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Remembering and repeating childhood dental treatment experiences: parents, their children, and barriers to dental care

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Background. Despite improvements over the past two decades, caries and its treatment remain a problem for Scottish children.

Aim. To investigate how the reported childhood dental care experiences of a group of Scottish parents impacted upon the dental treatment they accessed for their children.

Study design. In-depth, semi-structured interviews were conducted with 19 parents of varied age and social background whose children were referred to Dundee Dental Hospital for the assessment of dental extractions. Parents were encouraged to discuss their own and their child's experiences of dental care. The interview data were systematically coded using key theme headings, and summary charts constructed to facilitate the analysis.

Results. A sense of 'uneasiness' pervaded the parents' comments and perceptions of the dental care provided for their children. This was conceptualized as parents 'remembering in words' and 'repeating through actions' their own childhood dental experiences. They remembered and repeated their childhood experiences by delaying dental treatment for themselves and their children.

Conclusions. Acknowledging the influence of parental dental experience would help ensure that parents of young children access routine care for their children and themselves.

Introduction

Despite improvements in Scotland over the past two decades, 42% of 5-year-olds have had experience of dental caries[1] and over one-quarter of all child admissions to hospital in 2007 were for the extraction of teeth under general anaesthesia[2]. Furthermore, figures from National Surveys suggest that most of the caries continues to occur in a small percentage of the population[1,3]. The most recent epidemiological findings in Scotland show that 11% of 5-year-old children have 50% of the decay experience – a figure little changed over the past 10 years[1,4].

Children are dependent on their parents for their general physical and emotional well-being. Parents function as role models for their children with regard to the adoption of every-day dental health behaviours[5] and absorb dental health attitudes, particularly from their mothers[6]. Furthermore, the dental health behaviours and experiences of parents, both recent and past, are thought to be fundamental in forming a positive environment for the adoption and maintenance of good dental health[7,8]. The relationship between parental and child oral health behaviours was illustrated by Smith and Freeman[9]. Interviewing Scottish parents, they noted that parents battled to maintain their children's oral health in a society in which sweets were used to award, treat, and pacify children.

Although the importance of models derived in childhood[10] and the role of parental attitudes regarding the importance of dental behaviours in general, and dental attendance behaviours in particular, are well known[11–13], what remains unknown is how parents' own childhood and adult dental experiences affect the accessing dental treatment for their children. For instance, do parents' memories of unpleasant childhood dental treatments or frightening dental encounters exert an influence on their own dental care and that of

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their own children? Are there any hidden, psycho-social factors that might inadvertently perpetuate barriers and hinder parents accessing dental care? For parents of children with dental caries who present with toothache and require dental general anaesthetic extractions or extensive restorative treatment, what is the influence of the parents' own childhood experiences?

Previous literature has shown that parents' own childhood dental treatment experiences have a considerable influence upon their children's dental attendance patterns[5–8]; however, this body of work did not examined how parental experiences impacted upon the parents' capacity to access dental care for their children. Using the psycho-analytic formulation that memories may be expressed through actions rather than in words – i.e., repeating the experience rather than remembering it in words[14] – may allow the suggestion to be made that the child with toothache is an echo of the parents' own childhood dental experiences. In this psycho-analytic formulation, childhood memories of dentistry would be expressed through the action of delaying dental treatment resulting in the need for emergency dental care, which would mirror their own childhood experiences. Consequently, using this psycho-analytic formulation, how parental childhood dental experiences exert an influence on their children's dental treatment experiences could be explained. It is of central importance to explore the influence of parental childhood dental care experiences to discover how this may impact upon their children who present at emergency dental services with toothache[15]. The aim of this qualitative exploration was to investigate how the reported childhood dental care experiences of this group of Scottish parents impacted upon the dental treatment they accessed for their children.

