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Article

Adding the Psychological Perspective to Traditional Prevention in Pediatric Dentistry by PaFein + Project: Trained Parents Can Help

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Highlights

What are the main findings?

- Almost half (44.4%) of the parents of pediatric dental patients reported negative childhood dental experiences (mothers ss more, $p<0.001$) and 18.3% had shared these experiences with their children.
- More than 85% of parents stated that they prepared their kids for dental visits beforehand and almost all parents (97.9%) found the provided psychological advice on managing the child's dental visit useful.

What are the implications of the main findings?

- Parents need and appreciate initiatives that enable them manage their children's dental encounters in a positive supportive way, thus avoiding early onset of dental fear/anxiety and long-term consequences.
- Targeted booklets and videos with psychologic advice are useful and can be easily shared online or in dental clinics.

Abstract

Background. Emotional implications of childhood dental encounters are very important on the long run. The **aim** of the study was to assess parents' childhood dental memories and potential impact upon current attitudes towards dental treatment, and the perceived usefulness of an educational material on efficient psychological management of child's dental visit. **Method:** An educational booklet was produced. Parents were encouraged to read it and subsequently fill a brief questionnaire. Answers were analyzed using IBM SPSS Statistics 25. **Results:** During the first month, 142 parents (88% moms) filled the questionnaire; 44.4% reported negative childhood dental experiences (mothers ss more, $p<0.001$); 18.3% had shared these experiences with their children. Dental encounters-related emotional discomfort of various degrees was reported by 61.3% (38.7% a little, 5.6% some, 13.4% pretty much, 3.5% a lot). The self-reported level of dental anxiety was ss correlated to childhood negative experiences ($p<0.001$). Parents' level of education influenced criteria for choosing a dentist for their children: parents with higher education were ss more likely to choose a certified pedodontist

rather than a closer-to-home dentist ($p = 0.002$). Most respondents (97.9%) felt the provided educational material will, to variable extent, help them manage their children's dental visits better in the future (28.2% very much; 44.4% a lot) and 91.6% would share it with other parents/families. **Conclusions.** Childhood dental fear does not necessarily fade away with time. Parents need and appreciate initiatives that enable them manage their children's dental encounters in a positive supportive way, thus avoiding early onset of dental fear/anxiety.

Keywords: dental fear and anxiety; children; parental education

1. Introduction

Dental fear and anxiety (DFA) are very frequent findings in children and adolescents worldwide, with higher prevalence in preschool children and schoolchildren [1]. DFA however often remains underestimated in terms of occurrence, causes and – more important - long-term consequences. When DFA occurs in early years, it does not necessarily fade away with time, and negative perceptions regarding dental care risk to negatively impact oral health throughout life, as individuals with DFA shall tend to postpone or even avoid dental visits [2,3]. In consequence, children with DFA have higher caries experience, more untreated caries lesions and poorer oral health-related quality of life than children without dental anxiety [4-6].

There are two main categories of people that can, through their ways of managing the child's dental visit from their own respective perspectives, influence children's perception and attitude regarding oral care: Family and the Dental Team. Educating families and dental professionals in this respect thus appears crucial for growing new generations with healthy teeth and positive attitudes towards oral health.

Dental professionals may get, through under- and/or post-graduate programs, some training in behavior guidance (BG) techniques. BG teaching varies widely across various countries and is also subject to cultural influences and particularities. In the attempt to encourage evidence-based practice in all fields of medicine and dentistry, during the last decades, the subject has gained increased attention from researchers and international pediatric dentistry (PD) forums. The International Association of Paediatric Dentistry (IAPD), American Academy of Pediatric Dentistry (AAPD) and European Academy of Paediatric Dentistry (EAPD) provide, on their respective websites, scientifically based information for dental practitioners on this topic [7-9], and this tendency is being undertaken by national professional organizations as well.

While BG tools are being made available for dental practitioners, families do not necessarily have this kind of information at hand. With parents being, naturally, their children's very first models in life since very young ages, their approaches towards all aspects of being shall consistently impact their children's attitudes.

