Engaging Children's Cooperation in the Dental Environment through Effective Communication

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Abstract

Establishing a trusting relationship with the child patient is a critical requisite for the pediatric dentist in gaining the child's cooperation in the provision of oral health care. Developing such a relationship is predicated on the establishment of effective communication. Many publications in the psychological literature, specifically the parenting literature, describe communication skills that are relevant to the pediatric dentist in effectively communicating with children in the dental environment. Yet, several of these approaches to communication are not generally discussed or advocated in the dental literature. Among these skills are: (1) reflective listening; (2) self-disclosing assertiveness; and (3) the use of descriptive praise. This article: (1) reviews these 3 skills; (2) describes their theoretical foundations; (3) provides examples of when they are useful in the dentist-child clinical encounter; and (4) indicates why they are important aspects of the pediatric dentist's communication repertoire in establishing a positive, empathetic, and mutually cooperative relationship with the child patient. (Pediatr Dent 2006;28:455-459)

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A recent article in *Pediatric Dentistry* analyzed the literature on behavior management published during the past 30 years.[1] In reviewing the content of the 168 articles published, the authors devoted one section to elaborating on "communication techniques" identified from the literature. Among such techniques were: (1) tell-show-do; (2) voice control or voice modulation; and (3) distraction. Also included in this discussion on communication techniques was the issue of permitting a parent to accompany the child into the dental treatment area. The article concluded that the review of the literature suggests a "dearth of studies" addressing specific management techniques, whether communication approaches or advanced techniques such as conscious sedation. This paucity of information in the pediatric dental literature, specifically on substantive communication skills that can be effective in managing the behavior of children in the dental environment, is unfortunate. It is generally assumed that pediatric dentistry became a specialty of dentistry and that it maintains such a status primarily as a result of the skills pediatric dentists have developed in managing the behavior of children requiring oral health care. Establishing a trusting relationship with the child patient is a critical requisite to gaining the child's cooperation in providing whatever care may be required. Developing such a relationship is predicated on the establishment of effective communication.

There have been a number of publications, both books and journal articles, outside the dental literature that have addressed the issue of how the style and substantive content of one's communication can affect the behavior of children. While many of these publications in the psychological literature have been written primarily for parents in the context of the parent-child relationship, they have relevance and applicability for pediatric dentists in the dentist-child relationship. Skills are identified in these works that can assist in developing a positive, empathic relationship with the child patient, thus decreasing uncooperative responses to treatment. These skills are also helpful in securing the cooperation of a child whose initial presentation is one of uncooperativeness.

This article will review and discuss 3 communication skills that can serve as valuable tools for the pediatric dentist in securing and maintaining the cooperation of children in such a manner that:

1. the child is affirmed as a person;
2. the child is assisted in learning to enjoy the dental encounter; and
3. the required therapy is effectively provided.

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These skills are: (1) reflective listening; (2) self-disclosing assertiveness; and (3) using descriptive praise.

Communicating through reflective listening

In 1951, Carl Rogers, the distinguished clinical psychologist, published *Client-Centered Therapy*.[2] In it, he introduced an approach to communication important in any therapeutic relationship—reflective listening. Reflective listening, more recently referred to in the popular literature as "active listening," is the mirroring of the emotional communication, either verbal or nonverbal, of another.[3] Rogers also emphasized that, in a professional relationship, the clinician (such as a pediatric dentist) should demonstrate 3 qualities:

1. congruence—genuineness/honesty with the child;
2. empathy—the ability to reverse roles and understand the experience from the child's perspective; and
3. respect—acceptance of the child and unconditional positive regard.

The pediatric dentist is in a therapeutic relationship with a child that has strong emotional overtones. Unlike adults, who have been socialized to conceal their emotions in receiving oral health care, children tend to express, either verbally or behaviorally, their feelings. All too often, pediatric dentists (and other members of the dental team) tend to deny children's feelings, or attempt to talk children out of what they might be feeling. As an example:

Child: "I'm scared."
Dentist: "There is nothing to be scared about."

A crying child is escorted to the dental treatment area.
Dentist: "What are you crying about? There is no reason to be upset. We are just going to…"

In both instances and in other comparable scenarios, the pediatric dentist has denied the child's feelings rather than acknowledged them in an active, reflective manner. Children feel what they feel. Their feelings are a fact—a fact the pediatric dentist must accept and deal with in a therapeutic manner. Feelings must be acknowledged by mirroring these feelings back to the children so that they may appreciate that their feelings are recognized and understood.