Methods

Sample

A purposive sample of parents attending Dundee Dental Hospital (DDH) with a child referred for dental extractions under general anaesthesia was gathered. This nonprobability sampling procedure was used as it allowed access to a population of parents who shared similar experiences with regard to their children having dental caries, toothache, and accessing emergency dental services. This permitted parents to describe their experiences of living with a child with tooth decay. PAS attended the Children's Clinic at DDH, discussed the study with parents attending for the assessment for DGA extraction and invited them to participate in the study.

All 37 parents approached initially agreed to participate. Yet, 18 parents when contacted for interview after an interval of at least 24 h, having read the information sheet, and prior to the request to complete the consent form, decided to withdraw. In line with ethical approval, it was not possible to ask why the parents had decided to withdraw from the study; however, the parents who did participate represented a group of mothers and fathers of different ages and social circumstances, which broadly reflected the demographic profile of the area (Table 1). Recruitment was halted after interviews with 19 parents as the data had become saturated and no new issues or themes were emerging.

Ethical approval was granted by Tayside Committee on Medical Research Ethics.

In-depth interviews: the procedure

The interviews were conducted in an informal atmosphere in the participants' homes at a time of their choosing. The parents were informed that PAS was not a dentist and that the content of the interviews would not be disclosed to dentists involved in their own or

Table 1. Participants' profile.

Female/male ratio	14 : 5
Age (in years)	
25–30	5
31–40	9
41–50	5
Social class*	
Lower managerial, professional, and intermediate occupations	6
Lower supervisory and technical occupations	2
Semi-routine and routine occupations	11

*National Statistics Socio-Economic Classification.

their children's care. At the start of the interviews, the parents were encouraged to describe their own dental care story as well as those of their children. For example, parents were asked about their memories of dental treatment in childhood and their own current dental care regimes. Prompts were used to help ensure that areas of interest raised by parents were reflected back and further explored in subsequent interviews. These included what constituted a typical visit with their child to the dentist or how dental health fitted into their family's life. Finally, parents were given the opportunity to raise any other issues of importance to them including, for example, how they thought their child's experience could have been made easier and how they viewed the future for their child's dental health.

Each of the audiotaped in-depth interviews lasted up to 60 minutes and was transcribed at a later date.

Data analysis

The transcribed interviews were analysed using the 'framework' method[16]. This is a process that involves a number of interconnected phases incorporating a systematic process of sifting, charting, and sorting material according to key issues and themes. Beginning with the first tranche of interviews, PAS listened to tapes and read transcripts in order to gain an overview of the material before starting to see recurring themes and ideas. Thematic charts (in spreadsheet form) were then constructed with column headings for each topic area and a row for each interviewee. The transcribed interviews were then systematically codified and relevant sections slotted into the charts with the original text referenced so that the source could be traced. These were added to as the interviews progressed and additional themes emerged. This systematic approach allowed easy reworking of initial ideas and kept the researchers closely linked to the original data ensuring that the analysis reflected the uniqueness and variety of the participants' views[17].

Once the data had been interrogated to identify initial categories, PAS and RF met to discuss the emerging themes. Where a difference in interpretation occurred, discussions took place to ensure that agreement was reached. In this way, inter-observational agreement was obtained ensuring that the data analysis was valid and reliable.

Results

Sample

All participants had a child (ages from 3 to 12 years) who had recently been referred to the Children's Clinic at DDH for the assessment of dental extractions. All of the children had suffered pain, some for several weeks. The final sample included mothers and fathers of various ages and social backgrounds (Table 1). Pseudonyms are used throughout to protect participants' anonymity.

Emerging themes

The emerging thematic structure in this qualitative exploration was theoretically underpinned by the work of Halliday[18]. In Halliday's view, thematic structure is associated with the information provided by the participant, which 'ensures ''comprehension'' … and interpretation' of their words by the listener. Thus, details within a transcript may be noticeable as they represent 'elements [*which may*] be regarded as empathetic [*and which*] are normally dissociated from one another'. Although, initially the elements within the thematic structure may appear contradictory, they do in fact represent the participants' spoken words (or recoverable information within the manifest content) as well as the latent content (or the non-recoverable information) of the information provided. Thus, the thematic structure highlighted in this qualitative exploration was emphasized by a sense of uneasiness that revealed two behavioural systems, i.e., remembering in words (the manifest content) and remembering in actions (the latent content).

