INTRODUCTION

Behavioral and personality development in children is an evolving phenomenon. It is influenced by both genetic and environmental factors. Genetic factors such as medical syndromes have certain behavioral and personality trends. A good example is Trisomy 21 or Downs Syndrome. People with this disorder tend to exhibit very docile behavior, a congenial personality, and lower than normal intelligent quotients. Another example is Attention Deficit Hyperactivity Disorders or ADHD. People with this disorder often lack the ability to stay focused on a subject and thus can have increased anxiety in performing prolonged tasks. Environmental factors such as cultural influence many have certain behavioral and personality trends also. A good example is that in some cultures it is not acceptable to show emotion and so pain must be tolerated without any outward behavioral reaction. Likewise in some cultures it is common to find people with very withdrawn and reserved personalities where outward emotion is discouraged. Behavioral and personality development is certainly multifactorial in origin with both heredity and environment intermingled.

A standard pediatric textbook can be very helpful in understanding the behavioral manifestations and personality traits of the various genetic syndromes and behavioral/personality disorders. This is not the case in trying to understand the behavioral and emotional manifestations of the result of various environmental factors upon behavior and personality development in children.

Let’s see if we can delineate the various known behavior and personality development aspects of children through their stages of age and physical development. This may be helpful to the stranger adult (dentist and staff) as he/she tries to interact with the child. Because few of us will interact with infants and toddlers, let’s start with preschoolers.

EARLY CHILDHOOD (AGES 2 THROUGH 6 –PRESCHOOL YEARS)
In early childhood (ages 2 through 6 – the preschool years), development of intelligible speech allows the child to extend his/her social environment beyond parents and caregivers. This development is paralleled with adaptive motor development—walking, touching, etc. Verbal and motor skills encourage the child to make social relationships outside of the family unit. The child develops a presence of self and exhibits a sense of autonomy and self direction. Instinct becomes guided by thought patterns. Friend or sibling rivalry develops. The “terrible twos” starts this early childhood period as evidenced by the child’s actions of automation (“going everywhere”), physical exploration (“doing everything”), and verbal achievement (“saying anything”). Anger, assertion, and aggression all come into play during preschool years. Fantasy plays a major role in the development of relationships with both real and imaginary friends, objects, play, etc. Conscious and guilt develop and guide the child into developing a sense of self-control. Logical thinking and consequences of action begin to take hold as school age appears. Time means little to the child beginning this period but at the end it takes on a new meaning and importance.

Key Points To Understand About Interaction With Preschoolers

- They want to explore play with their peers but have been taught to avoid adult strangers. Even in the company of a parent, they are usually cautious with adults. Don’t expect a preschooler in the dental office to be very gregarious and outgoing. Since the preschooler likes to verbalize, use word he/she understands and likes.
- They will show emotion (cry) and movement (clinging to parent, fleeing the scene, anger striking, aggression, assertion, etc.) when stimulated with a stressful situation. Crying is communication and movement is escape – both reactions to stress and helplessness. Don’t expect a preschooler to use their verbal communication skills to express fear or helplessness. They may revert back to the basic forms of communication with crying and movement. Asking a lot of questions is not necessarily an indication of cooperation by the preschooler. Answering of questions doesn’t necessarily get cooperation either.
- Although encouraged by a parent, they may not explore a new environment. Trust in parent and fears of the unknown are at odds. Fears and unpleasant experiences in a medical office may override the sense of exploration. Use euphemistic description for unfamiliar objects. Avoid words and action that can make the preschool anxious.
- Logic and reasoning can start in latter stage but expect this to be minimal when stress and a sense of helplessness are present. Logic and reason communication in the dental office is often clouded by fear and helplessness even when supplemented with parental help. Modeling should be used in every situation.
In late childhood (ages 7 through 11 – the school years) the continued development of intelligence allows for the maturation of both behavior and personality. Self-dressing becomes important as an expression of self-image and acceptance into a peer group. Sexual differences become more important for peer relationships. This sexual difference at first is exclusionary to the peer group for one gender - boys play with boys, girls play with girls. Activities are centered around a peer group. Self-esteem is evaluated according to peer reference instead of parental reference. Achievement and competition comes into play as time is spent away from home at school and surrounded by others his/her age but not necessarily peers or close friends. Hero-worshipping (sports stars, musicians, media celebrities, etc.) is important and fantasies continue with role-playing. In this stage the child can be very critical of themselves in looks and social problems start to influence decisions. Interest in the opposite sex tends to start in the later part of this period. The peer group and/or the boy and girl relationship start to be more important than the family unit. Morality or a sense of right versus wrong shifts from authoritative control and majority rule to self-judging based upon praise/reward and blame/punishment. The struggle between morality with law and order and “what I can get away with without being caught” places the school age child in conflict.

