



# Behavior Management Conference

## Panel I Report—Rationale for Behavior Management Techniques in Pediatric Dentistry

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### Abstract

Panel I comprised of pediatric dentists, an attorney, child psychologists, parents, a specialist in early childhood education, and a pediatrician. The purpose of this panel was to discuss: (1) 8 questions that dealt with the appropriateness and effectiveness of current behavior management techniques; (2) the scientific support for those techniques; and (3) the role of the pediatric dentist in managing the difficult child. Issues of cultural diversity, access to care, and parental attitudes toward behavior management were also explored. Nonpediatric dentist members of the panel offered insights into how other health care professionals view the behavior management techniques used by pediatric dentists. The panel sought input from the conference attendees as part of its deliberations. The major recommendations of the panel included: (1) re-evaluate the definitions of child behavior in the dental setting, including definitions of appropriate behavior; (2) develop training in effective communication with parents for pediatric dentists and their staffs; (3) seek further information on the impact that changing parental attitudes towards behavior management techniques may have on the quality and accessibility of treatment; and (4) conduct research in specific areas of behavior management, particularly in communicative techniques. (*Pediatr Dent.* 2004;26:167-170)

**KEYWORDS:** BEHAVIOR MANAGEMENT, PEDIATRIC DENTISTRY

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The American Academy of Pediatric Dentistry (AAPD) assembled a panel consisting of pediatric dentists, an attorney, child psychologists, parents, a specialist in early childhood education, and a pediatrician. The purpose of this panel was to discuss:

1. Eight questions that dealt with the appropriateness and effectiveness of current behavior management techniques;
2. scientific support for those techniques; and
3. role of the pediatric dentist in managing the difficult child.

Also reviewed were issues of cultural diversity, access to care, and parental attitudes toward behavior management.

The following is a summary of the questions, deliberations, and discussions, including audience comments. (Note: The use of the term “parent” in this report refers to the child’s primary caregiver: The individual inside or outside the family who has accepted primary responsibility for the child’s well being and who has the legal authority to do so. For consistency in this report, the parent or child is referred to with feminine pronouns).

**Question 1:** How (and how well) do behavior management techniques meet the goals of the AAPD Clinical Guideline on Behavior Management; and other quality assurance criteria, to “ease fear and anxiety?” How do techniques promote an understanding of the need for good dental health and the primary objectives:

1. “to effectively and efficiently perform necessary dental treatment; and
2. to instill in the child a positive dental attitude?”

The panel reflected on a comment made by one of the previous day’s speakers that “behavior management begins with the parent’s initial call to the office.” The old adage that “you only have one chance to make a good impression” applies here. This approach suggests that offices and clinics strive to employ “first contact” staff who are adept at putting children and parents at ease. It was also considered important to have that person accompany the patient throughout the dental visit to provide consistency. One of the attendees suggested that “experience management” be used as a term that includes more than just behavior management.

Another attendee was concerned that no consensus exists on how to measure behavior management success. Furthermore, our measures of success may not coincide with those used by the patient or parent.

It was also noted that not every dental appointment can be a positive experience for every child, and that the pediatric dentist may not be able to instill a positive attitude in every patient. The goal is sometimes unobtainable when the child is in pain. It may also be difficult for the pediatric dentist to determine whether or not some children are affected positively.

The panel agreed that communicative techniques, particularly tell–show–do, are the tools most likely to enable the pediatric dentist to lead the child to a positive dental attitude. However, it was also agreed that the pediatric dentist needs all of the management techniques currently available and possibly available in the future.

Anything that can be done to improve communication with parents will likely lead to better dental experiences for the parent and child. This communication may be accomplished via a preappointment letter or through the practice's Web site. A more informed parent will likely be more relaxed and, therefore, may influence her child in a more positive way. Communication should establish the circumstances for and limitations of parental involvement in the care setting. Parents and patients should be treated with respect. The pediatric dentist should attempt to determine the parent's expectations for the dental visit and, where necessary, help establish realistic expectations. Such adjustments in parental expectations may prevent potential conflicts. To some extent, parents should also be involved in making decisions regarding the treatment options for their children. Their role in decision making will vary among parents, pediatric dentists, and clinical situations. Some parents are information seekers, others are not.

Much of the panel discussion centered on communication. The point was made that there is little or no formal training in our residency programs on communication *per se*. Panelists also agreed that the “art” in the “art and science” of behavior management is at least as important as the techniques themselves. For example, proper use of an aversive technique (ie, voice control) in a generally positive setting can be part of a positive experience for the child. One of the attendees suggested that no pediatric dentist uses a “pure” technique. Instead, most dentists develop a behavior management approach that amalgamates multiple techniques.

