



# Communication amongst Dentists, Patients, and Parents – A Triad

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## Abstract:

While pediatric dentists have been recognized to treat children in dental procedures, there are many implications in communication between the patient, parent, and professional. Many children have a chronic fear of visiting the dentist, which results in excessive aggravation in the chair. Maintaining open communication with the child and parent is necessary to ensure the best treatment and avoid referrals. This review focuses on aspects that can create a link between communication barriers and why children have fear in dentistry. Though, there is a lack of elaborative methods to solve the problem. Research shows that children are able to locate and express their pain, but the source of fear seems to come from the lack of understanding procedures or outcomes and parental influence. Increasing health literacy and open communication can potentially alleviate fear and anxiety in pediatric dentistry patients.

Fear is a feeling that most people experience at one point in their lives. An experience in the dentist's office can bring about this vivid emotion of fear. Fear and anxiety are common among many children in pediatric dentistry. Exploring the reasons behind those feelings motivates this review about communication barriers between the triad- patient, parent, and professional.

For pediatric dentists, who usually work with children ranging from ages 5-13 there is a vast communication concern. It is not only difficult to work with children, but it becomes tough when there is a literacy problem. Research shows that dentists should speak slower and try to explain procedures to their patient in the simplest terms possible. However, the idea of pain and discomfort disengages most children from the procedure. A common research barrier amongst communication with dentists and patients is a triad formation. Because many children look to their parents for explanations and support at that age, parents become a center point of the triad and have to try to explain the problems to the dentist and patient. While most health professions usually have one on one interaction with the

patient and doctor, pediatric dentistry gets much more complex because of terminology and the formation of a triad. To identify why children have fear and anxiety, this review will examine the communication barriers and techniques on improving health literacy skills amongst patients, parents, and dentists.

Communication among health professionals may seem fairly simple. Having background information about similar issues allows professionals to communicate on a higher and understanding level. However, the problem initiates between a patient and a professional. In pediatric dentistry, the first common issue arises when most children are not able to express how they feel or be able to show the need for support from their parents to explain their feelings. In "Communicating with Parents and Children in the Dental Office," (2013) Oariona Lowe, DDS, claims that communication skills are necessary amongst patients and parents before seeing a dentist (597). The problem with children who have anxiety and fear about seeing a dentist is a disadvantage to the patients, parents, and dentists because the primary focus should be dental care for the patient in a positive environment (598). Implementing new ideas and collaborative methods could positively affect communication within this triad. The information presented provides techniques in order to avoid complications in communication (599). A method with quantitative information of experimentations could create more depth and concrete

methods of evaluation. A majority of this paper focused on identifying the problem and becoming comfortable with communication amongst parents, patients, and dentists. Quantitative information, such as statistics and evaluations of research were lacking. Although this paper provides qualitative information to understand communication skills, more statistics would benefit for support.

Health literacy has a tremendous effect on the type of patient care received. While there is an insufficient amount of health literacy globally, many patients in the United States also lack that common knowledge. The most common definition of health literacy is to obtain, process and understand basic health information and services needed to make appropriate health decisions. While 90 million U.S. adults do not have those literacy skills, the potential effects on child dental care are unimaginable (518). In the article, "Dentist-patient communication techniques used in the United States: The results of a national survey," (2011) Dr. Gary Rozier, interprets health literacy as being unable to know the basic health tasks, not being able to use a chart to find the age at which a child should receive a vaccine, and being unable to read a drug label to determine when to take a medication (518). Although they discuss the definitions of health literacy in the US, the lack of information provided to parents in the dental office should contribute to the reasons as to why statistics for oral health literacy are

so low. A study discussed, showed oral health literacy to be associated with knowledge, dental care visits, dental caries severity, and oral health-related quality of life (519). Rozier's research began when parents of children enrolled in Medicaid realized that dentists were not providing information necessary for their children to have the best oral health. Dentists admitted to withholding information from patients due to lack of interest in a patient, if they knew the patient didn't have oral health literacy skills, or if the dentist believes they were able to make the correct judgmental calls about the providers decision on giving consent (519). This information designed the study in which the American Dental Association (ADA) conducted surveys of dentists and dental teams to display health literacy relating to knowledge, attitudes, and behaviors. This study would help ensure the levels of effective communication with patients along with the amount of information they knew about oral health literacy (520). Rozier evaluated the amount of communication skills used amongst patients and dentists. The surveys sent to private practices by ADA staff members supported the idea of collecting valuable information about communication use. The scales of communications skills represented by a questionnaire consisting of a list of 18 communication techniques in which participants specified a number from a five-point scale (0 being never to 4 being always) showed the engagement between dentists and patients (520).

