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Treatment Acceptability and Child Discipline: The Influence of Parent Factors

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TREATMENT ACCEPTABILITY OF CHILD DISCIPLINE METHODS: THE INFLUENCE OF PARENT FACTORS

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Abstract

The consideration of parents' acceptance of child discipline methods is important when developing culturally sensitive parent training programs, as treatment acceptability has been associated with treatment adherence and effectiveness. Past parent training research has primarily been conducted with middle-income, Caucasian mothers. The purpose of this study is to examine parents' acceptance of five common discipline methods often used by or recommended to parents. To address the lack of research considering parental factors, this study examines the influence of gender, race, and income on parents' acceptability ratings. Participants were 106 mothers from heterogeneous backgrounds. Acceptability ratings were measured using the Treatment Evaluation Inventory, Short Form (Kelley, Heffer, Gresham, & Elliott, 1989). Results indicated that parents from different racial and income backgrounds differed in their ratings of treatment acceptability, particularly in terms of medication and corporal punishment. These findings are relatively consistent with past studies, but suggest an increased acceptance of corporal punishment among some parent groups. This study supports the importance of considering parents acceptance of varying discipline methods when recommending and adapting parent-training programs.

Introduction

The past several decades of behavior therapy research has led to the ongoing development of behavioral parent training (BPT) programs to treat externalizing child behavior problems. Programs such as the Incredible Years and Parent Child Interaction Therapy (PCIT) have been firmly established as evidenced-based interventions for the reduction of behavior problems in children. BPT teaches parents to interact more positively with their children, to use descriptive praise contingent on appropriate behavior, and to employ timeout when a negative behavior occurs (Sanders et al., 2008). Considerable empirical research supports the efficacy of these programs (Thomas and Zimmer-Gembeck, 2007; Pelham and Fabiano 2008, Daley et al., 2014; Eyberg et al. 2008). Specifically, successful completion of BPT programs has led to improvements in parent-child communication (Kazdin, 199), parenting self-competence (Chacko et al., 2009), parental distress (Wahler, 1980).

Despite the proliferation of well-studied and efficacious parent training programs, many families fail to benefit from treatment. Chacko and colleagues (2016), for example, indicated that an average of 26% of parents drop out from parent training programs. Researchers have identified a number of child and parent variables associated with premature termination and poor treatment outcomes. For example, lack of social support (Fernandez, Butler, & Eyberg, 2011, Wahler, 1980), maternal stress and psychopathology (Kazdin & Wassell, 2000; Routh, Hill, Steele, Elliott, and Dewey, 1995), poor quality of life (Kazdin & Wassell, 2000), and racial minority status have been associated with poorer treatment outcomes.

Kazdin and colleagues identified four broad variables that may serve as barriers to effective treatment: stressors and obstacles, treatment demands, perceived relevance of treatment, and the parent-therapist relationship (Kazdin, Holland, & Crowley, 1997). These

barriers were associated with treatment drop out and poorer treatment outcomes. Further, the authors found increased barriers to be predictive of parents viewing treatment as less acceptable at post-treatment compared to parents experiencing fewer barriers.

Perceived relevance of treatment, or treatment acceptability, is the extent to which consumers find an intervention reasonable and practical for use. Treatment acceptability has shown to be associated with both treatment effectiveness and implementation (Kazdin 1980, 2000; Nock & Kazdin, 2001). Therefore, treatments perceived as unacceptable may pose a threat to consistent implementation by consumers. In considering attrition from parent training programs, certain groups of parents may find the disciplinary methods recommended in parent training to be impractical or unacceptable given their circumstances or parenting beliefs. For example, a method such as time-out, which requires physical isolation of a child, may be viewed as unfeasible within low-income households. Therefore, professionals must identify which discipline methods are judged to be acceptable and, therefore, more likely to be used by parents.

Initial research on treatment acceptability of child discipline methods presented parents with a vignette depicting a child with behavior problems and a series of possible discipline methods. Respondents rated each method with regard to perceptions of acceptability. A series of studies conducted by Kazdin (1908a, 1980b, 1981) found positive reinforcement to be perceived as more acceptable than punitive discipline methods such as time out and spanking. Subsequent studies evaluating perceptions of discipline methods found relatively consistent patterns of acceptability for reinforcement strategies to address mild to moderate behavior problems (Kazdin, 1981; Riemers, Wacker, & Cooper, 1991; Jones, Eyeberg, Adams, & Boggs, 1998). However, the majority of these early studies was conducted with college students or primarily

middle-income Caucasian parents and did not consider the possible influence of demographic or family factors.

Using similar methodology, Miller & Kelley (1992) compared mothers and fathers' ratings of treatment acceptability for positive reinforcement, response cost, chair and room timeout, spanking and medication. Mothers rated positive reinforcement, response cost, and room timeout as significant more acceptable than did fathers. In contrast, fathers rated spanking and medication as more acceptable than mothers. The study also found that maritally distressed parents rated positive reinforcement as significantly less acceptable than did non-distressed parents. Thus, gender and relationship factors were associated with significant differences in the acceptability of parenting practices.

