

# Parental Oral Health: Importance & Behaviors

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## Attitudes toward Importance of Parental Oral Health Behaviors

The attitudes held by parents regarding the importance of oral health behaviors constitute a critical, yet often complex, determinant of pediatric dental outcomes. These attitudes represent a psychological predisposition to evaluate oral health actions, such as routine brushing, flossing, and dietary control, with a certain degree of favor or disfavor. Understanding these underlying beliefs is paramount, as attitudes often precede and mediate the adoption of consistent, preventive practices within the household environment. The transition from merely possessing knowledge about good oral hygiene to actively prioritizing and implementing these behaviors daily is heavily influenced by the parent's subjective valuation of their necessity and efficacy. Therefore, parental attitudes serve as powerful filters through which health information is processed and subsequently translated into actionable care strategies for the child.

Crucially, the study of parental attitudes moves beyond simple awareness, delving into the emotional and motivational dimensions that shape decision-making. A parent may intellectually acknowledge that sugar consumption is detrimental, yet their attitude regarding the importance of strictly enforcing dietary restrictions might be low due to factors like stress, perceived difficulty, or cultural norms surrounding food rewards. This dissonance between knowledge and attitude is fundamental to understanding persistent pediatric dental decay, particularly Early Childhood Caries (ECC). Furthermore, parental attitudes extend beyond immediate actions to encompass the perception of professional dental care. Attitudes regarding the necessity of regular dental visits, trust in dental professionals, and the perceived severity of dental disease all influence the frequency and timeliness of preventive and therapeutic care sought for the child. Negative or indifferent attitudes toward professional intervention can lead to delayed treatment, resulting in more invasive and costly procedures later, reinforcing a cycle of reactive rather than proactive health management.

The development and stability of these attitudes are dynamic, influenced by a myriad of personal, social, and environmental factors. Personal experiences, such as having suffered severe dental pain or having positive interactions with dental healthcare providers, can significantly shape a parent's prioritization of oral health. Conversely, negative past experiences, fear of dental procedures (dental anxiety), or perceived financial barriers can foster attitudes of avoidance or resignation. These subjective valuations are often internalized and communicated non-verbally to the child, modeling the importance--or lack thereof--of oral care. Consequently, effective public health interventions must target not just the informational gaps, but the underlying attitudinal barriers that prevent the consistent application of known preventive techniques, acknowledging that attitude change is often a precursor to sustainable behavior change.

## Theoretical Frameworks Guiding Health Behavior

Several established psychological models provide robust frameworks for analyzing and predicting the influence of parental attitudes on oral health behaviors. The **Health Belief Model (HBM)** posits that health actions are driven by the individual's perceptions of threat and benefits. In the context of parental oral health, this translates into four key perceptions: the perceived susceptibility of the child to dental disease; the perceived severity of dental disease; the perceived benefits of taking action (e.g., brushing); and the perceived barriers to taking action (e.g., time, cost, child resistance). A parent who holds a strong attitude regarding the importance of oral health will likely perceive high susceptibility and severity, while viewing the benefits of preventive action as substantially outweighing the associated barriers. Conversely, if a parent minimizes the severity of cavities (e.g., viewing them as inevitable or treatable), their attitude toward rigorous daily prevention will remain low, regardless of their foundational knowledge.

The **Theory of Planned Behavior (TPB)** offers an equally critical lens, suggesting that the primary determinant of behavior is the individual's intention to perform that behavior, which is itself shaped by three core components: attitude toward the behavior, subjective norms, and perceived behavioral control. Attitude toward the behavior refers specifically to the parent's positive or negative evaluation of performing the oral health action. Subjective norms involve the perceived social pressure to engage in the behavior, reflecting the attitudes and expectations of important reference groups, such as the partner, extended family, or peers. If a parent's social circle minimizes the importance of early dental visits, the parent's intention to prioritize them may weaken, even if their personal attitude is positive. TPB highlights that attitudes are not isolated entities but are deeply embedded within a social context that either reinforces or undermines their translation into action.

