

Increasing Parental Self-Efficacy through Education to Impact Child Health Behavior

By

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A DNP Project

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May 8, 2017


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Abstract

Childhood obesity is a major public health crisis nationally and internationally (Karnik & Kanekar, 2012). The prevalence of childhood obesity has continued to increase causing a rise in several comorbidities at an early age. These comorbidities include but are not limited to hypertension, diabetes mellitus type 2, insulin resistance, hyperlipidemia, and psychosocial problems. These chronic diseases will likely persist into adulthood. According to the Centers for Disease Control and Prevention (CDC) there is approximately 17% (or 12.7 million) of children and adolescents aged 2-19 years are obese (CDC, 2012). If obesity trends continue to increase in future generations, the healthcare system will sparrow into a debt crisis. The decline and prevention of childhood obesity must become more family centered and family focused to see positive outcomes. Parental self-efficacy through education regarding therapeutic lifestyle changes will formulate stable and consistent progress to decrease childhood obesity. The focus cannot be only on the children losing weight but also on the changing of thinking and behavior among the parents. Parents are the ones that influence eating habits as well as physical activity. When there is a change behavior of how parents view obesity and complications, then the process of family centered progress can begin.

A Doctorate of Nursing Practice (DNP) project “Increasing Parental Self-Efficacy through Education to Impact Child Health Behavior” was implemented. The setting was a private practice pediatric health clinic in Northeast Mississippi. The purpose of this project was to increase parental self-efficacy through education on therapeutic lifestyle changes, which will impact child behaviors in regard to obesity. The project was successful with the results indicating that parental self-efficacy was improved.

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Background and Significance

Obesity is a global pandemic healthcare problem affecting more than 300 million adults and another 18 million children worldwide. The World Health Organization (WHO) has labeled this escalating healthcare problem as “globesity”. Obesity affects all ages, races, socioeconomic groups, and countries. Childhood obesity is an epidemic problem in healthcare that has affected approximately 17% or 12.7 million children and adolescents ages 2-19 years of age according to Centers for Disease Control (Centers for Disease Control and Prevention, 2012). The Centers for Disease Control (CDC) reported that children aged 12-19 years old had the highest percentage at 25% of obesity compared to children 2-11 years old.

Childhood obesity is also a global epidemic (Showell et al., 2013). If childhood obesity is not addressed, chronic diseases including hypertension, diabetes mellitus, heart disease, kidney disease, and cancers stand to increase exponentially. More than 30% of American children and adolescents are overweight or obese (Wang et al., 2013). The cost of taking care of a generation of chronically ill people could cause healthcare to become bankrupt. Not only will healthcare costs continue to skyrocket, but life expectancies will decrease due to the effects of these debilitating chronic illnesses brought on by childhood obesity and unhealthy lifestyle patterns engrained during childhood (Wang et al., 2013).

Childhood overweight and obesity brings with it them a multiplicity of risk factors, chronic disorders, and psychological ramifications. Therapeutic lifestyle changes among children may include healthy, nutritional eating and physical activity that will help decrease childhood obesity. Parental influence, including feeding style and ability to encourage increased child physical activity, are major determinants of childhood health behavior through altering food provision and social environment (Lo, Cheung, Lee, Tam, & Keung, 2015; Wijewardane, 2011).

Parents have a powerful influence in their children's early years when introducing foods and developing eating and physical activity patterns. Authoritative parenting, which includes high levels of warmth and behavioral control, has been associated with lower risk of obesity (Rhee et al., 2016).

Children began to develop these patterns that mirror those of their parents (or caregivers). Parents choose foods that are similar to their cultural practice which in turn begins to mold eating and behavioral patterns. When parents change eating and activity patterns, they act as models for children to do the same (Andriani, Liao, & Kuo, 2015). Education for parents of children who are at risk for overweight and obese will help ensure that these therapeutic lifestyle changes are implemented, and thus prevent or decrease risk factors for obesity related chronic diseases in the future. Parental perception about their child's overweight status is an important precursor or determinant for preventative actions (Peyer, Welk, Bailey-Davis, Yang, & Kim, 2015).

