The Relationship Between Treatment Acceptability and Familism

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Abstract

Many studies have examined the acceptability of treatments for children with disruptive behaviors. However, few studies to date have tested the effects of home environment variables such as family support on treatment acceptability. In the current study, parents' level of familism was used to predict their willingness to accept several behavioral child treatment techniques. Eighty-two parents completed measures related to familism, child behavior problems, parenting stress, and acceptance of corporal and non-corporal punishment techniques before rating the acceptability of six child management techniques. Results indicate that higher levels of familism, especially perceived family support, are associated with higher treatment acceptability. These results are discussed in terms of their implications for clinicians in the area of treatments for children.
Key words: Treatment Acceptability, Familism, Child Behavior Problems.

The number of children who experience emotional and behavior problems has been estimated to range from approximately 10 to 20% (Mash & Dozois, 2003; Weisz & Weiss, 1993), and many of these children continue to experience problems throughout their lives. For example, Hofstra, Van der Ende, and Verhulst (2000) found that 29% to 41% (depending on the informant) of children ages 4 to 16 diagnosed with a psychological disorder were still diagnosable 14 years later. Furthermore, as children become adults, their problems may become more severe and costly to themselves, those around them, and society as a whole (Cohen, 1998; Leibson, Katusic, Barbaresi, Ransom, & O'Brien, 2001; Loeber & Farrington, 2000). This is concerning given that less than one-third of children and adolescents with psychological or behavior problems actually receive mental health services (U.S. Congress, 1986, 1991). Of those children and their families who seek treatment, it has been estimated that approximately 47% terminate early (Wierzbicki & Pekarik, 1993), thus not receiving the full benefit of therapy. To address these problems, clinical researchers have examined many ways to help families utilize and complete treatments.

One factor that may influence families' likelihood to utilize a treatment is its social validity. Wolf (1978) defined social validity as the concept that a psychological intervention must have value to society. He outlined three areas of an intervention that contribute to its social validity: its goals, its procedures, and its effects. Thus, a treatment must aim to teach a skill or behavior that has value to the community; the community must see the treatment's methods as acceptable; and the effects of the treatment, including unplanned effects, must be satisfactory to the community.

The current study focuses on Wolf's second criterion, whether a treatment's methods or procedures are acceptable to the community, or treatment acceptability. Kazdin (1980) defines treatment acceptability as judgments, made by various laypersons that may be potential consumers of a treatment, about aspects of the treatment's procedures such as their fairness, reasonableness, non-intrusiveness, and consistency with conventional concepts of treatment. To be acceptable, a treatment must be seen by the community as fair, justified, reasonable, and palatable (Kazdin, 2000).

Kazdin (2000) has demonstrated that treatment acceptability has been found to be a predictor of treatment effectiveness. In addition, Kazdin (1980) has explained that it is important to research the acceptability of various treatments because those treatments viewed by the public as more acceptable are more likely to be sought out and adhered to than those viewed as less acceptable or unacceptable. Thus, more clients can be reached and helped with acceptable treatments. Kazdin (1980) also contends that

treatment acceptability is especially important when working with children. This increased importance is partly due to the fact that, according to Kazdin, society tends to be especially protective of children. Furthermore, because children usually depend on their parents or guardians to make treatment decisions for them, the treatment must be acceptable to the parent or guardian who is responsible for the child as well as to society as a whole.

When working with families who have children who are socially disruptive, treatment frequently involves teaching the parents new child management techniques. Therefore, the parents must not only be willing to allow their child to participate in the treatment procedures; they must also be willing to participate actively in the treatment themselves and engage in new techniques at home. Thus, the parents' home environment becomes an important variable in their child's treatment. However, while researchers have examined many variables that may influence consumers' attitudes about the acceptability of psychological treatments, such as aspects of the treatment and demographic characteristics of the clients, little attention has been paid to home-environment variables such as family support.

The research to date on family environment variables indicates that these variables have a large impact on families' willingness to seek treatment. For example, Miller and Kelley (1992) found that having more marital problems was associated with lower acceptability ratings for positive reinforcement. In clinical studies, several researchers have found that higher levels of parents' perceived stress and higher numbers of adverse life events predict higher levels of attrition (Kazdin & Mazurick, 1994; Kazdin, Mazurick, & Bass, 1993; Kazdin, Stolar, & Marciano, 1995). In addition, Cunningham, Bremner, and Boyle (1995) found that, among participants enrolled in traditional, clinic-based, individual therapy, attrition was higher for those with poorer family functioning. Other family functioning variables that appear to be associated with higher levels of attrition are higher levels of adverse childrearing practices and increased levels or history of parental antisocial behavior (Kazdin & Mazurick, 1994; Kazdin, Mazurick, & Bass, 1993; Kazdin, Stolar, & Marciano, 1995). Thus, poorer family functioning appears to be associated with reduced compliance with treatment.

