

BELIEFS ABOUT CHILDREN WITH PROBLEMATIC BEHAVIOR

by

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ABSTRACT

This study investigated the effect of respondent gender and a diagnostic label of autism spectrum disorder (ASD) on perceptions of children with ASD and their parents. A vignette about a child who met diagnostic criteria for ASD and who was exhibiting problem behaviors was provided to 184 college undergraduates (135 women, 49 men). Approximately half of the vignettes provided a label of ASD, and the other half did not. Participants rated their views about the cause of the behavior (i.e., parental or biological blame), consequences for the behavior, and how understandable the behavior was, given the circumstances. This study found that participants blamed parents less and thought that the behavior was more understandable given the circumstances when a label was provided. This study did not find any statistically significant effects for respondent gender or any statistically significant interactions.

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CHAPTER I

INTRODUCTION

Kanner's (1943) breakthrough publication, "Autistic disturbances of affective contact," documented the existence of "inborn autistic disturbances of affective contact" in 11 children (p. 250). Kanner's publication fueled the need for additional research into what we now refer to as autism spectrum disorder (ASD). Kanner proposed that "autistic" symptomology was due to "lack of genuine [maternal] warmth" (Kanner, 1949, p. 422). Kanner later retracted his theory that blamed mothers and focused on a biological perspective (Kanner, 1971). Bettelheim (1967), however, endorsed Kanner's original theory that mothers were responsible. Bettelheim's (1967) theory became more widespread and was referred to as the "refrigerator mother" theory. The "refrigerator mother" theory detailed that cold, distant mothers were responsible for "autistic" symptomology. Bettelheim (1967) explained in his book, *The Empty Fortress: Infantile Autism and the Birth of the Self*, that parenting style was to blame for a child's autism. Though "[the] 'refrigerator mother theory' has been completely discarded" (Lagercrantz, 2017, p. 1246), it has had lasting effects, and some parents still think they are blamed by others for their child's disorder (e.g., Neely-Barnes, Hall, Roberts, & Graff, 2011). There is no modern research addressing whether mothers are still blamed for their child's disorder, so it is important to study this.

Before considering if parents of children with an ASD diagnosis are blamed for their child's disorder, it is important to look at changes in the definition of ASD in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* throughout the years. The

DSM has gone through many changes in the definition of autism over the years. Up until the third edition of the *DSM* (3rd ed., *DSM-III*; American Psychiatric Association, 1980), autism was not listed as a distinct diagnostic category (McPartland, Reichow, & Volkmar, 2012). In the *DSM-III*, however, autism was referred to as “infantile autism” (American Psychiatric Association, 1980). In previous editions (*DSM-1 and DSM-2*) autism would have been diagnosed as “childhood schizophrenia” (McPartland et al., 2012). Though autism had its own separate diagnostic category in the *DSM-III* (McPartland et al., 2012), it was not until the development of the *DSM-IV* (American Psychiatric Association, 1994) that the criteria began to resemble what we now refer to as ASD.

Notably, the *DSM-IV* (American Psychiatric Association, 1994) broke down ASD into distinct diagnoses that varied based upon the degree of impairment (e.g., a person diagnosed with autistic disorder was considered to function at a lower level than someone who was diagnosed with Asperger’s disorder). The *DSM-5*, which is the most recent edition of the *DSM*, eliminated the distinct diagnoses (e.g., Asperger’s) and indicated that “individuals with a well-established *DSM-IV* diagnosis of autistic disorder, Asperger’s disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder” (American Psychiatric Association, 2013, p. 51). Thus, those who had not been previously diagnosed with the other disorders (i.e., autistic disorder, Asperger’s disorder, or pervasive developmental disorder not otherwise specified) will now have to meet the *DSM-5* diagnostic criteria for ASD (American Psychiatric Association, 2013). This means that distinct disorders (e.g., Asperger’s) will

soon be only of historical importance because separate diagnostic disorders no longer exist in the *DSM-5* (American Psychiatric Association, 2013). Instead of giving distinct disorders, the *DSM-5* breaks ASD down into three levels; these levels vary based upon how much support is needed for social communication and for restricted, repetitive behaviors (American Psychiatric Association, 2013). Consequently, because it is part of a spectrum, ASD is associated with varying degrees of social impairments and maladaptive behaviors.

With this in mind, it is important to realize that ASD is being diagnosed more frequently. Baio et al. (2018) estimated that 1 in every 59 children (based on children who were 8 years old in 2014) had a diagnosis of ASD. In 2014, it was estimated that 1 in every 68 children (based on children who were 8 years old in 2012) had a diagnosis of ASD (Christensen et al., 2016). Thus, most people in the community are likely to encounter individuals with ASD in their daily lives. Additionally, the “least restrictive environment” provision in the Individuals with Disabilities Education Act Amendments of 1997 (IDEA, 1997) has led to more children with disabilities being in classrooms with typically developing children. This further suggests that many people are likely to interact with someone with ASD. It is important, therefore, to study how children with ASD and their parents are perceived.

