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An analysis of the relationship between parenting self-efficacy, the quality of parenting, and parental and child emotional health

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Introduction

Approximately 15% of children and adolescents in epidemiological studies, and up to 65% of youth in clinic samples meet criteria for a Disruptive Behavior Disorder (Burke, Loeber, & Birmaher, 2002; Nock, Kazdin, Hiripi, & Kessler, 2006), a diagnostic category of behavioral disorders characterized by defiance, aggression, impulsivity and delinquency (American Psychiatric Association, 2013). Disruptive Behavior Disorders (DBDs) are highly chronic disorders associated with impairments in academic, familial and peer functioning (Carlson et al., 1999; Lendingham, 1999), with high rates of co-occurrence with substance use and mental health disorders (Burke et al., 2002; Merikangas et al., 2010), criminal acts, incarceration, risk of suicide, and premature mortality (Acri et al., 2018). Child serving systems including behavioral health, juvenile justice, and the educational system expend billions of dollars annually in response to the legal, correctional, educational and psychological needs of these youth (Burke et al., 2002; Loeber et al., 2000).

The development and maintenance of child DBDs is theorized to be connected to the quality of parenting and the parent/child relationship. Coercion Theory, which derives from Bandura's (1978) Social Learning Theory, suggests that disruptive behaviors arise when the child and parent are engaged in a rigid, mutually reinforcing cycle in which the child's misbehavior is sustained and reinforced by less than optimal parenting practices, and the

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Disclosure Statement:

The authors declare that they have no conflicting interests.

Compliance with Ethical Standards

Research Involving Human Participants

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent

Informed consent was obtained from all individual participants included in the study.

parent is shaped by this exchange to continue engaging in the same parenting behavior. For example, harshly punishing the child's aggression is posited to increase future instances of aggression, and the caregiver is likely to rely upon a similar parenting style in cases of future misbehaviors. Inconsistent parenting and disciplinary practices are also associated with child behavior problems, as research shows that caregivers who engage in harsh parenting practices, including abuse, are more likely to initially deliver punishment inconsistently and then escalate to physically abusive forms of discipline (Lunkenheimer et al., 2016).

Research amply supports this theory, showing a lack of positive parenting practices such as difficulty establishing child management skills and disciplinary practices, lack of consistent child supervision and monitoring, and decreased positive parental involvement and warmth, are linked to child and adolescent externalizing problems (Chacko et al., 2015; Colalillo & Johnston, 2016; Frick & Muñoz, 2006; Haggerty et al., 2013; Jones et al., 2013). Several of these factors (e.g., inconsistent monitoring and supervision, harsh and/or inconsistent parenting), as well as parental endorsement of oppositional behaviors and elevated family conflict, are linked to DBDs specifically among adolescents (Haggerty et al., 2013).

Parenting self-efficacy is one of the factors that is receiving increased attention in the literature for its relationship to parenting quality. (Kohlhoff & Barnett, 2013). Similar to Coercion Theory, the concept of self-efficacy derives from Bandura's (1978) Social Learning Theory, and is defined as the belief that one can fulfill or achieve a certain objective. In relation to caregiving, parenting self-efficacy is defined as the caregiver's belief that they are fulfilling their parental role (Weaver et al., 2008). In several studies, parenting self-efficacy has been associated with the caregiver's quality of parenting (Jones & Prinz, 2005; Saders & Woolley, 2005) and both are directly related to child behavior problems (Jones & Prinz, 2005; Weaver et al., 2008) and indirectly via its influence upon parenting practices (Jones & Prinz, 2005).

Collectively, the literature suggests that there is a relationship between parenting self-efficacy, the quality of parenting, and child behavior problems. However, much of what we understand about these factors is based upon studies that included fairly homogenous samples of young Caucasian children (Weaver et al., 2008). Thereit is not clear how these findings generalize to families at the highest risk for child behavior problems- families living in poverty, who are predominantly racially and ethnically diverse. Indeed, children living in poverty-impacted communities disproportionately experience DBDs at rates up to four times greater than found among their higher SES counterparts (Ghandour, Kogan, Blumberg, Jones, & Perrin, 2012) due largely to caregivers' exposure to stressors including unemployment, community violence, inadequate and insecure housing, and scarce health and mental health resources (Acri et al., 2018).

