Communicating with the New Generations. The Challenge for Pediatric Dentists

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Most of the children and parents are virtuous and will give us plenty of reasons to enjoy what we do. Unfortunately, we all know that something is somehow wrong with these new generations. Parents and children sometimes place Pediatric dentists in a dilemma. The social structure changes every few years causing a burden on how to deal with these families. For this reason, dentists might decide to sedate or go to the operating room when these children might be potentially good dental patients. Deciding this course of action, does not allow us to bond with them. Bonding with children must be worked and nurtured. This is part of what pediatric dentists are trained for. This manuscript will illustrate the major changes seen with the new generations of parents and children and how it affects us the way we work in our offices. We will show the importance of bonding with parents and children, moving beyond the biological aspects and venturing into the psycho-socio and cultural issues. Knowing our children and adolescents will allow us to detect potential physical or emotional hazardous behavior.

Key words: behavior, communication, dentist, children.

INTRODUCTION

Nobody should know more about children and adolescents than Pediatric dentists.

We see them at very early ages, once communication can be established and maintain this connection until adulthood. Logically, we should understand more about them from the volume of patients we see on a yearly basis, phenomena not matched by teachers, school principals or psychologists.

We are one of kind. We have the human quality to bond with children and become part of them. We can feel them and predict their behavior in most of the cases and act accordingly to make them feel comfortable in the dental setting. We can joke, talk freely, know their likes and dislikes, their hopes and dreams depending on each child´s age and character.

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Bonding is an inclusive phenomenon seen among children but is a connection we must look for[1]. We bond when we look beyond biology (physiological and pathological aspects) and insert patient´s and parents psycho social and cultural characteristics[2-5]. We bond when we immerse with them in their world, when we accompany them, when we show genuine interest.

Bonding is necessary to communicate

The world of science is crushingly objective. To get to this point, it has shattered the image of a man. It has removed the human being from of its natural and social environment has disconnected him from his history and its cultural core, cut him into pieces and dig further and further into its organ system, organs, tissues, cells, molecules, atoms and subatomic particles[2-5].

Knowledge in today´s society has specialized to a degree that we see only part of the human being[2]. Patients in many specialties make appointments to treat a root canal, or to remove wisdom teeth. One or two visits create a limited perishable relationship.

Fortunately for us, we are general dentists for children much like a family physician.

Bonding is necessary to educate

In the past, education was transmitted vertically, from grandparents, parents to their children. Today, education is generally transmitted horizontally, with peers and friends as the main tutors[1]. There is an imperious necessity for children to create and maintain ties with different groups according to common interests (School, social, gender, music, dress code, sports, corporal adornments). Children create more bonds that compete with parents and wear

away their relationships[1]. Imagine if parents have these problems, how this behavior is impacting our practice?

Up to the 1980's a generation changed every 20 years. Today, generations renew every 7 years and receive names like the X (baby boomers) [12], Y (Millelials) and Z generations[12-13].

Pediatric Dentists all over the world are experiencing this revolution in parents and children behavior. Once we believe we start to understand how to deal with them, they change the game. In a sense, the generation changes at the same speed than technology (Table 1).

These modifications obey to these variants[1]:

1. Culture has changed (working parents, parental problems, group culture).
2. Technology has changed (Cyber children, communication revolution).
3. Needs have changed (consumption, immediacy, belonging).
4. We have changed (specialists).

Types of Children and Parents

When a 3-year anxious child comes to our office for the first time, we have the ability to read children potential behavior and act accordingly. Most of them will behave depending on their age, education and compliance (cooperation, obedience, acquiescence, submission, passivity, defiance, disobedience, insolence, rebelliousness). Our work is to turn off the limbic system (reptilian mind). This primitive response seen in many animals is reactive to unknown or danger stimuli. Using the tell-show-do technique, we inhibit this response and activate the cognitive mind, logical mind found in the Neo cortex [6-7].

Unfortunately, in many cases because of behavioral changes [8-9], large amount of work needing several visits, lack of patience or experience, we tend to use and abuse nitrous oxide, sedation and general anesthesia to treat potentially cooperative healthy children, occurrence increasing dramatically in the world [10-11]. University settings and hospitals might encourage taking potentially good patients to the operating room in order to bring a greater income.

Lately we are seeing increasingly a growth of insecure children and abusive children. The first ones are easier to establish a connection. The second ones have reverted the natural logical order of parent-child relationships leading to unhealthy situations.

Insecure children

Parents of insecure children make them feel weak and restrain them from exploring new avenues. This way a psycho-affective dependence is established[1].

Mom can be anxious from poor past personal dental experiences and grips the child hand; child stays close to his mother. Mother will look defiantly protecting her child. In this case, no trust, no bond.

