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INFLUENCING ACCEPTABILITY OF PARENT TRAINING INTERVENTIONS  
THROUGH TREATMENT RATIONALES

by

Trisha Chase

A thesis submitted in partial fulfillment  
of the requirements for the degree

of

EDUCATIONAL SPECIALIST

in

Psychology

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Logan, Utah

2015

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**ABSTRACT**

Influencing Acceptability of Parent Training Interventions Through  
Treatment Rationales

by

Trisha Chase, Educational Specialist

Utah State University, 2015

Major Professor: Gretchen Peacock, Ph.D.  
Department: Psychology

Parent training is an effective intervention for parents of children with a variety of childhood disorders, including conduct problems, and parents often view behavioral parent training as acceptable. Explanations and rationales for parent training are commonly provided at the beginning of treatment. However, there is little research regarding rationales and how they may influence acceptability. There is also limited information on whether fathers and mothers judge the acceptability of parent training differently. The purpose of this study was to determine whether changing the description of a behavioral parenting intervention influenced parents' acceptability ratings and whether mothers and fathers differed in their ratings.

There were 78 participants (39 mother-father dyads) in this study. Participants viewed one of two descriptions of parent training that focused on either addressing deficits in parenting skills (one) or enhancing existing parenting skills (two). Parents'

acceptability of the treatment descriptions was evaluated using the Treatment Evaluation Inventory—Short Form. Participants also completed the Eyberg Child Behavior Inventory and The Parental Locus of Control Scale. A multiple linear regression and a mixed factorial ANOVA were used to analyze the data.

The results indicated that there was not a significant interaction between parent gender and parent training description type. There was also not a significant difference in the acceptability of the two parent training descriptions. However, mothers rated both treatment descriptions as more acceptable than did fathers. Results also indicated that parental locus of control significantly predicted acceptability of the parent training descriptions. The results of the current study suggested that treatment acceptability was not influenced by the way that the interventions were described. Future research should focus on how to increase acceptability of parent training for fathers and parents with an external locus of control.

**PUBLIC ABSTRACT**

Influencing Acceptability of Parent Training Interventions Through  
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by

Trisha Chase, Educational Specialist

Utah State University, 2015

Parent training is an effective intervention for parents of children with a variety of childhood disorders, and parents often view behavioral parent training as acceptable. Explanations and rationales for parent training are commonly provided at the beginning of treatment. However, there is little research regarding how rationales may influence acceptability. There is also limited information on whether fathers and mothers judge the acceptability of parent training differently. The purpose of this study was to determine whether changing the description of a behavioral parenting intervention influenced parents' acceptability ratings and whether mothers and fathers differed in their ratings.

Participants viewed one of two descriptions of parent training that focused on either addressing deficits in parenting skills or enhancing existing parenting skills. The results indicated that there was not a significant difference in the acceptability of the two parent training descriptions. However, mothers rated both treatment descriptions as more acceptable than did fathers. Results also indicated that parents' beliefs about their influence as parents significantly predicted acceptability of the parent training

descriptions. The results of the current study suggested that treatment acceptability was not influenced by the way that the interventions were described. Future research should focus on how to increase acceptability of parent training for fathers and parents who do not feel that they have control and influence over their children.

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Trisha Chase



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# **CHAPTER I**

## **PROBLEM STATEMENT**

### **Introduction**

Parent training is a treatment designed to decrease child behavior problems by teaching parents to interact more effectively with their children. Specifically, parents are taught how to reinforce their child for desired behaviors and to decrease the occurrence of undesired behaviors through consistent use of techniques such as differential attention and timeout. Parent training is an effective intervention for parents of children with a variety of childhood disorders including attention deficit, hyperactivity disorder (ADHD), anxiety, enuresis, and conduct problems. In a recent review article, parent training was classified as a “best practice recommendation” for young children with disruptive behavior problems (Silverman et al., 2008). It has also been shown to be effective with children who have developmental disabilities (McMahon & Forehand, 2003).

Historically, parent training was focused mostly on mothers. Father involvement was viewed as largely unnecessary (Lundahl, Tollefson, Risser, & Lovejoy, 2008). However, given the more recent findings on the importance of father involvement on child development, that view is no longer widely accepted (Lamb, 2010). Even as father involvement in parent training interventions has increased, the benefits that mothers and fathers receive are not equivalent. For example, one meta-analysis showed that treatment gains related to reports of improvement in children’s behaviors tended to be larger for mothers than fathers (Lundahl et al., 2008). Also, when both parents were involved,

mothers' parenting behavior improved significantly more than fathers' parenting behavior following the intervention. These results were obtained immediately following the treatment and maintained at follow up; however, the length of the follow-up period was not specified (Lundahl et al., 2008). There is concern that unsuccessful results with fathers will lead to less father involvement in parent training. Therefore, finding ways to increase fathers' meaningful participation in parent training programs may be important.

One significant issue that decreases both mother and father involvement in parent training is treatment drop out. The number of parents that drop out before parent training is completed ranges from 27% to 56% depending on the type of parent training program and the population served (Fernandez, Butler, & Eyberg, 2011; Friars & Mellor, 2007; Kazdin, 1996; Nock & Kazdin, 2005; Peters, Calam, & Harrington, 2005). Although many parent training studies do not report when parents drop out of treatment, several studies have shown that a significant percentage of participants do not even attend the first scheduled treatment session (Chacko, Wymbs, Chimiklis, Wymbs, & Pelham, 2012; Fernandez et al., 2011). Early termination of treatment might imply that the parents were not engaged in the treatment from the beginning. Socioeconomic status (SES) is the best predictor of whether parents will drop out of treatment. Low SES families are much more likely to drop out (Fernandez & Eyberg, 2009; Kazdin, 1996; Peters et al., 2005). Parents who drop out often believe that their lives are very stressful and that their child is more difficult than other children with similar disorders (Friars & Mellor, 2009). In another study, parents who dropped out of treatment were significantly more likely to endorse items on the Psychotic Distortion Scale related to pessimism and helplessness (Frankel &

Simmons, 1992). It may be that parents who have a negative view of their child and their life are less likely to become engaged with and remain in treatment.

Despite the problem of treatment drop out, parents often view behavioral parent training programs quite positively (Carter, 2007; Johnston, Hommersen, & Seipp, 2008; Reimers, Wacker, Cooper, & de Raad, 1992; Wilson & Jennings, 1996). However, some components of the program are rated as more acceptable than others. For example, parents tend to approve of strategies used to increase positive behavior more than they approve of restrictive approaches designed to decrease negative child behaviors (Calvert & McMahon, 1987; Tiano, 2008). Some studies have found that treatment acceptability varies depending on the severity of the presenting problem, the time commitment involved, and possible adverse side effects of the treatment (Kazdin, 1981; Reimers et al., 1992; Reimers, Wacker, & Koepl, 1987; Tarnowski, Rasnake, Mulick, & Kelly, 1989). Parental locus of control, or parents' explanations for children's behavior problems, is also associated with treatment acceptability of parenting interventions (Mah & Johnston, 2008). Treatment acceptability is an important area of study given that it affects treatment compliance and treatment completion (Chorpita, 2003; Stewart & Carlson, 2010). If consumers do not find a treatment acceptable they are much less likely to follow through with it (Witt, Elliott, & Martens, 1984).

Rationales for parent training are commonly provided at the beginning of a treatment program but it is not clear, based on current research, if changes in the way the clinician describes the intervention will increase acceptability. There is research that shows that using technical language when describing behavioral interventions led to less

acceptability than using more accessible language (Rolider, Axelrod, & Van Houten, 1998), but no studies have examined the influence of manipulating the attributional tone of parent training rationales. There is also limited information on whether fathers and mothers judge the acceptability of descriptions of parent training differently. The purpose of this study was to determine whether changing the description of a behavioral parenting intervention would influence parents' acceptability ratings of a treatment. Parents received one of two descriptions of parent training; one that focused on addressing deficits in parenting skills or another that focused on enhancing existing parenting skills to deal more effectively with problem behaviors exhibited by children. Parents' acceptability of the treatment descriptions was evaluated using the Treatment Evaluation Inventory—Short Form (Kelley, Heffer, Gresham, & Elliott, 1989). Differences in fathers' and mothers' acceptability judgments of the intervention were evaluated. The effect of parental locus of control and child problem severity on treatment acceptability was also examined. The specific research questions for this study were as follows:

### **Research Questions**

1. Will fathers and mothers differ in their acceptability ratings of two descriptions of parent training (one that focuses on enhancing existing parenting skills and one that focuses on addressing deficits in parenting skills) and will there be differences across the two descriptions?
2. Do other child and parent factors (e.g., child behavior severity, parental locus of control orientation) predict whether parents rate a description of parent training that

focuses on enhancing existing parenting skills as more acceptable than a treatment description that focuses on addressing deficits in parenting skills?



## **CHAPTER II**

### **LITERATURE REVIEW**

Behavioral parent training is an intervention that is designed to assist parents in actively developing their parenting skills. It is specifically targeted to decrease child behavior problems by teaching parents to interact more effectively with their children. Specifically, parents are taught how to reinforce their child for desired behaviors and to decrease the occurrence of undesired behaviors through differential attention and time-out.

The rationale behind parent training is that ineffective parenting techniques can exacerbate child behavior problems. Parents of children with behavioral problems often get caught in a negative cycle; their parenting techniques become more coercive in order to gain compliance from the child (Lorber, Felton, & Reid, 1984). There is also evidence that parents in this cycle inadvertently reinforce problem behaviors in the child. For example, a parent might smile or laugh when the child is engaging in a problematic behavior and ignore or criticize the child when he or she engages in a prosocial behavior (Barkley, 1997). Parent training addresses these ineffective parenting practices, which results in better parent-child relationships and more positive child behaviors.

