It's a Family Affair

Parental resistance – a communication dilemma

by Pat Mc Bride, BA, RDA, CCSH

Parents used to bring their children to the dentist or orthodontist with a limited agenda; specifically, a cleaning, a "cavity" or misaligned teeth. Today, dentists and orthodontists trained in airway health, facial growth guidance, function, breathing, sleep and cognition have the ability to comprehensively screen and serve pediatric patients in the focused, supportive environments of their practices. Expanding your practice to include a holistic patient care model with screening and assessment protocols encourages development of meaningful relationships with your patients and their families. This article addresses the special communication needs relating to children, our most precious resources. No longer providers of a simple cleaning or cavity prep, dental/orthodontic paradigms now include assessment of the functional airway and associated problems affecting our pediatric and adult patient populations. The days where it was easier to make therapy recommendations and leave it to the parents to decide what to do, have been replaced by a driving force to act (by screening and assessment) in accordance with what is best for the child. In order to act effectively however, clinicians must learn to communicate in a way which brings the family as an entity into the conversation.

Many current continuing education courses have some component of screening for breathing and sleep issues addressed. Some are quite specific, and others give a smattering of information and leave it to you the clinician to try and "figure it out" on Monday morning when you return to the office. Which we all know from experience, is far easier said than done.

Implementation of pediatric questionnaires, screening, education and assessment tools for oral rest posture, breathing, sleep, academic and behavior issues can (and will) be met with resistance from parents unwilling to consider that there is anything "wrong" with how their child/children sleep, breathe, speak, swallow, perform in school or behave. It is all too common to hear parents state clearly to the hygienist that, "Johnny is only here for a cleaning, I don't need to hear about anything else" when poor oral rest posture, mouth breathing, chapped lips or tongue tie are recognized and brought to the parents' attention. Pushback and resistance to new assessment measures is often based on parents' perceptions of their child, and their own inability to cope emotionally with the stresses surrounding any new revelation

about their child's health condition (Menahem and Halasz, 1998). Parents are vulnerable to psychological reactions which inhibit rational thinking and decision making especially when it concerns the welfare of their child. Social constructs such as denial serve to protect parents from overwhelming fears and anxieties, and if addressed with good communication and empathy may transform parental defensiveness to co-operation.

Adopting a holistic (whole person) clinical approach for assessment and management of pediatric patients in the general practice affords clinical observation of dysfunction and other issues over and above any presenting problem(s) (Menahem, 1983). As an example, non-presenting symptoms include unrecognized or ignored abnormalities such as maxillary insufficiency, retrognathia, tongue tie, snoring, swollen tonsils, nasal congestion, allergic shiners, inability to attend, poor sleep, school and behavior issues. How parents respond to questions regarding these issues however can range from grateful acceptance of your observations and clinical advice at one extreme to one of anger and total rejection on the other (Melton, 1996). You as an effective communicator can make or break the opportunity to change the life and health trajectory of every child in your practice.

Good communication is good medicine. Take time to learn to talk with parents. Not to parents, or at parents, but with them. Listening is an essential part of a two-way process, especially one where the parent is the consumer, and the child the patient. You must be able to communicate sufficiently well with the children themselves. It is absolutely not acceptable to talk over a child, especially if they are required at some point to buy into and participate in a proposed therapeutic protocol. Facial growth guidance, myofunctional therapy, breathing retraining and expansion therapy all require very high levels of patient and parental participation and cooperation for success. Can you dissect the child's issues into digestible pieces for the less dentally knowledgeable parent or care giver? All explanations you give must be clear, complete, and in a language that the parents can easily understand. Relying on your assistant who took high school Spanish for three years will not guarantee that the rationale for a sleep study referral is actually comprehended by the parents. Any and all therapy or treatment options must be explained clearly and completely in order for informed consent to be obtained; which means giving the family time to absorb the content of the conversation and ask questions without being rushed or directed (Settledge, 1991). Parents like knowing the truth, but sometimes, it is harsh and can be shocking, so delivery must be tempered with common sense and empathy (Metha, 2008). You must be patient and supportive when delivering information parents may not want to hear. You and your team must also be prepared at some point to deal with emotional outbursts such as blame, anger and grief as normal parental reactions. As you try and temper a potential blow to a family, remember, you cannot hedge around a serious health concern such as sleep apnea. Procuring necessary referrals for appropriate definitive diagnosis and treatment followed by reassurance that you will continue to monitor the child's progress closely is imperative to building trust and a safety net for the entire family. Many of the

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issues screened for are quite literally, family affairs. Helping the family relate what is going on with this child to perhaps a father, grandmother, aunt or other child brings stability and relevance to the situation. The family needs reassurance that they are not alone in this and you are there to help. The psychosocial adjustment to having a child with a potentially life long chronic disorder such as sleep apnea is daunting, and parents will need all of the support you and your team can provide.