In *Between Parent and Child*, Haim Ginott stated: "When children are in the midst of strong emotions, they cannot listen to anyone…they want us to understand what is going on inside of them—what they are feeling at that particular moment. Only when children feel right can they think clearly and act right. Strong feelings do not vanish by being banished."[4]

Accepting, respecting, and empathizing with such feelings, however, does not suggest that what children feel can be translated into unacceptable behaviors. All feelings should be permitted, but certain actions are limited.[3-5] One recommended response can be: "I can see that you are upset, but remember our rule—hands must stay in the lap."

Acceptance of children's emotions permits them to develop the sense that their feelings are not all that strange. The fact that the pediatric dentist understands, appreciates, and respects the internal emotional struggle taking place is truly empathetic. When a person is able to feel and communicate genuine acceptance of another, the stage is set to be a powerful helping agent for the other.[2,6] Feelings must be addressed before behavior can be improved.[7]

In the previously referenced interaction between a child and a pediatric dentist, the clinician could appropriately, through "active listening," reflect the children's feelings as such:

Child: "I'm scared."
Dentist: "I understand. Sometimes new things are scary. It is okay to be scared. Sometimes I am scared of things I do not understand or have not done before."

Then, the pediatric dentist might go on to explain that he or she will "tell and show before doing," an approach to managing behavior through communication that is widely recognized as helpful.[8] Consider this scenario:

A crying child is escorted to the treatment area.
Dentist: "I see one of my little friends who really looks upset. I'll bet you really didn't want to come to see me today."

Reflective or active listening children's feelings has the positive effect of reassuring children that what they're going through is a normal part of the human experience. It permits children to "own" their feelings, thus respecting children's autonomy.

Ways in which children's feelings can be acknowledged include[9]:

1. listening quietly and attentively;
2. acknowledging the feeling with a word: "Oh…mmm… I see";
3. giving the feeling a name: "It sounds like you are really *nervous* about coming to see me today";
4. granting in fantasy what cannot be given in reality: "I really wish I could make those scary feelings go away" or, "Wouldn't it be great if we didn't have to fix this tooth today?—I wish we could be out on the playground. We could have such great fun playing basketball together."

It is important not to argue with what children are experiencing. Children should not be encouraged to disown their feelings—that is, don't attempt to convince them that what they are sensing or feeling is not so. Sometimes pediatric dentists approach children with varying degrees of firmness with requests for behavior compatible with examination or treatment needs. Often, they frequently preface with explanations as to why the procedure is necessary or why good oral health is desirable. The typical child has little cognitive appreciation of oral health. This approach evidences more concern about conveying to the child what

needs to be accomplished for the visit to be considered a success for the pediatric dentist than appreciating the child's feelings about coming to the office for care.

Reflectively verbalizing the feelings a child may be experiencing can facilitate a positive relationship between the pediatric dentist and the child. If a child enters the treatment area smiling and at ease, such nonverbally expressed feelings can be acknowledged by words like: "You look *happy* to be here today. I am really glad to see you."

Or, if the child evidences a negative demeanor, the pediatric dentist could say: "You look *unhappy* about coming to see me today. I'll bet you didn't want to come. You would rather be home right now! You probably think we are going to do something you will not like. Today we are going to count your teeth and then take some pictures of them. Then we will be all done." With this approach, the pediatric dentist not only acknowledges the child's feelings, but also begins to alleviate fears about what will be accomplished. Such communication typically results in an improvement in cooperation.

The tone and modulation of the voice, coupled with an appropriate facial expression, can also express understanding, care, and empathy. Feelings can also be acknowledged nonverbally. Taking a young, apprehensive child in one's lap and holding him/her acknowledges understanding and sensitivity, as does stroking the face of a young child or tenderly reassuring with pats on the shoulder, arm, or hand.

Gaining cooperation through self-disclosing assertiveness

A major behavioral goal of the pediatric dentist is to relate to children in such a manner as to gain their cooperation. While empathically acknowledging feelings through active listening is an important first step, it is also necessary to motivate children to behave in ways consistent with being able to accomplish whatever treatment is indicated.