Problem Statement or Purpose

The purpose of this project was to measure the impact of the parental education component of the PHYC intervention for children referred to the program that is primarily for obese and overweight children. Childhood obesity has been attributed to poor eating habits, lack of exercise, certain medications, and illnesses; in general, unhealthy child health behaviors. Regardless of the cause, there has to be a planned implementation to decrease this growing problem. Healthcare providers must be proactive in the fight against childhood obesity. The focus must not be on the children alone, but must have complete and consistent involvement of parents. The implementation of a project to educate parents about and utilizing therapeutic lifestyle changes should improve parental self-efficacy to influence child health behaviors. As a

result, parents with improved self-efficacy to influence child health behaviors may be more likely to be effective in guiding their children to weight loss and healthier lifestyles in general.

Theoretical Framework

The theory selected to help guide this project directed at increasing parental self-efficacy through education to impact child health behavior was Nola J. Pender's Health Promotion Model (Pender 2016). Pender's Health Promotion Model is aimed at helping the individual change behavior by introducing influences on people to help change outcomes. Health professionals, such as providers, can influence change in behavior by introducing interventions on parents to navigate change regarding health issues regarding their children. Lifestyle changes can decrease school-aged children's risk factors by guiding them in healthier choices. Pender's model focuses on promoting desired outcomes from interventions introduced to individuals to improve health and better quality of life. Incorporating lifestyle changes to these school-aged children can begin changing a generation that is considered in epidemic trouble to wiser and healthier leaders of tomorrow.

Nola J. Pender's health promotion model (HPM) was fashioned to be a "complementary counterpart to models of health protection." Pender's model focuses on these three areas:

1. Individual characteristics and experiences
2. Behavior-specific cognitions and affect
3. Behavioral outcomes.

Health promotion model denotes that each person has their own set of characteristics and experiences which will affect actions. There are many variables that can affect behavioral specific knowledge which can become of significance. Healthcare providers can change these specific variables by introducing interventions which can change behavior. The interventions

introduced into a person situation should improve health, functionality, and quality of life during the time living. According to the Theoretical Foundations of Nursing health promotion is defined as behavior motivated by the desire to increase well-being and actualize human health potential. First, health protection and illness prevention in accordance with Pender's health promotion model is aimed at inspiring behaviors that try to avoid particular illnesses, intervene early, or maintain stability within the illness. Therefore, Pender's model in conjunction with lifestyle changes is focused at health protection or illness prevention to detect early or maintain functionality. Secondly, behavior-specific cognitions and affect deals positive outcomes, barriers to interventions trying to be introduced, self-efficacy, and interpersonal influences and situations. Lastly, a term used in Pender's health model is behavioral outcomes which are important in lifestyle changes. The person must be committed to adhering to a particular intervention to experience the positive outcomes of the implemented variable.

Project Description

The population of interest for this project was parents of children ages 3-16 years whose children are obese, overweight, or at risk for overweight. The intervention proposed was the parental education component of the Pediatric Healthy You Clinic (PHYC) to which many of these children are referred. No comparison group was used, as the phenomenon of interest is improvement of Parental Self-Efficacy to influence Child Health Behaviors. An evaluation of this specific area of parental self-efficacy on entry to the PHYC and at the second visit into the program was the comparison, while the hypothesized outcome was improved self-efficacy documented at the second visit into the program as measured by the Cooper Parental Self-efficacy Scale-Child Health Behavior (CPSS-CHB) (Wijewardane, 2011).

The CPSS-CHB is a 28 item scale designed to measure parental self-efficacy as it related to child health behavior. The CPSS-CHB contains three factors including problem times, stress times, and good times. The overall Alpha coefficient for the scale was 0.96. The problem times factor Alpha coefficient was 0.93, stressful times was 0.94, and good times was 0.86 (Wijewardane, 2011).

PICO Question

The PICO question that guided this project was as follows: “Can parental self-efficacy to affect child health behaviors be improved through implementation of a therapeutic lifestyle education program for parents of obese and overweight children who have been referred to an established education program?”

Definition of Terms

The following key concepts were defined for the project to clarify the implementation process. Each term was defined both theoretically and operationally.

Childhood Obesity.

Theoretical. For children and teens obesity is defined as a body mass index (BMI) at or above the 95th percentile of the same age and sex and can lead to multiple chronic conditions. (<http://www.cdc.gov/obesity/defining.html>)

Operational. For the purpose of this project, childhood obesity is a medical condition that affects children and adolescents whose parent participated in the project.

Parental Self-efficacy.

Theoretical. Parental self-efficacy can be defined by breaking down separately to formulate a meaning. A parent is a person who brings up or cares for another and efficacy is the power to produce a desire result or effect (Merriam-Webster Dictionary Online, 2015).

