AN EVALUATION OF A BRIEF PARENT TRAINING PROGRAM FOR INCREASING PARENTING KNOWLEDGE AND SELF-EFFICACY WHILE INCREASING APPROVAL OF NURTURING PARENTING PRACTICES AND DECREASING APPROVAL OF INEFFECTIVE PRACTICES

By

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Bachelor of Arts in Psychology

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Boston, Massachusetts

2001

Submitted to the Faculty of the
Graduate College of the
Oklahoma State University
in partial fulfillment of
the requirements for
the Degree of
MASTER OF SCIENCE
July, 2006

AN EVALUATION OF A BRIEF PARENT TRAINING PROGRAM FOR INCREASING PARENTING KNOWLEDGE AND SELF-EFFICACY WHILE INCREASING APPROVAL OF NURTURING PARENTING PRACTICES AND DECREASING APPROVAL OF INEFFECTIVE PRACTICES

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ACKNOWLEDGEMENTS

I would like to express my gratitude to Dr. Cynthia Hartung for her support, advice, and encouragement. I am also appreciative of my committee members, Dr. Thad Leffingwell and Dr. Maureen Sullivan for their time and effort; as well as to my lab-mates, Monica Armendariz, Elizabeth Lefler, and Carrie Little for their support. Additionally, this project would not have been possible without the dedicated undergraduate research assistants of the Disruptive Behavior Disorders lab. Finally, I would like to thank my family and particularly my wife, Kelly, for her support, love, and patience.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER I

INTRODUCTION

Disruptive behavior disorders (DBDs) consist of attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), and conduct disorder (CD). ADHD is characterized by inattention and/or hyperactivity-impulsivity. ODD is defined as a pattern of behavior that is negativistic, hostile, and defiant. CD is defined as a pattern of behavior that violates the basic rights of others or major age-appropriate societal norms or rules (APA, 2000). According to the DSM-IV-TR (APA, 2000), the prevalence rates for these disorders in children have been estimated at 3% to 7% for ADHD, 2% to 16% for ODD, and 1% to 10% for CD. Thus, a large number of children and their families are impacted by DBDs. In addition, to impacting large numbers of children and their families during childhood, DBDs put children at risk for future problems such as externalizing disorders, substance abuse disorders, aggression, child maltreatment, poor academic achievement, social problems, and employment instability (Chronis, Lahey, Pelham, Kipp, Baumann, & Lee, 2003; Ford, Raucusin, Elliss, Daviss, Reiser, Fleischer, & Thomas, 2000; Kandel, Johnson, Bird, & Canino, 1997; Mannuzza, Klein, Bessler, & Malloy, 1993; Wascbusch, Pelham, Jennings, Greiner, tarter, & Moss, 2002; Weiss, Hechtman, Milroy, & Perlman, 1985; Weiss & Hechtman, 1993)

Child maltreatment consists of physical abuse, sexual abuse, psychological abuse, and/or neglect. Child physical abuse is defined as the physical injury or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened (U.S. Department of Health and Human Services, 2005). Child sexual abuse is defined as inappropriate adolescent or adult sexual behavior with a child (U.S. Department of Health and Human Services, 2005). It includes fondling a child's genitals, forcing the child fondle the adult's genitals, intercourse, incest, rape, sodomy, exhibitionism, sexual exploitation, or exposure to pornography (U.S. Department of Health and Human Services, 2005). Psychological abuse is defined as a pattern of caregiver behavior or extreme incidents that convey to children that they are worthless, flawed, unloved, unwanted, endangered, or only of value to meeting another's needs. This can include parents or caretakers using extreme or bizarre forms of punishment or threatening or terrorizing a child (U.S. Department of Health and Human Services, 2005). Neglect is defined as the failure to provide for the child's basic needs. Neglect can be physical, educational, or emotional (U.S. Department of Health and Human Services, 2005). Child protective services agencies investigated reports alleging the maltreatment of almost 3 million children in 1998 in the United States. Of these 3 million children, just over 900,000 children were victims of substantiated child abuse and/or neglect. Among these substantiated reports, 53.5% of the children experienced neglect, 22.7% physical abuse, 12% sexual abuse and 6% or fewer each of psychological abuse and medical neglect (U.S. Department of Health and Human Services, 2000). Thus, as with disruptive behavior disorders, child maltreatment also impacts many children and their families.

Furthermore, child maltreatment also has continued effects including physical, psychological, and behavioral consequences. Physical consequences can include impaired brain development and/or poor physical health (Perry, 2002; Shore, 1997). Psychological consequences can include internalizing disorders, disruptive behavior disorders and other externalizing disorders, cognitive difficulties, and/or social difficulties (Morrison, Frank, Holland, & Kates, 1999; Silverman, Reinherz, & Giaconia, 1996; Teicher, 2000; U.S. Department of Health and Human Services, 2003). Behavioral consequences can include juvenile delinquency, adult criminality, substance abuse, and/or abusive behavior (National Institute on Drug Abuse, 1998; Prevent Child Abuse America, 2001; Widom & Maxfield, 2001).

Research has also shown that DBDs are comorbid with the occurrence child maltreatment and there appears to be a bidirectional relationship between DBDs and child maltreatment. Children that develop DBDs may present a greater challenge to parents and therefore may be more likely to be abused. Additionally, children who are maltreated are more likely to develop DBDs (Allen & Tarnowski, 1989; Kaufman & Cicchetti, 1989; Salzinger, Feldman, Hammer, & Rosario, 1993; Shields & Cicchetti, 1998; Toth, Cicchetti, Macfie, Rogosch & Maughan, 2000; Toth, Manly, & Cicchetti, 1992).

Children who have been maltreated or display disruptive behavior disorders (through no fault of their own) place a large financial strain on the United States. In 2000, it was estimated by the United States Department of Health and Human Services (AFCARS, 2002) that there were more than 550,000 children living in national foster care. A majority of the children in foster care are placed there due to child maltreatment and/or unmanageable behaviors (e.g., Brady & Caraway, 2002; Casey Family Services,

2001; Gorske, Srebalus, & Walls, 2003; Hussey & Guo, 2002; Mallucio & Fein, 1989; Needell, Cuccaro-Alamin, Brookhart, Jackman, Shlonsky, 2002; Silver, Duchnowski, Kutash, Friedman, Eisen, Prange, Brandenburg, & Greenbaum, 1992; Rosen, 1999; Zima, Bussing, Crecelius, Kaufman, & Belin, 1999).

Research has shown that parent training helps parents learn effective parenting skills and consequently decrease their children's behavior problems and child maltreatment (e.g., Anastopoulus, Shelton, DuPaul, & Guevremont, 1993; Baker, Smithen, & Kashimal, 1991; Brunk, Henggeler, & Whelan, 1987; Cowen, 2001; Huebner, 2002; Hughes & Gottlieb, 2004; Kearney & Silverman, 1995; Knox, Albano, & Barlow, 1996; Lutzker, 1992; Webster-Stratton, Kolpacoff, & Hollinsworth, 1989; Wells & Egan, 1988; Wolfe, Edwards, Manion, & Koverola, 1988). Although there is a wealth of research documenting the effectiveness of parent training as an intervention for children who are already manifesting DBDs or who are already victims of child maltreatment; there is little research on the use of parent training as a universal or primary prevention technique to limit the development of DBDs and child maltreatment. The widespread dissemination of parent training could have many impacts including decreasing the frequency of DBDs in children, children who are maltreated, and the number of children placed in foster care.

One reason that parent training has not become widespread is that there has not been sufficient research conducted as to the possible effectiveness of widespread dissemination of parent training as a primary prevention technique. There is not enough research showing whether or not parent training can be effective for individuals who are not yet parents or for individuals who have no immediate plans to have children. Are

these individuals motivated to learn parent education principles and will they remember these principles when they do have children? Other obstacles to the widespread dissemination of parent training are that it is expensive to implement, it is very time consuming, and most programs are designed to be administered by a trained professional.