Njarvik and Kelley (2008) found significant differences in Icelandic and US middle-income parents' acceptability ratings. The study found that 74% of the Icelandic parents rated discussion as their preferred discipline method compared to 26% of the US parents. The majority of US parents 63% rated response cost as their preferred discipline practice compared to 15% of the Icelandic parents.

Pertinent to the current study, Heffer and Kelley (1987) examined the effect of race and socioeconomic status on mothers' treatment acceptability ratings of positive reinforcement, response cost, time out, spanking, and medication. The study found that low-income parents rated response cost and positive reinforcement significantly more acceptable than timeout. In contrast, middle-upper income parents found the three parenting practices to be equally acceptable. Significantly fewer low-income, black mothers rated time out as at least moderately acceptable compared to white mothers and middle-upper income black mothers. Although the

majority of the middle-upper income white parents rated spanking as unacceptable, the majority of low and middle-upper income black mothers and low-income white mothers found spanking to be an acceptable parenting practice. Finally, low-income black mothers rated spanking and medication as more acceptable than timeout.

Treatment acceptability research serves to inform the development and adaptation of current parent training programs. Ortiz and Del Vecchio (2014) noted that racial-minority families were less likely to enroll in parent training, more likely to terminate prematurely, and more likely to have poor treatment outcomes relative to their white counterparts. Based on a meta-analytic study of cultural adaptations of psychological interventions, Thomas & Zimmer-Gembeck (2007) found culturally adapted interventions produced large differences in the remission of psychological symptoms in comparison to standard interventions that were not culturally sensitive.

Clearly, the literature suggests that a variety of familial, cultural, and ethnic factors may influence parents' perceptions of the acceptability of commonly used and/or taught parenting practices. Although a disciplinary method may be effective, parents from different backgrounds may differ in their perceived willingness to use the method. For example, African American parents tend to employ corporal punishment and display less warmth towards their children than white parents (Bradley, Corwyn,McAdoo, & Garcia-Coll, 2011). Many studies argue that these harsher forms of discipline are considered acceptable ways of developing obedience and respect in children, which African American families view as more important than general prosociality (Forehand & Kotchick, 2016). Therefore, without awareness of a family's beliefs about the methods taught, and if they are practical given parents' current parenting behavior, attempts to implement programs may fail.

Only one study to date has examined the relation between race and income on mothers' acceptability (Heffer & Kelley, 1987). Although Heffer and Kelley found race and income to be related to mothers' ratings of treatment acceptability, the study is dated and the relevancy is questionable. Furthermore, little research has examined the relation between mothers' acceptability of discipline methods often utilized in parent training programs and their use of the methods.

Therefore, this study addressed three broad gaps in the literature. First, the study obtained updated treatment acceptability ratings of commonly implemented discipline methods. Second, we examined the impact of race and income on mothers' acceptability of different discipline strategies.

Method

Participants

Participants were 106 mothers of children between the ages of 3 and 12. The sample consisted of 58 white mothers and 48 black mothers. Demographic characteristics of participants can be found in Table 1. Mothers' mean age was 37 years (SD = 8.90). The majority (70%) were married or living with a partner and 30% were single. Participants were classified according to their reported annual household income using the following criteria: (a) low-income mothers reported earning less than $25,000 a year, and (b) middle-upper income mothers reported earning $45,000 or more.

For the purposes of this study, low-income status is defined as families with an annual household income less than twice the federal poverty threshold for a family of four (National Center for Children in Poverty, 2016), while the threshold for middle class is based on a annual household income of two-thirds the national median when adjusted for a family of four (Pew

Research Center, 2016). Based on this criterion, the sample included 27 low-income and 31 middle-upper income white mothers and 23 low-income and 25 middle-upper income black mothers.

Table 1. *Demographic Characteristics*

	Total Sample *N* = 106
Age (in years)	
Mean (SD)	37.21 (8.9)
Range	18-55
Ethnicity	
Caucasian/White	58 (54.7%)
African American/Black	48 (45.3%)
Marital Status	
In Relationship	74 (69.8%)
Single	32 (30.2%)
Education	
High School/GED	12 (11.3%)
Some College	37 (34.9%)
Bachelor's Degree	30 (28.3%)
Graduate Degree	27 (25.5%)
Employment	
Employed	31 (29.2%)
Unemployed	75 (70.8%)
Income	
Low	50 (47.2%)
Middle-upper	56 (52.8%)
Parent Training Experience	
No	78 (73.6%)
Yes	28 (26.4%)

Procedure

Mothers were recruited from medical and psychology clinics, public libraries, after-school programs, and church groups in Southeast, Louisiana. Prior to participation, the purpose of the study was explained and the consent form was reviewed (Appendix A). Once mothers provided consent, they were given either a paper packet containing study materials or an online link to the study materials. Mothers were asked to read a description of a child exhibiting

noncompliance and aggression, followed by five different treatment descriptions. Treatment description order was randomized across participants to control for order effects. After reading each treatment description, participants were asked to rate each treatment using the TEI-SF then completed a questionnaire regarding their own parenting behavior. All mothers who completed the study were entered into a raffle to win a $50 gift card for their participation.

