

Parental Acceptance Of Some Behavioral Guidance Techniques Used In Pediatric Dentistry In A Governmental Hospital And Some Private Dental Clinics In Cairo, Egypt: A Cross-Sectional Study

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Abstract:

Background: Parental approval of various Behavioral Guidance Techniques (BGTs) can vary among cultures and socioeconomic norms within the same society

This study aims to assess the acceptance of some BGTs by parents of pediatric patients attending a governmental hospital and some private dental clinics in Cairo, Egypt.

Materials and Methods: This study involved 140 parents and was divided into two groups: Group P: parents accompanied their children to private clinics, and Group G: parents accompanied their children to governmental clinics. Both groups were subdivided into two subgroups 1,2 based on the child's age. Subgroup 1: parents of children aged from 2-6 years old and parents of children aged >6-12 years old. Parents were shown a customized video demonstrating the 9 BGTs. They rated the acceptance of each technique using a 3-point Likert scale and Visual Analogue Scale (VAS) and ranked them in order of preference from 1 to 9.

Results: In relation to different demographic parameters, there were significant gender differences in private and public healthcare facilities, with higher levels of government mothers and a higher number of siblings. A higher educational level, and parental employment status were found in the private group. Basic BGTs, regardless of the child's age, were accepted at a higher rate than advanced BGTs.

Conclusion: Tell-Show-Do (TSD) followed by Tell-Play-Do(TPD) and Modeling(M) were the most accepted BGTs by Egyptian parents. Protective Restraint(PR) was the most accepted advanced BGT, followed by General anesthesia(GA). GA was the least accepted technique by most parents.

Key Word: Behavioral-Guidance-Techniques, Behavior management, Parental acceptance, Child.

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I. Introduction

For children, going to a dental appointment can be a stressful event. These feelings can trigger behavioral changes as they undergo treatment, which can affect their quality of care. Effective communication with the parent is essential to establishing a stage in which prognostic possibilities and treatment expectations can be established. ⁽²⁾ The relationship between the dentist and the patient can be cultivated, confidence can be built, fear and anxiety can be reduced, and positive attitudes towards dental care can be enhanced for subsequent visits. ⁽³⁾

The dentist can predict potential behavioral issues by considering the patient's medical and dental history, which includes any observations of pain or painful previous medical visits. ⁽⁴⁾ Moreover, it's crucial to make sure the accompanying parent or guardian is aware of the BGTs that the dentist is likely to use and is ready for them. ^(3,4)

Dentists must have a variety of BGTs to meet the needs of each individual child and be patient and adaptable when using them because children exhibit a wide range of physical, intellectual, emotional, and social development as well as a diversity of attitudes and temperaments. ^(6,7) All choices regarding BGT must be made after reviewing the patient's social, dental, and medical histories and after assessing their present behavior. The dentist cannot be the only person to decide whether to use behavior coaching techniques other than communicative management, a parent and, if suitable, the child must be involved. ^(8,9,10)

The practitioner should effectively communicate behavior and treatment options, including potential benefits and risks, and assist the parent in determining what is in the child's best interests. ⁽¹¹⁾ Behavior modification aims to build a good dental mindset and foster a lifelong interest in the patient in order to promote continued prevention and improved dental health in the future. ^(8, 12)

The primary goal of BGT is to establish effective communication with the pediatric patient. When a child is unable or unwilling to cooperate because of their age or other related circumstances, BGT can be very useful. As a result, the following research was designed to evaluate how parents feel about and accept the BGT that pediatric dentists use.

The American Academy of Pediatric Dentistry (AAPD) categorizes BGTs into Basic Behavioral Guidance Techniques (BBGTs) and Advanced Behavioral Guidance Techniques (ABGTs). BBGTs include communication techniques like TSD, Distraction (D), positive reinforcement, VC, and parental presence/absence. While ABGTs are necessary for a small percentage of children who cannot be managed by BBGTs, Like PR, Nitrous oxide/oxygen (N₂O/O₂) sedation with nitrous oxide, and GA. ⁽¹⁾

In Egypt, no previous studies have been conducted to investigate and compare parental acceptance of some BGTs in private or government dental clinics.