The underlying theme of 'uneasiness' related to the quality and type of dental care provided by dentists. This perception of

uneasiness pervaded parental views of the dental care they received and that provided for their children. It seemed that the parents' own childhood memories of dental health, dentists, and dental care were recalled in both word and action. It became possible to conceptualize parents' delay in taking their children for dental treatment as a manifest indicator of a situation they had experienced before and were repeating again with their own children. It was as if the past and present had merged with the child and parent living and re-living disagreeable dental treatments respectively. Thus underlying the parental uneasiness were two distinct yet interconnected behavioural systems of 'remembering' (manifest content) and 'repeating' (latent content) their childhood dental experiences. The two behavioural systems were as follows:

1 Remembering in words.
2 Repeating through actions[14].

Remembering in words. Memories of childhood and dentistry were cloaked with feelings of unease and anxiety. Parental recollections of their own childhood encounters with dentistry were described as 'fraught'. Dentists were remembered as 'rough' and without a 'child friendly manner'. Margaret's recollections are illustrative:

I wasn't that great at the dentist. I was banned from the dentist … 'cos I wouldn't open my mouth but I think he was a bit … maybe a bit rough. He didn't have the child friendly manner that they have nowadays.

Parents recalled frightening and anxious experiences. These memories included the odour of 'the gas' that were said to be re-awakened simply by walking into a dental surgery and experiencing the dentist 'smells'. Parents spoke of fighting against the mask and finally having to surrender control to the dentist and the general anaesthetic:

... all I remember is a big face mask and having to put two things to bite on in my mouth and fighting like hell, not wanting to go under and having bad dreams so I don't know if it's any worse for my son. I talked to a guy at work and he says he still remembers that dream and I thought yeah, I still remember a strange dream as well. (Michael)

Despite the fact that the parents had experienced 'the gas' many years before in their childhood, images of the dental general anaesthetic were vivid, intense, and described with great fear and anxiety :

Dreadful, dreadful! I remember going through to get them taken out and the dentist was like that, he says, 'Right I've got some gas to put you to sleep or we'll use this – you know the big hammer!' … I remember waking up and my mouth all bleeding. (Alasdair)

These frightening childhood experiences had a pernicious 'repeating' effect in contributing to an avoidance of dental care, which persisted into adulthood. Most of the parents spoke of an aversion and had steered clear of dentists during their adolescence and adulthood. They only accessed dental care when the intensity of their toothache made treatment unavoidable. The opportunity to prevent dental disease had been missed with the result that initial adult encounters with dental services were occasions where invasive treatment was required, reinforcing the parents' fears of dental treatment.

I wish I didn't have a fear of the dentist … I would go on a regular basis and then my teeth would be good. But if you've got a fear of the dentist you don't go until your teeth are bad so it takes longer to get them fixed and the fact that you know it's going to be longer to get them fixed puts you off going until the point where all they can do is take them out. So I just wish that … I didn't have a fear of the dentist …. (Isobel)

Some parents perceived their adult encounters with dental care as reminiscent of their childhood experiences. They acknowledged that in childhood they had been 'terrifying' whereas in adulthood they perceived the treatment they received as 'unsatisfactory'.