#### **Description of Parent Training**

Although there are several different models of behavioral parent training, they all have similar components. Most of the models require the therapist to work primarily with the parent rather than the child (McMahon & Forehand, 2003). The techniques that

parents are taught are derived from the assumption that in order for children to develop appropriate behaviors they need to be given consistent limits and positive reinforcement for appropriate behaviors (Barkley, 1997; McNeil & Hembree-Kigin, 2010; Webster-Stratton & Hancock, 1998). Depending on the model, the techniques used to decrease problematic behavior may include selective attention, clear commands, and time-out or other response cost procedures. The techniques used to increase acceptable behaviors may consist of parental attention, specific labeled praise, and constructive play-time with the child (Barkley, 1997; McNeil & Hembree-Kigin, 2010; Webster-Stratton & Hancock, 1998).

Although there are many different types of parent training programs, this description will focus on some of the more commonly used programs that descended from Hanf's (1970) model. In these parent training programs, parents were first taught to give their child positive reinforcement. An "attend" (or descriptive statement) is one form of positive parental attention and it occurs when the parent provides a running commentary of what the child is doing (Barkley, 1997; McMahon & Forehand, 2003). For example, a parent might say to the child, "you are stacking the blocks." This is designed to give the child reinforcement for engaging in acceptable behaviors. Another form of positive reinforcement is praise. Although general praise such as "good job" is helpful, most programs promote the use of labeled praise (e.g., "Thank you for picking up your dirty clothes like I asked"; Barkley, 1997; McMahon & Forehand, 2003; McNeil & Hembree-Kigin, 2010; Webster-Stratton & Hancock, 1998). Positive physical contact, such as a hug, is also considered a reward. Parents are taught to use special games to

practice attending to what the child is doing and praising acceptable behavior. This often takes the form of a child-directed game. During the child's game, the child leads the activity and the parent follows along and attends to the child (Barkley, 1997; Briesmeister & Schaefer, 1998; McMahon & Forehand, 2003). For example, if a child is cradling a doll the parent might say, "You are holding the doll so gently." This kind of interaction is typically reinforcing for the child.

Parents are also taught how to respond to problematic behaviors that the child exhibits. One technique parents are trained to use is ignoring. When the parent ignores the child she or he does not look at the child, talk to the child, or touch the child (McMahon & Forehand, 2003; Webster-Stratton & Hancock, 1998). The parent continues to ignore the child until ten to fifteen seconds after the undesirable behavior stops. Ignoring is typically used for behaviors such as tantruming and whining. Most behavioral parent training programs promote the use of time out when a child engages in harmful behavior or fails to comply with parental direction. Time-out occurs when the child is removed from all people, places, and other stimuli that are reinforcing for him or her. The child might be placed on a chair in the corner or behind a closed door in a boring room. The child is allowed out of time out if he or she is exhibiting acceptable behaviors after the specified amount of time has passed.

Parents are also taught the importance of giving clear instructions to their child. Parents are encouraged to keep their directions brief, specific and direct. Parents can practice using clear instructions and implementing consistent consequences during the parent-directed play time. During the parent's game, the parent leads the activity and

gives commands to the child (Briesmeister & Schaefer, 1998; McMahon & Forehand, 2003). The child is expected to comply with the parent's commands. If the child does not comply, the parent will implement the techniques of ignoring and time-out as needed.

### **Outcomes of Parent Training**

The efficacy of behavioral parent training interventions has been widely studied and established (Comfort, 2005; Enebrink, Högström, Forster, & Ghaderi, 2012; Eyberg, Nelson, & Boggs, 2008; Kaminski, Valle, Filene, & Boyle, 2008; Maughan, Christiansen, Jenson, Olympia, & Clark, 2005; McCart, Priester, Davies, & Azen, 2006). Parent training is effective for parents of children with disorders such as ADHD, anxiety, enuresis, developmental disabilities, and conduct problems (McMahon & Forehand, 2003). A recent meta-analysis of 28 parent training outcome studies demonstrated an overall moderate effect ( $r = .34$ ) that supported behavioral parent training as an effective treatment for children with ADHD (Lee, Niew, Yang, Chen, & Lin, 2012). Parent training was classified as a “best practice recommendation” for young children with disruptive behavior problems (Silverman et al., 2008).

Overall, children show positive outcomes after their parents participate in parent training. A meta-analysis of the outcomes of behavioral parent training for children with disruptive behavior problems showed overall mean difference effect size estimates of  $d = .30$  for between-subjects design studies,  $d = .54$  for single-subject designs, and  $d = .68$  for within-subjects designs (Maughan et al., 2005). The authors converted these effect sizes to percentages and concluded that the average child whose parent participated in

behavioral parent training had better outcomes than 62%-76% of children whose parents did not participate in behavioral parent training (Maughan et al., 2005). Most studies show decreases in children's problematic, or externalizing, behavior after a parent training intervention (Thomas & Zimmer-Gembeck, 2007). However, one meta-analysis found that children's internalizing symptoms, such as anxiety and depression, improved more than their externalizing symptoms after a parent training intervention (Kaminski et al., 2008). It is possible that increasing parental support through more positive parent and child interactions not only improves child behavior problems but also relieves the child's internal psychological distress.

Parents may also receive benefits from participating in parent training interventions. The skills that parents gain during the training help them to increase their positive affect and warmth towards their child. Parents have been shown to be less authoritarian and hostile towards their children after participating in a parent training program (Leijten, Overbeek, & Janssens, 2012; Thomas & Zimmer-Gembeck, 2007). Parent training also decreased both the tendency of parents to overreact and to be lax when disciplining their children (Leijten et al., 2012). However, it appears that the more abstract aspects of parenting such as self-efficacy, knowledge, and attitudes may improve more than the concrete skills of parenting (Kaminski et al., 2008; Lundahl, Nimer, & Parsons, 2006). For example, in studies specifically looking at parent training for abusive parents, Lundahl and colleagues found an average mean difference effect size of  $d = 0.60$  for parents' child-rearing attitudes associated with abuse (i.e., increases in healthy child-rearing attitudes) and  $d = 0.45$  for documented abuse incidents (i.e., decreases in abuse

incidents). Another meta-analysis of parent training for disruptive behavior problems showed an average mean difference effect size for parent knowledge of 0.88, whereas the mean difference effect size for increasing positive parenting behaviors and skills and decreasing negative parenting behaviors was only 0.39 (Kaminski et al., 2008).

The benefits parents receive from parent training should be interpreted with the knowledge that parents tend to report better outcomes from parent training than do independent observers (Comfort, 2005; Maughan et al., 2005). One reason for this could be that the outcome measures completed by parents contain different constructs than the measures used by independent observers (Atkeson & Forehand, 1978; Maughan et al., 2005). Also, parents may report more positive results because they have put a significant amount of time and effort into the intervention. Despite the possible reasons for parents' positive reports, the implications are promising for parental involvement in parent training. If parents believe that parent training is producing positive outcomes for them and their child, they are more likely to persist with treatment.

The beneficial outcomes of parent training are present not only immediately following treatment but also often maintained over time (Comfort, 2005; Maughan et al., 2005; Somech & Elizur, 2012). One meta-analysis showed that the weighted effect sizes of behavioral parent training were higher at follow-up ( $d = .40$ ) than they were immediately following treatment ( $d = .30$ ) (Maughan et al., 2005). However, this finding has not been consistently supported in the literature; some studies report a moderate decrease in effect size from posttreatment to follow-up (Lee et al., 2012; Somech & Elizur, 2012). It is theorized that mediating factors such as effective parental discipline

and decreased parental distress predict whether a family maintains treatment gains or shows improvement at follow-up (Hagen, Ogden, & Bjørnebekk, 2011; Somech & Elizur, 2012).

There are several variables that seem to influence the efficacy of parent training. For example, age of the child is one of those variables. Some meta-analyses have shown that parent training is more effective with older preadolescent children than preschool and younger school-aged children. However, small sample sizes limit the generalizability of these findings (Maughan et al., 2005; Serketich & Dumas, 1996). Other studies, including research on Parent-Child Interaction Therapy (PCIT), which is directed toward younger children, have found positive effects with young children (e.g., Abrahamse et al., 2012). It is possible that various parent training models are differentially effective with children from different age groups. Overall, parent training has been proven efficacious with multiple age groups of children.

Another variable that influences the efficacy of parent training is the format of the parent training. Some research has shown that an individual format is more effective in reducing child behavior problems than a group-training format (Comfort, 2005; Lundahl, Risser, & Lovejoy, 2006; Maughan et al., 2005). This could be because of the greater attention that a parent and child receive in an individual format versus a group format. Also, a therapist involved in an individual treatment will have greater flexibility in tailoring the treatment to meet the family's needs (Lundahl et al., 2006). However, the superiority of individual format should be interpreted with caution as other studies using a group format have shown positive results (Maughan et al., 2005; Webster-Stratton,

Reid, & Hammond, 2004). The influence of treatment format may depend on the design of the study (e.g., within-subjects design versus between-subjects design; Maughan et al., 2005).

One meta-analysis parceled out what components of parent training programs contributed to better parenting behaviors and decreased child behavior problems (Kaminski et al., 2008). One of the treatment components that had a significant effect was increased positive interaction between the parent and child. Another important component to parent training programs was practice with the parent's own child during the sessions. Often when a parent practices the skills in session he or she receives feedback from the therapist. This real-time feedback may increase the parent's awareness of his or her use of positive and negative parenting behaviors. Additionally, if the parent experiences success while practicing with his or her own child in session it may increase their overall parenting self-efficacy and likelihood of following through with the techniques in the home setting.