II. Subjects And Methods

This cross-sectional study was carried out on 140 parents who were selected conveniently from a group of parents who accompanied their children to either a government or private dental clinic in Cairo, Egypt. Parents were recruited from the outpatient clinic of the Pediatric Dentistry and Dental Public Health Department, Faculty of

Dentistry, Ain Shams University, and two private dental clinics in Cairo, Egypt, and were directly interviewed by the principal investigator. Following the presentation of a specially designed video explaining 9 BGTs to parents, parental acceptance of some basic and advanced BGTs has been investigated. Duration of the study was conducted from February 2022 until January 2023. According to TREND guidelines⁽¹³⁾, the study was conducted and reported.

Study Design: cross-sectional study

Study Location: Pediatric Dentistry and Dental Public Health Department, Faculty of Dentistry, Ain Shams University, and two private dental clinics in Cairo, Egypt.

Study Duration: February 2022 until January 2023.

Sample size: 140 parents.

Sample size calculation: A power analysis was designed to have adequate power to apply a statistical test of the null hypothesis that there is no difference in parental acceptance of several behavior guidance techniques in governmental and some private dental clinics in Cairo, Egypt . By adopting an alpha level of (0.05) a beta of (0.2) i.e. power=80% and an effect size of (0.488) calculated based on the results of Boka, V., et al; the predicted sample size (n) was a total of (140) cases. Sample size calculation was performed using G*Power version 3.1.9.7⁽¹⁴⁾

Subjects & selection method: A total of 140 parents were divided into 2 main groups according to the type of dental clinics. Each group was divided into 2 subgroups according to the age of their children as follows: Group P: Included 70 parents who accompanied their children to private clinics in Cairo, Egypt. Group G: Included 70 parents who accompanied their children to the governmental clinic of the Pediatric Dentistry and Dental Public Health Department, Faculty of Dentistry, Ain Shams University, Cairo, Egypt. Both Groups P & G were divided into two subgroups P1 & P2 and G1 & G2 (n=35) each according to the age of children (2-6) & (>6-12) years old.

Inclusion criteria:

1. Parents of 2 - 12-year-old children.
2. Parents of medically free children.
3. Parents who are willing to participate and able to view and understand the demonstration material.
4. Parents who accepted to sign the consent.

Exclusion criteria:

Parents who have a child with special health care needs or from a vulnerable group; orphans, mentally or physically disabled.

Procedure methodology

Video: A video was filmed in a private dental clinic in Cairo, Egypt, with a volunteer mother and her eight-year-old child. A signed informed consent from the mother and verbal assent from the child were taken. Both were given detailed instructions before recording. A single operator performed the demonstration sessions, to ensure understanding of the procedure.

Video characteristics: The techniques were filmed individually and combined into an 8-minute video. After editing, the final video was 5 minutes and 40 seconds. A voice-over in the native Egyptian language was developed by the principal investigator, reviewed by two co-supervisors, and uploaded to describe each BGT which are: 1-TSD, 2-TPD. (figure 1), 3-M ,4-Distraction Virtual Reality (D(VR))(Figure2),(VC),6-HOM,7-Parent separation(PS),8-PR ,and 9-GA. The techniques were presented in the same order.

Parents were interviewed individually in a private room after signing consent forms, and the video demonstration was presented to them to understand every BGT. (Figure 3)



Figure 1: Tell-Play-Do technique



Figure 2: Distraction virtual reality technique



Figure 3: Interviewing parents

Questionnaire: A validated questionnaire has been used, based on a previous study ⁽¹⁵⁾. A direct face-to-face interview with the parents was done before filling out the questionnaire. The investigator arranged the questions to assess the parental acceptance of different BGTs that might be applied to their children in the dental clinic, which were assessed by two experienced evaluators in Arabic. The questionnaire was divided into **3 sectors**: **sector 1:** designed to gather demographic information about the parents: gender, age, educational level, employment status, and parental dental anxiety level by using the Modified Dental Anxiety Scale(MDAS)⁽¹⁶⁾. **Sector 2:** gathered Information about the child: name, age, type of school, presence of siblings, and his or her order in a family as well as previous experience with dental care. **Sector 3:** measured parental acceptance of each of the BGTs by using a 3-point Likert scale, and via a 100-millimeter horizontal VAS, the right end of the line represented “completely acceptable”, and the left end represented “completely unacceptable”(figure 4) ^(15,17). The parents were asked to list the techniques in order from 1 to 9, so that 1 is the most acceptable technique and 9 is the least acceptable technique, at the end of the evaluation of all techniques. ⁽¹⁸⁾

