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Protective stabilization in pediatric dentistry: A qualitative study on the perceptions of mothers, psychologists, and pediatric dentists

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Abstract

Background: Evidence regarding the feelings evoked, distress caused, and the best way to conduct protective stabilization for the management of young children is lacking.

Aim: Describe the perceptions of mothers, psychologists, and pediatric dentists regarding the use of protective stabilization during the dental care of children up to three years of age attending a University Dental Clinic in southern Brazil.

Design: After watching a video of dental care involving the protective stabilization technique, individualized qualitative interviews were held with three groups [mothers (n = 5), psychologists (n = 7), and pediatric dentists (n = 4)] to investigate four categories of interest: importance of the technique, affective attitude, distress caused to the child, and participation of parents. After the transcription of the recorded comments, qualitative content analysis was performed.

Results: Protective stabilization generated emotional discomfort but was well accepted by all groups. All expressed the need to create a bond between the dentist and caregiver; and the active participation of the caregiver was considered fundamental. The mothers and psychologists rejected other options, such as passive restraint, general anesthesia, and sedation.

Conclusion: The three groups admitted having negative feelings, recognized the importance of protective stabilization, and suggested conditions for its use.

KEYWORDS
behavior control, pediatric dentistry, physical restraint, qualitative study

1 | INTRODUCTION

The management of the behavior of children in the first three years of life is one of the major challenges in the clinical practice of pediatric dentistry. At the same time, parents have high expectations regarding the behavior of their children and the performance of the dentist. Behavioral problems during dental care are generally related to the fear, anxiety, and past experiences of the parents as well as the emotional characteristics of the child.[1,2]

The first three years of life are considered a pre-cooperative period, in which crying and resistance to care are expected, as the child does not have the maturity to understand the situation or express himself/herself.[3] However, most parents are averse to the perception that their child may experience any degree of physical or psychological distress during dental care.[1,4] This is

a barrier that leads to postponing appointments, which impedes a timely diagnosis and treatment, leading to an increase in the incidence and severity of oral problems.[5,6]

Behavior management techniques (BMT) constitute a process by which dentists establish communication, alleviate fear and anxiety, deliver quality dental care, build a trusting relationship between dentist/staff and child/parent, and promote the child's positive attitude toward oral health care.[7] The strategies are classified as basic and advanced behavioral guidance. The former refers to communication and communicative guidance and the latter encompasses protective stabilization, sedation, and general anesthesia.[7,8]

The broad definition of protective stabilization is the physical limitation of a patient's movements by a person or restrictive equipment, materials, or devices with or without the patient's permission for a finite period of time in order to provide an examination, diagnosis, and/or treatment in a safe manner.[3,8] The use of physical restraint provokes debate among clinicians and parents and has become a taboo subject, despite likely being a part of daily practice in pediatric dentistry.

Contemporary parents are increasingly less tolerant with BMT involving the use of authority or restraint. The literature is scarce, and divergent opinions are found regarding the indication, potential risks, and acceptability of protective stabilization on the part of parents of children younger than three years of age and healthcare providers.[1,9,10] Acceptability, in particular, has become a key consideration in the evaluation and implementation of healthcare interventions and is defined as a multi-faceted construct that reflects the extent to which people delivering or receiving an intervention consider it to be appropriate based on anticipated or experienced cognitive and emotional responses to the intervention.[11] The lack of scientific evidence, the increased emphasis on children's rights, and the requirement of informed consent by parents make dentists insecure about dealing with small children. Qualitative research deepens our understanding of human behavior, uncovers complex behavioral mechanisms, and portrays them in a rich context using individuals' own words.[12]

Therefore, the aim of this study was to describe the perceptions of mothers, psychologists, and pediatric dentists regarding the use of protective stabilization during child dental care, with an emphasis on the importance of and need for the technique, affective attitude during the technique, harm and distress caused to the child, and the participation of parents during the technique.

WHY THIS PAPER IS IMPORTANT TO PEDIATRIC DENTISTS

- Pediatric dentists, mothers, and psychologists recognize the importance of protective stabilization in the first three years of life, although they identify strong emotional discomfort.
- The present findings reveal the importance of the active participation of a family member/caregiver during protective stabilization.
- Protective devices (physical restraints) are associated with non-humanized conduct, whereas sedation and general anesthesia are rejected by mothers.

