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Influence of parental socioeconomic characteristics on children’s dietary and oral health habits

BOSTON UNIVERSITY HENRY M. GOLDMAN SCHOOL OF DENTAL MEDICINE

MASTER'S THESIS

INFLUENCE OF PARENTAL SOCIOECONOMIC CHARACTERISTICS ON CHILDREN'S DIETARY AND ORAL HEALTH HABITS

BY

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DEDICATION

This thesis is dedicated to:

My beloved parents who have always been an endless source of inspiration and encouragement. Thank you for all your love, guidance, sacrifice and support.

To my spouse Hassan for all her love and support, and my wonderful son Ryan, I am very thankful for them being so wonderful and patient, and I promise I will make up all the time I couldn’t spend with them.

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I would like to thank my wonderful advisor, Dr. Shanmugham, for sharing his invaluable knowledge, advice and guidance. It is a true honor to have you as my advisor and mentor.

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Abstract:

The aim of this study was to investigate the relationship between parent's socioeconomic status including age, income, marital status, parent's education level, and whether they stay at home and the influence of these factors on their children's dietary habits and oral health. A total of 60 parents of children aged 1-5-years were included in this questionnaire-based study. Parents were asked to complete a self-administered paper–pencil questionnaire that included 53 items assessing different factors such as their demographic information and their children's dietary and oral health factors. Demographic information included the parent's age, income level, marital status, parents' education level, and if the parents are stay at home parents. Although parents' age, marital status, income and employment status showed no significant relationship with children's eating schedule ($p>0.05$), parents' education level and whether they stay at home significantly impacted children's eating schedule ($p<0.001$ and $p=0.02$ respectively). Most of the parental characteristics did not significantly impact the consumption of juice and sugar except for parents' education level. Sugar consumption was inversely related to parents' education level ($p=0.02$). When comparing the prevalence of dental caries in the three categories of parents' education level, children of parents with a bachelor's degree or higher reported significantly lower prevalence of dental caries among their children than parents from other educational levels

(p=0.005). The parental demographical factors showed no influence on whether the child drank from a bottle or Sippy cup for children older than 1-year-old. Also, parents' income did not have a significantly impact on children's eating habits and the level of caries. In conclusion, our results suggest a possible association between dental caries and selected parental sociodemographic characteristics. Parent's education level had a significantly positive impact on the eating schedule of their children as well as children's sugar consumption. Having stay at home parents can positively and significantly impact on adopting a healthy eating schedule among children.

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INTRODUCTION

The importance of the family environment for children's and adolescents' health behaviors has been demonstrated.[1] Previous studies have indicated that a positive family system may be part of a process that establishes and promotes beneficial health behaviors through role modelling, provision of healthy foods, and support for engaging in healthy eating behaviors.[2] The family can be considered as a system, as it is more than the sum of individuals. One relevant aspect of the family environment may be the "family health climate which is defined as the shared perceptions and cognition concerning a healthy lifestyle within a family".[3] It reflects the individual experience of daily family life, the evaluation of health-related topics, and expectations with respect to typical values, behavior routines, and interaction patterns within the family. This conceptual framework includes psychosocial concepts such as family functioning, cohesion, conflicts, communication, socioeconomic status, parental practices, and parental style. Children's ability of imitating the actions of the others and learning by observation in particular from their parents' and caregivers' could explain the kind of food styles developed.[4]

Oral health is a part of general health that is affected by various aspects of quality of life, and it affects children's overall health. Despite marked improvements over the past decades, oral health is still a significant problem, and dental caries is one of the most prevalent chronic diseases and remains a major problem worldwide.[5] Approximately 60% - 90% of school-aged children and a vast majority of adults in industrialized countries suffer from dental caries. It is a multifactorial complex disease that is caused by a complex interplay between microbial, biochemical, genetic, and environmental factors.[6] Most studies have focused on behavioral and biological risk factors for dental caries, such as the use of fluoride, dietary habits, colonization of cariogenic microorganisms, and oral health behaviors.[7,8] Environmental factors such as socioeconomic status, lifestyle, income level, culture, educational level, race, employment status, dietary patterns and schedules and other socioeconomic factors have also been reported to have a great impact on the caries-development or caries resistance in a child.[9] In recent years, social and environmental factors have shown to influence the prevalence of dental caries, particularly parent-related influences such as parents' oral health knowledge and attitudes are gaining increased attention in the prevention and control of dental caries.[10,11] Parental skills and attitudes toward oral hygiene may affect the formation of their children's oral hygiene habits and play a major role in the preservation of healthy children's teeth as well as the prevention of oral diseases.[12] It has been reported that greater attention to children's oral hygiene habits or their dental care as well as keeping their teeth healthy is associated with parents with a high educational level and sufficient income. Parents create required proper environment for healthy lifestyle, increase self-confidence, and help habit formation among children.[13,14] Globally, a number of questionnaires and educational programs to evaluate and improve the level of nutrition knowledge have been developed, mostly for use among adults.[15] A few age-specific questionnaires and nutritional counseling have also been developed for children and adolescents which showed that improving nutrition knowledge among children and young adolescents may have led them to adopt better and healthier dietary habits. [15-20] A number of these studies have examined the relationship between the dietary intake among children and the nutrition knowledge of their guardians, particularly mothers, and most suggested that higher maternal nutrition knowledge promoted a healthier dietary intake among children.[21] The main goal of the present study was to evaluate the relationship between socio-demographic and socioeconomic status of parents and the influence on children's dietary habits and oral health.