These stressors also put caregivers at high risk for adverse behavioral health outcomes including depression, with recent studies suggesting that up to 25% of caregivers living in low-income environments meet criteria for depression (Gelaye et al., 2016), in comparison to 10% of the general population (Ertel et al., 2011). Not inconsequentially, caregiver depression is also one of the greatest threats to parenting self-efficacy (Bloomfield & Kendall, 2012; Kohlhoff & Barnett, 2013; Morawska & Sanders, 2007; Weaver et al., 2008),

parenting practices, and the parent/child relationship (Ertel et al., 2011; Lovejoy et al., 2000), and child behavior (Cummings & Davies, 1994; Feng et al., 2007).

Accordingly, the purpose of this study was to expand upon the literature by investigating the association between parenting self-efficacy, parenting practices child behavior problems, parenting practices and caregiver depression among a sample of ethnically-diverse families of youth with child-onset DBDs. This study was innovative in its focus on impoverished ethnic minority families who are at high risk for caregiver depression, as well as its focus on an older group of youth, who may have more complex behavioral problems and parenting challenges than infants and preschoolers.

The specific research questions under investigation were whether parenting self-efficacy was linked to the quality of parenting practices and child behavior problems, and if caregiver depression in turn was related to parenting self-efficacy. Based upon the existing literature, we hypothesized: (1) parenting self-efficacy would be inversely associated with child externalizing problems (Jones & Prinz, 2005; Weaver et al., 2008); (2) higher levels of parenting self-efficacy would be associated with positive parenting practices and lower levels of parenting self-efficacy would be associated with poor parenting practices such as inconsistent discipline and poor supervision (Jones & Prinz, 2005; Saders & Woolley, 2005); and (3) caregiver depression would be inversely related to parenting self-efficacy (Bloomfield & Kendall, 2012; Kohlhoff & Barnett, 2013; Morawska & Sanders, 2007; Weaver et al., 2008),

Methods

Study Overview

Participants include 213 caregivers of children between 7 to 10 years of age who participated in a NIMH-funded 4Rs and 2Ss Multiple Family Group field trial for youth Disruptive Behavior Disorder (DBD) from 2016 to 2018. Caregivers were recruited from 16 New York State Office of Mental Health-licensed public child mental health outpatient clinics in the New York metropolitan area. The 4Rs and 2Ss is an evidence-informed, manualized, family-centered, group delivered intervention that integrates essential practices of behavioral parent training, family therapy, and factors known to affect service utilization: Roles, Responsibilities, Relationships, Respectful communication, Social support, and Stress (4Rs and 2Ss; see Chacko et al, 2015, Gopalan et al., 2014 for a full description of 4Rs and 2Ss).

Inclusion criteria consisted of adults 18 years or older that spoke English or Spanish and were the primary caregiver of a child between 7 and 10 years of age who met criteria for Oppositional Defiant Disorder (ODD) as measured by the Disruptive Behavior Disorders Rating Scale (Pelham, Gnagy, Greenslade, & Milich, 1992). Caregivers were randomized to one of three conditions; services as usual, which are the typical services offered at outpatient mental health clinics for youth (e.g., individual therapy, pharmacology), or one of two treatment arms; 1) standard 4Rs and 2Ss, or 2) an adapted 4Rs and 2Ss model designed by a clinic implementation team consisting of providers, a clinic director, to fit the needs of the institution while maintaining fidelity to the intervention. The current sample consists of 213 participants, with 152 caregivers enrolled in the services as usual condition, 23 caregivers

enrolled in the standard 4Rs and 2Ss condition, and 38 caregivers enrolled in the adapted 4Rs and 2Ss condition. See Acri et al. (2018) for further details about the randomization procedure and treatment arms. New York University's Institutional Review Board provided approval for this study.

Table 1 presents demographic characteristics of the sample. Caregivers on average were 41 years of age ($SD = 11.61$) and most often identified as the child's mother (62%) and single/unmarried (42%). The majority of caregivers identified as Black/African American (34%) or White (24%) and roughly half Non-Hispanic/Latino (46%). Caregivers most often reported being US born (58%), speaking only English (51%), having education beyond high school (52%), and working full-time (38%). Caregivers most often reported a household income of less than \$9,999 a year (20%) or \$10,000 to \$19,999 a year (24%). On average, it was reported that there were 2.25 children within a household ($SD = 1.15$). As for youth, the average age was 9 ($SD = 1.49$) and the majority were male (68%). The majority of caregivers identified their child as Black/African-American (36%) or White (22%) and Hispanic/Latino (53%).

