

Dentist's Skills of Behavior Management: A Study of Knowledge, Attitude, and Practice of Dentists in Managing Child Patient

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Abstract

Context: Dental specialists are relied upon to analyze and deal with all the dental diseases successfully that is inside the information and abilities procured during dental education. However, with regard to child patients, the dentist plays a unique role. Yet, without legitimate conduct of behavior management technique (BMT), there would not be successful treatment outcomes. **Aim:** Therefore, the study aimed to explore dental specialist's skills in dental fear and to assess the knowledge, attitude, and practices of dental professionals in West Bengal giving treatment to pediatric patients. **Materials and Methods:** The cross-sectional study was conducted among dentists working in West Bengal providing treatment to pediatric patients. A structured English questionnaire intended with the end goal of this investigation was utilized. The gathered information comprises awareness and application of various BMTs while attending a child dental patient among dental practitioners; their sociodemographics; the level of professional training; working experience; faculty profile furthermore their perspectives concerning the improvement of practicing. Utilizing SPSS program version 18, frequency distributions and cross-tabulations analyses were performed. **Results:** Younger dentists were more aware (82.8%) about universally applied BMTs as compared to older (75%) ($P = 0.6855$). "Tell show do" were considered to be the most preferable technique (81.8%) and "Parental presence and absence" was the second most preferred technique (73.8%). **Conclusion:** As the degree of adequacy were marked "average" by the dental specialist in treating child patients. Subsequently, dental education ought to incorporate guidelines and techniques to prepare the impending dentists for an amazing practice in pediatric dentistry.

Keywords: Behavior management techniques, dental practitioners, survey

INTRODUCTION

"Getting into the good graces of children is almost half the work to be accomplished". - Raymond.

Children are not just little creations, managing such manifestations vary extensively in contrast with grown ups as they have distinctive psychological capacities; furthermore, they are egocentric, self-centered, extremely spontaneous, easily distracted, and their concentration span is very limited and much more. Subsequently, it is one of the greatest challenges for pediatric dentists in overseeing troublesome or rebellious behavior of children. Regardless of whether their declining nature or their unconquerable cry, you can find yourself at a loss for an effective way to provide the treatment.

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Effective management of child behavior is an integral component of pediatric dental practice.^[1] It is as fundamental to the successful treatment of children as are hand piece skills and knowledge of dental materials in dental practice^[2] To be affluent in pediatric dental treatment, it is necessary to choose adequate strategies based on procedures that stimulate a child's cooperative behavior and also implementing the knowledge that should have gained during formal dentistry training.^[3] The establishment of communication combined with a caring attitude is the key building block for developing sound rapport with any patient.^[2] As we

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traditionally know the 1:2 relationship (for example, dental specialist, child, and parents), a pediatric dentistry treatment triangle (1975) presently social assumption has been acceptably demonstrated to have an incredible effect in setting decent conduct (2003).

The perspective of behavior management has changed considerably during the second half of the 20th century, with an increasing emphasis on communication and empathic skills.^[4] More systemized into professionally derived guidelines. To date, a wide variety of behavior management techniques (BMTs) are available to dental practitioners, namely, tell-show-do, desensitization, modeling, positive reinforcement, voice control, distraction, parental presence/absence, restrain/protective stabilization, nonverbal communication, hand-over-mouth, sedation, and general anesthesia.^[5,6] Different authors have reported the application of BMTs in different countries/societies. In India, Sharath *et al.* (Chennai)^[7] and Grewal (Punjab)^[8] showed that Tell-Show-Do is the most common BMT used, and the more aversive management techniques were rarely used in managing children in the dental office. In addition, Grewal^[8] reported that 93% of the respondents used normal conversation techniques and 30% have increased the use of behavior modification techniques. In the United States, Carr *et al.*^[9] reported that the South-eastern US dentists use less aversive techniques and reported a marked reduction in the use of the hand over mouth exercise. A survey among active members of the American Academy of Pediatric Dentistry residing in the US and Canada showed that only a minority of practitioners used hand-over-mouth and active immobilization of sedated patients. In Israel, Peretz *et al.*^[10] showed that dentists used tell-show-do and material reinforcement more than any other behavior management strategies. Whereas in Australia, the most common strategies used were permitting the child to exercise some form of control over terminating the treatment if they were experiencing difficulties, furnishing waiting areas with play materials, and using a tell-show-do approach. Few of the Australian dentists used the hand-over-mouth technique also.^[11]

We have not come across any publications reporting awareness or application of BMTs in West Bengal despite its importance in creating a positive attitude toward dentistry which should best begin during early childhood, subsequently creating a child's healthy oral environment and a future healthy adult. Therefore, the objective of the study was to investigate the dental practitioners' knowledge about the use of the various type of BMTs in attending pediatric dental patients in West Bengal.

