Management of the Uncooperative Child

Meredith Blitz, DDS[a,b,c,*],
Kate Cerino Britton, MSEd, MA, BCBA[d]

KEYWORDS

• Pediatric • Oral surgery • Mental health • Behavior
• Autism spectrum disorders • Anesthesia

The management of a child who requires a medical procedure is a challenging issue for providers, patients, and families. It is particularly challenging for the oral and maxillofacial surgeon (OMS) and practitioners in the dental specialties. The office of the OMS is traditionally one in which short outpatient procedures are performed within brief appointment times often using only local anesthesia. For typical children, this brief procedure may be difficult, and for children with behavioral challenges, it may be impossible without the use of behavioral management techniques or pharmacologic modalities.

In the past, techniques to manage behaviorally challenged patients were limited, and these patients were often subjected to outpatient general anesthesia to accomplish simple surgical goals. However, with an increasing number of pediatric patients with mild to severe behavioral challenges, alternate approaches must be evaluated, taught, and practiced by clinicians who are involved in the surgical care of children.

In an article published March 19, 2000 in the *New York Times*, a 5-year-old male patient allegedly sustained a femur fracture while being actively restrained by his dentist. Although reports of injury such as this are rare, the management of uncooperative children is an important issue. Practitioners must be aware of current trends in pediatric mental health and should develop treatment protocols to avoid complications.

INCIDENCE

In the *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda* published in 2000, three major Federal Departments, the Department of Health and Human Services, the Department of Education, and the Department of Justice, were brought together to collaborate on a vision and goals for the pediatric population with mental illness. The low priority of this issue and the stigma surrounding mental illness are both factors contributing to the limited access these patients have to education and routine care. This action agenda included and prioritized the following goal, to "train frontline providers to recognize and manage mental health-care issues, and educate mental health providers about scientifically-proven prevention and treatment strategies."[1] To accomplish this goal, the suggested focus was the education and training of medical professionals in all aspects of childhood development and differences; training to enhance practitioners' knowledge base in these areas; development of multidisciplinary programs for health care professionals, which allow for a focus on pediatric mental health; and training support for professionals to keep abreast of new developments in the field of children's mental health.

However, a decade later, most dental schools and residency training programs of oral and

[a] Division of Dentistry, Department of Oral and Maxillofacial Surgery, Seton Hall University, 400 South Orange Avenue, South Orange, NJ 07079-2689, USA
[b] Department of Oral and Maxillofacial Surgery, University of Medicine and Dentistry of New Jersey, 110 Bergen Street, Newark, NJ 07103, USA
[c] Department of Oral and Maxillofacial Surgery, St Joseph's Regional Medical Center, 703 Main Street, Paterson, NJ 07503, USA
[d] Alpine Learning Group, 777 Paramus Road, Paramus, NJ 07652, USA
* Corresponding author. Department of Oral and Maxillofacial Surgery, St Joseph's Regional Medical Center, 703 Main Street, Paterson, NJ 07503.
E-mail address: Blitzgme@umdnj.edu

Oral Maxillofacial Surg Clin N Am 22 (2010) 461–469
doi:10.1016/j.coms.2010.08.002
1042-3699/10/$ – see front matter

maxillofacial surgery provide limited education in pediatric behavioral management for the outpatient setting. With the nation facing a public health crisis in mental health care for children and adolescents, almost all practitioners come into contact with a child with mental health problems that interfere with normal development and functioning.

According to the surgeon general's report, "one in ten children and adolescents suffer from mental illness severe enough to cause some level of impairment. Recent evidence compiled by the WHO indicates that by the year 2020, childhood neuropsychiatric disorders will rise proportionately by over 50 percent, internationally, to become one of the five most common causes of morbidity, mortality, and disability among children."[2] With this focus on childhood mental illness and its increasing prevalence, practitioners must stay updated in management strategies to facilitate proper care and positive outcomes in the mentally disabled pediatric patient.

The true incidence of individual mental health disorders in children has been difficult to obtain. Many factors, including concurrent mental health disorders, stigmatization leading to lack of parental admission and diagnosis, lack of access to services including diagnosis, and insurance regulatory issues, have led to difficulties in identifying all individuals in this subset of the population. However, with the recent reported increases in autism spectrum disorders (ASDs), a focus shift is occurring at the ground level and parents and practitioners are encouraged to seek early detection and intervention.

The Centers for Disease Control and Prevention now estimates that ASDs affect approximately 1 in 110 children.[3] ASDs are most commonly known as Asperger disorder, pervasive developmental disorder-not otherwise specified, and autism. Attention deficit disorder (ADD) with or without hyperactivity has been even more challenging to quantify. A recent study revealed a cumulative incidence of attention-deficit/hyperactivity disorder (ADHD) of 7.5%.[4] Additional disorders that are common in children and adolescents include oppositional defiance disorder, Tourette syndrome, anxiety disorders, childhood schizophrenia, aggressive conduct, bipolar disorders, and major depression. Many of the diagnosed children have comorbid conditions and can be categorized by more than one major disorder. This challenge makes the true incidence of each disorder very difficult to quantify. Both the *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition) and the *International Statistical Classification of Diseases, Ninth Revision* provide valuable information on the levels to which patients can be affected and on what a true crisis these disorders and others represent.

PREVIOUS TREATMENT STRATEGIES

In the past, many behavioral techniques have been used in an attempt to treat children and facilitate a positive learning experience with successful treatment outcomes. However, when dealing with a surge of patients with behavioral challenges, many of these techniques could become obsolete and potentially lead to future fear and anxiety in relation to oral care.

The technique most commonly used with pediatric patients has been the "tell, show, do" approach to learning. This technique can be very effective because it allows for desensitization to stimuli and a general understanding by the children of what they should expect in the oral care setting. However, many behaviorally challenged children have unusual fears and sensory processing issues along with verbal comprehension difficulties. This technique can be successfully initiated in the home by the child's parents and then transferred to the clinical setting. Should a patient have receptive language delays, this technique may or may not be effective. Many children with ASDs are visual learners, so visual presentation of materials can be helpful. Limited discussion and simple commands work best in this patient population (**Fig. 1**).

Papoose boards for managing children are still used in the dental setting and in hospital

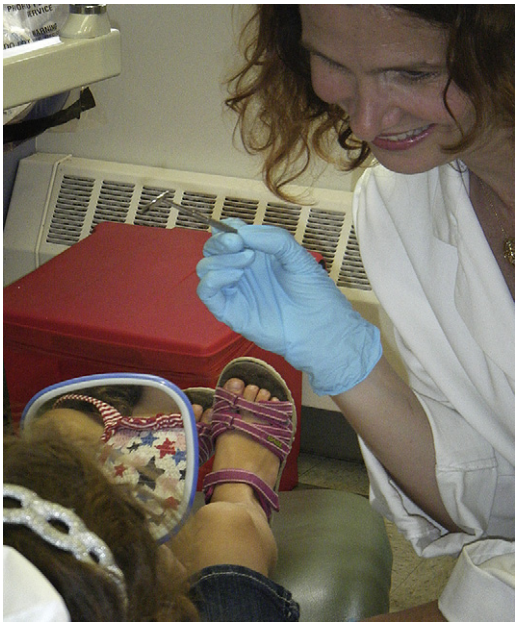

Fig. 1. Tell, show, do.