However, research investigating whether increased family involvement can improve treatment compliance and outcomes has yielded mixed results. In treatments for binge eating disorder (Gorin, Le Grange, & Stone, 2003) and for chronic headaches (Kneebone & Martin, 1992), treatment outcomes were not improved when spouses were involved in the treatment process. In contrast, other researchers have found that enrollment and attendance tend to be higher when a client's family is engaged in the treatment. For example, Edwards and Steinglass (1995), in a review of the literature on family involvement in treatment for alcohol abuse, found that while treatment outcomes were not always improved when families were involved, clients with alcohol-related problems were much more likely to enter treatment in the first place if their family members were taught techniques to encourage them to do so. Another study examined family treatment engagement among HIV-positive African American mothers with low incomes and found that mothers who had family members who were engaged in the treatment attended more treatment sessions (Mitrani, Prado, Feaster, Robinson-Batista, & Szapocznik, 2003). These studies appear to indicate that, while family involvement does not necessarily improve treatment outcomes, clients in some populations are more likely to accept and comply with treatment if their family members accept the treatment as well. However, this phenomenon has not been studied in relation to treatment for children with socially disruptive behavior problems.

It is plausible, based on social reinforcement theory (Borrego & Urquiza, 1998); to hypothesize that family support would be very important in treatment for children with disruptive behaviors. For example, Follette, Naugle, and Callaghan (1996) have described the importance of a therapist's use of appropriate social reinforcement to effect behavior change in a client, while Borrego and Urquiza (1998) have applied this concept specifically to therapy that involves parent training to manage child behavior problems. However, the family's social reinforcement of the client's participation in, compliance with,

and acceptance of a treatment and its procedures may be just as important as the therapist's use of social reinforcement. If the family creates a socially reinforcing environment for the parent when he or she uses new child management techniques, the parent is more likely to have positive feelings about these techniques. He or she will find the treatment to be highly acceptable and will be more likely to comply with the intervention. However, if the family is non-supportive of the treatment procedures and/or generates a negative environment around the parent when he or she attempts to use the new techniques, the opposite is likely to occur. The parent may have negative feelings about the treatment, find it less acceptable, and be less compliant.

Related to family, one important aspect is that of familism. Though this construct has primarily been examined with Hispanics, it may have some utility when working with parents who have children with socially disruptive behavior problems. Briefly, familism can be conceptualized as strong identification and attachment with nuclear and extended family members (Chun & Akutsu, 2003). This attachment and identification is displayed through increased social contact, social support, and reliance on these family members (Chun & Akutsu). Behaviorally, increased contact with family members will increase the likelihood that family members become aware that the parents are seeking treatment for their child. This is due to the fact that numerous behaviorally oriented child management programs include a homework component in which parents are asked to practice their newly acquired skills in different settings (e.g., when visiting other family members). As in the therapy room, social reinforcement of what the parent is doing in natural settings is crucial to the generalization of these skills to other settings and situations. Family members, along with other members of society, are key to assisting with this generalization.

Purpose

The current study tested the familism hypothesis by examining the relationship between family support and treatment acceptability. Parents' level of familism was used to predict their willingness to accept several child treatment techniques. In addition, familism was tested for its relationship with parent attitudes towards corporal punishment, the extent of their child's behavior problems, and their level of stress related to parenting.

Method

Participants

Participants were 82 parents of children aged 2 to 8. The mean age for parents was 32.74. Nineteen (23%) were male, and 63 (77%) were female. Fifty-seven (70%) were Caucasian, 22 (27%) were Hispanic, and one each was African-American, Asian-American, and Native American. Participants were recruited through community events, and their names were entered in a drawing for a gift certificate in exchange for participating.

Materials

Demographics form. Each participant was asked to complete a demographic questionnaire, which included questions regarding parent's age, gender, marital status, ethnicity, education level, income level, and number and ages of children.

Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999). The ECBI measures behavioral problems exhibited by children ages 2 - 16 years. Parents indicate the frequency of behaviors (Intensity score) and whether they are considered to be problematic (Problem score). Eyberg (1992) and Eyberg and Pincus (1999) reviewed studies demonstrating the reliability and stability of the ECBI, as well as the validity and sensitivity to change following parent training. The ECBI has been standardized on a number of populations (Eyberg & Pincus, 1999; Eyberg & Robinson; 1982; Eyberg & Ross, 1978). The

published cut-off scores for child deviancy are an Intensity score of greater then 131 or a Problem score of greater than 15.