Despite the increase in children being diagnosed with ASD, there are no current studies addressing whether the general population blames parents of children with ASD for their child’s disorder. This is important to address because parents have been blamed previously (e.g., Bettelheim, 1967). Parallel research, however, suggests that parents

may be blamed for their child's disorder (e.g., Mukolo & Heflinger, 2011; Perry, Pescosolido, Martin, McLeod, & Jensen, 2007). For example, parallel research on depression found that 81% of the general population blamed a child's depression on the way he or she was raised (Perry et al., 2007). Thinking that depression is caused by the way a child was raised may mean that the general population believes the same is true of ASD. Additionally, Mukolo and Heflinger (2011) found that parental blame was assigned differently across various disorders. More specifically, parental blame for attention-deficit/hyperactivity disorder (ADHD) was endorsed by 98.7%, depression by 97.7%, asthma by 71.4%, and daily troubles by 89.4% (Mukolo & Heflinger, 2011). The results surrounding parental blame in parallel studies suggest that parents of children with ASD are likely to be blamed for their child's disorder. Mukolo and Heflinger (2011) proposed that parents may be blamed less for a problem that is perceived as a medical diagnosis (e.g., asthma) than for a mental health (e.g., depression) or behavior problem (e.g., ADHD). Thus, it is likely that the general population will perceive that parents of children with ASD are to blame for their child's disorder as ASD is often considered to be a behavioral problem.

As suggested in parallel research (e.g., Mukolo & Heflinger, 2011), behavioral problems may lead to blame being placed on the parent of a child with ASD. Anecdotal research has found that individuals who have socially inappropriate behavior were more likely to be stigmatized by the general population than those who do not have such behaviors (Grey, 2002); thus, the parents may be subjected to stigma because the general population may believe that the child's behavior is because of bad parenting. Children

with ASD often have behavioral and social difficulties. The *DSM-5* states that an individual must exhibit repetitive and restrictive patterns of behavior and difficulties with social communication and interaction to meet criteria for ASD (American Psychiatric Association, 2013). Thus, the general population may view parents of children with ASD negatively due to their children's social difficulties.

Stigma Surrounding Individuals with ASD

Previous research involving perceptions of parents of children with autism/ASD has largely focused on the parents' thoughts about the stigma that they face from the general population (e.g., Grey 1993, 2002). Grey (2002) found that "slightly over three quarters of the parents" reported that they thought they were stigmatized by the general population for their child's disorder (p. 739). Some of the parents in that study thought that the general population was stigmatizing them when their child engaged in behavior that was outside of societal norms (Grey, 2002). Similarly, Tait, Mundia, and Fung (2014) found that parents of children with ASD in Hong Kong were likely to believe they were stigmatized by society because their children were less likely to meet the societal standards of academic achievement. Some of the parents also were likely to fear how others would treat their children, which led them to send their children to private special schools (Tait et al., 2014). Parents of children with ASD also were more likely to believe that they were more stigmatized than parents of children with other disorders (Werner & Shulman, 2015). For example, Werner and Shulman (2015) found that parents of children with ASD were more likely to think they were stigmatized than parents of children with physical or intellectual disabilities. This suggests that parents of children

with ASD are likely to perceive that they are stigmatized by society. Moreover, Werner and Shulman (2015) pointed out that parents of boys are more likely to believe they are stigmatized. Thus, it is important to determine whether society stigmatizes these parents.

Despite the lack of research on societal views of parental blame, the research shows that many parents engage in affiliate stigma (Grey, 1993, 2002; Werner & Shulman, 2015). Affiliate stigma is the subjective evaluation and internalization of stigma by a person who is close to the individual with the disorder (e.g., family member); this person regards him or herself as stigmatized by being associated with a person with a mental illness or disorder (Mak & Cheung, 2008). Affiliate stigma can negatively impact parents of children with disabilities because some families will socially withdraw from other family members and friends who do not show consideration for their child's disorder, and some families will conceal their child's disorder (Mak & Cheung, 2008). Thus, the general population may not know that a child has a disorder. Parents not disclosing a child's disorder can be particularly problematic. Portway and Johnson (2005) pointed out that many parents believe that their children with ASD appear physically normal. As a result of an individual with ASD appearing "normal," it is likely that the general population expects them to behave accordingly. Consequently, the general population is likely to believe that a child is "acting out" when he or she is exhibiting typical ASD behavior (Neely-Barnes et al., 2011, p. 213). Research has shown that the general population may not provide a label (i.e., diagnosis) to an individual with a disorder when a label is not provided (e.g., Anglin, Greenspoon, Lighty, Corcoran, & Yang, 2014; Nordt, Rössler, & Lauber, 2006). Given that parents of children with ASD

may conceal their child's disorder and the general population may not provide a label to a disorder, it also is important to study how labeling ASD affects how parents are perceived by the general population.

Labeling an Individual with ASD

Positive aspects. There are advantages to providing a label to an individual with a disorder. A positive impact of labeling can be observed in teachers' interactions with students. For example, parallel research with ADHD found that teachers were more willing to aid in treatment and make modifications to the classroom when the child was labeled with ADHD (Ohan, Visser, Strain, & Allen, 2011). This suggests that receiving a diagnosis can help children to obtain additional resources.

Additionally, Matthews, Ly, and Goldberg (2015) found that college students viewed peers with a label of ASD more positively than those who were expressing the same characteristics without a label. Similarly, Scior, Connolly, and Williams (2013) found that providing a label led to significantly less stigmatizing views (e.g., social distance). It can be hypothesized that participants would have less stigmatizing views of parents of children in a labeled vignette compared to an unlabeled vignette.

