

Parenting the Parents of Pediatric Patients

Abstract

Managing the behavior of pediatric patients has been the focus of many studies; however, paying attention to the parents and their individual circumstances may be just as important to achieve our treatment goals. Parents today expect to be involved in treatment decisions and often have distinct expectations regarding their children's experiences. Parental attitudes and emotions can adversely affect the tone of the appointment and negatively influence the child's perception of the event. Managing the behavior of a challenging child is difficult, but combining that with the challenging behavior of a parent can be exhausting. This article will provide anticipatory guidance on how to enhance communication skills to avoid confusion and offer direction to parents before, during, and after the treatment of their children.

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Preparing the parent for his or her child's dental visit begins with the first phone call to schedule an appointment. Practice policies, including scheduling, payment, and broken appointments are explained. Parents usually prefer not to take their children out of school for dental appointments, but school calendars with in-service days and holidays may be found on the Internet. Check with parents regarding home-schooling or recommend scheduling the appointment during a nonacademic period. With so many working parents, late-afternoon appointments may be requested for toddlers and preschoolers. If an examination reveals the need for multiple treatments, the parent may expect that these restorative appointments can also be scheduled late in the day.

Young children are more rested earlier in the day and cope better in the morning. This too should be understood before the first visit. Waiting for more than 15 minutes may be very disturbing for some parents, and morning appointments generally have less wait time. Saturday morning appointments may be an appreciated option for working parents with young children. Parents often choose to schedule all of their children at the same time for convenience, but this can result in hours of production loss because of the possibility of broken appointments. The amount of time reserved for the appointments should be stated on the phone along with any fee charged for a broken appointment. If a child's parents are divorced or separated, the parent responsible for payment must be given the opportunity to agree to payment before the initial examination and restorative treatment.

A brochure describing the first visit for a younger child, with the assurance that most behavior concerns can be carefully and appropriately handled by the dental staff, will help to calm the parent as well. Also, including advice in the brochure for the parents on how to approach the appointment of an apprehensive child is very helpful for both the parent and the child.

It is important to understand the family dynamic of the child, which is why "name of parenting adult" may be added to the health history questionnaire. It has been

my experience that grandparents functioning as parents, same-sex partners, live-in boyfriends and girlfriends, and guardians are commonly referred to as the parent by the child. When addressing a child's mother, keep in mind that women sometimes keep their maiden name after marrying. Refer to the ex-husband or ex-wife as Mr, Ms, or the child's dad or mom. The actual relationship must be determined before any treatment may be performed to obtain legal consent.

Understanding the Parent's Background

Because of our society's socioeconomic and cultural diversity, understanding cultural influences is necessary when directing our goals and expectations regarding treatment. Oral health behaviors and dietary practices vary among cultural communities, and effective intervention is not possible without understanding the cultural norms. For example, if there is not enough money for food and shelter, routine dental care cannot occur, and preventive care would be impossible to understand when living day-to-day is such a challenge. For families such as these, the need for dental intervention is determined only when there is pain. A study of emergency visits for dental caries-related pain found that single-parent families accounted for 66% of the children seen.¹

Horn and colleagues suggest that assessment of disciplinary techniques may be a wise addition to the health history because socioeconomic status should not be used to predict disciplinary practices.² Other family practices are important too. In some families, the mother is an adolescent, and the grandmother may direct feeding practices. Prolonged bottle feeding may occur in some cultures, such as Native American, because it symbolizes infancy, and the role as a mother is an important aspect of female identity.³ Severe decay in these children is considered to be normal, affecting all children.³ Latinos also have high caries rates possibly from prolonged bottle feeding and adding sugar to cow's milk, and prolonged bottle feeding for Vietnamese children occurs because the formula is considered to be a good source of nutrition.³

To obtain this kind of background information, Nelson recommended strategies such as asking parents open-ended questions and stressing to them that the dentist and family will work as a team to provide the best possible care for the child. She recommends assessing comprehension by frequently saying, "So that I can make sure that I am explaining this well, please tell me what your understanding is about your child's dental needs and the treatment we're considering today." She also suggests asking the parent, "How can we support your needs and practices while preserving your child's teeth?"⁴