The scales of measurement included interpersonal communication such as speaking slower, using simpler language, drawing illustrations or using printed pictures, teach-back methods including asking patients to repeat information back to the dentist, asking questions about follow up questions, patient-friendly, and etc (523).

The results that less than one-fourth of dentists used any of the 18 techniques on a regular basis suggest that open communication between the dentist and patient is limited (522). While this paper discusses communication among dentists who work at private practices only, the information can fall short when observing dentists who work for larger corporations because more limitations and rules can be applied (520). The information provided about communication techniques being impacted by literacy skills of some patients contribute to the overall lack of communication, which causes insufficient oral health care. The insight to background lifestyle of patient, oral health literacy skills, and communication techniques between the dentist and patient can assemble numerous possibilities of how dentists can work proficiently with their patients to facilitate a more understanding and helpful procedure.

Considering the impacts communication has on dentists and patients in the United States, there are also communication barriers, dental fears, and behavioral management problems in pediatric dentistry globally In Amsterdam, Marleen Antoinette Klassen

analyzed the different reasons why children can be referred to a specialist clinic in pediatric dentistry (469). In the article, "Dental fear, communication, and behavioral management problems in children referred for dental problems," (2007) the data conducted with 80 children with patient, parents, and dentist communication explored the issues and reasoning as to why some children have to be referred to specialist dentists (470). Referral to specialized dentist isn't always necessary, but clarification for referral and investigation of whether interactions among the patient, parent, and dentist triad had a negative effect on communication were essential for this case (470). The Fear Survey Schedule (FSS-FC) consisted of a specific dental fear questionnaire for children. The survey categorized about fifteen specific aspects of dental treatments, such as injections and drillings into a five-point scale. Although questions were asked to pediatric patients, parents and dentists were asked to indicate the importance of four different factors that might have played a role in the referral (471). The first factor to be considered was the child's temperament and character. The second factor was the dentist's patience, anger, and stress. The third factor was the parent's influence on the child. The fourth factor was the pain of treatment and treatment length. One of the main levels being tests was communication between the triad during the last treatment session leading to the referral (471).

The authors interpreted communication between patients, parents, and dentists and the fear within patients as the main problem leading to a referral (473).

Although the forms of communication that are available for communicating weren't exemplified, the specifics of why certain children have resistance toward treatment and are in need of referrals are discussed. In order to ensure validity of communication between the triad, there were specific questions asked to each member of the triad. The factors were rated and majority of the results suggest child factors, such as temperament and character contribute most to referral. While dentists scored child and parental factors higher, the parents scored dentist and child factors higher (475). In a little less than half of the cases, the child was referred directly after anesthesia, drilling, extracting, and x-rays (474). The interpretation of the studies by the authors, reveal that the child's fear of procedure and communication 'disturbances' during treatment increases the number of referrals (475). Throughout the study, the fear within children also showed problems in behavioral and emotional areas (475-476). However, dentists thought that they were of minor relevance when the child was being referred and parents thought they were of minor relevance. This back and forth blame presented an emotional role, which increased bias. The result of the child's uncooperative

behavior, such as pain, uneasiness, and need for referral, decided by dentists and parents, is the main reason for referral (475). With more information about the causes for uncooperativeness, the explanations will allow for clarity. The main reasons for the children being uncooperative remain unclear to dentists and parents. Although this study does not include further measurement plans, it does include bias amongst children who have already seen specialists. Because children are referred back to their pediatric dentist after seeking special care, there must be a modification in open communication by the specialist, parent, and patient that caused the child's fear to decrease (470). To develop more elaborate communication techniques, further questions and surveys about the experiences of children with the specialist should be conducted.

While communication barriers are measured and interpreted to provide a less chaotic conversation between the triad, the interpretation of pain in children varies. An important quality that most health professionals need to consider is the ability to detect symptoms and signs of pain within different age groups and determine whether they are caused by pain or other factors (125). Pediatric dentists consult patients from various ages and backgrounds, so having the knowledge to access pain is crucial for maintaining a healthy relationship and successful treatments. Amit A. Jain, a Postgraduate student at Kanti Devi Dental College in Uttar Pradesh, India, represents pain