2 | MATERIAL AND METHODS

The authors followed the recommendations of the Consolidated Criteria for Reporting Qualitative Research (COREQ).[13]

2.1 | Ethics

This study received approval from The Human Research Ethics Committee of the Universidade Luterana do Brasil (certificate number: 2.084.933) and was conducted in accordance with the ethical standards stipulated in the Declaration of Helsinki.

2.2 | Study design and participants

This qualitative study was conducted between August and December 2018. The participants of the study comprised three groups of interest and were selected based on the following inclusion criteria: first-time (primiparous) mothers of children up to three years of age (n = 5), psychologists with at least 10 years of experience in child psychology (n = 7), and pediatric dentists with at least 10 years of clinical experience (n = 4). The participants were selected by convenience among mothers of children under care at the clinic of the School of Dentistry of Universidade de Passo Fundo as well as psychologists and pediatric dentists who worked in the city of Passo Fundo (southern Brazil). There were no refusals. The exclusion criterion was participants with children who had previous dental experience.

2.3 | Data collection

After receiving clarifications regarding the objectives of the study and signing a statement of informed consent, all participants individually watched a three-minute video with scenes of dental care for ten children up to three years of age involving the use of the protective stabilization

technique (PST). The scenes included the positioning of the child in the chair and immediately after different routine procedures of clinical practice, such as a physical examination, prophylaxis, the application of a fluoride varnish, anesthesia, absolute isolation, and restorative procedures. PST was performed with the patient lying on the dental chair with the hands and legs restrained by a family member and the head restrained with the assistance of the staff. Some children cry when positioned on the dental chair. All children cry during the procedure and the majority struggle, with variations in the degree of physical resistance, such as moving the head, shaking the head and arms, and writhing the entire body. Some children cry at the end of the session (always with less intensity than during the procedure), whereas others have stopped crying by the end of the session.

Semi-structured guided face-to-face interviews with open-ended answers were then conducted individually in a reserved room by a female researcher (MCI) who had undergone training in qualitative research (MSc in Pediatric Dentistry and PhD student at the time of the study). Training involved 20 hours of theory classes, followed by practical activities involving the recording and analysis of interviews supervised by a researcher with a PhD in psychology. The interviewer did not know the participants prior to the study. Before the interview, the interviewer engaged in an initial dialog with the participants to determine whether they were willing to share their individual experiences and create a favorable environment in which they felt at ease.

The questions were adapted to the different groups (mothers, dentists, and psychologists) and were pilot-tested before. The interviews were guided by a structured questionnaire (Figure 1) addressing the following categories: (a) Importance of and need for the technique in dental care (participant's perceptions); (b) Affective attitude during the technique (feelings when watching the scenes); (c) Harm and distress caused to the child (participants' perception about harm and distress generated to the child because the use of the technique); and (d) Participation of parents during the technique (perceptions about participation of parents during the technique). Figure 1 lists the questions that guided the interview.

The interviews were recorded and transcribed for subsequent qualitative content analysis based on Bardin (2011).[14] The interviews lasted an average of 40 minutes and were analyzed before the completion of the data collection process to enable the determination of repetition in the comments, which indicated that saturation had been reached.[12] The transcripts were not returned to participants for comments or corrections.

2.4 | Data analysis

The information obtained in this study was interpreted using a thematic approach.[15] The analysis of the discourses was performed separately by two researchers (MCI and JR) and organized in three steps: pre-analysis, data analysis, and interpretation of the findings. Pre-analysis involved the organization of the material to systematize the ideas. The discourses were transcribed verbatim, maintaining grammatical errors and linguistic terms related to the local

(a) Importance and need for the technique	• What do you understand about the importance of the protective stabilization technique for dental care? • What is your perception about the need for using physical restraint during the dental treatment of children?
(b) Affective attitude during the technique	• Speak about your feelings when watching these scenes.
(c) Harm/distress caused to the child	• What do you understand about the possibility of this technique causing psychological harm to the patient? • Talk about your opinion if your child were treated in this way. • Talk about the possibility of a negative psychological effect generated in the child and parents in this situation. • Talk about the possible relationship between restraints in the medical setting and protective stabilization in the dental setting.
(d) Participation of parents during the technique	• What is your perception about the direct participation in physical restraint? / What is the influence of the emotional and psychological factors (anxiety, nervousness, fear, etc.) of the parents/caregivers on the physical restraint technique? • What is your perception about the dentist asking you to remove yourself from the office in which your child is being treated? • What is your perception when the dentist asks parents/caregivers to remove themselves from the office in which their child is being treated?