Negative aspects. Although children with an ASD label may receive helpful services, labeling also can have a detrimental impact on the individual. This detrimental impact can be observed in the classroom. Eikeseth and Lovaas (1992) found that when student-teachers were told that a child was "autistic," the students provided the child with more praise and less verbal correction for incorrect responses compared to a child without a disorder who was labeled as "normal." Labeling could prevent a child with

ASD from receiving the same level of education. Furthermore, Helps, Newsom-Davis, and Callias (1999) found that, compared to mental health professionals, teachers of children with ASD were likely to overestimate the child's cognitive abilities and believe that ASD was an emotional disorder. Helps et al. (1999) pointed out that this lack of understanding may lead to frustration in both the teacher and child with ASD and "the development of disruptive or aggressive behaviours" in the child with ASD (p. 294).

Additionally, parallel research on ADHD found that teachers viewed children who had a label of ADHD as having more severe problems than those who did not have a label provided, and the teachers believed that they were less competent to help the child (Ohan et al., 2011). Teachers not believing that they were competent suggests that children with a label of ASD may not receive the necessary accommodations to succeed in a classroom setting.

Moreover, research (Swaim & Morgan, 2001) has documented that children with ASD and Asperger's are perceived differently than their typically developing peers. Parallel research with ADHD found that when a child had a label of ADHD, teachers were more likely to report that they would seek help for the child (i.e., medication) compared to an identical child without a label (Ohan et al., 2011). This is problematic because a child who was exhibiting the same behavior without a label may not receive the same level of care. Additionally, seeking services for a child with a labeled diagnosis may suggest that assumptions about the child's needs are being based upon the label rather than the behavior.

Ideas about punishment. Providing a label also may influence ideas about punishment. In her study, Berryessa (2016) found that many Superior Court judges reported that they would not want to incarcerate an individual who they knew was diagnosed with ASD. On the other hand, some of the judges believed that the individuals with ASD were not in control of their behavior and may be a danger to themselves or others. Additionally, Payne and Wood (2016) used an unlabeled vignette in their study to describe a child with ASD symptomology, and they found that participants who were angry about the child's behavior were more likely to believe the child could control his or her behavior and should be punished. They did not, however, have a labeled vignette to which these results could be compared. A person believing that the child was in control of his or her behavior also may believe that the parent was more responsible for the child's behavior compared to individuals who did not believe the child was in control of his or her behavior. This is because parents are generally seen as responsible for controlling their child's behavior.

Respondent Gender

An individual's perception of parental blame also may be influenced by the participant's gender. The studies are mixed on whether gender influences views about an individual with ASD. Matthews et al. (2015) found that men held less stigmatizing views than women. Conversely, Gillespie-Lynch et al. (2015) found that women, compared to men, had less stigmatizing views. They also found that when participants were provided training about ASD that both men and women had less stigmatizing views than those who had not received the training. Chambres, Auxiette, Vansingle, and Gil (2008) found that

both women and men had less stigmatizing views when a label of ASD was provided when compared to when a label was not provided. Chambres et al. (2008) also found that men viewed a child with ASD more negatively when a label was not provided compared to when a label was provided. On the other hand, Swaim and Morgan (2001) found that girls and boys did not differ on their views about ASD. The research has not looked at the differences in the views regarding parents of children with ASD; therefore, it is important to determine if gender impacts these views.

Summary

The definition and prevalence of ASD has changed over time. The prevalence of ASD continues to increase (Baio et al., 2018). This has likely increased the frequency of the general population interacting with individuals who have been diagnosed with ASD. As the general population encounter more individuals with ASD, it becomes increasingly important to study the general population's perceptions of individuals with ASD, as well as their perceptions of the parents of children with ASD. Previous research has neglected to study how the general population view parents of children with ASD. There are no current studies addressing this concern. There are studies, however, that show parents of children with ASD think they are stigmatized (Grey 1993, 2002; Werner & Shulman, 2015). Additionally, there is a relationship between affiliate stigma and parents socially distancing themselves (Mak & Cheung, 2008). For example, Mak and Cheung (2008) found that parents, especially mothers who perceived themselves as being stigmatized, were more likely to socially distance themselves. The lack of research focusing on

whether parents are stigmatized illustrates the importance of exploring the general population's perceptions of these parents.

Although there is no research focusing on the blame of parents of children with ASD, studies have examined the impact of labeling an individual with a disorder (Eikeseth & Lovaas, 1992; Helps et al., 1999; Ohan et al., 2011). There were both positive and negative impacts of labeling. It is important to see if labeling influences blame of parents of children with ASD. This is because parallel research found that parents of children with other disorders (i.e., depression, ADHD, asthma, and daily troubles) were blamed (Mukolo & Heflinger, 2011).

There are mixed results in the literature on whether men or women have less stigmatizing views of individuals with ASD. Some of the research suggests that men have less stigmatizing views than women (Matthews et al., 2015). In contrast, some of the literature has shown that women have less stigmatizing views (Gillespie-Lynch et al., 2015). Further, some of the research suggest that girls and boys do not differ in their views of individuals with ASD (Swaim & Morgan, 2001). The research has not, however, looked at gender differences in perceptions of the parents of children with ASD. This suggests that it is important to determine whether gender impacts an individual's perception of parents of children with ASD.