A consultation permits 2-way communication with the parent. Relying on the traditional methods for health education has been shown to fail for the parents of high-risk children.⁵ At least 2 appointments of brief counseling and 1 or more follow-up telephone call has resulted in sig-

nificant reduction in caries.⁶ The ability of the educator to accept the beliefs and lifestyles of the parent is one of the most influential factors in the success of the consultation.⁶

The parent's personality that seems different from the norm may be the result of other circumstances. He or she may harbor a strong sense of fear regarding dental treatment, finances may be limited, or perhaps the parent is overloaded with other problems. If a child has been referred for treatment because of his or her behavior or failed attempts at treatment, the parent may be frustrated with the child. It has been my experience that extensive caries may create a feeling of guilt that is misconstrued as anger toward the practice, or the parent may be mistrustful and demanding. In this case, a pretreatment consultation is required so that every question can be answered, adequately informed consent can be acquired, and the most effective treatment style can be explained to the parent.

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Pretreatment Consultation

For a cooperative child, pretreatment consultation may require only a few minutes, but for a child with multiple restorative needs or with behavior guidance needs, more time will be necessary. The parent who will accompany the child for each visit should be present, if both parents are not available. A separate appointment is not required, and a well-trained assistant can lead this discussion. Areas covered should be noted in the chart for documentation and future reference. The time spent with this communication will avoid confusion, mistrust, and, in the worst case scenario, a law suit.

The need for morning appointments to perform longer procedures or for behavior management is explained. If the child had difficulty during a previous visit with another dentist, the parent may be asked what he or she believes went wrong. Questions may be as follows: Were you present while the treatment was being performed? How did that help or not help? Do you know exactly what the problem was?

The parent's response may provide a better idea regarding who or what was actually responsible for the child's reaction to treatment, determining whether the parent or child requires more behavior guidance. The final question may be, "How do you think your child will behave for treatment now?" This may be the optimal time to discuss the limitations that uncooperative behavior places on the quality of care that can be provided and to discuss your own management technique or style.

Ask the parent about his or her expectations of the child's ability to cooperate and discuss the reality of these

expectations. The parent's perception of the child's temperament is a good indicator of how the parent will respond if the child is uncooperative during treatment. A check-list format may be used with descriptive words (eg, cooperative, strong-willed, defiant, becomes hysterical easily, fearful, and afraid or cautious with new experiences). The influence of in-born traits because of temperament may be noted by the dentist or assistant, which may result in a more honest response from the parent regarding the child's personality. If the child's behavior during the initial examination is stubborn and defiant, but the parent believes that he or she is "just afraid because all children are afraid of the dentist," treatment will be difficult and may require sedation. However, parents who have a realistic response may be a relief for the dentist and staff. This parent can be informed that he or she, along with the dentist and the staff, will work together as a team to achieve the objective of treating the child. I have noted that a parent who is "sitting on the fence" regarding the desire to have the treatment completed, is a parent who can be easily influenced by the child's well-rehearsed skill of manipulation.

The dialogue between the parent and the child before the appointment should be discussed. I have found that the less said to the child before the treatment usually results in a better outcome. Tell the parent that most procedures are performed with the Tell-Show-Do approach. The procedure is described with age-appropriate terms. The instruments and materials to be used for the procedure are shown to the child using a DVD, another child as a model, or a stuffed animal. Finally, the procedure is performed.

Specific methods for managing the behavior of a more challenging child are discussed later when informed consent is obtained. Warn parents to be cautious with their choice of words: "You *get* to come back to see the nice dentist," instead of "You *have* to come back here." Bribes should not be offered nor statements regarding the need to be brave. For apprehensive children, parents should sit closely beside the child, reading a story before the appointment. This seems to calm the children more effectively than free play.

Local anesthesia and its anticipated use should be included in the pretreatment consultation. The dentist or assistant should forewarn the parent that the sensation caused by the local anesthesia may be more upsetting to a young child than the actual injection. Our practice tells parents to refer to the numb feeling as "fat and fuzzy" rather than "frozen."

