UNIVERSIDADE FEDERAL DO RIO GRANDE DO SUL
FACULDADE DE ODONTOLOGIA

DAIANA DA SILVA FERREIRA

ACEITAÇÃO PARENTAL DE DIFERENTES TÉCNICAS DE MANEJO DO COMPORTAMENTO INFANTIL: UMA REVISÃO DE ESCOPO

Porto Alegre
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Trabalho de Conclusão de Curso apresentado ao Curso de Graduação em Odontologia da Faculdade de Odontologia da Universidade Federal do Rio Grande do Sul, como requisito parcial para obtenção do título de Cirurgião-Dentista.

Orientadora: Tathiane Larissa Lenzi.

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Anelise Özkömür

Márcia Cançado Figueiredo

Universidade Federal do Rio Grande do Sul

Tathiane LarissaLenzi

Universidade Federal do Rio Grande do Sul

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RESUMO

As técnicas de manejo comportamental, tanto não farmacológicas como farmacológicas, são empregadas para reduzir a ansiedade, o medo e a birra do paciente odontopediátrico, estabelecer uma atitude positiva e realizar cuidados de saúde bucal com segurança física e emocional. A escolha das técnicas deve ser pautada no julgamento profissional, na individualidade de cada criança e na preferência dos pais. Sendo assim, o objetivo desta revisão de escopo foi investigar o nível de aceitação dos pais das diferentes técnicas de manejo do comportamento infantil. Uma abrangente busca foi realizada nas bases de dados PubMed/MEDLINE, TRIP, Lilacs eScopus, sem restrição de idioma e ano de publicação. Estudos que avaliaram as preferências do pais das técnicas de manejo comportamental usadas em Odontopediatria foram incluídos. De um total de 1.153 estudos, 61 artigos foram selecionados para leitura do texto na íntegra e 15 estudos transversais foram incluídos na revisão. Em geral, os artigos variaram com relação a amostra e metodologia para avaliação do nível de aceitação parental. Os estudos foram publicados entre 1997 e 2019, incluindo diversos países e etnias. Foram incluídos estudos que avaliaram a indicação das técnicas para crianças normorreativas com idade entre 3 e 15 anos submetidas a tratamento convencional. Os questionários para avaliação da aceitação parental das técnicas de manejo do comportamento foram respondidos principalmente pelas mães (53,2%). As seguintes técnicas foram avaliadas: falar-mostrar-fazer, reforço positivo, modelagem, comunicação não verbal, comunicação efetiva, distração, controle de voz, mão sobre a boca, presença/ausência dos pais, “escape contigente”, contenção ativa e passiva, pré-medicação oral, sedação com óxido nitroso, anestesia geral e hipnose. Reforço positivo (91,6%) e mostrar-falar-fazer (87,5%) foram as mais aceitas, enquanto que mão sobre a boca (31,5%), anestesia geral (34,4%) e hipnose (34,4%) foram mais menos aceitas. Em conclusão, os pais ainda preferem as técnicas que envolvem comunicação verbal em relação às técnicas farmacológicas ou avançadas.

Palavras-chave: Comportamento infantil, Odontopediatria, Revisão

ABSTRACT

Behavior management techniques, both non-pharmacological and pharmacological, are used to reduce the anxiety, fear and tantrum of the pediatric patient, establish a positive attitude and perform oral health care with physical and emotional security. The choice of techniques should be based on professional judgment, the individuality of each child and the parents' preference. Therefore, the aim of this scope review was to investigate the level of parental acceptance of different child behavior management techniques. A comprehensive search was carried out in the PubMed / MEDLINE, TRIP, Lilacs and Scopus databases with no language or date restrictions. Studies that evaluated the parents' preferences for behavioral management techniques used in pediatric dentistry were included. From a total of 1,153 studies, 61 articles were full text assessed for eligibility,and 15 cross-sectional studies were included in the review. In general, the papers varied by sample and methodological evaluation. Studies were published between 1997 and 2019, including several countries and ethnicity. Studies that evaluated the indication of techniques for normorreative children aged 3 to 15 years who underwent conventional treatment were included. Questionnaires for evaluating the parental acceptance of the behavior management techniques were answered mainly by mothers (53.2%). The following techniques were evaluated: tell-show-do, positive reinforcement, modelling, nonverbal communication, effective communication, distraction, contingent escape, voice control, parental presence/absence, active and passive restraint, oral premedication, nitrous oxide sedation, general anesthesia, hand-over-mouth, and hypnosis. Positive reinforcement (91.6%) and tell-show-do (87.5%) were the most acceptable, while hand-over-mouth (31.5%), general anesthesia (34.4%) and hypnosis (34.4%) were the least acceptable. In conclusion, parents still prefer techniques that involve verbal communication over pharmacological or advanced techniques.