Lastly, providing a label also may influence ideas about consequences. Some of the research (Payne & Wood, 2016) suggest that providing an unlabeled vignette describing a child with ASD symptomology led participants to believe the child could

control his or her behavior and should be punished. This suggests that it is important to determine whether labeling influences ideas about punishment.

Purpose of Study and Hypotheses

The purpose of this study was to address the gap in research surrounding blame of parents of children with ASD and the impact of providing a label to a child with ASD.

The following hypotheses were offered:

Hypothesis 1: There would be significant main effects for labeling. Specifically, participants who read the vignette in which the hypothetical child had a diagnosis of ASD would have higher scores on the Biological Blame subscale, lower scores on the Parental Blame subscale, and higher scores on the Understandable given the circumstances item when compared to individuals who read the vignette without a label. Additionally, participants who read the vignette in which the hypothetical child had a diagnosis of ASD would have higher scores on the Psychologically-Oriented Intervention subscale and lower scores on the Punishment-Oriented Intervention subscale when compared to participants who read the unlabeled vignette.

Hypothesis 2: There would be significant main effects for respondent gender on 3 of 4 subscales. Overall, it was predicted that women would have lower scores on the Parental Blame subscale when compared to men, regardless of whether a label was provided. There would not be a significant difference between men and women on the Biological Blame subscale. Additionally, women would have higher scores on the Psychologically-Oriented Intervention subscale and lower

scores on the Punishment-Oriented subscale when compared to men, regardless of whether a label was provided.

CHAPTER II

METHOD

Participants

Participants consisted of 184 (135 women, 49 men) students who were recruited from the Middle Tennessee State University (MTSU) Psychology research pool. Demographic information for the participants can be found in Table 1. Participants were restricted to undergraduate students who were enrolled in a General Psychology course, and who were at least 18 years old. As seen in Table 1, the majority of the students (i.e., 73%), self-identified as women. More than half (i.e., 58%) marked their race as Caucasian/White. Also, almost 90% (i.e., 89%) marked their age as 18 to 21 years old. Participants were provided with one research credit for participation. One participant, however, was not included in these analyses because the individual marked “Prefer not disclose/Other” with regard to gender, and this study was addressing gender differences. Additionally, a participant was dropped from the analysis of items pertaining to parental blame because there were too many items on the scale left blank to be able to analyze these results. Lastly, a participant was dropped from the analysis of the Consequence Scale because the participant chose to leave this page blank. Approval for the study was obtained from the Institutional Review Board of MTSU (see Appendix A).

Materials

Demographic form. Prior to completing the measures, the participants were provided with a demographic form (see Appendix B). The demographic form asked about gender (Male, Female, Prefer not to disclose/Other), age (18 to 21 years old, 22 to

Table 1

Demographic Information

Variable	<i>n</i>	%
Gender		
Men	49	27
Women	135	73
Age (in years)		
18 to 21 years old	163	89
22 to 25 years old	14	8
26 to 29 years old	2	1
30 years old and over	5	3
Race/Ethnic Group		
Caucasian/White	106	58
African-American/Black	39	21
Prefer not to disclose/Other	39	21

Note. $N = 184$.

25 years old, 26 to 29 years old, and 30 years old and over), and race/ethnic group (Caucasian/White, African-American/Black, Prefer not to disclose/Other). The author separated the age variable into groups to make it more difficult to identify those who represent the extreme (i.e., older, nontraditional students). All demographic questions were provided in multiple-choice format.

Responsibility Scale. The Responsibility Scale (see Appendix C) was created using questions from the General Social Survey (Davis & Smith, 2002). The General Social Survey is part of the public domain and has special modules pertaining to the general population's perceptions of adults and children with mental illness (Davis & Smith, 2002). For the purpose of this study, a modified version of the attribution scale from the General Social Survey was used. The original Responsibility Scale contains seven items. The current author modified and added an additional five items to the scale. The scale was broken down into subscales. The Biological Blame subscale consisted of three items and Parental Blame subscale consisted of five items. The remaining items served as distractor items to prevent participants from realizing the exact purpose of the study. See Appendix D for the specific breakdown of the items on the subscales. Each item on the scale was rated on a 5-point Likert-type scale with the responses ranging from *(1) not at all likely* to *(5) very likely*. In order to determine if all subscale items reliably measured the same variable (e.g., Parental Blame), a Cronbach's alpha was ran on the subscales with multiple items to see if they measured the same construct. The author examined the results of deleting items to see if the alpha level went up significantly, which indicated that the item should be dropped from the subscale in order

to increase reliability. Coefficient alpha for the Parental Blame subscale was .84, which was acceptable. Coefficient alpha for the Biological Blame subscale was .31, which was not acceptable. The coefficient alpha did not go up significantly by dropping items from the subscale. Consequently, the author broke the subscale into individual items (i.e., chemical imbalance, allergies, and inherited problem).