FIGURE 1 Semi-structured interview guide

TABLE 1 Characteristics of sample

Participant	Age (years)	Schooling	Other characteristics
Mothers			Child Sex/Age (y)
1	28	High school	Male/3
2	32	University student	Female/2
3	30	University student	Male/1
4	36	High school	Female/2
5	41	University student	Male/3
Psychologists			Time since graduation (y)
1	40	Master	17
2	36	Specialist	12
3	35	Specialist	10
4	60	Master	35
5	47	Specialist	23
6	52	Specialist	28
7	48	Doctor	25
Pediatric Dentists			
1	35	Master	13
2	55	Specialist	32
3	38	Doctor	15
4	36	Master	12

culture in order to maintain the emphasis and identity of each interview. Data analysis was performed considering the four categories defined a priori. Based on the content of the interviews, three additional categories were included a posteriori: other advanced behavior management techniques, the association with medical procedures, and characteristics of the dentist required for the use of the technique. Moreover, 'register units' were determined for each group (words that repeated most during the transcriptions and, therefore, best represented each group). To ensure the internal consistency of the data, the analysis was performed individually by two of the authors of this study. In cases of a divergence of opinion, a third author participated in the decision. The results were then described based on the set of categories, and triangulation was performed of the information among the groups.

3 | RESULTS

The sample was composed of psychologists aged 35 to 60 years, first-time mothers aged 28 to 41 years, and pediatric dentists aged 35 to 55 years. Table 1 displays the characteristics of the participants, and Figure 2 offers a summary of the participants' responses. The data were described based on the thematic categories established a priori and a posteriori.

3.1 | Importance of and need for the technique

All groups understood the objectives and the importance of PST to the safety of the child and dentist, although the caregivers and psychologist were previously unaware of its use in the dental setting. The psychologists reported the use of physical restraints for the emotional management of struggling children during psychotherapeutic care. Among the pediatric dentists, there was a consensus regarding the functioning of the technique, especially in urgent cases. They also reported that PST is challenging due to the stress caused to the dentist and parents. All groups reported that the intervention was important, as it enabled care.

> 'The **technique is necessary** for safety of child and dentist'.
>
> (Mother 1)

> 'As soon as a session begins, I already feel a bit uncomfortable, but then **we see that it is working'.**
>
> (Dentist 1)

> '**You have to do it**. How can I let my child go without treatment, without having the procedure? I don't see any other way'.
>
> (Mother 2)

Categories	Groups of interest					
	Mothers		Psychologists		Pediatric dentists	
	Keywords	Comments	Keywords	Comments	Keywords	Comments
Importance of technique	Necessary Need Was unaware	PS is necessary for safety of child and dentist.	Necessary Need Resource Safety	PS is necessary resource for safety of child and dental staff.	Necessary Bothers Urgencies Works Challenging	The crying bothers, but PS is necessary to perform care, especially in cases of urgency.
Affective attitude	Nervousness Distress Agony	Crying causes uncomfortable sensation and distress to caregiver.	Frightening Giant Unknown Fear Anguish	Child sees dentist as unknown giant, causing fear and anxiety.	Anger (mother) Pity (child) Discomfort Confident Safety	Feel that they are doing the right thing, despite the discomfort of the crying and pity for the child's situation.
Harm or distress	Traumatizes Context	Depending on how and when the procedure is performed, it could traumatize.	Context Management Register Individual Frequency	Trauma varies according to individual capacity, frequency of event and how situation was managed.	Do not recall Family trauma	Causes more harm to parents than child.
Participation of parents	Safety Presence of mother	Mothers who have emotional capacity prefer to participate actively.	Confident figure Fundamental Important Variable Respect Comfort	Parents that feel capable of participating in restraint play fundamental role in child's trust and tranquility.	Participation of caregiver Family restraint	Always with a caregiver who is willing to participate.
Other advanced behavior management techniques	(GA) Fear / Invasive (OS) Extreme cases (PP) Straightjacket	Medication would help, but everything depends on opinion of dentist and on what is going to be done.	(GA) Imagination / Exaggeration (OS) Extreme cases (PP) Straightjacket / Impersonal	Can use oral medication in more difficult cases. GA is exaggeration for dental procedures.	(GA) Unreal/high cost (OS) Insecurity (PP) Impersonal	Do not feel prepared and secure with other options.
Association with medical procedures	Vaccine Medical procedures	If they cry for a vaccine, they going to cry at the dentist's office. The difference is time.	Vaccine Medical procedures	Vaccines also cause child's resistance and are as important as dental care.	Vaccine Medical procedures	The difference between a vaccine and the dentist is the time it takes.
Characteristics of dentist required for use of technique	Playful Environment Trust Welcoming Conversation	Everything is based on trust in dentist and how he/she conducts situation.	Prepare Trust Truth Context Playful Environment	Trust in dentist is built and depends on preparation and how he/she acts during the procedure.	Anticipate Explain Trust Agility Organization	Always explain to help parents anticipate procedure, expediting and reducing treatment time.

