Behavioural Changes of Young Uncooperative Children Undergoing Dental Treatment in the Clinic versus Under General Anaesthesia

SUMMARY

Aim: This study compared the levels of dental anxiety experienced by young uncooperative children having dental rehabilitation using general anaesthesia (GA) with those who had their dental treatments by “Tell-Show-Do” technique in the dental clinic.

Methods: Out of 54 children, 26 had been treated under GA and 28 had been treated with the use of “Tell-Show-Do” behavioural approach method. At the initial examination, Frankl’s Behaviour Rating Scale, sitting patterns, Venham Picture Test (VPT) and Children’s Fear Survey Schedule-Dental Subscale (CFSS-DS) of the children were recorded and compared with scores after 1 year. The accompanying parents were asked to complete Corah’s dental anxiety scale (DAS). For statistical analysis, chi-square test, t-test, Mann-Whitney test and repeated measure Anova were used.

Results: The children in both groups showed similar behaviours with a reduction in their anxiety level after 1 year as measured by the Frankl’s Behaviour Rating Scale, VPT and the sitting pattern. The decrease in the CFSS-DS scores of the children in the clinic group was statistically significant (p<0.05). There was also a decrease in the children of GA group, but not statistically significant (p>0.05). Parents of both groups showed similar scores in the total DAS.

Conclusion: Although, the children whose treatments were performed in the dental clinic with “Tell-Show-Do” technique became more familiar with the dental environment and procedures, GA also could be a suitable alternative for treating young uncooperative children with rampant caries.

Keywords: Dental Anxiety, General Anaesthesia, Children, uncooperative

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Dental anxiety is most commonly measured using rating scales. To assess dental anxiety in children, many measurement techniques have been proposed. For example, Children’s Fear Survey Schedule-Dental Subscale (CFSS-DS) is a well-known instrument for assessing dental fear in children. The scale consists of 15 items related to various aspects of dental treatment. (Fig. 1). Scale scores are calculated by summing item scores; the total score can range from 15 to 75. Scores above 38 indicate significant dental fear.

The Venham Picture Test (VPT) is a self-report instrument using a picture technique for answering and consists of eight items measuring situational or state of anxiety. The child is presented 8 pairs of pictures of children exhibiting various emotions and is asked to choose the child that best reflects his own emotions. Scores are determined by summing the number of instances in which the child selects the high-fear stimulus. This scale has a range of “0”, meaning no fear, to “8”, meaning high fear (Fig. 2).

Corah’s Dental Anxiety Scale (DAS) consists of 4 questions to assess anticipatory dental anxiety. Each question has 5 possible responses which correspond to feeling “relaxed” (scoring 1) to “so anxious” (scoring 5). This gives a possible range from 4 to 20 (Fig. 3).

Another method, which has been used in behavioural research, is referred to as the Frankl’s Behavioural Rating Scale. The scale divides observed behaviour into 4 categories, ranging from definitely positive to definitely negative (Fig. 4).

The future behaviour of child in the dental environment had also attracted attention of researchers. Most of the previous reports have been focused on the behavioural changes of the children who received dental treatment under GA and under sedation, but little is known about the behavioural changes or anxiety of children who underwent dental treatment in a clinic with children whose dental treatments were performed under GA. The aim of the present study was to compare the expected future dental behaviour or anxiety after 1 year of a group of children who experienced dental treatment by the use of “Tell-Show-Do” technique with children who underwent GA.

<table>
<thead>
<tr>
<th>Items</th>
<th>not at all afraid</th>
<th>a little afraid</th>
<th>somewhat afraid</th>
<th>fairly much afraid</th>
<th>very much afraid</th>
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<tbody>
<tr>
<td>1. Dentists</td>
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<td>2. Doctors</td>
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<td>3. Injections</td>
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<td>4. Having somebody examine your mouth</td>
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<td>5. Having to open your mouth</td>
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<td>6. Having a stranger touch you</td>
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<td>7. Having somebody look at you</td>
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<td>8. The dentist drilling</td>
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<td>9. The sight of the dentist drilling</td>
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<td>10. The noise of the dentist drilling</td>
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<td>11. Having somebody put instruments in your mouth</td>
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<td>12. Choking</td>
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<td>13. Having to go to the hospital</td>
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<td>14. People in white uniforms</td>
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<td>15. Having the nurse clean your teeth</td>
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*Figure 1. Children's Fear Survey Schedule-Dental Subscale (CFSS-DS)*
Material and Methods

Study Population

The study population consisted of 54 (39 male, 15 female) young uncooperative healthy children, aged between 4-6 years, being referred for their dental problems to the Paediatric Dentistry Clinic of Ege University, Turkey.

