

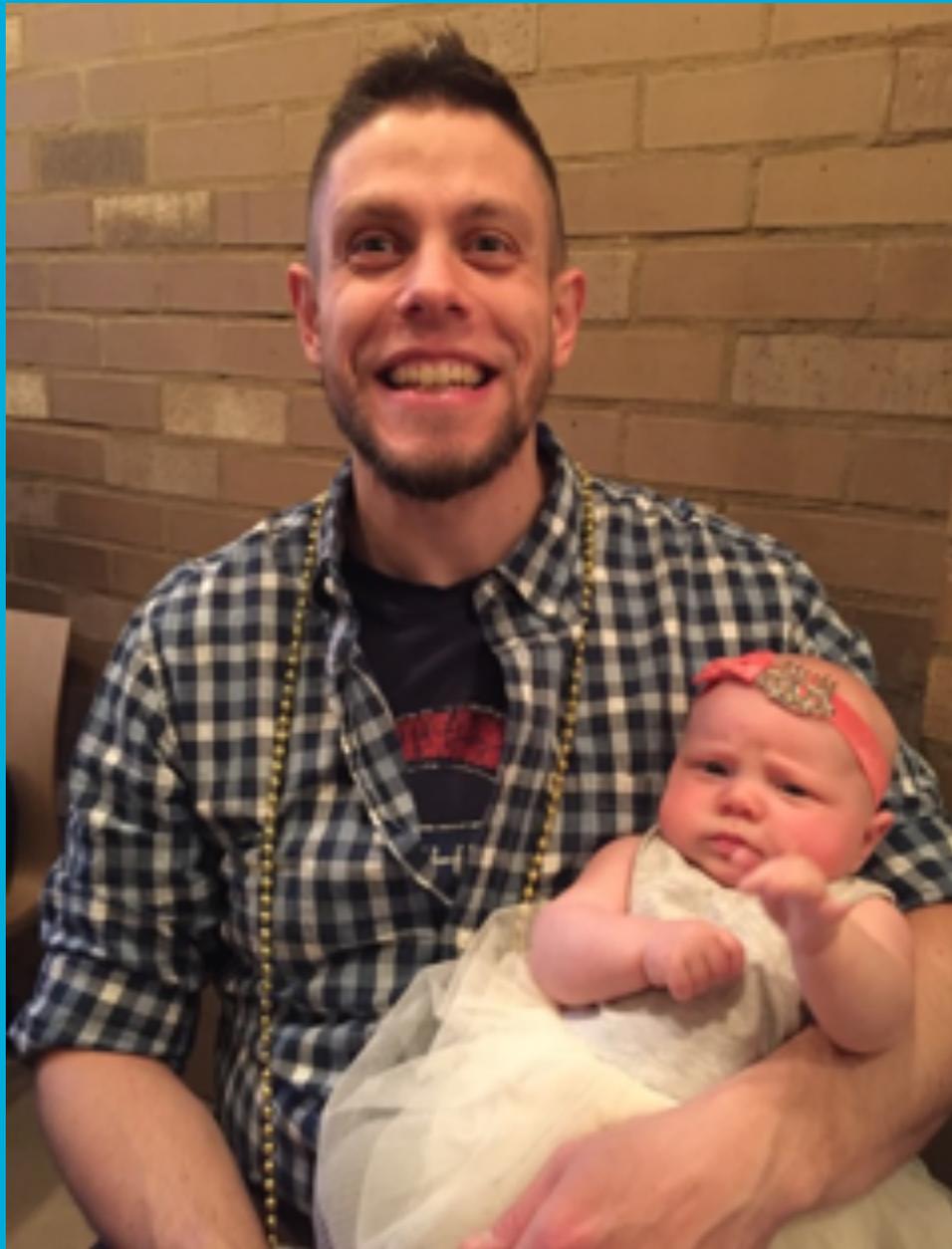
# Behaviour Management

Darsi Perusini BSc, DDS, MSc, FRCDC(C)