Measures

Demographic Questionnaire. The demographic variables (Appendix B) included mother's age, race, occupation, education level, family annual household income, previous experience with parent training interventions, and children's age.

Problem Child Vignette and Treatment Descriptions. Mothers were provided a written vignette (Appendix C) about Joe, an eight-year-old boy who exhibits argumentative, noncompliant and aggressive behavior. The problem child vignette used in this study was adapted from Heffer and Kelley (1987) and similar adaptations have been used to assess treatment acceptability of child discipline methods from parents (Frentz & Kelley, 1986, Miller & Kelley, 1992, Jones et al., 1998).

> Joe frequently disobeys his parents. He argues or ignores his parents when they ask him to do something. When Joe's mother asks him to complete chores, Joe often argues back. Joe often starts fights with his three-year-old sister, Lauren. He often calls her names. Also, he will push Lauren when she does not do what he wants. Joe's fighting and teasing makes Lauren cry at least two times a day.

Following the description of Joe, mothers were provided five different treatment descriptions Joe's parents might use to respond to his behavior. The following treatment descriptions were administered in randomized across participants: (1) Positive Reinforcement—Joe's parents praise him and provide stickers each time he obeys commands without arguing. (2) Response Cost—Joe's parents remove privileges after noncompliant or aggressive behavior. (3)

Time out—Joe's parents place him in a boring room for eight minutes after noncompliance or aggressive behavior. (4) Spanking—Joe's parents give him four hits on the bottom with the palm of their hand each time he displays noncompliant or aggressive behavior. (5) Medication—Joe's parents take him to the family physician, who prescribes him medication to improve his noncompliant and aggressive behavior.

Treatment Evaluation Inventory, Short Form. The TEI-SF (Appendix C; Kelley, Heffer, Gresham & Elliott, 1989) was modified from Kazdin's (1980a) and Witt's (1984) methodology. The TEI-SF 9-item acceptability rating scale of behavioral treatments designed for children. Each statement is rated on a five-point Likert-type scale (1= Strongly Disagree to 5= Strongly Disagree). Participants answered statements regarding how reasonable the treatment will be, how likely they would implement the treatment, and how effective they believed the treatment to be. A raw score of 27 on this scale indicates at least moderate acceptance of the treatment (Kelley, Heffer, Gresham, & Elliot, 1989).

Results

Treatment Acceptability

A 2 x 2 x 5 repeated measures multivariate analysis of covariance (MANCOVA) with one between-subjects variable (gender) and one within-subject variable (treatment) was conducted to test the first and second research questions of the study. Mothers' years of education and employment status were entered as covariates. The MANCOVA revealed that the assumption of homogeneity of covariance matrices was violated, as assessed by Box's M test (p = .001). Therefore, the Pillai-Bartlett Trace was used to interpret multivariate test effects and the Bonferroni method of correction was used for post hoc tests to minimize loss of power and

control for Type I error rate (Tabachnick & Fidell, 2005). Homogeneity of variances was found for the TEI-SF scores for: response cost (p=1.495), time out (p=. 193), spanking (p=. 814), and medication (p=. 134), but not for positive reinforcement (p=. 044), as assessed by Levene's test for equality of variances.

The MANCOVA results indicated significant differences between treatments, V = .20, F (4, 97) = 6.063, p = .001, partial η2 =0.20. Mothers' TEI-SF scores and standard deviations for the five treatments are provided in Table 2. Interactions between treatment and race, V = .273, F (4, 97) = 9.117, p = .001, and between treatment and income, V = .163, F (4, 97) = 4.735, p = .002, were significant. Additionally, a three-way interaction was significant between treatment, race, and income, V = .094, F (4, 97) = 2.513, p = .047. The covariates of education, V = .075, F (4, 97) = 1.977, p = .104, and employment, V = .039, F (4, 97) = .978, p = .424, did not have significant influences on these results.

Post hoc tests were conducted using a Bonferroni correction to determine which treatment descriptions were preferred over others. Overall, mothers rated response cost and positive reinforcement as equally acceptable. Positive reinforcement and time out were rated as equally acceptable. Further, time out was found to be significantly more acceptable than spanking, which was significantly more acceptable than medication.

Table 2. Mothers' *TEI-SF Means (SDs)*

Treatment	Mean (SD)
Response Cost	34.47 (5.71)[a]
Positive Reinforcement	32.41 (7.37)[a,b]
Time Out	30.42 (7.10)[b]
Spanking	24.46 (10.6)[c]
Medication	20.09 (8.67)[d]

Note. Means with superscripts are compared by treatment within group and differ significantly at p < .05 based on post hoc comparisons corrections.

The interaction between treatment, race and income was examined using post hoc comparisons. Low-income, white mothers rated response cost and positive reinforcement as equally acceptable. Positive reinforcement and time out were found to be equally acceptable, and significantly more acceptable than spanking. Spanking was found to be significantly more acceptable than medication. In contrast, low-income, black mothers rated spanking, response cost, and time out as equally acceptable and more acceptable than positive reinforcement and medication. Positive reinforcement and medication were rated as equally acceptable. Interestingly, low-income, black mothers were the only group that rated spanking to be more acceptable than positive reinforcement. Middle-upper income, white mothers rated response cost, positive reinforcement, and time out as equally acceptable. This was followed by spanking and medication, which were rated similarly. Middle-income, black mothers rated response cost and positive reinforcement as equally acceptable, followed by time out and spanking which were equivalent. Medication was found to be significantly less acceptable than all other methods.