**Question 2:** What is or should be the role or responsibility of pediatric dentists in managing “difficult” children?

First, the panel discussed the definition of a “difficult” child. The consensus was that the term “difficult” generally refers to a “noncompliant” child. Further, noncompliance may be based on: (1) behavioral issues (eg, ADD, psychological disorders); or (2) anxiety and fear. It should be assumed that most child dental patients are “normal” in terms of the extent and types of their anxieties. The panel agreed that the pediatric dentist's responsibility for managing noncompliant

children lies primarily with the second group. However, it was noted that pediatric dentists accept responsibility for managing a child's behavior when they accept the patient for care, unless the limits of responsibility are delineated with the parent.

Parents involved with the care of the children may also take responsibility for managing the difficult child. However, changes in parenting styles have increasingly placed the behavior management burden on the pediatric dentist. The panel agreed that attitudes toward oral health and oral health care providers vary widely among parents. Further, the suggestion was made that pediatric dentists should learn and develop techniques for managing parents, as communication with parents is critical for acceptance of a behavior management technique.

The definition of a “difficult” child may also include children whose parents often have difficult interactions with the pediatric dentist. Examples include parents who place little importance on their child's oral health or those who refuse necessary care.

Panelists pointed out that labeling a child as “difficult” may have implications for diagnosis, treatment codes (eg, reimbursement for behavior management), and payment. Determination of a child's temperament may be a better way to describe the “difficult” child. Pediatric dentists should also be aware of their own temperaments, strengths, and weaknesses in dealing with certain types of children and situations. This difference in pediatric dentists' temperaments may be a reason why one pediatric dentist may have difficulty managing a child while another is able to do so relatively easily. In any event, pediatric dentists should adopt some flexibility in their approach to difficult children and adjust their management techniques to meet the requirements of the child, rather than adopting a rigid approach to every patient. One of the panelists suggested that “difficult” children and their parents hear negative messages from multiple sources every day. This pediatric dentist panelist attempted to determine some positive attributes of the patient and comments on these factors. She found such comments helpful to the parent and child.

The development of a risk assessment tool for behavior management was suggested by one of the attendees. Such an instrument might include information on the temperament of the child and her family members. Another attendee noted that it would be helpful to have guidance on identifying parents with deficient parenting skills.

**Question 3:** How should the “appropriateness” of a behavior management technique be determined?

The appropriateness of a particular behavior management technique may be defined by several communities of interest, including patients, parents, other dental and medical professionals, educators, and legal professionals. Appropriateness of a technique is generally defined by its:

1. effectiveness; and
2. social validity (public perception and parental acceptance).

Appropriateness may also be defined in terms of facilitating care that might otherwise have to be accomplished in a more expensive or risky way. Appropriateness may be related to the complexity of a patient's medical history and/or treatment needs or the provision of emergency care. The social validity of any technique is increased when it is used to treat a child with kindness, dignity, honesty, and safety by an empathetic, caring professional. An attendee suggested that the appropriate management techniques for an individual child should be primarily based on the characteristics of the child, not the pediatric dentist.

The panel commented on the appropriateness of the behavior management techniques defined in the AAPD Reference Manual. Audience input was also solicited. There was little discussion or controversy regarding the appropriateness of tell-show-do, nonverbal communication, positive reinforcement, distraction, and voice control. The point was made, however, that pediatric dentists should be concerned about any of these techniques if they are not used in a caring, supportive way.

Most of the discussion centered on the hand-over-mouth exercise (HOME). There are a variety of ways in which the technique is used, but hand-over-mouth with airway restriction was viewed as inappropriate. Concern was expressed about HOME use in times of intense media coverage of child abuse and molestation, though clearly the technique is intended to facilitate treatment without causing harm to the child. Nondental panel members, however, admitted to having concerns about the technique's appropriateness when they first read its description. Their concerns, however, were tempered once they gained a better understanding of the technique's purpose and application. The audience comments on HOME were clearly polarized, ranging from "don't throw out a tried and true technique," to "times have changed and the technique is no longer appropriate." It was noted that the technique may soon be extinct. The surveys of residency programs and practitioners indicated that it is being taught as an unacceptable technique by a substantial number of programs, and it is being used by fewer practitioners than in years past.

The panel and conference participants also commented on active and passive immobilization. The term "protective stabilization" is used by some practitioners to better define the purpose of immobilization. It was noted that the technology of passive immobilization has improved and the passive form may be safer than active immobilization (restraint by another person). Throughout the entire discussion, it was stated repeatedly that safety is one of the goals of behavior management. In that regard, it was felt that protective stabilization is a critical aspect of care for some children.

