

Caregivers' Perceptions on Changing Parenting Styles

by
Shannitta Latrease Bridgers, DDS

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Approved by:

Michael Milano, DMD

Jessica Y. Lee, DDS, MPH, PhD

Margot Stein, PhD

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ABSTRACT

Shannitta Latrease Bridgers: Caregivers' Perceptions on Changing Parenting Styles (Under the direction of Michael Milano, DMD)

The purpose of this study was to characterize parenting styles of caregivers that present to a pediatric dental clinic, to assess parents' perceived changes in parenting styles and to explore the relationship between parenting styles and children's behavior in a pediatric dental setting. We used a survey instrument that was developed using adopted questions from the National Longitudinal Survey of Children and Youths as well as validated items from a pilot study. Surveys were given to caregiver-child dyads who met inclusion criteria. Our major explanatory variables were the caregiver's parenting styles and socio-demographic information. Our major outcome variable was child behavior. 104 surveys were completed. No relationship was found between parenting style and child behavior in a dental setting. Caregivers today report increased difficulty in parenting children and this may impact a child's behavior in the dental setting.

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BACKGROUND AND SIGNIFICANCE

Changes in Parenting Trends in America

Many authors have noted that parenting practices have undergone significant changes in the past 15 years that have likely impacted children's behaviors.¹ In a society comprised of more than a traditional nuclear family such as that seen in the 1950s, changes in parenting trends in America have become increasingly popular in the media. Parenting trends in America reflected during the era of "The Nelsons" and "The Waltons" would no longer serve as an accurate depiction of present day parenting models. Issues facing parents today are somewhat different than those faced by parents over 50 years ago. In today's society, parents are faced with more serious issues such as school suspension, teen pregnancy, drugs and violence. Parenting changes have been attributed to the media, internet, single parent homes, working parents, cultural shifts, and the fast pace of contemporary living which often comes with feelings of stress.¹ Parents are reported to be more accommodating regarding their current parenting practices. Discipline may not be as rigorously enforced within the home as it was in previous years.¹ Each individual's parenting style is influenced by internal aspects of his or her own history together with characteristics of the child such as age or temperament. Andrea Waylen with the Avon Longitudinal Study of Parents and Children (ALSPAC) states that parenting is also shaped by external factors such as class, culture, and the community and era into which the child is born.² Since parenting has been a huge topic of interest in society, many instruments have been developed to describe parents according to their parenting experiences and these experiences are consistent with specific styles that can be seen in past and current literature.

Importance of Behavior Management in Pediatric Dentistry

A child's behavior in a pediatric dental setting is a function of age, prior healthcare experiences, families' existing attitudes and practices with regards to dental health¹ and their respect for authority. Behavior management is critical when providing dental care to children and requires a specific level of cooperation from both the child and the child's parents. The quality delivery of pediatric care is determined by behavior management. However, societal norms have changed and these changes greatly affect pediatric dentists' ability to influence children as well as their parents.

While the majority of children are relaxed and display moderate levels of cooperation in the dental setting, there are children who demonstrate behaviors that disrupt dentists and make the safe delivery of acceptable treatment extremely challenging.³ Parents today are unsure about certain rearing practices and are very indecisive when it comes to agreeing on child behavior that is acceptable.¹ Behavior management techniques such as nonverbal communication, tell-show-do, positive reinforcement, distraction, and voice control are commonly used with children who have developed adequate communication skills.⁴ Tell-show-do (TSD) is a method in which the dentist or the dental assistant explains to the child what they should expect by using repetitive, simple terms. They continue to demonstrate with instruments on a model or the child or dentists finger to show the child the procedures that will be attempted.⁵ Voice Control is used to gain the attention of a difficult child by using a different tone or increasing the volume of the voice.⁵ Positive reinforcement rewards, usually in the form of compliments or praise, the child who demonstrates desired behavior within the pediatric dental setting.⁵ Ideally, behavior management techniques can be used to create an environment where treatment can be rendered and the child can be guided to develop proper behavior in the pediatric dental setting.³