Mother, will come into the operatory and refuse to leave. She will tell the dentist how to proceed. She might suggest lying down in the chair and placing the child on top of her. She may indicate when to start and when to stop. She will tell you if her child needs a rest to be comforted.

When a child does not develop with security, he interprets all the information like an alert.

The logic in these cases is to revert the fear factor into a more enjoyable experience. Show your confidence, explaining the mother and the child the whole procedure. The idea is extinguishing the distrust to get the job done. Once the procedure is complete, the child will feel he accomplished something out of this world, the mother will be appreciative. The aim in the long run is to have a self-confident child in your chair and the mother in the waiting room.

This good experience will be a learning exercise for mother and child.

Remember that sometimes we need more time at the beginning to save time at the end.

The paradox with overprotective parents generally backfires. These parents tend to abuse bottle or breastfeeding and pacifier use, increasing the possibility of severe early childhood caries and malocclusions.

Abusive, demanding children

This type of children has the power with no responsibility[1]. Parents loose the authority and respect. Children run the show (Emperor's syndrome) [14].

This behavior can be seen in children of older parents, affection deprived children, dysfunctional families, wealthy environments where the maids raise them. Parent´s sense of guilt will tend to fulfill every wish.

In these cases, bonding is generally very poor. Parents prefer to stay out, feeding the dentist to the lions. The children will call on their parents to save them. Children will generally cooperate, but in the end they are so frustrated and angry, because their power did not help them. They will not pick up their present at the end of the visit and will fight with their parents. Children will get some retribution to appease parent's remorse feeling.

We can see this type of behavior in 2 or 3 years old children demanding the bottle, pacifier or candies. They will pick up a tantrum if their wishes are not met immediately.

Abusive parents

There is a group of parents that will compete with their children. Some of them are self- centered or are not be fitted to be parents[1]. You will see them in your office very well dressed, with perfect bodies while their children are misaligned. They do not have the time for their children because they need this time for themselves. They will tend to erode their child's self confidence with sentences like". "*My child will never wear this appliance". "He does not loose his head because it is firmly set between his shoulders".* "*He is not capable to do this...". "Take out your thumb, you look stupid".* These parents could verbally and emotionally mistreat them because they did not turn out the way they wished [5].

They will believe that a 3 year old is perfectly capable to brush his/her own teeth. If a child's cry, they will "connect" them to the pacifier or the bottle to have peace.

They will make Pediatric Dentists responsible for the child´s buccal health and will not take responsibility for the lack of control at home.

Emotionally or physically abused children are perfect to bond with. They will feel protected, valued, appreciated, but most importantly they want to show their parents that their views about him/her are not correct.

By making them feel important, we take away their fear and create a confidence that could last. Few stronger emotions exist than the need to belong and make a meaning[14].

You will receive from these kids and adolescents only a "high five", a hug or a shoulder salute, but this simple display of affection says everything and will endure.

Sometimes, unfortunately, these parents might not bring back their child, because you stepped over them. However, our responsibility is primarily our kids. For this reason we have to be intelligent and praise also parents and child to have a "win,win,win" outcome.

BONDING TO CHILDREN AND ADOLESCENTS

Our brain is a neurosocial brain. Three types of brain resilience have been found[1,6,15]

1. / Neuronal resilience
2. / Psycho affective resilience.
3. / Sociocultural resilience.