MATERIALS AND METHODS

Study design and sample size:

A total of 60 parents of children aged 1-5 years were included in this questionnaire-based cross-sectional study.

Study location:

The survey was distributed in the Boston Medical Center Department of Pediatric Dentistry dental clinic between April to June 2018.

Recruitment and participation:

Participation in this study was voluntary and a convenience sampling method was used by inviting parents to participate while waiting for their children's scheduled dental appointment. Verbal consent was obtained from parents who were interested in participating in this study. This study was approved by the Boston University Medical Center Institutional Review Board (BUMC IRB).

Study questionnaire:

Once parents provided verbal consent to participate they were asked to complete a self-administered questionnaire with 35 items that obtained information on different factors such as their demographic information and their children's dietary and oral health factors (Appendix A). The questionnaire did not collect any identifying information thus the responses were kept anonymous. Demographic information in the study questionnaire included parent's age (under 35 years old and over 35 years old), income (less than 50000,50000 and more), marital status of parents (single parent's family, two parents' family), parent's educational level (less than high school/ high school graduate/ bachelor and higher), and whether parents stay at home (yes/no). Children's dietary habits were also evaluated in the questionnaire by collecting information on the children's eating schedule (one scheduled meal, with scattered snacking throughout the day/two scheduled meals with some scattered snacking throughout the day/three scheduled meals, with scattered snacking throughout the day/ scheduled meals and snack times with no grazing).

Statistical analysis:

Statistical data analysis was performed using STATA software version 14.0. Descriptive and univariate analysis were conducted including Pearson chi-square and Fisher's-exact tests for categorical data analysis to evaluate significant differences by socioeconomic factors. The statistical significance level was set at alpha = 0.05 with p-values ≤ 0.05 deemed as statistically significant.

RESULTS

Demographic findings:

Overall parents of 24 female and 26 male children participated in this study, and the mean age of the parents was 38 years. The relationship between parents' demographical data and their children's diet and oral health habits are shown in Table 1.

Although parents' age, parents' marital status, parents' income and job status showed no significant relationship with children's eating schedule ($p>0.05$), parents' level of education and if parents stay at home appeared to significantly impact children's eating schedule ($p<0.001$ and $p = 0.02$ respectively) (Table. 1). In our study educational level appeared to affect the children's dietary habits. For instance, parents with a bachelor's degree or above reported that their children consumed scheduled meals and had least amount of snacks. The results also highlighted that having one stay at home parent could also result in a healthier diet and less snack consumption.