Pediatric Dentist

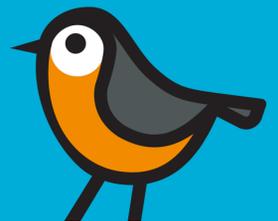






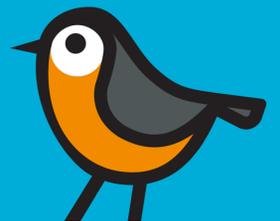
Behavioural

Determinants



# Social Determinants

- Cultural and ethnic factors influence views on behaviour and the acceptability of techniques.

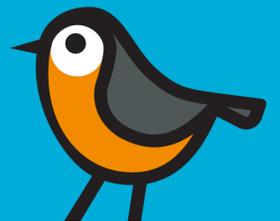


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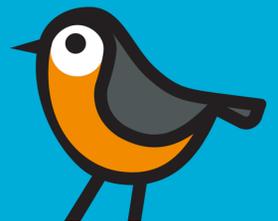


# Environmental Determinants

- Stress from work, school and home can influence a child's behaviour.



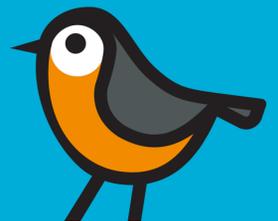






# Child Abuse

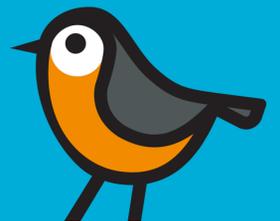
- If you suspect that a child is being abused - emotionally, physically or sexually - it is your responsibility to report this to Child and Family Services.
- There are no "bad" calls.

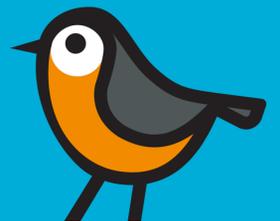


# Parents

- Want greater involvement in their child's healthcare.
- Can significantly influence their child's behaviour, especially if the parents have had negative experiences at the dentist.









# Parents

- Parenting styles have changed over the generations.
- Many children lack basic coping skills and self-discipline necessary to deal with new experiences in the dental office.



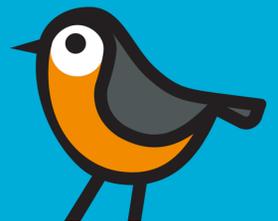
# Parents

- Occasionally, parents' expectations of their child's behaviour are unrealistic.
  - "Talk to her like an adult."
  - "Laughing gas works on toddlers, right?"
  - "She's an angel."
  - "He didn't cry at the pediatrician!"



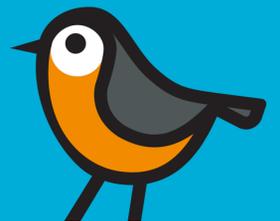


Behavioural  
Evaluation



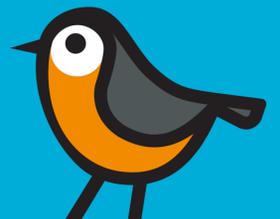
# Assessment

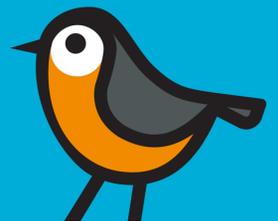
- Begins from the moment that the family enters your practice.



# Assessment

- How does the child interact with his or her parents?
- Is he or she playing in the waiting room?
- How does he or she interact with the office staff?





