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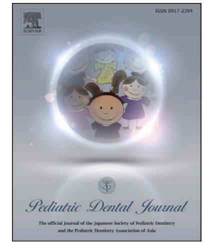

Original Article

Parental presence in the operatory: An update

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ABSTRACT

The purpose of this paper is to present an update on the current views of dentists and parents on the controversial issue of the parent in the dental operatory. In the past, parents were excluded from the operatory because it was felt a parent would be disruptive. This position is no longer valid due to a better understanding of fear in children, a greater acceptance by dentists to have the parent present, and an increased interest of parents to be present. By understanding the evolving cultural, legal, and social elements that have contributed to changes in parenting and the family, one will find parental presence is safe and beneficial. Practical measures like following the successful pediatric medical model, where parents are routinely allowed to be present, are given to ensure success. Cooperative behavior will improve compliance which will result in effective dental treatment.
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1. Introduction

Behavior management is important when treating pediatric dental patients. It is difficult to provide effective, proper, and safe dental care if the child's behavior can not be managed. Using accepted behavior management techniques are necessary to prevent future dental fear. There are a wide variety of behavior management techniques. One area of controversy is whether to allow the parent in the operatory. This paper presents recent evidence that demonstrates having the parent present is beneficial.

2. Background

Historically, parents were excluded from the operatory. In 1898, Belcher [1] recommended that parents be excluded from the operatory because "many parents spoil authority, and the child is not to be controlled, but looks to the parent for sympathy, and will not make an effort to control himself." This view gained momentum after World War I and continued to be echoed by organized dentistry in textbooks, articles, and in the curriculum of dental schools and postdoctoral training programs for decades [2,3]. Up to the 1970's, the American Dental Association even offered posters to be displayed in the dental office that explained the role of the parent was to remain in the waiting room [2]. Wright [4] considered a mother's anxiety to be the cause of negative behavior in a child. By 1983, 75% of surveyed dentists still restricted parents from the operatory because they considered them a hindrance to patient management [5]. This sentiment continues to the present where Soxman considers the parent a distraction and disruptive [6]. The reasons given to justify parent and child separation are [3]:

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1. the parent interferes with the development of dentist-patient rapport
2. parental anxiety has a negative influence on patient behavior
3. the practitioner may feel uncomfortable with the parent present

The predominant thinking among pediatric dentists clearly demonstrated an exclusion of all parents at all times. The pediatric dentist was considered, because of his training in non-coping and coping behavior, the expert to teach children of all ages how to behave in the office and the dentist was considered the intermediary between parental supervision and the dental operatory.

However, dentists' perceptions and attitudes contrasted sharply with studies in psychology that began to emerge in the 1940's which started to investigate the effects of parent-child separation. They found that parental presence has a positive effect on the child and was advantageous because it created a sense of security for the child and improved the child's coping behavior [7–10]. These studies questioned whether the separation itself caused the negative behavior. Though these studies did not directly examine the issue of parental presence in the dental setting, it did create an impetus for further assess this.

Few dental studies have attempted to examine prospectively the role of parent presence to facilitate coping skills among young children. Frankl [11] evaluated children from age 42–66 months over 2 visits. The first visit was a dental exam and the second one was a restorative procedure. He concluded a child's cooperation improved with the mother present between the ages of 42–49 months. The age group between 50 and 66 months showed no differences in behavior with the mother present or absent.

Other studies reported parental presence does not have a negative effect. Afshar [12] evaluated the cooperation of sixty-seven 5 year old Iranian children on the first and second dental visits with and without a parent by measuring heart rate, anxiety level, and cooperation. The first visit consisted of an exam and the second visit consisted of injections and dental procedures such as restorations and pulpotomies. The result was there was no difference in the measured parameters regardless whether the parent was present or not. Lewis and Law [13] tested the physiological reactions (heart rate, face and hand temperature, and galvanic skin response) of 18 children in the presence or absence of the parent in the dental operatory while performing an oral prophylaxis. There was no difference in behavior whether the parent was present or not. Venham [14] examined the consequences of parent-child separation when the choice was left up to the parent and child. They measured the child's response (heart rate, basal skin response, and clinical anxiety) during an examination, prophylaxis, topical fluoride application, administration of local anesthetic, and cavity preparation in children age 2–5 years old. They noted the parent's presence was not associated with a negative response and the child was more relaxed when the parent was present. They also noted a decrease in the number of parents who remained with their children during subsequent visits and this was interpreted to be a positive sign that the children were becoming more secure and relaxed as they became more familiar with the dental setting. Pfefferle [15] studied the behavior of 48 children between 36 and 60 months old with no previous dental experience at an initial dental exam and two subsequent restorative visits. The parents were told to be passive when present. The result was no difference in negative behavior if the parent was present or if the child was treated alone.

3. Understanding fear in children

Fear is defined as: 1) verbal expression of pain or discomfort 2) the behavioral expression of avoidance or interference with treatment and 3) the autonomic arousal that may accompany a stressful experience [16]. Kleinkenecht showed that these three indices do not necessarily vary together [17]. That is, how these vary depends on the patient's perspective. Children come to the dental setting with different learned behaviors, different life experiences, and different coping skills. It is the role of the dentist to help the patient develop skills and behaviors so the patient can receive dental care without anxiety or fear [18].

Criteria as to what constitutes child compliance in the dental chair has not been well defined [19]. The calm child who sits still in the chair with white knuckles may avoid dental care in the future [20]. Children who have had negative dental experiences are at risk for anticipatory anxiety and the possible development of dental phobias as an adult [21]. Pinkham [22] advocates using a systematic method of gathering information from the parent at the first visit before any procedures are done. The presence of a parent can help the dentist gain insight into the child's behavior from past visits to the pediatrician or from previous dental visits. Also, the dentist can gain insight into the patient by asking the parent how the child might behave at that visit.

There are four types of disruptive behavior [23]: resistant, anxious/fearful, shy, and out of control. Understanding the types of disruptive behaviors will determine the specific interventional technique for that child. Using a "one technique fits all" approach does not take into account the different personalities children have. The key to success is diagnosing and recognizing the different behaviors in order to use the appropriate approach to correct that behavior.

According to Davey [24], traumatic experiences are more likely to give rise to dental anxiety if they occurred at the first dental visit rather than during subsequent visits. Children tend to be less afraid if they have had several neutral visits (e.g. exams, cleaning) before exposure to invasive dental procedures like restorations or extractions.

Some negative behavior is common and age specific. For example, up to age 3, it is common for a child to express anxiety or distress if separated from the parent. When they cannot cope, children seek to escape the event. Separating the parent from a very young child, a child lacking cooperation, one with Special Health Care Needs, or a child with limited coping and communication skills will cause a negative response.

4. Changes in parenting and the family

In order to provide optimal dental care, one needs a contextual understanding of children and their families [25]. Over

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