Keywords: Child Behavior, Pediatric Dentistry, Review

SUMÁRIO

1 INTRODUÇÃO

Um tratamento odontológico de sucesso visa fornecer atendimento de qualidade aos pacientes. Entretanto, realizar um atendimento eficiente pode tornar-se difícil quando o paciente não está disposto a cooperar com o tratamento, seja devido à alguma deficiência, à baixa idade ou até mesmo pelo medo frente a procedimentos odontológicos. Crianças possuem naturalmente maior inquietude e ansiedade, e muitas apresentam um comportamento difícil durante o tratamento odontológico (AAPD, 2018). É imprescindível que qualquer abordagem infantil seja feita com empatia e preocupação com o bem-estar da criança (DESAI et al., 2019). Todavia, o gerenciamentodo comportamento infantil é complexo e é uma das bases do atendimento em Odontopediatria.

A adaptação do manejo comportamental visa estabelecer comunicação adequada, realizar atenção odontológica de qualidade, promover atitudes positivas para o cuidado de saúde bucal, desenvolver a confiança na relação paciente/família e profissional e prevenir ou aliviar o medo e ansiedade da criança. As várias técnicas de manejo do comportamento devem ser adaptadas individualmente, à cada criança, família e experiência odontológica, a fim de promover na criança uma atitude positiva ensinando-a a cooperar, ficar relaxada e autoconfiante no consultório odontológico (AAPD, 2018).

As técnicas de adaptação do comportamento infantil podem ser divididas em técnicas básicas, tais como: comunicação não verbal, falar-mostrar-fazer, controle de voz, modelagem, reforço positivo, distração, presença/ausência dos pais; e avançadas que envolvem contenção física (ativa e passiva), sedação com óxido nitroso, utilização de pré-medicação e anestesia geral

O comportamento infantil é influenciado por diversos fatores como ambiente em que a criança está inserida, a idade e a capacidade de compreensão. A atitude dos pais também é capaz de influenciar, negativamente ou positivamente, a cooperação do paciente durante o tratamento odontológico, visto que esses assumem um papel importante no controle da ansiedade da criança (DESAI et al., 2019). Sendo assim, uma boa comunicação com os pais é importante para torná-los confiantes e permitir que transmitam segurança e tranquilidade aos seus filhos.

A aceitação das técnicas de manejo comportamental pelos pais também é importante para o sucesso do tratamento odontológico infantil e pode ser aumentada

quando os pais recebem informações detalhadas a respeito de cada técnica (DESAI et al., 2019; LAWRENCE et al., 1991). Além disso, a atitude dos pais em relação a diferentes técnicas de manejo do comportamento não é constante e pode modificar-se ao longo do tempo. Percebe-se que a aceitação das técnicas de manejo que envolvem restrição física diminuiu ao longo do tempo enquanto técnicas farmacêuticas avançadas (sedação e anestesia geral) obtiveram maior aceitação (JAFARZADEH et al., 2014). O tipo de procedimento odontológico ao qual a criança será submetida também exerce influência na aceitação parental das diferentes técnicas de manejo (FIELDS; MACHEN; MURPHY, 1984), assim como o nível socioeconômico e a escolaridade dos pais (JAFARZADEH et al., 2014).

Tem sido demonstrado que as técnicas básicas são preferíveis em relação às técnicas avançadas em diversos países, incluindo China (CHEN; JIN; LIU, 2008), Índia (VENKATARAGHAVAN et al., 2016), Irã (JAFARZADEH et al., 2014) e Estados Unidos (EATON et al., 2005; MARTINEZ-MIER et al., 2019). Técnicas que envolvem um manejo mais comunicativo, como falar-mostrar-fazer, reforço positivo e modelagem apresentam maior aceitação pelos pais (DESAI et al., 2019). O manejo farmacológico tem maior aceitação quando comparado a técnicas mais avançadas, como controle de voz e restrição física (DESAI et al., 2019). Um recente estudo realizado na Alemanha demonstrou que os pais são mais propensos a aceitar técnicas avançadas de manejo do comportamento infantil em situações de emergência, sendo a sedação com óxido nitroso a técnica preferida (AL ZOUBI et al., 2019). Além disso, contenção passiva foi a técnica menos aceita pelos pais, independente do tipo de consulta odontológica (convencional ou de urgência)(AL ZOUBI et al., 2019).

A atitude dos pais em relação às técnicas de manejo comportamental pode impactar significativamente a escolha da técnica pelo clínico. Portanto, é relevante revisar sistematicamente a literatura e atualizar as informações a respeito da aceitação dos pais frente às diferentes técnicas de manejo comportamental infantil, bem como, identificar os possíveis fatores associados às escolhas dos pais.

