

Association Between Personality Traits, Dental Anxiety And Socioeconomic Profile With The Dental Myths Among Adults In Chennai City, India

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ABSTRACT: Purpose: The objective of the present study was to evaluate the association between personality traits, dental anxiety and socioeconomic profile with the dental myths among adults in Chennai City, India.

Methods: A pilot study was conducted among 90 adults aged 18 years and above by multistage random sampling methodology across the socioeconomic groups. The final sample size was found to be 162. A validated and a reliable, bilingual, self-administered questionnaire consisting of four sections namely 1. The demographic details, 2. Personality traits, 3. Modified Dental Anxiety and 4. A 26-item dental myth questionnaire. The collected data was analysed using SPSS version 20.0 and Chi-square test, One way ANOVA and correlations were done and a p-value <0.05 was considered as statistically significant.

Results: Dental myth scores was found to be more in the middle social class, followed by the lower and higher social class and this difference was not statistically significant (p=0.21). The personality traits and dental anxiety were found to be weakly correlated with dental myth scores.

Conclusion: The startling results of the study have shown no relationship between socioeconomic status, dental anxiety, personality traits with the occurrence of dental myths.

Keywords: Dental myths, dental anxiety, BFI, personality traits, association

1. INTRODUCTION

The health care industry, including dentistry, has evolved from a traditional practice based on folk cures to a structured medical discipline based on scientific evidence. Despite remarkable advances in science and technology, people continue to give importance to their traditional

values, customs, beliefs, and myth which are related to their familial upbringing.¹ Even though dentistry is one among the highly developed fields among the medical sciences, it has also been seeded with non-scientific knowledge and false traditional beliefs. *Myths* are stories shared by a group of people that are part of their cultural identity. These people have a very strong influence on their way of living, including seeking treatment during illness.⁶ Dental health-related disbeliefs and misconceptions, when handed down from one generation to next, can be called *dental myths*.⁶ While some myths are provincial, some might be heard everywhere. Thus the dental myths that exist in any population should be understood as it might have a bearing on the health status of the people. Dental myths can be detrimental at times and result in various degrees of disability.⁷ The factors which contribute to the onset of dental myths is not adequately investigated.

Studies conducted by Singh SV et al in 2012,⁷ Anup Nagaraj et al in 2014¹⁴ and Kiran GB et al in 2016,⁶ found that prevalence of myth has been high among the Indian population over these years. On one hand, dental myths might give rise to negative dental beliefs which ultimately creates an aversion towards dental treatment. On the other hand, factors such as socioeconomic status of a person,¹⁵ personality traits⁹ and dental anxiety⁵ also leads to an apprehension towards dental treatment. Hence, it can be hypothesized that there exist a relationship between these variables. But there is paucity in literature to show how dental myths, dental anxiety, personality traits and socioeconomic status of a person are related to each other. Hence this study was designed with the hypothesis that there exists a relationship between personality traits, dental anxiety and socioeconomic status with dental myths and the null hypothesis was that no such relationship occurs.

2. MATERIALS AND METHODOLOGY

A cross-sectional study was carried out to evaluate the relationship between personality traits, dental anxiety and socioeconomic profile with the dental myths among adults in Chennai City, India. A detailed protocol explaining the nature and purpose of the study was submitted to the Institutional Review Board and after its scrutiny, ethical clearance was obtained. Informed consent was obtained from the study subjects.

Questionnaire for Data Collection:

Section I consisted of questions used to record information on socio-demographic details of the study subjects including name, age, gender and were classified according to their socioeconomic status as upper, middle or lower social class, based upon the modified Kuppaswamy socioeconomic scale – 2018.²⁰ In the present study, the study population was classified as Upper, Middle and Lower by clubbing the Upper Middle and Lower middle as Middle class and Upper Lower and Lower as Lower Class.