Sometimes the need for local anesthesia is not initially planned, but if appointments are missed or the decay progresses rapidly, an injection may be necessary. Parents should not tell the child that he or she is not getting a shot because the plan could change. If a child is very apprehensive, senses are heightened, and local anesthesia may be indicated to assure that pain is not the rea-

son for deteriorating behavior. Parents often think that lack of local anesthesia was the main reason for the child's inability to previously cooperate. Whether or not this is an accurate assumption, the use of local anesthesia in an uncooperative child is probably a better plan for both the parent and the child. A tearful response to the injection is much more acceptable to a parent than a tearful response perceived to be caused by the procedure. Finally, fear of the injection may create a serious obstacle to begin treatment. The injection should not be discussed by the parent before the restorative appointment.

Tell the parents that your objective is to restore the teeth, but the child's behavior may limit your ability to complete the procedure or perform ideal dentistry. The block of time reserved on the schedule should be noted, along with the fee for this reserved time if the treatment cannot be accomplished because of the child's behavior. Inform the parent that the procedure could be at a point where immediate cessation would not be possible, but that every effort would be made to discontinue treatment as soon as possible if the child becomes hysterical or combative.

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Parental anxiety may transfer to the child. Apprehensive parents should be informed of the effect of their body language and facial expressions. Preschool children are a few years past the nonverbal stage of their lives, and these silent cues are readily interpreted. Maternal anxiety is especially influential.⁷ Most parents know who would be the better parent regarding the comfort level with dentistry. Parents of children with low dental fear are more likely to consider themselves as more contributory and as having the ability to influence the child's reaction. Whereas parents of children with high dental fear attributed the fear to factors beyond their control and felt powerless in helping their child to overcome the fear.⁸ It has been my experience that parents' anxiety regarding treatment may be alleviated by observing a similar procedure being performed on a younger child who is cooperative. Inform parents of children who require behavior guidance that generally behavior improves with each visit and that ultimately these fearful children are extremely relaxed patients.

In most cases, a child who requires behavior guidance should be brought to each appointment by the same parent. As the parent becomes more familiar and comfortable, so does the child. With each appointment, a rapport is developed among the dentist, parent, staff, and child. When a different parent accompanies the child for treatment, a new relationship must be established and the behavioral guidance initially tailored for

the parent and child may require modification in accordance with the presiding parent's philosophy.

Informed Consent

Informed consent may require repeated explanation. A study examined parents' knowledge of proposed treatment 2 weeks after informed consent was obtained. On the day of the treatment, 40% of the parents could not accurately answer questions regarding some significant aspect of their child's treatment.⁹ Besides a verbal explanation, photographs, models, a prototype of the appliance to be used, and brochures may be helpful to provide supplemental information. CAESY Pediatrics^a provides an entertaining and informative presentation on DVD for most procedures and other topics related to the child's care.

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Grandparents and caregivers cannot give consent for treatment. In the case of divorce, informing both parents of the treatment needs is recommended, particularly the parent who is responsible for payment. The laws regarding custody of young children vary, and advice from a local attorney may be necessary to determine the laws within the jurisdiction. An ethical dilemma regarding treatment could become a legal dilemma if treatment is provided without consent of the custodial parent. If a parent has visitation rights only, he or she may not be able to make treatment decisions.¹⁰ If the parent does not speak English, consent cannot be obtained using a minor as an interpreter. Document the conversation and all of the areas covered in the chart.

Behavior Management

In a survey of diplomates of the American Board of Pediatric Dentistry, almost 9 out of 10 concluded that they are observing negative changes in parenting styles, and these changes have adversely influenced their pediatric patients' behavior. Respondents ranked the reasons for this change from highest to lowest: parents are less willing to set limits, less willing to use physical discipline, unsure of their roles as parents, too busy to spend time with their children, and too self-absorbed or materialistic. The consequence is that behavior management techniques have become less assertive. The reasons for this shift in management technique may be the result of a defensive response to avoid the backlash of this more involved, protective parent or to use methods that may more effectively control behavior in order to accomplish treatment goals.¹¹

Parents may not be familiar with the methods used for behavior management. If the need for behavior man-

agement is deemed a possibility, the methods used by the practice should be discussed before the restorative appointment. The techniques may include voice control, hand-over-mouth, restraint, or pharmacological modalities. Sedation or general anesthesia may be preferred to physical restraint.¹² Strong avoidance or combative behavior will create limitations for treatment that may be harmful or affect the quality of the dentistry. The dentist may assist the parent in making the appropriate decision depending on the child's age, medical status, extent of treatment to be performed, and the child's ability to cooperate.