Table 3. *TEI-SF Means (SDs) for Mothers Across Demographic Group*

Treatment	LW	LB	MUW	MUB
Response Cost				
M	33.30	34.57	35.74	34.08
SD	6.08	7.12	4.13	5.55
Positive Reinforcement				
M	31.81	27.91	33.35	32.00
SD	7.98	8.43	6.42	5.19
Time out				
M	30.04	30.35	32.35	28.48
SD	8.14	7.81	5.55	6.76
Spanking				
M	22.19	33.48	17.19	27.64
SD	8.55	9.87	7.91	9.15
Medication				
M	17.38	27.07	14.99	22.93
SD	6.87	7.78	6.25	8.55

Note. LW = low-income, white mothers (*n*=27), LB = low-income, black mothers (*n*=23), MUW = middle-upper income, white mothers (*n* =31), and MUB = middle-upper, black mothers (*n*=25).

Comparison of TEI-SF Scores

Five separate chi-square analyses were conducted to examine whether mothers' ratings of discipline methods as acceptable varied depending upon their groupings by race and income (i.e., low-income black, low-income white, middle-upper income black, middle-upper income white). This approach allows for a greater understanding of the degree to which mothers within a demographic group are likely to view a discipline method as acceptable for use. White and black mothers from low and middle-upper income groups were categorized according to whether their total TEI-SF score for each treatment was equal to or above 27 (indicating endorsement that the discipline method is at least moderately acceptable; Kelley, Heffer, Gresham, & Elliott, 1989). Tests of chi-square test of independence were conducted between demographic groups and treatment acceptability categories (i.e., unacceptable, at least moderately acceptable). All expected cell frequencies were greater than five. When analyses revealed significant differences, follow-up analyses were conducted using the standardized residual method. Often the greater-than-two rule is used to indicate that the number of cases in a cell is significantly greater or less than what would be expected if the null hypothesis were true. This rule is used because a standardized residual of two approximates what the z critical value would be at the .05 level (Beasley & Schumacker, 1995). However, it is important to control for experiment-wise type I error. Adjusting to control for type I error is done by calculating the appropriate critical value of z based on the number of cell values being tested in the contingency table (see Sidak, 1967).

Significant differences were found for spanking, $\chi^2(3) = 27.035$, $p = .001$, Cramer's V = .51. Specifically, low-income black mothers (standardized residual of 3.8) were more likely to find spanking to be at least moderately acceptable compared to middle-upper income white

mothers (standardized residual of -4.1; $\alpha_{adj} = .006$, $z_{cv} = \pm 2.49$). No other significant differences in acceptability ratings for spanking were found between demographic groups of mothers. Significant differences were found for positive reinforcement, $\chi^2(3) = 8.609$, $p = .035$, Cramer's V = .27. However, cell-by-cell comparisons did not indicate significant differences between demographic groups of mothers once adjusting the critical value to reduce the chance of type I error. Significant differences were found for medication, $\chi^2(3) = 30.683$, $p = .001$, Cramer's V = .54. Specifically, white mothers (both low and middle-upper income) were much less likely to find medication as at least moderately acceptable compared to low-income black mothers, standardized residuals of -2.5, -3.4 and 4.4 respectively ($\alpha_{adj} = .006$, $z_{cv} = \pm 2.49$). The strength of association ranged from moderate for positive reinforcement (Cramer's V = .27) to large for spanking (Cramer's V = .51) and medication (Cramer's V = .54; Cohen, 1988). Notably, no significant differences were found in the numbers of mothers who rated time-out and response cost at least moderately acceptable were found between the demographic groups.