Attending for dental treatment resulted in feelings of being insignificant with insufficient attention being paid to their need for pain control or the discomfort they experienced. Some parents spoke of being on the receiving end of what they perceived as the dentist's rushed treatment. Thus, comments about adequate pain relief or the perception of being treated 'roughly' or 'harshly' had a flavour of their dental general anaesthetic experiences of childhood:

… sometimes [they] don't give you enough anaesthetic. Sometimes some dentists are like sort of, och you know a bit rough. (Sharon)

… some dentists if they don't know you they could be sort of like harsh with you and that wi' the needles … I'm terrified of needles. (Aileen)

Other parents described how they felt that dentists used a patronizing, judgmental manner that stirred-up feelings of being 'put down' and feeling like a small child once more. As Barbara commented:

I don't really feel that comfortable and think they're sort of putting you down. I know it's your teeth and [you] get into bad habits and that; but that's what scares me, going to the dentist.

This was reiterated by Fiona who described bitterly a recent encounter with dental services. Fiona felt that her dentist treated her as if she was just a nuisance '... with him it's like up in the chair, get out and get the next ain [one] in'. Her dental anxiety was of no consequence and he was unsympathetic to her considerable fear of dental pain:

And when I put it to him it was like, 'Well, I've gave you enough freeze so if it's no' enough for you …' – in other words – 'It's tough'. And I'm scared of the dentist and I was moving and that in the chair and it was like, 'Will you stay at peace [still]? Think what other patients out there need to be seen'. And I says to him, 'I'm no' coming back'. Then he got in touch with, ken, the NHS Dental thing and he's got me struck off for two year[s] … I mean if he hadn't hurt me I would have went back to … but there's no way after what he done to me I would put my boys there.

Fiona's current experience reinforced previous unpleasant experiences as a child and left her with considerable fears and uneasiness concerning dental treatment not only for herself but also for her children. It may be suggested that Fiona's reactions to her current dental experience was an expression of her reliving her childhood encounters and illustrates the interconnectedness of remembering in words and repeating through actions. In Fiona's case, the action was avoiding dental treatment for herself and her children.

Repeating through actions. The child with toothache reawakened parental associations of childhood dental treatment with unpleasant and frightening general anaesthetic experiences. For some parents like Janet this thought was uppermost as she took her son for his dental extraction appointment:

For a little boy, it's back to the dentist, you know and it's like, 'Oh,-my God, it's the man with the mask and the big chair'!

Fears were voiced that dentists demonstrated little empathy with their children's situation with parents voicing their suspicions that their children's oral health problems were not being treated with enough urgency or understanding. Some parents like Bill felt that dentists 'never take you serious[ly]'. As he commented when describing his daughter's toothache:

she did wake up a few times crying. … I was disappointed actually by that stage because I was thinking right, at what point he's going to start dealing with them, taking them out or whatever … I think they don't take complaints seriously … I can't be nasty and stuff because I don't want struck off, I don't want to be kept away from the dentist you know what I mean … because the dentist can open your mouth and haul your teeth out.

The association of the dental visit with dental *treatment* rather than *preventive check-up* to maintain oral health was a common approach adopted by the parents. A visit to the dentist was thus only necessary – 'If they get sair [sore]' or if there was a 'toothache' problem to be fixed:

'obviously dentists, they're there to fix your mouth and everyone is there for the same reason … toothache. (Janet)

This equating of a dental visit with 'treatment' rather than a 'check-up' contributed to the parents' dental anxiety and heightened their dislike of dental care. The fear of the unknown or uncertainty about what dental treatment might entail for either themselves or their children exacerbated anxiety:

You don't know what sort of treatment you and your child are going to get when you go to the dentist. (Sharon)

There was little doubt that parents' dental anxiety affected the readiness with which they were able to access dental care for themselves and their children. Isobel's wish, for instance, to be a regular attender was an unattainable goal. In the face of her high dental anxiety, she delayed treatment until she had no option but to attend – 'puts you off going … until all they can do is take them out'. Alasdair similarly described how he waited for toothache before he, himself, would visit his dentist.

No, I've no' been to the dentist for God knows how long. I mean it's terrible. I know I should go but then you think, well they're not sore or anything, they look OK.