Parenting styles have evolved a lot with time, constantly adjusting to changes in society. Public accessibility to information – be that scientifically sustained or not – has hugely increased and it is our professional responsibility, as dental professionals, to help families pick up and use the correct information in an appropriate manner, to the highest long-term benefit of children's health. This traditionally applies to the prevention of oral disease, but, for all the previously mentioned reasons, when it comes to prevention in dentistry, DFA should also be taken into account.

Parental engagement in friendly, stress-free relationship between child and dental team is very important on the long term. However, mere encouragement of parental engagement may not be enough. Shaping parents' involvement by teaching them how to efficiently manage the child's dental visit can be useful in many cases, and initiatives in this respect need to be developed.

Pre-appointment parental counselling is already demonstrated to be very effective. When parents are informed about the procedures their child will undergo and about the ways they should talk to their children about these procedures, using explanations, demonstration videos, drawings

etc., pediatric dental patients have lower levels of dental anxiety and fear, giving rise to more cooperative behavior during dental treatment [10,11].

Erasmus+ PaFein+ project aims to help grow generations of children with healthy teeth and positive attitudes towards oral care by fostering positive dental encounters, minimizing the early onset of DFA and reducing the need for dental sedation and general anesthesia, with a positive impact upon the environment as a natural consequence. Given the already mentioned considerations, providing parents and families with the appropriate information as to enable them to prepare and handle the dental visit of their children in a positively supportive way and reduce stress associated with pediatric dental visits for all involved – child, family, dental team – was identified as an important step towards more efficient prevention in dentistry on the long run. A dedicated Parents’ section of PaFein+ project was thus created. The present study is part of the research carried out within this section.

The aim of this study was to assess parents’ childhood dental experience and potential implications upon their current perception towards dental treatment and attitudes towards children’s dental treatment, as well as to test the usefulness of information provided by a targeted educational initiative within the project.

2. Materials and Methods

The Parents’ section of PaFein+ started as a pilot in 2025 in Romania. In the initial stage of the initiative, a booklet (figure 1) with advice on how to efficiently prepare and handle the child’s dental encounter was conceived by an interdisciplinary team of pediatric dentists and trained psychologists. The material provides information on how to handle and support the child before, during and after the dental visit in a manner that would naturally include such events in current, everyday living, thus minimizing potential stress for all involved – child, family, dental team.



Figure 1. Brochure with advice for parents.

Easy-to-understand language was used and examples with appropriate/unrecommended words to use were given in order to make communication more effective (figure 2).



Figure 2. – Sample advice from the brochure.

The material was shared through social media (digital version) and directly (brochures), in the Pedodontics Clinic of Carol Davila University, Bucharest (Romania). Parents were subsequently encouraged to complete a feedback questionnaire. The questionnaire had 4 sections. Section 1 contained demographic data; section 2 comprised 3 questions on personal childhood experience and present dental attitude; section 3 had 7 questions on attitudes towards children’s dental treatment; section 4 had 2 questions on the usefulness of the educational material provided. Average time for questionnaire completion was estimated to 4-5 minutes.

Parents’ answers were collected. Data was analyzed using IBM SPSS Statistics 25 and illustrated using Microsoft Office Excel/Word 2024. Quantitative variables were tested for normal distribution using the Shapiro-Wilk Test and were written as averages with standard deviations or medians with interquartile ranges. Quantitative variables with non-parametric distribution were tested between groups using the Mann-Whitney U Test/Kruskal-Wallis H Test. Qualitative variables were written as counts or percentages and were tested between groups using Fisher’s Exact Test. Z-tests with Bonferroni correction were used to further detail the results obtained in the contingency tables. The threshold considered for the significance level for all tests was considered to be $\alpha = 0.05$.

Depending on the results of this pilot study, the PaFein+ educational initiative targeting parents is to be extended in terms of both contents and geography, not only to the other countries participating in the project, but also to any interested regions.

3. Results

During the first month after the start of the pilot initiative, the material reached an estimate of roughly 7700 Romanian families, out of which 142 parents filled the feedback form. The characteristics of the analyzed participants are shown in Table 1.