Parenting Stress Index-Short Form (PSI-SF; Abidin, 1995). The PSI-SF was designed to provide clinicians with a shorter version of the original PSI. It seeks to identify parent-child dyads who are experiencing stress and who may develop dysfunctional parenting and child behavioral problems. The index consists of 3 subscales (Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child) and a Total Stress Scale. The manual (Abidin, 1995) reports alpha reliabilities of .79 for Parental Distress, .80 for Parent-Child Dysfunctional Interaction, .78 for Difficult Child, and .90 for the Total Stress Scale. The manual also reports that the PSI-SF has strong correlations with the PSI, indicating that it has good validity; however, it is noted that the PSI-SF's validity is not yet supported by independent literature.

Familism Scale. This study used the familism scale used by Sabogal, Marín, Otero-Sabogal, Marín, and Perez-Stable (1987). This scale is made up of 14 questions taken from familism scales developed by Bardis (1959) and Triandis, Marín, Betancourt, Lisansky, & Chang (1982). Each question is answered on a 5-point Likert-type scale (from "very much in disagreement" to "very much in agreement"). Sabogal and colleagues (1987) found that the scale yielded three subscales measuring different aspects of familism: Family as Referents, Familial Obligations, and Perceived Family Support.

Parenting Discipline Practices Questionnaire (PDP; Borrego, Ibanez, & Terao, 2002). The PDP is a 31-item questionnaire designed to assess a parent's attitudes toward different discipline practices. The questionnaire consists of items designed to assess acceptability of corporal punishment (e.g., spanking, hitting, pulling, pinching, and slapping) and non-coercive discipline techniques (e.g., time-out, reasoning, restriction of privileges, verbal reprimand, and ignoring). Items are rated on a six point acceptability scale ranging from 1= very acceptable to 6= very unacceptable. The questionnaire yields two factors: 1) a corporal punishment factor (e.g., spanking), and 2) a non-coercive discipline factor (e.g., time-out).

Treatment Evaluation Inventory-Short Form (TEI-SF; Kelley, Heffer, Gresham, & Elliott, 1989). The TEI-SF is a modified version of the Treatment Evaluation Inventory (TEI; Kazdin, 1980), which has been used in previous studies to rate the acceptability of treatments. Kelley et al. (1989) created the shorter, more efficient version by reducing the number of items from fifteen on the TEI to nine on the TEI-SF. The TEI-SF is a nine-question, 5-point Likert rating scale ranging from "Strongly Disagree" to "Strongly Agree." Kelley et al. (1989) found that the TEI-SF is an internally consistent and valid measure. The coefficient alpha was reported to be .85. However, more research is needed to further validate its psychometric properties.

Vignettes. Six vignettes, adapted from Jones, Eyberg, Adams, and Boggs (1998), asked participants to imagine that their child had been displaying behavior problems (meeting criteria for Oppositional Defiant Disorder) for several months. The vignettes then described a behavioral treatment option a therapist might recommend. The treatment options were Differential Attention, Ignoring, Token Economy, Response Cost, Time Out, and Overcorrection.

Procedure

Participants first completed the demographics form, ECBI, the PSI, the PDP, and the familism scale. The participants then read the vignettes asking them to imagine that their child has been exhibiting behavior problems and describing six different treatments for these problems. After reading about each treatment option, the parents rated its acceptability using the TEI-SF.

Results

A regression analysis indicated that the overall *Familism* score was predictive of treatment acceptability, with higher familism scores predicting higher acceptability ratings, $R^2 = .088$, $F(1,80) = 7.720$, $p = .007$. Overall treatment acceptability did not differ from Caucasians to Hispanics, $F(1,77) = .164$, ns, nor did the overall Familism score, $F(1,77) = 2.021$, ns. However, as the structure of familism tends to differ across ethnicities (Sabogal et al., 1987) and Hispanics had slightly but significantly higher scores (mean = 2.74) on the *Family as Referents* subscale than Caucasians (2.46), $F(1,77) = 4.207$, $p = .04$, an analysis was performed separately for Caucasians and Hispanics. Familism remained predictive of treatment acceptability for Hispanics, $R^2 = .225$, $F(1,20) = 5.799$, $p = .026$, but not for Caucasians, $R^2 = .027$, $F(1,55) = 1.552$, ns. However, an analysis of the optimal linear combination of the three factors making up the familism scale (Perceived Family Support, Family as Referents, and Familial Obligations) revealed that *Perceived Family Support* was the only factor accounting for a significant portion of the variance, $\beta = .326$, $t = 2.827$, $p = .006$ in treatment acceptability. Thus, a regression was performed using only the Perceived Family Support factor to predict treatment acceptability. This analysis revealed that higher Perceived Family Support predicted higher treatment acceptability for both Caucasians, $R^2 = .096$, $F(1,55) = 5.863$, $p = .019$ and Hispanics, $R^2 = .188$, $F(1,20) = 4.643$, $p = .044$.