Changing Parenting Trends and its Influence on Pediatric Dentistry

While dentists continue the use of traditional behavior management strategies, societal attitudes toward acceptable methods of interaction with children have changed. The assumption that parents are aware and approve of even the most commonly employed behavior management technique can no longer be made.⁵ In 1984, Fields and colleagues studied parents' attitudes toward common behavior management techniques and how these attitudes were affected by various treatment situations.³ They found that the majority of parents favored the use of positive reinforcement and tell-show-do overwhelmingly over pharmacological techniques, restraint, voice control and use of the mouth prop.³ The effect of parenting on the behavior of children in the dental setting has been well studied mainly in terms of chairside rendering of pediatric dental treatment. Various studies examining maternal anxiety and parental presence in the operatory have been conducted.⁶ In 2003, Adair and colleagues stated that 38% of pediatric dentists experienced an increase in parental presence in the operatory in the last five years.⁴ The major reasons for the increase were that parents either preferred or insisted on being present in the operatory.⁴

While it is suggested that parenting changes have affected child behavior and thus the practice of pediatric dentistry, data to support that argument is limited. In 2000, Diplomates of the American Board of Pediatric Dentistry were surveyed to gather opinions from pediatric dentists at various stages in their practice careers to determine their perceptions about whether parenting has changed and what effect if any this has had on child behavior, behavior management, and practice satisfaction.⁷ Among the Diplomates surveyed, 88% of practitioners perceived parenting styles had changed during their practice lifetime.⁷ In addition, 85% of dentists believed that these perceived shifts in parenting styles had resulted in "somewhat or much worse" patient behavior.⁷ In addition, 43% of dentists reported their

satisfaction with practicing dentistry had decreased as a result of these parenting changes.⁷ The most profound finding noted in this study regarding practitioners is the shift from the use of more aggressive behavior management techniques to those that are more acceptable by parents.^{5,7} The authors believe that the shift in behavior management techniques is directly “related to parenting as opposed to simply a [more] mature group of practitioners choosing to ease out of assertive patient management”.⁷

Casamassimo and colleagues also found that dentists also believed that today many parents are unsure of their role as parents.⁷ Barbara Sheller reports that parents have a diminished sense of their responsibility to establish boundaries, maintain discipline, teach self-control, and instill respect for others.⁸ Sheller also states that the practice of pediatric dentistry is affected by societal changes, marketing and media, technology and parenting practices.⁸ Dentists also believed that parents spend too little time with their children due to their busy schedules and that parents are focused more on themselves and acquiring material possessions.⁷ They also reported their belief that parents are less inclined to use physical discipline and set boundaries on their child’s behavior assuming the role of a friend as opposed to a parent⁷. When considering reasons for the shift in parenting styles, the highest ranked factor believed to be associated with parenting changes by dentists is societal changes toward liberalism and breakdown of norms.⁷ Other factors included divorce, both parents working, hectic lifestyles, loss of extended families, increased stress of maintaining lifestyles and frequent relocation.⁷ With regards to parenting, dentists also reported they exhibited little to no discipline with the child. The majority of dentists believe that parents were more likely to accept their child’s disrespect and more overprotective of their child. Parents also desire to prevent any suffering their child might experience from dental treatment.⁷ However, this study reports that parents demonstrated wide acceptance of dental treatment and showed

interest in their child's experience with receiving dental care.⁷

The patterns of parenting in America have been studied dating back to the 1960s. The changing nature of parenting styles and its influence on child behavior and behavior management techniques has become a hot topic of interest for several conference papers.^{1, 4, 8,}
⁹ In the recent literature, many studies have been published describing the dramatic change in parenting as seen by many professionals such as psychologists, sociologists, and other health professionals. The primary objectives of the American Academy of Pediatric Dentists Clinical Guideline on Behavior Management are to “effectively and efficiently perform necessary dental treatment and to instill in the child a positive dental attitude”.¹⁰ However, no studies exist which examine the relationship between parenting styles and child behavior in a pediatric dental setting.

