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Original Article

# Impact of Parenting Style and Maternal Self-Efficacy on Children's Dental Cooperation

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**Abstract**

**Background:** Children's behavior management problems are the most frequent issues that occur in pediatric dentistry, and parenting style is one of the factors that affect children's responses to dental treatment. Accordingly, the purpose of this study was to investigate the effect of parenting style on the child's cooperation in dentistry and to explore the role of the mother's self-efficacy in this regard.

**Methods:** The current cross-sectional research was conducted on a random sample of 88 children aged 4–6 years who visited a pediatric dental specialist's office in 2020. Parenting style, the mother's self-efficacy, and the child's cooperation were assessed using the Baumrind Questionnaire, Dumka's Self-efficacy Scale (Jackson et al., 1996), and the Frankel Index, respectively. The chi-square test was utilized to analyze the data ($P<0.05$).

**Results:** Overall, 75 (85.2%), 7 (8%), and 6 (6.8%) mothers had authoritative, authoritarian, and permissive parenting styles, respectively. In addition, 64 (72.7%), 20 (22.7%), and 4 (4.6%) mothers had high, medium, and low levels of self-efficacy, respectively. The results indicated that for the authoritarian parenting style, 77.4% of children exhibited good cooperation, whereas, for the other two parenting styles, none of the children showed good cooperation ($P=0.006$). For mothers with high, medium, and low self-efficacy, the percentage of children demonstrating good cooperation was 73.4%, 55%, and 0%, respectively ($P=0.006$). Among mothers with the authoritative parenting style, those with high self-efficacy reported the highest level of children's cooperation ($P=0.007$).

**Conclusion:** It can be concluded that children's cooperation is influenced by their mothers' parenting style and self-efficacy.

**Keywords:** Self-efficacy, Parenting style, Pediatric dentistry

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## Background

In dental clinics, a common concern, particularly for children, is their fear and anxiety toward dental services (1). Fear, as a reaction to a real or imaginary stimulus, is one of the primary aspects of normal evolution. Various factors contribute to the etiology of fear (2). Among the significant factors contributing to children's fear of dentistry are the child's age and psychological development, gender, parental anxiety, family socioeconomic status, strategies for preparing the child before dental visits, peer influence, parental influence, and the like (3).

When considering the influential factors contributing to a child's fear, it is crucial to acknowledge the impact of effective parenting styles on children's fear levels and cooperation (4).

Parenting styles, as conceptualized by Baumrind, can be categorized into permissive, authoritarian, and authoritative groups. A permissive parenting style is characterized by warm relationships between parents and children, with little to no supervision of their behaviors. The authoritarian parenting style, on the other hand, involves parents who expect strict obedience and submission from their children and tend to exert dominance through punishment. Eventually, the authoritative parenting style is characterized by parents who exhibit flexible, clear, and consistent behavior. They actively listen to their children while respecting their independence and autonomy, thereby maintaining a general sense of supervision in various situations (5).

Child development can be observed through their interactions with parents, and any dysfunction in these interactions can result in the child feeling insecure and

anxious. The child's personality changes, and their level and nature of interaction with the broader community can be assessed by examining different parenting styles, which is one aspect of this interaction when receiving dental services in dental centers (6).

Self-efficacy is a relatively recent concept in the field of personality, introduced by Bandura in 1977. It refers to an individual's belief in their capabilities to successfully complete a given task that can significantly impact their life. Individuals with high self-efficacy are able to navigate challenging life events, embrace new challenges, and have confidence in their abilities. Conversely, individuals with low self-efficacy often experience distress and disappointment when faced with life's obstacles, perceiving their ability to influence circumstances as limited (7).