Section II consisted of a pre-validated, standard ten closed ended questions related to the five personality traits of an individual, commonly called by the anagram OCEAN - Openness, Conscientiousness, Extraversion, Agreeableness, and Neuroticism based on the Big Five Inventory - 10 (BFI-10) scale given by Beatrice Rammstedt and Oliver P. John, 2007.²¹ The responses were coded either as (1) Disagree strongly, (2) Disagree a little, (3) Neither agree nor disagree, (4) Agree a little and (5) Agree strongly (Annexure 3). While calculating the score for each personality, one question is to be reverse coded, which is as follows: Openness (5R+10), Conscientiousness (3R+8), Extraversion (1R+6), Agreeableness (2+7R), and Neuroticism (4R+9). The scores range from 2-10 for each personality trait, and a higher score obtained among the five personality traits, represents the most dominant personality of that particular individual. If two personality traits share a common score, then the individual is considered to possess a mixed personality trait.

Section III consisted of a 5 item, pre-validated, standard questionnaire to assess the dental anxiety of an individual based on the Modified Dental Anxiety Scale – Revised version (MDAS-R) by G. M. Humphris, 1995.²² The responses were coded either as (1) Not anxious, (2) Slightly anxious, (3) Fairly anxious, (4) Very anxious and (5) Extremely anxious. The scores range from 5 – 25. All the responses are summed together to construct a Likert scale with a minimum score of 5 and a maximum of 25.

Development of questionnaire for assessing dental myths:

Apart from the available literature, inputs from various dental practitioners, academicians, subject experts and patients were collected to frame a 28 item dental myth questionnaire. Five subject experts who were not a part of study, evaluated the questionnaire, and the items lesser than 50% agreement were omitted from the questionnaire. Hence, the final questionnaire comprised of 26 items and a content validity ratio of 0.84 was obtained. The linguistic validation and reliability of the questionnaire was done. The scores for the dental myth questionnaire range from 26 – 130. A higher myth score indicates that the individual is said to have more myths.

Since Tamil is the regional language of Chennai, the questions in Sections I, II, III and IV were translated to Tamil. The linguistic validation of the questionnaire was checked by back translation method, involving retranslation of the Tamil questionnaire to English by blinded personnel well versed in both Tamil and English. For test retest reliability, a subset of 5 OPD patients completed the translated version of the questionnaire on two occasions separated by an interval of two weeks.²³ Test-retest reliability was assessed on these individuals and a Kappa value of 0.89 (good) was obtained. After the three stages of the content validity evaluations, which comprised (1) the development stage, (2) the expert judgement stage and (3) the quantification stage, the subjects willing to give a written informed consent, aged > 18 years and literate in Tamil or English were included and cognitively disabled people were excluded from the study.

A pilot study was carried out for a duration of two weeks (12-10-2018 to 26-10-2018) for which 90 adults from Chennai City were randomly selected. The pilot study was carried out to assess the feasibility of the study and to estimate the sample size for the main study. Data was collected and recorded in the prepared questionnaire. The questionnaire was self-administered and it took nearly 15-20 minutes to fill the entire questionnaire for each study subject. The sample size for the main study was calculated using a sampling software (G power version 3.1.9.2, Heinrich–Heine–Universität–Düsseldorf, Germany) based on the mean difference in the overall scores of Dental myths between the social classes obtained from the pilot study. Keeping the power of the study at 95% and α error at 5%, the minimum final sample size required for the main study was estimated to be 162 with 54 in each group.

3. SAMPLING METHODOLOGY

A multistage random sampling methodology was followed in the study.

Stage 1 - From the three administrative areas of Chennai, one area was randomly selected.

Stage 2 - From the selected area, a locality with residences of people belonging to different social classes was selected.

Stage 3 – From the selected locality, one arterial road was identified from which random selection of the houses were done

Stage 4 – From each selected house, one adult male and female from were considered for the study. The selection of the houses was continued till the required sample size was obtained.

Data collection was carried out using the prepared questionnaire. The questionnaire was self-administered to the participants by the investigator.