# Critical Factors

- Child's developmental level (physically, emotionally and intellectually)
  - Higher intelligence can predict increased anxiety
  - Developmental or cognitive delay can predict poor cooperation
- Child's temperament
  - Easy or flexible
  - Active or feisty (spirited)
  - Slow to warm or cautious
- Child's dental attitudes
  - Resistant
  - Indifferent
  - Motivated



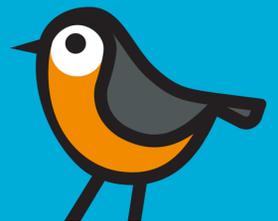
# Critical Factors

- Child's previous experience with medical/dental procedures
  - Stitches, vaccinations, etc.
- Parents' attitudes and communication styles
  - Resistant or confrontational
  - Indifferent
  - Motivated
- Parents' coping skills
  - Lacking, fair or strong
- Dentist's behaviour and attitudes
  - Do you like working with children?
  - Loving kids is NOT the same as working with kids



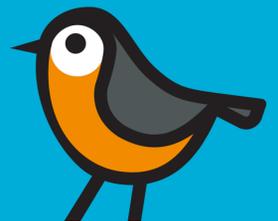
Strategies

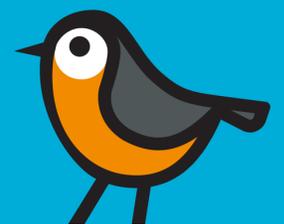
# Behaviour Modification



# Consultation

- Book an appropriate amount of time to consult with both the child and his or her parents.
- Spell it out, the good and the bad.
  - Predict complications and tell the parents what to expect.
  - Needles hurt in more way than one.
  - Happy > anxious > crying > screaming > thrashing
- Cooperation may deteriorate through the course of two, three or four restorative appointments.







# Consultation

- Obtain consent for behaviour management strategies you plan to utilize including:
  - Voice control
  - Parental presence/absence
  - Protective stabilization
  - Sedation
- You, as the practitioner, should effectively communicate all the potential risks and benefits, and help the parents decide what is best for their child.



# Consultation

- Are the parents prepared to stabilize their child in the event that the child *cuts 'er loose*?
- If you cannot meet the parents' expectations, be prepared to refer the child to a pediatric dentist.
- Parents' complaints are frequently based on inadequate communication with the dentist and his or her staff, and poorly defined expectations heading into a restorative or surgical appointment .







When parents are presented with treatment options in our clinic, one of the final things that we discuss is *how* we're going to do treatment. There are many factors to consider in this conversation, and the staff at Avenue PD strive to deliver care in a way that meets parents' expectation and, of equal importance, the child's needs.

At Avenue PD, we typically book treatment in one of three ways:

1. In the dental chair with freezing (local anesthesia), or
2. In the dental chair with laughing gas (nitrous oxide sedation) and freezing combined, or
3. Under general anesthesia where the child is asleep under the care of a board certified medical anesthesiologist.

It is important to be realistic when planning how things are going to proceed. Dr. Perusini emphasizes the following points to help guide the discussion, and to ensure the best course of action:

**Age** – in younger children, dental treatment with freezing alone can be quite traumatic. Fortunately, children develop coping skills with age, which can positively impact treatment outcomes.

**Development** – some individuals might find treatment in the chair challenging due to a lack of psychological or emotional maturity and/or mental, physical, or medical disability.

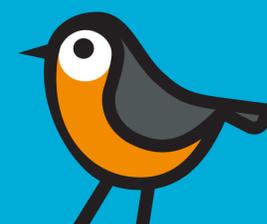
**Amount of Treatment** – exactly how many teeth need to be fixed? In the office, Dr. Perusini will typically do one corner of the mouth per appointment to minimize the length of the visit (children often do better with short and easy). Also, Dr. Perusini wants to ensure that he is using a good volume of dental freezing to maximize comfort in one corner without over-medicating, or minimizing the freezing's effectiveness in multiple corners.

