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DETERMINING PARENTING STYLES AND OTHER FACTORS RENDERING DEFINITELY NEGATIVE CHILDREN'S BEHAVIOR IN DENTAL OFFICE AT THE FIRST DENTAL VISIT

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ABSTRACT

Introduction: It is believed that parental styles not only can strategically impact how a child behaves but can also influence how a child can handle unfamiliar situations. Parenting styles also influence how a child copes with stresses and stimuli, including those in the dental office.

Aim of the study: To determine various parenting styles and other factors that may render children's behavior to be definitely negative in dental office at the first dental visit.

Subjects and Methods: Patients 3-6 years old, showing definitely negative behavior and apparently free from conditions limiting cognitive development were included in the study. Yet, patients with severe dental pain/ history of dental treatment / phobia were excluded. One of the researchers performed oral examination and dental prophylaxis to assess children's behavior. First questionnaire (PFQ) investigated family data. Second questionnaire (PCPR) assessed parenting style based on Baumrind's parenting types. Pilot study was performed, whereby; some questions were omitted while others were modified. Statistical analysis was performed & significance level was set at $P \leq 0.05$.

Results: This study was conducted on 150 patients; 83 males (55.3%) and 67 females (44.7%). Regarding results of PFQ, the followings were encountered; 84% of parents were married, 50% had secondary school education, 84.7% aged 25-35 years, 46.7% had two children, 67.3% reside in urban areas, 46.7% had monthly family income < 5000 Egyptian pounds and 50.7% reported that their children had no previous encounters with either a doctor or physician. Results of PPCPR showed that 54.7% of parents were permissive, 43.3% were authoritarians and 2% were authoritative. Statistical significant association between educational level and family size versus parental style (P-values = 0.007 & 0.010 respectively) was noted. While age, gender, marital status and monthly income showed no statistical significant association with parental style.

Conclusion: Definitely negative behavior was highly noted in children of permissive and authoritarian parents. Educational level and family size were significantly associated with parental style.

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INTRODUCTION

Children's behavior is a major challenge facing pediatric dentists in daily practice. In order to provide positive dental treatment, factors that may alter children's behavior in the dental clinic should be surveyed thoroughly. Children responses to dental treatment are greatly influenced by various factors. These factors may include; level of cognition and age, dental fear and anxiety, home environment and discipline rules, culture, nature of child-parent relationship and parental style. [1]

It is believed that parental styles not only can strategically impact how a child behave but can also influence how a child can handle unfamiliar situations. Further, parental styles may likewise influence how a child copes with stresses and stimuli, including those encountered in the dental office. [2] Parenting styles were defined early by Baumrind, 1971 [3] as authoritative, authoritarian or permissive. Although showing compassion, the authoritative parents exhibit firm communication with their children. Thus, show both high warmth and control. Authoritarian parents, on the other hand, display harsh practices as; strict commands, shouting and even physical punishment. Thus, show high control but low warmth. Whereas, permissive parents provide few to no commands and usually spoil their children. Thus, show high warmth but low control. [4,5]

Moreover, it is believed that parental styles are changing and hereafter, it is of utmost importance for pediatric dentists to take this manner into consideration in order to be properly equipped to treat each patient accordingly. [6, 7]

Any act that may affect a child physical or emotional status or future development is considered as abuse. An increasing awareness of this problem and its deleterious consequences on children's wellbeing and mental health has been noted globally. [8] Corporeal or rather physical punishment often implicates psychological burden as well. [9] Although banned by law in several countries, corporal punishment is still used as a means of discipline by some parents. Studies by psychology professionals weighed possible merits of this type of punishment (e.g. immediate compliance) against potential risks (e.g. child aggression and inexplicable mental health). Some studies had concluded that this approach in child discipline was somewhat effective, [10,11] however other studies had revealed that it was unproductive at its best and detrimental at its worst. [12,13]

In spite of the controversy among studies invoked on either side of the argument, investigating factors affecting children's behaviors as well as the settings associated with parental styles is crucial. This is to warrant suitable psychological management of children during dental treatment and hence delivering dental care of high quality. [14]

From this perspective, this study aimed to determine parenting styles and other factors that may render child's behavior to be definitely negative in dental office at the first dental visit.

