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ORIGINAL ARTICLE

Parents' assessments on the effectiveness of nonaversive behavior management techniques: A pilot study

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Abstract *Background/purpose:* Dental treatment for children often requires the use of behavior management techniques (BMTs). The aim of this pilot study was to determine the effectiveness of nonaversive BMTs by the ratings of parents who had observed their children during three sequential dental treatment sessions.
Materials and methods: Dental records of 47 children (age 5–13 years) who had received at least three sessions of dental treatment, two of which included local anesthesia administration, were analyzed retrospectively. Twenty-five out of 47 invited parents agreed to participate in the study. The parental form of the Children's Fear Survey Schedule – Dental Subscale was used for determining children's anxiety. Parents were asked to fill in a questionnaire after watching a descriptive video on eight widely-accepted BMTs to rate the effectiveness of each applied BMT on a 10-grade visual analog scale (VAS).
Results: All nonaversive BMTs were considered by the parents to be very effective on children's favorable behavior with a mean VAS score of 9.25. *Perceived control* and *positive reinforcement* were rated the most (VAS score: 9.80 and 9.52; $P > 0.05$).
Conclusion: All nonaversive BMTs were found to be effective by some Istanbulian parents on children's favorable behavior.
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Introduction

Pediatric dentistry aims to provide good oral health throughout life, which can only be achieved by healthy oral structures together with the absence of dental fear and

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anxiety. Management of pain and anxiety is therefore crucial and requires the successful use of behavior management techniques (BMTs).[1]

Many children perceive a visit to the pediatric dentist as stressful. This could be expected because an appointment includes several stress-evoking components, such as meeting unfamiliar adult people, attire worn by the clinicians, having to lie down, strange sounds and tastes, discomfort, dental injections, and pain.[2–8] It should be also noted that children comprise a group of individuals representing a large variation in age, competence, maturity, personality, temperament and emotions, experience, oral health, family background, culture, etc.

Sedation and general anesthesia (GA) are the pharmacological tools preferred when nonpharmacological BMTs provide insufficient cooperation of children.[1] Tell—show—do, voice control, nonverbal communication, positive reinforcement, parental presence and absence, distraction, and perceived control are some of the commonly used nonaversive and child-friendly nonpharmacological BMTs. Restraints and the hand-over-mouth (HOM) technique are aversive or aggressive nonpharmacological BMTs.

The use of BMTs is influenced by various factors, which change over time. Social attitudes, parental expectations, developing children's rights, and technology, in conjunction with leading research performed on BMTs urge reshaping of the strategies for the cooperative child. In a study conducted by Eaton et al,[9] rankings of parental acceptability for BMTs were presented and compared with similar studies from the 1980s[10] and 1990s.[11]

Higher parental acceptance for sedation and GA, and lower acceptance for aggressive techniques were found as apparent trends that change in time. A stable (or constant) and outstanding acceptability of the tell—show—do technique was interpreted as parents' emphasis and preference on the safest and least aggressive BMT.

Finn,[12] Davies and King,[13] and Brauer[14] suggested that the practitioner must recognize the importance of parental influence upon the thinking as well as the behavior of the child. Sermet[15] and Shaw[16] provided further clarification as they positioned the parent as pivotal in a child's acceptance of dental care.

Peretz and Zadik[17] reported the preferences of parents, who observed the BMTs actually employed on their children, toward the dentists' approach. When children do not cooperate, 56% of the parents preferred their children to be relaxed by explanation, whereas only 20% voted for sedation after explanation and 6% for firmness after explanation.

Parents' attitudes toward BMTs and their acceptance trend through the past decades indicate a higher demand for the use of nonaversive and child-friendly BMTs. Although the relevant literature and the clinical experiences observed support the obvious effectiveness of BMTs, the justification of carrying out such a study is needed, whereas there are no available scientific data reporting the effectiveness of these techniques from a parental perspective. Therefore the aim of the present study was to determine the effectiveness of nonaversive BMTs by the ratings of some Istanbulian parents who had observed their children during three sequential dental treatment sessions.

Materials and methods

The study protocol was approved by the Ethical Committee of Yeditepe University and written consent was obtained from all parents after explaining the objectives of the present study. Verbal consent for BMT recordings was obtained from the pediatric dental patient's parent.

Participants

Dental records of the children who were treated by the same pediatric dentist (O.O.K.) in the Pediatric Dentistry Department of Yeditepe University School of Dentistry were analyzed retrospectively. A computer program (HİS, Sürüm 1.2; T.C. Yeditepe University, Istanbul, Turkey) was used to identify children treated between September 2006 and September 2008 who had received at least three sessions of dental treatment, two of which included administration of local anesthesia. A total of 47 children met the criteria and their parents were invited to the study by both letter and telephone. Those who could not be reached ($n = 5$), were not available to attend in weekdays ($n = 11$), moved to another city ($n = 2$), or were unwilling ($n = 4$) did not participate the study. Parents' education level and gender, and children's age, gender, and previous dental experiences were noted.

Assessment of dental anxiety

Parents completed the parental form of the Children's Fear Survey Schedule — Dental Subscale (CFSS-DS), which was used to evaluate their child's anxiety level. The CFSS-DS has been extensively validated and consists of 15 items, related to various aspects of dental treatment such as *How afraid is your child of the noise of the dentist drilling?*.[18]

Each item can be scored on a 5-point scale: from (1) *not afraid at all* to (5) *very afraid*. Total scores thus range from 15 to 75. Previous research has defined scores between 32 and 38 as *mild dental anxiety and fear* and scores of 39 and higher as *high dental anxiety and fear*. Recently, Kuscu and Akyüz[6] and Kuscu et al.[8] demonstrated the rationale and validity to use the mean anxiety score of the study group as a cut-off point for categorizing children into *relatively anxious* and *nonanxious* groups. The reliability of CFSS-DS is high and it has a moderate validity.[19]

Assessment of children's cooperation

Parents were asked to rate their children's anticipated cooperation before and after the treatments using the Frankl scale, which is an observational scale introduced by Frankl et al in 1962 scoring: (1) *definitely negative*, (2) *negative*, (3) *positive*, and (4) *surely positive*.[18]

Assessment of the effectiveness of BMTs

Parents were asked to fill in a questionnaire after watching a descriptive video on BMTs with a guide pediatric dentist (E.C.), to rate the effectiveness of each applied BMT. The descriptive video being used in the present study was

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