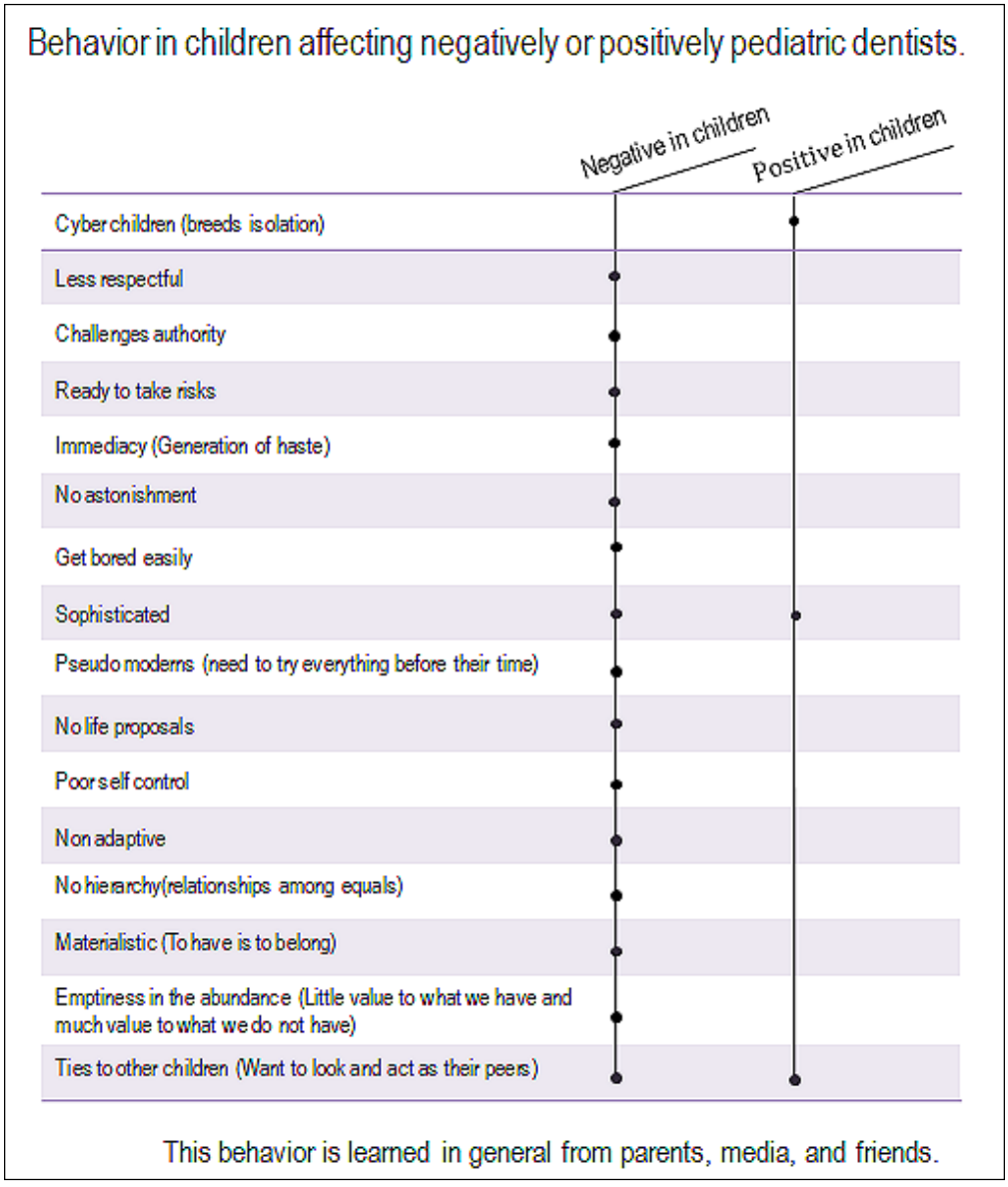
Among humans 99.7%[1] to 99.9%[6-15] of the DNA is equal. Our genes determine partially who we are.

The rest 0.1% to 0.3% is psycho-cultural. All this confers to humans a unique quality to be and behave the way we do. It expresses or may not express itself in function to its environment[1,6,15].

For this reason education is so unique because it involves so many different the psycho-social-cultural contexts and mutates constantly as we learn to coexist with our milieu.

This happens when the child comes for the first time to the dentist. When they perceive a good connection in the pediatric dental office setting (waiting room, warm receptionist, colorful operating area, smiling dental assistants). But the most important person is the dentist, creating a trustworthy relationship with our children and parents. The same way that children bond naturally among themselves, youngsters communicate primarily with others through their pose, attitude, dress code, objects they wear. This is the way these adolescents express who they are with their peers. Stance and dress code relay an image, a legacy, not necessarily monetary status, but their personal taste and their most intimate personality[16].

Table 1: Characteristics of the new generations



In the dental setting, you can identify these youngsters and know how to approach them. When a connection with children and adolescents exists we become nurturers, teachers, models, guides.

We connect when we look beyond the biological, physiological or pathological aspects.

If we do not bond, then a patient becomes a good or bad patient. He converts into caries, a crown, a class III malocclusion or the sign of money. We play the parents wishes, placing a resin when the child needs a crown.

When we do not bond we deal with a symptom and not a person.

So, is this formula, always a good formula?

Early Childhood Caries (ECC) + Poor Behavior (PB) = Sedation or General anesthesia(GA)?

ECC is a symptom that needs to be dealt with. The question is how, because there is a person who has the problem?

We decide that poor behavior or an acute situation of anxiety exists, let´s say in a healthy 4 year old.

It is not our specialty to modify the anxiety (limbic) into a cooperative (neocortex)?

Research has shown that children undergoing GA will tend to go back to the operating room for the same reason in the future, but most importantly, the brothers or sisters will follow the same path[17-22]. The reason: no bond, no communication, no education.

Today, there is an increase in the caries incidence all over the world.[23-29] Even first world countries have been experiencing this trend mostly among its most disadvantaged population [23-29]. Sugar consumption is increasing at a steady pace [30]. Children are not brushing and parents are not helping. Financial restrictions in third world or developing countries make patients visit the dentist for emergency reasons, ending up with extractions.[31-33]

This, as professionals is not acceptable. A daring new program shaped by Ramos *et al* and The University of California Los Angeles, is training dental professionals to look beyond biology and integrate cultural, environmental and related factors to improve oral health as an Educational tool in schools, hospitals, private practices[34].