The overall familism score was not significantly associated with PSI-SF scores, $R^2 = .0004$, $F(1,80) = .030$, ns; ECBI scores, $R^2 = .003$, $F(1,80) = .216$, ns; PDP corporal punishment scores, $R^2 = .009$, $F(1,79) = .710$, ns; or PDP non-corporal punishment scores, $R^2 = .007$, $F(1,79) = .551$, ns. Furthermore, the optimal linear combination of the three familism factors was not predictive of PSI-SF, $R^2 = .044$, $F(3,78) = 1.193$, ns; ECBI, $R^2 = .047$, $F(3,78) = 1.276$, ns; PDP corporal punishment, $R^2 = .019$, $F(3,77) = .501$, ns; or PDP non-corporal punishment scores, $R^2 = .064$, $F(3,77) = 1.769$, ns.

Discussion

This study tested the relationship between familism and treatment acceptability as well as with child behavior problems, parenting stress, and acceptance of corporal and non-corporal punishment options. Familism, especially Perceived Family Support, was significantly associated with treatment acceptability. Since ethnic differences in familism were expected and since Hispanics had higher scores on the Family as Referents subscale than Caucasians, the analysis was then conducted separately by ethnicity. Total familism remained predictive of treatment acceptability for Hispanics but not for Caucasians. However, the Perceived Family Support subscale was predictive of treatment acceptability for both Caucasians and Hispanics. Therefore, while Hispanics in this study were more likely to look to their relatives as guides for their behavior than were Caucasians, it appears that all participants, regardless of ethnicity, were more likely to accept the treatment techniques if they believed their families were supportive. Since the techniques must be performed at home, those who feel they have stronger family support may feel more comfortable with implementing them at home and in other settings. They may be more likely to expect their family members to support them whatever their need, including a need for child behavior management techniques.

Familism was not associated with the other variables examined in this study. This appears to indicate that familism varies independently of child behavior problems and parenting stress, although it should be noted that this was a community sample with relatively low scores and little variation in behavior problems and parenting stress. The lack of a relationship between familism and attitudes toward corporal and non-corporal punishment options is more surprising, since many of the non-corporal options are similar to the six techniques participants rated for treatment acceptability, which was associated with familism. It is possible that, because the treatment acceptability vignettes gave more detailed descriptions of the child's behavior problems and of the six treatment techniques, participants responded differently than to the shorter, less detailed items on the Non-corporal Punishment scale.

Clinical Implications

The association between Perceived Family Support and treatment acceptability indicates that family support is important when choosing a treatment. Clinicians therefore need to take the home environment into account when recommending treatment options, especially the home-based child management options studied examined in this study. Furthermore, clinicians should keep in mind that familism may vary independently of other family functioning variables such as child behavior problems, parenting stress, and beliefs about corporal and non-corporal punishment options. Thus, a lack of family support may cause difficulties even if parenting stress and/or child behavior problems are not clinically significant, while the presence of family support may provide assistance even if these variables are at clinically significant levels. Similarly, lack of family support may cause difficulties even if a parent has positive attitudes toward non-corporal punishment options while the presence of family support could have the opposite effect.

Limitations

As mentioned above, this study did not include a clinical sample. Parents whose children were actually exhibiting clinically significant disruptive behaviors could have had very different responses to the treatments described. Having a clinical sample would also have increased the range of variance in variables such as child behaviors; the study's participants had little variance in these variables, which may have limited the possibility of finding strong associations between factors. Another limitation was the relative lack of diversity in the participant pool. The Hispanic sample was relatively small, which may have limited the statistical power of the comparisons made. Furthermore, there was almost no representation of other ethnic minority groups. Fathers were also under-represented in the study.

Future Research

Future studies examining the effects of familism on treatment acceptability should use more ethnically diverse samples, as family involvement, family support, and treatment acceptance tend to differ across cultures. Researchers should also attempt to include more fathers in studies of treatments for children. Additionally, future studies should include a clinical sample in addition to a community sample, both to increase the variation in the sample and to be sure community findings generalize to clinical populations.

In summary, this study examined the impact of familism on several factors, most importantly treatment acceptability but also child behavior problems, parenting stress, and attitudes toward various discipline options. Familism was predictive of only treatment acceptability. While this relationship differed slightly across ethnicities, the relationship between family support and treatment acceptability was strong for both Caucasians and Hispanics. Thus, familism, especially perceived family support, appears to be important in a parent's decision to accept a treatment, independent of other family functioning variables. Researchers can use this information to gather more specific information on the impact of family environment variables on treatment acceptability and utilization. Clinicians should keep this information in mind when presenting treatment options to clients, as familism may impact a client's willingness to accept a treatment.

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