Consequence Scale. An author-constructed scale was used to assess the participants' ideas on effective consequences for the child's behavior (e.g., shoving the teacher). The Consequence Scale contained seven items (see Appendix E). The scale was broken down into subscales. The Psychologically-Oriented Intervention subscale consisted of two items, and the Punishment-Oriented Intervention subscale consisted of five items. See Appendix D for the specific breakdown of the items on the subscales. Each item on the scale was rated on a 5-point Likert-type scale with the responses ranging from (1) *not at all likely* to (5) *very likely*. In order to determine if all subscale items reliably measured the same variable (e.g., Psychologically-Oriented Intervention), a Cronbach's alpha was ran on the subscale items the same way they were in the Responsibility Scale. Coefficient alpha for the Punishment-Oriented Intervention subscale was .76, which was acceptable. Coefficient alpha for the Psychologically-Oriented Intervention subscale was .45. The coefficient alpha did not go up significantly by dropping items from the subscale. Consequently, the author broke the subscale into individual items (i.e., psychological services and medication).

Understandable given the circumstances item. The Understandable given the circumstances item was an additional item placed by the author into the Consequence

Scale to test if participants believed that the behavior was understandable given the circumstances.

Vignette. This study used a vignette to describe a boy with ASD. Both boys in the vignettes met *DSM-5* criteria for ASD (American Psychiatric Association, 2013), but one vignette (labeled) included the fact that the boy had a diagnosis of ASD and one (unlabeled vignette) did not. The vignette (see Appendix F) included a short description of a boy named Jon. This description included that he does not make friends easily. One day, he disturbed his class and teacher when his schedule was changed, and a planned field trip was cancelled due to rain. This cancellation resulted in Jon becoming very angry to the point of yelling and shoving his teacher. The teacher then called the principal.

Procedure

The General Psychology students signed up through the SONA System at Middle Tennessee State University (MTSU). Once participants arrived at the study, they were given the participant copy of the informed consent (see Appendix G) to read. They were given the researcher copy of the informed consent (see Appendix H) to read and fill out before the questionnaire was passed out. Following this, participants were told that the purpose of the study was to gather information about beliefs about children with problematic behavior. All participants then completed the survey after reading the short vignette about a child. All participants were provided with an identical vignette only differing in whether the diagnosis was provided (i.e., Jon who has a diagnosis of ASD). The first questionnaire asked demographic information (see Appendix B), followed by

the Responsibility Scale (see Appendix C) and the Consequence Scale (see Appendix E).

Participants were given a debriefing form (see Appendix I) that further explained the purpose of the current study. See Appendix J for an example of the complete survey.

CHAPTER III

RESULTS

Descriptive Statistics

Data were analyzed with a series of 2 (labeled versus unlabeled scenario) x 2 (respondent gender) ANOVAs. The alpha level was set to .01 instead of .05 to reduce the chances of incorrectly rejecting the null hypothesis (false positive). Descriptive statistics for individual items and subscales are presented in Table 2. Alpha coefficients for subscales in the acceptable range can be seen in Table 2. The current study found the internal reliability coefficient for the Parental Blame subscale to be .84 and Punishment-Oriented Intervention subscale to be .76, which were in the acceptable range. The alpha for the Psychologically-Oriented Intervention subscale was .45, which was not acceptable. The coefficient alpha did not go up significantly by dropping items from the subscale. Consequently, as seen in Table 2, the author broke the Psychologically-Oriented Intervention subscale into individual items (i.e., psychological services and medication). Additionally, the alpha for the Biological Blame subscale was .31, which also was not in the acceptable range. The coefficient alpha did not go up significantly by dropping items from the subscale. Therefore, as seen in Table 2, the author broke the Biological Blame subscale into individual items (i.e., chemical imbalance, allergies, and inherited problem).

Hypotheses Testing

The first hypothesis proposed that participants who read the vignette in which the hypothetical child had a diagnosis of ASD would have higher scores on items involving

Table 2

Descriptive Statistics for the Subscales and Individual Items

Variable	<i>N</i>	<i>M</i>	<i>SD</i>	α
Parental Blame	183	14.52	4.42	.84
Punishment-Oriented Intervention	183	9.74	3.70	.76
Understandable given the circumstances	183	2.90	1.21	--
Chemical imbalance	184	4.13	0.95	--
Allergies	184	1.75	0.91	--
Inherited problem	184	3.90	0.98	--
Psychological services	183	4.45	0.73	--
Medication	183	3.75	1.01	--

biological blame, lower scores on the Parental Blame subscale, and higher scores on the Understandable given the circumstances item when compared to individuals who read the vignette without a label. Additionally, participants who read the vignette in which the hypothetical child had a diagnosis of ASD would have higher scores on the Psychologically-Oriented Intervention subscale and lower scores on the Punishment-Oriented Intervention subscale when compared to participants who read the unlabeled vignette. Consistent with hypothesis one, participants who read the vignette with a label had lower scores on the Parental Blame subscale and higher scores on the Understandable given the circumstances item when compared to individuals who read the vignette without a label (Table 3). The hypothesis that participants who read a vignette without a label would have lower scores on the Punishment-Oriented subscale compared to participants who read a vignette without a label was not supported (Table 3).

It also was predicted that women would have lower scores on the Parental Blame subscale when compared to men regardless of whether a label was provided. Additionally, it was predicted that women would have higher scores on the Psychologically-Oriented Intervention subscale and lower scores on the Punishment-Oriented Intervention subscale when compared to men regardless of whether a label was provided. As can be seen in Table 4, these hypotheses were not supported because there were no statistically significant differences surrounding gender. As seen in Table 5, there were no significant interactions between respondent gender and scenario.