Operational. For the purpose of this project, parental self-efficacy is an evaluation of a parent's behavior in regard to implementing therapeutic lifestyle changes of their children who are obese as measured by the CPPS-CHB (Wijewardane, 2011).

Education.

Theoretical. The knowledge and development resulting from an educational process (Merriam-Webster Dictionary Online, 2015).

Operational. For the purpose of this project, education is an educational program instituted by a nurse practitioner at a Pediatric Healthier You Clinic located in Northeast Mississippi.

Influence.

Theoretical. The capacity to have an effect on the character, development, or behavior of someone or something or the effect of itself (Oxford Dictionary Online, 2015).

Operational. For the purpose of this project, influence is integrated to guide parents into consistency in introducing and continuing therapeutic lifestyle changes in their obese children.

Search Method

The search strategy was completed using Discovery Service through Mississippi University for Women Fant Library online. The conductor of this project began by searching child health behaviors, which yielded 2,084,399 search results. The term parental involvement was then added, which yielded 191,725 results, followed by parental self-efficacy, which yielded 22,371 results, then parental influence on child health behaviors, which yielded 19,504 results. Publication dates were limited to 2011 to present, which finally yielded 7,860 results. Limiting to academic journals yielded 7,037 results; limiting to scholarly journals in full text yielded 7,016 results. Limiting results to English only yielded 4,686 results. These results were crossed

referenced and limited to the subjects of child health behaviors, parental involvement, and self-efficacy to yield 96 results. After reviewing these for duplicates, 49 articles were reviewed, and 10 articles were retained.

Literature Synthesis

Spence, Campbell, Crawford, McNaughton, and Hesketh, (2014) conducted a cluster-randomized controlled trial study involving first-time parent's knowledge of feeding regimens with infant's ages 4-15 months of age. The researchers focused on determining if parental influences would have any barriers on the child's diet quality. Both parents were allowed to participate in the study. The results of the Melbourne Infant Program showed that maternal knowledge about feeding regimens improved child diet quality.

The urgent need for decreasing the prevalence of childhood obesity makes research on developing programs that can be adapted into clinical practice highly relevant (Ek et al., 2015). The researchers assessed the effects of early intervention in regard to starting treatment regimens in early childhood in relation to obesity. The researchers realized that parental involvement along with physical activity was crucial in gaining positive outcomes.

Davies, Terhorst, Nakonechny, Skukla, and El Saadawi (2014) conducted a study utilizing web-based information in regard to parental self-efficacy in regard to managing childhood obesity risk factors. Many parents access websites in regard to health problems. Sixty nine percent of the parents that utilized this website generated self-efficacy improvement in at least two of the nine risk factor areas implemented.

During toddlerhood, children commonly show obstinate and defiant behaviors as they strive to acquire more autonomy. At the same time, parents, while attempting to meet their expectations of compliance, begin to exert more control over their child's behavior (Rijen,

Gasanova, Boonstra, & Huijding, 2014). The study focused on the importance of parental actions in regard to the development of behavioral problems in the toddler. The researchers showed that early intervention with consistent parental guide does influence behavioral methods early.

Quelly (2014) conducted a study involving childhood obesity prevention focusing on school nurse's perception and practice. The researcher examined the responses of school nurses and parents when dealing with monitoring obesity in the school. The study showed that parents of certain ethnic groups inaccurately seen the correct perception of their child in relations to being obese. As for the school nurses, they were not prepared to talk with parents in regards toward obesity matters.

In a study focusing on infants, toddlers, and preschoolers up to age five, Nickelson, Lawrence, Parton, Knowlden, and McDermott (2014) looked at the consumption of sweetened beverages. The introduction of these sweetened beverages can cause early onset of obesity in these children. The early education to inform parents of the effects of sweetened beverages at an early age can increase the risk of becoming obese or overweight at an earlier age.

Webber and Loescher (2013) conducted a study on parental modeling. They found that children of parents who did engage in healthy eating and regular exercise maintained healthy weights. The influence here is noted in children whose parents demonstrated healthy lifestyles. Parental influence is crucial in shaping healthy behaviors among their children to prevent obesity or overweight issues.

The compilation of these findings from the literature underscores the profound influence that parents and other significant adults have on the development of good eating habits leading to good health, or contrarily, poor eating habits leading to obesity and negative health outcomes. This literature review laid a firm foundation for the legitimacy of a project that sought to

influence parental self-efficacy for improving healthy lifestyles among children inclined to be overweight and obese.