SPECIFIC AIMS

The purpose of this study was to characterize the parenting styles of caregivers that present to a pediatric dental clinic, to assess if parents perceive changes in parenting styles and to explore the relationship between parenting styles and children's behavior in a pediatric dental setting.

MATERIALS AND METHODS

Study Design and Survey Development

This cross-sectional study examined parenting styles and children's behavior in a pediatric dental setting and characterized those factors associated with the type of parenting styles identified. We used a 43-item survey instrument which was approved by Institutional Review Board at UNC. The survey was developed using questions adopted from the National Longitudinal Survey of Children and Youths as well as validated items which gathered socio-demographic information and caregivers' perception of change in parenting trends. The content of the survey questionnaire was based on the overall objectives of this study. This study was conducted at the University of North Carolina Graduate Pediatric Dental Clinic and given to caregiver/child dyads who met selection criteria.

Data Collection and Statistical Analysis

Eight trained and calibrated pediatric dentistry residents served as examiners to determine the child's behavior score during the initial clinical examination. The calibration session included a review of the study and the inclusion and exclusion criteria, as well as a review of the modified Frankl Behavior Rating Scale. Three video cases of children undergoing an initial clinical exam were reviewed and scored as one group. Immediately following the review session and discussion, the residents viewed five videos of children undergoing an initial clinical exam and individually scored them according to the behavior scoring descriptions listed on the scoring sheets. Discussion was held and calibration was completed. Examiners were re-calibrated at the halfway point in data collection and

residents were asked to view and score two new videos of children's initial clinical examinations. After the caregiver completed the health history questionnaire, the patient's record was reviewed to assess the health status of the child. The trained examiner then invited caregivers who met all selection criteria to participate in the study. Caregiver/child dyads presenting for their initial clinical exam appointment were asked to participate in the study if they met the following selection criteria:

1. Mothers

- Only biological mothers' of children less than 12 yrs of age
- Must have been legal guardian for their entire life
- Ability to read, speak and understand English

2. Children

- <12 yrs of age
- Healthy-ASA I, ASA II
- Must undergo or (at least attempt to undergo) initial clinical exam at UNC Pediatric Dental Clinic
- Both males and females included

IRB approved consent forms were given to obtain consent for both caregiver and child. The surveys were self-completed and the caregiver of the child was given the survey to complete by the end of their appointment. Completed surveys and signed consent forms were collected by the resident who provided the exam and were returned to the principle investigator for data analysis using STATA 9.0 Statistical Software.

The major explanatory variables were the caregiver's parenting style and socio-demographic information. The parenting style survey was adopted from National Longitudinal Survey of Children and Youths. It is comprised of 18-items measuring three

constructs related to parenting styles: 1) Positive Interaction, 2) Hostile/Ineffective and 3) Consistent. We also examined the caregiver's perception of child's behavior as well as caregiver's perception of changes in parenting styles. Additional questions were included to assess changing perceptions of parenting today.

The major outcome variable was the child's behavior as measured by the modified Frankl Behavior Rating Scale (RS) used in the UNC Department of Pediatric Dentistry. Each child of the parent/child dyad for which consent was obtained underwent an initial clinical exam during which the behavior was evaluated by a trained and calibrated examiner to obtain a behavior score. The modified Frankl Behavior RS (Figure 1) was used to assign scores to children participating in the study. The modified Frankl Behavior RS was adopted from the The Frankl Behavior RS which was developed in 1962 to provide an assessment of dental anxiety of a child in a dental setting. The scale was completed by the dentist and a score of 1-4 was given to denote (1) definitely uncooperative, (2) uncooperative, (3) cooperative, or (4) definitely cooperative behavior of the child during the dental appointment. Each behavior scoring form included the name of the resident providing the clinical examination as well as the actual behavior rating scale.

RESULTS

From December 2009 to August 2010, 104 surveys were collected from biological mothers of children presenting for their initial clinic exams at the graduate pediatric dental clinic. As represented in Table 1, the majority of respondents were Caucasian with the majority having a two year college degree or more. 53.9% of respondents were married with 99% of children living in their household full-time. The majority of children, 55.8% boys and 44.2% girls, were Caucasian and mostly enrolled in public school or not currently enrolled in school. The mean age for parents was 31.8 years and for children was 4.47 years.