2 ARTIGO CIENTÍFICO

Parental acceptance of behavior management techniques used in pediatric dentistry: A scoping review

Daiana da Silva Ferreira Faculty of Dentistry, Department of Surgery and Orthopedics, Federal University of Rio Grande doSul, Porto Alegre, RS, Brazil

DjessicaPedrotti
Faculty of Dentistry, Post-Graduate Program in Pediatric Dentistry, Federal University of Rio Grande doSul, Porto Alegre, RS, Brazil

Tathiane Larissa Lenzi
Faculty of Dentistry, Post-Graduate Program in Pediatric Dentistry, Federal University of Rio Grande doSul, Porto Alegre, RS, Brazil

✉**Corresponding author:**

Tathiane L. Lenzi
Faculty of Dentistry, Post-Graduate Program in Pediatric Dentistry, Federal University of Rio Grande doSul
Ramiro Barcelos 2492, 90035-003, Santa Cecília, Porto Alegre, RS, Brazil
Phone number: +55 51 3308 5493 E-mail: tathiane.lenzi@ufrgs.br

Author contributions

D.F. and D.P. performed the methodology and wrote the manuscript; and T.L.L. conceived the idea, performed the methodology, contributed substantially to discussion andproofread the manuscript.

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Abstract

Purpose: Toinvestigate the parental acceptance of different behavior management techniques (BMTs) used in pediatric dental treatment. **Methods:** A literature search was carried out in PubMed/MEDLINE, TRIP, Lilacs and Scopus databases with no language or date restrictions.Studies that evaluated the parental preference for BMTs used in pediatric dentistry were included. **Results:** From a total of 1,153 articles, 61 studies were full text assessed for eligibility, with 15 cross-sectional studies included in this scoping review. In general, the papers varied by population, and methodological evaluation. Studies were reported from 1997 through 2019, including several ethnicity and countries. Questionnaires for evaluating parental acceptance of the BMTs were answered mainly by mothers (53.2%). The following BMTs were evaluated in the included studies: tell-show-do, positive reinforcement, modelling, nonverbal communication, effective communication, distraction, contingent escape, voice control, parental presence/absence, active and passive restraint, oral premedication, nitrous oxide sedation, general anesthesia, hand-over-mouth, and hypnosis. Positive reinforcement (91.6%) and tell-show-do (87.5%) were the most acceptable, while hand-over-mouth (31.5%), general anesthesia (34.4%) and hypnosis (34.4%) were the least acceptable. **Conclusion:** Parents continue to prefer basic techniques over pharmacologic and advanced techniques.

Keywords: behavior management techniques; pediatric dentistry; parental preference; review

Introduction

A successful dental treatment aims to provide quality care to patients. However, a patient unwilling to collaborate can increase the difficulty of providing efficient dental treatment. Commonly, children have greater impatience and anxiety and many of them have a difficult behavior during dental treatment (1). The use of behavior management techniques (BMTs) reduces fear and anxiety, controlling and modifying the child behavior (1). Moreover, BMTs promote a positive attitude in the child by teaching them to cooperate, to be relaxed and self-confident in the dental office (1).

BMTs are classified as basic and advanced techniques. The basic BMTs include communication techniques such as tell-show-do, modeling, distraction, positive reinforcement, voice control, and parental presence/absence. Advanced BMTs comprise protective stabilization (active and passive restraint), sedation, and general anesthesia (1). These techniques must be individually adapted for each child, family and dental experience, since these factors influence on the child behavior (1).

Parental oral health knowledge, attitudes and dental anxiety directly affect the children oral health and behavior on dental office (2–5). In this sense, parents' acceptance of BMTs is also important for the success of children dental treatment and can be increased when parents receive detailed information about each technique (6–9).

Considering that parents play a crucial role in the successful dental treatment of the child, and the selection of the BMTs should be made between them and dentist, this scoping review aim was to investigate the parental acceptance of

different BMTs used in pediatric dental treatment, discussing the variables that may influence the results.

Material and Methods

This scoping review employed the Joanna Briggs Institute (JBI) (10) approach which provides the most recent method for scoping reviews and draws on the approaches of Arksey and O'Malley (11) and Levac et al (12).

The research question for this review was: "How is the parental acceptance of different BMTs of the children during dental care?"

Search strategy

A comprehensive literature search was undertaken through the PubMed/MEDLINE, TRIP, Lilacs and Scopus databases to identify literature up to August 2020 related to the research question. The search was conducted with no publication year or language limits. The subject search used a combination of controlled vocabulary and free text terms based on the search strategy for the PubMed/MEDLINE database as follow:

(((((((behavior management technique*) OR behavior guidance technique*) OR child behavior[MeSH Terms]) OR child behavior) OR child management)) AND ((((((pediatric dentistry[MeSH Terms]) OR pediatric dentistry) OR paediatric dentistry) OR pediatric dental practice) OR paediatric dental practice) OR pedodontics)) AND (((parental acceptance) OR parental) OR parents)

The search strategy was adapted to the Scopus, TRIP e LILACS databases and the results were cross-checked to find and eliminate duplicates.

