European Journal of Molecular & Clinical Medicine

ISSN 2515-8260 Volume 08, Issue 03, 2021

The Influence Of Parenting Style On Dental Anxiety- A Short Review

Running title: Influence of parenting style on dental anxiety

Typeof article: short review

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ABSTRACT

Dental treatment, altogether with its characteristics, represents quite stressful act that have influence on all of its participants especially the children. Children often show their distress with the dental situation in an aversive behavior which sometimes leads to management problems. Different pathways for the development of fear have been described. Most of the researches focus on the effect of parental presence and behavior during dental procedures. But however no in depth researches have been done on the influence of parenting style on the child's behaviour in the dental setting. Thus the purpose of the review is to analyse whether the parenting style really does influence the child behaviour or not.

keywords: Dental anxiety, Parenting style, child behaviour, dental treatment, dental fear.

INTRODUCTION

The sense of pain, anxiety and fear have always been an inevitable part of dentistry. It is the common human mentality that a sense of potential danger produces fear which in turn leads to the provocation of anxiety. Anxiety is usually classified as a disorder of neurotic nature and is often related to contexts of stress, with symptoms that may include worries, motor tension and even autonomic hyperactivity. This universal phenomenon can also be known as Dental phobia, dental anxiety or odontophobia. These experiences of anxiety and fear and their contributory effects upon pain can be thought of as a part of human existence[1].

Dental anxiety and fear are very common and troublesome not only for the dentist but is equally problematic for the patients. Fear of dental treatment and dental procedures are prevalent and have a great impact on the quality of life and well as the quality of dental treatment performed. Furthermore, dental fear still presents as a major barrier to the uptake of

dental treatment. Delay in seeking treatment as a result of dental anxiety often means that conservative treatment options are not viable [2].

Numerous factors are associated with dental anxiety, the most common ones being memory of prior painful dental experiences, the ambience of the dental clinic, pain expectation, and other psychological factors. All these factors have a major impact on the pain experience of the patient. Reducing dental anxiety is found to be profoundly reducing an individual's pain experience[3]. Dental anxiety affects individuals of all ages but has an dramatic effect on children and usually it's more difficult to manage in children compared to adults.

People are not born with anxiety and fear of dental treatment. This association occurs through the socialization process. Children are as susceptible to anxiety as adults, and their anxiety is derived from peer communication of reported bad experiences or even from threats that parents make. All of this makes clinical and psychological management more difficult because of children's' different understandings. Therefore, it needs to be possible to work beyond a simple approach of advocating regular visits to dentists, with emphasis on the notion that this is a normal everyday activity and that it may even be enjoyable.

Children and anxiety

Dental treatment, altogether with its characteristics, represents quite stressful act that have influence on all of its participants especially the children [4].

Children often show their distress with the dental situation in an aversive behaviour which sometimes leads to management problems. Different pathways for the development of fear have been described. Rachman in 1977 has proposed three pathways: directly through direct conditioning or indirectly via vicarious learning or via modeling. Unfortunately very little research has been done on the effect of parenting practices on the behavior of children during dental treatment. Most of the researches focus on the effect of parental presence and behaviour during dental procedures. The child behaviour seems not to influence the treatment content, but does influence the management techniques. Children showing more serious behaviour problems are more often treated using relative analgesia (rA) than using only management techniques.

Each child presents with individual health and behavioral considerations that can make efficient treatment difficult. An obstacle to effective treatment can be the behavior of the child. All children vary in their response to their dental experience, influenced by health, culture, parenting styles, child age and cognitive level, anxiety and fear, reaction to strangers, pathology, social expectations, and the child's temperament[5-8]. Temperament can be defined as those aspects of an individual's personality that are often regarded as innate rather than learned, and may account for various inappropriate and unexpected responses to different stimuli [9,10].

Parents have also been shown to play a key role in children's behaviour at the dental offce, especially when they have had negative experiences previously. An anxious or fearful parent can adversely affect the child's behavior in the dental office.

Parenting styles have been viewed with extreme interest recently. It is widely accepted that parents, exert an extremely significant influence on the development of their child's present and future emotional health and behavioural pattern. Home environment plays a vital role in determining a child's development and shaping children's everyday behaviour. Darling et al in his study stated that parenting styles directly affect the child's behaviors, which indirectly influences the child's development by moderating the relationship between parental expectations and child outcomes[11].

Baumrind defined three specific parenting styles, which are most often quoted in the literature: authoritative, authoritarian, and permissive [12]. According to Baumrind, parenting styles affect child's competence, achievement, and overall social development[13]. Specifically for dentistry, a large factor that could affect the child's behavior is social development.

1. The authoritarian (high control, low warmth) parenting style is defined by harsh practices of the parent including physical punishment, yelling, and commands[14].Authoritarian practices lack warmth and communication. The parent determines the rules, and the child follows this without question. This parent attempts to shape and control the child's behavior and attitudes, setting forth concrete expectations[15]. Authoritarian parenting is harsh and inconsistent punishment, and often times these parents will use destructive criticism. These children always tend to live in fear and usually avoid their company as much as possible. These children are usually distrustful and fear everything. This group of children also exhibit negative performance in school. The present information can all be related to the child's behavior in the dental office. If the child is distrusting, it can be theorized that these children are less likely to accept dental procedures[16,17].
2. The next type of behaviour would be the authoritative type. The authoritative (high warmth, high control) parenting style is defined by nurturing warmth, yet still maintaining firm control of the child's behavior. The authoritative parent is described as rational, encouraging the child continuously. The parent explains the child and makes them understand rather than commanding them to do a particular thing. These parents tend to exhibit bidirectional communication which helps to develop and nurture the relationship between the parents and children. These parents support them emotionally. Baumrind stated that the children in authoritative homes are more likely to have improved interaction with their peers and have more acceptable social behavior. These children have a better understanding of how to please others and often feel free to interact with new people. Authoritative parenting has been associated with higher levels of academic performance[18].
3. The permissive (high warmth, low control) parenting style is defined by high warmth and low control.

