Age appropriate
  - i.e., stickers, tokens, computer/game boy time
11 BEHAVIOR SHAPING (Stimulus-Response Theory)

- State general goal/task at outset
- Explain the necessity
- Divide explanation for procedure
- Give explanations at child’s level of understanding
- Use successive approximations (*TSD*)
- Reinforce appropriate behavior; be as specific as possible
- Disregard minor inappropriate behavior; ignored minor misbehavior will extinguish itself when not reinforced
II. TELL – SHOW – DO

- Choice of words should be age appropriate
  - your tooth will take a nap vs. put your tooth to sleep
  - Mommy and Dora will be proud of you
  - promise and trust
- Used in combination with other techniques
- Effective in 4:5 children over the age of 3 years
- Child shown as much of procedure as possible
- Verbal explanations
  - most effective after age 6
RETRAINING

• For children who approach visit with considerable apprehension or negative behavior

• Usually the result of a previous negative experience; *important to determine source*

• Objective is to build a new series of associations

• If child’s expectation of being hurt is not reinforced a new set of expectations is learned

• Learn the dentist can be trusted

• To offset generalization the dental team must demonstrate a difference
III. DISTRACTION

- diverting patient’s attention from what may be perceived as an unpleasant procedure
  - talking
  - counting; lift your leg and count to five
  - story telling
  - music/movie/TV
  - gameboy
  - games (geography Where’s Waldo)
  - ipod (adolescent)

- Don’t stop talking during local anesthesia *******
- very effective in combination with nitrous oxide and/or PO,IM,IV sedation

- Contingent distraction
  - access dependant on good behavior
  - Ingersoll et al. found a reduction in disruptive behavior (30-6%) in 3 - 9 yr old children
OTHER DISTRACTION TECHNIQUES

• **Live Modeling (video)**
  - Numerous studies have shown decreases in disruptive behavior

• **Contingent Escape**
  - Brief opportunity for escape can interrupt the chain of disruptive behavior
  - Signal for escape/stop of procedure

• **Desensitization**

• **Hypnosis**

• **Relaxation**
  - Take deep breaths through your nose and count to three before you breathe out (practice) now let’s do that five times

• **Imagery**
  - Smells, tastes, sounds, think of your favorite place
IV. NONVERBAL COMMUNICATION

- Reinforcement of behavior through appropriate contact, posture and facial expression
- Enhances the effectiveness of other communicative management techniques
- Culturally specific
- Gestures
  - recognized motor patterns that convey information
    - Facial expression
    - High Five
- Reciprocal Social Interaction
  - Eye gaze
  - Turn taking
  - Observe personal space
  - Read and respond to social signals
V. A) VOICE CONTROL

- A controlled alteration of voice volume/tone or facial expression (displeased) to influence and direct the child’s behavior
- Nonverbal component
  - Facial expression
  - Body posture

GOALS:
- Interrupt inappropriate behavior as it begins
- Gain the child’s attention
- Avert negative avoidance behavior
- Establish appropriate adult-child roles, sends message of who is in charge *
- Informed consent is recommended (verbal)

Inform Parent: I may speak to your child in a stern or loud manner
• loud or normal voice study groups (3-7 yo, n=40)
• voice control when used with children who were initially fearful and who disrupted the appointment quickly reduced unwanted behavior without increasing negative effect
• disruptive patients who received normal voice commands persisted in their disruptive behavior and reported lower pleasure
• increased fear or negative effect as measured by self report, was not observed among the loud voice group
V. B) HAND-OVER - MOUTH HOM

• Indications ...
  - Normal child who is old enough to understand directions and cooperate but who exhibit defiant or hysterical avoidance behaviors to dental treatment

• Contraindications...
  - children who due to age, disability, medication or emotional maturity are unable to understand, verbally communicate or cooperate
  - any child with an airway obstruction

• Informed consent
HAND-OVER-MOUTH (HOM)

- the intent is to help the hysterical child regain self-control
- a hand is gently placed over the child’s mouth and behavioral expectations are calmly explained
- upon the child’s demonstration of suitable behavior the hand is removed and communicative management techniques are then used
- nonverbal component
  - Facial expression
  - Body posture
VC/HOM OBJECTIVES

