ORIGINAL ARTICLE

Journal of Dentomaxillofacial Science (J Dentomaxillofac Sci) October 2025, Volume 10, Number 4: 183-188
P-ISSN.2503-0817, E-ISSN.2503-0825

The influence of parenting style on the severity of early childhood caries in school-aged children in Bintaro Village, South Jakarta

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Abstract

Objective: This study aimed to investigate the influence of parenting style on the severity of early childhood caries (ECC) in school-aged children in Bintaro Village, South Jakarta.

Material and Method: Thirty students from South Jakarta's Tat Twam Asi Kindergarten and Kalpataru Kindergarten were selected through purposive sampling for this analytical observational, cross-sectional study. ECC data were collected using the def-t index through intraoral examination and completion of the Parenting Styles and Dimensions Questionnaire by parents. Data were examined using descriptive statistics, the chi-square test, and the Spearman Rank correlation test.

Results: The study indicated that the predominant parenting style was authoritarian (80%), with a significant incidence of early childhood caries (56.7%). Chi-square test results: $p = 0.029$; Spearman rank test $R^2 = 17.06\%$ with $p = 0.045$.

Conclusion: Most parents exhibited authoritative parenting styles associated with severe ECC. There was a substantial correlation between parenting styles and ECC, with authoritative parenting styles accounting for 17.06% of the variance in ECC severity.

Keywords: Authoritative parenting style, Dental caries, Early childhood caries, Oral health
DOI: 10.15562/jdmfs.v10i4.1954

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Introduction

Parenting styles serve as frameworks for parental behaviors or interventions that nurture, guide, and shape children's characters.[1] These include authoritarian, authoritative, and permissive styles. Kumar et al. highlighted the correlation between effective parenting and the incidence of dental caries in children.[2] Parental attributes, such as socioeconomic status, parenting style, and oral hygiene practices, influence children's experiences with dental caries.[3] Children's dental hygiene behaviors are positively linked to their parents' oral hygiene practices; however, a harsh parenting style is negatively correlated.[4] Children from low socioeconomic backgrounds with parents who employ harsh parenting methods have a higher prevalence of dental caries.[2] Early Childhood Caries (ECC) is defined as the presence of one or more decayed (nonactivated or cavitated lesions), missing (due to caries), or filled tooth surfaces in any primary tooth in a child 71 months of age or younger. The causes of ECC include irregular tooth brushing, inadequate oral hygiene practices, dietary habits, nocturnal bottle-feeding, and frequent consumption of cariogenic substances.[2,5]

ECC is a multifaceted and complex condition that can be prevented. Its development is linked to several intricate pathways, often associated with social disadvantage, health disparities, low socioeconomic status, ethnic or immigrant identity, and maternal educational deficits.[4] These factors are associated with detrimental conditions for dental health and specific maternal behaviors that increase the child's risk of ECC. Dental biofilms are reservoirs of cariogenic bacteria, including Streptococcus mutans, Streptococcus sobrinus, and Lactobacilli, which ferment dietary carbohydrates to produce acid. When the pH decreases below a certain threshold, the tooth surface initiates demineralization, resulting in the loss of calcium and phosphate. Elevated salivary flow parameters facilitate cleansing, buffering, and enhanced calcium supply, which may inhibit demineralization, whereas fluoride promotes remineralization.[6] Demineralization and remineralization of tooth surfaces contribute to caries development. Carious lesions arise over time when demineralization exceeds remineralization. The etiology of ECC resembles that of normal dental caries, which is typically broad and rampant, possibly because of the thin enamel of newly erupted primary teeth, the prevalence of cariogenic bacteria, and an acidic environment without adequate preventive mechanisms.

ECC can cause significant discomfort in children, hindering feeding and communication. By the age of two or three years, depending on severity, children may have further developmental delays in speech patterns and articulation. Inadequate nutrition results in stunted physical growth, and discomfort may reduce appetite. The quality of life of a child's oral health is impacted by the pain and suffering resulting from caries.[7]

World Health Organization (WHO), in 2018 estimated 60–90% of children globally have dental caries, whereas 50% of children aged under six

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Received 28 February 2025
Revised 19 March 2025
Accepted 28 September 2025
Available online 30 October 2025

Table 1. Distribution of ECC by parents' education.