Study selection process

Titles and abstracts were reviewed independently by two authors (D.F. and D.P.) and selected for further review if they met the inclusion criterion: observational studies that assessed the level of parental acceptance of BMTs for managing children behavior during dental treatment.When only a relevant title without a listed abstract was available, a full copy of the article was assessed for evaluation. The reviewers were previously trained and calibrated for papers selection. Any discrepancies were solved through discussion and consensus of a third reviewer (T.L.L.). To retrieve all relevant papers, the same reviewers also screened the reference lists of the included papers and their related reviews. The calculation of interexaminer agreement (Kappa=0.87) indicated good agreement between the two authors.

A final decision about inclusion of the potentially relevant studies was made based on the full-text evaluation.Studies were excluded if they did not evaluate more than one BMT, did not present the frequency of level of parental acceptance of BMTs, did not present the BMTs to parents, and included parents of children with disabilities. Studies without full-access also were excluded.

Data extraction

A protocol for data extraction was defined. Both reviewers independently

collected the data of the eligible studies. For each paper, the following data were systematically extracted: publication details (authors, year, and country), sample characteristics (number, gender and age of participants, and sample size), methodology (method of presentation of the BMTs), and outcome information (BMTs evaluated and measurement mode of the level of parental acceptance of BMTs).

Descriptive analysis

A descriptive analysis of the characteristics of the included studies was performed and discussed between authors. The ranking of the parental acceptance of different BMTs was performed using the percentage of parents who rated each BMT as acceptable or totally acceptable. A table and figure were created to reflect the findings.

Results

Study selection

The search strategy identified 1,153 potentially relevant records, excluding duplicates. After screening titles and abstracts, 52 studies were retrieved to obtain detailed information. Another 9 studies were identified in reference lists. From the 61 full-text articles, 46 studies were excluded. Finally, 15 cross-sectional studies met the eligibility criteria and were included in the scoping review, totaling 1,762 parents assessing 14 different BMT for children treatment. Figure 1 summarizes the process of study selection and the reasons for exclusions.

Characteristics of the included studies

The main characteristics of the included studies are presented in Table 1. Studies were conducted in Germany (13), Turkey (14), India(15,16), Iran (17,18), Israel (19,20), Brazil (21,22), Colombia(23), Kuwait (24), United States (25), Saudi Arabia (6), and Thailand (26). Twelve studies (6,13,25,26,14–17,19–21,24) were published in English, one (22) in Portuguese, one (23) in Spanish and one (18) in Persian. The papers were reported from 1997 through 2019. Questionnaires for evaluating parental acceptance of the BMTs were answered mainly by mothers (53.2%). BMTs were presented to the parents through verbal explanation (17,20), power point (15,22), written descriptions (13,17,19,26), photos (13,21,26) and video (6,14,16–18,23–25). None study randomized the order of presentation of the different BMTs. Parents get informed about the techniques individually in six (6,13,15,17,21,24) included studies.

The following BMTs were evaluated in the included studies: tell-show-do, positive reinforcement, modelling, nonverbal communication, effective communication, distraction, contingent escape, voice control, parental presence/absence, active restraint, passive restraint, sedation (oral premedication), nitrous oxide sedation, general anesthesia, hand-over-mouth, and hypnosis.

Only one study (24) evaluated the effective communication and other paper(16) investigated the parental acceptance of contingent escape. Since these techniques are not described in the AAPD Guideline (1), they were not included in the analysis. Two studies (16,21) included parents of children with and without disabilities. However, we considered only data related to children without disabilities.

According to the ranking about parental acceptance level of BMTs (Figure 2), positive reinforcement (91.6%) and tell-show-do (87.5%) were the most acceptable, while hand-over-mouth (31.5%), general anesthesia (34.4%) and hypnosis (34.4%) were the least acceptable.

Discussion

Management of the behavior in pediatric dentistry is important to perform efficient oral health care with physical and emotional security for children (1). The success of this approach depends on the relationship and interaction between dentist, child and parents. Parents routinely accompany their children through dental appointments and are involved in the decision-making and delivery of care (8). Therefore, the BMTs of pediatric patients should be customized according to their individual needs and the parents' preferences. This is the first scooping review that pooled data about parental acceptance level of BMTs commonly used in pediatric dentistry. Positive reinforcement and tell-show-do were the most acceptable techniques, while hand-over-mouth, general anesthesia, and hypnosis were the least acceptable.