Table 3
Main Effects for Labeling

Variable	Labeled Scenario ^a		Unlabeled Scenario ^b		<i>F</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Parental Blame ^c	13.32	4.13	15.72	4.40	9.79*
Punishment-Oriented Intervention ^c	9.32	3.59	10.15	3.79	1.90
Understandable given the circumstances ^c	3.32	1.17	2.49	1.10	21.40**
Chemical imbalance ^d	4.13	0.94	4.12	0.97	0.26
Allergies ^d	1.73	0.89	1.77	0.93	0.07
Inherited problem ^d	3.97	0.97	3.84	0.97	2.24
Psychological services ^c	4.46	0.76	4.43	0.70	0.12
Medication ^c	3.75	0.98	3.76	1.04	0.74

Note. ^a*N* = 91-92 for Labeled Scenario. ^b*N* = 92 for Unlabeled Scenario.

^c*df* = (1, 179) for Parental blame, Punishment-Oriented Intervention, Understandable given the circumstances, Psychological services, and Medication.

^d*df* = (1, 180) for Chemical imbalance, Allergies, and Inherited problem.

p* < .01. *p* < .0001.

Table 4

Main Effects for Respondent Gender

Variable	Men ^a		Women ^b		<i>F</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Parental Blame ^c	14.88	4.14	14.40	4.53	0.53
Punishment-Oriented Intervention ^c	10.22	4.62	9.56	3.31	1.21
Understandable given the circumstances ^c	3.24	1.22	2.78	1.19	5.81
Chemical imbalance ^d	3.94	0.99	4.19	0.93	2.52
Allergies ^d	1.73	1.04	1.76	0.86	0.02
Inherited problem ^d	3.61	1.08	4.01	0.92	6.24
Psychological services ^c	4.29	0.89	4.51	0.66	3.33
Medication ^c	3.49	1.17	3.85	0.93	4.80

Note. ^a*N* = 49 for men. ^b*N* = 134-135 for women.

^c*df* = (1, 179) Parental blame, Punishment-Oriented Intervention, Understandable given the circumstances, Psychological services, and Medication. ^d*df* = (1, 180) Chemical imbalance, Allergies, and Inherited problem.

Table 5

Interactions between Respondent Gender and Labeling

Variable	Labeled Scenario				Unlabeled Scenario				F
	Men ^a		Women ^b		Men ^c		Women ^d		
	M	SD	M	SD	M	SD	M	SD	
Parental Blame ^e	13.96	4.13	13.08	4.14	15.83	4.02	15.68	4.55	0.26
Punishment-Oriented Intervention ^e	9.80	4.58	9.14	3.15	10.67	4.71	9.97	3.43	0.00
Understandable given the circumstances ^e	3.72	1.10	3.17	1.17	2.75	1.15	2.40	1.08	0.28
Chemical imbalance ^f	3.80	1.00	4.25	0.89	1.13	0.97	4.13	0.98	1.63
Allergies ^f	1.84	0.90	1.69	0.89	1.63	1.17	1.82	0.83	1.34
Inherited problem ^f	3.84	0.90	4.01	0.99	3.38	1.21	4.00	0.85	1.97
Psychological services ^e	4.32	0.99	4.52	0.66	4.25	0.79	4.50	0.66	0.05
Medication ^e	3.72	1.14	3.76	0.93	3.25	1.19	3.94	0.93	3.86

Note. ^aN = 25 for men with labeled scenario. ^bN = 66-67 for women with labeled scenario. ^cN = 24 for men with unlabeled scenario. ^dN = 66-68 for women with unlabeled scenario.

^edf = (1, 179) for the Parental Blame, Punishment-Oriented Intervention, Understandable given the circumstances, Psychological services, and Medication. ^fdf = (1, 180) for Chemical imbalance, Allergies, and Inherited problem.

CHAPTER IV

DISCUSSION

The purpose of this study was to explore perceptions of parents of children with ASD and the main effect of providing a label of ASD to the child. Specifically, this study looked at what participants viewed to be the cause (i.e., biological or parental blame) of a child's problematic behavior, the effectiveness of various interventions (i.e., punishment-oriented intervention or psychologically-oriented intervention), and whether the behavior was understandable given the circumstances. This study also explored whether respondent gender influenced perceptions of children with ASD and their parents.

In this study, several main effects emerged regarding labeling. Although there are no current studies addressing whether parents are blamed for their child's diagnosis, there is evidence that some parents believe that they are stigmatized for their child's disorder (e.g., Grey 1993, 2002; Werner & Shulman, 2015). As predicted in this study, parents were blamed less when a label was provided. The finding that parents are blamed less when a label is provided suggests that college students may be more understanding of an individual with ASD when they are aware of the individual's diagnosis. This could be because it helps to explain the behaviors that the child is exhibiting.

Additionally, previous research (Grey 1993, 2002; Werner & Shulman, 2015) has suggested that some parents thought they were stigmatized by the general population. This study, however, found that participants believed that the child's behavior was more understandable given the circumstances when a label was provided when compared to

when a label was not provided. This finding is consistent with those of Scior et al. (2013), who found providing a label led to less stigma (e.g., social distance). Therefore, providing a label may be beneficial to helping others understand behaviors that are exhibited by children with ASD.