MATERIALS AND METHODS

A cross-sectional study was performed among dentists working in West Bengal providing treatment to pediatric patients. A structured English questionnaire specifically designed for this study was used to collect information by sending it online

through social media or e-mail randomly to most dentists either practicing in hospitals or private clinics.

The questionnaire was based on the structured study done by Brahm *et al.* (2013),^[12] Kawia *et al.*^[13] [Figure 1].

The questionnaire was sent to more than 300 dentists of West Bengal and a total of 176 participants responded. The questionnaire was pilot tested before the actual study commenced. It included questions that inquired on participants' sociodemographic characteristics, level of training, year of graduation, working experience, awareness on various BMTs, self-reported skills, and their application.

Data entry, processing, and analysis were done using a statistical package for social sciences (SPSS) software program version 18. During analysis, age was dichotomized into younger practitioners (below 40 years) and older practitioners (40 years and above). Practitioners were categorized as urban and rural, public and private as well as hospital and health center/dispensary. The oral health-care providers' level of training and working experience was categorized into graduates (BDS and specialist).

BMTs were grouped into universally applied and nonuniversally applied modified from Roberts *et al.*^[11] The universally applied BMTs included tell-show-do, desensitization, nonverbal communication, positive reinforcement, modeling, and

1. Age <input type="checkbox"/> -below 40 <input type="checkbox"/> -above 40	13. Do you allow extra time for the examination and treatment of a child patient who you know suffers from dental fear? <input type="checkbox"/> -almost always <input type="checkbox"/> -sometimes <input type="checkbox"/> -every once in a while <input type="checkbox"/> -rarely <input type="checkbox"/> -never
2. Gender <input type="checkbox"/> -male <input type="checkbox"/> -female.	14. Do you adjust the treatment plan to the patient's dental fear? <input type="checkbox"/> -almost always <input type="checkbox"/> -sometime <input type="checkbox"/> -every once in a while <input type="checkbox"/> -rarely <input type="checkbox"/> -never.
3. Locality of practice <input type="checkbox"/> Urban <input type="checkbox"/> Rural	15. Are u aware about the various universally applied behaviour management (tell show do, desensitization, non-verbal communication, positive reinforcement, modelling technique)? <input type="checkbox"/> Aware. <input type="checkbox"/> Unaware.
4. level of practice? <input type="checkbox"/> Dispensary/health care center <input type="checkbox"/> Hospital	16. Which (s) behaviour management technique you use for child patient? <input type="checkbox"/> -pharmacological <input type="checkbox"/> -non-pharmacological.
5. Type of practice? <input type="checkbox"/> Public <input type="checkbox"/> Private	17. Among the Non-pharmacological what all technique you actually use during practice? <input type="checkbox"/> -Tell show do <input type="checkbox"/> -Distraction <input type="checkbox"/> -Parental presence or absence <input type="checkbox"/> -Desensitization <input type="checkbox"/> -Voice control <input type="checkbox"/> -Non verbal communication <input type="checkbox"/> -Positive reinforcement <input type="checkbox"/> -Modelling <input type="checkbox"/> -Hand over mouth <input type="checkbox"/> -Restrain / protective stabilization.
6. No. of year in clinical practice? • Below 5 yrs • Above 5 yrs	18. Do you refer the patient with dental fear to dental treatment under any type of anesthesia? <input type="checkbox"/> -almost always <input type="checkbox"/> -sometimes <input type="checkbox"/> -every once in a while <input type="checkbox"/> -rarely <input type="checkbox"/> -never
7. level of professional training? <input type="checkbox"/> -Graduate doing clinical practice. <input type="checkbox"/> -Post-Graduation in Pediatric dentistry. <input type="checkbox"/> -Post graduation in other speciality.	19. Mark the way through you would like to enhance the knowledge about behaviour management technique usage? <input type="checkbox"/> -Inclusion in graduate and post graduate courses. <input type="checkbox"/> -Through Formal classes <input type="checkbox"/> -Clinical Workshops <input type="checkbox"/> -OTHERS
8. Do you find yourself good at treating child patients with dental fear? <input type="checkbox"/> Adequate <input type="checkbox"/> Fair <input type="checkbox"/> Inadequate.	
9. What is your opinion today of your undergraduate dental training regarding dental fear? <input type="checkbox"/> -I wish I had recieved more training <input type="checkbox"/> -It was just enough <input type="checkbox"/> -I wish I had recieved less <input type="checkbox"/> -I had none.	
10. Have you attended any professional courses in the field of dental fear/care delivery after graduating? <input type="checkbox"/> -Yes, a few. <input type="checkbox"/> -Yes, several. <input type="checkbox"/> -No	
11. Have you on any or several occasion before treating a fearful child patient sought support or information regarding dental fear from the different sources? Mark your preference. <input type="checkbox"/> -Internet <input type="checkbox"/> -colleague at the clinic <input type="checkbox"/> -scientific paper <input type="checkbox"/> -Psychiatrist <input type="checkbox"/> -Paediatric dentist <input type="checkbox"/> -others. <input type="checkbox"/> -none.	