Measurement

All assessments for the purpose of this study were administered at baseline (prior to the intervention beginning for those in the intervention arm of the sample), and no differences between groups were assessed. Demographic characteristics were collected via a sociodemographic questionnaire used in prior studies that assessed contextual familial factors (e.g. gender, race, ethnicity, age, etc.).

Parenting self-efficacy—Self-efficacy in parenting was measured via a single item from the Parenting Stress Index Short Form (PSI-SF; Abidin, 1995) about one's role as a parent. Responses to the stem, "I feel that I am," range from *not very good at being a parent* (1) to *a very good parent* (5) with *average* in the middle (3)." For hypothesis 3, the 5 items were collapsed into 3 categories: better than average parent, average parent, and below average parent. As the current study involves participants of the underway 4Rs and 2Ss trial, it was not possible to add a full scale to assess for parenting self-efficacy. This limitation is reviewed in the discussion section.

Child ODD—ODD was measured by the Iowa Connors Rating Scale. Completed by the child's caregiver, this subscale consists of 10 items that are ranked using a 4-point Likert scale ranging from *not at all* (0) to *very much* (3). The scale consists of two five itemed subscales: Inattention/Overactivity and Oppositional Defiant. Total scores range from 0 to 30, and the established cutoffs in the literature for meeting criteria for inattention are 11 for children between 7 and 8 years of age, and 9 for children 9–10 years of age, while the cutoffs for the Oppositional Defiant Subscale are 9 for children 7–8 years of age, and 6 among children 9–10 years of age (Loney & Milich, 1982). A previous randomized effectiveness study of the 4Rs and 2Ss intervention found that this scale had good internal consistency with a Cronbach's Alpha at baseline of .86 (Acri et al., 2017).

Parenting factors—Parenting practices and factors were measured using the Alabama Parenting Questionnaire (APQ-9) short form, with specific focus on positive parenting, inconsistent discipline, and poor supervision (Elgar et al., 2007). Subscale items stem from the request to rate as to how often a statement typically occurs in the home, for example: *you let your child know when he/she is doing a good job* (positive parenting), *you let your child out of a punishment early* (inconsistent discipline), and *your child is out with friends you don't know* (poor supervision). The nine items (3 in each subscale) are measured in terms of frequency, ranging from *never* (1), to *always* (5). Items are summed to determine positive parenting, inconsistent discipline and poor supervision. The APQ-9 short form was shown to be reliable and valid in two prior studies and has a Cronbach alpha ranging from 0.59 to 0.84 in the first study and 0.80 to 0.92 in the second study (Elgar et al., 2007).

Caregiver depression—Depression was measured in caregivers using the Center for Epidemiologic Studies Depression Scale 7-item Short Form (CESD-SF; Levine, 2013; Radloff, 1997) at baseline. The CESD-SF is a free and publicly available screening tool consisting of 7 items that assess the frequency of depressive symptoms occurring in the past week: *rarely or none of the time* (0), *some or a little of the time* (1), *occasionally or a moderate amount of time* (2), *most or all of the time* (3). Participants were asked to respond to how often each statement was experienced, for example: *I did not feel like eating, I could not get going, and my sleep was restless*. CESD-SF scores are summed and range from 0–21, with a score of 8 and above considered measuring clinically significant depressive symptoms (Levine, 2013). Internal consistency among the total sample was good with a Cronbach's α of .82 at baseline.

Data Analysis

Data were analyzed using SPSS 24. Preliminary analyses included univariate and bivariate explorations of demographic and clinical characteristics to examine potential missing data, variable distributions, multicollinearity, and to describe and better understand the sample. All variables of focus had 2% missing data, on average, and were normally distributed with no evidence of outliers. Bivariate correlations were examined for all variables in hypothesis testing as well with no evidence of multicollinearity ($r < .6$). In addition, to explore the relationships between parenting self-efficacy and child externalizing problems prior to regression modeling, independent proportions of clinically youth inattention and ODD scores among differing perceptions of parenting were examined using Chi-Square tests. Next, a Linear Regression Model was built to examine the relationships between positive parenting, inconsistent discipline, poor supervision, and parenting self-efficacy. Lastly, a one-way between groups analysis of variance (ANOVA) was performed to examine the relationships between caregiver depression and three categories of parenting self-efficacy (better than average, average, and below average).