   Lamborn describes another type of permissive parenting style: neglectful. The neglectful style is defined by low warmth and low control, and describes emotionally detached parents. Permissive parents do not force control over the child, and provide few to no commands or limits to behavior. Research has shown that these children are seen as being more self-centered and cannot control their impulses; The behavior of the child who has permissive parenting could

complicate the visit in the dental office, especially if the child did not want to cooperate.

Parenting style has been correlated with cognitive behavior and also a child's social interactions[19]. Parenting style also influences how a child copes with stresses and stimuli, like in a dental setting. Some authors believe that there is a relationship between coping skills and dental stress tolerance in children and more authoritative parenting[20].

A child's behavior can be a significant obstacle to effective dental treatment. Depending on the situation, specific behaviors can prolong the time in the dental chair or lead to the need to use more advanced methods such as general anesthesia.

Poor behavior can also delay necessary dental treatment, thus allowing for further progression of disease. Parents today want to prevent their children from experiencing any pain or discomfort. Parents today are less accountable for behavior of their children and are, relying more on medical or psychological methods of management rather than asking or controlling their children. The fact is that parenting styles are changing, and it is a necessity for a pediatric dentist to be aware of this and to attempt to be ready to treat each patient in the most efficient and effective manner.

Maternal anxiety and child behaviour

Historically, the study by Johnson and Baldwin was one of the first to identify a positive and significant correlation between maternal anxiety and the repertoire of behaviour of children who were undergoing treatment[21].

Anxiety is frequently correlated with dental treatment because the pain and emotional reactions to this treatment are seen by many patients as threatening their wellbeing. One study that assessed dental fear levels, states of anxiety and physiological distress among children older than six years of age and their mothers during pediatric dental procedures concluded that maternal anxiety before children's dental treatment was significantly associated with children's fear of dental treatment [22].

Age is one of the factors with a higher impact on the presence of anxiety among children. Younger children tend to be more afraid of the unknown and of abandonment. However, various studies have reported that children in the age group between 7 to 10 years were the ones who most presented some level of anxiety. This may be due to the possibility that because they were older, they may have had previous painful or distressful experiences relating to dental care and may be due to influence from peers. In addition, children of this age have a higher level of attention and cognition, so they may have related others distressful experience to that of theirs.

According to the study by Paloma Bustato et al, Maternal anxiety was measured in four categories, among which most mothers were classified as slightly anxious (50%) or minimally anxious (40%). From the Corah scale, the above study showed that what makes mothers feel stressed (22.5%) and uncomfortable (22.5%) is the procedure of injected anaesthesia. In other study, states of anxiety and physiological distress levels were

significantly higher among mothers before their children's dental treatment but not afterward[23].

One of the most controversial points is mothers' presence in the dental office with their children during dental care [23]. Some authors have stated that child anxiety is associated with maternal anxiety, and that this relationship may result in uncooperative attitudes among children. The study by Paloma bustato showed that there was a significant association between maternal anxiety and child anxiety, in which the majority of anxious children (81.3%) had mothers with some level of anxiety. The most common causes that would ultimately lead to maternal anxiety would be maternal knowledge and experience of anesthesia, and high levels of maternal anxiety, may be related to increased anxiety among children undergoing surgery. Lack of psychological preparation of both the mother and the child would lead to inadequate treatment efficiency and makes success impossible.

Mothers emotional intelligence

Aminabadi et al in his research reports that maternal emotional intelligence positively correlates to the child's behaviour in the dental setting. This means children who have more emotionally intelligent mothers, have more adaptive behaviour during treatment course. Both children's behaviour and their ability to manage emotion may be affected by interactions with the parents. Although age, gender, temperament, and development all play a unique role in regulating children's coping responses when faced with stress, perhaps the most influential factor is exposure to the parental model of stress responses [24]. Parents with a high EQ may handle their emotions when they are faced with a stressful situation in a more appropriate manner and thus their children may develop their EQ by observing and learning from such role model.

Therefore, it could be suggested that parents' emotional intelligence i.e. interpersonal relationship, impulse control, problem solving, assertiveness and other component of emotional intelligence is most likely transferred to their children through daily interactions. Therefore, children of emotionally intelligent mothers are also emotionally intelligent and can handle their emotions appropriately in stressful conditions such as dental setting.

CONCLUSION

There have been numerous preliminary studies done on this topic, of which the results are quite contrary to each other, however no research has been covering in depth about the influence of parenting style on the child's behaviour in dental setting as this might have been possibly due to the large variations in data collection. There is a need for newer studies with standardised protocols and procedures that needs to be conducted to come to a firm conclusion on this topic as it is a highly subjective one.

Ethical clearance- not applicable. (Review)
Source of funding- Self funded
Conflict of Interest - Nil

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