Alasdair repeated the same action with his young son – he delayed and waited until the boy's complaints of toothache were so persistent that a dental visit could be postponed no longer and treatment became inevitable.

But you know it's an ongoing thing that sometimes he'd go through a phase of you know really complaining about sore teeth – but then he could go quite a while with not having any problems at all.

This procrastination had unhappy outcomes for the children. Many of them had suffered pain and had sleepless nights with extensive use of painkillers and antibiotics as a result of their dental problems. The parents were upset, fraught, and felt guilty about allowing these problems to develop. One way of rationalizing this state of affairs was to adopt a fatalistic approach that seemed to bind their memories of their own poor dental health to that of their own children's experience through the concept of genetic predisposition. Teeth were described as 'soft' and 'weak' and oral health problems were related to 'genetic' factors beyond their control.

I've the two girls and I've had bother with my teeth and my mum's had bother with her teeth. I asked the dentist yesterday if there was a genetic thing …. (Isobel)

With parents' concerns of how their children would be dealt with in the dental surgery, fears of treatment being rushed as Janet put it – '… the problem is she only gives ten to fifteen minutes and she doesn't like doing children' – and using the same actions to delay access dental care for themselves and their children it seems reasonable to propose that the parents repeated through action their own frightening dental treatment experiences of childhood. Despite all their worries and concerns, the parents welcomed the kindness and sympathetic approach afforded to them by the dental hospital staff – as one mother stated:

The dentist at the dental hospital was really nice.

Discussion

This qualitative study investigated how the childhood dental treatment experiences of a group of parents impacted upon the dental treatment they accessed for their children who had dental decay and toothache. Using

semi-structured interviews, parents' perspectives of their own childhood and adult dental treatment experiences as well as those of their children were investigated.

It was apparent that the parents stalled and felt inhibited when accessing dental care for themselves and their children. Moreover, they described this as an 'uneasiness' that was coloured by fear of the unknown and concerns about how they and their children would be treated. The words and expressions used to describe their uneasiness about dental treatment for their children suggested that the parents had experienced this situation before and were thus remembering it by repeating it with their own children. Thus, parental uneasiness was conceptualized and informed by the psychoanalytic formulation of 'remembering in words' and 'repeating in action'[14] their own childhood dental experiences.

What qualitative evidence is there to support this theoretical position? Parents spoke of frightening dental treatment, of surrendering control to the general anaesthetic 'mask and gas', which recurred as nightmare for some parents. Since reaching adulthood, most of the parents avoided dental treatment. Their dental anxiety was re-enforced by the feeling that dentists were not sufficiently attentive to pain relief and did not take their dental fears about pain and discomfort seriously. This resulted in avoidance of dental visits despite some parents knowing they urgently needed treatment. In their interactions with dentists, they reminisced of childhood experiences and feelings of worthlessness. It may be suggested that the parents' impression of being 'told off' and the shame that ensued, as discussed by Gregory *et al.*[19], induced a sense of low self-esteem and contributed to avoidance of dental care with the subsequent knock-on effects for their children.

Therefore, the parents remembered in words, in their dreams, and repeated in their actions by avoiding dental care until in pain. In this theoretical scenario, the parents recalled in words their unpleasant, traumatic, and painful childhood dental care experiences as well as repeating or reliving the original trauma as in their perceptions of unsatisfactory dental care in adult life[20,21].

The action of delaying dental attendance until a problem manifested was deeply ingrained in this group of parents, which suggested that something in addition was being repeated with their children. Although the connections between childhood experience, dental anxiety, and dental attendance decisions were clearly linked, the question remained – how did these experiences affect the type of dental care accessed for their children? It is proposed that the parents' childhood experiences were repeated through the action of delaying dental treatment for their children. In this psycho-analytic formulation, the parents' past collided with their children's current toothache experiences. For parents like Fiona, who accessed emergency dental treatment for their children, their own childhood frightening experiences were remembered not in words but through actions and those actions were their avoidance of dental treatment for themselves and their children. It may be suggested that Fiona repeated her own avoidance behaviours with her children by refusing to take them to the dental practice. Being 'struck-off the list' meant she was unable to access care elsewhere resulting in her children attending for emergency treatment. It seemed that Fiona relived her frightening childhood dental treatment experiences through the action of taking them for dental treatment only when in pain.