SUBJECTS AND METHODS

Study design and settings

This observational study was conducted on patients and parents presented to clinics of Pediatric Dentistry and Dental Public Health Department, Faculty of Dentistry, Cairo University for their first dental visit.

Sample size calculation

Sample size calculation was calculated based upon results of Baier et al., 2004 [15] regarding the proportion of children with definitely negative behavior in addition to average number of new patients attending daily the clinics of Pediatric Dentistry Department - Faculty of Dentistry - Cairo University. Proportion was 7% and average monthly number of patients was 2400 new patients/ month. Using α level = 0.05 and 4% margin of error; minimum estimated sample size was 147 patients. This calculation was performed using StatCalc formulas of Epi Info 7.2.2.2 software.

Selection criteria

Based on Howenstein et al., 2015 [16] criteria, patients were enrolled in or excluded from the current study according to the following inclusion and exclusion criteria

Inclusion Criteria

1. Patients aged 3-6 years old accompanied by their mothers.
2. Patients demonstrating definitely negative behavior (according to Frankl scale); refusing treatment, vigorous crying, apprehension or any other sign of pronounced negation.
3. Patients apparently free from any condition limiting cognitive development.

Exclusion Criteria

1. Patients with history of dental treatment & or severe dental pain.
2. Patients with history of any type of phobia.

Methods

One of the researchers performed oral examination and dental prophylaxis to assess children's behavior using Frankl scale. This scale classifies children's behavior into four categories; 1) Definitely negative: refusing treatment, vigorous crying, apprehension or any other sign of pronounced negation. 2) Negative: not cooperating during treatment or showing signs of unpronounced negative attitude. 3) Positive: accepting treatment or following commands in a cooperative manner. 4) Definitely positive: enjoying treatment and showing interest in dental procedures.

Oral examination and dental prophylaxis had already commenced or even completed before the researcher had asked about parents' interest in participating in the study. This sequence was followed to decrease any possible bias on children's behavior. When inclusion criteria were met and parents agreed to participate, informed consents were obtained. Accordingly, parents of children who were rated as definitely negative were asked to reply to queries in the questionnaires (Appendix).

In addition, written questions were translated -into Arabic language- to parents who participated in this study. This translation had been validated before commencement of the study through several back and forth translations during the pilot study. Verification was carried out to optimize the meanings of used wordings till final version was reached. Further, this translation was written down to warrant using standardized phrasing on repetition of questionnaire when addressed to different parents. Afterwards, the researcher marked the score for each item in the questionnaire.

Pilot study was carried out on small scale (n=20 parents) to pre-test questionnaires' feasibility, time taken to carry out patient examination and selection as mentioned earlier. In addition to trailing the study design, whereby, some questions were omitted (as their meanings were repeated in other questions but using similar synonyms) and others were modified as the monthly income range to suit average Egyptian wages. In addition, key words in each question in primary caregivers' practices report were marked in bold to emphasize them to be visually scanned with comfort. Questionnaires utilized in this study were modified versions of that used in the study by Howenstein et al., 2015. [16]

First questionnaire (Parent and Family Questionnaire-PFQ) investigated parent and family data. It included questions on accompanying parent's gender, age, marital status, family income, number of children in the family, parental educational and social level. In addition to questions related to child's health information. [3]

Second questionnaire (Primary Caregivers' Practices Report-PCPR) assessed parenting style based on Baumrind's primary parenting types. Parents were enquired to choose a score for behaviors on Likert scale as to how often they and their spouse practice each behavior. This scale gives

a score of one in case questioned behavior was "never" encountered, a score of two in case it was performed "once in a while", a score of three in case it was done "about half the time", a score of four in case it was made very often and a score of five in case it was "always" encountered. [3]

Scoring was used to classify parents into one of the three specific parenting styles; regarding authoritative parenting style there were 15 questions with a range of 0-75 whereas, authoritarian style included 12 questions with a range of 0-60 and finally, permissive style included five questions with a range of 0-25. Mean score in each parenting style determined each parent's particular style i.e. the highest mean score placed parent in one of the three categories. [3]

Besides, questionnaires that had revealed a tie between more than one parenting style -in which a particular parenting category was difficult to determine- were excluded from the study as well as statistical analyses and new patients were enrolled to sustain the defined sample size.