Variable	ECC Low N	ECC Low %	ECC Moderate N	ECC Moderate %	ECC High N	ECC High %	Total %
Mother							
High school	4	13.3	1	3.3	7	23.3	12
Diploma	1	3.3	2	6.7	4	13.3	7
Bachelor degree	5	16.7	0	0	6	20.0	11
Total	10	33.33	3	10.00	17	56.67	30
Father							
House wives	5	16.7	0	0	3	10.0	8
Private employees	3	10.0	0	0	5	16.7	8
Civil servants	2	6.7	0	0	4	13.3	6
Entrepreneurs	0	0	3	10.0	5	16.7	8
Total	10	33.33	3	10.00	17	56.67	30

Table 2. Distribution frequency of parents' income.

Income	Amount (n)	%
Father		
<1.500.000/ Month	0	0
1.500.000-2.500.000/ Month	0	0
2.500.000-3.500.000/ Month	2	6.7
>3.500.000/ Month	28	93.3
Mother		
<1.500.000/Month	10	33.3
1.500.000-2.500.000/ Month	2	6.7
2.500.000-3.500.000/ Month	7	23.3
>3.500.000/ Month	11	36.7

Table 3. Distribution of parenting style and caries frequency.

Parenting Style	Amount (n)	%
Authoritative	24	80
Authoritarian	5	16.7
Permissive	1	3.3
def-t score		
Low	10	33.3
Moderate	3	10
High	17	56.7

Table 4. Correlation between parenting style and severity of ECC.

Variable	ECC Low N	ECC Low %	ECC Moderate N	ECC Moderate %	ECC High N	ECC High %	Total	*p-value
Parenting								
Authoritative	8	33.33	1	4.17	15	62.50	24	
Authoritarian	2	40.00	1	20.00	2	40.00	5	0.029
Permissive	0	0.00	1	100.00	0	0.00	1	
Total	10	33.33	3	10.00	17	56.67	30	
Parenting Style	r		p-value		R2		Interpretation	
Authoritative à def-t	0.413		0.045**		17.06%		Correlated	
Authoritarian à def-t	-0.579		0.306**		33.52%		Not Correlated	

*Chi-Square
Authoritative à def-t" refers to the relationship between the authoritative parenting style and the severity of ECC, as measured by the def-t score. In this context, "def-t" is a scale used to assess ECC severity based on the number of decayed, extracted, and filled teeth in a child's primary dentition.

years are caries-free.[8] Indonesia exhibits the greatest prevalence of ECC globally at 90%, with the most severe cases in children aged three to five years, as evidenced by a def-t score over 6.[9] The 2018 Basic Health Research (RISKESDAS) indicated that the prevalence of caries in children aged three to four years was 81.5%, and for those aged five years, it was 90.2%, indicating a significant issue in Indonesia.10 The novelty of this study lies in its focus on the relationship between parenting styles and the severity of early childhood caries (ECC) in children aged three to four years, a group significantly affected by caries in Indonesia. While much of the existing literature has examined individual risk factors for ECC, this study uniquely emphasizes the role of parenting behaviors, offering new insights into how different parenting styles may influence children's oral health outcomes in a population with one of the highest global ECC prevalence rates.

This study aimed to investigate the relationship between parenting styles and the severity of ECC in children aged 3-5 years. By examining how different parenting behaviors influence children's oral health, this study aims to contribute valuable insights to the field of pediatric dentistry. The findings is expected to enhance understanding of the factors contributing to ECC development. This study may inform public health initiatives and interventions aimed at improving oral health behaviors in children and provide guidance for dental professionals in addressing the impact of parenting styles on early childhood caries prevention and treatment.

Material and Methods

This study followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines for observational research to ensure transparency, consistency, and reproducibility in the presentation of the study's methodology and findings.[11] Adhering to these guidelines provides a standardized framework that enhances the quality and clarity of reporting, allowing for a comprehensive understanding of the study design, statistical methods, and results.