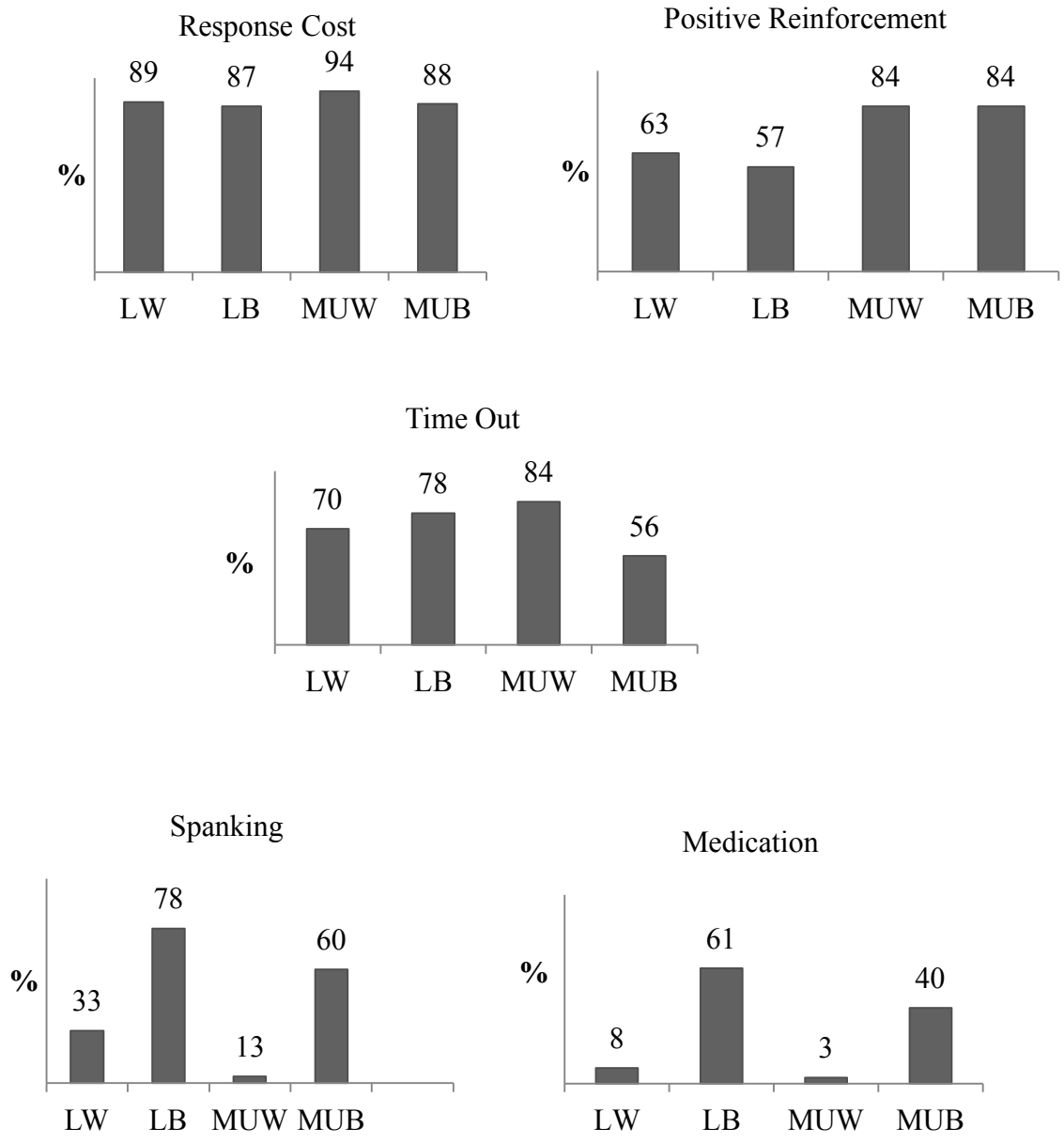

Figure 1. Each bar graph represents the percentage of parents within income and racial groups who gave a treatment of TEI-SF rating of 27 or above. LW = low-income, white mothers (*n*=27), LB = low-income, black mothers (*n*=23), MUW = middle-upper income, white mothers (*n* =31), and MUB = middle-upper, black mothers (*n*=25).

Discussion

The purpose of this study was to evaluate mothers' treatment acceptability of five common discipline methods used to increase children's appropriate, compliant behavior. The patterns of acceptability for these common discipline methods generally support those obtained in past research. Specifically, the results indicated that mothers rated response cost to be equally acceptable as positive reinforcement, and significantly more acceptable than the remaining treatments. Positive reinforcement was rated equivalently to time out, both of which were significantly more acceptable than spanking and medication. These findings are consistent in other treatment acceptability studies, which have found that response cost and reinforcement are viewed as more acceptable than time out, spanking, and medication to address child misbehavior (Frentz & Kelley, 1986; Heffer & Kelley, 1987, Miller & Kelley, 1992; Jones et al., 1998). Therefore, the results of our study suggest that overall mothers' preferences have not changed drastically over time.

The results of this study revealed that race and income were significantly associated with differential acceptability ratings from mothers. White low and middle-upper income mothers and middle-upper income black mothers rated response cost and positive reinforcement the most preferred discipline methods, followed by time out and spanking. These mothers consistently rated medication as the least acceptable method. The most marked findings are with those obtained with the low-income, black mothers. Specifically, low-income, black mothers rated spanking, response cost, and time out as equally acceptable and more acceptable than positive reinforcement and medication. This was the only group that rated spanking to be more acceptable than positive reinforcement and equally acceptable to positive reinforcement.

Updated Acceptability Ratings

Consistent with the findings of Heffer and Kelley (1987), the majority of mothers across groups were likely to find response cost and positive reinforcement to be at least moderately acceptable. Although response cost was not rated as significantly more acceptable than positive reinforcement, mothers' ratings of the punishment procedure were less variable across demographic groups than those obtained for the reward procedure. However, fewer low-income white mothers found positive reinforcement to be at least moderately acceptable (63%) compared to those in the previous study (95%).