Figure 1: Questionnaire.

distraction. The nonuniversally applied techniques included parental presence/absence, voice control, hand over mouth, passive or active restraining, and sedation. Regarding awareness, those who reported knowing all the universally applied BMTs were considered as being aware and their counterparts as not aware. Those who reported using more than five of the seven universally applied BMTs in their daily practice were considered as users while those reporting as infrequent use of the universally applied BMTs were considered nonusers.

Frequency distributions and cross-tabulations analyses were performed. Chi-square test was used to test for statistically significant associations between dependent (awareness, self-reported skills, and use of BMTs) and independent variables (sociodemographics, facility characteristics, level of professional training, and working experiences). The level of statistical significance was determined at $P < 0.05$.

RESULTS

Online survey links were sent to more than 300 dentists. A total of 176 dental practitioners participated in the study, of which 65.9% were males and 34.09% were females, 152 were aged 40 years or younger, 73.8% were working in urban located facilities. 112 participants (63.6%) were graduates (BDS) and 64 participants have done specialization (MDS). The majority of the participants were having experience near 5 years, majority of them reported having not attended any professional courses on BMT 144 (81.8%). Overall 81.8% of dentists were aware of the universally accepted BMT.

The sample distribution

As illustrated in table 1: Out of 176 participants, only 48 participants appraised themselves as "Adequate" in treating child's patients in dental fear. The majority of them (102) find themselves "Fair," while treating such patients, 14% of dentists answered the inadequacy. Dentists with such low self-efficiency responded positively about their opinion of undergraduate training they received regarding dental fear. The majority, 64.7% (114), participants answered "wish they had received more;" among these 48 (42.1%) were postgraduates also.

An altogether more generous extent (60.2%) of dental specialists including male and female reported permitting additional time to the child who they know suffer from dental fear. However, 50% of participants responded "always/often" to the question of whether their patients' dental fear led to an adjustment of the treatment plan, followed by "sometimes" (45.4%) and "rarely/never" (4.5%). Regarding the referral of a fearful patient to dental treatment under general anesthesia; the outcomes were "sometimes" – 17%, "rarely" – 38.6%, and never" – 44.3%.

Figure 2 demonstrates the frequency of the participants' responses regarding the data sources they prefer before treatment of fearful patients. A higher amount of dentists,

i.e., 38.6% takes help or refer the fearful child to a pediatric dentist. The practitioner's awareness regarding the universally applied BMT by age and type of practice is mentioned in Table 2. The frequency of distribution of practitioner's awareness about different types of BMTs is presented in Figure 3: Most participants, i.e., 81.8% prefer to use "Tell show do" and the second most commonly preferred technique is "parental presence or absence." Whereas, "Hand over Mouth" technique is the least (17%) preferable technique.