Study design

This analytical observational study, employing a cross-sectional design, was conducted according to the established inclusion and exclusion criteria.[12] The sample size was established using a purposive sampling approach.

Setting

This study was conducted in Bintaro Village, Pesanggrahan District, South Jakarta, focusing on children aged three to five years from two local kindergartens: Tat Twam Asi Kindergarten and Kalpataru Kindergarten. This setting provided a relevant context for investigating the relationship between parenting styles and ECC severity in a community setting with varied socioeconomic backgrounds.

Participants

The participants in this study were children aged three to five years with ECC who consented to undergo intraoral examinations. Owing to the young age of the participants, their parents were required to sign informed consent forms prior to participation. Additionally, parents who met the inclusion criteria agreed to complete a questionnaire, either via Google Forms or on paper, to provide essential data regarding their parenting styles.

Variables

The assessment of parenting styles in this

study was conducted using the Parenting Styles and Dimensions Questionnaire (PSDQ), developed by Robinson et al., which contains 32 statements evaluating interactions between children and parents: authoritative, authoritarian, and permissive parenting.[13] ECC severity was measured using the def-t score scale established by Gruebbel AO, which calculates the number of decayed (d), extracted (e), and filled (f) teeth in a child's primary dentition. The def-t score was categorized as follows: a score–0-2 indicates low severity, 3-5 indicates moderate severity; and ≥ 6, high severity.[14] This scoring system provides a structured method for assessing ECC severity and aids in diagnosis and treatment planning. The individual definition index, which includes components d, e, and f, is used to calculate the overall severity of ECC.

Data sources

The study utilized multiple data sources, including primary data collected through the direct participation of 30 students. Data were gathered using intraoral examinations to assess the severity of ECC using the def-t index. Data on parenting styles were obtained using the PSDQ, completed by the parents. Data were collected using both paper and Google Forms versions of the questionnaire to ensure accessibility and convenience for the participants.

Bias

Several measures were implemented to mitigate bias. The sample size was expanded by including diverse participants from different kindergartens and geographical areas to ensure better representation. Random sampling was used to enhance the external validity. To minimize social desirability bias, the PSDQ responses were anonymized. Objective measures, including direct observation of parenting behaviors and teacher data, were incorporated to accurately assess parenting styles. Trained examiners conducted intraoral assessments to minimize examiner bias while evaluating ECC.

Study size

The study size of 30 participants was determined using purposive sampling, based on specific inclusion and exclusion criteria. This sample size was deemed sufficient to explore the relationship between parenting styles and the severity of ECC in the target population of children from two kindergartens in South Jakarta. Although the sample size was relatively small, it was considered appropriate for the analytical observational study design and scope of the research.

Quantitative variables

In the analysis, quantitative variables were handled using categorical groupings to assess ECC severity and parenting styles. The severity of ECC was categorized based on the def-t index into three groups: low (0-2), moderate (3-5), and high (≥ 6). Parenting styles were categorized as authoritative, authoritarian, or permissive based on responses to the PSDQ. These groupings were chosen to clearly distinguish between varying levels of caries severity and examine how different parenting styles may influence children's oral health outcomes.

Statistical methods

Descriptive statistics were used to summarize demographic information and the distribution of parenting styles and ECC severity. To assess the relationship between parenting styles and ECC severity, the chi-square test was conducted, revealing a statistically significant correlation ($p = 0.029$). Additionally, Spearman's rank correlation was used to quantify the strength and direction of the relationship, with the results indicating that authoritative parenting accounted for 17.06% of the variance in ECC severity ($r = 0.413$, $p = 0.045$).

Results

Participants

Thirty children from Tat Twam Asi Kindergarten and Kalpataru Kindergarten in South Jakarta participated in the study. Initially, a larger group was considered, but only those meeting the inclusion criteria were evaluated for eligibility. After applying these criteria, all 30 children were confirmed as eligible. The children underwent intraoral examinations to assess the severity of ECC, and their parents completed the PSDQ. All participants completed the study without requiring follow-up, and data from these 30 individuals were analyzed. Among the 30 samples, 40% of mothers had completed high school, 23.3% held a diploma, and 36.7% had a bachelor's degree.