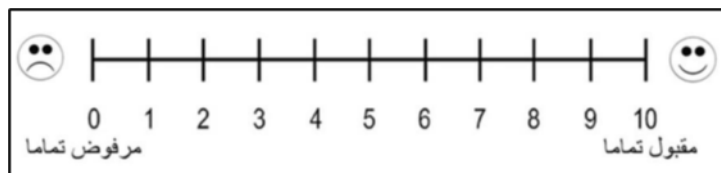


Figure 4:VAS

Statistical analysis

Categorical and ordinal data are presented as frequencies and percentages. Categorical data were analyzed using a chi-square test followed by pairwise comparisons utilizing multiple z-tests with Bonferroni correction. Numerical data are presented as mean, standard deviation (SD), median, and interquartile range (IQR) values. They were tested for normality using Shapiro-Wilk’s test. Age data were normally distributed and were analyzed using an independent t-test. Other non-parametric data were analyzed with ordinal data using the Mann-Whitney U test. The significance level was set at $p < 0.05$ for all tests. Statistical analysis was performed with R statistical analysis software version 4.3.2 for Windows1.

1R Core Team (2023). R: A language and environment for statistical computing. R Foundation for Statistical Computing, Vienna, Austria. URL <https://www.R-project.org/>.

III. Result

Demographic data :

Effect of age and gender: There was no significant difference between both groups regarding age and gender of children ($p > 0.05$). Similarly, there was no significant difference between parents' ages in both groups ($p = 0.757$). There was a significant difference in parents' gender with a significantly higher percentage of parents in the governmental group being mothers ($p = 0.040$).

Parental education level and employment:

There was a significant difference between both groups regarding parental educational level and employment status with a significantly higher percentage of parents in the private group having higher education ($p < 0.001$), and being employed ($p < 0.001$) than in the governmental group.

Technique acceptance:

a. By Likert Scale :

For HOM and PR techniques, significantly higher percentages of the parents in the governmental group found the technique acceptable in comparison to the private group ($p < 0.05$). For other techniques (TSD, TPD, M, D(VR), VC, PS, GA) the difference was not statistically significant ($p > 0.05$). (figure 5)

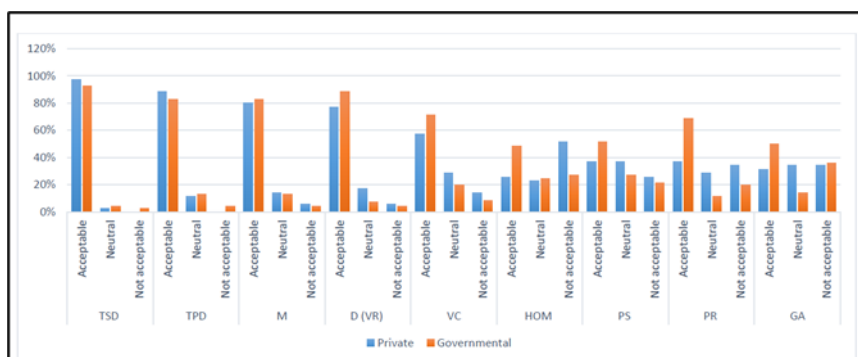


Figure 5: Bar chart showing percentage values for technique acceptance.

b. By VAS :

For TSD, TPD, D(VR), HOM, and GA, there was no significant difference in acceptance between both groups ($p > 0.05$). For other techniques M, VC, PS, PR acceptance score values measured in the governmental group were significantly higher than in the private group ($p < 0.05$). (figure 6)