Project Design

The population of interest for this project was parents of children ages 3-16 years whose children are obese, overweight, or at risk for overweight. The intervention proposed was the parental education component of the Pediatric Healthier You Clinic (PHYC) where many of these children are referred. Parents were given the Cooper Parental Self-efficacy Scale-Child Health Behavior (CPSS-CHB) tool to fill out during the ~~first~~ initial visit and prior to second visit, which occurred approximately one month later to analyze changes in parental self-efficacy. The project was supported by Will McDow, PHYC director and clinic staff members. There were no risks identified since the evaluation was focused on the education of parents to improve self-efficacy.

Evaluation Plan

No comparison group was used for evaluation since the phenomenon of interest was improvement of Parental Self-Efficacy to influence Child Health Behaviors. Each parent was given the CPSS-CHB form to fill out upon entry to the PHYC. The hypothesized outcome was improved self-efficacy at the second visit one month into the program as measured by the Cooper Parental Self-efficacy Scale-Child Health Behavior (CPSS-CHB).

Approvals

IRB approval was obtained from the Mississippi University for Women's Internal Review Board. A letter of agreement with Children's Health Center of Columbus PHYC and parents of children referred to the PHYC was completed regarding completion of the CPSS-CHB

during the initial visit and prior to second visit to measure parental self-efficacy on therapeutic lifestyle changes.

Data Analysis

The objective data was analyzed from the results of the CPSS-CHB completed by parents of children referred to the PHYC along with the subjective responses from the CPSS-CHB questionnaire. The results suggested that parents could influence healthy behavior in their children in regard to therapeutic lifestyle changes. In assessing parental influence to change child health behavior after education from the PHYC, responses revealed 83% (n=12) of parents agreed that education from the PHYC increased their awareness in regard to changing child health behavior through parental self-efficacy. Data revealed that 17% (See *Figure 1*) of parents did not feel that education in regard to parental self-efficacy in child health behavior changed anything. There was a total of n=12 respondents with one who did not fill out demographics. The average age of parents was 42 years old. Females to males with a ratio of 10:1 dominated the gender. When assessing race the dominating factor was African-Americans (n=7). As for marital status, married versus divorce was even at 5:5 with one single parent noted (See *Figure 2*). The average parental education years yielded 14.5 years of schooling. Respondent's income that was < \$15,000 (See *Figure 3*) along with a minimal of 12 years of education totaled the 17% analysis. This information indicated that education as well as economics may impact a role in parental self-efficacy when dealing with child health behavior.