DISCUSSION

Behavior management of a child is a clinical art and also the skills that built with experience and also with the goals to establish good communication, eliminating fear thus building a trust relationship between child, dentist, and parents. This will further promote the child's positive attitude toward oral health care. In this study, the most preferable technique for managing children was "tell show do" (81.80%), and the second preferable was parental presence or absence. This was in accordance with the study done by Grewal.^[8]

"Parental presence" can significantly influence the environment encompassing the dental visit while giving the dental treatment. This may sometimes hinder the process or may helpful depending on the age and also the behavior of a child. The children age ranges from 0 to 2 years are emotionally attached to their parents thus shows separation anxiety.^[11] Hence, it is a

Table 1: Sample Profile

Variable	Categories	%(n)
Age of participant	Younger dentist	86.3(152)
	Older dentists	13.6(24)
Locality	Urban	73.8(130)
	Rural	26.1(46)
Level of practice	Dispensary (Health care)	54.5(96)
	Hospital	45.4(80)
Type of practice	Public	44.3(78)
	Private	55.6(98)
Level of professional training	BDS	63.6(112)
	MDS	36.3(64)
Level of experience	Below 5 yr.	65.9(116)
	Above 5 yr.	34(60)
Aware of universally accepted BMT	Aware	81.8(144)
	Unaware	18.1(32)

Table 2: Distribution of practitioner's awareness of universally applied behaviour management techniques

		Aware	Unaware	P
Age	Younger dentists	82.8%(126)	17.1%(26)	0.6855
	Older dentists	75%(18)	25%(6)	
Type of practice	Private	85.7%(72)	30.9%(26)	0.367
	Public	80%(74)	4.3%(4)	

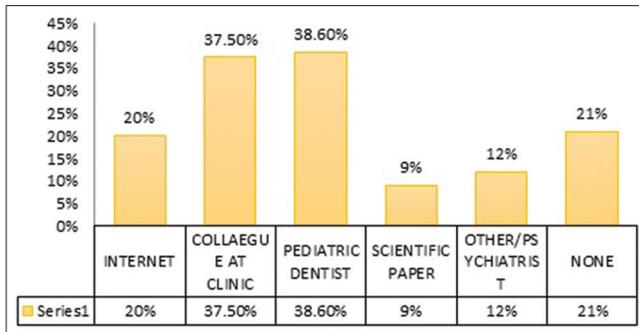


Figure 2: Sources of information and support used by the respondents before treating patients with dental fear.

crucial factor to consider, during the management of children concerning their age. The present study results showed that 73.8% of practitioners prefer to use this technique. Levy and Domoto^[14] reported that 88% of dental surgeons and staff allowed parents in the clinic, similarly a survey done by the Association of Pedodontic diplomats^[15] revealed that 90% of the dental surgeons allowed parents in their dental clinic. A study done by Olsen *et al.*^[16] found that 35% of general dentists and 87% of pediatric dentists allowed parents in their dental clinics. In a theory of separation-individualization by Margaret Mahler, where the author has classified the relationship between a child and a mother, based on which the presence of a mother is explained. This should be taken as an important trick in behavior management of a child which is to be updated by all dentists.^[17]

When the child reaches the age range of 2–7 years, they begin addressing the objects symbolically. They correlate things with other objects which they are accustomed to such as toys and games. Thus, “Euphemism” can be considered as an effective tool. In the present study, very less, i.e., 10.2% of practitioners use this technique. This may be due to a lack of awareness of child development age and cognitive levels also the amount of exposure in treating these children. The technique dentists were least comfortable with was the hand-over mouth (17%) technique. A study was done by Wali *et al.* likewise found that the most preferable technique was tell-show-do (93%) and the least preferable was hand-over mouth followed by physical restrain.^[18]

Other techniques for behavior management of a child are desensitization, modeling, and distraction. Desensitization can be used in a child who has preestablished fears; anxiety, and the child is gradually introduced to a less invasive procedure to complex treatment with lowering the stress over the child, this will also build confidence among the children.^[19] Bandura *et al.* explain the social learning theory, which is the foundation of the modeling technique which emphasizes the importance of observing and imitating the behaviors, attitudes, and emotional reactions of others.^[20] Thus, this modeling or learning by observation which is not only helpful in the acquisition of desirable behavior but also can help to eliminate undesirable behavior. The primary principle of