The results of this study suggest an increased acceptance in time out procedures. Low-income mothers in the Heffer and Kelley viewed time out as significantly less acceptable than positive reinforcement, with slightly more than half (65%) of low-income, white mothers and a minority of low-income black mothers (40%) rating time out as at least moderately acceptable. Contrast to these findings, our study found that a majority of low-income white and black mothers (70% and 78%, respectively) rated time out to be at least moderately acceptable. This suggests an increase in acceptability of time out by low-income mothers over the past two decades. This greater acceptance may be due to increased familiarity with the procedure over the years, as time out is often the most recommended discipline technique to parents and is commonly implemented in classrooms to address child misbehavior (Fonagy et al., 2015).

The association of income and race with the acceptability of medication and corporal punishment was the most drastic change from the results of Heffer and Kelley (1987). Our results found a drastic decrease in the likelihood that low-income, white mothers (8%) and middle-upper income white mothers (3%) in this study rated medication as at least moderately

acceptable compared to the previous study's findings (55% and 20%, respectively). Additionally, a greater percentage of black mothers across income groups rated medication as at least moderately acceptable compared to Heffer and Kelley's findings. Low-income, black mothers in this study rated medication to be as acceptable as positive reinforcement. Over half (61%) of low-income, black mothers found medication to be at least moderately acceptable, showing a slight increase from the low-income, black mothers in Heffer and Kelley's study (52%). Additionally, more middle-upper income, black mothers (40%) rated medication as at least moderately acceptable in this study compared to those in Heffer and Kelley's (23%).

In regard to spanking, the percentage of black mothers across income groups and middle-upper income white mothers who rated spanking to be at least moderately acceptable was relatively consistent with Heffer and Kelley's findings. However, our results showed a significant decrease in the percentage of low-income white mothers who found spanking acceptable (from 60% to 33%). Further analyses into group differences indicated that low-income, black mothers found spanking to be significantly more acceptable than positive reinforcement. Furthermore, a majority of low-income, black mothers (78%) found spanking to be at least moderately acceptable. This shows a significant increase in the percentage of low-income, black mothers that found this method to be least moderately acceptable (64%) in Heffer & Kelley's study. The social acceptance of corporal punishment, over more positive and effective discipline methods, has direct implications for treatment considering possible negative side effects on children. This is especially true considering the substantial evidence that corporal punishment is not only ineffective but also has harmful outcomes on children.

Strengths and Limitations

The results of this study not only confirmed patterns found in previous research, but also provided novel and practical information regarding preference of discipline methods and parental factors that influence treatment. To our knowledge, no study has examined specific parenting behaviors when evaluating which methods are found to be acceptable to mothers from heterogeneous backgrounds. The inclusion of demographic characteristics and parenting behaviors is particularly important, as our results suggest that these factors are associated with mothers' approach to managing child misbehavior.

Although this study included useful information than can be used in child behavior therapy and parent training research, some limitations should be considered. It is important to note that all data was collected in this study, as well as in the prior study conducted by Heffer and Kelley (1987), were obtained from parents living in Southern Louisiana. Therefore, responses may reflect regional differences. Future studies should consider replicating this methodology within a more regionally diverse sample of parents to aid in the generalizability of the results. Finally, the methodology relied on self-report data and therefore allowed for the possibility of socially desired responding, particularly in regards to spanking. However, the results of this study provide a strong foundation upon which future studies can expand, modify, and improve upon the information resulted from the current study.

Future Research

Treatment acceptability is an important aspect of social validity, as research has shown that it may reflect the willingness of consumers to implement effective treatments. Previous literature on treatment acceptability has examined various familial factors, such as maternal depression, social stress, and marital discord (Webster-Stratton & Hammond, 1990; Miller &

Kelley, 1992). The present study expands upon this literature by evaluating the relationship between demographic factors and treatment acceptability. Given the myriad of factors that may contribute to treatment, future research should continue to examine the parental factors that may influence treatment acceptance. Further consideration of the relationship between parental characteristics and treatment acceptability may lead to adaptations to parent training programs and professionals' recommendations, which would improve parental engagement and implementation.

Overall, the present study addresses gaps in the current literature and emphasizes the importance of soliciting parental opinions of recommended treatments. For instance, mothers' consistent preference for reinforcement methods may suggest that further research should focus on enhancing and teaching techniques that attempt to increase prosocial behavior. Furthermore, by increasing emphasis on sensitivity to parental factors, professionals may reduce disparities in treatment quality and child behavior outcomes. Given the high attrition rates among minorities and parents from low socioeconomic statuses and marked differential acceptance of certain discipline methods, it is essential for researchers and clinicians to identify which discipline methods are found to be acceptable and more likely to be implemented among individuals of varying demographics. Parent training program components should be individually tailored to the family's specific characteristics, particularly race, income, and parenting practices such as involvement as supervision, as these are associated with discipline preferences. Therefore, adjusting the components to be more practical among specific cultural groups may facilitate effectiveness of parent training programs and treatment adherence in diverse samples of parents.