Not infrequently, expressions described as "roadblocks to communication" are employed in an effort to gain cooperative behavior.[3,6] Not only are these expressions not effective in gaining children's cooperation, but they are actually destructive. Communication roadblocks, with children's potential reactions either internalized or expressed, include:

1. Blaming and accusing: "If we do not finish this treatment today, it's going to be your fault." Child: "So you think I care."
2. Name calling: "You are being a bad little girl." Child: "I hate you."
3. Threats: "If you don't sit still, I'll have to hold you down." Child: "Leave me alone."
4. Commands: "You stop that right now." Child: "No… try and make me."
5. Warnings: "Don't you touch that." Child: "Whatever I do I am in trouble."
6. Martyrdom statements: "Will you stop screaming? You are driving me crazy." Child: "Do you think I care?"
7. Comparisons: "Why can't you be good like Johnny over there?" Child: "I am a failure."
8. Sarcasm: "Wow, you sure are being helpful." Child: "He's mean."
9. Prophecy: "If you don't behave yourself and help me do this, you are going to have ugly teeth." Child: "I'm doomed."

Self-disclosing assertiveness permits pediatric dentists to confront children's lack of cooperation without employing these so-called roadblocks to communication. Note that attempts to gain cooperation by employing the roadblocks illustrated previously all call attention to the child and all emphasize the word "you." "It's *your* fault." "*You* are bad." "If *you* don't." "*You* stop that right now." "Don't *you*." "Why can't *you*?" "*You* sure are helpful (sarcastically)." "*You* are going to have ugly teeth." All of these expressions: (1) impugn the child's character; (2) deprecate the child as a person; (3) shatter the child's sense of self-esteem; (4) underscore the child's inadequacies; and (5) cast a judgment on the child's personality. They are all "put downs" that blame the child and expressions to which the child can object and take issue.

The key to gaining cooperation by being assertive is to understand that assertiveness is self-disclosing.[10,11] Self-disclosing assertive statements always begin with "I" and, consequently, have been designated by Gordon as "I messages."[3,6] Self-disclosure improves a pediatric dentist's personal self-awareness of what is required. In addition, self-disclosing "I messages" state explicitly to children what is required to be cooperative. It enables the pediatric dentist to be honest and clear with the child regarding the pediatric dentist's needs and expectations. "I messages" can:

1. describe what is seen;
2. share what is felt;
3. describe a problem being experienced; or
4. give information to the child that the pediatric dentist is aware of, but which the child might not be.

Examples of "I messages" include:

1. "I see hands that are not in the lap" (disclosing what is seen).
2. "I cannot see the teeth when the mouth is closed" (disclosing the problem).
3. "I become upset when my patients don't follow the rule of keeping their hands in their laps" (disclosing the feeling).
4. "I cannot spray sleepy water on the teeth when the mouth is not open" (disclosing the problem).
5. "I don't enjoy working when there is so much noise" (disclosing the feeling).
6. "I see teeth that have lots of plaque on them" (disclosing what is seen).
7. "I sure become discouraged when I see plaque on the teeth after I have worked so hard to teach how to brush and floss properly" (disclosing the feeling).
8. "I'm concerned that this crying will affect the other boys and girls" (disclosing the feeling).
9. "I'm afraid I might hurt you with all this moving around" (disclosing the feeling).

10. "I find it hard to see all of those back teeth when the mouth is not open real wide" (disclosing the problem).
11. "Ouch! That really hurt me. I do not like being bitten" (disclosing the information/feeling).
12. "I need the hands to stay in your lap" (disclosing the information).

Sending "I messages" is more effective at influencing children to modify unacceptable behavior than using the identified "roadblocks to communication."[12] Additionally, it is much healthier for the child-dentist relationship. "I messages" are much less apt to provoke resistance and rebellion. To communicate honestly to children that the effect their behavior is having is far less threatening than to imply there is something bad about them because they are engaged in that behavior. Consider the significant difference in a child's reaction to these 2 messages sent by a pediatric dentist after a child bites:

1. "Ouch! That really hurt me. I do not like to be bitten."
2. "Ouch! That is being a very bad boy. Don't you dare ever bite me or anyone else like that again!"

The first statement is self-disclosing, telling the child how he or she made the pediatric dentist feel. The second statement tells the child that he or she is bad and warns him or her not to do it again, both of which can be argued against and probably resisted strongly by the child.

"I messages," because they only disclose what is seen, felt, sensed, or wanted, are strong messages simply because they cannot be argued with—they are the practitioner's experience. "I messages" are also more effective because they place responsibility on the child for modifying behavior. An "I message" places the responsibility on the child to handle the situation constructively, trusting him/her to respect the clinician's needs.