### **Participants in Parent Training**

Mothers are typically the most involved in parent training interventions. Many parent training programs even require their involvement (Fabiano, 2007). Lundahl and colleagues (2008) went as far as saying that "Historically, parent training was synonymous with mother training" (p. 97). This is likely due to the fact that mothers traditionally completed most of the child rearing tasks. Recent research has continued to show that mothers spend more time engaged in child rearing tasks, spend more time



alone with children, and have more responsibility for their care than do fathers (Craig, 2006; U.S. Bureau of Labor Statistics, 2014). In addition to differences in the amount of time spent in child care, the types of tasks that mothers and fathers engage in with children also differ. For example, fathers spend more time recreating, educating, playing with, and talking with their children than they do participating in other types of child care (Craig, 2002, 2006). The child care activities that fathers are most involved in tend to be flexible and can be completed at the father's discretion, while the tasks that mothers are most involved in often must be performed on a schedule (e.g., feeding, bathing; Craig, 2006). Because of mothers' greater involvement in daily child care tasks, the importance of mother involvement in parent training is usually not questioned.

Fathers, on the other hand have largely been considered optional in parent training interventions. In Fabiano's (2007) review of father participation in parent training for ADHD, all of the studies included mothers but father involvement ranged from "not specified" to 87%. Although some studies "strongly encouraged" father participation in parent training, it was not required (Fabiano, 2007). Another meta-analysis found that only 16 of the 32 studies reviewed included fathers (Lundahl et al., 2008). Other studies have found even less father participation with less than half of the studies requiring father participation (Budd & O'Brien, 1982; Coplin & Houts, 1991). Even though fathers are often not required to participate in parent training interventions, there are factors that predict their participation. For example, father participation in parenting interventions increases, when mothers are more educated and there is low marital conflict (Wong, Roubinov, Gonzales, Dumka, & Millsap, 2013).

Some studies of father involvement in parent training have concluded that fathers do not increase the effectiveness of the intervention (Budd & O'Brien, 1982; Horton, 1984). However, a more recent study found that father involvement in parent training significantly improved child behavior outcomes (Bagner, 2013). The possible reasons for this discrepancy in the literature are plentiful. One study showed that even though father involvement did not affect treatment outcome immediately after the intervention, it did predict the maintenance of treatment gains at a 4-month follow-up (Bagner & Eyberg, 2003). If the effects of father involvement in parent training are most apparent at follow-up, the studies that do not include follow-up assessments (e.g., Budd & O'Brien, 1982; Horton, 1984) will likely not demonstrate a beneficial effect. Some scholars have concluded that limitations in the research base of father involvement in behavioral parent training make it difficult to determine the benefits of father involvement (Tiano & McNeil, 2005). Additionally, the impact of father involvement in parent training may depend on the child population being studied (e.g., children with developmental delays versus without delays).

Another reason that father involvement may not have increased the effectiveness of the intervention is that parent training interventions often target mothers and may not meet fathers' needs (Cruz, 2009; Fabiano, 2007; Meyers, 1993). For example, fathers tend to prefer parenting interventions that discuss how fathers positively contribute to their children's development and focus on parenting tasks that they are typically involved in (Frank, Keown, Dittman, & Sanders, 2014). It is likely that traditional parent training programs that often do not even require fathers to participate would not address these

topics. Additionally, fathers prefer parenting interventions that are presented by trained professionals and have a substantial evidence base. Although this is true of most parent training programs, it is possible that the qualifications of the professional and the research support for the program are not discussed as thoroughly as some of the other components of the program (Frank et al., 2014).

Despite fathers' historically low involvement in and questionable impact on parent training, recent research has shown that fathers are indispensable in their influence on child development (Lamb, 2010). Children who have highly involved fathers have better cognitive and socio-emotional development (Radin, 1994). A father's presence in the family can even decrease his children's risk of incarceration (Harper & McLanahan, 2004). Father involvement is also associated with a decrease in mother reported child behavior problems (Amato & Rivera, 1999). Given the positive impact that fathers have on other areas of child development, it seems best to include fathers in parent training despite the mixed results regarding their involvement.

### **Parent Training Drop Out**

Despite the overall effectiveness of parent training, there are still challenges to achieving positive outcomes for every client. One particularly salient challenge is treatment drop out. Drop out from parent training interventions is estimated to range from 27% to 56% depending on the type of parent training program and the population served (Fernandez et al., 2011; Friars & Mellor, 2007; Kazdin, 1996; Nock & Kazdin, 2005; Peters et al., 2005). Failure to complete a parent training intervention likely attenuates the

positive effects of parent training. Early drop out from treatment is particularly concerning given that the parent likely learns few skills in the short amount of time he or she is involved. One study showed that 16.9% of participants dropped out during the intake phase and did not attend any treatment sessions (Frankel & Simmons, 1992). Early drop out from a treatment might suggest that the client was not engaged or invested in the treatment from the start. Studies have shown that those with more severe symptoms or life stressors are more likely to drop out of treatment early (Aderka et al., 2011; Baruch, Gerber, & Fearon, 1998; Sonawalla et al., 2002). This finding has been replicated in the parent training literature. Parents who are facing the most difficulties in their life are the most likely to drop out of parent training throughout the intervention (Friars & Mellor, 2007). Not only do parents who drop out of treatment have more life stress, they are also more likely to think that the strategies taught in treatment will not work with their children and that their children are more difficult than others' children (Friars & Mellor, 2007).

There are several characteristics of parents who are less likely to complete a parent training intervention. The factor that has been found to best predict whether a family will complete parent training is the socioeconomic class that they are in (Kazdin, 1996; Peters et al., 2005). For each ascension parents make in social class category, they are three times more likely to complete treatment (Peters et al., 2005). The higher completion rate is probably due to the additional resources that upper class families have access to. Low income families are more likely to have scheduling problems, transportation issues, and work conflicts that increase the likelihood of them dropping out

of treatment (Holden, Lavigne, & Cameron, 1990). Additionally, single parent status, which is closely linked to socioeconomic status, also predicts increases in parent training drop out (Bagner, 2013). Age is also a factor in drop out from parent training; younger parents are more likely to drop out of treatment than are older parents (Hellenthal, 2010; Kazdin, 1996; Peters et al., 2005).

The perceptions and preconceived notions upon entering treatment are also an important determining factor in whether a family completes treatment. Parents who perceive more barriers to treatment are more likely to drop out of treatment (Kazdin, 1996). Attribution of responsibility is also an important factor in predicting treatment drop out. Mothers who attribute more responsibility to themselves for their child's behavior problems are more likely to attend more sessions and complete treatment (Peters et al., 2005). However, a tendency to blame the child for the behavior problems was not associated with attending fewer sessions. The way that treatment is presented may also affect a parent's likelihood of dropping out of treatment. Parents who were referred to a parent training study by psychologists were more likely to complete treatment than parents who were referred by psychiatrists (Peters et al., 2005). It is also important for parent training interventions to meet the expectations of parents. Parents who drop out of treatment often cite dissatisfaction with the treatment as one of the primary reasons for discontinuing (Holden et al., 1990). Although there is not a significant amount of literature on how to decrease parent training drop out, one study showed that discussing other concerns not related to parent-child interactions (e.g., health, employment) in addition to parenting, decreased the number of parents who drop out from treatment

(Prinz & Miller, 1994). More research is needed in this area to make definitive conclusions about how to reduce parent training drop out.

### **Acceptability of Parent Training**

Despite the problem of drop out from parent training, many people still perceive parent training as an acceptable treatment. Kazdin (1981) defined treatment acceptability as “judgments by lay persons, clients, and others of whether treatment procedures are appropriate, fair, and reasonable for the problem or client” (p. 493). In a study of treatments for children with ADHD, mothers were asked to rate the acceptability of hypothetical case descriptions of behavioral parent training or psychopharmacological treatment. Parent training was rated as more acceptable than psychopharmacological treatments even though the treatments were rated as equally effective. However, when mothers of children who had previously used both treatments were asked to rate their effectiveness, they rated medication as significantly more effective than behavioral management strategies (Johnston et al., 2008).

Some studies have shown that the acceptability of behavioral interventions depends on the severity of the problem being treated (D. S. Bennett, Power, Rostain, & Carr, 1996; Miller & Kelley, 1992; Reimers et al., 1992; Tarnowski et al., 1989). This finding should be interpreted with caution given that other studies have shown no relationship between problem severity and treatment acceptability (Cowan & Sheridan, 2003; Elliott, Witt, Galvin, & Moe, 1986; Tarnowski, Simonian, Park, & Bekeny, 1992; Wickstrom, Jones, LaFleur, & Witt, 1998). The influence of problem severity on

treatment acceptability may depend on the setting and ecological validity of the study. Several studies of behavioral consultation in schools found no relationship between problem severity and acceptability (Cowan & Sheridan, 2003; Wickstrom et al., 1998). Another school-based study looked at children's acceptability ratings for interventions with misbehaving peers. Again, they found no relationship between problem severity and acceptability (Elliott et al., 1986). In one study of treatments for child behavior problems parents rated the acceptability of positive reinforcement, time out, or medication for either a mild severity problem behavior case description or severe problem case description. Parents rated positive reinforcement and time-out as more acceptable for the less severe behavioral problem and medication as more acceptable for the more severe problem. This finding was replicated when the parents were asked to rate the acceptability of a positive reinforcement treatment recommended to them for use with their own children. Parents of children who had less severe behavioral problems rated the positive reinforcement procedures as more acceptable (Reimers et al., 1992). It is possible that parents view medication as more effective than behavioral interventions and thus, they believe that medication is a more acceptable way to treat severe behavior problems. A study of children with ADHD found that mothers' and fathers' acceptance of counseling was positively correlated with child externalizing behaviors. Parents who rated their children as more aggressive and disruptive were more accepting of counseling for their child (D. S. Bennett et al., 1996). More research is needed to determine with certainty whether problem severity affects treatment acceptability.

Mothers and fathers often differ in their views of the acceptability of various

parenting strategies (Borrego, Ibanez, Spendlove, & Pemberton, 2007; Tiano, 2008).

Mothers tend to view response cost strategies, room time out, and positive reinforcement as significantly more acceptable than fathers (Miller & Kelley, 1992; Tiano, 2008).