A few years later, parenting self-efficacy was conceptualized based on Bandura's self-efficacy model. It refers to parents' belief in their ability to effectively handle various aspects of child-rearing. Several significant factors influence parenting self-efficacy, including the mother's perception of her initial relationship with the child, social support, education, and gender. The mother's perception of her initial interactive relationship with the child can be considered the primary source of self-efficacy. When mothers feel competent in their parenting role, they tend to develop warm and consistent relationships with their children, fostering healthy parent-child dynamics (8,9). While the parenting style has been well established in relation to modelling children's reactions toward various life events, specific details about how parenting influences children's reactive behaviors in dental settings are only peripherally explored. However, while a number of studies have reported a link between parenting styles and cooperation in children during general medical treatment, maternal self-efficacy in this context represents a conspicuous gap in the literature. Self-efficacy involves beliefs in one's capability to execute courses of action required to deal effectively with prospective situations. However, how far maternal self-efficacy influences a child in dental procedures has not been clearly shrined upon, hence forming a key lacuna in the existing literature (10).

Despite the extensive research on parenting and children's behavior in dental environments, to the best of our knowledge, there is a lack of studies investigating the relationship between maternal self-efficacy and children's dental cooperation, particularly in Iran. Given the importance of various factors influencing a child's dental cooperation and the influential role of mothers in their child's upbringing, this study aims to evaluate the association of self-efficacy and the type of mother's parenting style on the level of a child's cooperation within a dental environment.

## Materials and Methods

### *Ethical Considerations*

This cross-sectional study was conducted randomly on children aged 4–6 years who were referred to a private practice of pediatric dentistry in 2020. The study received approval from the Ethics Committee of Zahedan University of Medical Sciences (ethical code IR.ZAUMS.REC.1399.253).

### *Inclusion Criteria*

Based on the G-power program, $\alpha = 0.05$, power of 80%, and an effective size equal to 0.33, the sample size was determined to be 90 children. The inclusion criteria included children aged 4–6 years, no previous history of dental treatment, parental willingness to participate in the study, absence of mental or psychological disorders in both children and parents, and no medical conditions limiting cognitive development in the child. The remaining inclusion criteria were no chronic medical problems in the child, living arrangements with both parents or solely with the mother, and the presence of the mother during treatment. On the other hand, the exclusion criteria encompassed noticeable questionnaire incompleteness and failure to complete all three questionnaires.

### *Participation Method*

A total of 90 children who met the inclusion criteria were selected for the study. The dental students introduced themselves to both the mother and the child, providing a clear explanation of the study's purpose. Written consent was obtained from parents if they expressed satisfaction with their child's participation.

In this study, data were collected using three instruments a demographic questionnaire, a parenting style questionnaire, and a questionnaire assessing the mother's self-efficacy.

The questionnaires were administered to the mothers in the waiting room under the supervision of a dental internship student. Any uncertainties were clarified, and efforts were made to minimize errors. The child's behavior during dental visits and fluoride therapy was assessed and recorded by a pediatrician using the Frankel Index. This double-blinded approach was employed to prevent bias in evaluating the child's behavior.

The first questionnaire collected data on various aspects, including the child's demographic background (age and gender), the family's socioeconomic position (parents' education and occupation), and the family structure (type of marriage, relationship with paternal family, and post-marriage paternal family support).

The Baumrind questionnaire was utilized to assess parenting style in the study. This questionnaire consisted of 30 items, measured on a 5-point Likert-type scale (1–5), to evaluate permissive, authoritarian, and authoritative parenting styles. Each question inquired about specific aspects of each parenting style, and participants were assigned scores ranging from 1 (absolutely disagreed) to 5 (absolutely agreed). The total score for each parenting style was calculated, and the style with the highest score was identified as the dominant parenting style (6).

The Dumka's self-efficacy scale (PSAM), developed by Jackson, Storezinger, Dumka, and Roza in 1996, was employed to assess the mother's self-efficacy in the study. This questionnaire evaluates parenting self-efficacy by measuring parents' overall confidence in their parenting role, their ability to resolve parent-child conflicts, and their effort and resilience as parents. The scale comprises 10 items, and respondents rate each item on a 7-point scale. The scoring method involves summing the scores of all items, with the scores of five questions (8, 6, 5, 3, 1) being reverse-scored. The validity and reliability of this questionnaire have been assessed in Iran (11).

During fluoride therapy, the child's cooperation was evaluated by the operator using the Frankel Index, which has been identified as one of the most valid and reliable tools for assessing a child's behavior during dental treatment (12).