Statistical Analysis

Qualitative data were presented as frequencies and percentages Fisher's Exact test was used to study the associations between different qualitative variables. Significance level was set at $p \leq 0.05$. Statistical analysis was performed with IBM® SPSS® Statistics Version 20 for Windows.

RESULTS

This study was conducted on 150 patients; 83 males (55.3%) and 67 females (44.7%). Mean age of children was 4.8 +/- 0.1 years.

Parent and family questionnaire (PFQ)

Parents who participated in this study were females exclusively as accompanied mother was one of the inclusion criteria. Most of parents (n=126, 84%) were married while some were divorced (n=24, 16%). Nine parents (6%) had no education, 46 parents (30.7%) had primary school education, 50% had secondary school education while 20/150 (13.3%) had college degree. The majority of the study sample (84.7%) aged 25-35 years old while 15.3% aged 35-45 years old. Most of the parents (n=70, 46.7%) had two children, 32/150 parents (21.3%) had one child, 30/150 parents (20%) had three children and 18/150 parents (12%) had four children. The majority (n=101, 67.3%) of parents reside in urban areas while some (n= 49, 32.7%) live in rural areas. Regarding family income, 70 families (46.7%) had estimated monthly income < 5000 Egyptian pounds (LE), 34 families (22.7%) had either 6000-10000 LE/month, 14 families (9.3%) chose the range between 11000-20000 LE while 32 parents (21.3%) didn't answer this question and preferred not to disclose this information.

Regarding previous visits to physician/dentist, 76 parents (50.7%) reported that their children had no previous encounters with either a doctor or a physician, 16% had one encounter, 6.7% had 2-3 encounters while 20% had 4 or > encounters. Regarding children's medical status, 16 children (10.6%) had been diagnosed with diagnosed chronic medical condition where; asthma (n=7/150, 4.7%), speech difficulties (n=5/150, 3.3%), heart diseases (n=2/150, 1.3%) and trauma (n=2/150, 1.3%) were reported. Further, it was reported that 2 children (1.3%) had sleeping disorders. Regarding children's behavioral condition, majority of parents (n=121, 80.7%) didn't report the problem. However, 29 parents (19.3%) reported it, among which hyperactivity (n=17, 11.3%) and fear (n=3, 2%) were noted while 9 parents (6%) reported undetermined conditions.

Primary caregivers' practices report (PCPR)

Results of primary caregivers' practices report were presented in Table (1). Mean score for three dimensions was calculated and parental style was determined (Figure 1). Accordingly, three parents (2%) were authoritative, 65 parents (43.3%) were authoritarians and 82 parents (54.7%) were permissive.

TABLE (1) Frequencies and percentages of primary caregivers' practices questionnaire responses in the study sample.