Table 1 presents the distribution of ECC severity across different levels of maternal education. Children of mothers with a high school education had the highest incidence of high ECC (23.3%), while those of mothers with a bachelor's degree had the lowest incidence of moderate ECC (0%). Housewives and private employees had the highest percentage of children with high ECC, while entrepreneurs had a higher percentage of children with moderate ECC.

Table 2 illustrates the income levels of parents, showing that 93.3% of fathers have a monthly income exceeding IDR 3,500,000, while a mere 6.7% earn between IDR 2,500,000 and 3,500,000. In contrast, 36.7% of mothers earn more than IDR 3,500,000 per month, 33.3% earn less than IDR 1,500,000, and the remaining 30% are categorized under other income brackets. Descriptive data.

The study included children from varying socioeconomic backgrounds, as indicated by their parents' education and income levels. Regarding parental education, 40% of mothers had completed high

school, 23.3% held a diploma, and 36.7% had a bachelor's degree. The majority of fathers (93.3%) earned above IDR 3,500,000 per month, whereas 33.3% of mothers earned below IDR 1,500,000 per month. The participants' social and economic conditions varied, with different maternal occupations, including housewives, private employees, civil servants, and entrepreneurs. The exposures considered in this study included the type of parenting style (authoritative, authoritarian, or permissive), as assessed by the Parenting Styles and Dimensions Questionnaire (PSDQ), and the severity of ECC, measured using the def-t index. Potential confounders included maternal education, income, and occupation, which could influence both parenting styles and ECC outcomes.

Outcome data

In this study, parenting styles formed the basis for exposure categories, with a significant majority of parents (80%) adopting an authoritative approach, 16.7% employing an authoritarian style, and a mere 3.3% opting for a permissive one. The severity of ECC among participants was categorized into three levels using the def-t index: 33.3% of children exhibited low ECC, 10% had moderate ECC, and 56.7% experienced high ECC. These distributions illustrate the varying degrees of ECC severity associated with different parenting styles, with the authoritative style being most common among children with high ECC severity.

Table 3 shows the distribution of parenting styles and caries frequency among the 30 participants. The majority (80%) practiced an authoritative parenting style, while 16.7% followed an authoritarian style, and only 3.3% adhered to a permissive one. This indicates that authoritative parenting was the most common among the sample, which is significant because the study aimed to explore the relationship between parenting style and the severity of early childhood caries (ECC). The severity of ECC categorized based on the def-t index into three groups: low (33.3%), moderate (10%), and high (56.7%). Most children in the study exhibited a high level of ECC, with 56.7% showing severe caries, indicating a prevalent oral health issue within the sample group.

Table 4 presents the correlations between different parenting styles and ECC severity. The Chi-square test showed a significant association between parenting style and ECC severity ($p = 0.029$). Among the children of authoritative parents, 62.5% exhibited high ECC, whereas only 40% of children with authoritarian parents showed severe caries. The permissive parenting style had a low prevalence of severe caries, with only one child falling into the high ECC category. Spearman's correlation analysis revealed a significant correlation between authoritative parenting style and ECC severity ($r = 0.413$, $p = 0.045$), explaining 17.06% of the variance in ECC severity. In contrast, authoritarian parenting was not significantly related to ECC severity ($r = -0.579$, $p = 0.306$), with 33.52% of the variance in ECC severity attributed to other factors. This suggests that, while authoritative parenting is correlated with higher ECC severity, authoritarian parenting does not exhibit a statistically significant effect.

Other analysis

In addition to the primary analyses, the study also included subgroup analyses were performed to examine the distribution of ECC severity based on maternal education and occupation. These analyses showed that children of mothers with a high school education had the highest proportion of severe ECC, and maternal occupation also influenced the severity of ECC. For instance, children of housewives had the highest proportion of children with low ECC, whereas those of private employees and entrepreneurs showed higher percentages of children with moderate or high ECC. However, no sensitivity analyses were conducted to assess the robustness of the findings or to explore alternative model specifications.