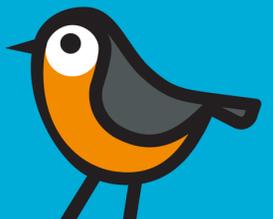
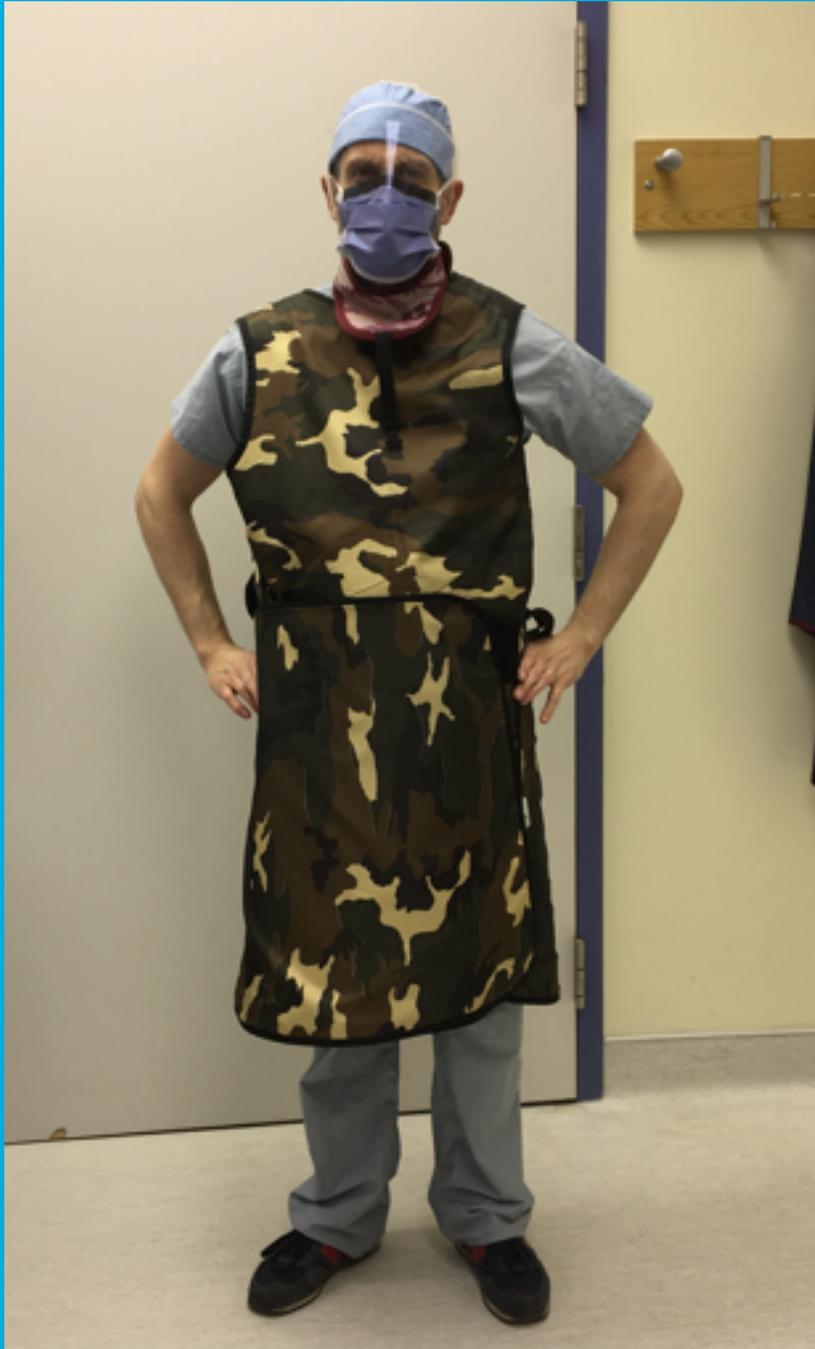
**Procedure** – restorative dentistry and minor oral surgery often require that a child be perfectly still during the procedure. This can sometimes be challenging for a child depending on her or his age, anxiety or emotional development.