Furthermore, the concept of **Self-Determination Theory (SDT)** sheds light on the quality of motivation underlying the parental attitude. SDT distinguishes between autonomous motivation (actions performed because they are personally valued and congruent with one's goals) and controlled motivation (actions performed due to external pressure or guilt). Parental attitudes that are intrinsically motivated--where the parent genuinely values their child's health as a core personal responsibility--are far more likely to lead to sustained, high-quality oral health behaviors than attitudes driven solely by external factors, such as fear of the dentist's disapproval or institutional requirements. Interventions aimed at promoting lasting attitude change must therefore strive to foster autonomous motivation, helping parents internalize the value of preventive care rather than merely complying with external directives. This theoretical underpinning is crucial for developing effective communication strategies that resonate deeply with parental values.

## The Role of Parental Self-Efficacy and Locus of Control

Beyond general attitudes toward importance, the psychological construct of **parental self-efficacy** plays a pivotal role in determining the execution of oral health behaviors. Self-efficacy, defined as the belief in one's ability to successfully execute a specific course of action, acts as a bridge between the positive attitude (e.g., "I know brushing is important") and the actual performance (e.g., "I can successfully brush my resistant toddler's teeth twice a day"). A parent may hold a very strong attitude regarding the importance of daily flossing, but if they possess low self-efficacy--feeling overwhelmed or unskilled in performing the task--the behavior is unlikely to be consistently implemented. Low self-efficacy is particularly common when dealing with challenging behavioral management tasks, such as enforcing strict dietary limits or managing a child's fear during brushing sessions. Consequently, interventions must not only reinforce the importance of the behavior but also build confidence and practical skills necessary for successful execution.

The parent's **Locus of Control (LOC)** regarding health outcomes further modulates the translation of positive attitudes into consistent action. LOC refers to the degree to which individuals believe that they, as opposed to external forces, have control over the outcomes of their lives. Parents with an internal LOC believe that their actions, such as vigilant brushing and dietary supervision, directly determine their child's oral health status. This belief strongly reinforces a positive attitude toward preventive behaviors, as the effort is perceived as worthwhile and effective. Conversely, parents with an external LOC may attribute dental decay to fate, genetics, or environmental factors beyond their control. Even if they intellectually agree that brushing is important, this external attribution minimizes the perceived effectiveness of their personal effort, leading to lower motivation and inconsistent application of preventive measures. This fatalistic attitude is a significant barrier to behavioral change, regardless of the level of health education provided.

The interplay between self-efficacy and LOC suggests that attitudes are not merely cognitive assessments but are deeply intertwined with motivational beliefs about personal agency. Research indicates that low self-efficacy in managing child health behaviors, combined with an external locus of control, often results in passive attitudes characterized by resignation and minimal engagement with preventive care. Conversely, high self-efficacy and an internal LOC empower parents to view oral health as a manageable outcome, reinforcing a strong, proactive attitude toward the importance of their role. Therefore, effective educational and clinical encounters must be designed to enhance the parent's sense of competence and control, moving beyond general advice to provide specific, actionable strategies that boost confidence in managing complex daily routines.

## Environmental and Socioeconomic Determinants of Oral Health Attitudes

While psychological factors are central, parental attitudes toward the importance of oral health are profoundly shaped by the socioeconomic and environmental context in which the family operates.

Socioeconomic status (SES), typically measured by income, education, and occupation, is consistently linked to differences in health attitudes. Parents with higher levels of education are often exposed to more comprehensive health information, possess stronger health literacy skills, and are generally more equipped to interpret and prioritize long-term health benefits over immediate concerns. This educational advantage often translates into a stronger, more proactive attitude toward preventive care. Conversely, low SES families frequently face significant structural barriers that undermine positive attitudes, such as chronic financial instability, limited access to high-quality dental care, and environments saturated with cheap, high-sugar foods, making strict dietary enforcement exceptionally challenging.

The physical and social environments are powerful determinants of attitude formation. Access to fluoridated water, availability of affordable dental services, and the cultural normalization of preventive care within the community all contribute to the perceived importance of oral health. If a community lacks accessible dental providers or if preventive care is viewed as a luxury rather than a necessity, parental attitudes will naturally reflect this environmental reality, prioritizing more immediate needs. Furthermore, cultural beliefs and practices regarding teething, tooth loss, and traditional remedies for pain can significantly override standard public health recommendations. For example, some cultures may view the decay of primary teeth as inconsequential because these teeth will eventually be replaced, fostering an attitude of indifference toward early intervention. Addressing these cultural norms requires sensitivity and tailored public health messaging that respects community values while promoting scientifically validated practices.