The collected data was analysed using Statistical Package for Social Sciences (SPSS) version 20.0. Descriptive statistics like frequency, percentage, mean, and standard deviation were calculated. Descriptive statistics were obtained for all demographic variables. The qualitative data in the present study was assessed for statistical significance using Chi -square test. Quantitative analysis for Inter-group comparison was carried out using One way ANOVA. Correlation between Dental myth, Dental anxiety and Personality trait based on Socio economic class were carried out using Pearson's order correlation coefficient test. P-value <0.05 was considered as statistically significant.

4. RESULTS

A cross-sectional analytical study was carried out among 162 subjects and were classified according to their socioeconomic status into upper (n=54), middle (n=54) and lower class (n=54). Demographic details including age, gender, religion, personality traits, dental anxiety and dental myths were recorded and compared between the three social classes.

The mean age of the study participants were 41.32 ± 10.55 years with males representing 51.20% of the study subjects (Graph 1). Hindus (67.90%) were the major representative religion followed by the Christians (17.30%) and then by the Muslims (14.80%). (Figure 1). Among the study subjects, 14 of them were slightly anxious, 22 subjects were moderately anxious, 120 subjects were very anxious, 6 subjects were extremely anxious and none of them reported to be not anxious (Graph 2). The dominant trait exhibited by the study subjects was agreeableness followed by extraversion, conscientiousness, neuroticism and openness (Graph 3).

Nearly half of the population had agreed to at least one dental myth (45.4%). The most prevalent myths among the study subjects were that "brushing the teeth using salt, whitens the teeth" 140(86.4%), "betel nut quid chewing with slaked lime can keep gum problems away" 137(84.6%), "if the tooth enamel is white, then the tooth is said to be healthy" 133(82.1%), "there are worms inside a decayed tooth" 125 (77.2%), "throwing the exfoliated milk tooth of the child on the roof of the house can lead to eruption of healthy permanent tooth" 113(69.8%), and "we should not do any household chores after a tooth removal" 118(72.8%). The least prevalent and disagreed myths among the study subjects were "placing a milk tooth under a pillow would transform to money" 162 (100%), "Zandu balm relieves tooth ache" 153(94.4%) and "tooth decay is caused by the God for the sins we have committed" 150 (92.6%) (Table 1)

The intragroup comparison of mean dental myth scores based on socioeconomic status showed in the high socioeconomic status group, it was 69.83 ± 8.97 , in the middle social class, it was 72.53 ± 7.36 and in the lower social class, it was 71.12 ± 7.65 and this difference was not statistically significant ($p=0.21$) (Table 2).

Correlating the variables with dental myth scores, the dental anxiety scores among the study subjects were found to be positively correlated ($r=0.10$) and this correlation was not statistically significant ($p=0.17$). On correlating the personality traits with dental myth scores, there was a negative correlation between openness with dental myth scores and extraversion with dental myth scores ($r= -0.02$, $r= -0.03$ respectively) and correlating conscientiousness with dental myth scores, agreeableness with dental myth scores and neuroticism with dental myth scores, there was a positive correlation ($r=0.03$, 0.09 , 0.07 respectively) and these correlations were not statistically significant ($p=0.75$, 0.65 , 0.63 , 0.24 and 0.37 respectively (Table 3)

5. DISCUSSION

Myths are a false belief among people which is not always substantiated by fact. There are a variety of reasons due to which dental myths can be prevalent in a population like poor education, lack of awareness, negative dental experiences, cultural beliefs and social misconceptions that are passed on from one generation to the other.

In the present study, this population was chosen as they can be good representatives of people coming from various regions. The questionnaire was self-designed and in order to avoid confusion in results, it was framed in close-ended format with options of strongly agree, agree, neutral, disagree and strongly disagree. The questions were grouped under the topics like dental caries, oral hygiene, tobacco, and general dental aspects.

Nearly half the study population had at least one dental myth which was in line with the study conducted by Ramandee Singh et al (2015)⁵ and Kiran GB et al (2016).⁶ One of the most widely believed myth was that “If the tooth enamel is white, then the tooth is said to be healthy”. This shows that their knowledge and awareness regarding oral health is poor that predisposes them to false beliefs and ideas.