Some Key Points To Understand About Interaction With School Age Children

- They can interact with the adult stranger, but prefer to develop some form of bond first before they will interact completely. In the dental office, bonds can be formed by office design (sports theme, hero theme, etc.), by comment on clothes (cool shoes, etc.), by discussion of activities (sports, etc), and by talking with them not at them.
- Logic and reasoning play a role in behavior in decision making, but they don’t like being talked down to or made wrong. The dentist and staff should be complimentary and use peer rationalization. Never say, “Quit acting like a baby.” Instead say, “A lot of your friends have handled this just fine.” They are children, but individuals. The positives should be emphasized over the negatives. Show concern, not disdain.
- Outward appearance is a personal viewpoint with schoolers so be careful not to impose your opinions on appearance and looks, which may be much different than theirs. Hygiene is not their thing!
- Rewards are important, so communication in the dental office should be geared toward what motivates the schooler.

ADOLESCENCE (AGES 12 THROUGH 19 – TEEN YEARS)

Adolescence (ages 12 through 19 – the teen years) can be a difficult period for teenager, parent, and other people of authority (teacher, counselor, employer, etc.). The teen often thinks of himself or herself as an adult but many times doesn’t want the responsibility of adulthood. Their body is undergoing tremendous physical and hormonal changes that often outpaces their maturity and is oftentimes not well understood. The biologic,
physiologic, psychologic, and social development is totally out of sync. Puberty comes earlier in the female teen. The teen wants only conformity within their age group and independence from any authority, especially a parent. Self-expression in terms of physical appearance (tattoos, body piercing, hair color or style, etc.) defines identity. The future is on hold as the early teen lives in the moment. Experimentation with sexual relationships and recreational drugs is thought to have no lasting consequences. Solo friendships (best friends) initiates intimacy that is the precursor to adult relationships. Advice from authority is heavily discounted. Religion and the concept of spirituality enter into consideration for the later teen. Identification of vocational roles has shifted from hero-worship to some type of humanity cause. Part time work gives the much-needed spending money but without much hope of future skill development. The occupation of a parent may be looked upon with distain. There is tremendous internal struggle with peer pressure, parental expectation, education, occupation, potential partner, etc. Time management is difficult. Prioritization is next to impossible. Life seems to be a roller coaster of emotions. The latter period is coupled with conflicts of wanting to be on one’s own but still wanting to enjoy the security of a parental home.

Key Points To Understand About Interaction With Adolescents

- Well Good Luck! If you are a parent you already know that interaction with a teenager is frustrating. The most important thing is not to loose your temper. Teenagers don’t respond well to confrontation much less angry, aggressive and assertive communication. In the dental office, avoid confrontation and making the teen feel ashamed and wrong. The teen wants to be popular and the dental office is no exception. Loyalty and confidentiality is a must between the teen and dental staff if a trustful relationship is to be established. Don’t withhold information from the parent, but get acceptance from the teen to bring the parent in on a conversation.
- Appearance is identity. Identity is important for acceptance into their peer group. In the dental office avoid placing your norms of appearance and dress on the teen. Cosmetic dentistry to a teen might not have the same definition as it does to you.
- Teens may be experimenting with alcohol, tobacco, or recreational drugs. It’s a fact of life. In the dental office, keep discussion about these to the positive aspects of quitting the habit and about the problems encountered in the mouth with these habits. Don’t refuse care or other penalties of habit continuance. Let the teen see you as a friend, not as correctional officer.

SUMMARY

From conception to adulthood, the development of child and adolescent behavior and personality is very complex with a genetic base and an environmental influence. The definition of what constitutes normalcy in child behavior and personality is not easy to define in today’s ever-changing world. What might be considered normal by a parent might be considered abnormal by a teacher or a policeman. Child psychology continues to be an evolving discipline because of this dichotomy.
Well, now you see why interacting with patients in any of these three child and adolescent periods is “challenging”. And, as the child and adolescent get more stimulation from the media, internet, their peers, etc. and as the described behavioral and personality traits become more complex, think of what happens to this interaction.

