Classifying Children's Cooperative Behavior

Numerous 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, and 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

The pattern of child behavior at certain age with expected development:

2-year-old children: Dentists sometimes refer to such children as being in the pre cooperative stage and often referred to as being in the stage of the "terrible twos."
3- year-old children: Children communicate more easily than 2 years old, but they need their parents to remain with them in clinic to feel more security.
4- year-old children: The child usually listens and has a response with interest to dentist explanation and verbal direction.
5- year-old children: If the child properly prepared by the parents, he will have no fear of new experience.
6- year-old children: The child need proper introduction about dental treatment in order to respond in a satisfactory manner because the tensional manifestation rise to peak at this age.

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

Note: 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.
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.

At times, special behavior guidance techniques are used for these children. Although their treatment can be carried out, immediate major positive behavioral changes cannot 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.

The adverse reactions have been given specific labels for descriptions of potentially cooperative patients.

Potentially Cooperative Group Are Further Categorized As Follows:

1. Uncontrolled behavior

- ✓ 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")

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

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.
- ✓ Needs to gain self-confidence of the child.

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.

- ✓ 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 (++)

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.

Pre appointment 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.

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. Pre appointment 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, as from a highspeed handpiece. The merits of modeling procedures, commonly involving audiovisual or live models, are recognized by psychologists.

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 cares.

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 written plan has to 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.

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.

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).

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.

Communicating With Children

Communicative management is used universally in pediatric dentistry with both the cooperative and uncooperative child.

There are two ways of establishing communication:

1. Verbal - Spoken language to gain confidence.
2. Nonverbal - Expression without words like welcome hand shake, patting, eye contact.

Objectives of communication

a. Establishment of communication:

Communication helps the dentist to learn about the child and makes the child at ease and relaxed. There are many ways of initiating verbal communication, and the effectiveness of these approaches differs with the age of the child. Generally, verbal communication with younger children is best initiated with complimentary comments, followed by questions that elicit an answer other than "yes" or "no."

b. Establishment of the communicator:

Communicator may be any person in the clinic who can provide information. The receptionist who welcomes the child and the parent with the smile provides initial communication. This initial communication is very important in building confidence and projecting the attitude of the clinic staff to the patient.

c. Message clarity:

Message content varies from a hearty good morning to relevant information and thank you. Message should be simple and easy to understand by a young child. Euphemisms can be used. While talking to a child it is important to remember certain points. They are

- The child may not respond to a question immediately. It takes more time for the question to 'sink in' than for adults
- The command that are given should be simple and within the ability of the patient to obey
- All commands should be given in a positive language since the negative approach may tend to stimulate fear. Example — "Do not move" is avoided and replaced by "I can't fix your teeth until you sit still"

To improve the clarity of messages to young patients, dentists use euphemisms to explain procedures. For pediatric dentists, euphemisms or word substitutes are like a second language.

Word Substitutes for Explaining Procedures to Children

Dental Terminology	Word Substitutes
Rubber dam	Rubber raincoat
Rubber dam clamp	Tooth button
Rubber dam frame	Coat rack
Sealant	Tooth paint
Fluoride varnish	Tooth vitamins
Air syringe	Wind gun
Water syringe	Water gun
Suction Vacuum	cleaner
Alginate	Pudding
Study models	Statues
High speed	Whistle
Low speed	Motorcycle

Non-verbal communication

It literally means communicating 'without talking', so non-verbal communication is the reinforcement and guiding behavior through contact, posture, and facial expression. Body contact can be a form of nonverbal communication.

Eye contact is also important. The child who avoids it often is not fully prepared to cooperate. Apprehension can be conveyed without a spoken word. Detecting a rapid heartbeat or noticing beads of perspiration on the face are observations that alert the dentist to a child's nervousness.

There are 3 'essential messages' that we want to send to child patients mainly through nonverbal communication:

1. "I see you as an individual and will respond to your needs as such".
2. "I'm thoroughly knowledgeable and highly skilled".
3. "I'm able to help you and will do nothing to hurt you needlessly".

Objectives

1. To enhance the effectiveness of communicative management techniques.
2. To gain or maintain the patient's attention and compliance.

Contraindications:

Children who due to their age, disability or emotional maturity are unable to cooperate.

Problem Ownership

In difficult situations, dentists sometimes forget that they are guiding the behavior of children. They begin by sending "you" messages, for example, "You stop that immediately!" or "If you don't stay still, we will have to hold your hands." "You" messages have been termed roadblocks to communication; instead of gaining cooperation, they only undermine the rapport between a pediatric patient and dentist. "You"? messages may impugn a child's character, depreciate him as a person, shatter his selfesteem, underscore his inadequacies, and cast judgment. They are more likely to provoke conflict and rebellion than "I" messages. "messages reflect the practitioner's experience and disclose the focus of the problem, such as "You can't fix your teeth if you don't open your mouth wide." They are honest, clear, and inarguable.

This self-disclosing assertiveness is one technique that is particularly well suited to increase the flow of information between the dentist and the pediatric patient. A technique that encourages the use of "you" is attending. Attending describes the desirable conduct to help shape compliance. For example, "You are staying so still" reinforces the specific cooperative

behavior that is necessary for the treatment to be completed. Positive attention to discrete behaviors confirms to children that they are doing what was requested and can nurture the relationship between patients and providers.

Active Listening

Listening is important in the treatment of children. Children express their feelings by word and by action. Listening to the spoken words may be more important in establishing rapport with the older child, whereas attention to nonverbal behavior is often more crucial in guiding the behavior of a younger child. Active listening mirrors the communicated emotion. Whether the child says "I'm scared" or hesitates in opening his mouth, the dentist needs to acknowledge, not ignore, what the child is feeling. Sensitivity to the expressed emotions can reassure the child and encourage genuine communication. The patient is stimulated to express feelings, and the dentist does the same, as necessary processes In communication.

Appropriate Responses

Another principle in communicating with children is that the response should be appropriate to the situation. The appropriateness of the response depends primarily on the extent and nature of the relationship with the child, the age of the child, and evaluation of the motivation of the child's behavior. An inappropriate response would be a dentist's displaying extreme displeasure with an anxious young child on the first visit when there has been insufficient time to establish a good rapport. On the other hand, if a dentist has made inroads with a child, who then displays unacceptable behavior, a dentist may well express disapproval without losing personal control. The response is then appropriate