Prophylaxis was performed using a low-speed handpiece set at 2500–3000 rpm. Prophylaxis paste was applied to the tooth surfaces using a rubber cap, followed by instructing the children to rinse their mouths.

After isolating and drying the teeth, DuraShield fluoride varnish (Sultan Chemists, Englewood, NJ, USA) was applied to various tooth surfaces using a special brush. The child was then instructed to remain in the same position for one minute to allow the varnish to dry. During this time, the operator recorded the child's level of cooperation. Throughout the procedure, the tell-show-do technique and verbal communication methods were employed for behavioral control. In cases where a child did not cooperate, parents and dental assistants were requested to assist in holding the child without exerting force. Finally, parents were provided with counseling regarding the child's oral health needs, proper hygiene practices, and dietary recommendations.

### *Statistical Analysis*

The obtained results were analyzed using SPSS, version 20 (SPSS Institute, Inc., Chicago, IL, USA). A chi-square test was conducted to compare fear and cooperation (qualitative and ranking variables) across different parenting styles and types of self-efficacy. The cooperation scores were transformed into quantitative values on a scale of 1–4 for comparative purposes. Given the relatively small sample sizes, *P* values were calculated using the Monte Carlo method. The statistical tests were performed at a significance level of 0.05.

## Results

### *Sample Characteristics*

A total of 90 children and parents initially participated in this study. However, two cases were excluded due to incomplete questionnaires, resulting in a final sample size of 88 children and parents. Among them, 35 (39.8%) were girls, and 52 (60.2%) were boys. In terms of age distribution, 17 (19.3%) 4-year-old children, 35 (39.8%) 5-year-old children, and 36 (40.9%) 6-year-old children were included in the study.

### *Analyses*

Based on the statistical analyses and the Frankel classification, 32 (36.4%) children exhibited completely positive and cooperative behavior, and 26 (29.5%) children displayed positive behavior. In addition, 16 (18.2%) and 14 (15.9%) children demonstrated negative and completely negative behavior, respectively.

In general, 75 (85.2%), 7 (8%), and 6 (6.8%) mothers had authoritative, authoritarian, and permissive parenting styles, respectively.

Based on the results, 64 (72.7%), 20 (22.7%), and 4 (4.6%) had high, medium, and low self-efficacy, respectively.

The results demonstrated that the average age of mothers was 33.5 years, while the average age of fathers was 36.6 years. Additionally, the average age of marriage for mothers and fathers was 22.5 and 24.5 years, respectively, with an average marriage duration of 11.3 years. Moreover, the average number of children per couple was two, ranging from a minimum of one to a maximum of five.

The results (Table 1) revealed a significant difference in children's cooperation based on their mothers' parenting styles. Positive cooperation and completely positive cooperation from children were only observed in the authoritative parenting style.

According to the obtained data (Table 2), there was a significant variation in children's cooperation based on their mothers' self-efficacy ($P=0.006$). The highest levels of positive and completely positive cooperation (73.4%) were found in mothers with high self-efficacy, followed by mothers with medium self-efficacy (55%). However, for

**Table 1.** The Comparison of the Child's Dental Cooperation with the Mother's Parenting Styles

| Cooperation | Parenting Style | | | Total |
|---|---|---|---|---|
| | Authoritative (n=75) | Authoritarian (n=7) | Permissive (n=6) | |
| Completely negative | 8 (10.7%) | 3 (42.9%) | 3 (50.0%) | 14 (15.9%) |
| Negative | 9 (12.0%) | 4 (57.1%) | 3 (50.0%) | 16 (18.2%) |
| Positive | 26 (34.7%) | - | - | 26 (29.5%) |
| Completely positive | 32 (42.7%) | - | - | 32 (36.4%) |
| Test results: $\chi^2=29.69$, $P<0.001$ | | | | 88 (100%) |

*Note*. $\chi^2$: Chi-square test statistic. The *P* value was computed using the Monte Carlo method.

mothers with low self-efficacy, no child exhibited good cooperation.