CRYING

Crying maybe one of the most misunderstood emotional acts in children and adolescents. In infants, crying is no more than a form of communication. As a matter of fact it is the first communication before speech and other non-verbal motions. It is thought that there are three types of crying in infants. The Basic Cry is describes as a cry coupled with a followed silence and then a repeat of the cry. It is usually in response to hunger or other bodily function. The Anger Cry is louder than the Basic Cry and is in response to helplessness of their situation. They are tired and want to sleep. They have a soiled diaper and want it changed. They are too hot, too cold, etc. Often the crying is the result of stimulation. They are helpless to change the stimulation so they cry. The Pain Cry is unlike the first two in that it is louder and interrupted only by period of breath holding. It is in direct response to a painful stimulation.

Infants “learn” very quickly that crying usually elicits a response from an adult (parent, caregiver, etc. it doesn’t matter). Maybe “learn” isn’t the correct word in child psychology but it serves the purpose. Action is followed by reaction. If the crying in an infant produces the results that the infant wants then what’s to stop the infant from crying as they progress into the toddler period, early childhood period (preschool), and maybe into the later childhood period (school)? Answer? Nothing.

Crying in preschool children continues along the same lines as that of the infant or toddler. Verbal communication, non-verbal communication, and the Anger Cry can be used singularly or in combination (temper tantrum) by the child to communicate feelings. The Anger Cry still denotes a feeling of helplessness. The Pain Cry still denotes feelings of pain, uncomfortableness, etc.

Crying in school age children is often a reaction to distress. They are angry or anxious about a situation. They don’t want to be at school. They don’t want to go to bed. They don’t want to do their chores, or homework or stop playing, or whatever. The Basic Cry has been replaced by verbal and/or non-verbal communication. If that fails then they can resort to the Anger Cry with or without the tantrum. It continues to denote a feeling of helplessness. The Pain Cry in school age children can also be in a response to pain or other unpleasant stimulations. The Pain Cry can occur when the child has a sore throat or when the child gets a vaccination shot. Crying in school age children is often less voluminous and noise producing. It has become more sobbing in nature.

Crying in adolescents is not uncommon. It continues to be a reaction to distress. They are again angry or anxious about a situation. Their friend just dumped them. They lost a sports game. Again, the Basic Cry has been replaced by the verbal and/or non-verbal communication. If that fails to relieve tension then it can be coupled with the Anger Cry
now more of a sobbing. Tantrums are very rare and can be a sign of other systemic behavioral disorders. Crying still denotes a feeling of helplessness. The Pain Cry in adolescents can also occur when the teen experiences a painful stimulation such as a sports injury or other trauma. Again, the crying is more sobbing in nature.

CRYING IN THE DENTAL OFFICE

The majority of crying in the dental office is in response to helplessness. It is typically the Anger Cry. No matter what the age the child or adolescent doesn’t want to be in this situation. They feel stressed and crying/sobbing seems to relieve that stress. No matter what the age they feel that crying/sobbing will bring sympathy by parent/caregiver and they will be rescued from the situation (i.e., reappoint the procedure to another day). Sometimes, the crying in the dental office is the result of a painful or uncomfortable stimulation (the administration of a local anesthetic, the removal of a tooth, etc.). Oftentimes an uncomfortable situation can elicit an inappropriate reaction of angry more than pain. It is common in the dental office for the child to express feelings of helplessness with crying/sobbing and have this misinterpreted by the parent/care giver as crying/sobbing in response to pain. With the use of modern pain control practices, it is rare for children and adolescents in today’s dental office to experience pain. They are more likely to experience feelings of helplessness and anxiety. However, it is not a good practice to dismiss with either patient or parents any feelings of pain or discomfort and the reactions of crying/sobbing. Whether pain is real or imaginary, the feeling of helplessness is still an underlying factor.

Key Points When Interacting With A Crying Child Or Adolescent

- Don’t look mad. Don’t act mad.
- Acknowledge the parent. Acknowledge the child or adolescent. Parent could feel embarrassed or guilty. Child can feel same. Parent can disappointed.
- Acknowledge that others have felt this way in your office also. This brings in the peer relationship and that the crying is normal in the peer group.
- Don’t let parent take control. This often exacerbates the situation. Ask the parent to let you ask the questions, make the suggestions, assist in comfort.
- Attempt to determine if the crying is episodic (one time only) or if it is continual (always occurring).
- Attempt to determine if the crying is a precursor to other forms of poor behavior
- Attempt to determine if the crying will lead to loss of cooperation and management for care.
- Remember that crying is a form of communication and is normal in younger age groups and less normal in older age groups.
- Crying maybe noisy and thus disturbing, but take away the noise and it is becomes less disturbing. Don’t make a big deal out of the noise.
THE PARENTING TRENDS IN TODAY’S WORLD

We have already discussed that child behavior is a factor of both heredity and environment. So, the parental hereditary factors coupled with the parental environment play a major role in child behavior and personality development.