GA: general anesthesia; PS: protective stabilization; OS: oral sedation; PP: pediatric package.

FIGURE 2 Summary of participants' answers according to category evaluated

3.2 | Affective attitude during the technique

The feelings evoked by PST were classified as unpleasant. Strong feelings of anguish and discomfort were expressed in all groups.

'It's a strong scene, because it's a moment of **discomfort and anguish** for both the child and the parents'.

(Psychologist 6)

The crying of the children was described as the greatest cause of emotional discomfort.

> '**Your heart gets tight**, because, as a mother, we don't want to see a child crying'.
>
> (Mother 5)

3.3 | Harm/distress caused to the child

This category involves the perceptions of the participants regarding the impact of the protective stabilization on the child. The mothers stated that PST could cause trauma, whereas the psychologists stated that this is a broad concept that depends on factors such as the family context, the conduct of the dentist, the frequency and individual recall of the child, and the post-operative conduct of the caregivers.

> '**Everything depends on the case**, the child, the family environment, what is said, the measures that are taken, what follows next…'
>
> (Psychologist 1)

According to the pediatric dentists, children do not have a long-term memory to establish a psychological trauma in such cases, as their behavior tends to improve over time and they begin to cooperate more during appointments and procedures.

> 'The younger they are, the less long-term memory they have. As they continue treatment, the likelihood is that **things get better…** In fact, I have no doubt about it'.
>
> (Dentist 3)

> 'They are not going to recall it… **but the parents never forget**'.
>
> (Dentist 4)

3.4 | Participation of parents during the technique

All groups were in agreement regarding the importance of the participation of the accompanier, especially a family member, to enhance the child's sense of trust. Physical restraint without the presence of a caregiver was considered less humanized conduct. The discourses revealed that the acceptance of PST was closely linked to the dentist's attitude and the creation of a relationship of empathy and trust with the nuclear family.

> 'I only do it with the parents in the office … at this age, no one leaves the office. **I like it when the parents see everything**'.
>
> (Dentist 2)

> 'I hold her; I prefer to hold her. I think that it's her trust, you know? She trusts me. **I make her feel safe'.**
>
> (Mother 2)

It was also considered important to give explanations beforehand and offer possible options.

3.5 | Other advanced behavior management techniques

Advanced behavior management techniques involving sedation and general anesthesia were not well accepted by the groups. The mothers were confused and indecisive regarding the choice of other techniques. The pediatric dentists did not feel confident in performing sedation, whereas the psychologists suggested its use for more difficult cases. General anesthesia was considered an excessive measure for dental procedures, involving risks and a high cost. The psychologists stated that general anesthesia could fuel the child's imagination and increase the aversion to dental treatment. Passive PST with mechanical devices (pediatric package) was considered impersonal and was completely rejected.

> 'The oral route (sedation) – I **don't feel trained or prepared for it**'.
>
> (Dentist 3)

> 'Wrapping the child in a sheet … I think it's worse; **I associate it with a mental hospital**. Impersonal; there is no sensitivity'.
>
> (Mother 5)

> 'General anesthesia is expensive and implies many different things. Almost an exaggeration… **There is a lack of options'.**
>
> (Psychologist 4)

3.6 | Association with medical procedures

All groups related PST to other medical procedures, such as vaccines. One of the mothers compared it to the need to contain a child during pediatric appointments.

> '**Same thing as taking her to the doctor or for a vaccine…** I am aware that she is going to be scared and will not be calm. At the pediatrician, she cries and I have to hold her'.
>
> (Mother 3)

3.7 | Characteristics of dentist required for use of technique

The mothers and psychologists stated that some characteristics of the dentist are conditions for using the technique, such as establishing a bond and creating a welcoming environment. According to the psychologists, it is fundamental to establish a relationship of trust with the child and parents.

