Effects of changing U.S. parenting styles on dental practice: perceptions of diplomates of the American Board of Pediatric Dentistry

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Abstract

Purpose: This study surveyed board-certified pediatric dentists on their opinions about changes in U.S. parenting styles and the effects on the practice of pediatric dentistry.

Methods: A questionnaire was developed, piloted, and mailed to 1,129 members of the College of Diplomates of the American Board of Pediatric Dentistry during the summer of 2000.

Results: A total of 577 respondents (51%) returned questionnaires, equally distributed across AAPD districts, with male:female ratio of 4:1 and 90 % married. A majority perceived parenting styles had changed during their practice lifetime (88% "absolutely or probably changed"), with older practitioners significantly more likely to say so. Ninety-two percent felt changes were "probably or definitely bad" and 85% felt that these changes had resulted in "somewhat or much worse" patient behavior. Practitioners report performing less assertive behavior management techniques than in the past due to these changes.

Conclusions: Diplomates report that parenting changes have occurred and they believe these are negative (bad) and have adversely influenced behavior and caused changes in pediatric dentists' behavior management.*(Pediatr Dent 24:18-22, 2002)*

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Lay and popular media report the changing complexion of American society with respect to parenting. The portrayal of families the baby boomer generation grew up with on television sitcoms like "Father Knows Best" or "Leave It To Beaver" has given way to a different reality. More contemporary programs like "Roseanne" or " Married with Children" more closely describe the family of today and the changing face of the parent-child dynamic.

The professional community has also noted – and studied – parenting and its effects on many aspects of American life, including such diverse topics as child aggression, delinquency and parenting behaviors of teenage mothers. Well known clinical psychologist and author, Mary Pipher, describes the American family beset with relentless attacks by media in a culture war in which children are bombarded with Internet, television, and other messages that promote materialism and glorify celebrity behaviors.[1] David Elkind, another long-time observer of American child rearing, suggests the culprits are the media that promote violence to children, divorce, peer pressure and a dangerous society.[2] Others echo his sentiments, such as Kenneth Condrell, who says divorce, parental fatigue, and a hurried lifestyle prevent parents from setting limits and providing consistent discipline. Children do not have consequences for their behaviors in today's child rearing paradigm.[3]

While it is beyond the scope of this paper to profile the depth of professional investigation into parenting and its effects on child mental, emotional and physical health, it is important to note that significant research and medical opinion have been devoted to areas related to health and behavior. Physical discipline and its effect on future antisocial behavior,[4,5] as well as parenting style and family constellation[6,7] have been investigated at length. Alternative "parenting" styles, including daycare and preschool,[8] have