I have often said that it takes a license to drive a car but not to have a child. By that flipped remark I mean that very few school today teach one of the most common vocations that humans do and that is parenting. Humans “learn” parenting skills from a number of sources. These include;
1. Their own parents and relatives
2. Their friends
3. Media (TV, movies, magazines, etc)
4. Formal instruction at school, church, agencies, web sites,
5. Pet Rearing

OUR PARENTS AND RELATIVES

Parenting trends often get established by modeling the parents that raised them. Conversely, parenting trends can also get established by rejecting the modeling of their parents. Parents may admire and respect the way they were raised and thus continue in this form of parenting, or they may disapprove of the way they were raised and adopt another form of parenting. So, parents can have a positive or a negative influence on the way their children will be parents. For instance, parents might have been strict disciplinarians and so the children when they become parents either can adopt this same parenting approach or reject it in favor of less disciplined and more lenient parenting. The latter can result in parents whose children lack limits and who have no control by parents or authority. With age expectancy increasing it is quite common for children to have numerous grandparents and great grandparents as well as aunts and uncles, etc. These people can play a major positive or negative role in the parenting skills of the new parent. All of us have seen the situation where both parents work and the child is raised during the day one way by a grandparent or aunt and then another way after work by the parents. No wonder children get confused. Similarly, a single parent household can have the child raised by day care givers and then a single parent after work.

OUR FRIENDS
Parenting trends can also get established by modeling friends or peers that have children and how they raise these children. Our society is a very mobile society. Chances are great that children grow up move away from home, get married, have children, and do not have the close relationship physically with their parents that would assist them in child raising. This can be both beneficial and detrimental. Maybe the grandparents could be a good influence or bad influence on the grandchild rearing. Even so, in today’s world parents are always peering conscious and tend to raise children based upon peer pressure. Just look at the after school or summer sports programs where parenting is often molded around the concept of winning and not team building.

THE MEDIA

Parenting trends are direct results today of the massive media exposure that parents receive today. The Internet, television show, motion pictures, radio, magazines, newspapers, music, etc. can all influence in a positive or negative manner parenting trends today. Plus the child is exposed to these same stimuli that the parent is being exposed to also.

INSTRUCTION

Schools, churches, government agencies, non-profit foundations, web sites, etc are all becoming involved with instructing new parents on the raising of children. The problem is that each might have a bias toward the proper child rearing. But at least it is an attempt to offer prospective and new parents formal instruction in child behavior and personality development.

PET OR ANIMAL REARING

If parents allow children to raise a pet or animal chances are great that both parent and child learn a lot about rearing from animal behavior. Clubs like 4H, dog retriever trials, horse jumping, etc. often instill in both parent and child a sense of cooperation with animal rearing that carries over into their relationship as parent and child.

THE TRENDS OF TODAY

As a whole parenting trends of today tend to be very liberal and permissive. Children are said to be “maturing” faster than in other generations. I don’t think the right word is “maturing” because they are not maturing. A better term would be they are “evolving”. They are evolving into a more controlling person who generally lacks discipline, control, and direction. They think that they “run the show” and in many cases they do. Complex lifestyles of parents today coupled with the multiple variations of parent demographics (two parents married, two parents unmarried, two parents divorced, single parent, single parent with cohabitation partner, parents of different sexual orientation, etc., etc.) can foster tremendous problems in child rearing. This tends to reverse the attention of the
parent and child. No longer is the child seeking the attention and approval of the parent, but the parent/s seek the attention and approval of the child.

Parenting mimics the lifestyle of their current society. Their value systems and beliefs reflect the generation. The generational experiences of child rearing that have preceded the current parents have oftentimes been discounted as restrictive and out of touch with modern child psychology.

Historically, parenting has utilized methods of reward and punishment for behavior development. Most modern methods now discourage any corporal punishment and in most countries physical punishment has been prohibited by law. Non-physical punishment now includes such disciplinary methods as isolation (time out) supervision (close proximity with parent), accountability (remedial work) structure (performing task) control (supervised area) etc.

Parenting today is often considered a shared responsibility. Parents soon realize that life is much easier if they can share child rearing with someone else. So, other relatives such as a grandparent, other older children such as an older sister, day care providers, teachers, organization leaders (scouting, sports, etc.), church pastors, etc. can all be “recruited” by the parent/s to assist them in raising their child. What was once thought of as a full time job of being a parent has in many families become a shared part time job. What results is child rearing with many different directions. No wonder the child doesn’t know discipline, control, direction and has no limits. There are multiple parent figures.