More than 77% of the participants in the present study believed that “Worms are there inside a decayed tooth”. This percentage is less as compared to some other study reports conducted by Tewari D, Nagesh L and Kumar M (2014)²⁵ in Bareilly District where more than 90% of subjects believed in this myth. This could be due to the reason that majority of people do not know about initiation and progression of dental caries. To explain them about dental caries, most of the dentists relate dental caries to a “worm” in the native language that needs to be taken out to save the tooth.

Furthermore, 70% of participants were of the opinion that throwing the exfoliated milk tooth of the child on the roof of a house, can lead to the eruption of the healthy permanent tooth which is similar to the findings of a study conducted by Nagaraj A, Ganta S, Yousuf A, Pareek S in 2014. It is believed that squirrel takes the old tooth and returns it for a new one. Such kind of behaviour can be attributed from their family members, especially their grandparents, who exerted a significant influence on their family especially their younger generation.

Myths such as “Cleaning with salt makes teeth white, and that the “use of neem sticks instead of toothbrushes cleans the teeth better”, will have a negative effect on oral health as these are not recommended oral hygiene practices. Though the extracts of many twigs/stems of plants have yielded potent antimicrobial and antiplaque substances, the disadvantages also includes gingival trauma and occlusal wear. Usage of coarse materials such as salt in cleaning procedures could abrade the enamel and also damage the periodontal ligament.²⁵

In the present study, about 75% of the study population disagreed that, the baby teeth are not as important as the permanent teeth which is more than that of a study conducted by Saad Ahmed Khan et al in 2012,²⁷ where he found about 37.5% of the subjects considered the retention of baby teeth to be important. It is crucial that children learn proper oral hygiene at an early age which helps them form permanent habits that are essential for oral health. Furthermore, early loss of deciduous teeth will interfere with mastication and affect the child’s nutrition, which leads to drifting of the adjacent teeth and closure of some of the space that is required for the succeeding permanent teeth to erupt into. Such loss of space will result in crowding of permanent teeth.²⁸

The prevalence of dental myths was found to be common among all the three social classes and there was no statistically significant differences between them which was similar to a study conducted by Archana Rai et al in 2016.¹⁹ The personality traits and dental anxiety were found to be weakly and negatively correlated with dental myth scores. Emotional

factors, including shame, embarrassment, guilt and loss of self-esteem that are proven to be common among dentally anxious people could have biased the answering pattern.⁹

The external validity of the present study results are possible since the sample size was scientifically evaluated, a multistage random sampling methodology was followed, people belonging to different socioeconomic strata were included and a new questionnaire to assess dental myths was developed and tested for validity and reliability and the CVR value of 0.84 was obtained which is said to be good. Since the questionnaire consisted of 41 items, chances of participant fatigue and social desirability bias could have occurred.

6. CONCLUSION

The startling results of the study are one of a kind and have shown no relationship between socioeconomic status, dental anxiety, personality traits with the occurrence of dental myths. Indian Nation is rich in diverse cultural practises and the presence of these external factors like traditional beliefs and cultural practises handed down the generations may be the basic cause for the prevalence of myths in this study.

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Conflict of interest statements: Nil

7. REFERENCES

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Table 1: Prevalence of dental myths based on each question