The purpose of this study was to evaluate the effectiveness of a brief parent training intervention for teaching parenting skills to expectant mothers and their spouses and/or partners and to college students who are not immediately expecting children. The first goal of this study was to develop a reliable and valid parenting knowledge measure for evaluating the effectiveness of a brief parenting program. The second goal was to determine whether expectant parents would gain significant knowledge, increase approval of nurturing parenting practices, increase self-efficacy and decrease approval of ineffective parenting practices immediately following the program. The third goal of this study was to determine if non-expectant college students would also gain knowledge, increase approval of nurturing parenting practices, increase self-efficacy, and decrease approval of ineffective parenting practices following the program. A longer-term goal of this line of research is to see if changes in knowledge and attitudes are maintained over time. The overarching goal of this line of research is to determine if the widespread dissemination of brief parenting programs to high school and college students as well as the availability of parent training through clinics, doctor's offices, and hospitals for expectant mothers and their spouses and/or partners is warranted.

CHAPTER II

REVIEW OF LITERATURE

First, the research on the effectiveness of parent training for parents whose children already have DBDs or for parents who already have histories of abusing or neglecting their children will be reviewed. Next, the literature on the effectiveness parent training intervention administered via video and self-administered video will be reviewed. Finally, the research pertaining to the use of parent training as a primary prevention technique for parents or expectant parents without a history of abuse or neglect and without children with DBDs will be reviewed.

Parent Training Interventions

All parent training interventions share the common goal of modifying and remedying destructive and dysfunctional patterns of family interaction in order to produce long lasting and constructive changes (Patterson, 1969). Parent training programs utilize empirical techniques based on theories of behaviorism and social learning. Behaviorally-based approaches attempt to modify patterns of antecedents and consequences operating in the child's social system so that positive, prosocial behaviors receive reinforcement and negative, deviant behaviors receive consistent punishment or, at least, no reinforcement (Dumas, 1989). This is accomplished by modifying parent behavior and interactions with their child to increase prosocial behaviors and decrease

maladaptive behaviors. The skills parents are taught may include increased monitoring of behaviors, attending to appropriate behaviors, using discipline for maladaptive behaviors (timeout vs. spanking), giving rewards and consequences, active ignoring, giving clear instructions, effective communication, contracting, and anticipating new conflicts or problems (McMahon & Wells, 1989; McMahon & Forehand, 2003; Miller & Prinz, 1990). Parent training formats most often use social learning techniques such as modeling, rehearsal, feedback, and structural homework assignments in order to help teach and hone the skills mentioned previously (Schaefer & Briesmeister, 1998).

The majority of parent education interventions are designed to be implemented by trained professionals and typically comprise of 8-12 weekly sessions. The COPE program is one exception (Cunningham, Bremner, & Secord-Gilbert, 2000). The program takes approximately eight weeks to complete but is designed to be administered in the community by individuals who were previously participants in the class. Therefore, the program is designed to be more easily dispersed than traditional parent education programs and is, therefore, more cost effective.

Parent training has been applied and shown to be effective in the treatment of numerous childhood disorders. Parent training has shown to be effective in treating ODD, CD, ADHD, anxiety disorders, fears, obsessive-compulsive symptoms, child abuse and neglect, and developmental disorders (Anastopoulus, Shelton, DuPaul, & Guevremont, 1993; Baker, Smithen, & Kashimal, 1991; Kearney & Silverman, 1995; Knox, Albano, & Barlow, 1996; Lutzker, 1992; Webster-Stratton, Kolpacoff, & Hollinsworth, 1989; Wells & Egan, 1988; Wolfe, Edwards, Manion, & Koverola, 1988).

Video and Self-Administered Video Programs

A relatively new technique for parent training has been the use of video in parent training sessions (i.e., Webster-Stratton, 1992). These videos usually contain vignettes showing parents interacting with their children in both appropriate and inappropriate ways. After the video vignettes are shown, the therapist may lead a discussion about the interactions observed and the parent's responses. Another new approach has been self administered video parent training (i.e., Gordon, 2000). Self administered video parent training incorporates all the aspects of traditional parent training. The video contains recorded vignettes containing both appropriate and inappropriate interactions between family members. The vignettes are followed by didactic instruction. There are several advantages to using parent training self administered video over other parent training methods. Both methods require no training for implementation. The video method may be useful for individuals and/or cultures where stigma may impact the likelihood of seeking mental health services. However, these self-administered videos often take as long to complete as traditional parent training. Parent training using video tapes both administered by a therapist and self administered have been shown to be as effective or more effective as interventions that do not use videos (Flanagan, Adams, and Forehand, 1979; Nay, 1976; O'Dell, Krug, Patterson, & Faustman, 1977; Webster-Stratton, 1990; Webster-Stratton, 1992).

Parent Training as Primary Prevention

There has been a paucity of research concerning the effectiveness of parent training as a primary prevention for child behavior problems. Previous research has displayed that parenting skills can be effectively taught, even to high school students.

Research has shown that parent training with high school students produced significant increases in behavioral and reflective parenting skills, greater parenting knowledge, and more positive expectations of parenting (Britner & Reppucci, 1997; Lagges & Gordon, 1999; Zoline & Jason, 1985). Additionally, previous research has shown that high school students believe that they need training in certain areas of parenting. Research has revealed that individuals in high school expressed the strongest needs in terms of parent education in the areas of planning and decision making, parenting and child care, and adolescent social development (Mensah, Schultz, & Hughes, 1983). These research findings, although limited, provide some evidence that parent training can be effective for high school students, that they are motivated to learn parenting skills, and that they believe they need some knowledge about parenting. However, it is not clear whether the knowledge gained in a high school parenting class will impact later parenting behaviors. Thus, it is not known whether skills taught before an individual becomes a parent can be maintained over time.

In terms of prevention of childhood behavior problems and maltreatment, it seems logical to teach parenting skills to expectant parents or to high school or college students who are not yet parents. However, there is limited research concerning the effectiveness of parent training with expectant mothers and their spouses and/or partners. Most of the research conducted has involved individuals who already have children. However, research that has used primary prevention to prevent child maltreatment has been shown to be effective. A 16 week parent education program with low-income mothers displayed reductions in use of spanking and other types of harsh discipline and increases in use of gentle discipline. Participants also displayed increases in knowledge and self-efficacy.

These increases and reductions were maintained at one year follow-up (Peterson, Tremblay, Ewigman, & Saldana, 2003). In a four week parenting education program implemented by student nurses, which involved hospital and home education, mothers reported more realistic expectations of behavior, embraced more democratic child-rearing principles, provided more verbal stimulation to their infants (reflecting an increased sensitivity), and displayed increased problem-solving abilities (Taylor & Beauchamp, 1998).

In 2001, California initiated the First 5 Program which distributes parenting kits to both prenatal and postnatal parents. The kits are available to parents through prenatal care, hospitals, home visits, a toll-free telephone number, and other programs. The kits contains a set of five videos on (1) prenatal/child health and nutrition, (2) early childhood development, (3) child safety, (4) quality childcare, and (5) early literacy. The kit also included 13 related brochures, a Parents Guide with links to resources available by telephone and through Internet sites, and a cardboard baby book. Parents who received the kit both prenatally and postnatally showed significant increases in parenting knowledge from pre-test to post-test and higher levels of knowledge than parents who did not receive the kits. Prenatal and first time parents were more likely to use and gain knowledge from the kits (Center for Community Wellness, 2001).

A program which involves visits by nurses to first time socially disadvantaged mothers has been shown to be effective in reducing child maltreatment. The visits begin prenatally and continue until the child is two years old (Olds, Henderson, Chamberlin, & Tatelbaum, 1986). In a fifteen year follow up, mothers who received the intervention had children who had fewer arrests and convictions and lower levels of substance use and

promiscuous sexual activity (Olds, Eckenrode, Henderson., Jr., Kitzman, Powers, Cole, Sidora, Morris, Pettitt, & Luckey, 1997)

Additionally, research has shown that expectant teen mothers who received parent training scored higher on measures of parenting knowledge, belief in the effectiveness of adaptive parenting practices over coercive practices, and adaptive parenting skills to hypothetical problem situations (Lagges & Gordon, 1999). Expectant mothers were also less likely to have founded reports of maltreatment; they were more likely to have completed high school, taken some college courses, and delayed subsequent pregnancies until after age 21 (Britner & Repucci, 1997). As far as attitudes about readiness for parenting and beliefs about parent training, Dossin-Shanahan and Bradley-Johnson (1980) found that half of the mothers they surveyed in a maternity ward felt they lacked sufficient information on parenting, and nearly all indicated a desire for more information. This study also found that a large majority indicated a desire for parent education programs in maternity wards and felt high school classes on parenting should be required for both girls and boys (Dossin-Shanahan & Bradley-Johnson, 1980). Nonetheless, we still do not know if parenting skills taught in high school can be maintained until students become parents. Gager, McLanahan, and Glei (2002) found that the likelihood of being unprepared is higher among racial and ethnic minorities and parents with low educational attainment (no participation in college classes). The limited research on parent training for expectant mothers seems to show positive effects. Research reveals that expectant mothers fear not being prepared for parenting and this is especially true for racial and ethnic minorities and individuals with low educational

attainment. There seems to be a research basis for providing parent training to expectant parents and individuals who are not expectant but will be parents in the future.