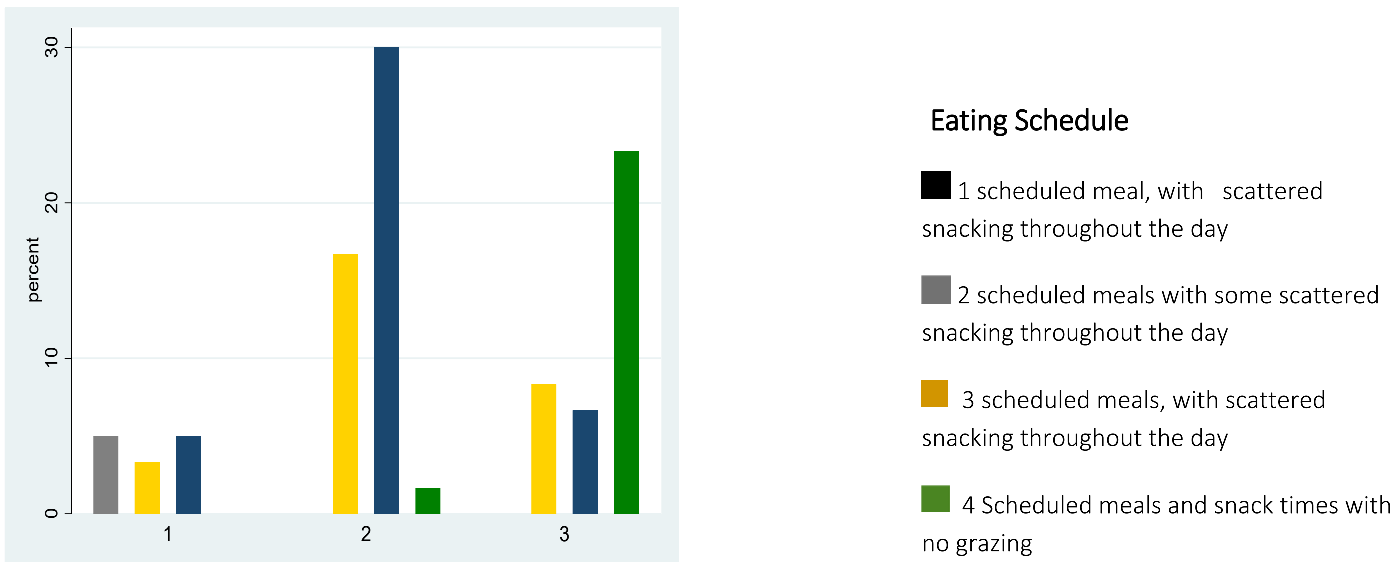
Table. 1: Relationship between parent's demographic data and their children eating schedule (n=60)

Demographic data	Eating Schedule 1	2	3	4	p-value
Parents' age					
Under 35 years (32)	0	11	13	8	0.2
Over 35 years (28)	3	6	12	7	
Parent's education					
Less than high school(8)	3	2	3	0	**<0.001***
High school graduate(2)	0	10	18	1	
Bachelor and higher(23)	0	5	4	14	
Parents' marital status					
Single parent's family	1	9	12	3	0.2
Two parents' family	2	8	13	12	
Stay at home parent					
Yes	0	6	14	12	0.02*
No	3	11	11	3	
Parent's income					
Less than $ 50000	3	15	23	12	0.67
$50000 and more	0	2	2	3	

Frequency of eating schedule patterns by parents' education level and if one or more parents stayed at home:

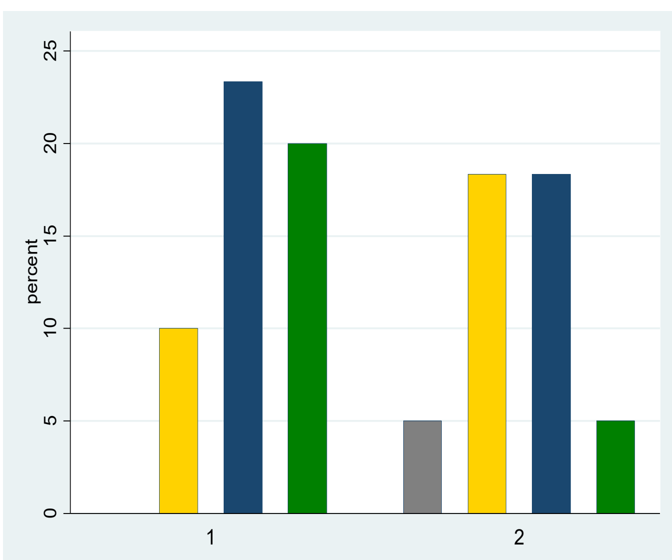
The frequency of eating schedule in four categories related to the relationship between parent's educational level and if one or more parents stayed at home is presented in Figure 1. In the family with a parent having a bachelor's degree and higher, a healthy eating schedule is more common (Figure 1A). In addition, having a stay at home parent is related to a higher frequency of having organized meals with no grazing (Figure 1B).

Figure 1 A: Children's eating schedule by parents 'education level.



1.Less than high school, 2.High school graduate/GED, 3.Associate's bachelor's degree and higher

Figure B: Children's eating schedule by having stay at home or working parents



1: stay at home parent, 2: working parents

Relationship between parent’s demographic data with children’s consumption of juice and sugar:

The relationship between parent’s demographic data and children’s juice consumption and consumption of too much sugar is shown in Tables 2 and 3. Most of the parental characteristics did not significantly impact the juice and sugar consumption except for parents’ educational level. Majority of parents regardless of their age or socioeconomic level gave juice to their children frequently. Sugar consumption showed a significant inverse relation to the parents’ educational level where parents who were educated at high school level or higher reported higher sugar consumption among their children (p=0.02).