SUMMARY

As we will see when interacting with a child you are interacting with the parents also. You cannot separate the two. It is a triangular interaction with the child, the parent/s and you. This does not exist when you interact with another adult. It is a one on one interaction. NOT SO WITH THE CHILD.
THE INTERACTION OF CHILD, PARENT AND DENTIST

Quite a lot is written about the behavior and personality of children and about parental rearing of children. Very little is written for the person that interacts with children and parents together. Almost nothing is presented in dental education for the dentist. Often, the dentist is left on his/her own to figure it out. Often by trail and error, the dentist relationship with the child patient and the parent develops with OTJ – On The Job – training.

When interacting with a child in the health care setting it is important to realize that this interaction is a triangular relationship between child, parent, and dentist. There are many issues that act separately on each and then totally on all three. These include issues on legality, psychology, custodianship, communication, and confidentiality, to name just a few.

FIGURE OUT THE CHILD

First and foremost the dentist must observe and analyze the behavior and personality of the child. Outgoing versus shy. Inquisitive versus quite. Explorative versus withdrawn. Constant motion versus being still. Clinging to parent versus touching others. Talking versus crying. Spoiled. Pampered. Selfish. The list could go on. It doesn’t take a Ph.D. in child psychology to size a child up.

FIGURE OUT THE PARENT

Next, the dentist must observe and analyze the behavior and personality of the parent. Star individual or team player. Reprimanding versus suggesting. Controlling versus Uncaring. Authoritative versus Free spirit. Demanding. Uninterested. The list could likewise go on. It doesn’t take Ph.D. in parental psychology either to size up a parent.

FIGURE OUT YOURSELF

Finally, the dentist must observe and analyze his/her behavior and personality. It’s no secret that many dentists became a dentist because they wanted to be in the healing arts and sciences. Observation, analytical behavior and communication skills were never considered. Manual dexterity and psychomotor skills – yes. Cognitive analysis and

THE TRIANGLE OF CHILD, PARENT, AND YOU

Visualize a triangle. The child sits at one point, the parent at another, and you at the third. Now each of you talks, asks questions, gives answers, etc. The child and parent may communicate with both verbal and non-verbal body language. You can too. But, your role is to facilitate a process to find out what the child and parent want from you. Each wants something. The child usually wants nothing done and then out. The parent usually wants something done and then out. You also want something done and then out also. So, your goal is compatible with the parent but not the child. At least you have the parent agreeing with you on a goal. Now your next role is to strengthen this bond with the parent so much so that the parent will follow your actions as to a plan on how to treat the child who wants nothing done and wants out. Strengthening this bond comes in sequential steps that you initiate. If there is disruption or disagreement the triangle “opens. This can happen when the child takes control of the conversation. For instance, crying of the child can make the parent distracted and stop the communication with the dentist. The parent has let the child take over the control of the triangle. When the child takes control of the triangle, you have lost the parent. You must have control. The parent must have control. The child must not have control.

THE TEN ITEMS OF AGREEMENT BETWEEN YOU AND PARENT

Get agreement on the facts between you and the parent. Use these ten items of agreement in this logical and sequential order.
1. Caries occur in children in an alarmingly high rate. (Agreement)
2. Caries in a child can be prevented by some simple diet control and home oral hygiene program. (Agreement)
3. Caries can be identified visually and radiographically. (Agreement)
4. Caries can be treated to restore both esthetics and function to the mouth of a child. (Agreement)
5. Children who do not wish to have treatment done can be treated with safe, modern methods (Hint: like pediatric oral conscious sedation) (Agreement)
6. Program can be designed to have a child remain caries free (Agreement)
7. Alternatives to treatment include no treatment which can lead to serious dental problems and possible pain that will need treatment at a later date. (Agreement)
8. Financial arrangements can be reached to make treatment possible. (Agreement)
9. Many other parents have faced the same situation that you face and have been satisfied with the care our practice provides. Otherwise you wouldn’t be here. (Agreement)
10. Let’s get started. (Agreement)
Granted, these agreements with you are easier in some parents than others. This is based upon the value parents place on good dental health. In general, all parents want what is best for their children. They just need help in deciding what is best and how to get what is best. But, proceeding slowly and asking open ended question that require more than a yes or no answer will make the process work most of the time. If there is disagreement anywhere along the list, don’t proceed. Proceed only if you and the parent agree on an item. As children get older (adolescents) they may be invited to participate in these ten steps. But, for younger children expect non-compliance with the process. Remember, all they want is out. You will be surprised that many parents will say that they wish this process were available to them when they were children. Get the parent to bond with you and you will keep the triangle closed and under control.