Importance of the study

As discussed earlier, significant percentages of children have DBDs and/or suffer child maltreatment. One possible way to decrease these numbers is with widespread dissemination of parent training in high schools, colleges, clinics, doctor's offices, and hospitals as a preventative measure for behavior disorders and child maltreatment. Parent training has been shown to effectively reduce children's behavior problems and research, although limited, has supported the use of parent training to expectant mothers and high school students. One obstacle to this widespread dissemination is the fact that most parent training programs are lengthy, expensive, and must be administered by a trained professional.

The purpose of this study was to add to the evidence on the effectiveness of parenting training with both expectant and non-expectant individuals. The study will also evaluate the effectiveness of Perry's (2004) Positive Discipline: Without Shaking, Shouting, or Spanking which is a parent training video endorsed by the American Academy of Pediatrics. The complete intervention is approximately an hour and a half long and split into three sections containing information about parenting children aged birth to one year, one to two years, and three to five years. Additionally, the effects of parent training among expectant males and females as well as non-expectant males and females will be compared.

Hypotheses

Based on previous literature, parent training administered via video should be effective for increasing parenting knowledge, self-efficacy, and approval of nurturing parenting practices while decreasing approval of ineffective parenting practices in both expectant and non-expectant men and women. Based on traditional societal roles, it is expected that women, regardless of pregnancy status, will display more baseline parenting knowledge, more approval of nurturing parenting practices, more self-efficacy, and less approval of ineffective parenting practices than men. Moreover, parent training might be more effective for expectant mothers than for expectant fathers given that mothers are often the primary caregivers and, therefore, may view this information as more relevant for them. Additionally, because individuals who are not expecting children would most likely have less interest in learning parenting skills, parent training might be more effective for expectant parents than for non-expectant college students.

CHAPTER III

METHODOLOGY

Participants

Participants were 89 adults some of whom were expecting and child and some of whom not. The expectant parents were recruited from an obstetrics clinic in a small college town in the Southwest. Undergraduate men and women, who were not parents and not currently expecting, were recruited from a large public university through the undergraduate subject pool. If an undergraduate reported that he/she was also an expectant parent, this participant was moved to the expectant parent group (n = 1). Additionally, if an undergraduate reported that he/she already had children their data was not considered (n = 4). In total, 85 individuals participated including 25 expectant women, 14 expectant men, 24 non-expectant undergraduate women, and 22 non-expectant undergraduate men.

The 37 expectant parents ranged in age from 17 to 39 with a mean age of 27. The mean level of education completed was 15 years. Sixty seven percent of the sample identified themselves as Caucasian, 18% as Asian, 13% as American Indian, and 3% as other. The majority of participants (90%) self-reported that they are currently married or in a committed relationship. Thirty nine percent of the sample previously has had children. The participants reported that their mean household income was between

$24,000 and $30,000. They reported that their parent's mean household income was between $30,000 and $36,000.

The 46 undergraduate men and women ranged in age from 18 to 36 with a mean age of 21. The mean level of education completed was 14 years. Seventy four percent of the sample identified themselves as Caucasian, 11% as biracial, 7% as African-American, 4% as Asian, and 4% as American-Indian. The majority of participants (74%) self-reported that they are currently single. The participants reported that their parent's mean household income was between $42,000 and $48,000.

Measures

Test-retest reliability and/or internal consistency were established for all the measures in the pilot study. Forty-one undergraduate men and women were recruited from a large public university to complete the measures before and after a one-week interval.

Demographics Questionnaire (Appendix A). The Demographics Questionnaire was designed specifically for this study. The questionnaire includes items regarding the participant's age, race/ethnicity, parenting status, annual salary, marital status, education level, relationship of expectant parents, relationship status, child care experience, parent's education, education status, high school, and college GPA.

Positive Parenting Knowledge Test (PPKT; Appendix B). The PPKT contains 47 multiple choice questions. Scores are the sum of correct answers. Higher scores display more parenting knowledge. The test was designed to measure parenting-skills demonstrated in Perry's (2004) Positive Discipline: Without Shaking, Shouting, or

Spanking as well as other general parenting skills. The test-retest reliability for the PPKT was .80.

A revised version of Fox's Parenting Behavior Checklist (PBC; Appendix C). The PBC contains 50 questions rated on a Likert-scale ranging from one to four. The test was designed to measure approval of ineffective and nurturing parent practices. Higher scores reveal more endorsement of ineffective and/or nurturing parenting practices. This questionnaire was adapted, with permission from the authors (R. Fox, personal communication, July 20, 2005), to measure expectant parents' approval as opposed to approval of parents. The test-retest reliability for the positive and negative attitude scales of the PBC were .85. The internal consistency for the positive scale was .84 and for the negative scale was .89.

A revised version of Gibaud-Wallston and Wandersman's Parenting Sense of Competency Scale (PSOC; Appendix D). The PSOC contains 7 questions and uses a Likert-scale ranging from one to six. The test was designed to measure parent's self efficacy towards parenting. Higher scores reveal more self-efficacy. This scale was adapted, with permission from the authors (C. Johnston, personal communication, July 22, 2005), to measure expectant parents' sense of competency as opposed to sense of competency in parents. The test-retest reliability for the PSOC was .70. The internal consistency was .84.

Perry's (2004) Positive Discipline: Without Shaking, Shouting, or Spanking. Perry's (2004) Positive Discipline: Without Shaking, Shouting, or Spanking is a parent education video. The video consists of three volumes approximately 30 minutes in length. Each volume addresses effective parent management skills as well as developmental

information for children of specific age groups – infants, toddlers, and preschoolers. Some of the topics presented are parent and child anger management skills, time-tested baby comforts, token economies, time outs, colic, post-partum depression, bedtime routines, prevention, and the effects of shaking, shouting, and spanking. Although this is a self-administered brief parenting education video, for this study researchers supervised the viewing of videos to ensure that participants watched the entire video.

Procedures

Following informed consent procedures and consent for future contact, each participant completed the demographics questionnaire, PPKT, PBC, and PSOC. Next, Perry's (2004) Positive Discipline: Without Shaking, Shouting, or Spanking video was viewed. Following this intervention, each participant again completed the PPKT, PBC, and PSOC.

CHAPTER IV

FINDINGS

To examine the hypotheses, multiple statistical analyses were conducted. Bonferroni corrections were calculated for each set of analyses. Resulting alpha values are noted for each set of results.

Preliminary Analyses

Independent samples t-tests were conducted to identify if there were significant differences among demographic variables between expectant and non-expectant participants and between men and women. A total of eight T-tests were conducted. The Bonferroni correction resulted in an alpha level of .006. There were no significant differences between men and women on demographic variables. However, the expectant and non-expectant participants significantly differed on age and parent's household income. The expectant participants were significantly older and their parent's household income was significantly lower than the college students.

Additionally, Independent samples t-tests were conducted to identify if there were significant differences among pre-test, post-test, and the difference between pre-test and post-test scores in expectant parents based on whether or not they already had children. A total of twelve T-tests were conducted. The Bonferroni correction resulted in an alpha level of .004. Expectant parents who did not previously have children gained significantly more self-efficacy towards raising children than expectant parents who previously had

children. None of the other analyses were significant. Therefore, the expectant men (n = 4) and women (n = 11) who already had children were not included in subsequent analyses involving self-efficacy. Means and standard deviations for all variables are shown in Table 1.

Pre-Test Analyses.

A 2 (gender) x 2 (expectant vs. non-expectant) ANOVA, was conducted on baseline knowledge, approval of parenting practices, and self-efficacy. The results are shown in Table 2. A total of 4 ANOVAS were conducted. The Bonferroni correction resulted in an alpha level of .0125. The analyses did not produce any significant results with or without adding age and parent's income as covariates. Therefore, results with covariates will not be reported. However, the majority of analyses for the main effects of gender, but not pregnancy status or the pregnancy status by gender interaction, approached significance. Specifically, the women, regardless of pregnancy status, displayed higher levels of parenting knowledge, more approval of nurturing parenting practices, and less approval of ineffective parenting practices at pre-test, $t(1) = 6.11$, $p = .016$, $t(1) = 4.73$, $p = .033$, and $t(1) = 4.34$, $p = .040$, respectfully (see Table 2).