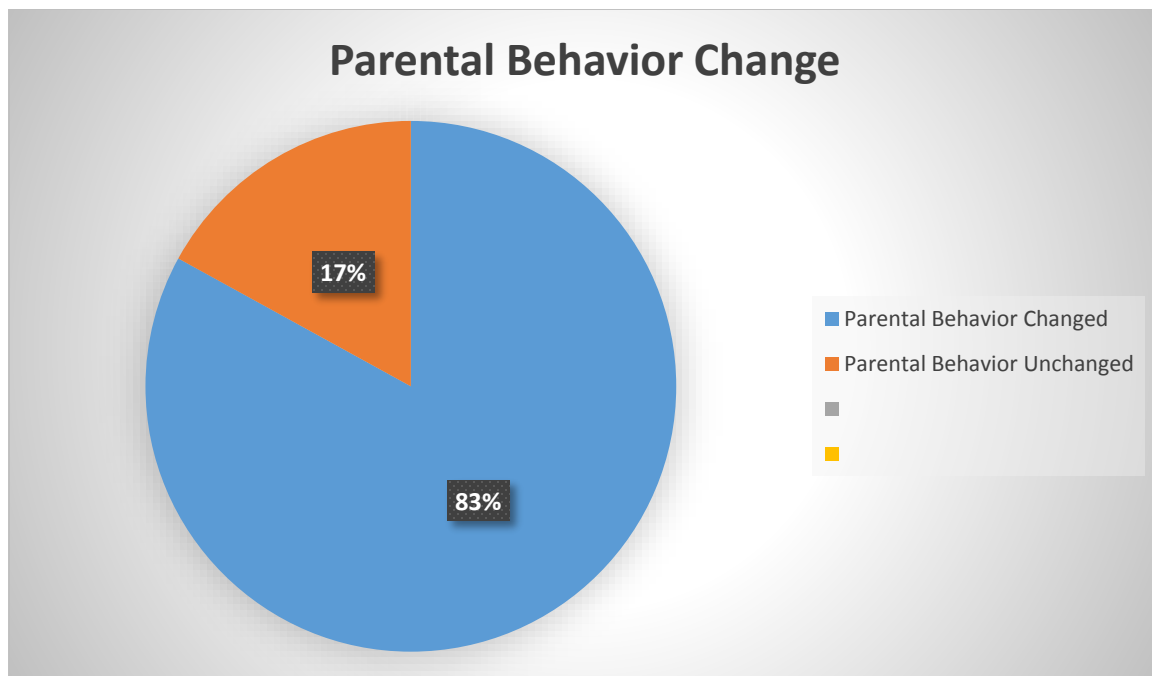


Figure 1. Parental behavior change outcome.

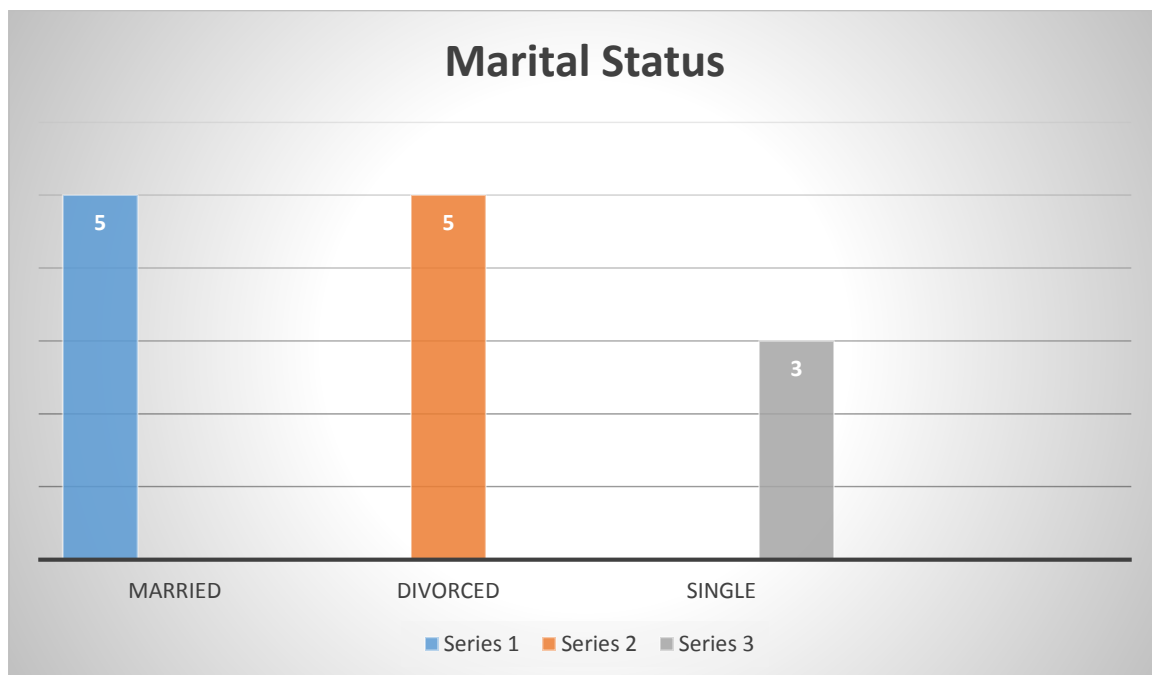


Figure 2. Marital status of parents.