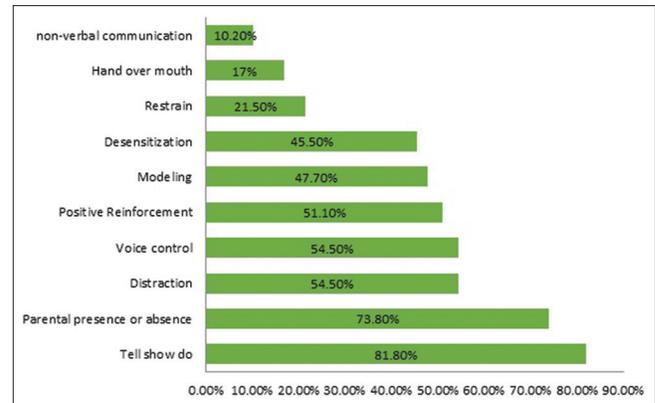


Figure 3: Frequency of distribution of preferred technique of behaviour management.

this technique is vicarious extinction, in which “fearful and avoidant behavior can be extinguished vicariously through observation without any adverse consequences accruing to the performer.” This method is helpful in better learning as the child can observe desirable behaviour while dentist working over the patient. Another new technique is “Positive reinforcement” effective in the children of 6–12 years, as the child drives for a sense of industry and accomplishment during this stage of development. All three of these techniques were found to be less in preference, as compared to other techniques in the present study. This may be due to a lack of awareness or the revision of advanced BMTs in the curriculum.^[7]

Out of 176 participants, 63.6% were graduates and 36.3% have done specialization. Among them, only 27.2% of dentist evaluated themselves “adequate” in treating fearful child. A study done by Strøm *et al.*^[21] likewise found 21% of dentist good in treating the anxious child. This self-efficiency may be due to a lack of execution abilities of various techniques and also the curriculum of educating about various techniques. Since 64.7% of dentist wished to learn about the BMT during their curriculum. Thus, treating patients with dental anxiety is considered to be a positive challenge; however, it is also reported to be difficult.

In the current investigation, the younger and less experienced dentists reported having higher awareness regarding the universally applied BMT (82.8%) as compared to older dentists (75%). This is supported by the study done by Strøm *et al.*^[21] and Brahm *et al.*^[12] This indicates an increase in awareness of BMTs in dental education. The practitioners working at dental facilities placed as an oral health-care provider in hospitals were more aware of BMTs than those working in centers providing the oral care as in dispensaries. However, dentists working in the organized hospital mostly have a specialization or may have knowledge of the behavior guidance due to the working environment. This is contrary to study done by Kawia *et al.*^[13] in Tanzanian dental practitioners. A study has done by Juntgen *et al.*,^[22] who reported that the type of practice influences the utilization of various BMTs. In this study, the private practitioners were more aware of using

various BMTs. These practitioners may have enough time to allocate to handling children and also can accomplish the parents' demand.

Most children get managed effectively using the universally applied BMT and form the foundation for all of the management activities provided by dental surgeons. Whereas, advanced techniques including stabilization, sedation, and general anesthesia may be helpful in many convoluted scenarios. In this study, only 17% of dentist refer the child for treatment under general anesthesia. This is accordance to the study done by Wali *et al.*^[18] showed that 4.5% of dental surgeons preferred the child to be treated in general anesthesia. However, Kain *et al.*^[23] observed greater compliance during anesthesia. It may be due to the need for advanced training in pediatric dentistry program for using these techniques.

The information was less among all the respondents about implementation of general sedation as BMT. This might be because of the requirement for the improved level of training in pediatric dentistry programs needed among professionals. In this case, the current examination was directed among postgraduates and graduates, right now working over the youngster patients. However, the extremely less number of postgraduates reacted to the survey. This could be the constraint of the investigation in light of the fact that the level of the exposure and awareness in treating the child was better in postgraduates. Albeit, an extraordinary number of postgraduates in our investigation evaluated themselves less satisfactory in treating a youngster with anxious behavior. As the parenting style has changed a ton in contrasted with bygone eras. Subsequently, the new advances in behavior management technique need to learn and the professionals should be refreshed with respect to their usage. Ongoing advances, for example, Tell-Play-Do, Mobile application, virtual reality distraction is the innovative strategies that a dental specialist should know off.^[24]

CONCLUSION

An incredible number of dental specialist knew about generally applied BMTs. Aside, from the normal methods (Tell-show – do, voice control, and parental presence) experts are less aware of different strategies, for example, modeling, desensitization, and positive reinforcement that can be considered as a successful instrument. Essentially, advanced BMTs are seen as less satisfactory. Henceforth, there is a need of building great familiarity with different mental hypotheses and their application among dental graduates.

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Conflicts of interest

There are no conflicts of interest.

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