Lec.4

CLASSIFYING CHILDREN'S COOPERATIVE BEHAVIOR

Various systems have been developed for classifying children's behavior in the dental environment.

An understanding of these systems can be an asset to the dentist in several ways:

- ✓ Assisting in directing the behavior guidance approach
- ✓ Providing a means for the systematic recording of behaviors
- ✓ Assisting in evaluating the validity of current research.

Behavior patterns of a child can be classified in various ways:

I) According to age

• Pre-cooperative stage-less than 2 years

• Cooperative stage-above 2 years

<u>The pattern of child behavior at certain age with expected development:</u>

Children's behavior and cooperation evolve with developmental milestones. Understanding these stages allows dentists to predict responses and plan strategies accordingly.

Age Group	Behavioral Characteristics	Cooperative Stage
< 2 years	Limited communication, high dependence on caregiver, minimal understanding of instructions	Pre-cooperative stage
2 years	"Terrible twos" — increasing Independence, limited reasoning ability.	Pre-cooperative
3 years	Better communication; needs parental presence for security	Early cooperative
4 years	Response well to verbal guidance; curiosity increases	cooperative
5 years	If well-prepared by parents, shows minimal fear of new experiences	Fully cooperative
6 years	Anxiety may peak; proper introduction to dental treatment is crucial.	Cooperative with guidance
7+ years	Cognitive maturity increases; understanding of cause-effect	Mature cooperative

Recent study (APD, 2024) confirm that emotional regulation develops significantly after age 4, emphasizing importance of preparatory communication before dental procedures.

II) According to Clinical classification of behavior patterns

Wright's clinical classification places children in one of three categories:

- Cooperative
- Lacking cooperative ability
- Potentially cooperative

Not: when a child is being examined, his/her cooperative behavior is taken into account because it is a key to the rendering of treatment. Most children seen in the dental office are cooperative.

Cooperative children are:

1) Reasonably relaxed.
2) They have minimal apprehension and may even be enthusiastic (ENJOMENT).
3) They can be treated by a straightforward, behavior-shaping approach. When guidelines for behavior are established, these children perform within the framework provided.

Lacking in cooperative ability children are (In contrast to the cooperative children): This category includes

1. Very young children with whom communication cannot be established and of whom comprehension cannot be expected. Because of their age, they lack cooperative abilities.
2. Another group of children who lack cooperative ability is those with specific debilitating or disabling conditions. The severity of the child's condition prohibits cooperation in the usual manner.

Management:

Focus on desensitization, parental involvement, and modified behavioral or pharmacologic techniques. Immediate major changes should not be expected.

Potentially cooperative child is "behavior problem":

This type of behavior differs from that of children lacking cooperative ability because these children have the capability to perform cooperatively. They have the ability to cooperate but they choose not to (the most challenging pts.) and they are the most common pts you are going to meet. This is an important distinction.

When a child is characterized as potentially cooperative, clinical judgment is that the child's behavior can be modified; that is, the child can become cooperative.

They require skill use of behavior modification and trust-building strategies. This group is further divided into subtypes based on the nature of uncooperative behavior:

1. Uncontrolled behavior

This is typically presented by 3 to 4 years old children at their first dental visit or by older children at the time of injection

- Seen in 3-6 years.
- Tantrum may begin in the reception area or even before.
- This behavior is also called as 'incorrigible'.
- Tears, loud crying, physical lashing out and flailing of the hands and legs- all suggestive of a state of acute anxiety or fear.
- School aged children tend to model their behavior after that of adults.
- If it occurs in older children, there may probably be deep rooted reasons for it.

2. Defiant behavior (challenging one) (Also referred to as "stubborn" or "spoilt" harm in character)

When the child starts getting older, he will try to resist you, small children refuse to open their mouth by saying " I don't want to" but when they are a little bit older, they will sit and open their mouth but at the same time they will start pushing you by their hands.

- Can be found in all ages, more typical in the elementary school group.