**Infection** – depending on the severity of a dental infection, freezing alone may not be sufficient to guarantee the child's comfort during the procedure.

Dr. Perusini and the staff at Avenue PD recognize that each child is unique, and what works for one may be inappropriate for another. We take great pride in building relationships with our families to better understand their needs and expectations.

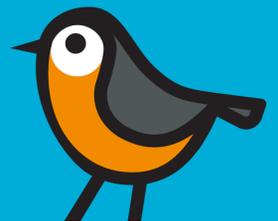




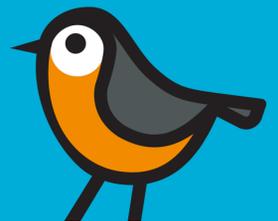
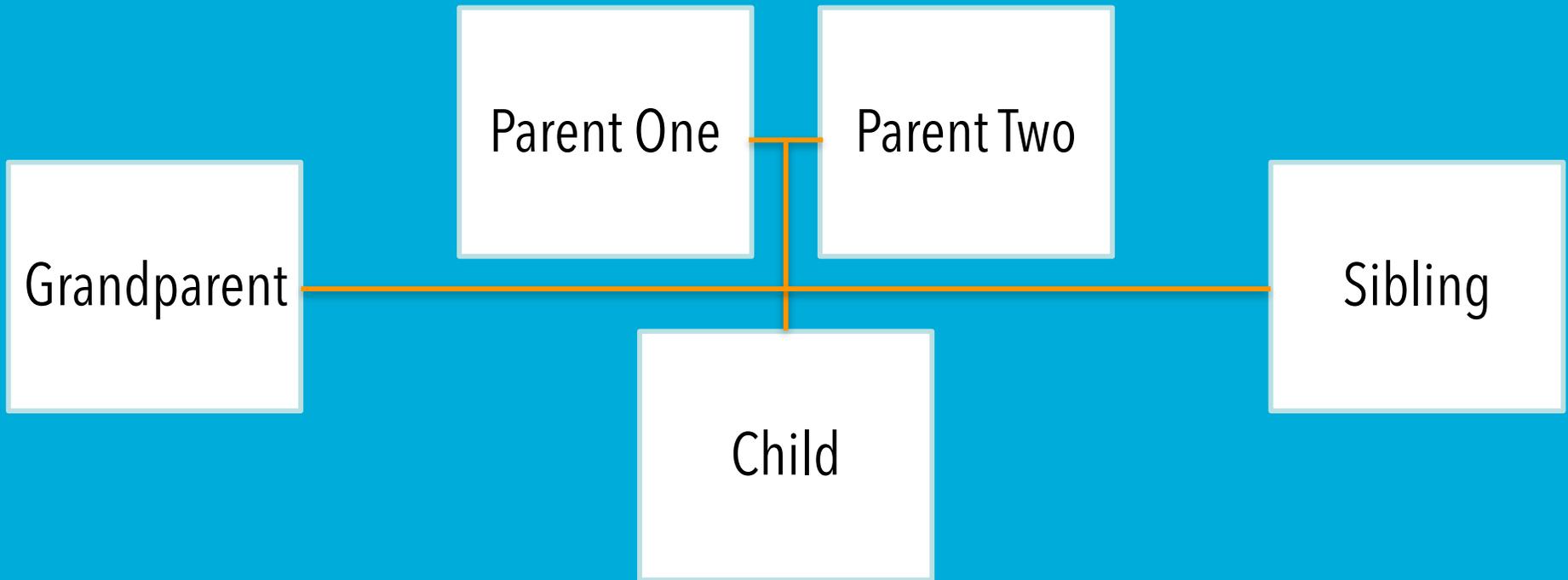