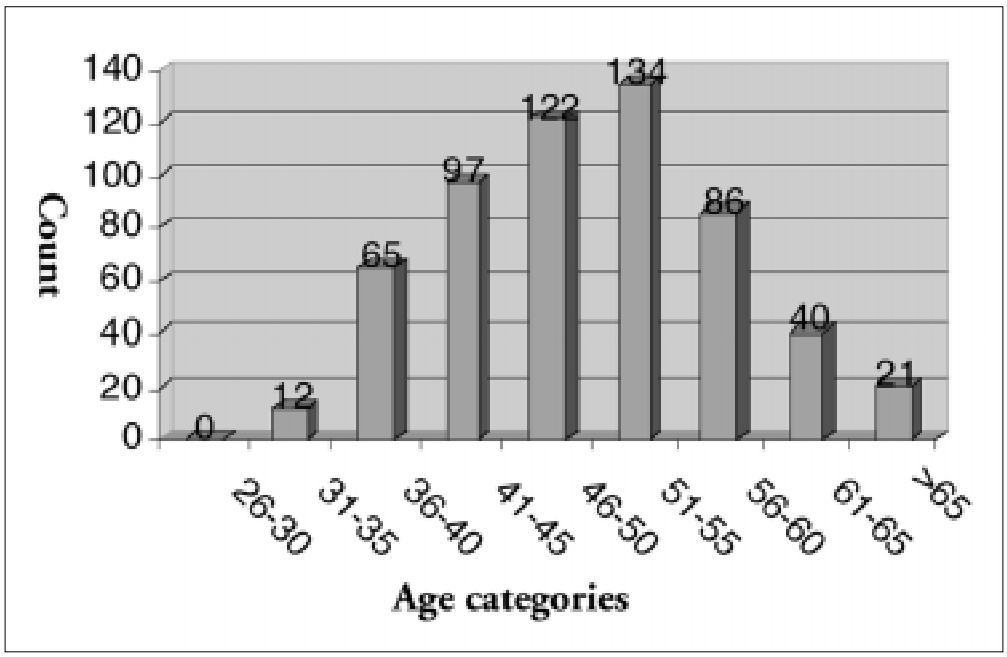

Fig 1. Distribution of respondent age categories (number of respondents)

been subjects of research and commentary. Perhaps most salient to the topic of this report is that the medical community has noted an increase in psychosocial problems in children and their families[9] and that the role of parenting in health care and health behaviors is now well established.[10]

The effect of parenting on behavior of children in the dental setting has been well studied, but primarily in terms of chairside delivery of dental care. Maternal anxiety and parental presence in the operatory have been studied widely.[11,12] Venham, almost 20 years ago, studied child rearing variables and their effects on the child's response to stress in the dental setting[13] and concluded that they influenced the child's acquisition of coping skills and tolerance to stress. More recently, the College of Diplomates conducted a workshop that recognized the need to address changing parenting mores during pediatric dental care.[14] Editorials in pediatric dental journals, addressing parenting changes, have appeared often.[15-17]

While commentary suggests that parenting changes have affected child behavior and thus the practice of pediatric dentistry, data to support that contention remain sparse. This study was initiated to gather opinion 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. The membership of the College of Diplomates of the American Board of Pediatric Dentistry offered a group of mid-level to senior pediatric dentists who could provide both contemporary and historical perspectives on the question of changing parental mores. The purpose of this study was to survey diplomates' opinion about changes in parenting and their perception of effects on the practice of pediatric dentistry.

Methods

The authors developed a 25-item questionnaire that varied in item formatting; however, most items were either a multiple response item, ranking of response items (Likert scale), or open-ended questions. The first five questions were demographic in nature and the remaining items were concerned with various aspects of parenting, changes in parenting style, and impact of the changes on dental practice. The content for questions was derived from popular and professional literature describing changes in parenting and relating these changes to child behaviors. The authors piloted the questionnaire by having colleagues read and comment prior to a final revision.

The questionnaire and cover letter were sent to all 1,129 members of the American Board of Pediatric Dentistry College of Diplomates in the summer of 2000. The letter introduced the purpose of the study and explained the methodology associated with completing the questionnaire. The respondents were asked to complete the questionnaire and return it in an enclosed, return-addressed envelope within a four-week period. A second mailing was not done. Respondents were asked to include their names to facilitate follow-up on anecdotes and comments, with the understanding that any publication resulting from the study would maintain confidentiality.

The returned questionnaires were tabulated and entered into a spreadsheet database (Excel) by one investigator (LG). The database was downloaded into a software statistical program (SPSS⁺ PC)'. The data were checked for entry errors and corrected by scrutinizing raw distributions. Statistical manipulation included descriptive statistics, frequency distribution, cross-tabulation with Chi square analysis, and graphic representation. *A priori* statistical significance was set at $P < 0.05$ and percentages were rounded to whole numbers for reporting purposes.

Results

A total of 1,129 questionnaires were mailed and 577 (51%) usable questionnaires were received. It should be noted that not every respondent answered every item, resulting in some discrepancy in the total number of respondents/item. The reported data for each item will include only valid percentages defined as the response category percentages based on the number of respondents who answered the particular item.

The sample included 469 (81%) males and 108 (19%) females. Ninety percent of the respondents were married. Respondents across Academy districts I-VI were normally distributed. The distribution of respondent age can be seen in Figure 1. The range in the number of years respondents have been engaged in pediatric dental practice was from 3 to 55. There was a significant difference in the frequency distribution of males/females as a function of the years in dental practice with males having been in practice longer (χ^2 = 57.7, P< 0.001).