Clinical Examination

The children were examined in the Paediatric Dentistry Clinic by an experienced dentist (Ö.Ö) with a mirror and a probe. The caries status was recorded using the criteria of DFS scores (D: decay, F: filling, S: surface).

Questionnaire

After obtaining the written consent of the informed parents, a standard questionnaire was also answered by
mothers, which included the general history of their children and their socio-demographic information (age and education). They were also asked to complete Corah’s DAS to assess their dental anxiety status.

**The Criteria in Choosing the Treatment Modality**

The parameters in the decision to offer treatment under GA or in the dental clinic included the amount and complexity of the dental treatment, the expected quality of treatment, children and parents’ behaviour and social competence as determined during the consultation appointment. Home distance was also a criterion that determined the treatment of choice: children living 50 km. far from our clinic were offered GA.

One experienced dentist (Ö.Ö) carried out the dental rehabilitation of children who were treated in the dental clinic by “Tell-Show-Do” technique with sessions of lasting maximum 20 minutes. Completion of the dental treatment generally took 5 sessions. The accompanying parent was allowed to enter the clinic during the treatment.

From 54 children, 26 were treated under GA in the operating room of the Paediatric Surgery Clinic of Ege University, and 28 children were treated with the use of “Tell-Show-Do” behaviour approach method in the Paediatric Dentistry Clinic of the same university.

In GA procedure, the children received premedication (Dormicum®, Roche, 0.5-0.75 mg/kg) 30 minutes before GA. Inhalation induction was employed using nitrous oxide (50%)-oxygen (50%) and sevofluorane (8%) (Sevorane®, Abbott). Halothane 1-1.5% (Halothan®, Hoeschst Marion Roussel) and Sevofluorane (2-3%) were anaesthetics for the maintenance of anaesthesia. The mean duration of treatment was 60 minutes. Parents were allowed to enter the operating room at the induction of anaesthesia. No overnight postoperative hospital admission was found to be necessary, and children were discharged from the hospital approximately 4 hours after the operation. None of the children suffered adverse events postoperatively. Children who undergone GA were routinely given a follow-up appointment after 1 week and every 3 months.

Parents of both groups were instructed to return after 1 year. In addition to a routine full dental examination, the teeth of the children were cleaned with pumice with a slow-rotating bur, and chlorhexidine varnish (Vivadent, Schaan, Liechtenstein) was applied for prevention.

The examiners were calibrated before the study and the end of 1 year. Inter- and intra-reproducibility were determined using the Cohen-Kappa scores. The examiners were calibrated before the study and the end of 1 year. Inter- and intra-reproducibility were determined using the Cohen-Kappa scores. The results of the calibration were good and Kappa values were 0.92 for intra-examiner reality and 0.88 for the inter-examiner assessment.

The children in the GA group had significantly greater mean numbers of teeth with dentinal decay compared with children treated in the clinic (DFS score in GA group: 24.7±20.9, DFS score in clinic group: 14.2±14.5).

46 (46.2%) percent of the parents whose children were treated under GA preferred their children to be treated under GA again if required. 14 (14.3%) percent of the parents whose children were treated in the dental clinic preferred GA if needed.

The behaviour of children in the GA and clinical groups at the first visit and after 1 year, according to Frankl’s behavioural rating scale, was demonstrated in table 1. In the GA group, 10 children out of 26 who were described as Frankl 1 or 2 (negative) became positive. In the clinic group, 18 children out of 27 who were described as Frankl 1 or 2 became positive. “Positive” behaviours (Frankl 3 and 4) were found more prevalent in both groups after 1 year, but without statistical significance.
Table 1. Children’s behaviour at initial and follow-up examinations by Frankl’s scales

<table>
<thead>
<tr>
<th></th>
<th>Initial visit</th>
<th>Follow-up visit</th>
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<tr>
<td></td>
<td>n</td>
<td>Frankl 1</td>
</tr>
<tr>
<td>GA</td>
<td>26</td>
<td>17 (65.4%)</td>
</tr>
<tr>
<td>Clinic</td>
<td>28</td>
<td>12 (42.8%)</td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>29 (53.7%)</td>
</tr>
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</table>

Table 2. The sitting patterns at initial and follow-up visits

<table>
<thead>
<tr>
<th></th>
<th>Initial visit</th>
<th>Follow-up visit</th>
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<tr>
<td></td>
<td>n</td>
<td>Sitting alone</td>
</tr>
<tr>
<td>G.A</td>
<td>26</td>
<td>14 (53.8%)</td>
</tr>
<tr>
<td>Clinic</td>
<td>28</td>
<td>17 (60.7%)</td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>31 (57.4%)</td>
</tr>
</tbody>
</table>

* - statistically significant (p<0.05)

Table 2 demonstrates the “sitting pattern” of children in both groups. More children sat alone on the dental chair without the assistance of their parents at the end of 1 year and the difference between the initial period and 1 year was statistically significant (p<0.05). There were no statistical differences between the groups both at the initial period and after 1 year.