Discussion

This study aimed to explore the relationship between parenting styles and ECC severity in children. The findings revealed a significant correlation between authoritative parenting and higher ECC levels, with most children in the study exhibiting severe caries. These results underscore the complex interplay between parenting behaviours and children's oral health outcomes, suggesting that parenting styles may play a crucial role in the development of ECC.

Authoritative parenting style was most common with severe early childhood caries, and parenting styles strongly correlated with early childhood caries severity.[2] However, a study conducted in Jember, Indonesia, determined no significant variations in parenting styles and ECC.[15] This study further revealed that culture might affect parenting techniques, which, in turn, increases the risk of early childhood caries. Alongside commending their children for their inherent qualities, authoritative parents establish expectations for their future conduct.[14] Authoritarian parents mostly control and evaluate their children's behavior based on a set of codes of conduct. Parents view obedience as essential and often resort to strict methods and punishments to suppress their children's will when their actions or beliefs diverge from what parents consider appropriate behavior. They tend to dismiss their children's opinions verbally, believing that their children should simply accept their views. Parents believe that to instill a sense of hard work in their children, it is

essential to establish boundaries, restrict their freedom, and assign them responsibilities around the house.[16]

A notable effect of authoritative parenting was also reported to link to fewer caries as reported during initial dental appointments.[2,17,19] Although the majority of parents practice authoritative parenting, students' def-t index may still fall within the high range due to the multifactorial nature of caries, which extends beyond itself.[18]

The analysis results indicated that children of parents exhibiting authoritarian parenting styles had a lower incidence of caries than those raised with an authoritative approach. This aligns with Sukanya's research, referenced by Syaputri DI.[2,19] In contrast to the findings of Kumar et al., which indicated that children of parents with authoritarian parenting styles exhibited higher ECC.[2] An individual acquires knowledge, comprehension, expertise, and insight through a structured educational process encompassing various activities. As an individual's educational attainment increases, so does their accumulation of knowledge.[20] Mothers with high school education levels represented the majority of the children with elevated caries rates.[21]

Several studies show a relationship between the oral health status, preventive behavior, and the educational level of parents/caregivers.[17,22,24] Study shows that housewives had an increased capacity to focus on their children's oral health. and had the highest proportion of children with low ECC.[23] Mothers employed as civil servants had children with a high ECC, whereas those who were private employees or entrepreneurs had a higher rate of high ECC. In contrast, the prevalence of low ECC in children was linked to mothers employed in the professional, technical, or service sectors. Parents with knowledge of oral health are more capable of exemplifying attitudes and actions that assist their children in preserving optimal oral health.[21] Increased parental understanding of oral health correlates with a reduced risk of dental caries in children.[25,26] Given that parents significantly influence their children's oral hygiene behaviours and habits, examining their knowledge, attitudes, and practices regarding ECC will elucidate the necessity for oral health promotion, education, and motivation to enhance and foster effective preventive measures for their children.[27] Socio-economic status is another aspect that might affect ECC.[28]

Although this study contributes to theoretical and their practical implication on parenting styles and ECC levels, this study shall admit several limitations. The relatively small sample size of 30 participants limits the generalizability of the finding. Furthermore, reliance on self-reported data from parents presents the potential for social desirability bias. The cross-sectional design also restricts the ability to establish causal relationships between parenting styles and ECC severity. Future studies should include larger, more diverse samples and utilize a longitudinal approach to explore the long-term effects of parenting styles on ECC.

Conclusion

This study underscores the significant link between parenting styles and the severity of ECC in children aged 3-5 years. The findings indicate that authoritative parenting is associated with greater ECC severity, with children of authoritative parents showing the highest caries levels. While this research enhances our understanding of the role parenting styles play in ECC development, it also highlights the necessity for further investigation into the underlying mechanisms and potential confounders that affect this relationship. Future studies should incorporate larger, more diverse samples and longitudinal designs to provide more comprehensive insightss into how parenting behaviors influence children's oral health outcomes.

Acknowledgments

None.

Conflict of Interest

The authors report no conflict of interest.

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