However, fathers view medication and spanking more favorably than mothers (Borrego et al., 2007; Miller & Kelley, 1992; Tiano, 2008). These differences may be due to the influence of gender role stereotypes which dictate that fathers be “tough” on their children. Additionally, at least one study has shown that fathers view the parent training program as a whole, as less acceptable than mothers (Tiano, Grate, & McNeil, 2013). However, this study looked at one specific type of parent training known as parent-child interaction therapy and it is not clear if this finding is consistent for all parent training programs.

Additionally, parents’ culture may also impact acceptability of parent training interventions. In ethnic minority samples, acculturation may impact the acceptability of treatments. A study with Mexican American parents showed that acculturation did not affect mothers’ ratings of the acceptability of child management techniques but it did impact fathers’ ratings. Fathers who were more acculturated viewed token economy systems as more acceptable than less acculturated fathers (Borrego et al., 2007). In contrast, another study found that less acculturated fathers were more likely to participate in a parenting intervention (Wong et al., 2013); although participation is not necessarily synonymous with acceptability it is an indicator of an individual’s perception of an intervention. In addition to acculturation, the impact of ethnicity on parent training acceptability has also been examined. Some research has shown that acceptability of



parent training interventions is not affected by ethnicity (Morawska et al., 2011).

Culturally adapted interventions may also influence the acceptability of parent training. Although an extensive review of cultural adaptations of parent training is outside the scope of this project, a brief summary will be given here. Culturally adapted parent training interventions have been created to increase utilization of services by culturally diverse groups. Although culturally adapted parent-training interventions may appeal to culturally diverse parents and be rated as acceptable (Beasley et al., 2014), they have not been shown to significantly outperform standard evidence-based parenting interventions on child externalizing behavior outcomes (McCabe, Yeh, Lau, & Argote, 2012; Ortiz & Del Vecchio, 2013). It may be that other aspects of diversity, such as socioeconomic status or parent age, are more influential in acceptability and effectiveness of parent training interventions (Ortiz & Del Vecchio, 2013; Tiano et al., 2013).

It is important to understand the variables that influence treatment acceptability because it is theorized to affect treatment use and treatment integrity. This in turn is hypothesized to affect treatment effectiveness (Eckert & Hintze, 2000; Reimers et al., 1987). These theories are largely based on logical conclusions, as there are limited empirical data to support them. The available research is unclear as to whether treatment acceptability affects adherence to treatment. Reimers and colleagues (1992) found that parents reported more compliance with a treatment that they initially rated as most acceptable. However, this finding was directional, indicating that compliance early in treatment led to more acceptability at follow-up. They also found that acceptability ratings influence parents' views of the effectiveness of a treatment; with parents reporting

higher levels of effectiveness and more positive behavior change in treatments they rated as highly acceptable (Reimers et al., 1992). A study of parents of children with ADHD found that parents' acceptability endorsements at intake were not predictive of follow-through with the recommended counseling and medication treatments at follow-up (D. S. Bennett et al., 1996). However, considerable research has also shown that treatment acceptability or consumer satisfaction with parent training is related to child behavior improvement post-treatment (Brestan, Jacobs, Rayfield, & Eyberg, 1999; MacKenzie, Fite, & Bates, 2004). More research is needed to make a conclusion on whether treatment acceptability affects treatment outcome. It may be that when parents invest time and energy into a treatment that they believe is effective they are more likely to report that it is an acceptable treatment in order to make their beliefs and actions consistent.

Parent training programs commonly provide rationales to parents at the outset of treatment, which are intended to help increase parent "buy-in" (or acceptability) of the intervention. For example, in parent-child interaction therapy, parents are told that they are not responsible for their child's problems but they have the power to resolve the problems. They are then given an explanation of "specialized parenting" which includes the idea that very difficult children require a special kind of parenting to effectively manage their challenging behaviors (McNeil & Hembree-Kigin, 2010). Other parent training programs do not explicitly state how they describe their program to parents but they do note the importance of using a supportive and facilitative style rather than being confrontational (Barkley, 1997). Although the rationale of the parent training program is an important component of treatment, it is not known whether changing the description of

a parent training program can influence parents' acceptability of treatment.

### **Parental Locus of Control**

Parental locus of control is another factor that may influence acceptability of parent training interventions. Locus of control is a belief about the extent to which one can control his or her environment. An internal locus of control is defined as a belief that the outcomes experienced by an individual are due to his or her behaviors or characteristics. An external locus of control is defined as a belief that outcomes are due to luck, chance, or powerful others (Rotter, 1966). Parental locus of control is defined as parents' sense of control over and responsibility for their child's behavior (Campis, Lyman, & Prentice-Dunn, 1986). Parents who have an internal locus of control believe that their child's behaviors are determined by their parenting efforts while parents who have an external locus of control believe that their child's behaviors are due to forces outside of their control (Freed & Thompson, 2011).

There is a clear relationship between child behavior and parent perceived control. Parents who had infants who displayed negative emotionality and irregular sleeping and eating schedules perceived themselves as having less control when the child was older. This was also true for parents whose toddlers displayed acting out behaviors (Hagekull, Bohlin, & Hammarberg, 2001). Additionally, parents who have an external locus of control tend to have children with more problem behaviors (Hagekull et al., 2001; Roberts, Joe, & Rowe-Hallbert, 1992). There is evidence that this relationship is bidirectional with child behavior problems predicting an increase in parental external

locus of control (Freed & Tompson, 2011) and external locus of control predicting greater child behavior problems (Freed & Tompson, 2011; Tone, Goodfellow, & Nowicki, 2012). For example, one longitudinal study found that fathers with an external locus of control orientation, measured prenatally, had children with more behavior problems 7 years later (Tone et al., 2012).

Parental locus of control tends to follow predictable patterns. For example, mothers' locus of control tends to be more external than fathers. This is evident in both parents experiencing typical levels of stress and parents experiencing high levels of stress (Rubinstein, 2004). This is consistent with literature from the broader gender literature, which shows that men tend to attribute their success to internal factors and their failure to external factors while women tend to attribute their success to external factors and their failure to internal factors (Deaux, White, & Farris, 1975; Nicholls, 1975; Rubinstein, 2004). There is also evidence that a parent's locus of control impacts parental stress. Parents who have an external locus of control experience more parenting stress and stress in other areas of their lives than parents who have an internal parenting locus of control (Hassall, Rose, & McDonald, 2005; Lanfranchi & Vianello, 2012). Thus, an internal parenting locus of control leads to less parental stress and improved child behavior (Hassall et al., 2005; Tone et al., 2012).

Parental locus of control impacts parenting behaviors and can be influenced by parenting interventions. Parents who participated in parent training to manage the behavior of their children with oppositional behaviors developed a more internal locus of control by the end of the intervention (Roberts et al., 1992). In another parent training

study, the researchers found that parental attributions predicted parenting style. For example, attributions about the degree to which the child could control his/her behavior predicted parental verbosity, which is the tendency for parents to use lengthy verbal explanations to control the child's behavior. This relationship was such that the more control parents felt the child had over his or her behavior before treatment, the less they demonstrated parental verbosity after treatment. In the same study the researchers found that parents who attributed their child's behavior to factors outside the child's control, demonstrated less parental overreactivity after treatment (Whittingham, Sofronoff, Sheffield, & Sanders, 2009). This study also demonstrated that parental control attributions did not significantly predict treatment outcome (child behavior) but attributions were altered by participation in the program. Following participation in the study, parents were less likely to believe that the cause of their child's behavior problems were internal (child disposition) and more likely to believe that the child's behaviors were due to situational factors. This shift in attribution is consistent with the assumptions of behavioral parent training strategies.

The shift in attribution is important because it has been hypothesized that a mismatch between parental attribution of child behavior problems and the basis of behavioral parent training leads to lower acceptability of the treatment (Mah & Johnston, 2008). Parents with an external locus of control are likely to find parent training less acceptable because they do not think that their behavior is contributing to the child's problems. Parents with an internal locus of control will find parent training strategies that target their management of the child's behavior more acceptable since they believe they

have an influence over their child's behavior (Mah & Johnston, 2008).

### **Summary**

Parent training is an effective treatment for children with behavior problems that is often viewed positively by mothers and fathers. The rationales provided at the beginning of parent training interventions offer an opportunity to increase parents' acceptability ratings of the treatment. The purpose of this study is to determine whether changing the description of a hypothetical behavioral parent training program will influence fathers' and mothers' acceptability of the treatment. The influence of parental locus of control and the severity of a child's behavior problems on mothers' and fathers' acceptability of the treatment will also be examined. If treatment rationales can increase parental acceptability of parent training interventions, treatment drop-out may decrease and parents may be more engaged in treatment. Also, if parents find a treatment more acceptable they are more likely to have positive outcomes for themselves and their children (Brestan et al., 1999; MacKenzie et al., 2004; Reimers et al., 1992).

## CHAPTER III

### METHODS

#### Participants

There were 78 participants (39 mother-father dyads) in this study. Participants were required to have their spouse, partner, or coparent complete the survey and have a child between the ages of 2 and 12. The family characteristics, as reported by mothers, are shown in Table 1. The participants were mostly the biological parents of the child on whom they were completing the measures (97.4%,  $n = 38$ ). Most of the children were

Table 1

#### *Family Characteristics*

Variable	Mean	SD	%	<i>n</i>
Number of children per family	3.00	1.26		
Child age	4.83	3.08		
Marital status				
Married			87.2	34
Divorced/remarried			12.8	5
Income				
< \$15,000			10.3	4
\$15,000 - \$30,000			23.1	9
\$30,000 - \$45,000			12.8	5
\$45,000 - \$60,000			10.3	4
\$60,000 - \$75,000			20.5	8
> \$75,000			20.5	8
Child gender				
Female			61.5	24
Male			38.5	15
Child race/ethnicity				
White/Caucasian			94.9	37
Other			5.1	2
Child mental health services				
Yes			10.3	4
No			38.7	35

white/Caucasian and the majority of the children were female. Most of the participants reported that their child had never received mental health services or medication for mental health concerns. Mother and father characteristics are shown in Table 2. The majority of the participants were married and most were members of The Church of Jesus Christ of Latter-day Saints (LDS; a religious group prominent in Utah). The majority of the sample had either some college or bachelor's degrees.

