Rethink Retraining: A Review

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Abstract

As we advance with time, there is a change in the attitude of the kids and their parents which in turn demands a change in the pediatric dentist's approach to them. When we treat young children, there is an added responsibility to gain their co-operation for rendering the best treatment. Sometimes, the added challenge will be to gain the confidence and co-operation of the child as well as the parents with a previous unpleasant dental experience. Hence, there is a need to re-evaluate the retraining of a patient by considering advanced and innovative behavioral guidance and management techniques.

Keywords: *Retraining, Reframing, Dental Anxiety, Behavioral management.*

Introduction

Establishing a connection with the child, the child's family and the dental team is an energetic process. This can be in the form of an exchange of pleasantries, voice tone, body language, facial expressions and other ways of non-verbal communication. The dentist needs to have at their dispersal a variety of behavior management and communication techniques to deal with children of different mindsets.[1,2]

The complexity of growing up involves a lot of things that can be pleasant as well as frightening to the children and they learn to deal with new experiences as they develop their cognitive skills. In this regard a very important but, often overlooked is the consideration of the cognitive stage of child patients before we approach them. So, when the patient with a previous unpleasant dental experience ends up on your dental chair, it is better to start retraining the patient by first assessing the cognitive stage of child development she/he is in.Retraining involves usage of a combined approach of different behavior management and modification techniques to assist the child to show favorable behavior.

Retraining Techniques in Sequence:

1. **Pre-requirements of a dental set up:** Before even thinking of treatment for any patient it is important to have a clean dental operatory set up. Dental clinics should not have a cluttered environment as it leads to a cluttered mind. The dental set up should attract and instigate some sort of inquisitiveness in a child patient.
2. **Attire of the dentist:** When dealing with children with 'White coat anxiety' it is better to avoid wearing the usual doctors coat or replace it with a less threatening attire.
3. **Appointment timings and duration:** Morning appointments with brief waiting time and short treatment time of not more than 30 minutes is appropriate to avoid appointments in their nap or playtime which might make them more restless and irritable.
4. **Team Effort:** Pleasant and warm welcome to the child and the parents by the receptionist and other staff members will put them at ease and calm them.[3]
5. **Positive pre-visit imagery:** Before taking the child to the operatory chamber, showing them images that are agreeable and compliant to the child puts them in the path of acceptable behavior. This can be used in any patient. The objectives of positive pre-visit imagery are to:
   - Provide children and parents with visual information on what to expect during the dental visit.
   - Provide children with a context to be able to ask providers relevant questions before dental procedures are initiated.[4]

6. **Functional questionnaire:** Set of questions can be asked to gather information regarding the child's temperament and their previous dental visit such as:
   - How did the child behave during the past dental/ medical visits?
   - Age of the child in the last dental visit?
   - What is the anxiety level of the parent? (anxiety in parents is reflected in the child's behavior)
   - How does the parent think the child would behave in the operatory?[2]
   - What caused the unpleasant dental experience in the past? (Any particular treatment/incident)
   - Visual scaling of the patient's perception regarding dental treatment if the patient is old enough to interpret it.[5]
7. **Recognizing dental anxiety:** Feeling of restlessness about the dental treatment that is not essentially connected to a particular external stimulus is defined as Dental Anxiety. In the opinion of Chadwick and Hosey (2003), children are familiar with anxiety and the symptoms depend on the age of the child. Crying is a common expression of anxiousness in children. Phase of development plays an important role in the way a child deals with anxiety. Sometimes, children cannot be supported as they may be very young or have special health care needs with whom cooperation may not be accomplished. Anxiety of a child can also have their roots in parent anxiety levels or previous dental experience Recognition of this paves the way for a different path to be taken for a child with unpleasant dental experience.[6]
8. **Communication:** Communication has a twofold purpose as a preventive measure in behavior management (setting the tone of the environment into which the child enters) and a part of the behavior management strategy later.

Verbal communication: The choice of words is extremely important to establish the environment. Words of affirmation and expectations of behavior can be communicated to the patient by the doctor, assistant, or receptionist. Multiple targets may also be used to convey information. For example, affirmation can be given to the child for good behavior by telling the assistant or the parents how well the child is doing. Similarly, explanations about potential behavior management strategies can be given to the parent in case of an uncooperative child. When a child and his or her family do not speak a language known to the practitioner then an interpreter may be necessary. Employing auxiliaries or staff with the language skills represented by the surrounding community is favorable. Training the auxiliaries to communicate in a way consistent with the dentist's is important in such cases. In any event, nonverbal communication becomes more significant.

Non-verbal communication: It involves communicating with a child through physical contact, posture, facial expression and eye movements.[7] Either way, communication must be appropriate to the developmental age of the patient and the cultural context of the family.[4]

Reframing: Reframing is defined as, "taking a situation outside the frame that up to that moment contained the individual in different conditions and visualize (reframe) it in a way acceptable to the person involved and with this reframing, both the original threat and the threatened"solution" can be safely abandoned." It is a part of neuro-linguistic programming that helps to strengthen the relationship between the dentist and the child. The content is perceived depending on how it is framed. So, to change the behavior of the patient we need to change the content in the frame by changing the meaning or sense of the situation or by changing the context. [8,9]