> 'It depends of the skills of the person (dentist). If he is playful and able to establish a **bond with the child**, everything becomes less frightening'.
>
> (Psychologist 3)

> '**Sensitivity, empathy, trust**. In this field of healthcare, the basis is trust'.
>
> (Psychologist 6)

4 | DISCUSSION

To the best of our knowledge, this is the first qualitative study to evaluate the perceptions of mothers, psychologists, and pediatric dentists regarding the use of PST during dental care for children. Among the advanced behavior management techniques, protective stabilization seems to be a safer, less invasive method for the dental treatment of uncooperative children. This method discards pharmacological interventions and hospitalization, reducing the risks and costs of treatment. The results of this study revealed that, despite the emotional discomfort, the technique was well accepted by the mothers due to their understanding of the need to perform dental procedures. Moreover, mothers, psychologists, and pediatric dentists considered fundamental to create a relationship of trust between the dentist and caregiver and involve the active participation of the caregiver during protective stabilization.

PST, sedation, and general anesthesia have been described as behavior management options that are the least accepted by parents and caregivers.[1,4,9,10] However, the results of this study demonstrate that caregivers understand, accept, and recognize the importance of PST during dental care. Moreover, although this method is considered challenging and stressful for pediatric dentists, it is often used in situations of urgency, including procedures for resolving pain.[16] The psychologists reported not being aware of the use of PST by dentists, but, like the majority of the mothers, understood the need and effectiveness of the technique in particular situations.

PST generated emotional discomfort for both the mothers and dentists due to the excessive crying, resistance to treatment, and the child's position of vulnerability. Feelings of distress, nervousness, agony, and pity were described. The mothers exhibited insecurity regarding the possibility of PST causing psychological harm to the child and asked about other forms of treatment. The scant literature concerning the psychological and cognitive effects of physical restraint suggests that it may be perceived as punitive and aversive.[17] However, there are studies that support the view that physical restraint does not exert a negative impact on the future dental behavior of children.[18] According to the psychologists, dental treatment per se is not capable of causing trauma to a child, although this concept is broad and complex. Trauma is related to repetitive events, most often involving physical abuse, negligence, and a lack of care. Trauma also depends on factors associated with the family context and problems related to the conduct of the dentist.[8]

In this study, the acceptance of PST was directly associated with the active participation of a person, generally a family member, that transmitted a sense of security to the child in the dental setting. The likelihood of adhering to treatment and accepting what the dentist proposes increases when the parents participate. According to the psychologists, the participation of a family member makes treatment more humanized. The American Academy of Pediatric Dentistry states that the participation of caregivers seems to be the most humanized and comfortable method for all involved. Indeed, parents feel more comfortable accompanying younger children with little experience regarding dental treatment.[19] Moreover, the direct contact seems to reduce the level of fear and make the child's behavior more cooperative.[20,21]

The use of mechanical restraining devices (passive restraint) was considered a cold, non-humanized conduct resembling the use of a straightjacket. This option was completely rejected by the mothers and psychologists. Protective stabilization devices (PSDs) are consistently at the bottom of parental acceptability rankings when compared to other methods of behavior management. Studies have shown a general trend of a decrease in the use of PSDs.[16,22] In both the professional and lay media, restraint is routinely referred as 'strapping down' or 'tying up a child' and may be seen as child abuse.

The avoidance of PSDs has expanded the demand for sedation and general anesthesia (GA) in some countries.[23,24] In this study, however, the psychologists and pediatric dentists drew attention to the risk, high cost, and limited access to specialized healthcare services that offer such options, suggesting that they should be used in select cases. Sedation and GA in a non-hospital environment have historically been associated with an increased incidence of 'failure to rescue'

from adverse events, because such settings may lack immediately available backup.[7,25] Moreover, although GA is relatively safe when administered in a hospital setting, it is expensive and not free of complications; it should only be used after exhausting all less invasive measures of behavior management.[18,24] The US Food and Drug Administration (FDA) does not recommend sedatives for children younger than three years of age, as they are particularly vulnerable to the effects on respiratory drive, airway patency, and protective airway reflexes.[26]