Our goal as Pediatric dentists is to produce healthy mouths and contribute to have healthy children. This can only be done with communication.

Is the decision to go to GA based on my lack of patience, experience, time, the possible alteration of my practice or achieving fast results?

There are times that Nitrous Oxide, Sedation or GA are needed[35]. But aren´t we overdoing it?

How to achieve a change

We should not tag the child (pain in the neck, ECC,) or trust the parents labeling their child (John is non adaptive, he is absent minded, he will loose his appliance) because we become biased and defensive. Defensive means, our primitive mind, the reptilian mind kicks in and not the rational mind. The paradox is; we start behaving the same way the child does. The child is afraid and so we are and we take the easy way out (General anesthesia when we could treat him in the office or fixed orthodontics when a removable appliance can correct the problem).

Changing the dentist´s behavior

There are few points that could be helpful if we decide to control behavior in the office.

Learn to say NO

Saying NO is a dangerous exercise, because it implies you are in charge.

The word NO is a poor answer for who only likes to hear the word YES.

Child and parent must recognize that a hierarchy order exists when they visit a dental office. They are in our space, we are the specialists and they seek our expertise.

It is challenging confronting and exercising our authority under the premise that patients are our life and bread and the source of potential new referrals.

The levels of tolerance for a negative answer are generally very low, but it can be necessary when communication cannot be established with children or parents.

“No, you cannot stay in the operatory”, “No, your child needs a crown”, “No, you cannot text message when I am working”, “This is YOUR responsibility” (brushing your child´s teeth, controlling sugar at home, bringing him to the office).

Electronic devices such as phones, tablets and earphones are acceptable when we decide. They can have a soothing effect or hamper our work or communication with us.

We need to distinguish potential mischievous children to scared ones and act accordingly.

Parents can be help or be a nuisance in the operatory. If you decide that the parent can stay, the rule “you are silent observers, you can hold the child´s hand, but no words can be muttered”. If they do not follow your rule, they will have the leave the operatory or you can decide to stop the procedure all together.

Parents as a nuisance in the operatory can have words like “ are you sure this is the tooth? Doctor, he is bleeding a lot! Oh my God! This is a shot. Squeeze my hand honey, you will get an injection!”

“I read on the internet....” Parents become experts in 5 minutes and will question your authority, experience and knowledge. Most of them will find their information in obscure web pages. This occurrence can be also found in other professional fields like the pediatrician office, where parents can refuse vaccinating their young babies.

In these cases, it is advisable to have a written consent or refuse treating the child.

Other responses in empowered abusive children need to be swift and clear, when poor behavior is found such as kicking, biting, cursing. The child needs to understand immediately that these actions are not tolerated. But you need to make sure that this behavior is not triggered by fear from previous poor experiences. In these cases, communicating with them is essential and generally bears positive responses. Compared to other medical fields, cooperation is a must. If the child does not open his mouth, we cannot work.

Open bay treatment areas are advisable. Seeing other children lying down and cooperating can exorcize the fear factor. Younger brothers watching older brothers, having the same procedure is the best “tell-show-do exercise”.

Having a completely uncooperative 8 year old next to a classmate is the best blessing for the dentist. This child will fully cooperate. He is not interested being gossiped and made fun at school.

But the most relevant point we would like to emphasize is, when we bond to children and adolescents and we know them from the bio-psycho-social and cultural viewpoint we will be able to detect potentially physical or emotional hazardous behavior.

We can detect bulimic/anorexic problems, smoking, changes in weight, or emotional behavioral changes which could involve bullying, drugs or other substances even potential suicidal tendencies.

But to detect these changes you need to know your child and when you know him/her you can talk to them. This is what bonding is all about.

However, we need to be sure before we emit a verdict.

For example if you see a shiny, polished loss of enamel substance in the palatal area of anterior permanent teeth, we will be tempted to think of a possible bulimic problem.

We need to ask questions, because it is possible the patient likes to suck on lemon or lime, has gastro esophageal reflux or is a chronic non caloric (acid) soda drinker.

Always, observe-THINK-Understand-talk.

CONCLUSIONS

In many countries around the world, the specialty of Pediatric Dentistry does not exist. We, as experts are trained to deal with healthy young children and young and old people with special needs. However, the challenges that a new generation of children and parents is inflicting on the way we work will increase definitively the amount of sedations and General anesthesia cases.

For this reason, we need to work harder to communicate. Bonding with children must be proven once again.

We need to go back from the simplest to the most complex. Paradoxically, General anesthesia is the easiest because there is no connection, no communication, no behavior control; and unfortunately when no bond exists, we cannot educate.

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