• Distinguished by “I don’t want to” or “I don’t have to” or “I won’t”.
• They protest when they are brought to the dental clinic against their will, as they do at home.
• Once won over, these children frequently become highly cooperative.

3. Timid behavior

Often expressed by young children, particularly at the initial dental appointment. It is a result of child's anxiety about the dental and how he is expected to perform in the office. The child's anxiety may prevent him from listening attentively to the dentist, so instruction must be given slowly, quietly and repeatedly when necessary. Once the child gains confidence in the dentist he can become excellent patient. They are (Mostly female) they hide their faces by their hands or hide behind their mother and maybe at any time they deteriorate to uncontrolled.

• Milder but highly anxious.
• If they are managed incorrectly, their behavior can deteriorate to uncontrolled. May shield behind the parent.
• Fail to offer great physical resistance to the separation.
• May whimper, but do not cry hysterically.
• May be from an overprotective home environment or may live in an isolated area having little contact with strangers.
• Requires confidence-building and gentle desensitization.

4. Tense cooperative behavior

> 7 years, they try to help us but they are very anxious, we call them white knuckles, they hold something with their hand(s) in a constant position, a chair for example so their knuckles become white. They are extremely tensed, body language is different; tremor in voice; sweating palms, hands, they can be cooperative if behavior managed well. Benefit from reassurance, distraction, and relaxation techniques

• Border line behavior
• Accept treatment, but are extremely tense
• Tremor may be heard, when they speak
• Perspire noticeably

5. Whining behavior

(No pain, no tears) just "naaaaaa" Usually continuous, it's annoying.

- They do not prevent treatment, but whine throughout the procedure
- Cry is controlled, constant and not loud
- Seldom are there tears
- These reactions are at times frustrating and irritating to the dented team
- Great patience is required while treating such children

III) According to Frankl's Behavior Rating Scale

- **Rating 1:** Definitely negative. Refusal of treatment, forceful crying, fearfulness, or any other overt evidence of extreme negativism (Defiant behavior)

- **Rating 2:** Negative. Reluctance to accept treatment, uncooperativeness, some evidence of negative attitude but not pronounced (sullen, withdrawn) (Timid and whining behavior)

- **Rating 3:** Positive. Acceptance of treatment; cautious behavior at times; willingness to comply with the dentist, at times with reservation, but patient follows the dentist's directions cooperatively (Tense co-operative, Whining and timid)

- **Rating 4:** Definitely positive. Good rapport with the dentist, interest in the dental procedures, laughter and enjoyment.

- Wright (1975) added symbolic modifications to the Frankl's rating scale and made it more applicable and easier to understand child behavior:

  Rating no. 1 - definitely negative (- -)
  Rating no. 2 - negative (-)
  Rating no. 3 - positive (+)
  Rating no. 4 - definitely positive (++)

The functional Inquiry

Before the dentist treats a child, medical, dental, and social histories are essential. However, a functional inquiry, from a behavioral viewpoint, should also be conducted. During the inquiry, there is primary goals:

(l) to learn about a patient and parental concerns

(2) to gather information to enable a reliable estimate of the cooperative ability of the child.

Coupling the findings from the functional inquiry with the clinical experience, the dentist is in a much position to meet the patient's needs and to apply appropriate behavior guidance strategies treat individual pediatric patients than by simply proceeding inadequately informed.

STRATEGIES OF THE DENTAL TEAM

The primary goal is to guide the child toward a positive dental attitude through progressive exposure and positive experiences. Fortunately, most children progress easily and pleasantly through their dental visits, without undue pressure on themselves or the dental team. These successes can be attributed to several factors, such as a child's confident personality, a parent's proper preparation of the child for the appointment, or a dental team's excellent communicative skills. In contrast, some children's dental office experiences cause anxiety and the beginning of negative attitude. Sometimes these controllable but apprehensive children managed without medication, as long as appropriate non pharmacological psychological techniques are used.