Table 3 presents the distribution of child's cooperation in terms of parenting style and mother's self-efficacy level. Among mothers with the authoritative parenting style, those with high self-efficacy reported the highest level of children's cooperation ($P=0.004$). Due to small sample sizes, the test was not conducted for the two other styles.

## Discussion

The study examined the influence of parenting style on a child's cooperation in dentistry and the role of maternal self-efficacy in this context. The findings revealed that 36.4% of children exhibited completely positive and cooperative behavior. Further, 29.5%, 18.2%, and 15.9% displayed positive, negative, and completely negative behavior, respectively. In terms of parenting style, 85.2%, 8%, and 6.8% of mothers had authoritative, authoritarian, and permissive parenting styles, respectively. The results confirmed a significant difference in children's cooperation based on their mothers' parenting styles, with positive and completely positive cooperation observed only in the authoritative parenting style. Furthermore, our findings demonstrated a significant variation in children's cooperation based on their mothers' self-efficacy. The highest levels of positive and completely positive cooperation (73.4%) were found in mothers with high self-efficacy, followed by mothers with medium self-efficacy (55%). However, no child displayed good cooperation for mothers with low self-efficacy. The distribution of child's cooperation in terms of parenting style and mother's self-efficacy level indicated that among mothers with an authoritative parenting style, those with high self-efficacy reported the highest level of cooperation. However, the test was not performed for the other parenting styles due to small sample sizes.

Our findings align with those of previous studies, highlighting the prevalence of authoritative parenting styles (6,13) and indicating that changes in parenting styles have occurred worldwide.

Based on the results of the present study, 77.4% of children appropriately cooperated with treatment in the context of an authoritative parenting style. These results are consistent with those of studies conducted by Asl Aminabadi and Mostofi Zadeh Farahani (13), Yusuf and Galib (14), Howenstein et al (15), and Viswanath et al (16). An authoritative parenting style is a logical approach that upholds the rights of both parents and children. Parents express reasonable expectations for their children and enforce these expectations by setting boundaries and emphasizing obedience. Simultaneously, they maintain intimacy and affection in their interactions. These characteristics serve as protective factors against behavioral problems in children. Consequently, children raised by parents who employ the authoritative parenting style experience fewer behavioral issues compared to their counterparts (17).

Mehdipour et al found that children with authoritarian parents exhibited lower levels of cooperation during dental procedures, which is in line with our study's findings (6). However, they did not observe a significant correlation between permissive and authoritative parenting styles and dental cooperation, which contrasts with our study's results. These differences could be attributed to other factors that influence a child's fear and cooperation during dental visits, such as previous dental experiences, parental anxiety, child temperament, dental environment, and communication skills.

To the best of our knowledge, no specific study has so far examined the impact of a mother's self-efficacy on a child's dental cooperation in Iran. Additionally, in global studies, most studies have focused on a mother's self-efficacy and its relationship with children's hygiene levels

**Table 2.** The Comparison of the Child's Dental Cooperation with the Mother's Self-efficacy

| Cooperation | Mother's Self-Efficacy | | |
|---|---|---|---|
| | Low (n=4) | Medium (n=20) | High (n=64) |
| Completely negative | 3 (75%) | 4 (20%) | 71 (10.9%) |
| Negative | 1 (25%) | 5 (25%) | 10 (15.6%) |
| Positive | - | 8 (40%) | 18 (28.1%) |
| Completely positive | - | 3 (15%) | 29 (45.3%) |
| Test results: $\chi^2=19.21$, $P=0.006$ | | | |

*Note*. $\chi^2$: Chi-square test statistic. The *P*-value was computed using the Monte Carlo method.