The influence of structural factors often manifests as a trade-off in resource allocation. For parents struggling with multiple competing demands--such as securing housing, managing employment, and addressing immediate medical needs--oral health, particularly prevention, may drop significantly in priority. This reduction in perceived importance is not necessarily due to a lack of knowledge, but rather a rational response to resource scarcity. The lack of reliable transportation, inflexible work schedules, and the high cost of dental insurance act as formidable barriers, transforming a positive attitude into an unfulfilled intention. Therefore, policies aimed at improving parental attitudes must extend beyond the individual level to address the systemic inequalities that constrain behavioral choices. Effective strategies include improving school-based oral health programs, offering mobile dental services, and implementing policies that reduce the financial burden of preventive care, thereby making it easier for positive attitudes to translate into tangible actions.

## Measuring Parental Attitudes: Methodological Considerations

Accurately measuring parental attitudes toward the importance of oral health behaviors is essential for both research and clinical practice, yet it presents significant methodological challenges. Attitudes are latent constructs, meaning they cannot be directly observed but must be inferred

through self-report measures. The most common tool is the standardized Likert-scale questionnaire, which asks parents to rate their agreement with statements reflecting the perceived importance, value, and necessity of specific oral health actions. Items typically cover areas such as the importance of early dental visits, the necessity of supervising brushing, and the perceived effectiveness of fluoride application. Developing instruments that are reliable (consistent) and valid (measuring what they intend to measure) requires rigorous psychometric testing, especially when adapting tools for diverse linguistic and cultural populations.

A major challenge in attitude measurement is the pervasive issue of **social desirability bias**. Parents are often aware of the socially acceptable or "correct" responses regarding health behaviors. Consequently, they may over-report positive attitudes (e.g., strong belief in the importance of brushing) and under-report negative attitudes or passive behaviors, leading to an inflated assessment of their true motivational state. To mitigate this bias, researchers often incorporate indirect measures or triangulate self-reported attitudes with observed behaviors (e.g., clinical examination of the child's plaque levels or decay status) or proxy reports (e.g., reports from dental hygienists or teachers). Furthermore, integrating qualitative research methods, such as in-depth interviews or focus groups, can provide richer context and uncover underlying ambivalences and environmental constraints that quantitative scales often miss.

Another crucial methodological consideration involves the distinction between general attitudes and specific behavioral intentions. A parent might express a strong general attitude toward the importance of "good health," but this general attitude may not strongly predict the specific behavior of "flossing the child's teeth daily." Measures must therefore be highly specific to the target behavior being studied. Researchers often utilize sophisticated statistical techniques, such as Structural Equation Modeling (SEM), to test the complex causal pathways linking attitudes, subjective norms, perceived control, behavioral intentions, and ultimately, observable oral health outcomes. The refinement of these measurement tools is vital for creating precise, targeted interventions that address the specific attitudinal barriers most relevant to the population being served, ensuring that limited public health resources are deployed effectively.

## Impact of Attitudes on Child Oral Health Outcomes

The correlation between parental attitudes and child oral health outcomes is robust and well-documented, confirming that the parent acts as the primary gatekeeper and educator of health behaviors during early childhood. Positive parental attitudes toward prevention are directly associated with lower rates of dental caries, higher utilization of preventive services (such as sealant application and fluoride varnish), and better adherence to recommended recall schedules. When parents prioritize oral health, they invest the necessary time and resources into ensuring the child receives adequate daily care, often supervising brushing until the child develops the necessary motor skills and cognitive maturity, typically around the age of seven or eight. This

consistent, high-quality supervision, driven by a strong parental attitude of importance, is the single most protective factor against ECC.

Conversely, indifferent or negative parental attitudes significantly increase the risk profile for the child. When parents view decay as inevitable or brushing as a low priority, children are more likely to experience early and severe dental disease. Studies have demonstrated clear links between parental fatalism (an external locus of control) and increased prevalence of untreated carious lesions. These negative attitudes often lead to a pattern of reactive rather than preventive care seeking. Parents may only seek dental attention when the child is in significant pain, resulting in advanced disease that requires extensive restorative treatment or extraction. This reactive approach not only compromises the child's quality of life but also reinforces negative attitudes toward dentistry, potentially fostering dental anxiety in the child that persists into adulthood.

