Letter to the Editor

More than ever, today we should "dance with the child," not "dance the child"

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Child behavior management in pediatric dentistry has changed through the years from an authoritarian approach in which aversive conditioning including "hand over mouth" was acceptable, to an empathic approach in which the child is allowed some supervised control of the treatment. This is a practice that years ago was considered undesirable by many. These changes can be summarized as going from "dance the child" to "dance with the child." On the other hand, some may be using sedation or general anesthesia for children who years ago could be successfully managed with behavior management techniques that today are no longer considered adequate.

These changes are not the result of unsuccessful pediatric dental practices. Previously and today most of our patients had or have no problem tolerating our treatment and are happy to visit our clinics. The change is an evolutionary adaptation process elicited by societal changes. We must continue to be aware of societal changes. Among others, we witness reports that indicate an alarming increase in the prevalence of atypical behavior patterns such as ADHD and autism, which may overlap. Even if the published numbers are exaggerated, it is a fact that we face an increasing likelihood of having children with ADHD and/or autism in our clinics.

These children may be "knocked out" with sedation or general anesthesia for dental treatment purposes. However, a more behavioral approach should also be considered, an approach based on understanding the mental perspective and needs of children with atypical behavior. Out of many helpful resources in the literature, we may educate ourselves by reading "Ten Things Every Child with Autism Wishes You Knew."[1] Examples include: "my sensory perceptions are disordered"; "I interpret language literally"; "focus and build on what I can do rather what I can't do"; and "distinguish between won't and can't." We should also be aware of techniques such as the "D-Termined Program of repetitive tasking and familiarization in Dentistry" which is designed for children with autism.[2]

Obviously there is no "best approach" to every child with typical or atypical behavior. By "dancing with the child" we increase the possibilities of finding the tune that best fits each child and the dental team. We should not just "tell, show and do", we should "tell, show, do, listen (carefully), and react accordingly.

References:

1. Notbohm E. Ten things every child with autism wishes you knew. Texas: Future Horizons; 2005.
2. Tesini D. D-Termined Program of repetitive tasking and familiarization in dentistry. New Hampshire; Specialized Care Co. DVD; 2007.

Erratum

In the abstract of **Faytrouny M, Okte Z, Kucukyavuz Z. Comparison of two different dosages of hydroxyzine for sedation in the paediatric dental patient. Int J Paediatr Dent 2007;17:378-82,** which appeared on page 381 of the September/October 2007 issue of Pediatric Dentistry: The dose for hydroxyzine (Atarax) for patients in Group 1 was stated as "20 mg/kg." This is, in fact, the dose specified by the authors in the "Materials and methods" section of the original publication. However, the dose given elsewhere in that manuscript is "20 mg of hydroxyzine," which is the correct dose.