# Treatment

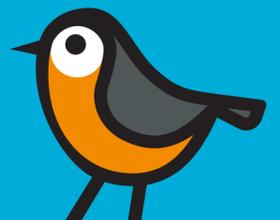
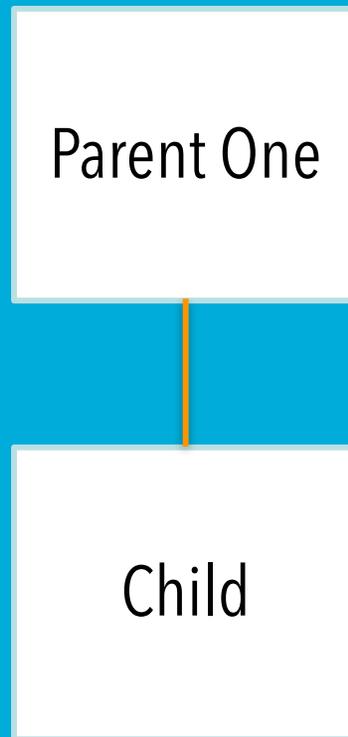
- Book an appropriate amount of time to complete treatment and manage any complications.
- Closed operatories help minimize noise and the domino effect.
- Parental presence or absence?



# Who Are We Managing?



# Downsize





Strategies

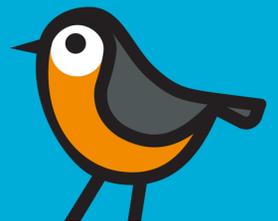
# Nitrous Oxide

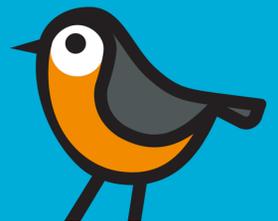




# Assessment and Selection

- Many parents have unrealistic expectations of nitrous oxide sedation.
  - Your child will be awake.
  - Nitrous oxide is a mild sedative.
  - Your child must be willing to cooperate.
- Nitrous oxide sedation combats anxiety, not resistance.







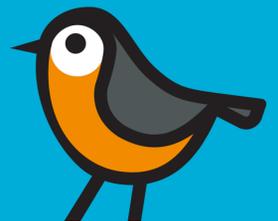
# Pre-Game

- Children might be afraid of the nasal hood.
  - Why are you putting this on my face?
- Prepare a few narratives to help children accept the nasal hood.
  - Fighter pilot
  - Fairy princess gas



# Pre-Game

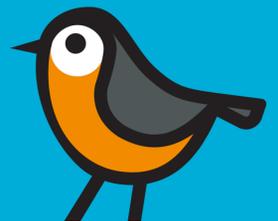
- Be assertive and repetitive:
  - Keep your mouth closed.
  - Take deep breaths through your nose.
  - Shrink the balloon.





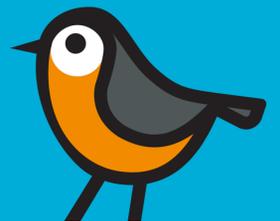
# Intra-Operatively

- Never ask a child, are you feeling it?
  - Feeling what??
- Tell the child how she or he is feeling.
  - Guided imagery
  - Sensations (e.g., magic dust in your lips, fingers and toes)
  - Dental assistants need to be comfortable with this.



# Intra-Operatively

- Nitrous oxide is 20% physiological and 80% psychological.



# Additional Pearls

- For some children, nitrous oxide sedation will never work:
  - Psychiatric illness
  - Cannot tolerate loss of control
  - Aggressively defiant



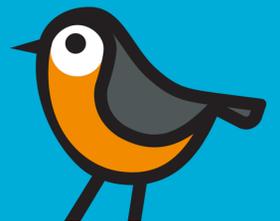
# Additional Pearls

- For other children, nitrous oxide sedation may not have an optimal effect:
  - Upper respiratory tract infection
  - Recent psychological trauma (e.g., Grandpa died last week)



# Additional Pearls

- In some instances, you may use the nasal hood as a tool to achieve cooperation.
  - I will remove the laughing nose if you agree to lay still and open your mouth.



# Thank You

Questions?