Most children can be managed effectively using the techniques outlined in basic behavior guidance, and they seem to be preferable by parents when compared to advanced techniques (1). Basic BMTs assessed in this review were: positive reinforcement(6,14–16,19,21,23–26), tell-show-do(6,14,26,15,16,19,21–25), distraction (6,21,23–26), modeling (15,16,19,23,24), nonverbal communication (6,24,25), parental presence/absence (6,14,18,24–26), voice control (6,14,25,26,15,16,18–22,24), hypnosis (19,24,25). Advanced BMTs assessed were:

active restraint (6,13,25,15–17,20–24), oral premedication (6,14–17,20,24–26), nitrous oxide sedation (13,15,19,21–25), passive restraint (13–17,19–21,23,26), general anesthesia (6,13,24–26,14–18,21–23) and hand-over-mouth (6,15–18,22,24–26). The technique most evaluated by the studies was general anesthesia while the least investigated were hypnosis and non-verbal communication. Considering the ranking of these three techniques, it appears that the data collected in our review are well distributed.

Some studies assessed the parental acceptance of BMTs using a visual analogue scale (7–9,27–31). However, the descriptions and method of applying the scale varied a lot, making difficult to pooled data. Thus, we included only studies that presented the frequency of parental acceptance of BMTs. For the calculation of the acceptance percentage, the number of parents who considered the technique as acceptable or totally acceptable was divided by the total sample.

Hand-over-mouth is a controversial technique and it is no longer included in the AAPD guideline (1). Nine studies (6,15–18,22,24–26) included in the review assessed the parental acceptance of this technique and they have shown a sharp decline in its acceptance over the years. The possible psychological effects on the child and the legal aspects of this technique application may be related to its rejection (32). There is a lack of information about this technique effectiveness and considering the low parental acceptance, the hand-over-mouth is considered a socially unacceptable technique and is not recommended nowadays.

Parents influence on child’s behavior at the dental office in several ways (1,2). They could transmit their own dental anxiety and fear and negatively affect the children behavior, or transfer positive attitudes toward oral health care and decrease caries prevalence (8). Likewise, parental preferences for BMTs may be related to

parental dental anxiety (14). It has been shown that parents with the higher level of anxiety tend to reject voice control and sedation (19). Moreover, parents from different ethnic groups express different preferences for BMTs (27,28,33). This suggests that practitioners should take into account parental factors and cultural differences when choosing the proper BMTs for managing children behavior.

Most parents who answered the questionnaires of the selected studies were female (53.2%). Mothers are the main caregivers of children and the habitual company in the diary activities, including dental treatment (21,32). It has been reported that parental acceptance of the BMTs is not influence by sex (16,24,25), as well as parents age (16,17,20), education level(20,24) and occupation (23,27). On the other hand, parents from low-income group (16) and parents with lower educational level (6,16) were morereceptive for BMTs.

There were a variety of methods used to present the BMT to parents; however, most included studies used videotape that are more eye-catching and may have a lasting effect on the observer. Despite the lack of association of parental acceptance and methods of presentation of the BMTs (17), videotape seems to be an educational method and parents stated that its help to improve their understanding and acceptability of the techniques(8). Furthermore, parents were more receptive for BMTs once they received explanations about the need for their use (6–8,25). It is essential for pediatric dentistry professionals to inform parents about each technique’s objectives before application. This avoids possible misunderstandings and foster a trusting relationship between the child, parents and dentist (32).

The order of presentation of the BMTs was not randomized in the included studies, i.e. they were explained to all parents in the same order, which could alter

their perception (7). There is a tendency for those parents who rated the techniques in group to express lower acceptance level of BMTs than those who made individual ratings (6,30). In our review, only six studies (6,13,15,17,21,24) made it clear that the parents answered the questionnaire individually.

The findings of this scoping review show that parents prefer techniques that involve less aggressive and more communicative management. Nitrous oxide sedation and oral premedication were more acceptable when compared with passive restraint. All studies evaluated parental acceptance of BMTs during conventional dental treatment. Previous studies reported that parents are more willing to accept advanced BMTs in the emergency situation, e.g. when the child is experiencing pain or discomfort (13,31). Moreover, parental acceptance of advanced BMTs seems to increase when they have had previous experience with them (25,31), and decrease as treatment costs becomes higher (31). It is important to highlight that included studies were not evaluated regards their scientific rigor because scoping reviews generally do not included critical evaluation of the methodological quality as systematic reviews.

We recommend that dentists seek a good relationship with parents and children, recognizing the family characteristics and providing a good explanation of the BMTs. This may facilitate the choice and application of BMTs most appropriate for each child and their parents, contributing for treatment success. Furthermore, it is important continuously to reevaluate the parental acceptance of BMTs to maintain optimal dentist-parents communication.

Conclusion

Parents continue to prefer basic techniques over pharmacologic and advanced techniques.