• redirect the child’s attention, enabling communication with the dentist so appropriate behavioral expectations can be explained (rules and roles)
• extinguish excessive avoidance behavior and help the child gain self-control
• ensure the child’s safety in delivery of quality dental treatment
• reduce the need for sedation or general anesthesia
VI. MEDICAL IMMOBILIZATION

- Partial or complete immobilization is sometimes necessary to protect the patient, practitioner and/or dental staff from injury while providing dental care

- Immobilization with:
  - therapeutic restraint (papoose)
  - mouth prop
  - tape, cloth wraps, sheets
  - staff restraint

- Informed consent and documentation
  - Type used
  - amount of time in use
  - patient’s behavior
  - Indications - mental or physical handicap; safety of patient, dentist or staff; ineffectiveness of other techniques
  - Not to use as a punishment
VII. Behavior Modification

- **Target Behavior**
  - The behavior that you / parent wants to occur again

- **Determine Behavior Reinforcers**
  - Preferably decided before an episode or situation
  - Age appropriate and meaningful

- **Reinforcer**
  - Immediately follows behavior that results in increased likelihood that behavior will occur in the future

- **Punisher**
  - Kind of consequence used when the child is engaging in inappropriate or undesirable behavior that is to be decreased

- **Response Cost**
  - Punishment by contingent withdrawal (loss of positive reinforcer)
VII. Behavior Modification

- Identify target behavior
- Assess motivating factors
- Continuous reinforcement to build a skill and variable reinforcement to maintain a skill
  - Familiarization Visits
    - Repetitive tasking
- Behavior Contracts
  - Dentist/Parent/Child

- Rewards or reinforcers
  - are defined by the effect on future behavior not on current behavior
  - must be meaningful and tailored to the specific child
  - must be attainable; start new every day
  - must be tolerable by parent

- Punisher/Response cost
  - immediate
  - set duration reasonable
  - consistently applied
BEHAVIOR MODIFICATION TECHNIQUES - PRETEACHING

- Highlights importance of communication regarding expectations and conveys in advance the antecedent behavior and consequences

- Preschool children- preteach at each transition (coming/going) helps to develop appropriate behavior

- Goal: child will learn to self regulate their emotional and behavioral responses to events in their environment (≥ 4 yrs)
INFORMED CONSENT
WRITTEN AND VERBAL

• Discuss alternatives to your recommended treatment including risks, benefits, alternatives and complications
• Encourage to discuss with family, partner or friends
• Ask, “what do you want, what do you expect, how important is this to you ?”
• Inform them how and why you want to treat their child SAFELY

• Lawsuits occur;
  – When parent’s manipulate the dentist’s standard of care
  – When parents are not informed about the procedure or BM technique
    • “Did not explain”
    • “Did not ask permission”
HOW TO INFORM FOR CONSENT

- Parents (n=120) were shown descriptions of eight traditional BM techniques via one of four different presentation methods: one of two types of video, oral and written.
- The oral method produced higher consent rates and more well-informed parents (95%).
- 75% of parents believed that the information about the technique was relative to their decision to consent.

- Parents (n=67) viewed videotapes of 10 BM techniques.
- The least acceptable was the papoose and general anesthesia.
- Most acceptable were TSD and positive reinforcement.
- Approval of HOM and VC were significantly correlated.

» Allen et al.
» Murphy et al.
THE PROVIDER’S ROLE IN BEHAVIOR MANAGEMENT

• The behavior management technique will not be effective if the provider believes that the technique
  – promotes anxiety
  – compromises the child’s self esteem

• Trial and Error

• Anticipate
  – Contingency plan

• Confidence and self awareness
Understanding the principles of behavior management and developmental norms of children

Preparing yourself
- deciding on your strategy for handling the child
- assess the child

Preparing parents
- helping parents prepare the child
- risks, benefits, alternatives and complications
- treatment plan / financing

Prepare the child
- the predental visit

The dental appointment
- structure
- reinforcement

Non-pharmacologic BM

Pharmacologic BM
- nitrous oxide,
- sedation, PO, IM IV,
- general anesthesia

Use of restraint techniques (therapeutic, passive etc)
**Exam and cleaning visits:**
- Create a healthy dialogue between you and the parents
- Articulate your options and your limits
  - Informative
  - Redefines your personal convictions
- Pretreatment orientation to restorative visit

**Restorative visits:**
- First restorative visit:
  - Define roles of dentist, parent and patient
  - Tell, show do of restorative procedure

- Sets the plan for future restorative visits
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