In Table 2, parenting practices of caregivers are reported. Most mothers worked 10 hours or less outside the home and spent more than 30 hours a week with their child. The majority of mothers also report that they spend more than 75% of the time spent at home interacting with their child. When asked about their opinion of their child's overall behavior, the majority of mothers report that their children's behavior was "very good" and "good" with the majority believing that their child will cooperate in a dental setting. Over 90% of mothers reported that their child did not have problems that would affect their ability to get dental care. Approximately 21% of children were referred to our clinic for behavior problems.

Results of the parenting survey are reported on Table 3. We used the National Longitudinal Survey of Children and Youths, a previously validated survey measurement, to determine parenting style of the mother as either positive interaction, hostile/ineffective or consistent. For the positive interaction domain, the mean score was 16.4, with a range of 9 to

20. For the hostile interaction domain, the mean score was 8.5 with a range of 3 to 17. For the consistent parenting domain, the mean score was 9.07 with a range of 3 to 19. The survey revealed that 49% of parents feel that they “never” have trouble managing their child and 52% of parents report that they discipline their child repeatedly for the same thing.

Table 4 reports changes in parenting and 94.2% of mothers believe that parenting trends have changed since they were children with the majority either not or “probably not” raising their children the way that they were raised. Mothers also report that their child’s behavior is probably or absolutely similar to their behavior as a child. Over 70% of mothers report the belief that parenting is more difficult now than when they were children. Reasons for increase in difficulty of parenting include stress, single parent home, working full-time and divorce. Approximately 23% of mothers believe that parenting is not more difficult than when they were children. The child’s behavior score, rated using the modified Frankl Behavior Rating Scale, is reported in table 4 and 67.3% demonstrated cooperative or definitely cooperative behavior at their dental visit. 32.7% of children demonstrated uncooperative or definitely uncooperative behavior.

The multivariate analysis examining factors associated with children’s behavior in a pediatric dental setting are presented in Table 5. The type of insurance and child’s age were statistically significantly associated with behavior after adjustment for parenting style ($P<0.05$). None of the parenting style domains were statistically significant ($P<0.21$). Children with other insurance were approximately three times more likely (OR 2.95) to be cooperative than those who were Medicaid recipients. Age of the child had a positive effect on cooperation. Older children were significantly more likely (OR=1.48) to be cooperative. No association was found between parenting style and child behavior in the pediatric dental setting.

DISCUSSION

Although studies have been done to examine the pediatric dentist's perception of changes in parenting styles and how it relates to pediatric dental behavior, this is one of the first studies to examine parental perceptions of changes in parenting styles while characterizing parenting styles of caregivers and exploring the relationship between parenting styles and children's behavior in a pediatric dental setting. Caregivers today report changes in parenting and increased difficulty in parenting children and this may impact a child's behavior in the dental setting. An overwhelming majority, 94%, of mothers report perceived changes in parenting and although the majority of respondents' behavior is similar to that of their child, caregivers report that they are not raising their child the same way they were raised. Almost 50% of respondents reported that they "never" have trouble managing their child; however, 52% of parents report that they discipline their child repeatedly for the same thing. The data suggest that parents prefer to be perceived as having a grasp on their child's behavior while maintaining the expectation that children oftentimes misbehave. Over 70% of mothers report the belief that parenting is more difficult now than when they were children. Reasons for increase in difficulty of parenting include stress, single parent home, working full-time and divorce. However, in this present study there was no association found between parenting style and child behavior. Reasons for this may include the small sample size, the wide variation in the age of patients included in this study, examiner reliability, and the use a behavior scale that was not sensitive enough to objectively assess the child's behavior. Over 100 (104) children ranging from one year to 12 years of age were