Conflict of Interest

The authors declare no conflict of interest.

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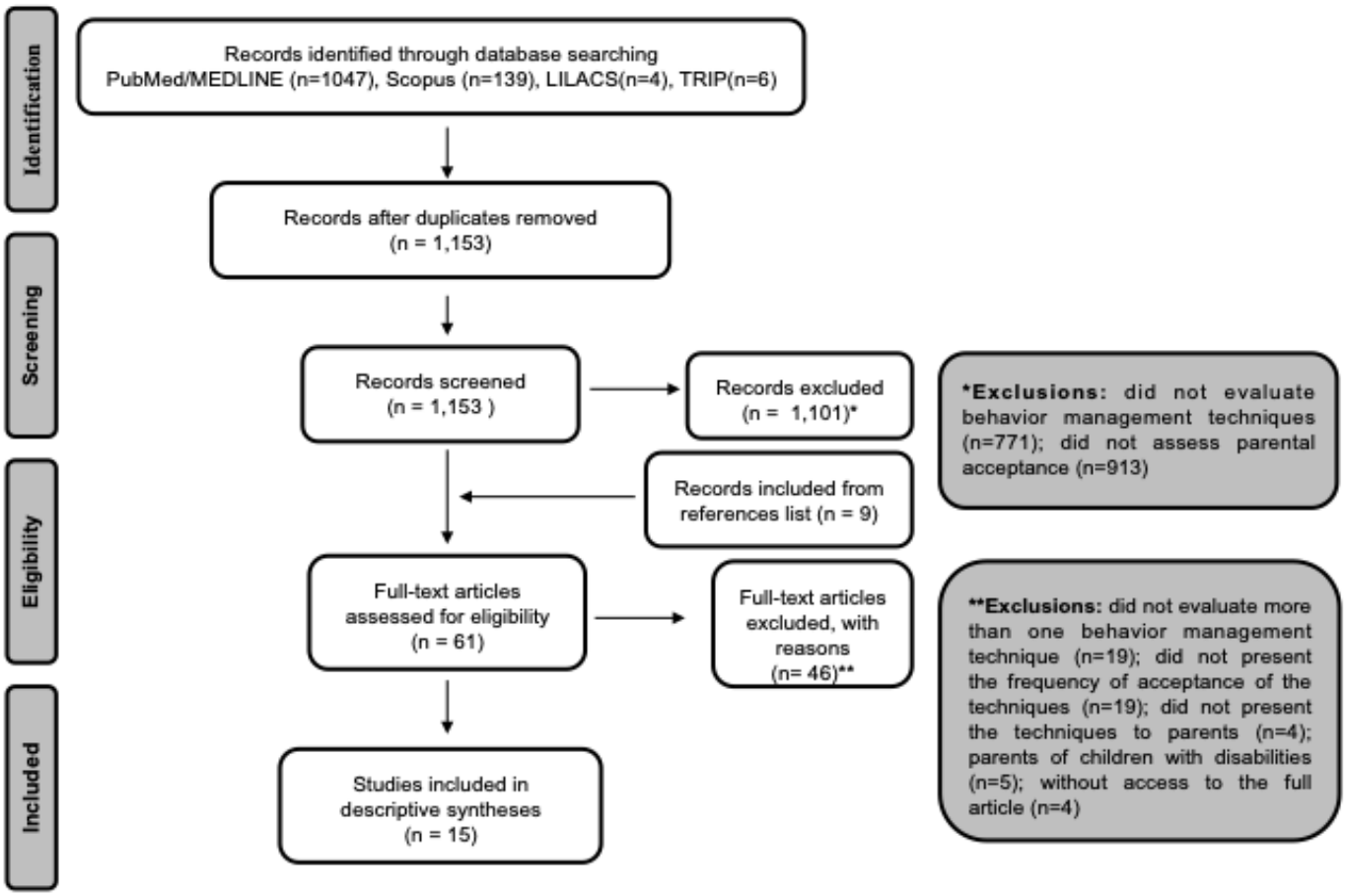

Figure 1. Flow diagram of the search results from the databases.