### Measures/Materials

Participants were asked to complete a basic demographic form that included

Table 2

#### *Mother and Father Characteristics*

Variable	Mothers				Fathers			
	Mean	SD	%	<i>n</i>	Mean	SD	%	<i>n</i>
Age	31.92	6.32			34.90	8.30		
Race ethnicity								
White/Caucasian			97.4	38			89.7	35
Asian/Asian—other			2.6	1			0.0	0
Native American/Native American—other			0.0	0			5.1	2
Black/African American/Black/African American—other			0.0	0			2.6	1
Latino/Hispanic			0.0	0			2.6	1
Religion								
LDS			74.4	29			71.8	28
Other			15.4	6			17.9	7
Atheist/Agnostic			7.7	3			5.1	2
Protestant			2.6	1			5.1	2
Education								
High school graduate (GED)			12.8	5			12.8	5
Some collage/trade school/associate degree			59.0	23			43.6	17
College graduate/bachelor's degree			25.6	10			23.1	9
Graduate or professional degree			2.6	1			20.5	8
Received mental health services for self			48.7	19			23.1	9
Attended parenting classes			48.7	19			30.8	12



questions about their relationship to the child, gender, race/ethnicity, age, religion, marital status, income, and education attained (see Appendix A). Parents were also asked how many children they had, whether they had ever participated in parenting classes, received mental health services, and whether their child has ever received mental health services or medication for behavioral or mental health issues.

Two different descriptions of parent training were used in this study. The descriptions were one paragraph in length and were presented to the participants electronically, along with the other measures, on Qualtrics (see Appendix B). The two descriptions differed in the way that the intervention was presented to the parents. The deficit description focused on parents' contributions to the child's behavior problems and how parents can improve their deficits in parenting skills. The empowerment description focused on empowering parents to resolve the behavioral problems and explaining that some children are more difficult to parent due to temperament and other extraneous factors.

Prior to the study, the two parent training descriptions were piloted with a small undergraduate psychology class to determine if the students perceived differences in the two descriptions. Five students read and evaluated the deficit description and five different students read and evaluated the empowerment description. The results of the pilot administration were mixed but provided some support for the descriptions as conceptualized. Three of the five participants who read the deficit description felt that it was focused on both remediating poor parenting skills and enriching parents' existing skill set. One felt that it focused only on remediating poor parenting skills and another

felt that it focused solely on enriching parents' existing skill sets. The participants were also asked to evaluate the description based on the message it conveyed about who is responsible for children's behavior problems. Four of the five participants stated that the deficit description attributed more responsibility to the parent. All five of the participants felt that the empowerment description focused on both remediating poor parenting skills and enriching parents' existing skill set. Three of the five participants stated that the empowerment description attributed more responsibility to the parents; one stated that it attributed more responsibility to the child, and one felt that it attributed responsibility to both the parents and the child equally. Despite these results from the pilot study, the researchers decided to proceed with the current descriptions. The researchers concluded that if the descriptions were further polarized the study would lose its relevance and generalizability because it is unlikely that the descriptions would resemble something that a clinician would actually say to parents seeking treatment.

To assess the acceptability of the hypothetical parent training interventions the Treatment Evaluation Inventory—Short Form (TEI-SF) was used (Kelley et al., 1989). The TEI-SF was adapted from Kazdin's (1980) Treatment Evaluation Inventory (TEI) with the goal of creating a shorter and simpler measure. The TEI is a measure of the acceptability of treatments for children with behavior problems. A factor analysis was conducted by Kelley and colleagues using the 15 original TEI items and it yielded two factors: acceptability and ethical issues/discomfort. The six items with the highest loading on acceptability and the three items with the highest loading on ethical issues and discomfort were selected for the short form version. Respondents were asked to rate

items such as “I like the procedures used in this treatment” and “I would be willing to use this procedure if I had to change the child’s problem behavior” on a 5-point Likert scale with 5 representing strongly agree and 1 representing strongly disagree. Scores can range from 9 to 45 (Kelley et al., 1989). The TEI-SF total score was used in this study.

The TEI-SF is quicker to complete and easier to understand than the original TEI. This led to the TEI-SF being preferred by 71% of participants (Kelley et al., 1989). Both the TEI and the TEI-SF have adequate internal consistency reliability with coefficient alphas of .89 and .85 respectively (Kelley et al., 1989). This means that the less cumbersome and more accessible version of the measure does not have substantially reduced reliability. In the current study Cronbach’s alpha for the TEI-SF was .80. One study found that compared to the TEI the TEI-SF may be biased due to overestimating the acceptability of reinforcement and underestimating the acceptability of more punitive strategies (Spirrison & Noland, 1991). Despite this finding, the TEI-SF is used more often than the TEI in applied clinical research (Finn & Sladeczek, 2001).

The Eyberg Child Behavior Inventory (ECBI) was used to measure the frequency of externalizing behavior problems in the children of the parents who participated in this study. This measure was designed to be used with children ages 2 to 16. The inventory contains 36 items that measure both the intensity of the disruptive behavior and whether parents perceive it as problematic (Funderburk, Eyberg, Rich, & Behar, 2003). The intensity scale raw score was used in the current analyses. Intensity scale raw scores can range from 36 to 252. The raw scores can also be converted to standardized *T* scores, which range from 33 to 94. Raw scores above 131 (*T* scores above 60) are considered

clinically significant. Test-retest reliability of the ECBI over ten months is .75 (Funderburk et al., 2003). The ECBI scales are highly correlated with the Child Behavior Checklist Externalizing scale, which demonstrates concurrent validity (Boggs, Eyberg, & Reynolds, 1990). The Internal consistency coefficient reported in the ECBI professional manual is .95 for the Intensity scale (Eyberg & Pincus, 1999). In the current study, the Cronbach's alpha for the ECBI Intensity scale was .93.

The Parental Locus of Control Scale (PLOC) was used to measure whether parents are more internal or external in their locus of control orientation. This measure was initially tested using parents of elementary school-aged children. The original scale contained 47 items, however the authors recommended omitting one item that was commonly misinterpreted (Campis et al., 1986). The items were rated on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). The scale contains five subscales: parental efficacy, parental responsibility, child control, fate/chance, and parental control. Scores can range from 47 to 235, with higher scores representing a more external locus of control. The total scale score was used in the current study. The analyses in this study were conducted using both the PLOC total score and the PLOC total score with the suggested item omitted. There were no statistically significant differences in the results of the analyses so all 47 items were retained. In this study, the wording was changed slightly on four of the items to increase clarity and remove regional colloquialisms. The total scale reliability coefficient for the PLOC is .92. Another analysis showed that subscale alpha coefficients range from .62 to .79. Discriminant validity was demonstrated in that parents who had previously requested services for

parenting problems endorsed a more external locus of control than parents who had not reported difficulties with parenting (Campis et al., 1986). In the current study the Cronbach's alpha for the PLOC total scale was .87.

### **Procedures**

University IRB approval was obtained prior to recruiting participants for this study. All study materials were available online using the Qualtrics survey platform website. The Qualtrics website included a letter of information describing the study (see Appendix C), the demographics questionnaire, a description of a parent training intervention, the TEI-SF, the ECBI, and the PLOC. The anticipated sample size was 68 mother-father dyads (see data analysis section for power analyses). Participants were recruited from main campus classes at a state university, from the university's regional campuses, from the university's online courses, which are delivered across state lines, and from the community. During recruitment, fliers were posted in the community with removable tabs containing contact information for the researcher. Fliers were also posted on the university campus and distributed in university classrooms. Additionally, information about the study was posted on the online research participation site associated with the university and sent out to local family-oriented internet groups. Overall, 35.9% ( $n = 28$ ) of the sample was recruited from the University, 14.1% ( $n = 11$ ) of the sample was recruited from the community, and 50.0% ( $n = 39$ ) of the sample was recruited by their partner or spouse.

The fliers included instructions for interested participants to email the student

researcher. Eligibility for the study was confirmed by the student researcher via email by asking if the interested participants had a spouse, partner, or coparent who would participate in the study and a child between the ages of 2 and 12. After participants confirmed their eligibility, they were sent a link via email that directed them to the password-protected survey. Participants were given instructions to access the survey and were instructed to share the link with their partners or spouses. Upon entering the survey, participants created a unique code using their wedding date, first two letters of the female partner's first name, and the male partner's day of birth. This allowed the researchers to match both partner's data without identifying them.

There were 126 individuals that participated in the study; however, only the data from 78 participants (39 matched mother-father dyads) were included in the analyses. There were 48 participants whose data was not included in the analyses for various reasons including the participant's partner not participating ( $n = 22$ ), partners completing the measures on different children ( $n = 14$ ), same-sex couple status ( $n = 2$ ), incomplete surveys ( $n = 4$ ), and outlier status ( $n = 6$ ).

Prior to entering the survey, participants were randomly assigned to receive one of the two parent training descriptions, with partners receiving the same treatment description. Of those who were included in the final analysis, 20 mother-father dyads viewed the deficit description and 19 mother-father dyads viewed the empowerment description. All of the participants were instructed to complete the measures on their youngest child between the ages of 2 and 12. This ensured that bias was not introduced through parents selecting the child they felt had the most or the least behavioral

problems. The presentation of the measures was counter balanced to control for potential order effects (see Appendix D). At the end of the survey, participants were directed to another survey for the purpose of distributing incentives. Their responses on the incentive survey were not linked to their responses on the research survey. If they were enrolled in a university class that offered extra credit for research participation, they were given the option to submit their name, the name of the course they were enrolled in, and their instructor's name. If they were not enrolled in such a class, they were given the option to enter their email address to either receive a \$5 gift certificate ( $n = 39$ ) or enter a drawing for one of four \$25 gift certificates ( $n = 46$ ).