	Never		Once in a while		About half the time		Very often		Always		No answer	
	N	%	N	%	N	%	N	%	N	%	N	%
Dimension 1: Authoritative												
1.1: Connection												
1. I am responsive to child's feelings and needs	0	0	0	0	55	36.7	28	18.7	63	42	4	2.7
7. I encourage our child to talk about his/her troubles	17	11.3	75	50	29	19.3	29	19.3	0	0	0	0
12. I give comfort and understanding when our child is upset	10	6.7	48	32	79	52.7	7	4.7	6	4	0	0
14. I give praise when our child is good	13	8.7	36	24	30	20	44	29.3	27	18	0	0
27. I have warm and intimate times together with our child	21	14	22	14.7	23	15.3	28	18.7	56	37.3	0	0
1.2: Regulation												
5. I explain to our child how we feel about the child's good and bad behavior	34	22.7	73	48.7	3	2	37	24.7	3	2	0	0
11. I emphasize the reasons for rules	22	14.7	53	35.3	44	29.3	28	18.7	3	2	0	0
25. I give our child reasons why rules should be obeyed	8	5.3	38	25.3	27	18	67	44.7	10	6.7	0	0
29. I help our child to understand the impact of behavior by encouraging our child to talk about consequences of his/her own action	8	5.3	36	24	30	20	76	50.7	0	0	0	0
31. I explain the consequences of the child's behavior	0	0	0	0	55	36.7	43	28.7	52	34.7	0	0
1.3: Autonomy												
21. I show respect for our child's opinions by encouraging our child to express them	17	11.3	50	33.3	37	24.7	36	24	10	6.7	0	0
9. I encourage our child to freely express himself/herself even when disagreeing with parents	0	0	55	36.7	39	26	56	37.3	0	0	0	0
22. I allow our child to give input into family rules	40	26.7	78	52	11	7.3	21	14	0	0	0	0
3. I take child's desires into account before asking the child to do something	7	4.7	42	28	43	28.7	48	32	10	6.7	0	0
18. I take into account our child's preferences in making plans for the family	18	12	63	42	49	32.7	14	9.3	6	4	0	0

Dimension 2: Authoritarian												
2.1: Physical coercion												
2. I use physical punishment as a way of disciplining our child	0	0	13	8.7	62	41.3	47	31.3	28	31.3	0	0
6. I spank/hit when our child disobeys	0	0	20	13.3	20	13.3	53	35.3	57	38	0	0
19. I grab our child when being disobedient	0	0	13	8.7	25	16.7	40	26.7	72	48	0	0
32. I slap our child when the child misbehaves	7	4.7	3	2	15	10	53	35.3	72	48	0	0
2.2: Verbal hostility												
13. I yell or shout when our child misbehaves	0	0	0	0	10	6.7	62	41.3	78	52	0	0
16. I explode in anger towards our child	0	0	7	4.7	6	4	47	31.3	90	60	0	0
23. I scold and criticize to make our child improve	0	0	0	0	25	16.7	65	43.3	60	40	0	0
30. I scold or criticize when our child's behavior does not meet our expectations	0	0	7	4.7	48	32	65	43.3	30	20	0	0
2.2: Non-reasoning/Punitive												
4. When our child asks why they must conform, I state: "because I said so," or "I am your parent and I want you to.	0	0	15	10	55	36.7	50	33.3	30	20	0	0
10. I punish by taking privileges away from our child with little to no explanation	8	5.3	31	20.7	45	30	36	24	30	20	0	0
26. I use threats as punishment with little or no justifications	0	0	0	0	0	0	15	10	135	90	0	0
28. I punish by putting our child off somewhere alone with little if any explanations	22	14.7	73	48.7	35	23.3	10	6.7	10	6.7	0	0
Dimension 3: Permissive												
8. I find it difficult to discipline our child	0	0	11	7.3	48	32	41	27.3	50	33.3	0	0
15. I give into our child when the child causes a commotion about something	0	0	10	6.7	45	30	54	36	38	25.3	3	2
17. I threaten our child with punishment more often than actually giving it	0	0	0	0	0	0	43	28.7	107	71.3	0	0
20. I state punishments to our child and do not actually do them	0	0	3	2	3	2	88	58.7	56	37.3	0	0
24. I spoil our child	0	0	8	5.3	64	42.7	41	27.3	37	24.7	0	0

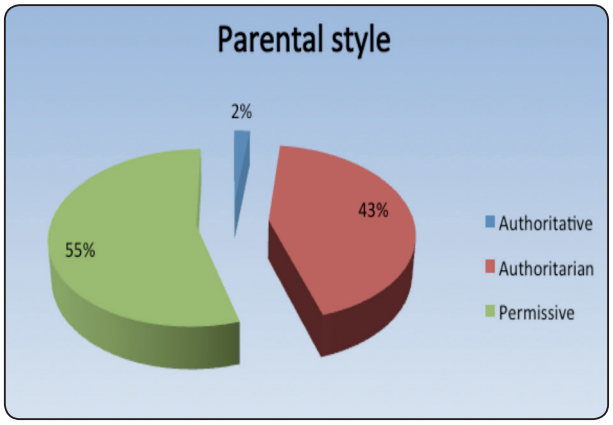

Fig. (1) Pie chart representing parental styles in the study sample.