Myth Questions	Prevalence: n (%)	
	Number of subjects who agreed	Number of subjects who Disagreed
1. Worms are there inside a decayed tooth	125(77.2%)	37(22.8%)
2. Decay present in a tooth is a hereditary process, so nothing can be done	98(60.5%)	64(39.5%)
3. Presence of teeth at birth is harmful to grandparents	17(11.9%)	145(87.9%)
4. Cleaning of the teeth by a Dentist makes the teeth loose	68(42%)	94(58%)
5. When gums bleed, it is better not to brush the teeth	66(40.7%)	96(59.3%)
6. Teeth should be buried after extraction for new teeth to grow without any problem?	58(35.8%)	104(64.2%)
7. Keeping any tobacco product beside a painful tooth reduces the tooth pain	55(34%)	107(66%)
8. Artificial teeth set contain natural teeth of other person?	50(30.9%)	112(69.1%)
9. Tooth decay is caused by the God for the sins we have committed	12(7.4%)	150(92.6%)
10. Zandu balm relieves tooth ache	9(5.6%)	153(94.4%)
11. Throwing the exfoliated milk tooth of the child on the roof of house can lead to eruption of healthy permanent tooth	113(69.8%)	49(30.2%)
12. Betel nut quid chewing with slaked lime can keep gum problems away	137(84.6%)	25(15.4%)
13. More you brush using hard bristles, whiter your teeth becomes	82(50.6%)	80(49.4%)
Myth Questions	Prevalence: n (%)	
	Number of subjects who agreed	Number of subjects who disagreed
14. Brushing your teeth using salt, whitens your teeth.	140(86.4%)	22(13.6%)
15. Expensive toothpastes are always better than cheap ones	93(57.4%)	69(42.6%)
16. If the tooth enamel is white, then the tooth is said to be healthy	133(82.1%)	29(17.9%)
17. Baby teeth are unimportant because they are going to fall out	87(53.7%)	75(46.3%)
18. Extraction of teeth in the upper jaw leads to loss of vision	51(31.5%)	111(68.5%)
19. Crowding or irregular placement of the teeth is	44(27.2%)	118(72.8%)

lucky		
20. Eating Brinjal leads to staining of the teeth	47(29%)	115(71%)
21. Tree sticks cleans the teeth better than a tooth brush	62(38.3%)	100(61.7)
22. Removal of the wisdom tooth lowers the intelligence	92(56.8%)	70(43.2%)
23. Placing a milk tooth under a pillow would transform to money	-	162(100%)
24. If the tooth in the upper jaw erupts first, then the child is said to be lucky	103(63.6%)	59(36.4%)
25. If the milk teeth eruption is delayed, then the teeth is said to be stronger	96(59.3%)	66(40.7%)
26. We should not do any household chores after a tooth removal	118(72.8%)	44(27.2%)

Table 2: Intragroup comparison of mean dental myth scores among the study subjects based on socioeconomic status

	Socioeconomic status (Mean \pm SD)			P value ^A
	High	Middle	Low	
Myth score	69.83 \pm 8.97	72.53 \pm 7.36	71.12 \pm 7.65	0.219

^AANOVA – Analysis of variance

P value < 0.05 is statistically significant

Table 3: Correlation of dental anxiety, personality traits with dental myths

Study participants N = 162	Dental myth score	
	R value	P value ^A
<i>Dental anxiety</i>	0.106	0.17
<i>Personality traits</i>		
Openness (O)	- 0.024	0.75
Conscientiousness (C)	0.038	0.63
Extraversion (E)	-0.035	0.65
Agreeableness (A)	0.093	0.24
Neuroticism (N)	0.070	0.37