### **Data Analysis**

A mixed factorial ANOVA was used to answer the first research question in this study with parent gender (mother or father) serving as the within-subjects variable and parenting description type serving as the between subjects independent variable. The dependent variable was the TEI-SF total score. A variety of demographic variables that could have an impact on treatment acceptability were evaluated as possible covariates in order to answer the second research question. The severity of the child's behavior problem, total scores on the PLOC, gender of the child and parent, age of the child and parent, and number of children in the family were explored as covariates in the analysis. The only variable that was significantly related to the TEI-SF Total score was scores on the PLOC. However, PLOC scores could not be included as a covariate because the assumption of homogeneity of regression slopes was violated. Because the assumptions

of ANCOVA were violated, a regression analysis was conducted to determine the relationship between the PLOC and the TEI-SF rather than using it as a covariate. A priori power analyses were conducted using the G\*power 2 program. For the mixed factorial ANOVA interaction analysis the default effect size ( $f = 0.25$ ) was used, power was set at 0.8 and alpha was set at .05; the required sample size was determined to be  $n = 34$ . For the regression analysis, the default effect size ( $f^2 = 0.15$ ) was used, power was set at .80 and alpha was set at .05; the required sample size was determined to be  $n = 68$ .



## CHAPTER IV

### RESULTS

#### Preliminary Analyses

Means and standard deviations were calculated for all of the measures included in the study. A visual inspection of a boxplot graph of TEI-SF scores reveals that there were three outliers with exceptionally low acceptability ratings. These three outliers and their partners were removed from all analyses. The means and standard deviations for the TEI-SF are contained in Table 3. The descriptive statistics for the ECBI and PLOC are displayed in Table 4. The mean ECBI Intensity score for both mothers and fathers was within the normal range, which means that on average parents in this sample did not have children with clinically significant behavior problems.

The bivariate Pearson correlations between the measures are presented in Table 5. There was a statistically significant negative correlation ( $p < .001$ ) between the TEI-SF and the PLOC such that an external locus of control was associated with lower acceptability ratings of the parent training descriptions. There was also a statistically significant positive correlation ( $p < .001$ ) between the ECBI and the PLOC such that

Table 3

#### *Descriptive Statistics for TEI-SF*

Variables	Mothers			Fathers			Total		
	<i>M</i>	<i>SD</i>	Range	<i>M</i>	<i>SD</i>	Range	<i>M</i>	<i>SD</i>	Range
Deficit description	36.00	4.51	26 - 43	33.25	3.95	26 - 42	34.63	4.41	26-43
Empowerment description	35.05	4.53	27 - 43	34.00	3.97	26 - 41	34.53	4.24	26-43

Table 4

*Descriptive Statistics for ECBI and PLOC*

Variables	Mothers ( <i>n</i> = 39)			Fathers ( <i>n</i> = 39)			Total ( <i>N</i> = 78)		
	<i>M</i>	<i>SD</i>	Range	<i>M</i>	<i>SD</i>	Range	<i>M</i>	<i>SD</i>	Range
ECBI total raw score	108.21	26.85	60 - 179	118.54	29.68	61 - 180	113.37	28.60	60-180
ECBI total <i>t</i> score	53.31	7.61	40 - 73	56.15	8.40	40 - 74	54.73	8.09	40-74
PLOC score	110.23	15.89	82 - 150	107.59	16.70	71 - 134	108.91	16.25	71-150

Table 5

*Bivariate Pearson Correlation Matrix for Study Measures*

Measures	1	2	3
1. TEI-SF	—		
2. ECBI total raw score	-.073	—	
3. PLOC total score	-.442**	.394**	—

\*\* Significant at the .01 level (2-tailed).

higher levels of child behavior problems were associated with a more external parental locus of control.

### **Mothers' and Fathers' Treatment Acceptability**

A mixed factorial ANOVA was conducted to address the first research question of whether fathers and mothers differed in their acceptability ratings across the two treatment description types as measured by scores on the TEI-SF. There was not a significant interaction between parent gender and parent training description type,  $F(1, 37) = 1.12, p = .296, \eta^2 = .029$ . The post hoc statistical power analysis for the interaction

effect indicated that power was 0.44. There was a significant main effect for parent gender,  $F(1, 37) = 5.64, p = .023, \eta^2 = .132$  which suggests that mothers and fathers differed in their judgments of the acceptability of the parent training descriptions. Mothers rated both descriptions as more acceptable than did fathers (see Table 3). The statistical power for this analysis was 0.98. There was not a significant main effect for parent training description type,  $F(1, 37) = .008, p = .929, \eta^2 = .000$ , which suggests no difference in the acceptability of the deficit description and the empowerment description. The statistical power for this analysis was .05, which is reflective of the 0 effect size for this analysis.

### **Prediction of Treatment Acceptability**

A linear regression was conducted to examine the relationship between parental locus of control scores and treatment acceptability. A visual inspection of the residual versus fit plot was conducted and the data appeared to be linear. Prior to running the regression analysis, paired sample  $t$  tests were conducted to examine the difference between mothers and fathers' scores on the PLOC and the ECBI. There was a significant difference between mothers and fathers on the ECBI ( $t = 2.35, p = .024$ ). There was not a significant difference between mothers and fathers on the PLOC ( $t = -.882, p = .384$ ). The regression analysis was run separately for mothers and fathers due to the significant difference on the ECBI scores. Post hoc power analyses indicated that power was .84 for the regression for mothers and .97 for the regression for fathers. The results of the regression analysis are contained in Tables 6 and 7.

The PLOC Total score and ECBI raw score were entered into the regression equation using the enter method. For fathers, the regression equation significantly predicted TEI-SF scores:  $F(2, 36) = 8.85, p = .001; R^2 = .33$ . However, the PLOC score was the only significant predictor ( $t = -4.20; p < .001$ ; see Table 6). For mothers, the regression equation also significantly predicted TEI-SF scores:  $F(2, 36) = 5.34, p = .009; R^2 = .23$ . Again, the PLOC score was the only statistically significant predictor ( $t = -3.26, p = .002$ ); however, there was a trend towards higher ECBI scores predicting higher TEI-SF scores ( $t = 1.84, p = .074$ ; see Table 7).

Table 6

*Linear Regression Analysis of TEI-SF Scores for Fathers*

Variable	<i>B</i>	<i>SE B</i>	$\beta$	<i>t</i>	<i>p</i>
PLOC	-.14	.03	-.59	-4.20	< .001
ECBI	.01	.02	.11	.77	.447

Table 7

*Linear Regression Analysis of TEI-SF Scores for Mothers*

Variable	<i>B</i>	<i>SE B</i>	$\beta$	<i>t</i>	<i>p</i>
PLOC	-.17	.05	-.60	-3.26	.002
ECBI	.06	.03	.34	1.84	.074

## **CHAPTER V**

### **DISCUSSION**

Although parent training is a well-established treatment for child behavior problems, there is a high dropout rate from treatment (Fernandez et al., 2011; Nock & Kazdin, 2005; Silverman et al., 2008). Examining ways to further increase acceptability of parent training is an important area of study because greater acceptability is associated with treatment compliance and treatment completion (Chorpita, 2003; Stewart & Carlson, 2010). Previous research examined the relationship between treatment acceptability and various aspects of treatment such as problem severity, time commitment required, and possible adverse side effects (Kazdin, 1981; Reimers et al., 1992), but there was a dearth of research on the topic of increasing treatment acceptability through treatment rationales presented at the outset of parent training (Mah & Johnston, 2008). There was also limited research on whether mothers and fathers differ in their judgments of the acceptability of parent training.

The purpose of the current study was to determine if changing the way parent training is presented to parents affects their acceptability ratings of the treatment. Specifically, this study aimed to determine if parents differed in their acceptability ratings of two distinct treatment descriptions and if mothers and fathers differed in their acceptability ratings of the parent training descriptions. Another purpose was to determine whether locus of control and/or parent-reported child behavior problems would predict acceptability of parent training interventions. Mothers and fathers were asked to independently rate their child's behavior problems using the ECBI and rate their locus of

control orientation using the PLOC. Mother and father dyads were randomly assigned to read one of two brief descriptions of parent training. The deficit parent training description stated that poor parenting skills contribute to child behavior problems and parent training is intended to ameliorate those deficits. The empowerment parent training description stated that some children are more difficult to manage and parent training will enhance parents' existing management skills. The participants rated the acceptability of the descriptions using the TEI-SF.

### **Mothers' and Fathers' Acceptability Ratings of Parent Training Descriptions**

The influence of parent gender and treatment description on the acceptability of parent training was examined. There was not a significant interaction between parent gender and parent training description type. There also was not a significant difference in the acceptability between the empowerment and the deficit descriptions. However, there was a significant difference in mothers' and fathers' acceptability ratings, with mothers rating the parent training descriptions as significantly more acceptable than did fathers. Lower acceptability in fathers could be due to several factors including dislike of the techniques used in behavioral parent training, a mismatch between the structure of the intervention and father's needs, and a belief that their behavior management skills do not require intervention.

The first possible explanation for lower acceptability of the parent training package in fathers is consistent with findings from previous research that fathers tend to

find the behavior management techniques associated with parent training less acceptable than do mothers (Miller & Kelley, 1992; Tiano, 2008). Fathers tend to view response cost strategies, room time out, and positive reinforcement strategies, two of which were mentioned in the treatment descriptions of the current study, less favorably than mothers (Miller & Kelley, 1992; Tiano, 2008). It may be that the difference in acceptability found in the current study is due to differences in mothers' and fathers' preferences for specific behavior management strategies.