The mean values of VPT at the initial and at the end of one year were 2.69±1.4 and 2.12±1.1 in the GA group, 2.79±1.8 and 2.01±1.7 in the clinic group, respectively. This reduction was not statistically significant. There was no statistical difference between the groups.

The mean scores of CFSS-DS of the children in the GA group and in the clinic group were 36.58±9.5 and 37.0±10.3, respectively at the initial visit. The mean scores of CFSS-DS of the children in the GA group and in the clinic group were 32.62±7.7 and 28.86±8.9, respectively after 1 year. The decrease in the level of anxiety of the children in the clinic group was statistically significant (p<0.05), but although there was a decrease in the anxiety level of the children in the GA group, this decrease was not statistically significant.

The dental anxiety levels of parents were similar in both groups (total DAS 9.45 and 9.10 in the GA and clinic groups, respectively).

It was found that ages of the children and the anxiety scores of the parents (DAS) had no significant main effects and no interactions on the differences of the CFSS-DS scores among the groups.

**Discussion**

The results of the present study demonstrated that young uncooperative children who had the dental treatment under GA or in the clinic, showed similar behaviour in 1 year routine follow-up examination, as measured by the Frankl’s behaviour rating scale, VPT and by the “sitting pattern”. The explanation for the similar dental behaviour in the follow-up examination between the GA and clinic groups could be the natural maturation of the children in the follow-up examination. Curry et al also suggested that children were more capable of repressing previous traumatic experience and better coping with the dental situation than adults. Furthermore, half of these children (57.5% in the GA, 42.9% in the clinic group) had suffered from pain before the treatment and after the treatment they could feel more comfortable in the clinic because of the release of pain. In addition, Huq et al
also suggested that children experienced less discomfort during treatment than they or the operators had expected. Furthermore, in the present study, the period that had passed after the completion of treatments was 1 year and this period could be faded the memory. On the other hand, Veerkamp et al\(^1\) found that fearful behaviour in children was still clearly present 1.5 years after the first treatment phase. Venham et al\(^10\) found that children’s response to dental treatment became more positive when they had 5 or 6 restorative visits. Berge et al\(^19\) found that the level of fear in the children of their study group decreased after several sessions. We also suggest that increasing the number of treatment sessions (5 sessions in the clinic group) could decrease the level of dental anxiety. Varpio et al\(^13\) also stated that children who had conventional treatment more often show a lasting positive acceptance than do children who had received GA. They postulated that children undergoing GA probably did not experience the positive feeling of having coped with a difficult situation by their own efforts and thus were not given the possibility of changing their negative attitude toward the dental situation. In the present study, the children in the GA group had a positive change in their negative attitude toward the dental situation due to the frequent visits to our clinic during 1 year. It could be suggested that they might become more familiar to our clinic, instruments and dentists.

Although, the reliability scores of behavioural ratings (Frankl Scale and VPT) were frequently high (20), validity could be more problematic and there are reports of weak correlation between behavioural ratings and psychometric methods (CFSS-DS)\(^21\). The CFSS-DS appeared to be preferable over the VPT and Frankl Behaviour Rating Scale as a self-report measurement of dental anxiety in children. Moreover, the CFSS-DS covered more aspects of the dental situation than the others\(^22\). In the present study, the only statistically significant difference between the 2 groups determining the anxiety level of children was the scores of CFSS-DS test. It could be suggested that GA and operating room could lead a distressing atmosphere because the risk of GA both for the child and parents results in negative behaviour in the future. In addition, not all of the parents (46.2%) whose children were treated under GA preferred their children to be treated under GA again if required. In the present study, the amount of dental caries was the most important factor in the decision to offer GA. The authors considered that completing the comprehensive dental treatments in 1 appointment under GA was more suitable for the anxious children who had more than 6 caries rather than subjecting them to numerous clinic visits.

In this study, the parents’ ages, which could affect their anxiety, were similar in both groups. The mothers’ DAS scores were also similar in both groups and did not correlate to child dental fear in the present study.

In the present study, although the reduction in dental anxiety achieved after using “Tell-Show-Do” technique was more permanent than the reduction in anxiety achieved by GA, there was also a noticeable positive behaviour after 1 year in comparison with the initial examination in the GA group. The authors suggested that GA could be a suitable alternative for treating young uncooperative children with rampant caries. Further research is needed to assess the long-term behaviours of these children with enlarged sample size in school age, or in adolescence.

References


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