Effectiveness of Intervention

A 2 (pre-test vs. post-test) x 2 (gender) x 2 (expectant vs. non-expectant) repeated measures ANOVA, was conducted on knowledge, approval of parenting practices, and self-efficacy. The results are shown in Table 3. A total of 4 ANOVAS were conducted. The Bonferroni correction resulted in an alpha level of .0125. The analyses did not differ significantly with or without adding age and parent's income as covariates. Therefore, results with covariates will not be reported. As hypothesized, there were significant

increases in parenting knowledge, positive parenting attitudes, and self-efficacy. There were also significant decreases in approval of ineffective parenting practices. (See Table 3 and Figures 1 – 4). However, contrary to the hypotheses, there was a trend suggesting that men, regardless of pregnancy status, displayed greater increases in parenting knowledge and approval of nurturing parenting practices and greater decreases in approval of ineffective parenting practices, $t(1) = 3.68$, $p = .059$, $t(1) = 3.10$, $p = .082$, and $t(1) = 2.34$, $p = .130$, respectfully (see Table 3).

Post-Test Analyses.

A final 2 (gender) x 2 (expectant vs. non-expectant) ANOVA, was conducted on post-intervention knowledge, approval of parenting practices, and self-efficacy. The results are shown in Table 4. A total of 4 ANOVAS were conducted. The Bonferroni correction resulted in an alpha level of .0125. The analyses did not produce any significant results with or without adding age and parent's income as covariates. Therefore, results with covariates will not be reported (see Table 4).

CHAPTER V

CONCLUSION

The purpose of this project was to evaluate whether or not a brief parent education intervention would be effective in increasing parenting knowledge, approval of nurturing parenting practices, and self-efficacy toward parenting while decreasing approval of ineffective parenting practices in both expectant and non-expectant men and women. Additionally, the project was designed to investigate whether or not gender or pregnancy status would effect changes parenting knowledge, attitudes, and self-efficacy. The ultimate goal of this line of research is to provide evidence for the efficacy of adding parent education to school curricula and programs provided at hospitals, clinics, colleges, and doctor's offices. Specifically, the goal is to make parenting education more easily accessible to both expectant and non-expectant individuals. It is anticipated that making brief parenting education programs available would be an effective primary prevention for child maltreatment and disruptive behavior disorders.

Baseline levels of knowledge, parenting practices, and self-efficacy between men and women and between expectant and non-expectant individuals were compared. Although only approaching significance, women regardless of pregnancy status had higher levels of baseline parenting knowledge, more approval of nurturing parenting practices and less approval of ineffective parenting practices. There were no differences between baseline levels of self-efficacy among any of the groups. These findings suggest that men are more in need of parent education than women. Men appear to have less knowledge of parenting and less approval of nurturing parenting practices. Men also

endorsed more approval of ineffective parenting practices which in combination with less knowledge and approval of nurturing parenting practices could be a risk factor for child maltreatment and disruptive behavior disorders.

To evaluate whether or not the parent education intervention was effective for male and female expectant and non-expectant individuals, all participants completed measures of parenting knowledge, approval of nurturing parenting practices, approval of ineffective parenting practices, and self-efficacy prior to and following the parent education program. As hypothesized, participants displayed increases in parenting knowledge, positive parenting attitudes, and self-efficacy while displaying decreases in approval of ineffective parenting practices. Overall, it appears that the intervention was effective particularly for increasing parenting knowledge and decreasing approval of ineffective parenting practices, such as endorsement of spanking, yelling, hitting, and threatening children in the future.

It was hypothesized that women would have greater increases in parenting knowledge and approval of nurturing parenting practices while having greater decreases in approval of ineffective parenting practices due to societal norms which dictate that women will most likely become the primary caregivers to their children. However, although only a trend, men displayed greater increases in parenting knowledge and approval of nurturing parenting practices and greater decreases in approval of ineffective parenting practices. One explanation for this finding is that men displayed lower levels of parenting knowledge, less approval of nurturing parenting practices, and more approval of ineffective parenting practices initially as compared to women so there was more room

for improvement. This finding suggests that men are more in need of parent education and are likely to benefit to a greater extent from parent education interventions.

Finally, post-intervention levels were compared between groups on levels of parenting knowledge, approval of nurturing parenting practices, approval of ineffective parenting practices, and self-efficacy. There were no significant differences or trends on any of the variables between groups. Given that men, regardless of pregnancy status, displayed less parenting knowledge, less approval of nurturing parenting practices and more approval of ineffective parenting practices before the program and that there were no differences between men and women on these measures following the program, this shows that men improved to a level that was consistent with that of women. Men were more in need of parent education and benefited more from the intervention. However, following the intervention men were as well prepared to become parents as the women, in terms of knowledge and parenting practices.

There are several limitations to the present study. First of all, the sample size was relatively small. Many of the analyses approached significance but did not reach significance. With more participants these analyses may have reached significance. In addition, some of the expectant parents previously had children and some did not. Even though the only significant difference between these two groups was on self-efficacy, whether or not the expectant parents had children or not may be a possible confound. Finally, although this study showed significant increases in knowledge, approval of nurturing parenting practices, and self-efficacy and decreases in approval of ineffective parenting practices, initially and prior to the child's birth, these changes may not last.

In summary, this brief parent education intervention was effective for increasing parenting knowledge, approval of nurturing parenting practices, and self-efficacy towards parenting while decreasing approval of ineffective parenting practices. These changes were evident for both expectant and non-expectant men and women. Initially, women displayed higher levels of knowledge, more approval of nurturing parenting practices, and less approval of ineffective parenting practices than men. However, men displayed greater increases in parenting knowledge and approval of nurturing parenting practices, and greater decreases in approval of ineffective parenting practices. Following the intervention, there were no significant differences between men and women on these variables. Pregnancy status did not influence an individual's gain in parenting knowledge, approval of nurturing parenting practices, and self-efficacy towards parenting. Nor did pregnancy status influence an individual's decrease in approval of ineffective parenting practices. These findings support the efficacy of adding parent education to college and, possibly even, high school curricula. Stated differently, it appears that non-expectant college students can learn as much from parenting education as expectant men and women. Thus, adults do not need to have parenting on their immediate horizon to benefit from the program.

The results of this study are important in several different ways. First, it appears that even a very brief parent education program can be effective in providing individuals a base of parenting knowledge, increasing positive attitudes toward nurturing as opposed to approval of ineffective parenting practices, and self-efficacy that could guard against future child maltreatment and disruptive behavior disorders for both expectant and non-expectant parents. The research adds to the empirical literature supporting widespread

dissemination of parent education as a primary prevention. Additionally, although this parent education intervention has already been distributed and is endorsed by the American Academy of Pediatrics, there is now research support. The majority of parent education videos do not have research support. Parents or future parents do not know the quality or effectiveness of the videos that are available. In addition, it appears that men benefited more from the intervention. If men feel prepared, knowledgeable, and have adequate self-efficacy towards raising children they may be more involved in parenting their children and there may be more equal sharing of parenting responsibilities between the mothers and fathers. Finally, the research provides validity and reliability to the Positive Parenting Knowledge Test as a basic test of parenting knowledge.

Future research should be focused on whether or not the changes initially displayed after brief parent interventions will be maintained over time and whether or not this will translate into more positive parenting practices and less instances of maltreatment and disruptive behavior disorders. Additionally, whether or not men are more involved in the parenting responsibilities of their children. In addition, a larger sample size could help determine whether the gender differences found are significant.

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APPENDIX A

DEMOGRAPHIC QUESTIONNAIRE

Please answer the following questions. All responses will be kept confidential.