Another possible explanation for the differences in acceptability is a mismatch between the structure of parent training and the needs of fathers. Previous research has shown that behavioral parent training may not meet fathers' needs (Fabiano, 2007). For example, many studies of parent training address correspondence to mothers and only require mothers to complete questionnaires and interviews. Fathers may be inadvertently receiving the message that their participation is not required or even desired (Fabiano, 2007). Additionally, the content of parent training sessions often focuses on roles and activities for which the mother is primarily responsible; fathers may not consider the content to be applicable to them (Fabiano, 2007). Although the structure and specific content of parent training programs was not presented to participants in the current study, activities such as discipline and one-on-one time with the child were discussed. At this time in the U.S., mothers still spend more time than fathers on child-care activities (U.S. Bureau of Labor Statistics, 2014). This may have led fathers to be less interested in the treatment.

Another possible explanation is that fathers may not feel that their behavior

management skills need to be improved, and thus they may not be interested in a program they feel they do not need. In one study, the researchers found that fathers had a more internal locus of control, higher self-esteem, and more parenting efficacy than mothers (Hoza et al., 2000). This means that fathers tend to feel better about themselves as parents than do mothers, and may be less interested in intervening on their parenting skills (Fabiano, 2007). Further research is needed to confirm these explanations for fathers' lower acceptability ratings.

As noted above, there was not a significant difference in the acceptability of the two different parent training descriptions. There are several possible explanations for this. The most obvious reason is that the manipulation may not have been powerful enough. Perhaps, a written description presented electronically does not capture the variability with which interventions are presented by live therapists. Variables like interpersonal style, tone of voice, facial expression, and the therapist's relationship with the family all may have a greater impact on the acceptability of the intervention presented than the actual words that are used. Acceptability may be tied to these factors that were not assessed in the current study. Another possible explanation is that it does not matter how parent training is presented. Although it is possible that the way treatment is presented does not affect acceptability, it seems unlikely given the previous finding that treatment completion in parent training is due in part to which professional made the referral (e.g. psychologist, psychiatrist; Peters et al., 2005). It also may be that treatment acceptability of parenting interventions is influenced more broadly by an individual's attitudes towards treatment in general, rather than subtle differences between treatment descriptions.



However, using treatment completion as a proxy for treatment acceptability may be inaccurate because people who complete treatment may have numerous reasons for doing so. Individuals who complete treatment are likely to rate the treatment as more acceptable for reasons other than their initial beliefs about the treatment. For example, they may have developed a positive relationship with the treatment provider. Additionally, parents who remain in parent training long enough to complete treatment have likely experienced a positive outcome even if they did not initially find the treatment acceptable; acceptability likely increases over time as parents experience positive outcomes. The impact of treatment completion on treatment acceptability was not measured in the current study.

### **Parental Locus of Control**

Another variable that was examined in the current study was parental locus of control and its relationship with treatment acceptability. The results indicated that for fathers and mothers, locus of control orientation significantly predicted acceptability ratings of the parent training descriptions, with a more external locus of control orientation associated with lower acceptability of the parent training descriptions and a more internal locus of control associated with higher acceptability. The finding that an internal locus of control predicts greater acceptability of parent training makes intuitive sense. Parent training is an intervention that requires parents to actively participate and serve as the agent of change for their child's behavior. Parents with an internal locus of control are more likely to find this type of intervention acceptable because they have a

sense of efficacy in changing their child's behavior. Parents who do not believe that they have the ability to control their child's behavior are not likely to be interested in an intervention that targets parenting behavior. This finding is consistent with related research that demonstrates that parents who attribute the cause of their child's behavior problems outside of themselves (e.g., internal to the child) find behavioral strategies less acceptable (Morrissey-Kane & Prinz, 1999).

Though the relationship between locus of control and acceptability makes intuitive sense and has been supported in the literature, there is uncertainty about whether this association extends to treatment initiation. One study demonstrated that parents who present for treatment for parenting problems have a more external locus of control than parents of children who do not seek treatment (Campis et al., 1986). This discrepancy may be explained by the difference in the task; rating the acceptability of a treatment that one does not plan to undertake is quite different from actually initiating treatment. Parents who are seeking treatment are likely occupied with the crisis of the child's behavior problems and the logistics of obtaining treatment and may not be thinking existentially about their influence as a parent. However, parents who are evaluating treatments in the abstract may have the luxury of thinking about their beliefs about the child's behavior problems and how those beliefs mesh with the described treatment.

Another possible explanation is that parents who present for treatment, but have not yet been introduced to parent training, may believe that the clinician will work with their child directly rather than working with them to change the child's behavior. Parents in the current study were aware that the treatment would target their parenting which may

have decreased acceptability in those with an external locus of control. Previous research has demonstrated that pretreatment conceptualizations are associated with treatment engagement. For example, one study found that parents of children with conduct disorder who believed that therapy would directly target their child had the highest dropout rate from a parent-only treatment condition compared to a child-only treatment and parent-child treatment conditions (Miller & Prinz, 2003). It is clear that there is a relationship between parental attributions for child behavior problems and treatment acceptability and engagement.

### **Child Behavior Severity**

Child behavior problem severity was also examined as a potential predictor of treatment acceptability. In the current study there was a trend indicating that for mothers, higher levels of child behavior problems were associated with greater acceptability of the parent training descriptions. One possible explanation for this is that mothers of children with more behavior problems are more likely to find any intervention acceptable, regardless of what it is. Conversely, mothers who do not report child behavior problems are less likely to want to engage in an intervention that targets their management of the child's behavior. It is interesting to note that in the current study, there was no association between child problem severity and treatment acceptability in fathers. It is possible that fathers do not see themselves as responsible for their children's behavior problems and thus the child's problem severity does not impact their ratings of treatment acceptability. There is a well-documented history of mothers rather than fathers, being held responsible

for child behavior problems (Caplan & Hall-McCorquodale, 1985). Additionally, fathers may not feel responsible for the child's behavior problems because mothers still have more responsibility for and spend more time providing child care (Craig, 2006). It is possible that in this study, both mothers and fathers are attributing responsibility to mothers for the child's behavior problems and thus mothers find the treatment more acceptable. This explanation is consistent with research that shows that parents who attribute more responsibility to themselves for their child's behavior problems are more likely to follow-through with parent training (Peters et al., 2005). However, more research is needed to explore this explanation because at least one study has found that a sample of nonparents held fathers more responsible for child externalizing problems than mothers (Phares, 1993).

Overall, the results of this study do not provide a clear answer to the question of whether child behavior problem severity affects treatment acceptability. Previous research in this area is also mixed. Some studies have found that increased problem severity predicts parents' acceptance of intense treatments (e.g., medication; E. Bennett, English, Rennoldson, & Starza-Smith, 2013; Miller & Kelley, 1992; Reimers et al., 1992; Tarnowski et al., 1989), while other studies have not found that association (Cowan & Sheridan, 2003; Elliott et al., 1986; Tarnowski et al., 1992; Wickstrom et al., 1998).

### **Limitations**

There were several limitations in this study. The first of which, was the unknown influence of the experimental manipulation. It is unknown to what extent the content of

the parent training descriptions contributed to the non-significant results between the two descriptions. Although the descriptions were piloted with a small sample before data collection began, the results were inconclusive as to whether the descriptions were viewed distinctly. However, in order to preserve generalizability, there were limitations to how powerful the distinction between the two descriptions could be. For example, although greater differences in acceptability ratings of the two descriptions likely could have been found if the deficit description had been made more pejorative, artificial unacceptability may have been created. Even the least skilled and least experienced therapists would likely not use such a pejorative explanation when presenting parent training. Generalizability was prioritized over making the experimental manipulation artificially powerful. Another possible explanation for the lack of difference between the two descriptions is that for some parents, behavior change in their child is more influential than their opinions of the treatment. Information about the degree of behavior change obtained from the treatment was not included in the descriptions in this study.

Another limitation of the current study was the demographics and size of the sample. The researcher originally intended to have a sample of 200 participants (100 mother-father dyads). It was difficult to recruit participants for this study because of the inclusion criteria. In order to participate, both partners had to complete the survey and have children within the restricted age range. There were numerous individuals who were interested in participating in the study but did not meet the inclusion criteria. Additionally, the sample was taken mostly from one city in the U.S. in which residents tend to be more religious, educated, and wealthier than the general population. The

sample also had less racial and ethnic diversity than would be found in the general population. Thus, results should be generalized with caution. However, the demographics of the sample may also have influenced the outcome of the study in unique ways. For example, most of the participants in this study were members of the LDS church (a.k.a., Mormon). This church places emphasis on the importance of families and parenting. It is possible that because of this emphasis, parents in this study, and specifically fathers, may spend more time with their children than most fathers. However, there is at least one study that did not show differences in father involvement between Mormon fathers and other fathers (Bollinger & Palkovitz, 2003). More research is needed to determine the impact of LDS church membership on parental involvement.

Another limitation of this study was that the sample contained parents who on average would not actually be candidates for parent training. The average ECBI scores for both mothers and fathers in this sample were well below the clinical cutoff. Previous research shows that parents who are referred for child behavior problems often have scores that are above the clinical cutoff and significantly higher than other groups of parents (Eyberg & Ross, 1978). Perhaps, the acceptability ratings of the two descriptions would have been different if the study had been conducted with parents who needed parent training because the interventions described would have been more salient for them. A parent who has a child with significant behavior problems may be more sensitive to the rationale the therapist provides for intervening with their parent management strategies.

Additionally, this study did not include the problem scale of the ECBI that

assesses how problematic the child's behavior problems are for the parent. This scale would have provided useful data given the finding that parental perceived burden from the child's behavior problem is a better predictor of treatment initiation than is child behavior problem severity (Morrissey-Kane & Prinz, 1999).