Because behavior guidance techniques are used daily and come naturally to many persons, their importance sometimes is overlooked or taken for granted. This increases the potential for avoidable behavior problems. However, a full understanding and conscious implementation of strategies can lead to recognizable improvements in child management skills (which is a complex problem) that requires a team effort involving the parent, the dental staff and sometimes even the teacher.

Principles of behavior management technique is as following:

1.Anticipation: Explaining the child regarding the procedure and answering the question regarding dentistry and procedures. This can be done through Tell Show Do approach, Good communication etc.

2. Diversion: Diverting the child's attention away from fear producing situation may calm the child and allow the dentist to perform the treatment without disturbance i.e. Audio analgesia, etc.

3. Substitution: It involves substituting unwanted behavior by an accepted behavior. This can be done by contingency management, modeling etc.

4. Restriction: Restricting a child from exhibiting unwanted behavior. This can be achieved through physical restrains or pharmacological behavior management technique.

Behavior management can be achieved by basically two methods:

1. Nonpharmacological methods **2. Pharmacological methods**

Non-pharmacological Management Methods

Psychologists have developed many techniques for modifying patients' behaviors by using the principles of learning theory. These techniques are called behavior modification. Usually, they are thought about in conjunction with dentist-patient intra operatory relationships.

Various techniques are present:

1. Preappointment behavior modification

- Audiovisual aids, videos, virtual pre-visits, or sibling modeling
- Digital storytelling and interactive web modules are now standard (AAPD, 2024)

2. Behavior modification techniques: can be classified as follows:

A) Communicative management

Voice control
Non-verbal communication
Desensitization

Tell-Show-Do
Modelling
Contingency management (positive and negative reinforcement)
Distraction

B) Hand-Over-Mouth (HOM/Aversive conditioning) Rarely recommended today; use only with informed consent and ethical compliance

C) Patient immobilization Used only in exceptional cases; preference for protective stabilization under AAPD guidelines. Immobilization is done by dentist/staff/parents. Physical rest immobilization devices

1. Preappointment Behavior Modification

It is aimed at preparing the child for a dental visit so it refers to anything that is said or done to have a positive influence on the child's behavior before the child enters a dental operatory. If the first visit is pleasant, it paves the road for future successes.

The merit of this strategy is that it prepares the pediatric patient and eases the introduction to dentistry. It has received a great deal of attention because the first dental visit is crucial in the information of the child's attitude toward dentistry. If the first visit is pleasant, it paves the road for future successes. Various methods used for pre appointment behavior modification includes audiovisual aids, letters, films and videotapes. Children cure explained the importance of maintaining the teeth in health. Video clipping may include other children undergoing dental treatment so that the child will feel the similarity and reproduce the behavior exhibited by the model. Preappointment behavior modification can also be performed with live patient as models such as siblings, other children or parents.

Many dentists allow young children into the operatory with parents to preview the dental experience. Because the observing child likely will be initiated into dental care with a dental examination, a parent's recall visit offers an excellent modeling opportunity. On these occasions, many young children climb into the dental chair after their parents' appointments. These previews should be selected carefully. Young children are sometimes frightened by loud noises, like from high-speed handpiece.

The merits of modeling procedures, commonly Involving audiovisual or live models, are recognized by psychologists. Summarized them as follows:

(l) Stimulation of new behaviors,
(2) facilitation of behavior in a more appropriate manner,
(3) disinhibition of inappropriate behavior due to fear,
(4) extinction of fears.

These procedures offer the practicing dentist some interesting ways to modify children's behavior before their dental visit.

Another behavior modification method involves preappointment parental education via mailings, prerecorded messages, or customized web pages.

Mails can be sent se o the child that provides brief information regarding the procedure. It is called as preappointment mailing. Parents can also be given advice for preparing the child for their dental visit.

Precontact with the parent can provide directions for preparing the child for an initial dental visit, explain office procedures, and answer questions.

Setting expectations for the first visit can increase the likelihood of a successful appointment. parents understood the letter's contents, acknowledged the dentist's thoughtfulness, and welcomed the concern for the proper presentation to their children. Dentists using preappointment educational materials should be selective. Overpreparation could confuse a parent or p e unnecessary anxiety.