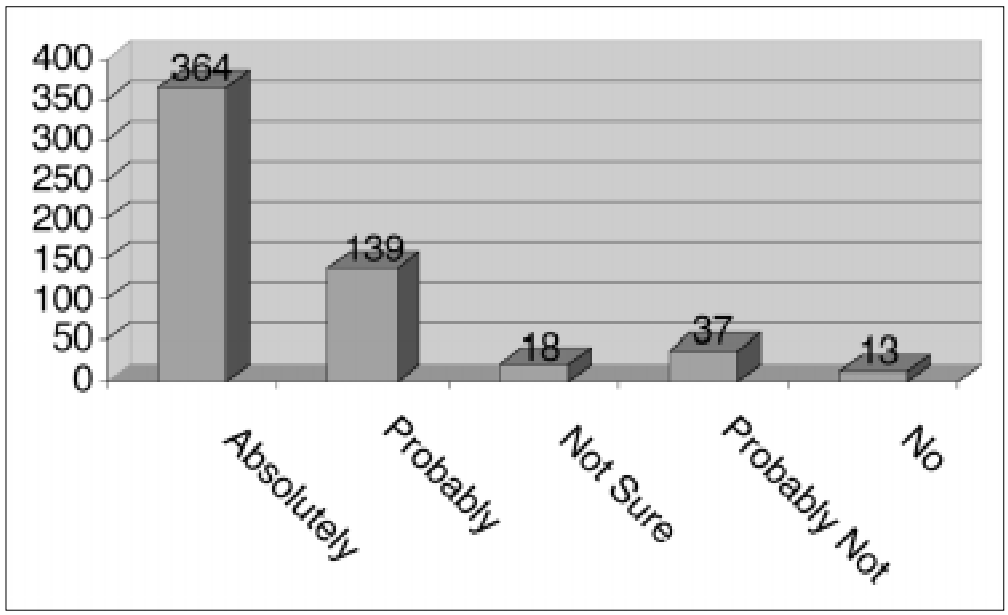

Fig 2. Distribution of respondents' beliefs that parenting styles have changed (number of respondents)

Figure 2 shows the distribution of responses to the item addressing whether parenting styles have changed since the respondents began practicing. The majority indicated that parenting styles have changed, with 88% cumulatively responding "absolutely" or "probably." There was no significant difference in parenting style change as a function of Academy district. However, a significant difference was found for change in parenting styles as a function of years in practice with the older practitioners more likely to indicate a change than younger practitioners (χ^2 = 98.4, P< 0.001).

Table 1. Distribution of predominant characteristics of parents in respondents' practices (percentage of respondents)

Characteristics of parents		
Demographics		
Married (79)	Divorced (15)	Cohabitating (6)
Perceived as stable family (21)	Perceived as variably stable (68)	Perceived as unstable (10)
Perceived as traditional (12)	Perceived as contemporary (75)	Perceived as free thinking (13)
Social position and mobility		
Affluent (16)	Middle class (74)	Poor (10)
Busy (77)	Average (20)	Lots of free time (3)
Overachieving (19)	Achieving (63)	Underachieving (18)
Parenting		
Strict with child (0.5)	Appropriate with child (42)	No discipline with child (58)
Respected by child (9)	Mostly respected by child (78)	Disrespected by child (12)
Interaction with dental care		
Very supportive (16)	Accepting treatment (80)	Distrustful (4)
Inquisitive about care (15)	Interested about care (68)	Uninterested in care (18)

The respondents ranked from highest to lowest the reasons why they believe parents have changed. The rankings (highest to lowest) were that parents are less willing to set limits, less willing to use physical discipline, unsure of their roles as parents, too busy to spend time with children, and too self-absorbed or materialistic. Likewise, the rankings of factors from highest to lowest believed to be associated with causing changes in parenting and child rearing were societal changes toward liberalism with breakdown of norms, divorce, two-parent working families, hectic lifestyles, loss of extended families, increased stress of maintaining lifestyles, and frequent relocation or mobility in society.