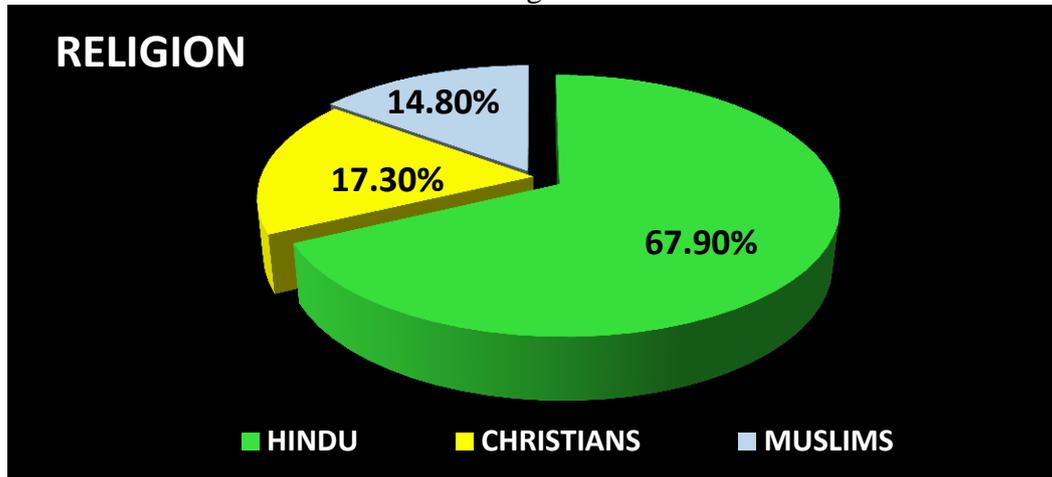
^A Pearson's Correlation

r: Correlation coefficient

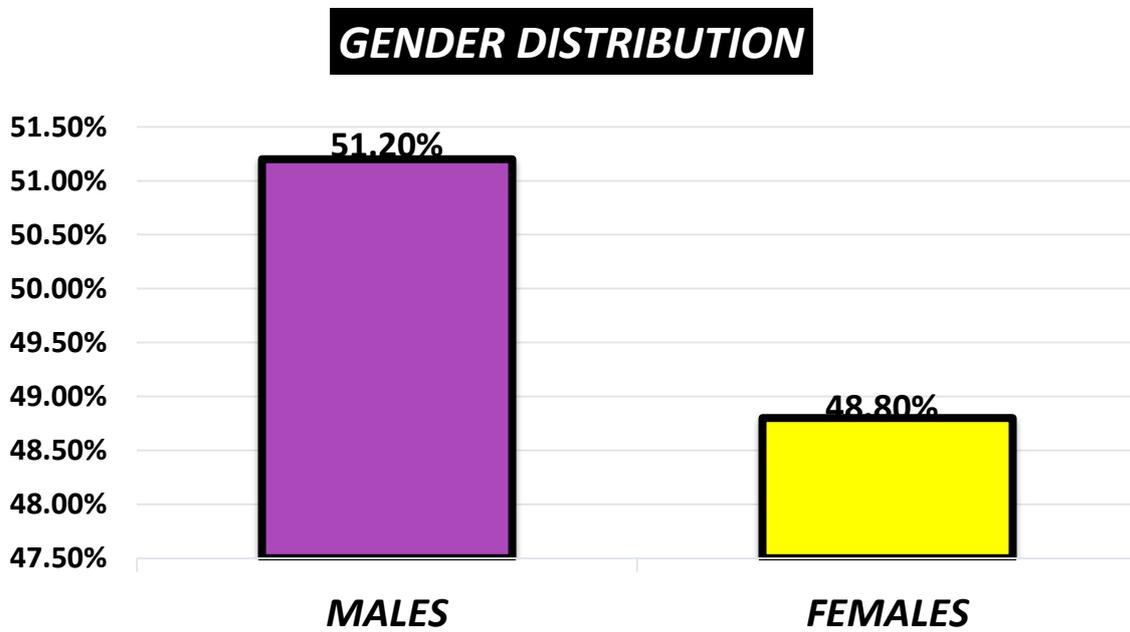
P <0.05 is statistically significant

Graphs

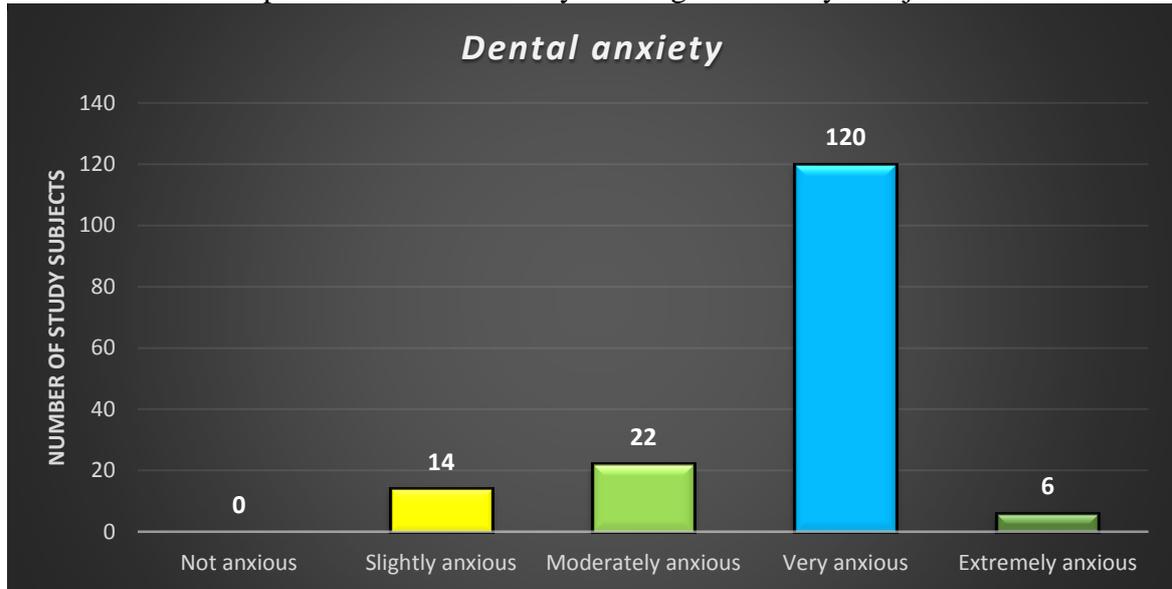
Figure 1: Demographic characteristics of the study participants based on religion