The perceptions of the participants regarding advanced behavior management techniques can also be briefly discussed from the standpoint of Applied Behavior Analysis, which consists of exploring factors that are antecedent to a given behavior and noting the consequences of the behavior that make it likely to happen again.[27] Although previous experiences with examinations or procedures that caused fear or pain may serve as a trigger mechanism, crying or refusal in children up to three years of age is generally caused by emotional immaturity inherent to the young age. Pediatric dentists, however, should be aware of the possible consequences of protective stabilization and avoid (as far as possible) sensations of pain or discomfort and feelings that may reinforce the negative behavior in the future. With regard to sedation and general anesthesia, the psychologists pointed out that not facing the situation of dental care could contribute to fueling a child's imagination and increasing the level of fear regarding the procedure to be performed. In particular, children undergoing GA likely do not experience the positive feeling of having coped with a difficult situation by their own efforts and are thus not given the possibility of changing their negative attitude toward dental treatment.[18]

The acceptability of PST was associated with the creation of a bond and a relationship of trust between the dentist and caregiver. Previous desensitization sessions and explanations regarding treatment create a welcoming environment and contribute to the success of dental treatment.[28,29] A previous study reports that the way a dentist transmits information regarding physical restraint exerts an influence on the acceptance of the technique by the parents.[30] The dentist is one of the bases in the triangular relationship that includes the child and caregiver and must project trust, empathy, and safety. This situation is not limited to the dentists; it is often encountered by physicians as well.[18,20] Thus, the planning and implementation of a health intervention should consider its acceptability, including recently suggested constructs that are not restricted to the concept of satisfaction, such as ethicality (how the intervention fits an individual's value system), intervention coherence (how the participant understands the intervention and how it works), and perceived effectiveness (how the intervention is perceived as likely to achieve its purpose).[11]

The American Association of Pediatric Dentistry (AAPD), British Society of Paediatric Dentistry (BSPD), and the Brazilian Association of Pediatric Dentistry (ABOPED) indicate PST when there is an immediate need for a diagnosis or treatment in uncooperative patient due to a lack of maturity or physical/mental disability; at the same time, it should not be used as a means of discipline, convenience, or retaliation.[3,8] Among the implications of this study, the use of PST by pediatric dentists should involve the creation of a bond of trust, the active participation of the caregiver, and the recognition that the technique causes discomfort to all involved. Facing the challenge of the technique and establishing a relationship of trust and safety can result in adherence to treatment and a more satisfactory bond with the dentist. Moreover, the dentist will have a unique, complex relationship with each child.

This study has limitations that should be addressed. The investigation sought to maximize the external validity of the findings by using videos from clinical settings. The disadvantage of this approach is that it does not allow for the experimental manipulation of variables, such as treatment outcome, which might be important in determining participants' ratings of acceptability. Such experimental approaches have been previously described in studies adopting a vignette methodology.[31] However, it would be impossible in this situation for the participants to view the variety of procedures and reactions compiled in the video, which represents the real world of dental care for children up to three years of age. It, however, would be impossible in this situation for the participants to view the variety of procedures and reactions compiled in the video, which represents the real world of dental care for children up to three years of age. The sample was selected by convenience and does not necessarily reflect the perceptions of all psychologists, pediatric dentists, and mothers. Moreover, the perceptions of the participants may, at least partially, reflect cultural aspects of the local community. Qualitative studies, however, capture real-life examples (voices) and provide a proficient means of obtaining in-depth information and perspectives from a relatively small sample. This method enables a more comprehensive, individual understanding regarding a specific situation that may not be possible in epidemiological studies with population-based samples. Besides the triangulation of the data from the interviews with health professionals and the parents of patients, theoretical saturation was reached; after a certain point, no additional data emerged that enabled the addition of properties to a given category in the groups investigated, enabling the understanding of the phenomenon investigated with validity.[16] Future studies that unite theoretical/technical knowledge with behavior management and emotional issues could contribute to the implementation of procedures that offer physical and emotional safety to patients and family members as well as professional satisfaction to dentists.

Lastly, the video presented to the participants exclusively involved children with different degrees of resistance to care

because the aim of the study was to estimate the perceptions of the participants regarding PST. Care without the child experiencing distress, however, is possible, even for patients up to three years of age. Thus, pediatric dentists should recognize and apply techniques that prevent or reduce the child's resistance and distress, such as graded exposure or positive reinforcement, before using PST.

5 | CONCLUSION

Pediatric dentists, caregivers, and psychologists recognize the importance of PST, even whereas admitting the emotional discomfort that this technique causes. The formation of a bond between the dentist and caregiver and the active participation of the caregiver to generate an atmosphere of trust were described as fundamental to the success of the technique. In contrast, protective stabilization devices were considered non-humanized conduct and were completely rejected by the mothers and psychologists. Other behavior management options, such as general anesthesia and oral sedation, were discarded by the three participating groups.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

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