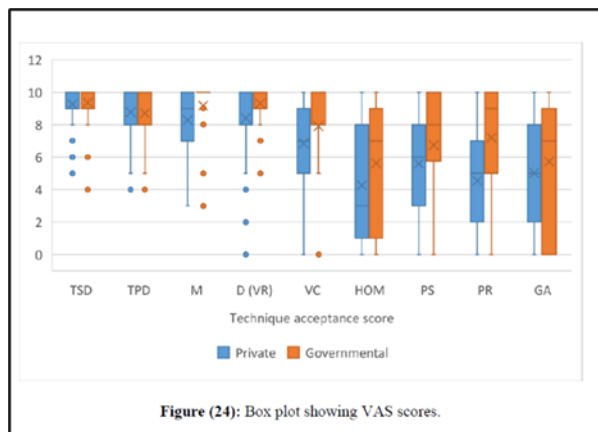


Figure 6: Box plot showing VAS scores.

Association between age and technique acceptance:

Within both groups, there was no significant association between age and acceptance of different techniques by Likert scale and VAS ($p>0.05$).

Listing the techniques from the most accepted to the least accepted:

In both groups, TSD has the highest rate of acceptance, followed by TPD, M, and D(VR). Then, VC, PS, PR and, the last one was GA. (figure7)

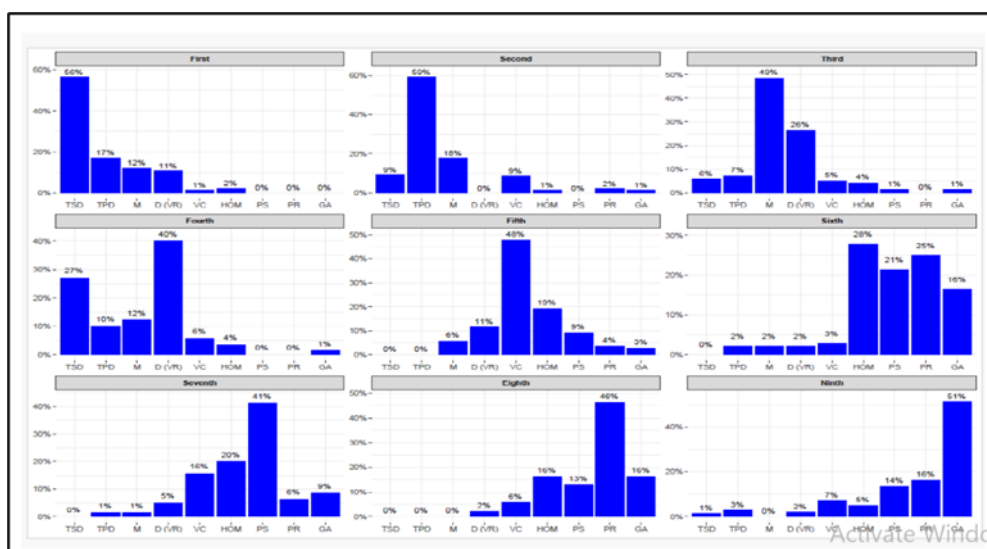


Figure 7: Ranking the techniques by acceptability.

IV. Discussion

Parental acceptability of various BGTs may fluctuate among cultures and socioeconomic norms within the same country. ⁽¹⁹⁾ In this study, parents were introduced to a brief explanation of the characteristics and aims of each BGT through an audiovisual demonstration, as several studies have shown that explanations of BGTs positively affect parental acceptance of BGTs. ^(15,19)

Eaton et al. ⁽¹⁷⁾ and **Boka et al.** ⁽²⁰⁾ reported that there was no effect on the acceptance of different BGTs on the level of parental social and educational status, age, and gender which was in contrast with this study. On the contrary, contradictory findings have been reported by further researchers. ^(21,22,23,24)

This study was conducted in Egypt, as there were no previous studies to investigate and compare parental acceptance of some BGTs in private or government dental clinics. Regarding technique acceptability by the Likert scale, results of this study showed there was a significant difference in HOM and PR techniques with a higher percentage of parents in the governmental group than in the private group. A possible explanation for that might be due to the old-school traditional raising versus the recent modern raising. **Seangpadsa et al**, 2020 found that PR has been regarded as a safe, protected, and efficient technique, and it might be useful in treating young children with some minor dental procedures. ⁽²⁵⁾