Table. 2: Relationship between parent's demographic data with children juice consumption.

Demographic data	Consumption of Juice		p-value
	Yes n (%)	No n (%)	
Parent's age:			
<35 Year	25(56)	7(47)	0.5
>35 Year	20(44)	8(53)	
Parent's education:			
Less than high school	8(18)	0(0)	
High school	22(49)	7(47)	0.1
Bachelor and higher	15(33)	8(53)	
Stay at home parents:			
Yes	23 (51)	9(60)	0.5
No	22 (49)	6(40)	
Parent's marital status:			
Single parent family	20(44)	5(33)	0.4
Two parents family	25(56)	10(67)	
Parent's income:			
less than $ 50000	39(89)	14(93)	0.6
$50000 and more	6(13)	1(7)	

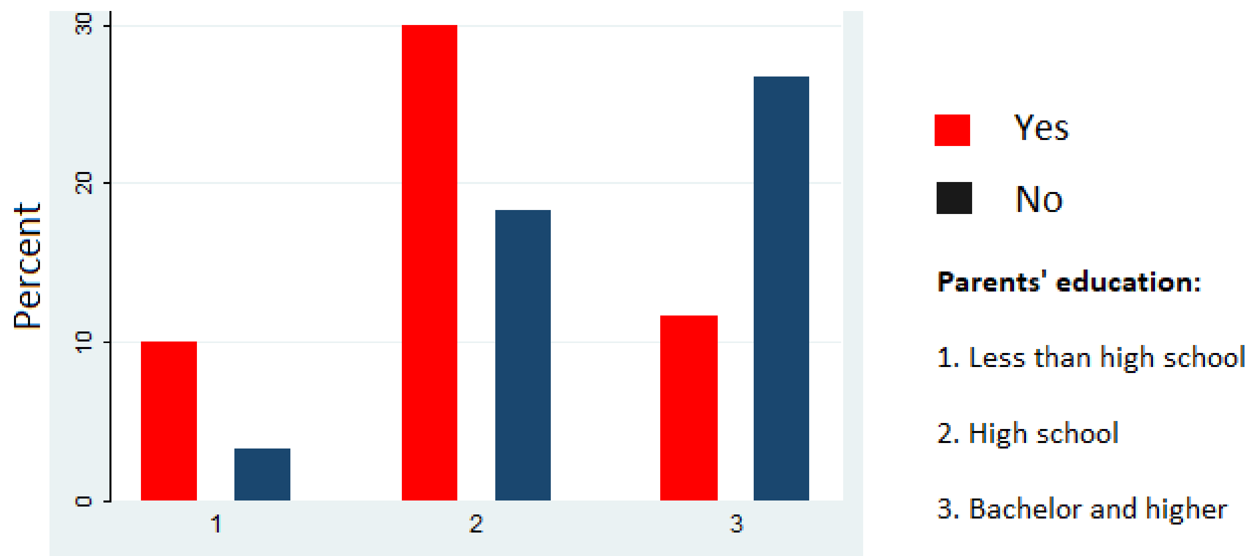
Table. 3: Relationship between parent's demographic data with children's consumption of too much sugar.