Furthermore, the current study investigated whether providing a label influenced ideas about the effectiveness of punishment. This study predicted that providing a label would lead participants to believe that punishment would be less effective for treating the behavior of the boy in the vignette. This hypothesis was not supported; there was no difference in ideas about the effectiveness of punishment based on whether a label was provided. The statistical nonsignificance in the current study could be because the participants perceived the behavior as severe. Further, there might have been differences if the behavior had been depicted as chronic rather than a one-time incident.

Moreover, this study investigated the main effect of labeling on ideas about psychologically-oriented intervention. This study found the Cronbach's alpha for the Psychologically-Oriented Intervention subscale to be 0.45, which was unacceptably low. As a result, the author broke the subscale into individual items. The author did not find a significant main effect of labeling on any of the individual items on the subscale. The author may have depicted a child who engaged in behaviors that college students found to be very problematic. This could have led the participants to believe the problematic behavior could profit from psychological services whether or not a diagnostic label was provided. Further, this study investigated a one-time incident of behavior rather than a chronic problem. The behavior only occurring one time still led the participants to

believe that the behavior was severe enough to need psychological services when a diagnostic label was provided ($M = 4.46$ on a 5-point scale) and when it was not ($M = 4.43$ on a 5-point scale).

Furthermore, this study investigated the main effect of gender in perceptions of children with ASD and their parents, but no statistically significant differences were found. The results show that both men ($M = 10.22$ on a 25-point scale) and women ($M = 9.56$ on a 25-point scale) were likely to believe that punishment would not be effective in changing the child's behavior. Further, men ($M = 4.29$ on a 5-point scale) and women ($M = 4.51$ on a 5-point scale) believed that the problematic behavior would benefit from psychological services. The lack of a statistically significant main effect for respondent gender was not surprising because results on how respondent gender affects views of individuals with ASD is currently mixed. Swaim and Morgan (2001) had similar results to this study in that they found that girls and boys did not differ in views of children with ASD. On the other hand, some of the research suggests that men have less stigmatizing views than women (Matthews et al., 2015). In contrast, Gillespie-Lynch et al. (2015) found that women had less stigmatizing views.

There were several limitations to the current study that could have impacted the results. First of all, this study had measurement issues. This study used a measure adapted from the General Social Survey (Davis & Smith, 2002), and measures that were created by the author. This could have impacted the outcome of this study because the reliability and validity of these measures have not been tested. Although there was not a measure of validity in this study, the author ran Cronbach's alpha on all subscales with

multiple items and ensured that the items measured the same construct. The author examined the results of deleting items to see if the alpha level went up significantly, which would indicate that the item should be dropped from the subscale to increase reliability. Alphas for the Biological Blame subscale was .31, and the alpha for the Psychologically-Oriented Intervention subscale was .45; both were unacceptably low. The coefficient alphas did not go up significantly by dropping items from the subscales. Consequently, the author broke the Biological Blame subscale into individual items (i.e., chemical imbalance, allergies, and inherited problem). The Psychologically-Oriented Intervention subscale also was broken into individual items (i.e., psychological services and medication). Scales with individual items are less reliable than scales with multiple items when making assumptions about the findings.

Additionally, both scenarios depicted a boy exhibiting problem behavior and, thus, it was not possible to compare the results to a scenario depicting a girl. Participants may have viewed the child's hitting as a typical behavior of male children, but it may have been perceived differently if the child was female. Another issue with the vignette was that the child was higher functioning and more similar to a typically developing child, which could have impacted how participants viewed the child.

Moreover, this study involved a relatively small convenience sample; however, the sample size was adequate for statistical purposes. The results of the study may not be representative of the general public because the sample was restricted to the research pool of undergraduate students enrolled in a General Psychology course at one university. Additionally, there were many more women than men in the sample; however, this is not

uncommon in research completed with undergraduate General Psychology students. The majority of the students (i.e., 89%) identified as being between 18 and 21 years old. Also, more than half (i.e., 58%) identified as being Caucasian/White. Therefore, it would be inappropriate to generalize these findings to other populations.

Despite these limitations, the results from the current study could provide valuable insight into understanding beliefs about children with ASD, as well as perceptions of their parents. This study found that providing a label led participants to blame parents less and believe that the behavior was more understandable given the circumstances. This could help parents of children with ASD to believe they are less stigmatized for their child's behavior. This is because this research suggests that college students blame parents less when they know that the child has a diagnosis of ASD, which could be the same for the general public. Further, there were no differences in the way men and women viewed children with ASD and their parents. This suggests that both men and women benefit from knowing that the child has a diagnosis when assigning blame. Additionally, participants found that the behavior was more understandable given the circumstances when a label was provided. This may suggest that knowing that a child has a disorder could allow the general public to understand why a child is engaging in behaviors that may be considered to be outside the norm.

The statistically nonsignificant findings also could provide valuable insight into beliefs about children with ASD and their parents. This is because this research suggests that there are no differences in the way men and women viewed children with ASD.

Furthermore, this study suggests that providing a label does not influence ideas about the effectiveness of punishment.