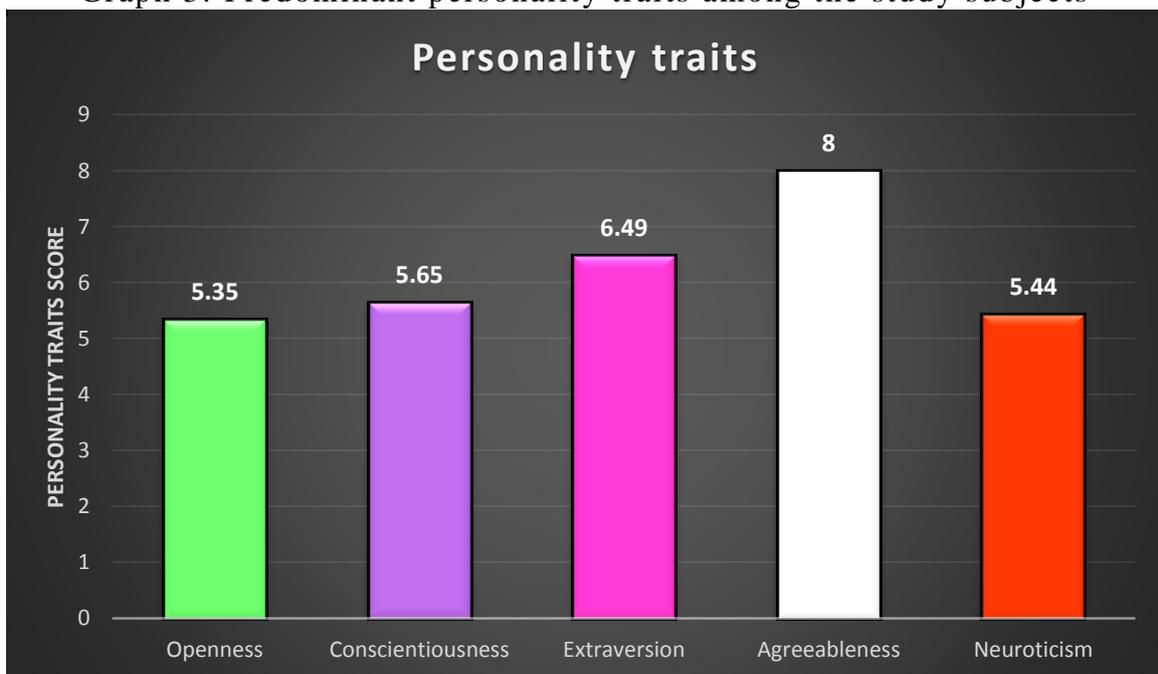
Graph 1: Demographic characteristics of the study participants based on gender



Graph 2: Dental anxiety among the study subjects



Graph 3: Predominant personality traits among the study subjects



Reporting Guidelines: The manuscript follows STROBE guideline