1. Your sex (check one): ☐ Male ☐ Female

2. Your age: _____

3. Your ethnicity: (Please check all that apply)

☐ Caucasian ☐ American Indian _____

☐ African-American ☐ Biracial _____

☐ Hispanic/Latino ☐ Other _____

☐ Asian/Asian-American

4. Your highest level of education completed (check one):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 (Grade school)

☐ 9 ☐ 10 ☐ 11 ☐ 12 (High school)

☐ 13 ☐ 14 ☐ 15 ☐ 16 (College)

☐ 17 and over (Graduate School)

5. Your total household income per month (check one):

☐ Less than $800 ☐ $800-$1,000 ☐ $1001-$1,500 ☐ $1,501-$2,000

☐ $2,001-$2,500 ☐ $2,501-$3,000 ☐ $3,001-$3,500 ☐ $3,501-$4,000

☐ $4,001-$4,500 ☐ $4,501-$5,000 ☐ $5,001 and above

6. Your parent's household income per month (check one):

☐ Less than $800 ☐ $800-$1,000 ☐ $1001-$1,500 ☐ $1,501-$2,000

☐ $2,001-$2,500 ☐ $2,501-$3,000 ☐ $3,001-$3,500 ☐ $3,501-$4,000

☐ $4,001-$4,500 ☐ $4,501-$5,000 ☐ $5,001 and above

7. Current Relationship Status (check one):

☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed ☐ Dating

☐ In a committed relationship

8. Do you have children (check one)? ☐ Yes ☐ No

9. If yes, please provide the following information:

Child's age ☐ Sex: ☐ Male ☐ Female

Child's age ☐ Sex: ☐ Male ☐ Female

Child's age ☐ Sex: ☐ Male ☐ Female

10. Are you currently expecting a child (check one)? ☐ Yes ☐ No

11. If you are currently expecting a child, please enter your expected due date. ☐

12. If you are expecting a child, please describe your relationship with your expectant child's mother/father (check one).

☐ Married ☐ Divorced ☐ Separated ☐ Single

☐ Widowed ☐ Dating ☐ In a committed relationship

13. If you are not currently expecting a child, are you thinking about having children (check one)?

☐ Yes ☐ No

14. What type of child care experience have you had (check all that apply)?

☐ Babysitting

☐ I already have children

☐ Parenting classes ☐

☐ Parenting books ☐

☐ Parenting videos ☐

☐ Parenting cd-roms ☐

☐ Other ☐

APPENDIX B

POSITIVE PARENTING KNOWLEDGE TEST

Please choose the correct answer.

1) When a baby is crying it most often means that the baby
   a) is hungry or uncomfortable
   b) is spoiled and wants attention
   c) is sick and needs to go to the doctor
   d) all of the above

2) When going outside, babies should wear
   a) several more layers of clothing than adults plus a blanket
   b) several more layers of clothing than adults
   c) the same or one more layer of clothing than adults
   d) one less layer of clothing than adults

3) When a baby is playing with something unsafe a parent should
   a) Take the object away and give the baby a firm spanking
   b) Take the object away and give the baby an explanation
   c) Take the object away and give the baby a lecture
   d) Get the baby's attention, say "no", and replace the unsafe object with an appropriate one

4) If a parent responds quickly when a baby is crying the baby will
   a) likely become spoiled
   b) learn to cry more often if this is the only time the parent attends to the child
   c) learn to cry more often if the parent also attends to the baby when he/she is not crying
   d) always learn to cry more often

5) Shaking a baby lightly can cause
   a) the baby to stop crying
   b) brain damage
   c) death
   d) all of the above

6) A baby's personality or temperament
   a) Is inborn and typically does not change much
   b) Can be changed with love and affection
   c) Can be changed if the baby is neglected
   d) Is usually the same as the mother's

7) Which of the following are ways to connect with a baby
   a) develop routines
   b) read to a baby
   c) use physical touch
   d) all of the above

8) Babies may misbehave because
   a) they are curious at this age
   b) they enjoy making their parents angry
   c) their parents are giving them too much freedom to explore
   d) their parents are not using effective discipline strategies

9) It is important for a parent to know and use appropriate anger management techniques because
   a) An angry parent might get carried away and hurt a child
   b) An angry parent might scare a child
   c) An angry parent might use ineffective discipline techniques
   d) all of the above

10) Colic usually lasts for no more than
   a) 1-3 months
   b) 3-4 months
   c) 5-12 months
   d) 1-2 years

11) A parent should _____ let a baby have a pacifier during the first few weeks of breast feeding.
    a) always
    b) never
    c) sometimes
    d) only after a baby has been fed

12) Postpartum depression can occur at any time within _____ after the birth of a baby.
    a) 3 months
    b) 6 months
    c) 1 year
    d) 2 years

13) How long do symptoms of depression have to be present for in order for a mother to have postpartum depression?
    a) 1 week
    b) 2 weeks
    c) 1 month
    d) 2 months

14) How long should a mother breast feed a baby?
    a) For two months
    b) For four months
    c) Until the baby starts eating solid food
    d) The longer the better

15) The most effective way to prevent a toddler from being in a dangerous situation is to
    a) set clear rules and boundaries
    b) supervise the toddler closely
    c) childproof the house
    d) all of the above

16) When a toddler is in danger a parent should remove the child from the situation and
    a) give the child a firm spanking
    b) give the child a firm but brief explanation (ex. that's not safe)
    c) give the child a detailed explanation
    d) send the child to his/her room without any explanation

17) If a toddler bites another child, a parent should
    a) give the child a firm spanking
    b) bite the child back to teach a lesson
    c) give a firm but brief explanation (ex. "No biting")
    d) tell the child not to do it again

18) Biting usually stops around age
    a) 1-2 years
    b) 2-3 years
    c) 3-4 years
    d) 4-5 years

19) One reason why a toddler may bite is that
    a) he/she is angry
    b) he/she is teething
    c) he/she is confused about the difference between kissing and biting
    d) all of the above

20) At 12 months of age (1 year), toddlers
    a) begin to understand and follow simple rules consistently
    b) begin to understand but not follow simple rules consistently
    c) do not understand but follow simple rules consistently
    d) do not understand and do not follow simple rules

21) At 24 months of age (2 years), toddlers
    a) begin to understand and follow simple rules consistently
    b) begin to understand but not follow simple rules consistently
    c) do not understand but follow simple rules consistently
    d) do not understand and do not follow simple rules

22) Which statement would be most effective in teaching a child rules?
    a) Only adults can walk in the street.
    b) Don't ever do that again.
    c) Always walk on the sidewalk.
    d) Never walk in the street.

23) How often should a parent offer food to a toddler?
    a) Approximately 3-4 times per day (every 4-6 hours)
    b) Approximately 5-6 times per day (every 2-3 hours)
    c) Immediately when the child asks for food
    d) 15 minutes after the child asks for food if he/she is still hungry

24) Which of the following is the most effective question for a toddler at snack time?
    a) What do you want to eat?
    b) Do you want carrots?
    c) Do you want carrots or grapes?
    d) All of the above are equally effective

25) If a toddler starts playing with his/her food at the table, a parent should
    a) send the toddler to bed without dinner
    b) force the toddler to finish the food on the plate
    c) take the food away and give the toddler a treat
    d) take the food away and provide the toddler with another activity

26) Toddlers prefer foods with what type of texture?
    a) Smooth
    b) Rough
    c) Hard
    d) Light

27) One way to possibly prevent obesity in later life is to
    a) Feed a toddler approximately 3-4 times per day (every 4-6 hours)
    b) Feed a toddler approximately 5-6 times per day (every 2-3 hours)
    c) Let a toddler follow his/her own hunger signals
    d) Withhold food

28) An effective strategy for increasing cooperation at bedtime would be
    a) Changing the bedtime routine every evening
    b) Using the same bedtime routine every evening
    c) Playing actively with the child after reading quietly together
    d) None of the above

29) If a child leaves his/her room after the bedtime routine has been completed, a parent should
    a) yell at the child and let him/her stay up a little longer
    b) let the child stay up a little longer and then gently lead the child back to bed
    c) talk to the child about why he/she doesn't want to go to bed
    d) gently lead the child back to bed

30) Giving a child a brief warning before changing activities (ex. in 5 minutes it will be time to put your pajamas on) will
    a) Encourage the child to argue with you
    b) Increase the likelihood that the child will comply
    c) Decrease the likelihood that the child will comply
    d) Take the control away from the parent

31) A parent tells a child that it will be time to turn off the TV when the current show is over. After the show is over, the child politely asks the parent to let him/her watch one more show. The parent should
    a) turn off the TV
    b) turn off the TV and discuss the situation at length with the child
    c) let the child watch one more show since he/she asked politely
    d) let the child watch one more show if he/she promises to turn off the TV after that show

32) If time out does not seem to be working for a preschooler a parent should
    a) increase the length of the time out
    b) not engage in a positive activity with the child after the timeout
    c) give up on time out because it does not work for the child
    d) stop using time out temporarily and focus on increasing positive family relations

33) Preschoolers may become defiant or oppositional because
    a) they enjoy making their parents angry
    b) they are asserting their new found independence
    c) their parents did not discipline them enough when they were toddlers
    d) their parents are not using effective discipline strategies

34) Which of the following is a good question for a preschooler?
    a) Do you want to get dressed?
    b) Do you want to wear your blue shirt?
    c) What do you want to wear? You can wear anything you want except your red shirt.
    d) Do you want to wear your blue shirt or your red shirt?