Table 1 shows the distribution of 10 general areas describing predominant parent characteristics found in the respondents' practices. Similarly, Table 2 shows the distribution of eight areas of discipline used by parents in respondents' practices.

The majority characterized these parenting changes as either "probably bad" (54%) or "bad" (38%). The respondents characterized their satisfaction in practicing affected by parental changes as decreased (43%), not affected (46%) or increased (11%). Table 3 depicts the distribution in change of behavior management techniques from when the respondents began practicing compared to today. Respondents' age or gender did not significantly affect the changes. The response distribution of practitioners related to whether the parenting changes have affected the behavior of patients were "much better" (1%), "somewhat better" (3%), "no change" (11%), "somewhat worse" (65%) and "much worse" (20%).

Table 2. Distribution discipline techniques of parents in today's practice compared to when the respondents began practicing (percent of respondents)

Discipline approach	Seen more often	Seen about same	Seen less often
Uses physical discipline	2	10	88
Talks to influence child	68	21	11
Bribes child	71	28	1
Uses positive reinforcement	48	32	20
Tries to prevent suffering	61	37	2
Accepts child's disrespect	88	10	2
Protects child's ego	55	39	6
Is overprotective of child	83	16	1

Discussion

This study was designed to obtain the opinions of chairside pediatric dentists about changing parenting practices in the U.S. and how these might have affected the practice of pediatric dentistry. We chose the members of the College of Diplomates as our study population for several reasons. They represent pediatric dentists who tend to have, by virtue of their pursuit of certification, maintained clinic practice. They also tend to be older since the traditional pathway to diplomate status required significant time in service to negotiate certification. Thus, this group provided pediatric dentists who would be most likely to appreciate any changes in parenting and their manifestation in pediatric dental practice.

The primary purpose of the study was to see if the dentists sampled felt parenting had changed and overwhelmingly they felt that it had, with almost 9 out of 10 respondents indicating a change. The response rate of over 50% is considered good and strengthens the finding of parenting changes, as does the fact that this finding was consistent across Academy districts. It is not surprising that the older dentists were more likely to feel strongly on this issue than younger ones. This is most likely because of a broader time frame of experience offered by the older dentists, but may also be explained by generational or gender factors. For example, younger practitioners tend to be more likely to allow parents in the operatory and to see infants.[18] They may also be more flexible in parental behaviors as well.

A third possibility may be that today's graduating practitioner has a very different view of behavior management and expectations about parental and thus child behavior. Many, in fact, may be products of parenting styles closer in character to that of their patients than older pediatric dentists. An area of future study would be to compare older and younger dentists in terms of their approaches to clinical situations that require behavior management. The younger dentist may have skills different from those of their older colleagues by virtue of their own rearing, their own parenting styles, or contemporary teaching.

Respondents also categorized parenting changes negatively, with more than 9 out of 10 considering them "bad" to some degree. The corresponding response about how these changes had affected chairside behavior is in line with this negative view of the changes, with an almost identical ratio (8.5:1 versus 9:1 ratio) of respondents commenting that patients were worse now than they once had been.

Perhaps the most profound finding of this study is the shift of practitioners' use of behavior techniques. It is our assumption, based on the structure of the questionnaire, that this shift relates to parenting (as opposed to simply a maturer group of practitioners choosing to ease out of assertive patient management). The implications for practice, training and other aspects of practice are significant. If pediatric dental practice shifts to a less assertive (eg, less frequent hand-over-mouth technique (HOM)) as these data would suggest is happening, then training programs and guidelines will need to be modified. It seems legitimate to ask also whether the changes noted by this study in behavioral management techniques are simply protective responses to counter a more involved and difficult parenthood or are adaptations by clinicians to more effectively deal with behaviors to accomplish treatment.