included in this study. We found that older children were significantly more likely to be cooperative; however, it may be expected that a two year old child would demonstrate uncooperative behavior and this behavior may be considered to be age appropriate cooperative behavior. In addition, children experienced a “happy visit” and children may not have been challenged to demonstrate a higher level of cooperation similar to that which may be required during an operative visit. The modified Frankl Behavior RS was adopted from the The Frankl Behavior RS which was developed in 1962 to provide an assessment of dental anxiety of a child in a dental setting. This scale employs the use of subjective criteria to assess behavior. Other behavior rating scales exist which use more objective criteria to assess behavior; however, the behavior scales may include many items that may be difficult to assess during a relatively brief dental appointment. Regarding examiner reliability, eight examiners were used and although calibration was completed, this may have contributed to the non-association between parenting styles and child behavior.

Limitations and Strengths

Limitations of this study include the cross sectional design, the small sample size, and that the clinic sample may be bias and results may not be representative of the entire population of parents. This was a self-reported survey and parents may have completed surveys with the intent of portraying themselves as ideal parents versus answering questions without bias.

Strengths of this study include the relevance of this research topic and blinded parenting scores. The relationship between parenting styles and child behavior is a very important topic which may affect child behavior in a pediatric dental setting. This investigation attempted to examine the relationships between parenting styles, child behavior, parental perceptions and outcomes needed to provide a better understanding of current

parenting trends and its influence on child behavior in a dental setting. In addition, the examiners who assessed child behavior were blinded to parenting scores. Several items on the questionnaire addressed the caregiver's prediction of their child's behavior; therefore, the mothers included in the study were asked to complete the surveys prior to their child's dental exam.

Future Research

Nevertheless, future research is needed on this important topic to further investigate the relationship between parenting styles and child behavior in a pediatric dental setting. Considerations for future research in this area include using a larger sample size, fewer examiners and a more sensitive behavior rating scale to assess behavior. Consideration of the child's previous dental and medical experiences should be taken when assessing child behavior. Children who have experienced a previous dental visit, pleasant or unpleasant, may respond differently than a child who has had no previous dental experience. This study may lead to the development of more effective behavior management strategies according to caregiver-child interactions ultimately delivering the optimal pediatric dental care.

Figure 1. Modified Frankl Behavior Rating Scale

Category of Behavior	
Rating 1:	DEFINITELY UNCOOPERATIVE Refusal of treatment, crying forcefully, fearful, or any other evidence of extreme uncooperative behavior. Treatment is not completed.
Rating 2:	UNCOOPERATIVE Reluctant to accept treatment and generally uncooperative, but some treatment is accomplished with difficulty.
Rating 3:	COOPERATIVE Acceptance of treatment, at times cautious; willingness to comply with the dentist, at times with reservation, but patient follows the dentist's directions cooperatively.
Rating 4:	DEFINITELY COOPERATIVE Fully accepts treatment. Completely cooperative and patient follows directions readily.

Table 1: Demographics of Parents (N=104)*

Demographics		N	%
Race	Caucasian	55	52.9
	African American	35	33.7
	Asian	7	6.7
	Native American	3	2.9
	Hispanic	11	10.6
Parent Education	Some high school or less	12	11.5
	High school or GED	24	23.1
	Some college or 2 yr college degree	42	40.4
	4 yr degree or more	26	25.0
Marital Status	Single	29	27.9
	Living together-married	56	53.9
	Living together-unmarried	8	7.7
	Separated/Divorced	11	10.6
Child Gender	Boy	58	55.8
	Girl	46	44.2
Birth order of child	Only child	18	18.9
	1st born	25	26.3
	2nd born	30	31.6
	3rd born or more	22	23.2
Children Living in household	Full-time	103	99.0
	Part-time/other	1	0.96
Type of medical insurance	Medicaid	44	42.7
	NC Health Choice	10	9.7
	Private Insurance	33	32.0
	No insurance	13	12.6
	Other	3	2.9
Child's race	Caucasian	61	58.7
	African American	37	35.6
	Asian	8	7.7
	Native Hawaiian/Pacific Islander	1	96.0
	Native American	3	2.9
	Hispanic	11	10.6
	Other	1	0.96