As with the active listening of feelings, voice modulation/intonation and facial expressions can support the sending of "I messages." An authoritative statement in a louder than normal tone of voice and with a congruous facial expression (eg, "I am upset. I need your hands to stay in your lap and your mouth to remain open.") communicates the pediatric dentist's resolve. Research indicates that when voice control is employed, the voice needs to be louder than normal.[13] Pinkham points out that individuals, including children, respond to facial expressions as well as voice tone and modulation.[14] Therefore, it is important for the pediatric dentist to insist that the child look directly at him/her when sending an "I message" with voice control, thus reinforcing the authoritative self-disclosing statement with a stern look.

"I messages" can also be sent nonverbally. A firm placing of a child's hands back in his or her lap and casting a disapproving look strongly communicates the message "I am upset—I need your hands to stay in your lap."

Joined with empathic reflective (active) listening, assertive self-disclosure helps develop a climate of trust and an expectation of cooperation.[12]

Reinforcing behavior through descriptive praise

Acknowledging the correctness of a child's behavior is a powerful tool to reinforce desirable behavior. There are, however, appropriate and inappropriate ways to do so. According to Ginott, "The single most important rule is that praise deal only with the child's efforts and accomplishments, not with his character and personality…our comments should be so phrased that the child draws from them positive inferences about his personality."[4]

All too often in attempting to gain children's cooperation practitioners praise children with evaluative terms such as "great," "good," and "wonderful." No doubt such expressions are an attempt at "behavior shaping." Skinner emphasized the role of positive reinforcement in shaping behavior.[15] The principle is that if the consequence of a certain behavior is pleasant or desirable, that behavior is more likely to be repeated in the future. Praise of desirable behaviors is consistent with this principle of operant conditioning. The problem, however, is that praise using evaluative terms places the pediatric dentist in the role of judge. With such use, the child tacitly understands that the clinician is in an evaluative role relative to their behavior, and that the child's behavior can just as easily, at a future point in time, be designated as "bad." Such evaluative praise can create a sense of anxiety in the child over possible failure in the future. The most notable feature of a positive judgment is not that it is positive, but that it is a judgment. People, including children, do not like to be judged.

Kohn sees evaluative praise as counter-productive because children ultimately see through it as being manipulative.[16,17] Additionally, he believes it "steals a child's pleasure" in deciding when to feel good about their behavior and when not to. Conditioned by global evaluations, children continually look to an adult for a verdict. Branden stated the issue strongly: "There is no value judgment more important to man [children], no factor more decisive in his psychological development and motivation than the estimate he passes on himself…The nature of self-evaluation has profound effects on a man's [child's] thinking processes, emotions, desires, values, and goals. It is the single most significant key to his behavior."[18]

The alternative to global evaluative praise is descriptive praise.[4,7,9] Rather than saying "good job," it is important to reflect on the reason such a judgment or evaluation was going to be made and then express that reason to the child. For example: "You sat so very still and held your mouth open so big and wide while I sprayed the sleepy water on your tooth." Or, in the third person, say: "I saw a young woman who opened her mouth so big and wide and sat so very still while I spayed sleepy water on her teeth." In both instances, the pediatric dentist is describing what happened—not evaluating—thus leaving the judgment to be made by the child about the quality of his or her behavior. Not only can you describe what is seen, you can also describe how you feel when a child responds positively (eg, "It is really a pleasure to be the pediatric dentist of a young lady who is so cooperative.")

A third way to praise descriptively is to sum up the child's behavior in a word (eg, "I see a young man with his hands in his lap. That's what I call cooperation!")

Skills in context

The communication skills and strategies explained and advocated in this article are not natural or intuitive and are not easily learned. Learning to use them effectively is analogous to learning to use a foreign language. Only practitioners who are willing to discipline themselves to acquire the language through practice and repetition will come to understand and appreciate its value. Utilization of these skills has the effect of "humanizing" the relationship between the pediatric dentist and the child. The skills help promote a healthy relationship of respect and positive regard.

However, "the agents of help are never solely the techniques, but the person who employs them. Without compassion and authenticity, techniques fail."[19] If the communication strategies advocated are employed only as techniques to engage a child's cooperation, they will likely fail. If, however, they are skills that flow from one who is genuine, empathetic, and respectful, they can be successful strategies for fostering the type of relationship with a child that facilitates their desire to be helpful and cooperative.

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