The influence of parental attitudes extends beyond clinical outcomes to affect the child's developing relationship with health behaviors. Children learn by observation and modeling; if a parent demonstrates a strong, positive attitude toward personal oral hygiene, the child is more likely to internalize these values. This modeling effect creates a powerful intergenerational cycle of health promotion. However, if the parental attitude is characterized by ambivalence, neglect, or fear of dental care, the child is likely to adopt similar patterns, perpetuating health disparities across generations. Therefore, addressing and modifying parental attitudes is not merely about treating current disease but represents a long-term investment in the child's lifelong health literacy and self-care capacity, emphasizing the importance of targeting the parent as the key agent of change.

## Interventional Strategies Focused on Attitude Modification

Given the central role of parental attitudes in pediatric oral health, effective interventions must be strategically designed to foster positive attitude change, moving parents from passive acceptance of health advice to active prioritization of preventive behaviors. Traditional educational methods, which focus solely on imparting knowledge (e.g., lectures on brushing technique), are often insufficient because they fail to address the underlying attitudinal, motivational, and self-efficacy barriers. Modern, evidence-based interventions emphasize personalized communication and motivational strategies.

One highly effective approach is **Motivational Interviewing (MI)**, a patient-centered counseling style designed to explore and resolve ambivalence regarding behavior change. In the context of oral health, MI helps parents articulate their own reasons for prioritizing (or neglecting) preventive care, thereby strengthening their intrinsic motivation. The MI process typically involves:

Exploring the parent's current attitudes and perceived importance of oral health.

Eliciting "change talk" by asking open-ended questions about the benefits of change and the risks

of maintaining the status quo.

Rolling with resistance rather than arguing, recognizing that resistance often stems from low self-efficacy or external pressures.

Supporting self-efficacy by collaboratively developing small, achievable action plans (e.g., focusing on just one target behavior like reducing bedtime sugary drinks).

By focusing on the parent's values and goals, MI helps align the parent's personal attitude with the desired health behavior, leading to more sustainable change than advice-giving alone.

Furthermore, interventions must incorporate strategies to boost parental self-efficacy. This can be achieved through hands-on training, such as demonstrating effective knee-to-knee brushing techniques for toddlers, followed by guided practice and positive reinforcement. Providing parents with practical resources, such as visual aids, reminder systems, and clear instructions on managing common challenges (like child refusal), directly addresses the "perceived barriers" component of the HBM. Group-based educational sessions can also be beneficial, allowing parents to share successful strategies and normalize the challenges of maintaining oral hygiene routines, which strengthens subjective norms and reduces feelings of isolation or failure. Ultimately, successful attitude modification relies on a holistic approach that simultaneously informs, motivates, and empowers parents to confidently assume the role of their child's primary oral health advocate.

## Future Directions in Research and Policy

Future research concerning parental attitudes toward the importance of oral health behaviors must move toward more nuanced and longitudinal investigations. While cross-sectional studies establish correlations, longitudinal designs are necessary to understand how attitudes evolve over time, particularly in response to major life events, socioeconomic shifts, or specific dental interventions. There is a need for greater exploration into the heterogeneity of parental attitudes, recognizing that the factors influencing a single mother in an urban environment may differ significantly from those influencing parents in rural, multi-generational households. This requires the development and validation of culturally sensitive measurement tools that accurately capture attitudinal nuances across diverse populations, moving beyond simplified Western-centric scales.

Policy implications derived from attitude research are critical for reducing pervasive oral health disparities. Policy efforts should focus on structural changes that support positive parental attitudes by reducing external barriers. This includes advocating for universal access to preventive dental care starting in infancy and integrating oral health education into existing public health infrastructure, such as Women, Infants, and Children (WIC) programs or pediatric primary care settings. Furthermore, policies should support training healthcare providers--including pediatricians and family physicians--in evidence-based attitude modification techniques, such as motivational

interviewing, ensuring that oral health counseling is standardized and consistent across all points of contact.

Finally, a critical area for future investigation involves harnessing digital technology to support and reinforce positive parental attitudes. The development of mobile health (mHealth) applications that provide personalized reminders, educational modules tailored to the child's age, and interactive tools for tracking behavioral progress offers a promising avenue. These tools can help bridge the gap between initial positive attitudes formed during a clinical visit and the consistent behavioral maintenance required daily at home. By focusing on both the individual psychological landscape and the supportive structural environment, research and policy can work synergistically to elevate the perceived importance of oral health behaviors, ultimately leading to improved outcomes for the next generation.

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