The study design created certain limitations. The College of Diplomates represents only about 30% of practicing pediatric dentists, so opinions might not be representative of pediatric dental practitioners in general or a valid view of parenting change and its effect on practice. However, because the sample studied was consistent across AAPD districts and because it comprised dentists with a longer-term perspective, we are confident of the findings.

Another limitation was the structure of the questionnaire which offered choices for most responses. We attempted to make choices mutually exclusive, but often this was not possible, particularly with questions about perceived causality. For example, choices of "two-parent working families" and "hectic lifestyle" within the same question may seem to have been redundant to some respondents. We did attempt to use exclusive "causes," as indicated in the professional literature, whenever possible.

The overwhelming response that change has occurred, while intuitive for those of us in clinical pediatric practice, is important to document. Similarly, the paradigm shift in behavior management techniques reported by responding dentists begs further research because of the implications for clinical practice and our pediatric dental education system.

Table 3. Changes in practitioner's management of patients since beginning practice (percentage of respondents)

Management technique	Increased	No change	Decreased
Parents in operatory	64	28	6
Number of sedations	38	31	31
Use of hand-over-mouth	1	17	82
Use of immobilization (restraint)	7	40	56

Conclusions

1. Board-certified pediatric dentist respondents overwhelmingly reported changes in parenting had occurred during their practice careers and those changes were regarded as negative.
2. Board-certified pediatric dentist respondents reported that they had shifted their behavioral management techniques to less assertive ones as a result of perceived parenting changes.

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References

1. Pipher M. *The Shelter of Each Other: Rebuilding Our Families*. New York: Random House; 1996.
2. Elkind D. *The Hurried Child, Growing Up Too Fast. Too Soon.* 3rd ed. Cambridge, MA: Perseus Publishing; 2001.
3. Condrell K. *Wimpy Parents – From Toddler to Teen – How Not to Raise a Brat*. New York: Warren Books; 1998.
4. Wolraich ML, Aceves J, et al. Guidance for effective discipline. *Pediatrics* 101:723-728, 1998.
5. Straus MA, Sugarman DB, Giles-Sims J. Spanking by parents and subsequent antisocial behavior of children. *Arch Pediatr Adolesc Med* 151:761-767, 1997.
6. Barnett D, Kidwell SL, Leung, KH. Parenting and preschooler attachment among low-income urban African-American families. *Child Dev* 69:1657-1671, 1999.
7. Annie E. Casey Foundation: *Kids Count Data Book*. Baltimore: The Annie E. Casey Foundation; 1999.
8. Zigler, E. School should begin at age 3 years for American children. *Dev Behav Pediatr* 19:38-40, 1998.
9. Kelleher KJ, McInerny TK, Gardner WP, Childs GE, Wasserman RC. Increasing identification of psychosocial problems: 1979-1996. *Pediatrics* 105:1313-1321, 2000.
10. Green M, Palfrey JS. *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents.* 2nd ed. Arlington, VA: National Center for Education in Maternal and Child Health; 2000.
11. Pinkham JR. Chapter 23, Patient Management. In: *Pediatric Dentistry – Infancy through Adolesence.* 3rd ed. Pinkham JR, et al. Philadelphia: WB Saunders; 363.
12. Pfefferle JC, Machen JB, Fields HW, Posnick WR. Child behavior in the dental setting relative to parental presence. *Pediatr Dent* 4:311-316, 1982.
13. Sonis AL, Ureles SD. Workshop on parenting methods to minimize disruptive behavior. *Pediatr Dent* 21:469-470, 1999.
14. Teuscher GW. Prejudice and parental philosophy of care. *ASDC J Dent Child* 59:400, 1992.
15. Casamassimo P. My dad has a 14" tube. *Pediatr Dent* 18:3, 1996.
16. Teuscher GW. Place the problem where it belongs. *ASDC J Dent Child* 63:320, 1996.
17. Casamassimo P. Dan Quayle was right. *Pediatr Dent* 16:6, 1994.
18. Erickson PR, Thomas HF. A survey of the American Academy of Pediatric Dentistry membership: infant oral health care. *Pediatr Dent* 19:1, 17-21, 1997.