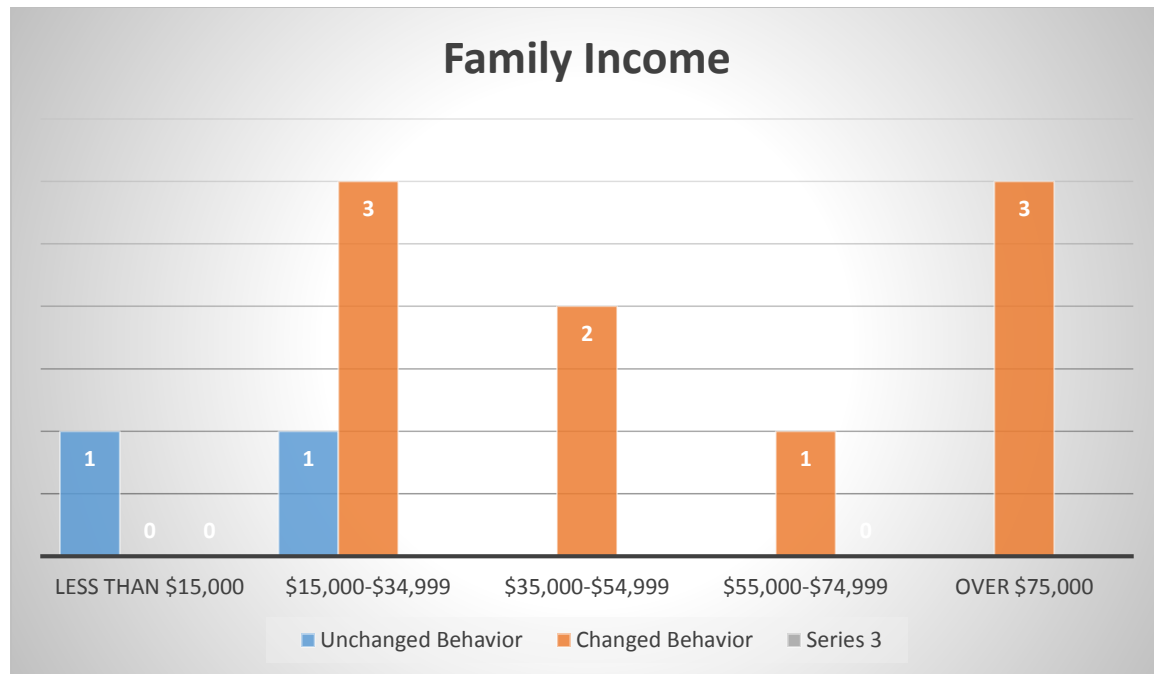


Figure 3. Family income of participants

Project Outcomes

The positive outcome of this project was that 83% of parents benefited from education in regard to lifestyle changes caused by parental self-efficacy with child health behavior. Childhood obesity can decrease if parental self-efficacy begins to be the focus of healthcare providers when dealing with therapeutic lifestyle changes. The implementation of an education program for parents on therapeutic lifestyle changes among children will decrease childhood obesity. These methods will bring about a decrease in multiplicity risk factors, chronic disorders, and psychological revocations. This could alter the epidemic of childhood obesity not only at this local clinic but state or regionally.

Limitations/Barriers

A major limitation of this project was that of children being in school which prohibited them from attending follow up visits. In addition, some appointments conflicted with parents' work schedules. Longer implementation of this project would probably have yielded increased

participation from parents and children if appointments were made during the summer months, which could allow parents and children to attend more faithfully.

Discussion/Implications

This PHYC was ideal for the DNP project because the clinic clients are seen from birth to 21 years old. The PHYC was located inside the clinic which gave continual assess to parents and the pediatric population. The project will increase parental self-efficacy due to education on therapeutic lifestyle changes, which will impact behaviors in regard to childhood obesity. In addition to measuring parental self-efficacy, parents indicated that the CPSS-CHB tool triggered educational alerts about their children's decreased physical activity, increased television and video game time, and cultural food habits which they did not realize were negative factors relating to obesity risks. This DNP project could be implemented by other clinics that are focused on decreasing childhood obesity. If other clinics do not have a PHYC within their practice, the PHYC along with the parental self-efficacy education would be a potential blueprint for the establishing of a PHYC within a clinic.

Recommendations

Increasing parental self-efficacy through education to impact child health behavior can decrease the risk factors associated with childhood obesity. Appropriate theoretical implication of Nola Pender's (2016) health promotion model was instrumental in directing the DNP project. The model follows a theoretical path of exploring factors and relationships that aim at health promoting lifestyle which enhances health and the outcomes of behaviors. Focusing on educating parents and children about exercise and nutritional self-management can be instrumental in turning around the sedentary lifestyle which has become a way of life for children in the United States due to advanced technology of computers and games. The choice of playing a game for

four to six hours too often takes precedence over going outdoors on the playground where children would be getting the proper exercise. The epidemic increase in childhood obesity will not be halted until sedentary lifestyles and improper nutrition are addressed.