Results

The majority (58%) of caregivers reported that they were a *better than average parent*. Scores for parenting practices were 13.38 ($SD = 2.06$) for positive parenting, 8.36 ($SD = 2.82$) for inconsistent discipline, and 3.53 ($SD = 1.50$) for poor supervision. As for youth

externalizing behavior, on average, inattention scores at baseline were 10.42 ($SD = 3.21$) and ODD 9.93 ($SD = 3.11$). The majority of youth met clinical cutoff for inattention (60%) and ODD (82%). The mean depression score for caregivers was 7.68 ($SD = 5.64$).

A significant difference in the proportion of caregiver's parenting self-efficacy was found among youth who did and did not meet clinical cutoff for child inattention problems ($\chi^2(2) = 6.31, p < .05$). Among parents who perceived themselves as being a "better than average parent," there was a greater percentage of youth who met clinical cutoff for inattention problems (57%) as compared to youth who did not meet clinical cutoff for attention problems (43%). There were no significant differences in the proportions of caregiver parenting self-efficacy among youth who did and did not meet clinical cutoff for child ODD.

The linear regression model (Table 2) examining relationships between parenting self-efficacy and parenting practices (positive parenting, inconsistent discipline, and poor supervision) demonstrated good model fit ($F(3,196) = 5.51, p < .01$). For every one-unit increase in positive parenting scores, on average, there was an associated increase in parenting self-efficacy, holding constant inconsistent discipline and poor supervision ($b = .14, SE = .04, p < .01$). In other words, as use of positive parenting practices increased, perceptions of parenting self-efficacy became more favorable. In addition, for every one-unit increase in perceptions of parenting, on average, there was an associated decrease in inconsistent discipline scores, holding constant positive parenting and poor supervision ($b = -.06, SE = .03, p < .05$). Thus, as caregivers' discipline became less consistent, perceptions of parenting self-efficacy became less favorable. There was no significant relationship between perceptions of parenting and poor supervision ($b = .07, SE = .01, p > .05$).

Lastly, a one-way between groups analysis of variance (ANOVA) was performed to examine caregiver depression and three categories of parenting self-efficacy (better than average, average, and below average). Illustrated in Table 3, significant differences were found in caregiver depression scores between differing categories of parenting self-efficacy (better than average ($M = 6.48, SD = 4.72$), average ($M = 8.36, SD = 5.03$) and below average ($M = 11.30, SD = 5.97; F(2, 193) = 11.55, p < .001$). In looking at the multiple comparisons with a Post-hoc Tukey HSD test, depression scores of caregivers who reported the perception of being a below average parent were significantly different from those who reported being an average parent ($p < .05$) and those above average ($p < .001$). Essentially, depression scores among caregivers who identified as a below average parent were greater than depression scores of caregivers who identified as an average parent or above average parent.

Discussion

This study, conducted with impoverished, ethnic minority families of children with Oppositional Defiant Disorder, set out to examine the relationship between caregivers' perceptions of their parenting and the functioning of their children. The first hypothesis of this study, which proposed that there would be an inverse association between self-efficacy and child externalizing problems (Jones & Prinz, 2005; Weaver et al., 2008), was not supported by the data in this study. In fact, over half the caregivers in the sample perceived themselves to be better than average parents but within this group, there were a higher

proportion of children with inattention problems than children without this problem. Consequently, caregivers' higher perceived parenting was not related to better child outcomes, and in fact, the opposite result was found.

There are multiple possible interpretations for this finding. It may be that parents do not see a connection between parenting and their child's behavior problems or they may attribute their child's behavior problems to innate or other fixed causes that are beyond their influence. It may also be that child inattention, which is one of several manifestations of ODD, was not considered to be a major problem, given the many parenting and social challenges with which these families must cope.