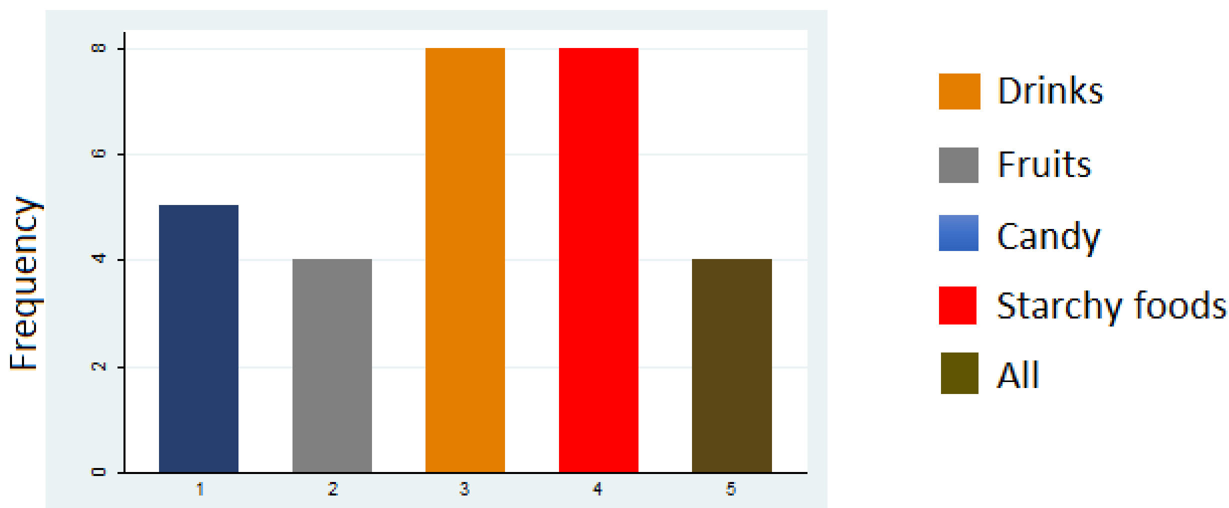
Demographic data	Consumption of Too much sugar		P value
	Yes N (%)	No N (%)	
Parent's age:			
>35Year	14(45)	18(62)	0.1
<35 Year	17(55)	11(38)	
Parent's education:			
less than high school	6(19)	2(10)	
High school	18(58)	11(35)	**0.02***
Bachelor and higher	7(23)	16(55)	
Stay at home parents:			
Yes	19(61)	13(46)	0.2
No	12 (39)	16(55)	

Frequency of children's consumption of too much sugar by parents' educational level (Table 3).

The frequency of consuming too much sugar was related to parent's educational level and this is presented in Figure. 2. The frequency of consuming too much sugar was significantly related with the family having a parent with high school degree ($p = 0.02$) (Figure. 2A). The frequency of distribution for the source of sugar showed that starchy foods and candies were the most common sugar sources for all families (Figure. 2B).

Figure. 2: (A) Frequency of children's consumption of too much sugar by parents' educational level and (B) distribution the source of sugar.





Relationship between parent's demographic data and children' habit of using bottle or Sippy cup for drinking liquids:

The parental demographical factors showed no relationship with children's drinking habits such as using a bottle or Sippy cup (Table. 4).

Table. 4: Relationship between parent's demographic data and children' drinking using bottle or Sippy cup after 1-year-old age

Demographic data	Bottle and Sippy cup		P value
	Yes	No	
Parent's age:			
<35Year	13	19	0.2
>35 Year	16	12	
Parent's education:			
less than high school	4	4	
High school	13	16	0.9
Bachelor and higher	12	11	
Stay at home parents:			
Yes	16	16	0.7
No	13	15	
Parent's marital status:			
Single parent family	13	12	0.9
Two parents family	16	19	
Parent's income:			
less than $ 50000	25	28	0.7
$50000 and more	4	3	

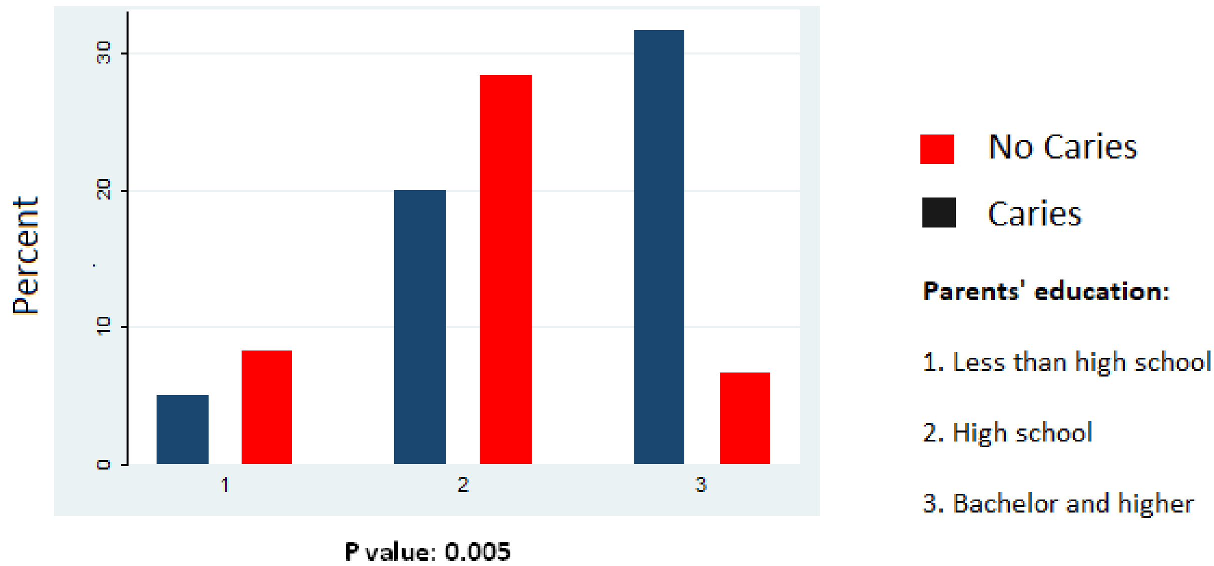
Relationship between parent's demographic data and prevalence of dental caries among their children:

The data on the relationship between parent's demographic information and the presence of dental caries among their children showed that the children who have parents with higher educational levels reported significantly lower prevalence of dental caries compared to other parents. Other parental demographic factors were not related to the children's caries status (Table. 5). The frequency of dental caries by parents' educational level showed that the children with parents who had a bachelor's or higher degree of education reported a lower frequency of dental caries among their children when compared to parents in other educational categories (p=0.005) (Figure. 3).

Table. 5: Relationship between parent's demographic data and incidence of dental caries of their children

Demographic data	Caries		p value
	Yes n (%)	No n (%)	
Parent's age:			
>35Year	15(56)	16(50)	0.7
<35 Year	12(44)	16(40)	
Parent's education:			
less than high school	5(19)	3(9)	
High school	17(65)	12(35)	**0.005***
Bachelor and higher	4(16)	19(56)	
Stay at home parents:			
Yes	13(50)	19(56)	0.6
No	13(50)	15(44)	
Parent's marital status:			
Single parent family	12(35)	13(50)	0.2
Two parents family	22(65)	13(50)	
Parent's income:			
less than $ 50000	25(96)	28(82)	0.1
$50000 and more	1(4)	6(18)	

Figure. 3: The frequency of dental caries by parents' educational level.



DISCUSSION

The aim of this study was to investigate the relationship between parent's socioeconomic status including age, income, marital status, education's level, and stay at home status of parents, and the influence on children's dietary habits and oral health. Our analysis found that the parent's educational level had a positively significant impact on the eating schedule of their children as well as children's sugar consumption. Our findings also showed that the prevalence of dental caries is inversely associated with parental educational levels. Also, the presence of at least one stay at home parent enhanced healthier eating habits among children.

Previous studies have reported that parental socioeconomic status influence dental caries in children due to varying levels of oral health knowledge and oral health practices.[22,23] The evidence from the literature suggest that parental education level in particular can significantly decrease the level of dental caries. This may be related to the higher knowledge level among parents and their increased awareness in caring for their children's teeth before the second year of life, and the maternal tooth brushing assistance for their children between the third and sixth year of life may help in preventing the occurrence of dental caries.[24,25]

Dietary habits are established early in childhood and track into adulthood.[26] The development of a child's eating habits is strongly influenced by the family, particularly the parents. As children are born without innate ability to choose a nutritious diet, they learn their food habits through experience and education.[27,28] The parents may reduce the availability and amount of foods with low nutritional value in the child's diet and support healthy food choices in various social circumstances.[29,30] In previous research, there is some inconsistency on the effect of parent's educational level on children diet. Some previous studies have reported findings that concur with our study findings that parents' higher educational level strongly impacts children's diet.[9.25] It has also been shown that children whose parents had low education levels have approximately two times the relative risk of decay compared to children who have parents with higher education levels.[16] Other studies have supported this as well where higher parent education levels were found to be positively associated with healthy eating behaviors among their school children with a decrease in the prevalence of dental caries.[6,22] In contrast to our findings, Chen et al (2018) reported that unhealthier diet among children was reported among those with parents who had higher educational level. This discrepancy can attribute to the differences in participants' characteristics and children's age range. In Chen's study school age children were included and at that age children tend to be more independent and maybe influenced by school and their classmates and peers.[31] Therefore, they may have not followed their parent's orders. Also, in Chen's study only one ethnicity was included thus the findings may pertain to only that group.

In our study, stay at home parents positively and significantly impacted having a healthy eating schedule among children. Having one stay at home parent improved children eating habits because parents might have had better control over their children's food choices and also physically spend more time with their children than working parents. This is consistent with previous evidence as well. In contrast, previous research has also reported lower prevalence of caries among employed parents. A cross-sectional study in Switzerland that included children aged 36 to 71 months showed that parental employment with higher professional level was significantly inversely associated with the prevalence of caries.[32] This was also reported in another study by Bernabé et al. (2017) which reported that having parental employment was significantly associated with lower rate of caries increment in children aged 1 to 4 years.[33] Finally, maternal employment has been reported to be associated with dental caries in Brazilian (Piovesan et al., 2010), South African (Khan et al., 1998), Japanese (Tanaka et al., 2013), African-American (Ismail et al., 2009) and Mongolian (Jigjid et al., 2009) preschool children.[34-38] In these previous studies, the findings support that children of employed parents have a lower level of dental caries which could be related to a higher level of knowledge and awareness among these parents that could have motivated their increased attention and care of their children's oral health status.