Table 1: Demographics of Parents (N=104)*-continued

Child's school setting	Public school	36	35.0
	Private school	3	2.9
	Home school	9	8.7
	Not currently enrolled	35	34.0
	Daycare	20	19.4
# of children cared for in household	One	20	19.4
	Two	42	40.8
	Three	29	28.2
	Four or more	12	11.7
Age		<u>Mean(SD)</u>	<u>Range</u>
	Parent's age	31.8	18-49
	Child's age	4.47	1-12

* If total does not add up to 104, responses were missing

Table 2. Parenting Practices (N=104)*

		N	%
Hours worked outside home	Less than 10 hrs	55	52.9
	11-20 hrs/wk	10	9.6
	21-30 hrs/wk	10	9.6
	31-40 hrs/wk	21	20.2
	More than 40 hrs/wk	8	7.7
Time spent with child at home	Less than 5 hrs/wk	1	0.96
	6-15 hrs/wk	5	4.8
	16-30 hrs/wk	23	22.1
	More than 30 hrs/wk	75	72.1
% of time spent interacting w/child	Less than 10%	1	1
	11-25%	3	3.0
	26-50%	15	14.9
	51-75%	38	37.6
	More than 75%	44	43.6
Parents' overall rating of child's behavior	Excellent	17	16.4
	Very good	46	44.2
	Good	36	34.6
	Fair	4	3.9
	Poor	1	0.96
Parents opinion of child's willingness to cooperate	No	22	21.2
	Yes	47	45.2
	Unsure	35	33.7
Problems that would affect child getting dental care	No	94	90.4
	Yes	5	4.8
	Not sure	5	4.8
Was child referred for behavior?	No	82	78.9
	Yes	22	21.2

* If total does not add up to 104, responses were missing

Table 3: Parenting Style Survey (N=104)*

	N	Mean	SD	Min	25 th %	50 th %	75 th %	Max
Positive Interaction Parenting	104	16.38	2.13	9.0	15.0	16.0	18.0	20.0
Hostile/Ineffective Parenting	103	8.50	3.12	3.0	6.0	9.0	10.0	17.0
Consistent Parenting	104	9.07	2.35	3.0	8.0	9.0	10.0	19.0

*If total does not add up to 104, responses were missing

Table 4. Changes in Parenting (N=104)*

		N	%
Do believe parenting trends have changed since you were a child?	No	2	1.9
	Not sure	4	3.9
	Probably	35	33.7
	Absolutely	63	60.6
Do you believe you are raising your kids the way you were raised?	No	31	29.8
	Probably not	28	26.9
	Not sure	5	4.8
	Probably	28	26.9
	Absolutely	12	11.5
Do you believe your child's behavior similar to your behavior as a child?	No	15	14.4
	Probably not	9	8.7
	Not sure	21	20.2
	Probably	42	40.4
	Absolutely	17	16.4
Do you believe parenting is more difficult now?	No	13	12.5
	Probably not	3	2.9
	Not sure	15	14.4
	Probably	29	27.9
	Absolutely	44	42.3
Reasons for parenting being more difficult	Stress	44	42.3
	Divorce	15	14.4
	Working full-time	19	18.3
	Single parent home	28	26.9
	Parenting is not more difficult	24	23.1
	Other reasons	37	35.6
Frankl Behavior Score	1-Definitely uncooperative	9	8.7
	2-Uncooperative	25	24.0
	3-Cooperative	24	23.1
	4-Definitely cooperative	46	44.2

* If total does not add up to 104, responses were missing

Table 5. Bivariate Analysis (N=104*)

	Behavior N(%)		P-value
	Uncooperative (1 & 2)	Cooperative (3 & 4)	
Race			
White	18(52.9)	37(52.9)	p<.001
Minority	16(47.1)	33(47.1)	P<.001
Education			
High school/GED or less	13(38.2)	21(61.8)	0.29
Some college or more	23(32.9)	47(67.1)	0.29

* If total does not add up to 104, responses were missing

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