However, the more likely and complex explanation may relate to cultural and contextual factors that influence the notion of parenting self-efficacy. While it is widely understood that perceived self-efficacy refers to confidence in one's ability to complete a task or role, recent critiques have pointed out that there is little understanding of what composes this confidence, or how this construct works for different cultural or ethnic groups (Burke et al., 2009). With regard to self-efficacy in parenting, confidence may be based on particular conceptualizations of good parenting that were not captured in this study. Indeed, research indicates families from low-income neighborhoods, where threats to psychosocial functioning are greater, place emphasis on racial socialization strategies as a means of preparing their children for hardships they may face as racial minorities (Rodriguez, McKay, & Bannon, 2008). For African American parents, this involves balancing the tasks of promoting cultural pride, preparing children for the demands of life in mainstream society, and equipping children to deal with racism and discrimination (Rodriguez, McKay & Bannon, 2008). Amongst this group, assessments of self-efficacy may be determined by one's ability to enact "conversations and actions that communicate to children how to survive with dignity and pride in a racist world" (Stevenson, Davis, & Abdul-Kabir, 2001, p. 46), rather than by universally accepted notions of positive parenting and discipline. Being a "better than average" parent may be a ranking adopted by those who believe they are able to keep their children safe in a harsh, unsupportive and sometimes violent environment. In light of the high degree of environmental adversity facing the sample represented in this study, a broader understanding of the nuances of parental self-efficacy is needed.

The second hypothesis, that perceptions of parenting would be associated with parenting practices (Jones & Prinz, 2005; Saders & Woolley, 2005), was supported, in that high levels of parenting self-efficacy were associated with high levels of positive parenting (e.g. praising and complimenting their children when they behave well) and consistent discipline (e.g. following through with a punishment for their child). This finding is consistent with the extant literature, which suggests that parental self-efficacy impacts parenting practices and may be seen as a possible predictor of parental competence (Jones & Prinz, 2005). Some research on parenting self-efficacy has been conducted with ethnic minorities specifically, and results seem to concur. Dumka and colleagues' (2010) longitudinal study of parenting self-efficacy and parenting practices in Mexican American families provided evidence supporting parenting self-efficacy as an antecedent causal variable in relation to parents' positive control practices (monitoring and consistent discipline).

In light of this relationship, enhancing parental self-efficacy may be an important intervention strategy for promoting positive parenting. It is plausible that with improved and more effective parenting practices, parenting self-efficacy may ameliorate. Research shows that there are such strategies at the family level that can be implemented effectively. One example is the Triple P-Positive Parenting Program (Sanders 1999), which aims to strengthen parents' self-regulation skills and self-efficacy in managing parenting tasks. A systematic review and meta-analysis of 101 studies conducted over a 33-year period showed significant effects of this program for parenting practices, parent satisfaction and efficacy (Sanders et al., 2014).

The third hypothesis, which posited that there would be an inverse relationship between parenting self-efficacy and caregiver depression (Bloomfield & Kendall, 2012; Kohlhoff & Barnett, 2013; Morawska & Sanders, 2007; Weaver et al., 2008), was also supported in this study. Caregivers who identified as a better than average parent had lower depression scores than caregivers who identified as an average or below average parent. This finding aligns with a substantial body of research that points to an inverse relationship between caregiver depression and parenting self-efficacy (Bloomfield & Kendall, 2012; Kohlhoff & Barnett, 2013; Morawska & Sanders, 2007; Weaver et al., 2008). Caregiver depression is concerning not only because of the parental distress it causes, but also because of the parenting difficulties and subsequent child externalizing and internalizing problems associated with it (Goodman & Gotlib, 1999; Lovejoy et al., 2000). Therefore, this study adds further evidence to the need for caregiver support and strategies to improve self-efficacy to promote the well-being of parents and their children. This need is particularly dire amongst impoverished families because of the influence of poverty upon parental emotional health.

In light of the findings, there are several limitations of the current study. First, there was no formal measure of parenting self-efficacy in the current study. Ideally a standardized multi-item scale would be used to measure all constructs, yet the constraints of this ongoing NIMH-funded 4R2S study did not allow for changes to measurement at this point in time. Thus, findings should be interpreted with the knowledge that self-efficacy was a one-item measure and future research should utilize a full standardized scale. Second, yet stemming off from the self-efficacy measurement issue, we recognize that there are potential differences in perceptions of what it *means* to be a less than average, average, or better than average parent. Meanings surrounding these categories are likely impacted by sociocultural factors and it would be beneficial for future research to examine these meanings qualitatively. Lastly, there are potential limitations that threaten internal validity. In addition to the potential of confounding variables, self-selection bias and social-desirability are of concern. Participants in various clinics were told about the study and completed a screening assessment to determine eligibility if interested in participating. Since participants were not randomly selected and essentially volunteered for participation after hearing about the study, it is important to consider the potential of differences to be apparent between those who did and did not seek or pursue participation. Future research should include a small assessment for those who refused to participate. As for social-desirability, it is always possible participants may respond to questions in a socially desirable way, especially when parenting self-efficacy is a topic of question.