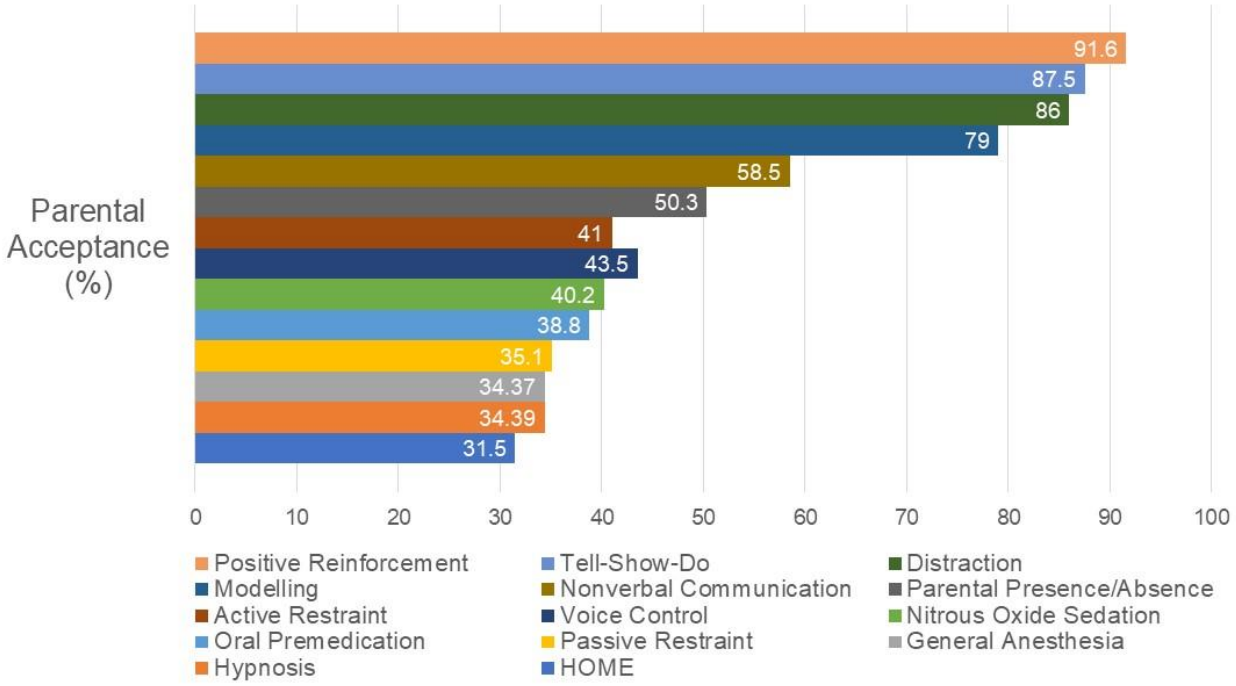

Figure 2. Ranking of parental acceptance of BMT used for pediatric dentistry treatment.

Table 1. Detailed chart related to studies included in the scoping review.

Author (year)	Country	Sample	Gender	Mean age (range)	Children Age	BMT Assessed	BMT presentation	Method of presentation
Al Zoubi et al.(13) (2019)	Germany	136	95 mothers 41 fathers	-	-	Passive restraint, active restraint, nitrous oxide sedation, general analgesia	Written description and photos	Individual
Taran et al.(14) (2018)	Turkey	142	125 mothers 17 fathers	-	6.83 (3-12)	Tell-show-do, voice control, positive reinforcement, parental presence/absence, passive restraint via a Papoose Board (Olympic Medical Co., Seattle, Wash., USA), oral premedication, general anesthesia	Video	-
Acharya et al.(15) (2017)	India	50	18 mothers 32 fathers	(20-40)	3-6	Voice control, tell-show-do, positive reinforcement, mouth prop, modelling, hand-over-mouth exercise, active restraint, oral premedication, nitrous oxide sedation, general anesthesia	Power point	Individual
Paryab et al.(17) (2014)	Iran	90	Only mothers	30 (22-42)	3-6	Active restraint, passive restraint via a Papoose Board (Olympic Medical Co., Seattle, Wash., USA), hand-over-mouth, oral premedication, general anesthesia	G1: written description; G2: verbal explanation; G3: video.	Individual
Peretz et al.(19) (2013)	Israel	90	66 mothers 23 fathers	42 (27-59)	8.8 (2-15)	Tell-show-do, modelling, positive reinforcement, voice control, passive restraint, hypnosis, nitrous oxide sedation	Written description	-
Castro et al.(21) (2013)	Brazil	40	Only mothers	33.7	4-8	Voice control, tell-show-do, positive reinforcement, distraction, nitrous oxide sedation, active restraint, passive restraint, general anesthesia	Photos	Individual
Cordero et al.(23) (2012)	Colombia	129	103 mothers 26 fathers	35 (19-54)	3-15	Tell-show-do, modelling, positive reinforcement, distraction, active restraint, passive restraint via a Papoose Board (Olympic Medical Co., Seattle, Wash., USA), nitrous oxide sedation, general anesthesia	Video	-