Direct observation: Patients are shown a video or are permitted to directly observe a young cooperative patient undergoing dental treatment to familiarize the patient with the dental setting and dental procedure. This also allows the patient and parent to enquire about the dental procedure in a safe environment. It is based on the "Observational learning theory" by Bandura given in 1969. It aids in removing the fear of dental treatment and it can also be used to make the child aware of the expected co-operative behavior like the model(live or video) while undergoing treatment.[10, 11]

Ask tell ask: This method involves enquiring the child about their current emotions and anxiety level (ask) and then offer reassurance by explaining the procedures through demonstrations and non-threatening language appropriate to the cognitive level of the patient (tell). After comforting the child is again enquired how they are feeling (ask).[2] If the concerns continue, we need to address them and assess the situation, and modify the procedures or behaviorguidance techniques

if necessary. This will assess the anxiety that may lead to non-compliance during treatment and also teach how the procedures are going to be accomplished.[12]

Teach Back: A similar strategy called teach-back is similar to the dentist or dental assistant asking the patient to **teach back** what they have learned. It may be useful for patients with low literacy who cannot rely on written reminders. It is important to inculcate this process as a part of the routine. The patient is asked to tell/demonstrate what they have understood and if they express it incorrectly or doubtfully, we need to reteach/ demonstrate them.[4]

Successive approximation/Tell show do: "Tell show do" technique was given by Addleson in 1959. This is one of the most effective techniques of behavior modification. The child is told about the procedure in a language and manner understandable to the child after which the child is shown the equipment and the performing method(approximation). When the child becomes assured and relaxed, the treatment can begin.[3] This is most beneficial for a child who is progressing beyond the pre-cooperative stage. This also effective in an uncooperative child with 'fear' as a core issue. This is used to even demonstrate patience and concern in compensatory and overprotective parents and to retrain their vocabulary in front of kids. Successive approximation can be used to gradually expose the child to invasive procedures.[7]

Being tolerant and truthful: It is important, to tell the truth to children as that is what lets us gain their confidence. In case if they are about to receive an injection, they need to be told the same and shown how little pain would be caused like that of a prick or a mosquito bite. This way they would be prepared to receive what is told to them. Lying that there won't be any pain and then inflicting pain will only shatter their confidence. At the same time, it is of utmost importance for the dentist to be patient and maintain their tolerance levels even in case of an uncooperative child.[5]

Systemic desensitization: Introduced by Joseph Wolpe in 1952, this method introduces dental treatment to children progressively from a competing response such as relaxation to progressively increasing the threatening stimuli.[6] The first sitting involves only examination and diagnostic x-ray procedures if required followed by less invasive procedures like scaling, restorations, sealants,etc and then invasive procedures like extractions or endodontic treatments in the consecutive visits. This will tune the child to the dental setting and treatment procedures.[5]

Memory restructuring: It is a behavioral approach in which memories associated with a negative or difficult dental event are restructured into positive memories using information suggested after the event has taken place. Restructuring involves four components: visual reminders; positive reinforcement through verbalization; concrete examples to encode sensory details; and a sense of accomplishment. A visual reminder could be a photograph of the child smiling at the initial visit (i.e., before the difficult experience). Positive reinforcement through verbalization could be asking if the child had told her parent what a good job she/he had done at the last appointment. Concrete examples to encode sensory details include praising the child for specific positive behavior. The child then is asked to demonstrate these behaviors, which leads to a sense of accomplishment. The aim is to restructure difficult or negative past dental experiences and improve patient behaviors at subsequent dental visits.[13, 14]

Flexibility: In the current times, it is not uncommon to come across patients who show uncooperative behavior despite trying the common behavior management and retraining techniques. In such cases treatment shouldn't be done by force or immediately resort to protective stabilization. It is better to give time to the child and schedule another appointment for treatment after gaining their trust in the initial visit.[5]

The Current Needs of Parents from a Dentist: The parents of today seem to be moving toward a more laissez-faire attitude in parenting by providing the child with lavish freedom and choices leading to them having no self-control and discipline in some cases. Perhaps this is the reason we have newer categorization of children.[15] Children of today often present with a variety of behavioral problems such as attention- deficit hyperactivity disorder, conduct disorder, oppositional defiant disorders, and other disruptive behavior disorders. This calls for a change in the professional guidelines for behavioral guidance as well as retraining procedures.[16] Verbal reprimands and voice control are far less favored when compared to time outs. Interestingly, in a 2002 survey of 577 diplomates of the American Board of Pediatric Dentistry88 percent of respondents felt that parenting styles had changed in their practice lifetime, with 92 percent believing that these changes were

"probably or bad." Most respondents (85 percent) also believed that these changes resulted in "somewhat or much worse" patient behavior. In concert with changing parental attitudes, the diplomates reported less use of assertive behavior management techniques.[17] Younger practitioners, who may have grown up with modern values of parenting bear the influence of the modernist generation.[7]

Using classic behavior management techniques with assertive method is not favorable in the current times. Usage of physical restraints is not acceptable to most parents and Hand over-mouth exercise has fallen out of favor even with dental practitioners, possibly as a result of the implications of abuse. Voice control is questionable to overindulgent parents who consider it against the self-esteem of the child.

Conclusion

So, right now it is important to understand every child's parenting method of disciplining their children and incorporate it in our approach to the child along with behavior management science and it should be custom made for every child as they are all different from one another in one way or the other. Our goal should be to maximize their comfort levels on our dental chair especially in cases requiring retraining.

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