Parents' income level did not significantly impact children's eating habits and risk of caries in our present study. While several studies have investigated the relationship between parental socioeconomic factors and dental caries in children based on household income level,[6,32,34,36] the evidence has been inconsistent. A recent study confirmed that higher levels of parental household income may decrease the prevalence of dental caries in young children.[3] In other evidence children from mothers with low household income levels presented with higher decayed teeth scores.[36] While, lower household income has been significantly reported to be associated with higher risk of dental caries in children aged 0–6 years (Baggio et al., 2015; Hooley et al., 2012; Piovesan et al., 2010),[33,34,40] this is in contrast to previous findings that reported a lack of association with family's household income (Tanaka et al., 2013; Khan et al., 1998)[35,36]. Few other studies have also reported that kids of higher income families have unhealthier eating habits, however, this needs further exploration.[41] Our study was inconclusive about the effect of parent's income with children eating habits as most of our participants were low-income families and therefore there was not enough variability to detect differences between different income groups.

Parent's marital status and age showed no significant influence on the presence of dental caries among their children. This is in agreement with evidence from a previous study by Abed et al (2020) where the authors reported that parent's marital status had no impact on their children's dental caries occurrence.[42]

Overall, our study result support the potential impact of parents' socioeconomic and demographic characteristics on children's dietary patterns and presence of dental caries. Parent's education level had a significant impact on the eating schedule of their children as well as their children's sugar consumption. Having a stay at home parent positively and significantly impacted on having a healthy eating schedule in children. Further exploration in larger analytical studies may help in evaluating the effect of these factors on children dietary patterns and oral health status.

LIMITATIONS

As this is a questionnaire based cross-sectional study, there may be reporting bias, especially on questions related to poor dietary habits and income. Recall bias is also a limitation in this type of study as parents' are asked to recall their children's eating and snacking habits. As the study participants in this study were enrolled just from one clinic with the majority of the participants from low-income groups this limits the generalizability of the results. Lastly, small cell size in certain categories of the variables may have led to spurious results during data analysis.

FUTURE DIRECTIONS

There is a need for further research due to the inconsistent evidence in previous studies as highlighted in the discussion. Studies with larger sample size and higher statistical power will aid in analyzing the effect of multiple factors while controlling for confounding bias. Future research should focus on more diverse study populations which will help us to evaluate and understand the effect of socioeconomic and demographic factors including race, ethnicity, and even culture.

CONCLUSION

While there are limitations in this study, the results highlight the relationship between parental characteristics and their children's oral health status and dietary habits. Understanding the relationships between oral disease, nutritional intake and dietary behaviors is the foundation for parents' education in pediatric dentistry setting. Parental influence in the early ages can positively impact children's health status. Therefore, it is important to increase the knowledge and awareness of parents through education and counseling. Pediatric dentists can explore ways to incorporate the oral health educational and dietary counseling components into routine care services. This will in turn help in enhancing the children's oral and systemic health. Interprofessional care through collaboration with pediatrics departments and working with children's pediatrician will aid in better understanding of the dietary patterns and the collaborative effort will also help in educating parents about making positive changes in their children's dietary and oral health habits. Lastly, it is important to understand the barriers and facilitators to healthy eating among parents from low socioeconomic groups so that the providers can connect the parents to the most beneficial and appropriate resources.

APPENDIX A

BOSTON MEDICAL CENTER AND THE
BOSTON UNIVERSITY SCHOOLS OF MEDICINE,
PUBLIC HEALTH AND DENTAL MEDICINE

Research Study Title: Effectiveness of Nutritional Counseling in the Dental Clinic Setting

Baseline Questionnaire

Thank you for choosing to take part in this study. This is the first questionnaire that you complete. Please answer all questions to the best of your ability. Your answers will be kept confidential, and will in no way affect the care your child receives today. The survey will take about 15-20 minutes to complete. You may decide to discontinue participation at any time. A follow-up questionnaire will be given in 3-6 months time. If you have any questions or concerns about this study you may contact the principal investigator Dr. Jayapriyaa Shanmugham at 617-638-5038 or email jshanmug@bu.edu