Table 1. Characteristics of the analyzed participants

Parameter	Value
Parent – Gender (Female) (Nr., %)	125 (88%)
Parent – Age (Nr., %)	
18-25 years	3 (2.1%)
26-35 years	20 (14.1%)
36-45 years	74 (52.1%)
46-55 years	42 (29.6%)
> 55 years	3 (2.1%)
Number of children (Nr., %)	
One	62 (43.7%)

Two	74 (52.1%)
Three	6 (4.2%)
Child – Age (Mean ± SD, Median (IQR))	8.4 ± 5.17, 8 (5-11)
Parent education (Nr., %)	
Lower secondary	2 (1.4%)
Secondary	12 (8.5%)
Post-secondary	10 (7%)
Tertiary	118 (83.1%)
Negative childhood experiences (Nr., %)	
Absent	68 (47.9%)
Present	63 (44.4%)
Don't remember	11 (7.7%)
Narration to children (Nr., %)	
Absent	41 (65.1%)
Present	18 (28.6%)
Don't remember	4 (6.3%)
Dentist anxiety (Nr., %)	
Not at all	55 (38.7%)
Low	55 (38.7%)
Neutral	8 (5.6%)
High	19 (13.4%)
Very high	5 (3.5%)
Dentist visit with children (Nr., %)	134 (94.4%)
Child – Age - Visit (Mean ± SD, Median (IQR))	4.45 ± 2.3, 4 (3-6)
Dentist visit – Reason (Nr., %)	
Pain	8 (6.1%)
Check-up	72 (54.5%)
Cavity	32 (24.2%)
Other	20 (15.2%)
Child – Negative experiences (Nr., %)	12 (8.5%)
Informing children before visit (Nr., %)	121 (85.2%)
Preferred dentist (Nr., %)	
Pediatric dentist	104 (73.2%)
Same dentist as parents'	24 (16.9%)
Let children decide	8 (5.6%)
One closer to home	6 (4.2%)
Child pain tolerance during treatment – normal (Nr., %)	95 (66.9%)
General anesthesia – ideal for pain control (Nr., %)	
Highly disagree	56 (39.4%)
Disagree	29 (20.4%)
Neutral	34 (23.9%)
Agree	20 (14.1%)
Highly agree	3 (2.1%)

3.1. Demographic Data

Most of the participating parents (88%) were mothers. The age range of the respondents was 18 to over 55 years, with 52.1% of them in the 36-45 years age group. The age of their children at the time of their first dental visit ranged between 5 and 11 years, with a mean age of 8.4 years [SD 5.17]. Main reported reason for dental visit was check-up (54.5%), followed by noticed cavity (24.2%).

3.2. Own Childhood Dental Experience

Negative childhood dental experiences were remembered and reported by 44.4% of the parents. Z-tests with Bonferroni correction pointed out that mothers were ss more likely to remember negative childhood experiences ($p<0.001$), and 18.3% had already shared these experiences with their children. A proportion of 38.7% of the respondents stated they felt no unease related to dental encounters, while the other 61.3% admitted they feel emotional discomfort of various degrees (38.7% a little, 5.6% some, 13.4% pretty much, 3.5% a lot). The self-reported level of anxiety was ss correlated to negative childhood dental experiences (Fisher’s exact test, $p < 0.001$) (Figure 3).