Despite the limitations noted, this study along with previous research pointing to the effectiveness of behavior parent training programs for child DBDs (Burke, Loeber, & Birmaher, 2002), underscores the need for involving parents in interventions targeting Disruptive Behavior Disorders. Clinics such as the ones recruited for this study may benefit from guidance on the importance of offering services to parents when families seek help for their children with DBDs. As this study showed, parental self-efficacy is associated with positive parenting and lower levels of depression, so programs that target this goal are needed. Yet, the majority of families of children with behavior problems do not receive such interventions (Acri et al., 2018). Policy makers and decision makers in the child health and social service systems must be made aware of this dire need, so that funding and access to family-oriented services can be enhanced. Furthermore, ensuring that such intervention strategies are effective requires consideration of the many determinants of parental self-efficacy estimations. In this study, culture and ethnicity may have played into parental perceptions, and researchers have identified other variables as well, from contextual factors such as employment status and social support (Coleman & Karaker, 1998), to parental factors such as knowledge of child development and perceptions of stress. Development of informed, effective intervention strategies designed to increase parental self-efficacy requires a clear understanding of these determinants, and parents themselves are well positioned to illuminate them. Services grounded in evidence that help parents enhance their self-efficacy must become a priority for funders, service providers, and parents themselves.

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Table 1.

Demographic characteristics of participants

Characteristic	n	%
Child age (M ± SD)	203	8.79 ± 1.49
Caregiver Age (M ± SD)	199	40.74 ± 11.60
Child Gender		
Male	144	67.6
Female	69	32.4
Child Race		
White/Caucasian	46	21.6
Black/African American	76	35.7
Native American	6	2.8
Asian/Pacific Islander	8	3.8
Child Ethnicity		
Hispanic/Latino	112	52.6
Non-Hispanic/Latino	93	43.7
Primary Caregiver		
Mother	133	62.4
Father	5	2.3
Grandparents	14	6.6
Mother and father	46	21.6
Caregiver Marital Status		
Married/Common Law/Domestic Partner	77	36.2
Single	89	41.8
Divorced	18	8.5
Separated	15	7.0
Widowed	7	3.3
Caregiver Race		
White/Caucasian	50	23.5
Black/African American	72	33.8
Native American	2	0.9
Asian/Pacific Islander	5	2.3
Caregiver Ethnicity		
Hispanic/Latino	97	45.5
Non-Hispanic/Latino	98	46.0
Caregiver Education		
High School (HS) or Less	48	23.1
Completed HS/GED	50	23.5
Beyond HS/GED	110	52.0
Caregiver Employment		
Full-time	80	37.6
Part-time	25	11.7

Characteristic	n	%
Disabled	25	11.7
Unemployed	49	23.0
Family Income		
Less than \$9,999	43	20.2
\$10,000 to \$19,999	51	23.9
\$20,000 to \$29,999	33	15.5
\$30,000 to \$39,999	23	10.8
\$40,000 to \$49,000	14	6.6
Over \$50,000	30	14.1

Note: n= 213

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Table 2:

Linear regression of parenting practices and self-efficacy

Predictor	<i>B</i>	SE	<i>t</i>	<i>p</i>
(Constant)	2.450	.580	4.224	.000
Positive Parenting	.136	.040	3.412	.001
Inconsistent Discipline	-.059	.029	-2.059	.041
Poor Supervision	.706	.001	1.508	.133

Note: SE= standard error; dependent variable is parenting self-efficacy; n= 213

Table 3:

Post Hoc Test of One-Way ANOVA

Parenting Self-Efficacy (I)	Parenting Self-Efficacy (J)	Mean Difference (I-J)	SE	<i>p</i>
Below average	Average *	2.94	1.14	.029
	Better than average **	4.82	1.03	.000
Average	Below average *	-2.94	1.14	.029
	Better than average	1.88	.83	.065
Better than average	Below average **	-4.82	1.03	.000
	Average	-1.88	.83	.065

*
<.05**
<.001

SE = standard error

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