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APPENDIX A

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|--|----------|
| Estimated Beginning Balance..... | \$400.00 |
| Printing, Copy Paper, Office Supplies..... | \$65.00 |
| Gas Mileage..... | \$80.00 |
| Manuscript typing fees..... | \$100.00 |
| Publishing fees..... | \$75.00 |

APPENDIX B



CHILDREN'S HEALTH CENTER OF COLUMBUS, INC.

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September 6, 2016

To Whom It May Concern:

My name is Will McDow and I am the director of Pediatric Healthier You Clinic, a subsidiary of Children's Health Center. I have given permission to Calvin French, CFNP, to complete his thesis with me. His topic is *Increasing Parental Self-Efficacy through Education to Impact Child Health Behavior*. If you have any questions you may reach me at 662-329-2955 x111.

Sincerely,

Will McDow, ACSM

APPENDIX C

Cooper Parental Self-Efficacy Scale - Child Health Behavior (CPSS-CHB)

Information Letter for Field Study

September 9, 2016

Dear Parent or Care Giver,

This letter is about participation in a research study to evaluate a questionnaire to determine how confident parents are in creating a healthy home for children. You have been selected because you are a parent or caregiver or know a parent or caregiver of a child between 3 and 16 years of age. You have been selected from Children's Health Center of Columbus, Inc.'s subsidiary clinic, Pediatric Healthier You Clinic.

Please forward this information and the survey link to anyone you may know who is a parent of a child ages 3 to 16 years of age.

If you agree to participate, you will be asked to complete a short questionnaire. The questionnaire will take approximately 15 minutes to complete and does not contain information that can personally identify you.

Participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty. The results of the research study may be published, but your name will not be used.

I am a graduate student under the direction of Dr. Jaqueline Phelon in the School of Nursing at Mississippi University for Women. If you have any questions concerning the research study, you may contact me at (662) 329-2955 or cjfrench@myapps.muw.edu. You can also contact Dr. Phelon if you have questions at [REDACTED] or [REDACTED] muw.edu.

Completing the questionnaire will be considered your consent to participate.

Thank You,

Calvin French, MSN, APRN, FNP-BC

Cooper Parental Self-Efficacy Scale-Child Health Behavior (CPSS-CHB)

This survey is about parents and caregivers (step-parents, grandparents, foster parents, etc.) of children between the ages of 3 and 16 years. If you have more than one child in this age range, please answer the questions about your youngest child in this age range.

Parents are the first teachers of their children and can have a strong influence on the how their child thinks, behaves, and learns about making healthy choices. The following statements are about having an influence on or how you affect your child's behavior. Please read each statement carefully and indicate your level of agreement on a scale 1 "Strongly disagree" to 5 "Strongly agree".

I appreciate you taking the time to complete the survey. I understand how valuable your time is.

APPENDIX D

| Cooper Parental Self-Efficacy Scale-Child Health Behavior (CPSS-CHB) | | | | | |
|--|-----------------------|-----------------------|------------------------------|-----------------------|-----------------------|
| 1. Please choose the number that best describe your agreement with each item. | | | | | |
| | Strongly Disagree | Disagree | Neither Agree or Disagree | Agree | Strongly Agree |
| 1. I can affect my child's physical activity when I feel rested. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. I can affect my child's food choices when I have personal problems. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. I can affect my child's health choices when I feel out of control with my own weight. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. I can affect my child's food choices while he or she watches TV. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. I can affect my child's health behavior when he or she is upset or depressed. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 6. I can affect my child's health choices when I feel support from my spouse. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 7. I can affect my child's food choices during a vacation. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 8. I can influence my child's food and physical activity choices when I feel happy. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 9. I can affect my child's food and physical activity choices when I have money concerns. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 10. I can affect my child's food and physical activity choices when I feel worried. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 11. I can affect my child's food choices and physical activity when I feel support from family and friends. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 12. I can affect my child's food choices when I prepare meals for my child and family. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 13. I can affect my child's physical activity when family matters upset me. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 14. I can affect my child's health choices when things are good at work. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 15. I can affect my child's food choices during holidays and parties when high fat foods are served. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 16. I can affect my child's food choices when he or she and I are tempted by tasty but bad foods in the grocery store. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 17. I can affect my child's physical activity when I feel angry. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 18. I can affect my child's food choices when we eat out. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 19. I can affect my child's health behavior at family reunions. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 20. I can affect my child's food choices when we visit a city and want to try the local food. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 21. I can affect my child's physical activity when the weather is too rainy, snowy, or hot. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 22. I can affect my child's food choices and physical activity when my child's friends are staying over. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 23. I can affect my child's health choices when I have job type stress. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 24. I can affect my child's food choices during holiday times. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 25. I can affect my child's physical activity when I feel bored. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 26. I can affect my child's food choices when I am very hungry. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 27. I can affect my child's food choices during church or community sponsored events (pot luck dinners, fish fries, community/county fair, the church bazaar). | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 28. I can affect my child's food and physical activity choices when he or she is out of school for the summer. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Cooper Parental Self-Efficacy Scale-Child Health Behavior (CPSS-CHB)