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Appendix A

Consent Form

1. **Study Title**: Treatment Acceptability of Child Discipline Methods: The Influence of Parent Factors

2. **Performance Sites:** Private clinics and after-school programs

3. **Name and Telephone Numbers of Investigators:** The following investigators are available for questions about the study:

   Mary Lou Kelley, Ph.D. (225) 578-4113 Kasia S. Plessy (225) 578-6731
   Anna Long, Ph.D. (225) 578-7605

4. **Purpose of the Study:** This study will examine parents' treatment acceptability ratings of child discipline methods and the various parental factors that may influence these ratings.

5. **Participant Inclusion:** African American, Caucasian, and Hispanic parents of children aged 3-12 years.

6. **Participant Exclusion:** Parents under the age of 18.

7. **Number of Participants:** 100

8. **Study Procedures:** Parents will receive a packet containing study measures that will require them to answer questions about themselves and their perceptions of the described child discipline methods. At the end of the data collection period, a raffle drawing will occur and two participants will win gift cards.

9. **Benefits:** The outcome of this research study will provide practitioners and families with information that will help them better understand parents' perceptions of common discipline interventions and what factors may influence successful implementation of these interventions.

10. **Risks:** This study poses no foreseeable risk to participants.

11. **Right to Refuse:** You may choose not to complete the measures or quit the study at any time without any consequences.

12. **Right to Privacy:** This study may be published, but you and your child's names will not be included in the publication. No information provided by you or your child will be linked back to you. Once data collection is completed, all identifying information (e.g., contact information) will be replaced by a code and deleted from the data file.

This study has been discussed with me and all my questions have been answered. I may direct additional questions regarding study specifics to the investigators. If I have questions about participants' rights or other concerns, I can contact Dennis Landin, Ph.D., Chairman of the LSU Institutional Review Board, at (225) 578-8692. I agree to participate in the study described above and acknowledge the researchers' obligation to provide me with a copy of this consent form if signed by me.

_____ _____

Signature of Parent Date

Appendix B

Demographics Questionnaire

CODE: _____ Date: _____

Name: _____ Gender: Male / Female

Age: _____

Email Address (optional): _____

Occupation: _____ Full-time or part-time: FT / PT

Highest level of education completed: _____

Annual Household Income: _____

Have You Ever Engaged In a Parent-training Program? Yes No

Child(ren) Age(s): _____

Who is the main disciplinarian in the household: Me Spouse/Partner Both/Equal

What is your racial heritage (select all that apply)?

_____ American Indian / Alaskan Native

_____ Asian / Pacific Islander

_____ Black / African American

_____ Caucasian / White

_____ Hispanic / Latino

_____ Other: _____

_____ Decline to answer

What is your marital status?

____ Married ____ Living with Partner, if yes, how long in relationship? _____

_____Single ____Widowed ____Divorced/Separated

APPENDIX C

Child Problem Vignette

Instructions

This is a story about Joe. Joe is an 8-year old boy with behavior problems at home. The next pages describe five different ways Joe's parents might respond to his behavior. **After reading about each method, please rate how you feel about the parenting method**. If you do not understand the instructions or something you read, please ask for help from the researcher.

Joe's Behavior Problems

Joe frequently disobeys his parents. He argues or ignores his parents when they ask him to do something. When Joe's mother asks him to complete chores, Joe often talks back. Joe often starts fights with his three-year-old sister, Lauren. He often calls her names. Also, he will push her sometimes when Lauren does not do what he wants. Joe's fighting and teasing makes Lauren cry at least two times a day.

To improve Joe's behavior, his parents place him in a boring room for eight minutes. Joe must do this each time he disobeys his parents or fights with Lauren. Joe's parents also tell him why he is in time out. If Joe misbehaves while in the room or leaves the room, he must stay in the room an extra ten minutes.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly agree
1. I find this method to be an acceptable way of dealing with the child's problem behavior					
2. I would be willing to use this method if I had to change this child's problem behavior					
3. I believe that it would be acceptable to use this method without children's consent					
4. I like this method					
5. I believe this method is likely to be effective.					
6. I believe the child will experience discomfort during the method					
7. I believe this method is likely to result in permanent improvement of the child's behavior.					
8. I believe it would be acceptable to use this method with individuals who cannot choose their own treatment.					
9. Overall, I have a positive reaction to this method.					

To improve Joe's behavior, his parents spank him when he disobeys or fights with Lauren. When they spank Joe, they tell him that they do not like his behavior. Then they spank him with

their hand four times on the bottom. If Joe's bad behavior continues, his parents will give them four more spanks on the bottom.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly agree
1. I find this method to be an acceptable way of dealing with the child's problem behavior					
2. I would be willing to use this method if I had to change this child's problem behavior					
3. I believe that it would be acceptable to use this method without children's consent					
4. I like this method					
5. I believe this method is likely to be effective.					
6. I believe the child will experience discomfort during the method					
7. I believe this method is likely to result in permanent improvement of the child's behavior.					
8. I believe it would be acceptable to use this method with individuals who cannot choose their own treatment.					
9. Overall, I have a positive reaction to this method.					