Creating a pathway for a healthier and happier next generation.

Do you have the ability to convince a patient and their parents to follow a treatment plan? We are not talking about selling a two stage serial extraction ortho plan here, but real ongoing cross disciplinary healthcare with longitudinal expectations and goals for the child. If parents are resistant to screening, what makes you believe they will accept your proposed therapy? This is especially important when embarking on prolonged, expensive, difficult, or alternative/adjunctive therapy. Facial growth guidance and expansion therapy have multiple phases, and at any given point a family may falter if they believe the child suffers psychologically due to peer reactions that are unsupportive of temporary facial changes. Can you and your staff effectively support this situation? Ongoing self-esteem promoting dialogue and support for both parents and child are critical especially for example, when a child must wear a reverse pull headgear all day long at school. Your commitment to the process, the patient and the family unit is paramount. This may mean numerous "support" calls after hours, but ultimately those few minutes on the phone serve the child's best interests for improved compliance and clinical outcome. In the end, a few moments of reassurance to stay the course provide a scaffold and foundation for the establishment of a solid relationship based on mutual respect and trust with the parents and the child. Their confidence in you and your commitment guarantees that they will tell other people about what you are doing to help their child.

Being able to put all classes of parents at ease and converse with them regarding non-medical issues also creates an atmosphere of comfort and concern, allaying many of the fears and anxieties parents have regarding their child and the treatment they may be needing. No matter how busy your schedule, or how far "behind" you are, these families need your attention at that moment, and that should be the priority. The time you spend on the front end will more than take care of everything else as treatment moves along.

As more providers embrace holistic care models to better serve our patients and their families, we accept the challenge and responsibility of service to all strata of society, especially our cherished kids. The community of our peers is stepping in to fill an ever expanding gap in coverage of essential care for people. Dentists spend, typically, 60 minutes with families, far more than a routine pediatrician visit. This statistic is incredibly important to keep in mind as dentistry is expanding to fill an essential healthcare need and provide a higher standard of global screening and assessment for our patients. With our faltering managed care health system, you and your team may very well be more heavily invested in that child's health and wellbeing than their own doctor. According to a recent study, the average well child pediatric appointment is <10 minutes. Visits of short duration are associated with reductions in content and quality of care, and parent satisfaction with care (Halfton et. al, 2011). Your commitment to screening every patient in your practice including special attention directed towards the pediatric patient population followed by effective communication and appropriate therapy interventions when necessary can and will create a pathway for a healthier and happier next generation.

1. Halfon, N., Stevens, G. D., Larson, K., & Olson, L. M. (2011). Duration of a Well-Child VAssociation With Content, Family-Centeredness, and Satisfaction. *PEDIATRICS,* 128(4), 657-664. doi:10.1542/peds.2011-0586
2. Mechanic, D. (1962). The concept of illness behavior. *Journal of Chronic Diseases,* 15(2), 189-194. doi:10.1016/0021-9681(62)90068-1
3. Melton, G.B. (1996). The child's right to a family environment. *American Psychologist,* 51, 1234-1238
4. Menhem, S. (1983). Therapeutic concern for the 'non-presenting symptom' in paediatric practice. *Child Psychiatry and Human Development,* 14,87-91
5. Mehta, P. (2008). Communication Skills- Talking to Parents, *Pediatrics in Practice,* 45,300-304.
6. Settlage, C. F., Bemesderfer, S., Rosenthal, J., Afterman, J., & Spielman, P. M. (1991). The Appeal Cycle in Early Mother-Child Interaction: Nature and Implications of a Finding from Developmental Research. *Journal of the American Psychoanalytic Association,* 39(4), 987-1014. doi:10.1177/000306519103900406
7. Tates, K. (1998). Doctor-parent-child communication over the years. *Patient Education and Counseling,* 34, S11. doi:10.1016/s0738-3991(98)90017-9