Elango et al.(16) (2012)	India	102	49 mothers 53 fathers	(20-41+)	-	Tell-show-do, positive reinforcement, live modeling, contingent escape*, mouth prop, voice control, active restraint, hand-over-mouth, oral premedication, general anesthesia	Video	-
Muhammad et al.(24) (2011)	Kuwait	118	64 mothers 54 fathers	37.6 (24-51)	8.8 (6-13)	Tell-show-do, positive reinforcement, nonverbal communication, effective communication**, modeling, voice control, parental absence/presence, distraction, hand-over-mouth, active restraint, hypnosis, nitrous oxide sedation, oral premedication, general anesthesia	Video	Individual
Razavi et al.(18) (2009)	Iran	50	Only mothers	-	-	General anesthesia, parental presence/absence, hand-over-mouth, voice control	Video	-
Alammouri et al.(25) (2006)	United States	138	70 mothers 66 fathers	-	-	Tell-show-do, positive reinforcement, nonverbal communication, voice control, parental presence/absence, distraction, hand over mouth, active restraint, hypnosis, nitrous oxide sedation, oral premedication, general anesthesia	Video	-
Abushal et al.(6) (2003)	Saudi Arabia	91	47 mothers 44 fathers	37 (-30 – 50+)	-	Tell-show-do, positive reinforcement, hand-over-mouth, oral premedication,active restraint, distraction, voice control, parental absence/presence, nonverbal communication, general anesthesia	Video	Individual
Kamolmatayakul et al.(26) (2002)	Thailand	185	120 mothers 27 fathers	36.6	7.1 (2-15)	Tell-show-do, positive reinforcement, distraction, parental absence/presence, voice control, hand-over-mouth, passive restraint, oral premedication, general anesthesia.	Written description and photos	-
Peretz et al.(20) (1999)	Israel	104	-	38 (25-52)	6.5 (2-13)	Voice control, passive restraint, active restraint, oral premedication	Verbal explanation	-
BisiJr et al.(22) (1997)	Brazil	297	-	-	-	Tell-show-do, voice control, active restraint, hand-over-mouth, nitrous oxide sedation, general anesthesia	Power point	-

***contingent escape**(16): A brief period of escape (about 5 s) from ongoing dental treatment is provided by the dentist if the child exhibits cooperative behavior. Any disruptive behavior will delay the escape until cooperation is gained. This technique will diminish undesirable behavior and teach the child adaptive coping strategies. ****effective communication**(24): Essential for establishing relationship with the child to develop positive attitude toward dental health.

3. CONCLUSÃO

Os pais preferem o uso de técnicas básicas de manejo do comportamento infantil durante o atendimento odontológico, sendo reforço positivo e falar-mostrar-fazer as mais aceitas. Por outro lado, as técnicas avançadas e farmacológicas, como mão sobre a boca, anestesia geral e hipnose são as menos aceitas. É importante destacar que esses achados referem-se ao manejo de crianças normorreativas submetidas a tratamento odontológico convencional, ou seja, não envolvendo situações de urgência.

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ANEXO A – Aprovação da COMPESQ

Sistema Pesquisa - Pesquisador: Tathiane Larissa Lenzi

Retornar

Dados Gerais:

Projeto N°:	38576	**Título:**	ACEITACAO PARENTAL DE DIFERENTES TECNICAS DE MANEJO COMPORTAMENTAL INFANTIL E FATORES ASSOCIADOS: PROTOCOLO DE REVISAO SISTEMATICA		
Área de conhecimento:	Odontopediatria	**Início:**	31/03/2020	**Previsão de conclusão:**	31/03/2021
Situação:	Projeto Não Iniciado				
Origem:	Faculdade de Odontologia Programa de Pós-Graduação em Odontologia	**Projeto Isolado**			
Local de Realização:	não informado				

Não apresenta relação com Patrimônio Genético ou Conhecimento Tradicional Associado.

Objetivo:

O objetivo desta revisão sistemática será investigar o nível de aceitação dos pais frente às diferentes técnicas de manejo comportamental infantil, bem como, identificar os possíveis fatores associados às suas preferências. Uma ampla pesquisa bibliográfica será realizada nas bases de dados PubMed/MEDLINE, Scopus, TRIP e LILACS a fim de identificar os estudos relacionados com a questão de pesquisa. Dois

Palavras Chave:

ODONTOPEDIATRIA
REVISÃO SISTEMÁTICA
TÉCNICAS DE MANEJO COMPORTAMENTAL

Equipe UFRGS:

Nome: Tathiane Larissa Lenzi
Coordenador - Início: 31/03/2020 Previsão de término: 31/03/2021

Nome: DAIANA DA SILVA FERREIRA
Técnico: zzz Outra Função zzz - Início: 31/03/2020 Previsão de término: 31/03/2021

Nome: Djessica Pedrotti
Outra: Aluno de Doutorado - Início: 31/03/2020 Previsão de término: 31/03/2021

Avaliações:

Comissão de Pesquisa de Odontologia - **Aprovado** em 30/01/2020 Clique aqui para visualizar o parecer

Anexos:

Projeto Completo **Data de Envio:** 16/01/2020