**Table 3.** The Comparison of Children's Dental Cooperation With Mothers Having Different Parenting Styles and Self-efficacy

| Style | Self-Efficacy | Child's Cooperation | | | | *P* value |
|---|---|---|---|---|---|---|
| | | Completely Negative | Negative | Positive | Completely Positive | |
| Authoritative | Low | 2 (66.7%) | 1 (33.3%) | - | - | 0.004 |
| | Medium | 2 (13.3%) | 2 (13.3%) | 8 (53.4%) | 3 (20%) | |
| | High | 4 (7.0%) | 6 (10.5%) | 18 (31.6%) | 29 (50.9%) | |
| Authoritarian | Low | 1 (100%) | - | - | - | - |
| | Medium | 1 (50%) | 1 (50%) | - | - | |
| | High | 1 (25%) | 3 (75%) | - | - | |
| Permissive | Medium | 1 (33.3%) | 2 (66.7%) | - | - | - |
| | High | 2 (66.7%) | 1 (33.3%) | - | - | |

*Note*. The chi-square test statistics for the authoritative style was $\chi^2=18.01$. The test could not be computed for the two other styles due to the small sample sizes.

(18). However, our study highlights the significant role of parenting style and maternal self-efficacy in shaping a child's cooperation during dental visits, specifically in the context of dentistry.

Okati et al (11) reported an inverse relationship between maternal self-efficacy and children's anxiety levels. However, our study identified a positive relationship between maternal self-efficacy and children's cooperation. It is interesting to note that the above-mentioned study also explored the relationship between parenting style and maternal self-efficacy, revealing a connection between higher levels of self-efficacy and an authoritarian parenting style. In contrast, our study did not find a significant relationship between children's cooperation and parental self-efficacy within the authoritarian parenting style. These contradictions could be attributed to variations in the study population and evaluation methods. Moreover, it is important to note that children's cooperation in dental settings is influenced by various factors and may vary in impact across different populations.

Furthermore, Shim and Lim (19) demonstrated a correlation between fathers' self-efficacy and children's behavioral issues, with more positive and nurturing behavior from fathers associated with fewer behavioral problems and greater cooperation. Although our study focused on maternal self-efficacy, it was revealed that higher levels of maternal self-efficacy were associated with a higher percentage of children displaying positive behaviors, highlighting the importance of warm and structured relationships between mothers and their children.

One of the strengths of our study was examining the role of maternal self-efficacy in promoting children's cooperation during dental visits. Our research demonstrated that both parenting styles and maternal self-efficacy play significant roles in influencing children's cooperation. Specifically, the findings confirmed that mothers with high levels of self-efficacy, especially those practicing authoritative parenting, observed higher levels of cooperation from their children.

Accordingly, it is recommended that children's cooperation during dental visits be improved through enhancing maternal self-efficacy and providing education on effective parenting styles. These findings provide insights for dental professionals and oral health caregivers, as increasing maternal self-efficacy and offering education on effective parenting styles can have a positive impact on improving children's cooperation during dental visits.

On the other hand, our study had some limitations. The present study focused solely on parenting style and self-efficacy while not examining other influential factors, such as cultural influences, the child's cognitive development, and additional parent-child dynamics. Furthermore, the study only considered a specific age range and geographical area, hindering the generalizability of the findings to other age groups and geographic regions. Additionally, the study overlooked the role of fathers in the child's overall personality development. It is crucial to conduct research in diverse cultural and geographical contexts, encompassing various age groups and considering all possible parent-child gender pairs to obtain a more comprehensive understanding of these dynamics.

## Conclusion

The findings of this study demonstrated that both parenting styles and maternal efficacy play a significant role in promoting the positive cooperation of children during dental visits. Specifically, it was revealed that mothers with high levels of efficacy, especially those who adopt an authoritative parenting style, observed a higher level of cooperation from their children.

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### Authors' Contribution

**Conceptualization:** Forough Amirabadi.
**Data curation:** Seyed Hosein Mousavi.
**Formal analysis:** Seyed Hosein Mousavi.
**Methodology:** Forough Amirabadi.
**Project administration:** Forough Amirabadi.
**Writing–original draft:** Forough Amirabadi.
**Writing–review & editing:** Mahsa Moradi.

### Competing Interests

The authors declare that there is no conflict of interests regarding the publication of this paper.

### Ethical Approval

The study received approval from the Ethics Committee of Zahedan University of Medical Sciences (ethical code IR.ZAUMS.REC.1399.253).

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