To improve Joe's behavior, his parents praise him when he obeys without arguing. He also earns stickers that are placed on a sticker chart each time he complies with his parents' instructions to plays nice with Lauren. When Joe has five stickers his parents give him a special treat such as: extra TV time, special snack, or a trip to the park.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly agree
1. I find this method to be an acceptable way of dealing with the child's problem behavior					
2. I would be willing to use this method if I had to change this child's problem behavior					
3. I believe that it would be acceptable to use this method without children's consent					
4. I like this method					
5. I believe this method is likely to be effective.					
6. I believe the child will experience discomfort during the method					
7. I believe this method is likely to result in permanent improvement of the child's behavior.					
8. I believe it would be acceptable to use this method with individuals who cannot choose their own treatment.					
9. Overall, I have a positive reaction to this method.					

To improve Joe's behavior, every time he disobeys his parents or fights with Lauren he is scolded and has one of his privileges taken away for the entire day. Joe's parents tell him why he is losing the privilege for that day. Privileges that Joe might lose include: TV time, dessert, electronics, or his favorite toy.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly agree
1. I find this method to be an acceptable way of dealing with the child's problem behavior					
2. I would be willing to use this method if I had to change this child's problem behavior					
3. I believe that it would be acceptable to use this method without children's consent					
4. I like this method					
5. I believe this method is likely to be effective.					
6. I believe the child will experience discomfort during the method					
7. I believe this method is likely to result in permanent improvement of the child's behavior.					
8. I believe it would be acceptable to use this method with individuals who cannot choose their own treatment.					
9. Overall, I have a positive reaction to this method.					

To improve Joe's behavior, his parents talk to Joe's family doctor about medication options. After an evaluation, Joe's doctor prescribes Joe medicine. The medication is taken two times a day and is meant to control Joe's defiant and aggressive behavior. The medication has no obvious side effects.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly agree
1. I find this method to be an acceptable way of dealing with the child's problem behavior					
2. I would be willing to use this method if I had to change this child's problem behavior					
3. I believe that it would be acceptable to use this method without children's consent					
4. I like this method					
5. I believe this method is likely to be effective.					
6. I believe the child will experience discomfort during the method					
7. I believe this method is likely to result in permanent improvement of the child's behavior.					
8. I believe it would be acceptable to use this method with individuals who cannot choose their own treatment.					
9. Overall, I have a positive reaction to this method.					

APPENDIX D

IRB Approval Form

ACTION ON PROTOCOL APPROVAL REQUEST

Institutional Review Board
Dr. Dennis Landin, Chair
130 David Boyd Hall
Baton Rouge, LA 70803
P: 225.578.8692
F: 225.578.5983
irb@lsu.edu | lsu.edu/irb

TO: Mary Lou Kelley
Psychology

FROM: Dennis Landin
Chair, Institutional Review Board

DATE: March 10, 2016

RE: **IRB#** 3700

TITLE: Treatment Acceptability of Child Discipline Methods: Influence of Parent Factors

New Protocol/Modification/Continuation: New Protocol

Review type: Full ___ Expedited _X_ **Review date:** 2/15/2016

Risk Factor: Minimal ___X___ Uncertain _____ Greater Than Minimal_____

Approved_____X_____ **Disapproved**_____

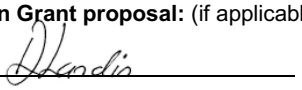
Approval Date: 3/10/2016 **Approval Expiration Date:** 3/9/2017

Re-review frequency: (annual unless otherwise stated)

Number of subjects approved: 100

LSU Proposal Number (if applicable)**:**

Protocol Matches Scope of Work in Grant proposal: (if applicable) _____

By: Dennis Landin, Chairman 

PRINCIPAL INVESTIGATOR: PLEASE READ THE FOLLOWING –
Continuing approval is CONDITIONAL on:

1. Adherence to the approved protocol, familiarity with, and adherence to the ethical standards of the Belmont Report, and LSU's Assurance of Compliance with DHHS regulations for the protection of human subjects*
2. Prior approval of a change in protocol, including revision of the consent documents or an increase in the number of subjects over that approved.
3. Obtaining renewed approval (or submittal of a termination report), prior to the approval expiration date, upon request by the IRB office (irrespective of when the project actually begins); notification of project termination.
4. Retention of documentation of informed consent and study records for at least 3 years after the study ends.
5. Continuing attention to the physical and psychological well-being and informed consent of the individual participants, including notification of new information that might affect consent.
6. A prompt report to the IRB of any adverse event affecting a participant potentially arising from the study.
7. Notification of the IRB of a serious compliance failure.
8. **SPECIAL NOTE: When emailing more than one recipient, make sure you use bcc.**

**All investigators and support staff have access to copies of the Belmont Report, LSU's Assurance with DHHS, DHHS (45 CFR 46) and FDA regulations governing use of human subjects, and other relevant documents in print in this office or on our World Wide Web site at http://www.lsu.edu/irb*

VITA

Kasia Plessy, a native of New Orleans, Louisiana, received her bachelor's degree at Loyola University Chicago in 2014. Given on her interest in children and families experiencing emotional and behavioral disturbances, she made the decision to enter graduate school in the Department of Psychology at Louisiana State University. She will receive her master's degree in May 2017 and plans to begin work on her doctorate upon graduation.