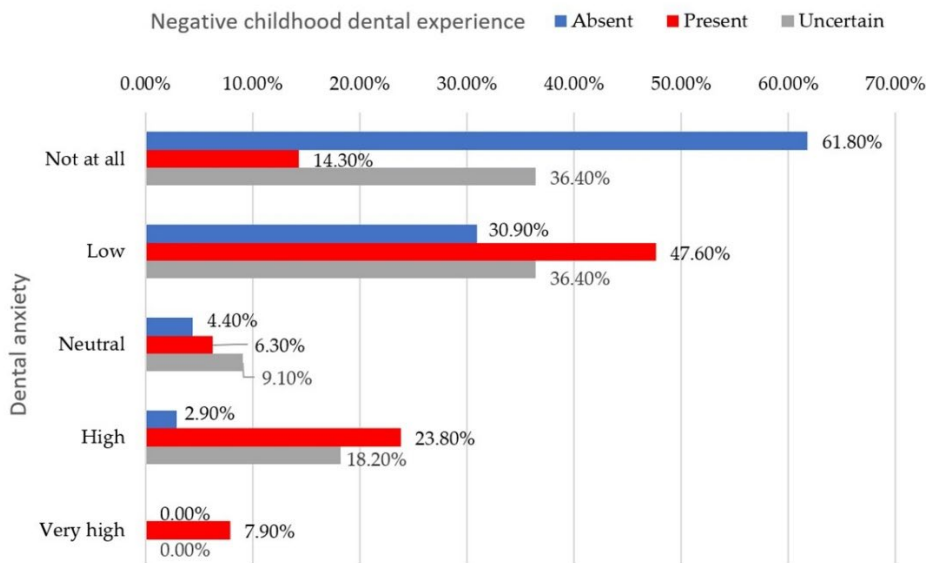


Figure 3. Distribution of the participants according to the existence of negative childhood experiences in parents and dentist anxiety.

3.3. Attitudes Towards Children’s Dental Treatment

Most of the parents (73.2%) preferred their children to be treated by a trained pediatric dentist. Differences of opinion in choosing a dentist for their child were significantly influenced by parents’ level of education: parents with no academic studies were ss more likely to make their choice taking into account the geographic criteria rather than the dental professional’s specialization, preferring a dentist situated closer to their home (20.8% vs. 0.8%, $p=0.002$) (Figure 4).

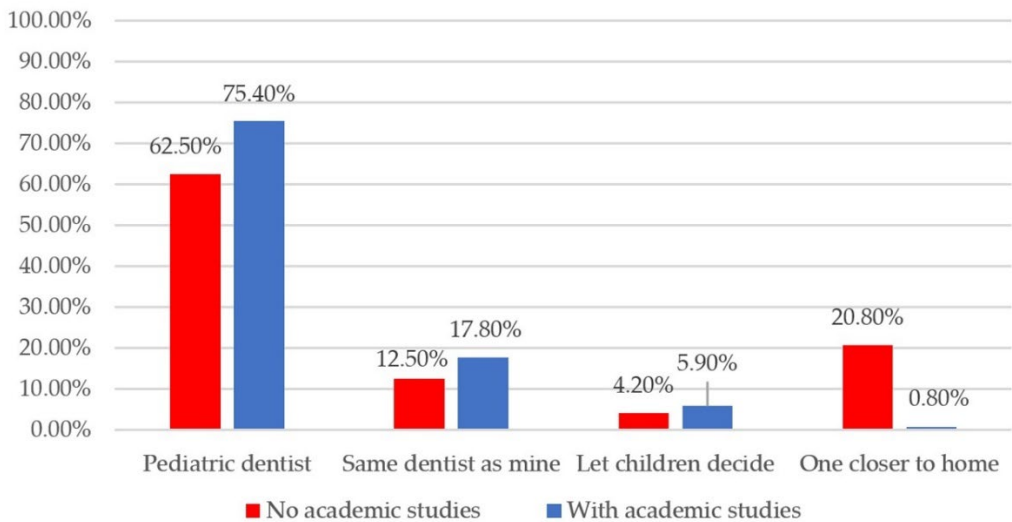


Figure 4. Distribution of the participants according to parents’ level of education and opinions in choosing child’s dentist.

A great majority of the responding parents (85.2%) stated they prepared their kids for dental visits. Most respondents (66.9%) considered that it is normal for a child to feel some pain during dental treatment, fathers being significantly more inclined to agree to that than mothers ($p = 0.001$), while 14.1% felt that general anesthesia should be the golden standard for stress and pain-free pediatric dental treatments. This latter finding is however not correlated with parents’ dental anxiety (Table II). Similarly, parents’ tendency to tell their kids stories about their own negative childhood dental experiences is not correlated with their self-reported degree of dental anxiety (Table II).