Parental presence in the treatment setting also received consideration. It was generally agreed that not every parent should be invited to accompany her child to the operatory. It was also noted that a parent may be helpful when present with one child, but not helpful with another.

In summary, it is important to partner with parents in the care of their children.

**Question 4:** Is the quality/accessibility of treatment compromised due to changing attitudes toward behavior management techniques?

The panelists were not sure if changing attitudes toward behavior management techniques would affect access to care for many children. The variety of behavior management philosophies used among pediatric dentists usually ensures that a parent can find a practitioner with whom she is comfortable. In areas where pediatric dentists and general dentists who treat children are in short supply, there may be few choices for the parent. This question received only a brief discussion, and was otherwise not fully explored.

**Question 5:** How does the increased cultural diversity of patients entering our practices affect our behavior management techniques?

The increased cultural diversity of our patient population prompted discussion on language differences and communication barriers. Offices may find it necessary to have bilingual staff or access to interpreters for communication, including behavior management communication. The use of visual aids is also helpful. Children from other cultural backgrounds may be accustomed to modes of behavior management (or the lack thereof) that differ from techniques that pediatric dentists normally use. These differences may affect the pediatric dentist's willingness to use certain techniques, or perhaps the willingness to see patients of diverse cultural backgrounds. Among some cultures, there may be less trust of health care professionals than assumed, which may be a reason that pediatric dentists often do not see these children until they have advanced dental disease.

**Question 6:** How do behavior management problems affect access to oral health care for needy children?

Much of this discussion centered on workforce issues. When practices are full, pediatric dentists may have little desire to change their behavior management techniques simply to increase access to care. In a busy practice that accepts government insurance payments (and therefore reduced reimbursements), the staff has little time to spend with parents on behavior management education. Access to care for needy children is not limited so much by behavior management techniques as inadequate reimbursements. If the child's dental plan does not cover sedation or general anesthesia, then pediatric dentists are limited to treating them with communicative and other nonpharmacological techniques.

**Question 7A:** How do pediatricians and other health professionals view the behavior management techniques used in pediatric dentistry?

**Question 7B:** How does pediatric dentistry's approach to health care delivery/behavior management compare to that of the medical community (and other child care professions)?

The pediatrician panelist indicated that, prior to the conference, she was unaware of what pediatric dentists do on a daily basis. Hence, it is likely that pediatricians and other health care professionals are less aware than assumed about

what pediatric dentists do in their day-to-day delivery of care. Thus, they may not understand the importance of behavior management in the dental setting. However, their perceptions create a “reality” for them that is not consistent with the way pediatric dentists practice. The panel suggested that the AAPD explore opportunities for joint conferences with pediatricians, child psychologists, Bright Futures, child life specialists, the early childhood community, and others dealing with communication and child behavior.

**Question 8:** What is the state of scientific support for the current AAPD Clinical Guideline on Behavior Management?

The panel agreed that pediatric dentists have a wealth of good data on pharmacologic approaches (sedation, general anesthesia) to behavior management. While further data on these approaches will be welcome, it was noted that fewer data are available on communicative techniques and the quality of these data is not as high as the data on pharmacologic techniques. The panel cited a need for studies comparing pharmacologic and nonpharmacologic techniques.

### Recommended actions

With input from conference participants, the panel made the following recommendations:

1. re-evaluate the definition of behavior in the dental office, including appropriate and inappropriate behaviors;
2. develop videos of behavior management techniques that could be used in practices to educate parents on management techniques employed for a variety of situations. Behaviors that led to the technique’s usage should be included in the video;

3. develop training for pediatric dentists, dental auxiliaries, and other office staff to enable them to become more effective communicators with parents and other family members;
4. consult with psychologists to determine the availability of behavior scales, questionnaires, or other instruments that distinguish between anxiety related behaviors and those related to other factors;
5. seek further discussion and information on the impact that changing attitudes towards behavior management techniques may have on the quality and accessibility of treatment (Question 4).
6. research the following areas:
  - a. characteristics of well-behaved children;
  - b. effectiveness and long-term consequences of HOME, immobilization, and other advanced techniques;
  - c. effectiveness of pharmacologic vs nonpharmacologic techniques, including their social validity;
  - d. evaluation of perceptions of our behavior management techniques by other health care providers;
  - e. responses to various behavior management techniques of children who have suffered previous nonaccidental orofacial trauma;
  - f. stress on pediatric dentists from dealing with difficult children; and
7. establishment of a research network similar to the American Academy of Pediatric’s Pediatric Research in Outpatient Settings (PROS).

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### Panel I Members

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