FUNDAMENTALS OF BEHAVIOR GUIDANCE

Behavior guidance is the means by which the dental health team effectively and efficiently performs treatment for a child and, at the same time, instills a positive dental attitude.

Effectively in this definition refers to the provision of high-quality dental care. Efficient treatment is a necessity in private practice today. Quadrant dentistry, or perhaps half-mouth dentistry, utilizing auxiliary personnel is vital in the delivery of efficient service to children. Finally, the development of a pediatric patient's positive attitude is an integral part of this definition. In the past, many practitioners have considered "getting the job done" to be behavior management. The current definition suggests a great deal more.

Although various methods in managing pediatric dental patients have evolved over the years, certain practices and concepts remain fundamental (principle) to

successful behavior guidance. These are basic to the establishment of good dental team—pediatric patient relationships. These practices Increase the chances for success in the provision of care for children.

The success of behavior management is based on the attitude and integrity of entire dental team.

Dental office and dental personnel must have the following quality:

1. The positive approach:

There is general agreement that the attitude or expectation of the dentist can affect the outcome of a dental appointment. Thus, positive statement increases the chances of success with children.

2. The team attitude:

Personality factors of the dental team play an important role in the success of behavior management. For example, warmth welcomes with interest that can be conveyed without a spoken word are critical when dealing with children. A pleasant smile tells a child that an adult care.

Children respond best to a natural and friendly attitude. Often this can be conveyed immediately to the pediatric patient through a casual greeting.

Children also can be made to feel comfortable in the dental office by the use of nicknames, which can be placed on a patient's record. Noting school accomplishments or extracurricular activities such as scouting, baseball, gymnastics, or other hobbies helps in initiating future conversations and demonstrates a friendly, caring attitude to a pediatric patient.

3. Organization:

Pediatric dental clinic must be well organized. Each dental staff must train for his specialized work. For example, if a child creates disturbance in the reception area who will manage with the problem? Each dental office must devise its own contingency plans, and the entire office staff must know in advance what is expected of them and what is to be done.

Also, a well-organized, written treatment plan must be available for the dental office team. Such plans are key features of many pediatric dental offices because they increase efficiency and contribute to successful dental staff–pediatric patient relationships. Delays and indecisiveness can build apprehension in young patients.

4. Truthfulness:

The truthfulness of dental team is extremely important in building trust; it is a fundamental rule for dealing with children. Unlike adults, most children see things as either "black" or "white." The shades between are difficult for them to discern. To youngsters, the dental health team is either truthful or not. Because truthfulness is extremely important in building trust, it is a fundamental principle in caring for children. Recognizing and acknowledging a patient's fear and anxiety can strengthen that trust. Empathizing with, rather than denying, such emotions helps provide assurance that the dentist appreciates the patient as an individual.

5. Tolerance:

It refers to the dentist ability to rationally cope with misbehaviors while maintaining composures (state of being calm and in control of yours feeling or behaviors).

Recognizing individual tolerance level is especially important when dealing with children. Different individual showed different tolerance level (Tolerance level varies from person to person). For example, an upsetting experience at home can affect the clinician mood in the dental office. High tolerance level prevents loss of self-control.

Some people are in a better frame of mind early in the morning, whereas the coping abilities of others improve as the day progresses. Thus afternoon people should instruct receptionists not to book children with behavior problems the first thing in the morning. Learning to recognize factors that overtax tolerance levels is another fundamental because it prevents loss of self-control.

6. Flexibility:

Because children lack maturity, the dental team has to be flexible and prepared to change its plans at the time of treatment as situations demand.

A child may begin fretting or squirming in the dental chair after half an hour, and the treatment intended for that day may have to be divided into multiple appointments.

On the other hand, a dentist may plan a step-wise indirect pulp treatment, but because the child is difficult, the indirect pulp procedure may have to be completed during a single session. Treatment of small children may demand a change in operating position. Thus, the dental team must be as flexible as the situation demands.