to be the prominent tool necessary for measurement in correspondence to fear and dentistry. (125) In the article, "Measurement and Assessment of Pain In Children-A Review," (2012) Jain indicates the potential sources of pain measurement, responses to pain control, and distraction based on pediatric developmental stages (125). A model of whether children are successful in communicating painful distress was reviewed. The first part of the model indicated the experience of pain being influenced by the patients thoughts and feeling which could be expressed nonverbally, verbally, or physiologically. The next stage of pain assessment interprets the relationship between the observer and the person in pain. In the last stage, pain management according to the reaction of the patient is interpreted (126). The potential sources of pain discussed, aid to confirm ideas about self-report measures, behavioral measures, physiological measures, and composite measures (127-128). The data included with different types of measurement scales aid to create various experimental measurement techniques for pain. According to the Jain, the first and most important approach to pain measurement in children, is self-report measures (127). Depending on their age, a child is typically able to respond to questions depending on how much they have developed and learned. While two year olds are able to report presence and location of pain they cannot describe pain intensity until three of four years of age. At

about age eight, a child is able to rate the quality of pain. One of the most effective measurements noted was facial expression scales. Facial expressions corresponded to how much pain the child was in and how much pain was felt. While facial expressions are easy to administer, several prior studies showed 55-90% of pediatric nurses believed children over-reported pain levels (127). Behavioral measures such as facial expressions, crying, posture, and movements during procedures are indicators of discomfort and pain (127). These elaborative pain scales created by various experimenters in the past were evaluated by the authors based on measurement parameters of each study (130). Communication between the patient and dentist are essential to limit levels of pain. Jain concludes by devising that pain management in children remains undertreated because of the factors discussed. Therefore, the scales should be assessed according to a patient, individually (132). While the scales of measurement presented in the article can be used simultaneously to develop better understanding for pain assessment, they are only appropriate for slight to moderate pain (132). Although detailed alternatives for coping with pain were not presented, identification of the problem and acknowledgment of pain measurement was supported with adequate evidence. Jain describes pain management, but because of underlying measures due to a child's background, age, and other issues, there isn't a method to treat

the pain factors. Consultations with pediatric patients and research with other dentists and psychologists can prove to further expand why children in various age groups have these fears and how they can be overcome.

As discussed, pain in an underlying factor for uncomfortable dental settings. While pain has been measured by facial expressions, anxiety is also measured in similar ways. In, "Design and Preliminary Validation of the Verbal Skill Scale in the Dental Setting: An Anxiety scale for children (2012)," Naser Asl Aminabadi, DDS, professor at Tabriz University of Medical Sciences in Tabriz, Iran, evaluated how fear and anxiety can be measured in various ways amongst children ranging from ages four to six. The data included were exclusively between the patient and dentist. The scales of measurement: eye contact, verbal performance, and facial expression were classified as the Verbal Skill Scale to conduct questionnaires for children so their expressions could be noted (44). The evaluative methods conducted by professionals such as child psychologists, graduate students, certified dentists, and dental assistants ensured the quality of feedback from the children. The paper described effective ways to measure anxiety and fear in children. However, only children from the following criteria were selected: stable physical and mental health, no history of uncomfortable experiences in previous dental settings, no hearing or speech disorders, no previous experience

of dental treatment, and much more (44). Also, the study only had three measurement scales. Although some subjects measured to be anxious and fearful in one third of the case, they did not fit in all the categories (45). Aminabadi found the verbal skill scale to be a concise measure of dental anxiety for children aged four to six because it was easy and quick to administer (48). However, considering each individual child has their own reactions to treatment, methods of intensity should have been discussed. Additional categories to test for fear and anxiety would benefit explanations as to why certain children only fell into specific categories, rather than all. This could potentially create different scales of fear and anxiety so that individual cases could be treated successfully.

Communication barriers and child fear in pediatric dentistry has been an ongoing discussion for several years. The concerns about these problems are presented in the United States of America, Amsterdam, India, Iran, and many other countries. While studies are able to indicate who the communication barriers are between, what age group children are able to express their pain, and how much fear and anxiety children have when visiting the dentist, the bridge to solve these problems is lacking. The studies have showed children to be stubborn, in a developing stage, uncooperative, and much more. The lack of health literacy was discussed to be prominent in the United States.

However, India, a third world country, also has similar barriers, if not many more. While most studies were conducted outside of the US, the absence of research within the United States suggest various other barriers such as influence of communities, society, literacy, lifestyle, and residence. Studies in the United States can benefit in understanding which barrier is most common and how it can be resolved. While fear and anxiety about dental procedures will remain in children, communication between the triad- patient, parent, and dentist, can create elaborate methods to ease the process. For any problem to be solved, all parties must be willing to cooperate. Effort, patience, knowledge, and understanding of the gap between communication among the triad can ensure positive techniques to ease child fear during dental visits.

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