Moreover, Alasdair's postponing dental treatment for his son in the same way he did for himself was also suggestive of repeating through actions rather than in words. The parents appeared to be repeating through action their childhood treatment experiences with their own children. This was illustrated by the avoidance of regular care that contributed to their children experiencing the very type of frightening encounter that they, the parents, had experienced in their own childhood. Parents repeated through action their own childhood dental treatment experiences as they and their children attended for emergency dental services in pain.

The children's need for extractions or long-term restorative treatment was shocking to the parents. As well as regret at their child's predicament, it triggered unpleasant

memories of their own. Drawing on their own experience of poor oral health as children and poor experiences with adult dental care, it may have seemed impossible to prevent tooth decay in their children[22]. The parents' fatalistic attitude to oral health and the requirement for dental extractions echoed their own experiences as children and appeared to have contributed to a reactive, illness-prevention focus[6]. In other words, the parents repeated through actions their own dental health experiences with their children. This conjecture is supported in the qualitative data as the parents were reluctant to subject their children to what they saw as unpleasantness of dental treatment. Yet, the unintended consequence of this reactive approach was that their children only attending sporadically and often when the situation was irredeemable and needing the very thing that they were trying to avoid – the extraction of teeth.

Although a sample of parents who regularly access dental care for their children could have been used for the purposes of comparison and to provide alternative and disconfirming evidence, this was not the aim of this qualitative exploration. This work was designed to explore in detail how the childhood dental experiences of this group of parents impacted upon their accessing dental care for their children. Although it does not allow us to comment on the distribution of these experiences, it nonetheless provides important insights into the difficulties parents experience when maintaining their children's oral health. Furthermore, it allows an alternative and supporting explanation to be proposed – that the parents did not perceive themselves or their children as candidates for routine dental care. Jackson *et al.*'s[23] qualitative study of women's attendance at antenatal clinic showed that the mothers found accessing the clinic as anxiety-provoking and 'distressing'. Moreover, in this study, the parents' did not wish their own fears to be communicated to their children[24] and this may have contributed to their view that they were not candidates for dentistry. Therefore, using Jackson *et al.*'s formulation an alternative view may be proposed – that the parents' dental anxiety and their childhood experiences contributed to their opinion that their children and themselves were not candidates for routine dental care.

As has been suggested elsewhere[5], attention to parents of children with a poor caries record is needed if family attitudes are to be changed. Most parents, in this qualitative exploration, discussed improving their children's dental prospects in future by being a good example to them and trying to better their own dental health and dental attendance. For this to be successful, it seems that much encouragement from their dentists will be required if the remembering and repeating of parents' own childhood experiences is to be overcome enabling them to promote positive feelings about dental care to their own children.

Looking to the future, the parents found their children's treatment at the dental hospital to be sympathetic and encouraging, and so it may be suggested that those working in the emergency dental care arena may be able to assist parents overcome their dental 'uneasiness' and enable them to access routine care for themselves and their children[25–27].

What this paper adds

- This study explores how Scottish parents' reported childhood dental care experiences influence the access of dental treatment for their children.
- Parents remembered in words and repeated through actions their own frightening childhood experiences of dental care.
- A consequence of their actions is that they may be hindered in seeking dental treatment for their children.

Why this paper is important to paediatric dentists

- Paediatric dentists should acknowledge parents' own childhood dental treatment experiences as an influence in their children's dental attendance patterns. Doing so may help parents to break the cycle of repeating through action their own frightening childhood dental experiences and help them access dental treatment for their children.

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