35) An example of a good directive for a preschooler would be
   a) Put on your socks, shoes, and coat
   b) Put on your coat
   c) Would you like to put on your coat?
   d) None of the above

36) Preschoolers need approximately how many hours of sleep in a night?
   a) 8-10
   b) 10-12
   c) 12-14
   d) 14-16

37) One reason a preschooler might act aggressively is that
   a) he/she has limited self control
   b) he/she is getting used to being away from home
   c) he/she is hungry or tired
   d) all of the above

38) How long should a timeout last?
   a) It depends on what the child did
   b) Approximately one minute for every year old the child is
   c) Approximately 5 minutes
   d) Approximately 15 minutes

39) Using physical punishment like spanking with a hand or belt
   a) rarely causes harmful physical and emotional side effects
   b) may cause harmful side effects if the parent is angry or frustrated
   c) usually does not teach a child that hitting solves problems
   d) often helps children learn not to hit, kick, or bite because it is hurtful

40) Using physical punishment like spanking with a hand or belt
   a) is always an effective way to discipline a child
   b) may stop the unwanted behavior for a short time
   c) is a more effective way to discipline than time out
   d) is a more effective way to discipline than grounding

41) Shouting, threatening, lecturing, or using put downs
   a) is a more effective way to discipline than spanking
   b) is likely to damage a child's self-esteem
   c) often helps children learn to speak respectfully to adults
   d) often stops the unwanted behavior for a long time

42) If you verbally praise a child frequently following good behavior
   a) The child will become spoiled
   b) The praise will seem insincere when the child achieves a major accomplishment
   c) The likelihood that the good behavior will occur again will increase
   d) The likelihood that the good behavior will occur again will decrease

43) Which of the following is the best example of effective use of praise?
   a) Thanks for putting your gum in the garbage and not under the table like you usually do.
   b) I'm glad you are making your bed, but why can't you do it every morning?
   c) Thank you for sitting and waiting quietly for me while I was on the phone.
   d) You came to the table when I asked but you should have washed your hands first.

44) Which of the following is an example of effective use of reward
   a) You can watch TV after you clean up your room.
   b) You can watch TV if you promise to clean up your room when the show is over.
   c) You can watch TV if you don't tell your brother.
   d) None of the above.

45) Which of the following is an example of ineffective use of reward?
   a) You can play ball if you feed your dog.
   b) You can play ball if you promise to feed your dog when you get back.
   c) Since you cleaned your room, you can play ball.
   d) None of the above

46) Ignoring a child who is misbehaving
    a) should never be done
    b) can be an effective technique for managing a child's behavior
    c) should be discontinued if a child further escalates his/her behavior
    d) teaches a child that he/she is alone in the world

APPENDIX C

REVISED VERSION OF FOX'S PARENTING BEHAVIOR CHECKLIST

We are interested in how individuals will raise children. Regardless, of whether you have never had children, expecting to have children, are in the middle of having your family, or have finished with childbearing, you will have beliefs about how you will raise children. This questionnaire is designed to help us understand those beliefs.

For each statement, choose an answer that applies to how you will raise your child. Choose only one answer to each statement. Do not skip any item.

1. I will read to my child at bedtime.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

2. I will spank my child at least once a week.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

3. My child and I will play together on the floor.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

4. If my child hits, kicks, bites, or scratches someone, I will spank him/her.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

5. I will get books for my child (from the library or store) at least once a month.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

6. When my child doesn't do what I tell her/him to do, I will spank her/him.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

7. If my child hit me in anger, I will hit or spank my child.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

8. If my child is overactive, I will yell at her/him.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

9. If my child is overactive, I will involve her/him in quiet activities.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

10. I will take my child to the park, playground, movies, library, and ballgames.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

11. I will yell at my child for whining.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

12. If my child cries after being put to bed, I will spank him/her.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

13. If my child cries after being put to bed, I will yell at him/her.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

14. I will play make-believe with my child.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

15. To toilet train my child, I will make him/her sit on the toilet for over 15 minutes.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

16. I will spank my child for refusing to eat.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

17. I will get so angry with my child I will spank him/her on the bottom.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

18. I will let my boy play with dolls or my girl play with trucks.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

19. I will spank my child in public for bad behavior.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

20. I will yell at my child for being too noisy at home.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

21. I will scold my child for soiling in his/her pants.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

22. I will threaten to tell my spouse/partner about my child's bad behavior.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

23. I will threaten to punish my child but then I won't.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

24. I will tell my child that he/she is bad.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

25. I will plan surprises for my child (birthday parties, gifts).

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

26. I will scold my child for playing with his/her private parts.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

27. I will tell my child to behave so that my spouse/partner won't get angry.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

28. I will yell at my child for spilling food.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

29. I will find it useful to talk to other parents about raising children.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

30. I will punish my child for wetting the bed.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

31. I will spend at least one hour a day playing with or reading to my child.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

32. I will make my child stay at the table until all of his/her food is gone.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

33. I will spank my child for wetting his/her pants.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

34. I will read to my child at least once a week.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

35. I will slap my child for being sassy or backtalking.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

36. I will tell my child he/she should be ashamed of him/herself for soiled pants (bowel movement).

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

37. When my child has a temper tantrum, I will spank him/her.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

38. I will hit my child with an object (such as a spoon or belt) when he/she behaves very badly.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

39. I will allow messy play (finger painting, play dough).

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

40. I will take walks with my child at least once a week.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

41. I will talk to or hold my child when he/she is scared.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

42. When I need help or advice about my child, I will read books or magazines about parenting.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

43. When I need help or advice about my child, I will talk to my friends.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

44. I will arrange activities for my child to play such as coloring, painting, or toy play.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

45. I will tell my child God doesn't like children who lie.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

46. I will praise my child for learning new things.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

47. I will send my child to bed as a punishment.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

48. My child will have a regular bedtime routine (such as wash up, put on pajamas, read a story, say prayers).

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

49. I will encourage my child to spend time with my spouse/partner or other relatives.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

50. I will tell my child that his/her bad behavior will make God sad.

1	2	3	4
almost never/never	sometimes	frequently	almost always/always

APPENDIX D

REVISED VERSION OF GIBAUD-WALLSTON AND WANDERSMAN'S PARENTING SENSE OF COMPETENCY SCALE

We are interested in individual's beliefs about their readiness to raise children. Regardless, of whether you have never had children, expecting to have children, are in the middle of having your family, or have finished with childbearing, you will have beliefs about your readiness to raise children. This questionnaire is designed to help us understand those beliefs.

For each statement, choose an answer that applies to how much you agree with each statement. Choose only one answer to each statement. Do not skip any item.

1) The problems of taking care of a child will be easy to solve once I know how my actions affect my child.

1 2 3 4 5 6

STRONGLY DISAGREE STRONGLY AGREE

2) I will make a good model for a new mother/father/parent to follow in order to learn to be a good parent.

1 2 3 4 5 6

STRONGLY DISAGREE STRONGLY AGREE

3) Being a parent will be manageable, any problems will be easily solved.

1 2 3 4 5 6

STRONGLY DISAGREE STRONGLY AGREE

4) I will meet my own personal expectations for expertise in caring for my child.

1 2 3 4 5 6

STRONGLY DISAGREE STRONGLY AGREE

5) If anyone will be able to find the answer to what is troubling my child I will be the one.

1 2 3 4 5 6

STRONGLY DISAGREE STRONGLY AGREE

6) I feel thoroughly familiar with the role of being a mother/father/parent.

1 2 3 4 5 6

STRONGLY DISAGREE STRONGLY AGREE

7) I honestly believe that I have all the skills necessary to be a good mother/father/parent to my child.