Table 2. Comparison of participants’ characteristics according to reported dentist anxiety.

Anxiety/Children narration (No., %)	Very low	Low	Neutral	High	Very high	p*
Absent	8 (88.9)	19 (63.3)	4 (100)	7 (46.7)	3 (60)	0.307
Present	1 (11.1)	10 (33.3)	0 (0)	5 (33.3)	2 (40)	
Don’t remember	0 (0)	1 (3.3)	0 (0)	3 (20)	0 (0)	
Anxiety/General anesthesia – Ideal (No., %)	Very low	Low	Neutral	High	Very high	p*
Highly disagree	23 (41.8)	25 (45.5)	4 (50)	4 (21.1)	0 (0)	0.124
Disagree	9 (16.4)	10 (18.2)	1 (12.5)	8 (42.1)	1 (20)	
Neutral	11 (20)	14 (25.5)	3 (37.5)	5 (26.3)	1 (20)	
Agree	9 (16.4)	6 (10.9)	0 (0)	2 (10.5)	3 (60)	
Highly agree	3 (5.5)	0 (0)	0 (0)	0 (0)	0 (0)	

* Fisher’s Exact Test.

3.4. Perceived Usefulness of Provided Info

The great majority of the respondents (97.9%) felt the provided educational material will, to variable extents, help them better manage their children’s dental visits in the future (44.4% a lot; 28.2% very much); 91.6% stated they would share it with other parents/families (54.2% very high level of agreement, 37.3% high level of agreement) (table III).

Table 3. Perceived usefulness of information booklet.

		No.	%
Utility of information booklet	Not at all	3	2.1%
	Low	13	9.2%
	Neutral	23	16.2%
	High	63	44.4%
	Very high	40	28.2%
Recommendation to other parents	Highly disagree	0	0%
	Disagree	7	4.9%
	Neutral	5	3.5%
	Agree	53	37.3%
	Highly agree	77	54.2%

4. Discussion

The calculated mean age of the respondents’ children at the time of their first dental visit is rather high from the prevention point of view. This finding is in line with previous reports [12]. Similar ages at first visit were previously reported [13] despite the recommendations of international professional organisations for children to have their first dental visit by the age of 12 months, in order to establish a “Dental Home” (DH) at the earliest possible time [14, 15]. The advantages of the DH system are well known and proven in time, both for healthy children and for children with special healthcare needs [15,16]. The absence of dental fear can be cited among the most important positive characteristics of this care model.

A tendency to agree for some degree of pain in association with their children’s dental treatment was obvious in two thirds of the subjects (66.9%). This rather surprising perception could be due to a cultural background that “traditionally” links dental treatment to suffering, as well as to parents’ own childhood experiences, given that many parents were children in a time when Romania was still under a communist regime, with much lesser access to advanced means of pain avoidance during dental treatment. The fact that fathers were significantly more prone to this perception than mothers may be regarded as an expression of fathers’ greater tendency to show some harshness in handling and educating children. In contrast with our findings, a recent systematic review on parents’ perception regarding dental interventions performed on their children pointed practitioner’s abilities in alleviating pain and fear as important elements for treatment acceptance [17].

Studies show that children psychologically prepared for their dental encounters beforehand are less anxious [10,18,19]. Psychological preparation can address children either directly, in the waiting room [18,19], or indirectly, using parents as vectors [10,20]. A controlled trial conducted by Fox & Newton (2006) demonstrated that positive images of dentistry showed to the children prior to their appointment promotes a positive relationship with the dentist by short-term reductions in anticipatory anxiety in children. In their study, anticipatory anxiety was not correlated to age and gender [18].