This study found that BBGTs such as TSD, TPD, M, and 3-D(VR) were well-accepted by both groups, no matter the child's age. However, ABGTs such as PR, N2O/O2 sedation, and GA are not as well accepted as basic techniques. The possible explanation is that the technique of TSD offers children a stronger understanding of dental instruments/equipment. Also, TPD technique might offer an entertaining and interactive experience with the dentist.⁽²⁶⁾ While parents might think that ABGTs were considered to be more invasive techniques that might be traumatic to their children.⁽²⁰⁾

In agreement with this study, **Desai et al.**⁽²⁷⁾ reported that the acceptance of different BGTs was not influenced by child age. It has been reported that all subgroup ages were most acceptable to the TSD technique. Also, **Candan et al.**⁽²⁸⁾ in 2023, reported that Turkish parents were most accepted to the TSD technique. On the other hand, contrary to **Allen et al.**⁽²⁹⁾, research suggests that parents with younger children are more likely to accept N2O/O2 sedation, whereas those with high socioeconomic status are more accepting of the GA technique. Some studies suggest that parents of uncooperative children, regardless of age, are more willing to accept advanced BGTs, particularly if their child is enduring pain or discomfort.^(20,30,31)

In the present study, TSD had the highest rate of acceptance, followed by TPD and Modeling. The present study also confirmed previous findings regarding TSD as being the most accepted BGTs by parents^(15,20,25,27,28). These findings were congruent with a recent meta-analysis of Brazilian research, in 2022, by **Massignan et al.**⁽³²⁾ that indicated parents were more likely to agree with basic BGTs than advanced BGTs. Furthermore, in a study by **Eaton et al.**⁽¹⁷⁾, GA was the third most accepted BGT after TSD and N2O/O2 sedation.

In the present investigation, GA was ranked as the least acceptable ABGT followed by PR technique. In harmony with our study, **Razavi and Purtaji**⁽³³⁾, found that GA had the lowest acceptability followed by PS, HOM, and VC. However, the study showed that mothers in this population were predominantly from low to middle-class socioeconomic backgrounds. These effects could be associated with high costs of GA and poor knowledge about oral hygiene. In contrast, **Boka et al.**⁽²⁰⁾, showed that parents preferred GA over PR, HOM, and VC techniques. One possible explanation is that these parents feel that GA will be less stressful for their children and that utilizing such invasive treatments will be traumatic for them.

In 2015, **Jafarzadeh et al.**⁽³⁴⁾ found that, over time, the acceptability of advanced pharmacological techniques such as GA and N2O/O2 sedation is increasing. The growing familiarity of parents with outpatient procedures using pharmacological techniques may be the cause of this increased tendency.

HOM was ranked as the fourth least accepted technique followed by PS, PR, and GA in this research. It appears that with time, parental acceptance of HOM has decreased. In 1998, **Scott and Garsia-Godoy**⁽³⁵⁾ reported that HOM was ranked as the third least accepted technique. **Eaton et al.**⁽¹⁷⁾ in 2005 argued that HOM was the least accepted technique available. Later **Abdulla et al.**⁽³⁶⁾, concluded that HOM in Bahrain was the least accepted technique by Bahraini parents. All these studies came in accordance with our results.

Abushal et al.⁽²³⁾ are compatible with our research and reported that Saudi parents rank PS as the least acceptable BGT, along with VC and HOM. According to **Desai et al.**⁽²⁷⁾, most parents won't allow their children to be separated from them during treatment, assuming that their presence would improve the child's cooperation with the dentist.

V. Conclusion

The acceptance of more invasive BGTs such as VC, HOM, PS, PR, and GA was lower than basic techniques, especially in the younger age groups of both private and governmental groups. TSD followed by TPD were the most accepted BGTs by Egyptian parents. On the other hand, PR was the most accepted ABGT followed by GA which was the least accepted technique by most parents.

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