1 2 3 4 5 6

STRONGLY DISAGREE STRONGLY AGREE

APPENDIX E

Institutional Review Board Approval Letter

Oklahoma State University Institutional Review Board

Date	Thursday, March 30, 2006	**Protocol Expires:**	**9/5/2006**
IRB Application	AS065		
Proposal Title:	An Evaluation of a Brief Parent Training Program for Increasing Knowledge of Parenting Skills and Changing Potentially Maladaptive Parenting Beliefs and Atitudes; Phase II		
Reviewed and Processed as:	Full Board **Modification**		

Status Recommended by Reviewer(s) **Approved**

Principal Investigator(s) :

Benjamin Sigel
215 North Murray
Stillwater, OK 74078

Cynthia Hartung
215 N. Murray
Stillwater, OK 74078

The requested modification to this IRB protocol has been approved. Please note that the original expiration date of the protocol has not changed. The IRB office MUST be notified in writing when a project is complete. All approved projects are subject to monitoring by the IRB

☒ The final versions of any printed recruitment, consent and assent documents bearing the IRB approval stamp are attached to this letter. These are the versions that must be used during the study.

TABLE 1

Means and Standard Deviations for All Study Variables

	Non-Expectant						Expectant					
	Women			Men			Women			Men		
	n	*M*	*SD*	*n*	*M*	*SD*	*n*	*M*	*SD*	*n*	*M*	*SD*
Knowledge												
Pre	24	29.46	3.26	22	26.50	5.38	25	30.00	6.25	14	27.29	5.27
Post	24	36.96	4.68	22	36.27	5.52	25	37.08	6.22	14	35.21	5.89
Nurturing Practices												
Pre	24	67.08	6.57	22	63.55	5.38	25	65.12	7.86	14	61.86	8.34
Post	24	69.63	7.01	22	66.95	6.59	25	66.96	8.89	14	66.36	7.49
Ineffective Practices												
Pre	24	40.42	7.28	22	44.23	12.17	25	37.56	6.92	14	42.00	8.44
Post	24	34.29	5.72	22	36.50	9.75	25	33.24	5.64	14	35.93	6.20
Self-Efficacy												
Pre	24	27.25	5.55	22	27.23	6.78	14	25.79	4.42	10	25.30	4.42
Post	24	29.13	5.73	22	31.68	6.40	14	30.36	5.64	10	28.90	5.24

TABLE 2

2 (Gender) x 2 (Expectant vs. Non-Expectant) ANOVAs for Baseline Knowledge, Approval of Parenting Practices, and Self-Efficacy

	Main Effects of Pregnancy Status			Main effects of Gender			Interactions of Pregnancy Status x Gender		
	F	*df*	η^2	*F*	*df*	η^2	*F*	*df*	η^2
Knowledge	.33	1	.00	6.11	1	.07	.01	1	.00
Nurturing Practices	1.36	1	.02	4.73	1	.06	.01	1	.00
Ineffective Practices	1.65	1	.02	4.34	1	.05	.03	1	.00
Self-Efficacy	1.40	1	.02	.03	1	.00	.03	1	.00

* $p < .0125$

TABLE 3

2 (Pre-Test vs. Post-Test) x 2 (Gender) x 2 (Expectant vs. Non-Expectant) Repeated Measures ANOVAS for Changes in Knowledge, Approval of Parenting Practices, and Self-Efficacy from Pre-Intervention to Post-Intervention.

	Main Effects of Intervention			Interactions of Intervention x Gender			Interactions of Intervention x Pregnancy Status			Interactions of Intervention x Gender x Pregnancy Status		
	F	*df*	η^2	*F*	*df*	η^2	*F*	*df*	η^2	*F*	*df*	η^2
Knowledge	393.41*	1	.83	3.68	1	.04	1.94	1	.02	.77	1	.01
Nurturing Practices	37.67*	1	.32	3.10	1	.04	.038	1	.00	.80	1	.01
Ineffective Practices	122.00*	1	.60	2.34	1	.03	2.49	1	.03	.01	1	.00
Self-Efficacy	32.26*	1	.33	.40	1	.01	.52	1	.01	1.93	1	.03

* $p < .0125$

TABLE 4

2 (Gender) x 2 (Expectant vs. Non-Expectant) ANOVAs for Post-Intervention Knowledge, Approval of Parenting Practices, and Self-Efficacy

	Main Effects of Pregnancy Status			Main effects of Gender			Interactions of Pregnancy Status x Gender		
	F	*df*	η^2	*F*	*df*	η^2	*F*	*df*	η^2
Knowledge	.14	1	.00	1.05	1	.01	..23	1	.00
Nurturing Practices	.93	1	.01	.94	1	.01	.37	1	.01
Ineffective Practices	.27	1	.00	2.44	1	.03	.02	1	.00
Self-Efficacy	..27	1	.00	.14	1	.00	1.80	1	.03

* $p < .0125$

FIGURE 1

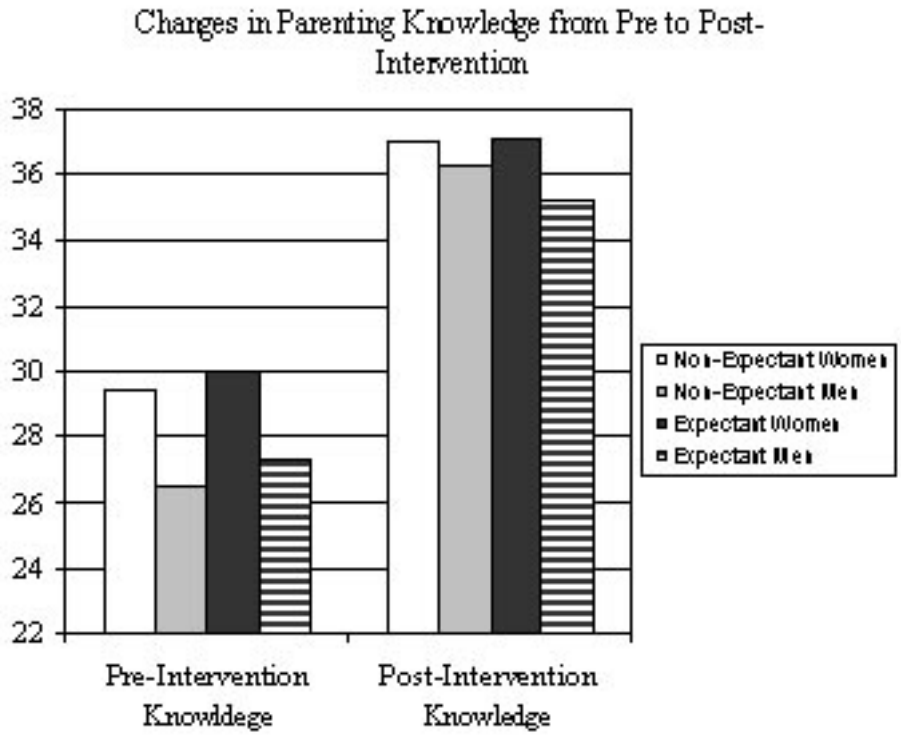

Changes in Parenting Knowledge from Pre to Post-Intervention
38
36
34
32
30
28
26
24
22
Pre-Intervention Knowldege
Post-Intervention Knowledge
Non-Expectant Women
Non-Expectant Men
Expectant Women
Expectant Men