English Version by Ralf Schwarzer & Matthias Jerusalem, 1993

1. Please choose the number that best describes how much you agree with each item.

| | not at all true | hardly true | moderately true | exactly true |
|--|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. I can always manage to solve difficult problems if I try hard enough. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. If someone opposes me, I can find the means and ways to get what I want. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. It is easy for me to stick to my aims and accomplish my goals. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. I am confident that I could deal efficiently with unexpected events. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. Thanks to my resourcefulness, I know how to handle unforeseen situations. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 6. I can solve most problems if I invest the necessary effort. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 7. I can remain calm when facing difficulties because I can rely on my coping abilities. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 8. When I am confronted with a problem, I can usually find several solutions. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 9. If I am in trouble, I can usually think of a solution. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 10. I can usually handle whatever comes my way. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

| Cooper Parental Self-Efficacy Scale-Child Health Behavior (CPSS-CHB) | | | | |
|--|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Please choose the number that best describes how much you agree with each item. | | | | |
| | Strongly Disagree | Disagree | Agree | Strongly Agree |
| 1. I feel that I'm a person of worth at least on an equal plane with others. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. I feel that I have a number of good qualities. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. All in all, I am inclined to feel that I am a failure.** | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. I am able to do things as well as most other people. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5. I feel I do not have much to be proud of.** | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 6. I take a positive attitude toward myself. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 7. On the whole, I am satisfied with myself. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 8. I wish I could have more respect for myself ** | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 9. I certainly feel useless at times. ** | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 10. At times I think I am no good at all. ** | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Cooper Parental Self-Efficacy Scale-Child Health Behavior (CPSS-CHB)

1. Which best describes your relation to the children you care for?

- ☐ Parent
- ☐ Step-parent
- ☐ Foster parent
- ☐ Grandparent
- ☐ Legal guardian

2. What is your gender?

- ☐ Man
- ☐ Woman

3. What is your race?

- ☐ African American
- ☐ Caucasian
- ☐ Hispanic
- ☐ Native American
- ☐ Asian or Pacific Islander
- ☐ Other

4. What is your marital status?

- ☐ Single (never married)
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Common law

5. What is the TOTAL number of years of school you have completed (include grade school and high school as well as college or vo-tech)?

Number of years in school

Cooper Parental Self-Efficacy Scale - Child Health Behavior (CPSS-CHB)

6. How many children in each of these age categories live in your household today?

| | |
|------------------|----------------------|
| 0-36 months | <input type="text"/> |
| 3-5 years | <input type="text"/> |
| 6-9 years | <input type="text"/> |
| 10-12 years | <input type="text"/> |
| 13-15 years | <input type="text"/> |
| 16 years or over | <input type="text"/> |

7. What is your age?

Years

8. Counting all sources of income including wages, interest, welfare payments, gifts, etc., what was your TOTAL FAMILY INCOME in 2015?

- ☐ LESS THAN \$15,000
- ☐ \$15,000 to \$29,999
- ☐ \$25,000 to \$34,999
- ☐ \$35,000 to \$44,999
- ☐ \$45,000 to \$54,999
- ☐ \$55,000 to \$64,999
- ☐ \$65,000 to \$74,999
- ☐ \$75,000 to \$84,999
- ☐ Over \$85,000

Cooper Parental Self-Efficacy Scale-Child Health Behavior (CPSS-CHB)

Thank you for completing this survey. Your time and input is very valuable to me.

APPENDIX E**Education PowerPoint Outline:**

- I. C.J. Baby Picture
- II. C.J. Wedding Picture
- III. Background and Significance
- IV. Purpose
- V. Parental Influence
- VI. Project Description
- VII. Outcome Pie Graph
- VIII. Outcomes Percentages
- IX. Limitations
- X. Implications
- XI. References

APPENDIX F

Parental Self-Efficacy Strategy Map