Association between parental styles and parental data

A statistically significant association between educational level and parental style (p-value = 0.007) was noted. The highest percentage of authoritative parents was standard college degree graduates whereas, the highest percentage of authoritarian as well as permissive parents was secondary school graduates (Table 2).

Further, a statistically significant association between number of children in the family and parental style (p-value = 0.010) was revealed. The highest percentage of authoritative parents had one child whereas, the highest percentage of authoritarian as well as permissive parents had 2 children (Table 2).

TABLE (2) Frequencies, percentages and results of Fisher's Exact test for the association between parental style and parental data.

Parental data	Authoritative (n = 3)		Authoritarian (n = 65)		Permissive (n = 82)		*p-value*
	N	%	n	%	n	%	
Marital status							
Married	1	33.3	55	84.6	70	85.4	0.104
Divorced	2	66.7	10	15.4	12	14.6	
Educational level							
Nil	0	0	3	4.6	6	7.3	
Primary school	1	33.3	26	40	19	23.2	0.007*
Secondary school	0	0	33	50.8	42	51.2	
Standard college degree	2	66.7	3	4.6	15	18.3	
Age							
25-35 years old	3	100	53	81.5	71	86.6	0.694
35-45 years old	0	0	12	18.5	11	13.4	
Number of children in the family							
One	2	66.7	15	23.1	15	18.3	
Two	0	0	30	46.2	40	48.8	0.010*
Three	0	0	8	12.3	22	26.8	
Four	1	33.3	12	18.5	5	6.1	

Residence							
Urban	2	66.7	43	66.2	56	68.3	0.937
Rural	1	33.3	22	33.8	26	31.7	
How many previous encounters with a doctor/physician has your child had?							
None	0	0	34	52.3	42	51.2	
One	1	33.3	12	18.5	11	13.4	0.109
Two	2	66.7	4	6.2	4	4.9	
Three	0	0	4	6.2	6	7.3	
Four or more	0	0	11	16.9	19	23.2	
Estimated monthly income							
Less than 5000 LE	0	0	12	18.5	20	24.3	
6000 – 10000 LE	1	33.3	31	47.7	38	46.3	0.756
11000 – 20000	2	66.7	15	23.1	17	20.7	
No answer	0	0	7	10.8	7	8.5	
Has your child been diagnosed with a chronic medical condition?							
Yes	0	0	6	9.2	16	19.5	0.172
No	3	100	59	90.8	66	80.5	
Does your child have trouble sleeping?							
Yes	3	100	65	100	80	97.6	0.523
No	0	0	0	0	2	2.4	
Has your child been diagnosed with any specific behavior problems/ disorders?							
Yes	3	100	60	92.3	78	95.1	0.593
No	0	0	5	7.7	4	4.9	

: Significant at P ≤ 0.05

DISCUSSION

Patients recruited in this study represented a convenience sample from patients reported to clinic of Pediatric Dentistry and Dental Public Health Department, Faculty of Dentistry, Cairo University for their first dental visit. Consequently, the results of this study do not represent the whole Egyptian population, rather they represent merely patients of certain socioeconomic level who attended the clinics of the department to benefit from treatments offered.

Various rating scales are used in researches to assess children's behavior and responses to dental treatment. Frankl scale was used in the current study because it is simple, widely accepted and validated behavior scale. [17,18]

Oral examination and dental prophylaxis were performed by one of the researchers to assess children's behavior. This was carried out for the sake of standardization and consistency of the results. Although, due to the nature of investigated behavior (definitely negative) which is a dependent variable in this study, it was not possible to examine either intra or inter-reliability because recurrent examination could not be performed for the first time to the enrolled child once more. This could have contributed to exaggeration of children who behaved otherwise (definitely positive, positive and negative) during simple dental examination and prophylaxis which created a difficulty recruiting the required study sample.