Study ID number: ________________________________

1: What is your age?
1. under 25 years old
2. 26-30 years old
3. 31-35 years old
4. 35-40 years old
5. over 40 years old

2: What is your ethnicity?
1. African American
2. Asian
3. Hispanic
4. Pacific Islander
5. White
6. Other

3: What is the highest degree or level of education you have completed?
1. less than high school
2. high school graduate/GED
3. some college, no degree
4. Associate's degree
5. Bachelor's degree
6. Graduate or professional degree

4: What is your marital status?
1. single, never married
2. married
3. separated
4. divorced
5. widowed

5: Including the child here with us today, how many children do you have living in your home with you?
1. 1
2. 2-3
3. 4-5
4. more than 5 children

6: What was your average annual household income before taxes?
1. less than $25,000
2. $25,000 - $34,999
3. $35,000 - $49,999
4. $50,000 - $74,999
5. $75,000 - $99,999
6. $100,000 - $149,999
7. $150,000 or more

7: Who in the household is the main grocery shopper?
1. yourself
2. someone else
3. split equally between yourself and someone else

8: Roughly how much money per week do you spend on groceries for your household?
1. $0-99
2. $100-149
3. $150-200
4. more than $200 per week

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BOSTON MEDICAL CENTER AND THE
BOSTON UNIVERSITY SCHOOLS OF MEDICINE,
PUBLIC HEALTH AND DENTAL MEDICINE

Research Study Title: Effectiveness of Nutritional Counseling in the Dental Clinic Setting

Baseline Questionnaire

Thank you for choosing to take part in this study. This is the first questionnaire that you complete. Please answer all questions to the best of your ability. Your answers will be kept confidential, and will in no way affect the care your child receives today. The survey will take about 15-20 minutes to complete. You may decide to discontinue participation at any time. A follow-up questionnaire will be given in 3-6 months time. If you have any questions or concerns about this study you may contact the principal investigator Dr. Jayapriyaa Shanmugham at 617-638-5038 or email jshanmug@bu.edu

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7: Who in the household is the main grocery shopper?

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8: Roughly how much money per week do you spend on groceries for your household?

1. $0-99
2. $100-149
3. $150-200
4. more than $200 per week

12: Overall, do you feel you have been successful in changing your child's diet?

1. yes
2. no
3. unsure
4. haven't tried

13: Are you more conscious and concerned about the foods/snacks your child eats during the day?

1. no
2. yes
3. the same

14: Is your child still breastfeeding?

1. no
2. yes
3. never breastfed

15: If you said yes, what are your tentative plans for weaning the child?

____

16: If you said no, when did you wean your child?

1. less than 6 months of age
2. 6 months to 1 year of age
3. 1 year to 18 months of age
4. older than 18 months

17: If your child currently using a bottle or sippy cup?

1. yes
2. no

18: If you answered yes, what types of fluids are you putting in the bottle/sippy cup? Select all the apply.

1. water
2. milk
3. juice
4. soda
5. formula
6. sports drinks
7. other: ______________

19: Are you using a bottle to put your child to sleep at night and/or during the day for naps?

1. yes
2. no

20: Since your last visit, are you more conscious about the fluids in your child's bottle?

1. yes
2. no
3. about the same

21: Does your child see a pediatrician regularly?

1. yes
2. no

22: Is your child's pediatrician concerned about your child's weight or overall health?

1. yes
2. no

23: Has your child's pediatrician talked to you about healthy eating habits for your children and your family?

1. yes
2. no

24: If yes, do you feel these conversations have been helpful?

1. yes
2. no

Please explain:
____

25: If you had questions about your child's dietary health, do you know where you could find quick, reliable information?

1. yes
2. no

26: Do you feel that your child and your family are eating too much sugar?

1. yes
2. no

27: If yes, where do you think most of this sugar comes from?

1. drinks
2. fruits
3. candy
4. starchy foods (breads, pasta, crackers, cookies, etc)

28: If you could change one thing about your child's diet, what would it be?

____

29: Did you find the discussion and materials presented to you at the first clinical visit helpful?

1. yes
2. no

30: Did you learn anything new during the clinical counseling session?

1. yes
2. no

31: Did the clinical discussion and materials empower you to try changing your child's diet?

1. yes
2. no

32: Please provide any feedback you can about the clinical counseling session and/or materials you received.

____

This is the end of the follow-up questionnaire. Thank you again for participating. I truly hope you found it helpful.

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