FIGURE 2

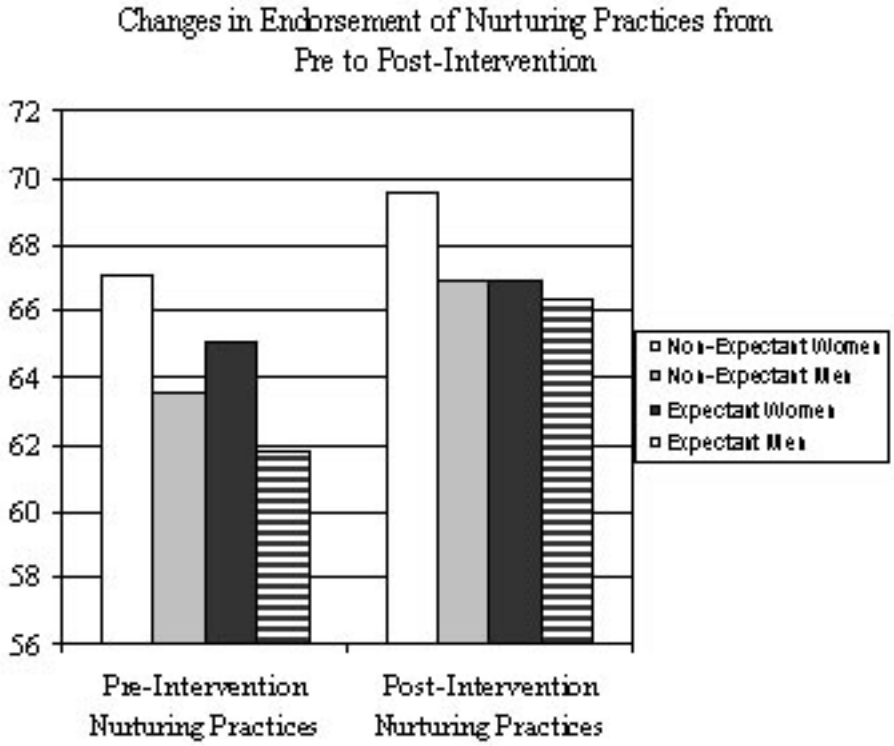

Changes in Endorsement of Nurturing Practices from Pre to Post-Intervention
72
70
68
66
64
62
60
58
56
Pre-Intervention Nurturing Practices
Post-Intervention Nurturing Practices
Non-Expectant Women
Non-Expectant Men
Expectant Women
Expectant Men

FIGURE 3

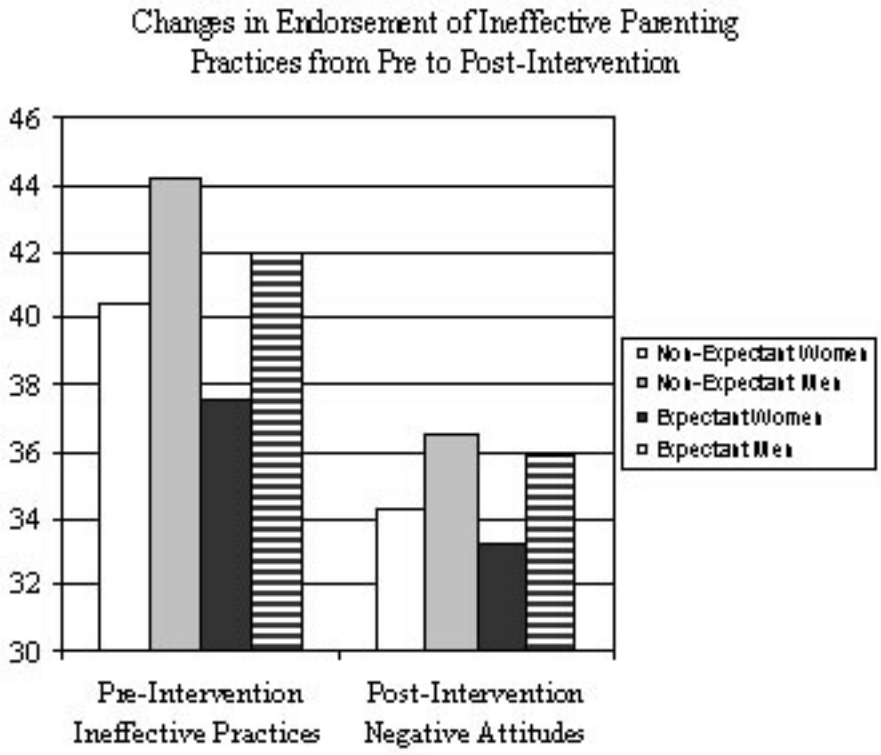
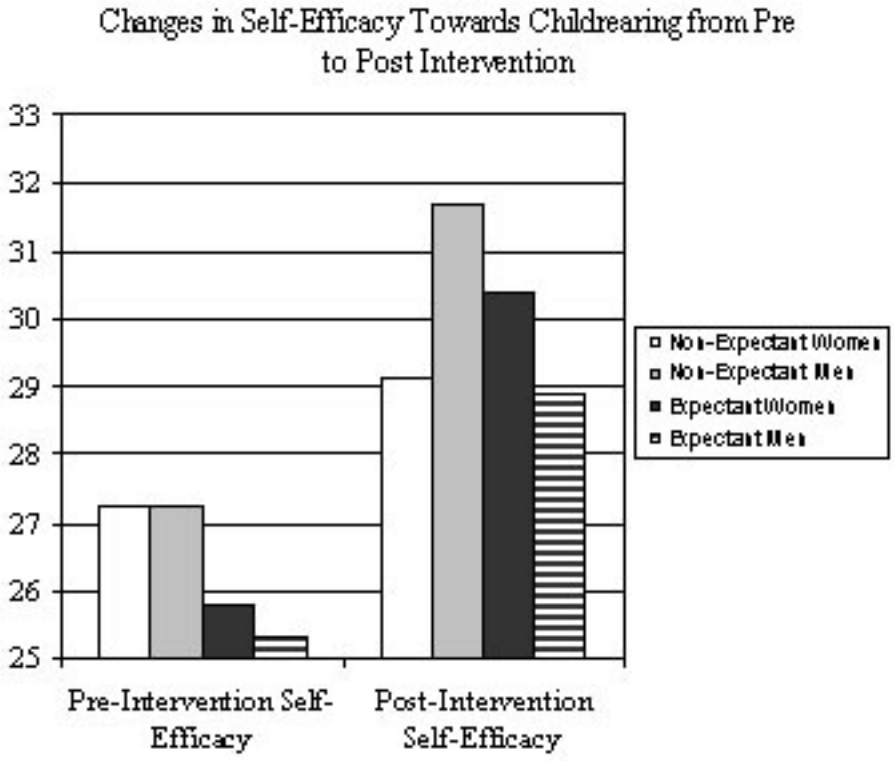

Changes in Endorsement of Ineffective Parenting Practices from Pre to Post-Intervention
46
44
42
40
38
36
34
32
30
Pre-Intervention Ineffective Practices
Post-Intervention Negative Attitudes
Non-Expectant Women
Non-Expectant Men
Expectant Women
Expectant Men

FIGURE 4


Changes in Self-Efficacy Towards Childrearing from Pre to Post Intervention
33
32
31
30
29
28
27
26
25
Pre-Intervention Self-Efficacy
Post-Intervention Self-Efficacy
Non-Expectant Women
Non-Expectant Men
Expectant Women
Expectant Men

VITA

Benjamin Aaron Sigel

Candidate for the Degree of

Master of Science

Thesis: AN EVALUATION OF A BRIEF PARENT TRAINING PROGRAM FOR INCREASING PARENTING KNOWLEDGE AND SELF-EFFICACY WHILE INCREASING APPROVAL OF NURTURING PARENTING PRACTICES AND DECREASING APPROVAL OF INEFFECTIVE PRACTICES

Major Field: Clinical Psychology

Biographical:

Personal Data: Born in Worcester, Massachusetts on January 1, 1979 to John Sigel and Kathleen Sigel.

Education: Graduated from Holy Name Central Catholic High School, Worcester, Massachusetts, in May 1997; received Bachelor of Arts degree in Psychology from the Boston University, Boston, Massachusetts, in May 2001. Completed requirements for the Master of Science degree with a major in Clinical Psychology at Oklahoma State University, Stillwater, Oklahoma, in July 2006.

Name: Benjamin A. Sigel Date of Degree: July, 2006

Institution: Oklahoma State University Location: Stillwater, Oklahoma

Title of Study: AN EVALUATION OF A BRIEF PARENT TRAINING PROGRAM FOR INCREASING PARENTING KNOWLEDGE AND SELF-EFFICACY WHILE INCREASING APPROVAL OF NURTURING PARENTING PRACTICES AND DECREASING APPROVAL OF INEFFECTIVE PRACTICES

Pages in Study: 56 Candidate for the Degree of Master of Science

Major Field: Clinical Psychology

Scope and Method of Study: The focus of this project was to evaluate the effectiveness of a brief parent education program, as a teaching and preventative tool for both expectant and non-expectant individuals. The study was designed to test whether or not this parent education program would be effective in increasing parenting knowledge, approval of nurturing parenting practices, and self-efficacy while decreasing approval of ineffective parenting practices.

Findings and Conclusions: This brief parent education intervention was effective in increasing parenting knowledge, approval of nurturing parenting practices, and self-efficacy towards parenting while decreasing approval of ineffective parenting practices. These changes were evident for both expectant and non-expectant men and women.

ADVISER'S APPROVAL: Cynthia M. Hartung, Ph.D.