The reason behind including PFQ was to determine presence or absence of association between any of questioned family related factors to parental style. In addition, PCPR was used to determine parental style as defined by Baumrind as: permissive, authoritarian and authoritative. Although PCPR is validated and reliable, parents might adopt different parenting styles depending on the situation e.g. in emergencies. Similarly, a response bias might have occurred. Though it was assumed that parents had replied to questionnaires truthfully, rating their acts -as spoiling their children or criticizing them- is subjective and might therefore differ from one parent's perspective to another.

According to the results of this study, permissive parenting was the most prevalent followed by authoritarian. Whereas, the least prevalent type was the authoritative parenting. This was in contrast to results encountered by Howenstein et al., 2015 [16] where the number of authoritarian parents was limited compared to authoritative and permissive styles.

Early psychological research by Baumrind, 1971[3] had reported that children of authoritative parents possessed high social maturity and were comfortable in general, and therefore would show decent behavior during dental treatment. Likewise, other studies had reported that authoritative parenting was associated with positive child behavior in comparison with other styles. [19, 20]

This was in contrast to the results encountered in this study where only 2% of the parents were authoritative. This could be considered as a limitation which might have resulted from potential selection bias. Though this could be a normal distribution among the investigated population, as to the best of our knowledge, no study reported a definite prevalence of parenting style in Cairo/ Egypt.

Besides, based on several studies, worse behavior in dental office were associated with permissive and authoritarian parental styles rather than the authoritative. [16, 20] This is because, permissive parents allow their children to take the lead in decisions and as a result in the dental clinic, those children often misbehave, and parents do not provide warning or punishment. Whereas, children of authoritarian parents usually act fearfully around strangers and therefore display poor behavior during dental treatment. This was in agreement with the high prevalence of permissive and authoritarian in comparison to authoritative parents in this study. This could be explained by the fact that definitely negative behavior was one of the inclusion criteria and accordingly permissive and authoritarian were high.

Regarding characteristics of the parents, the current study showed statistically significant association between educational level and parental style (p-value = 0.007). The highest percentage of authoritative parents was standard college degree graduates whereas, the highest percentage of authoritarian and permissive parents was secondary school graduates. This was in agreement with the results of Kamran et al., 2011 [21] and Shao et al., 2016 [18] where it was reported that the higher education the better parental style and child behavior. This could be explained by the impact of level of education on the parents' behaviors, style of parenting and of course their children's attitudes.

Further, a statistically significant association between number of children in the family and parental style (p-value = 0.010) was revealed. The highest percentage of authoritative parents had one child. This was concurrent with the results of other studies which reported that as the size of family or rather the number of children in the family increased, the possibility of corporal punishment by parents might get intensified. [22-24] This might be due to stresses and financial burdens that might arise with increase in family size.

Parents' age showed no statistical significant association with parental style in the current study. This was in contrast to other studies in which younger parents showed more frequent punishments than older ones due to lack of experience of dealing with children in various contexts. This difference might be because the majority of parents who participated in this study were in the age range of 25-35 years old and hence, the rest of age groups were not represented greatly among the study sample. [24-26]

Regarding the gender of parents, only mothers participated in the current study. As a result, no attempt was made to associate gender and parental style. This was in agreement with results encountered by other studies which showed no differences in corporal punishment between mothers and fathers. [26, 27]

This disagreed with results of other studies where mothers reported more common use of punishments perhaps because they spend more time disciplining their children meanwhile fathers were highly committed to work. [24, 25, 28]

Regarding the marital status of parents, majority of parents involved in this study were married and therefore no statistically significant association was conducted between marital status and parental style. This was in contrast to McCabe et al., 1999 [29] and Loeber et al., 2000 [30] who reported that single parents tend to exhibit harsh punishment to their children in comparison to married ones which they explained by additional responsibilities and loads which might in turn create tentative nervous environment.