By having this discussion before treatment, you also offer the parents the option to decide in an uncharged atmosphere whether these management techniques are agreeable with their own parenting philosophies. The parent who was present for the discussion and demonstration of the possible or planned behavior management should accompany the child for treatment. Parents, and often the parents of the same child, have very different opinions regarding the use of behavior management.¹³ Some parents find voice control to be too upsetting. If the parent appears to be reluctant to permit the dentist's methods for behavior management, the dentist may suggest that another practice's treatment style may be more suitable.

Parental Presence for Treatment

Parents generally accompany their young children for pediatric medical examinations, so it follows that they would expect to do the same in dental practices. Some want first-hand information, some believe that the child wants them present, and some believe that the dentist cannot manage their child's behavior without their assistance. Also, there are the parents who prefer not to be present for treatment. Ultimately, parental presence for treatment is determined by each practice's philosophy and the circumstance that ensures optimal care for the child.

The first visit should be not only to meet the child, but also to develop a rapport with the parent. If both parents come for the first visit, inform them that only 1 parent should accompany the child for restorative appointments to avoid the child misinterpreting the seriousness of the next visit. If both parents prefer to accompany the child, only 1 may be present in the operatory for treatment. Parents may begin a conversation or argue during the procedure, creating a distraction.

Toddlers and preschoolers see parents as having a protective power in a new or threatening environment. The child's temperament and emotional health will determine the ability to separate from the parent. The separation is facilitated if the parent understands that by age 5 and for most 4-year-olds, the ability to separate is a normal milestone in development.¹⁴ Parental trust enforces the child's trust and empowers the child. The unspoken message to the child is that the parent trusts the dentist, there is nothing to worry about, and that the child is capable.

^a CAESY Education Systems From Patterson, Vancouver, WA 98683; (800) 685-2599

Children seem to fare better if the separation occurs in the reception area rather than after being seated for treatment.

Parents may become the “court of appeals” with the child’s avoidance behavior. Explain that both the procedure and the child deserve our undivided attention and that the parent can unintentionally distract both the dentist and the child. Reassure the parent that the door to the operatory will remain open and that once the procedure has begun, he or she may periodically check on the child. If a parent is in the reception room and the child begins to cry loudly or uncontrollably, it is best to bring the parent into the operatory. A parent who hears his or her child screaming during treatment may not only become distraught but very angry.

If the parent refuses to separate, the dentist should review the rules: the parent is the silent partner. His or her presence is support for the child. Warn the parent not to parrot the dentist’s requests of the child, not to attempt to explain the procedure, and not to comment on the time remaining to complete the procedure. The dentist cannot talk to the child through the parent. The dentist cannot compete with the parent for the child’s attention; the child’s attention must consistently be directed back to the dentist. The dentist must be perceived as the authority figure. Prepare the parent for a predetermined cue that indicates it is time for him or her to leave should his or her presence interfere with the treatment objective.

Parents of children with high dental fear attributed the fear to factors beyond their control and felt powerless in helping their child to overcome the fear.

For the disruptive and noncompliant parent who refuses to leave, treatment should cease with a reminder of the previously discussed guidelines. If the parent persists, compromising the treatment, the dentist may say, “I am not able to provide quality care at this time; perhaps we should reschedule. If you prefer, I can help you to find another dentist who may better suit your needs.” This method has been quite effective in my practice in engaging the parent’s cooperation.

Posttreatment Consultation

Parents should comfort the child if necessary, but dentists should suggest not to dwell on the difficulties. If the child was emotionally upset during the appointment, tell the parent not to talk about the difficulties during the appointment because this may negatively influence future visits. Reassure the parent that most children eventually become very comfortable with treatment. Praise the parents for their good parenting when their children demonstrate good coping skills.

Conclusion

Each parent brings a new perspective of beliefs and behaviors depending on his or her cultural influences and personal history. Multiple issues will influence parental personality and expectations. Involving the parent through communication and engendering a cooperative spirit will assure reduced stress when treating our pediatric patients. Take the time to get to know the parents. By identifying their needs and appreciating their strengths, not only will the quality of the dental care be enhanced, but so will the quality of the emotional care for each child and his or her parent.

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