### **Future Directions**

Since individuals with an external locus of control find parent training less acceptable, it is important for future research to examine how to increase treatment acceptability for parents with an external locus of control orientation. Increasing treatment acceptability is important because of the hypothesized relationship between acceptability and treatment compliance (Eckert & Hintze, 2000; Reimers et al., 1987). One possible way to do this is to have treatment providers address parents' misconceptions about whether the parents or the child will be working directly with the clinician and/or provide services that engage both the parent and the child when a parent has an external locus of control. This is important because previous research has demonstrated that parents who believed that the clinician would be working with the child directly were most likely to drop out of a parent training treatment (Miller & Prinz, 2003). Another way to increase acceptability in those with an external parental locus of control may be to emphasize the importance of parents in the management of their child's behavior when initially presenting the intervention. This could be thought of as a pre-intervention in order to increase parents' beliefs in their influence and control as parents.

Future research should also examine how to increase treatment acceptability of

parent training for fathers. One suggestion is for practitioners to share with families the expectation that fathers will be involved in treatment (Fabiano, 2007). This would require practitioners to actively engage fathers in treatment perhaps by reaching out specifically to them to encourage their participation (Ramchandani & Iles, 2014). It would also be useful for practitioners to present child behavior problems and remediating them through parent training as a normative experience to make participating in the intervention less threatening for fathers (Addis & Mahalik, 2003). Additionally, there may be structural changes that a practitioner can make to encourage father participation including providing flexible scheduling of appointments and childcare so that both parents can attend (Fabiano, 2007). Treatments that focus on the aspects of parenting that fathers are most involved in (e.g., recreation) may also increase acceptability for fathers (Frank et al., 2014). Relatedly, it would be beneficial for future research to update the outdated literature on which parent is held responsible for child behavior problems. It would be particularly useful to query mothers and fathers rather than non-parents.

Additionally, future research should replicate the current study with a sample of parents who have children with clinically significant levels of behavior problems. As mentioned earlier, one possible explanation for the nonsignificant differences between the treatment descriptions is that the parents in the current study would not likely be referred for parent training because, on average, they were not reporting significant behavior problems. It may be useful to conduct a study with a sample of parents who are on a waiting list for behavioral intervention services for their children. Parents of children with significant behavior problems may be more sensitive to the rationale presented for



parent training.

Future research could also examine whether the introduction of interpersonal variables, not present in a written script, such as tone of voice, facial expression, and body language influence acceptability of treatment rationales. It would be useful for future studies to have participants view video recordings of a therapist presenting the parent training rationales and then rate the acceptability of the two descriptions. It is possible that if participants are able to see and hear the therapist present the parent training rationales, differences in acceptability between the two descriptions may increase.

One final direction for future research is to explore the impact of parenting perfectionism on acceptability of parenting interventions. It is possible that if parents place high importance on their abilities as parents, they may find parenting interventions less acceptable, no matter how they are presented. Treatments targeting parenting skills may seem threatening to them. Future studies could add a measure of perfectionism to determine if this variable impacts the relationship with treatment acceptability.

In conclusion, the current study was conducted to determine whether changing the way that parent training is presented to parents, influences treatment acceptability. Ultimately, the results of the current study suggested that although treatment acceptability varied on important variables such as parent gender and parental locus of control orientation, treatment acceptability was not influenced by the way that the interventions were described.

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## **APPENDICES**

Appendix A  
Demographic Questionnaire

## Demographic Questionnaire

1. Your gender

- ☐ Male
- ☐ Female

2. Your Age

\_\_\_\_\_

3. Race/Ethnicity

- ☐ Black/African American
- ☐ Latino/Hispanic
- ☐ Asian
- ☐ White/Caucasian
- ☐ Native American
- ☐ Pacific Islander
- ☐ Other \_\_\_\_\_

4. Religion

- ☐ Catholic
- ☐ Protestant
- ☐ Latter-Day Saint
- ☐ Jewish
- ☐ Buddhist
- ☐ Muslim
- ☐ Hindu
- ☐ Atheistic/Agnostic
- ☐ Other \_\_\_\_\_

5. Marital Status

- ☐ Single/Never married
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Separated
- ☐ Divorced/Remarried
- ☐ Other \_\_\_\_\_

6. Education

- ☐ Less than High School Graduate
- ☐ High school graduate/GED
- ☐ Some college/Trade School/Associate's Degree
- ☐ College Graduate/Bachelor's Degree
- ☐ Graduate or Professional degree

7. Annual Household Income

- ☐ Less than \$15,000
- ☐ \$15,000-30,000



- ☐ \$30,000-45,000
- ☐ \$45,000-60,000
- ☐ \$60,000-75,000
- ☐ More than \$75,000

8. How many children are in your family?

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9. Have you ever participated in parenting classes?

- ☐ Yes
- ☐ No

10. Have you ever received mental health services or medication for behavioral or mental health issues?

- ☐ Yes
- ☐ No

Please complete the following questions based on your youngest child between the ages of 2 and 12 currently living in your home.

11. What is your relationship to the child?

- ☐ Biological Parent
- ☐ Step Parent
- ☐ Adoptive Parent
- ☐ Legal Guardian

12. Child's gender

- ☐ Male
- ☐ Female

13. Child's Age

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14. Child's Race/Ethnicity

- ☐ Black/African American
- ☐ Latino/Hispanic
- ☐ Asian
- ☐ White/Caucasian
- ☐ Native American
- ☐ Pacific Islander
- ☐ Other \_\_\_\_\_

15. Has the child that you are completing these measures for ever received mental health services or medication for behavioral or mental health issues?

- ☐ Yes
- ☐ No

Appendix B  
Parent Training Descriptions

**Parent Training Description #1**

Parent training is a program designed to assist parents in improving their parenting skills in order to cope more effectively with the behavior problems of their child. Poor parenting practices may contribute to and exacerbate behavior problems in children. Parents who are inconsistent in disciplining and providing reinforcement for their child are likely to increase their child's oppositional behavior. This program will help parents learn how to positively reinforce their child's appropriate behavior using attention and praise. For example, parent and child one-on-one time will be discussed as a way to improve the parent-child relationship and increase appropriate child behaviors. Parents will also be instructed on how to decrease their child's undesired behavior using ignoring and time out. The parent training will run for 12 weekly 45-minute sessions. The sessions will be held at a set time each week. It is expected that the parents and child attend each week.

**Parent Training Description #2**

Parent skill enhancement is a program designed to teach specialized parenting skills to the parents of children with difficult behaviors and temperament. Some children are more difficult to parent than others due to their personalities, attention span, and inflexibility. The parent skill enhancement program will assist parents in effectively managing their children's difficult temperament and behaviors. This program will help parents learn how to positively reinforce their child's appropriate behavior using attention and praise. For example, parent and child one-on-one time will be discussed as a way to improve the parent-child relationship and increase appropriate child behaviors. Parents

will also be instructed on how to decrease their child's undesired behaviors using ignoring and time out. The parent program will run for 12 weekly 45-minute sessions. The sessions will be held at a set time each week. It is expected that the parents and child attend each week.

## Appendix C

### Letter of Information

## LETTER OF INFORMATION

### *Parent Perceptions of Interventions for Children*

#### **Introduction/ Purpose**

Gretchen Peacock, PhD and graduate student Trisha Chase in the department of Psychology at Utah State University are conducting a research study to find out more about parents' perceptions of interventions for children. You have been asked to participate in this study because you are a parent of a child between the ages of 2 and 12. There will be approximately 200 total parents (mothers and fathers of 100 children) who participate in this study.

#### **Procedures**

If you wish to participate in this study, you will complete four questionnaires through an online survey system. The first questionnaire includes demographic questions. You will also be asked to complete a questionnaire about your child's behavior. Additionally, you will be asked to read and rate your perceptions of a treatment description. Finally, you will be asked to complete a questionnaire about your perception of your influence as a parent.

#### **Risks**

Participation in this study involves no more than minimal risk. You may experience some discomfort when answering questions about your child's behavior. There is a small risk of loss of confidentiality but we will take steps to reduce that by not collecting any personally identifying information on the survey and by protecting the data as described below.

#### **Benefits**

Participation in this study will not provide direct benefit to you. However, information gained in this study may allow researchers to have a better understanding of parents' perceptions of different types of interventions which may benefit families in the future by helping design interventions that parents will complete.

#### **Explanation & offer to answer questions**

If you have any questions or concerns you may contact Dr. Peacock at (435) 797-0721, [Gretchen.peacock@usu.edu](mailto:Gretchen.peacock@usu.edu) or Trisha Chase at (509) 948-5737, [trisha.chase@aggiemail.usu.edu](mailto:trisha.chase@aggiemail.usu.edu)

#### **Voluntary nature of participation and right to withdraw without consequence**

Participation in this study is completely voluntary. You may refuse to participate, refuse

to answer any question, or withdraw at any time without penalty.

### **Confidentiality**

Data collected during this study will be kept confidential. The data will be temporarily stored on a secure server connected with the survey website. The website is password protected. The data on the website will be deleted following the conclusion of the study. A copy of the data will be kept on a password protected computer in a locked office. To protect your privacy, you are not required to provide identifiable information. Your computer's IP address will not be sent to the researchers and the email address you provided will not be connected with your responses to the questionnaires.

### **Payment**

If both you and your partner complete the surveys for this study you will each be given the option to receive one \$5.00 gift certificate. If you are a USU student and in a class that offers extra credit for participation in this study, you can elect to receive extra credit in lieu of receiving the gift certificate. You will be asked for contact information for the gift certificate or extra credit after you have completed all questionnaires and that information will be kept separate from your responses.

### **IRB Approval Statement**

The Institutional Review Board for the protection of human participants at Utah State University has approved this research study. If you have any questions or concerns about your rights or a research-related injury and would like to contact someone other than the research team, you may contact the IRB Administrator at (435) 797-0567 or email [irb@usu.edu](mailto:irb@usu.edu) to obtain information or to offer input.

### **Investigator Statement**

"I certify that the research study has been explained to the individual, by me or my research staff, and that the individual understands the nature and purpose, the possible risks and benefits associated with taking part in this research study. Any questions that have been raised have been answered."

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Appendix D  
Presentation of Measures