Furthermore, average monthly income showed no significant difference when associated to parental style. Probably, this was encountered because most of the parents who participated in this study have monthly wage < 5000 LE and the rest of income strata were not equally presented in the study sample. This was in contrast to results of Wissow, 2001 [26] study, in which rates of corporal punishment were highest among parents who earn within the middle-income range.

Moreover, the geographic region to which the parents belong whether urban or rural area showed no statistical significance when associated to parental style. This contradicted the results of studies performed by Straus & Stewart, 1999 [25] and Gershoff, 2002 [14] which found that area in which families resided, had possibly lead to different parental styles and conflicting cultural beliefs which might either permit or prohibit using corporal punishment with children.

CONCLUSION

Definitely negative behavior was highly noted in children of permissive and authoritarian parents. Educational level and family size were significantly associated with parental style.

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APPENDIX

PARENT AND FAMILY QUESTIONNAIRE (PFQ)

1. Gender a.Male b.Female	**2. Marital status** a. Married b. Divorced
3. Educational level a. Nil b. Primary level c. Secondary level School d. Standard college degree e. Graduate or professional training	**4. Age** a. 25-35 years b. 35-45 years c. 45-55 years d. above 55 years
5. Number of children in the family a. 1 b. 2 c. 3 d. 4 e. 5 or more	**6. Social level** a. City, Urban b. Rural
7. How many previous encounters with a Doctor/Physician has your child had? a. 0 b. 1 c. 2 d. 3 e. 4 or more	**8. Estimated monthly income** a. < 5,000 b. 6,000-10,000 c. 11,000-20,000 d. 21,000 or >
9. Has your child been diagnosed with a chronic medical condition? a. Yes b. No	**10. Does your child have trouble sleeping?** a. No b. Yes, if yes, **have they been diagnosed with sleep apnea?** Yes or No
11. Has your child been diagnosed with any specific behavior problems/disorders? a. No b. Yes, Please Specify----------	

PRIMARY CAREGIVERS' PRACTICES REPORT (PCPR)

1. I am **responsive** to child's feelings and needs	2. I **use physical punishment** as a way of disciplining our child
3. I take child's **desires into account** before asking the child to do something	4. When our child asks why they must conform, I state: "**because I said so**," or "I am your parent and I want you to.
5. I **explain** to our child how we feel about the child's good and bad behavior	6. I **spank/hit** when our child disobeys
7. I **encourage** our child to **talk** about his/her troubles	8. I find it **difficult to discipline** our child
9. I encourage our child to **freely express himself/**herself even when disagreeing with me	10.I **punish by taking privileges away** from our child with little to no explanation
11.I emphasize the **reasons for rules**	12.I give **comfort** and understanding when our child is upset
13.I **yell or shout** when our child misbehaves	14.I give **praise** when our child is good
15.I **give into** our child when the child causes a commotion about something	16.I **explode in anger** towards our child
17.I **threaten** our child **with punishment** more often than actually giving it	18.I take into account our **child's preferences** in making plans for the family
19. I **grab** our child when being disobedient	20.I state **punishments** to our child and **do not actually do** them
21.I show **respect** for our child's **opinions** by encouraging our child to express them	22.I allow our **child to give input** into **family rules**
23.I scold and **criticize** to make our child improve	24.I **spoil** our child
25.I give our child **reasons why rules** should be **obeyed**	26.I use threats as **punishment** with little or **no justifications**
27.I have warm and **intimate times** together with our child	28.I **punish** by putting our child off somewhere **alone with little if any explanations**
29.I help our **child to understand the impact of behavior** by encouraging our child to talk about consequences of his/her own action	30.I scold or **criticize** when our child's behavior does not meet our expectations
31.I explain the **consequences** of the child's behavior	32.I **slap** our child when the child misbehaves

1=Never, 2=Once in a While, 3=About Half the Time, 4=Very Often, 5=Always