Another option is to train parents (by booklets, videos, smartphone application etc.) on how to efficiently prepare the child before the dental visit [10,20]. A study performed by Bagattoni et al. (2022) analyzed the efficacy of this method. Before the child’s first dental appointment, parents received by e-mail a booklet with suggestions on how to prepare the child for this visit. The importance of the first dental visit in developing a positive attitude towards dental team was also explained. During the first visit, visual examination of the oral cavity was performed using a dental mirror and a dental probe, without any operative or invasive procedures. The results of this study demonstrated that children whose parents used the advice from the booklet reported less pain and assessed this visit as more enjoyable than children whose parents did not receive the booklet [10]. It is important that this psychological preparation occurs in a safe environment and is made by an affectively relevant person for the child [10].

Mittal et al (2025) conducted a randomized controlled trial aiming to evaluate the impact of a specially designed dentistry modelling story on dental anxiety and managing behavior among 6-8-year-old children. They compared a group of children who received a booklet describing the various aspects of the dental visit, dental team, instruments etc. aiming to familiarize children with the dental visit with another group of children who received a folk story. Children in both the groups showed a significant reduction in anxiety after storytelling, and differences in the anxiety and behavior of the children between the two groups were not statistically significant. Dentistry modelling story was preferred by the parents. [21].

All these interventions (comic strips, booklets etc.), designed to give details about the dental treatment and preparing the child for dental visit, are relatively inexpensive, easy to administer, and generate a positive behaviour [10,22-24].

In order to be more effective, advice for parents how to prepare the child for dental visits should mainly address parents of young children, without prior dental experience. It was demonstrated that children who had negative experience in the first dental visit have a higher risk of developing DFA than children who had a potentially painful experience after a few positive dental visits [10].

In our study, a great majority (more than 85%) of the parents taking part in this section of PaFein+ project stated that they prepared their kids for dental visits beforehand. Almost all respondents (97.9%) considered that the provided material would help them manage their kids' dental encounters better in the future and many (over 90%) would share the info with peers.

These findings were considered encouraging by the project team, therefore educational materials for families are subsequently being diversified and developed in accordance to feedback. As previous studies emphasized that parents tend to find storytelling videos relatable and reflective of real-life experiences [17], an original video on appropriate versus improper ways to support children before, during and after their dental encounters was produced. The material depicts a real-life inspired 5-year old's first visit to the dentist, from entering the waiting room to treatment completion. It is structured in 5 distinct chapters, each of which contains "do's" and "don't's". The video is freely available (in two languages, English and Romanian) on youtube: <https://www.youtube.com/watch?v=SBTjpmGo5k0> (EN), <https://www.youtube.com/watch?v=QgCeQBw470M> (RO)

More activities are planned and involvement of new potential partners (e.g. national PD societies, universities, parents' groups and associations, technology providers) is sought and encouraged in order to further develop project contents and increase project impact.

This study has some limitations. Research has a cross-sectional design and cannot assess the long-term impact on the children behavior and cooperation in the dental setting. Further longitudinal studies are necessary to analyze the long-term efficacy of the educational materials for parents.

Feedback was exclusively collected from parents, while the actual ultimate beneficiaries of such initiatives are the children. Objective measurements are also needed to evaluate the effects of parental involvement on their children behavior.

Difficulties in collecting answers to feedback forms were encountered, especially when parents accessed the info through media channels. Larger number of respondents would give more accurate feedback.

5. Conclusions

Childhood dental fear does not necessarily fade away with time. Parents need and appreciate initiatives that enable them manage their children's dental encounters in a positive supportive way, thus avoiding early onset of dental fear/anxiety, with long-term beneficial effects upon oral health.

Targeted booklets and videos with psychologic advice for parents are useful and can be easily shared online or in public and private dental clinics.

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administration, BK; Resources, AM, RS, MT; Supervision, AG, BK; Validation, RS, MT, AG,AGB, OOK, SP; Visualization, AV; Writing-original draft: AV and AM; Writing-review & editing, AM, AV, AP . All authors have read and agreed to the published version of the manuscript.

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Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki, and approved by the Ethics Committee of Carol Deavila University Bucharest, Romania (approval no.11580/30.04.2024).

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: The data presented in this study and the information booklet are available on request from the corresponding authors.

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Abbreviations

The following abbreviations are used in this manuscript:

PD	Pediatric Dentistry
BG	Behavior Guidance

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