Future research on perceptions of children with ASD and their parents could benefit from looking into the perceptions of the general public and others, such as mental health professionals. Moreover, future research may benefit from vignettes with varying degrees of ASD, as well as different ages in the vignettes to see if this would influence perceptions of individuals with ASD or their parents. Further, research could benefit from changing the gender of the child to see if the behavior would be perceived differently. Lastly, research could see how parents of children with ASD view the behavior.

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APPENDICES

APPENDIX A

Middle Tennessee State University Institutional Review Board Approval Letter

IRB**INSTITUTIONAL REVIEW BOARD**

Office of Research Compliance,
010A Sam Ingram Building,
2269 Middle Tennessee Blvd
Murfreesboro, TN 37129

**IRBN007 – EXEMPTION DETERMINATION NOTICE**

Monday, August 06, 2018

Principal Investigator **Kristen Nelson Howton** (Student)
Faculty Advisor Mary Ellen Fromuth
Co-Investigators NONE
Investigator Email(s) kh6h@mtmail.mtsu.edu; maryellen.fromuth@mtsu.edu
Department Psychology

Protocol Title ***Beliefs about children with problematic behavior***
Protocol ID **19-1014**

Dear Investigator(s),

The above identified research proposal has been reviewed by the MTSU Institutional Review Board (IRB) through the **EXEMPT** review mechanism under 45 CFR 46.101(b)(2) within the research category (2) *Educational Tests*. A summary of the IRB action and other particulars in regard to this protocol application is tabulated as shown below:

IRB Action	EXEMPT from further IRB review***	Date	8/6/18
Date of Expiration	NOT APPLICABLE		
Sample Size	NOT APPLICABLE		
Participant Pool	General Adults (18 years or older) - MTSU students enrolled in a General Psychology course		
Exceptions	Permitted to recruit participants through MTSU SONA system		
Mandatory Restrictions	<ol style="list-style-type: none"> 1. Participants must be 18 years or older 2. Informed consent must be obtained from the participants 3. Identifying information must not be collected 		
Restrictions	The data may not be re-identified without IRB's written consent. Storage of participant information to comply with MTSU SONA academic policy is permitted.		
Comments	NONE		

***This exemption determination only allows above defined protocol from further IRB review such as continuing review. However, the following post-approval requirements still apply:

- Addition/removal of subject population should not be implemented without IRB approval
- Change in investigators must be notified and approved
- Modifications to procedures must be clearly articulated in an addendum request and the proposed changes must not be incorporated without an approval
- Be advised that the proposed change must comply within the requirements for exemption
- Changes to the research location must be approved – appropriate permission letter(s) from external institutions must accompany the addendum request form
- Changes to funding source must be notified via email (irb_submissions@mtsu.edu)
- The exemption does not expire as long as the protocol is in good standing
- Project completion must be reported via email (irb_submissions@mtsu.edu)

Institutional Review Board

Office of Compliance

Middle Tennessee State University

- Research-related injuries to the participants and other events must be reported within 48 hours of such events to compliance@mtsu.edu

Post-approval Protocol Amendments:

The current MTSU IRB policies allow the investigators to make the following types of changes to this protocol without the need to report to the Office of Compliance, as long as the proposed changes do not result in the cancellation of the protocols eligibility for exemption:

- Editorial and minor administrative revisions to the consent form or other study documents
- Increasing/decreasing the participant size

Only THREE procedural amendment requests will be entertained per year. This amendment restriction does not apply to minor changes such as language usage and addition/removal of research personnel.

Date	Amendment(s)	IRB Comments
NONE	NONE.	NONE

The investigator(s) indicated in this notification should read and abide by all applicable post-approval conditions imposed with this approval. [Refer to the post-approval guidelines posted in the MTSU IRB's website.](#) Any unanticipated harms to participants or adverse events must be reported to the Office of Compliance at (615) 494-8918 within 48 hours of the incident.

All of the research-related records, which include signed consent forms, current & past investigator information, training certificates, survey instruments and other documents related to the study, must be retained by the PI or the faculty advisor (if the PI is a student) at the secure location mentioned in the protocol application. The data storage must be maintained for at least three (3) years after study completion. Subsequently, the researcher may destroy the data in a manner that maintains confidentiality and anonymity. IRB reserves the right to modify, change or cancel the terms of this letter without prior notice. Be advised that IRB also reserves the right to inspect or audit your records if needed.

Sincerely,

Institutional Review Board
Middle Tennessee State University

Quick Links:

[Click here](#) for a detailed list of the post-approval responsibilities.
More information on exempt procedures can be found [here](#).

APPENDIX B**Demographic Form**

Part A: Please circle the answer that best describes you.

1. **Please identify your gender?**
 1. Male
 2. Female
 3. Prefer not to disclose/Other

2. **Please identify your age**
 1. 18 to 21 years old
 2. 22 to 25 years old
 3. 26 to 29 years old
 4. 30 years old and over

3. **Please identify your race/ethnic group**
 1. Caucasian/White
 2. African-American/Black
 3. Prefer not to disclose/Other

APPENDIX C

Responsibility Scale

Part B: Please answer the following questions. Circle the number that fits best with your opinion:

- 1 - not at all likely
- 2 - not very likely
- 3 - neutral
- 4 - somewhat likely
- 5 - very likely

1	How likely is it that Jon's behavior might be caused by a chemical imbalance in the brain?	1	2	3	4	5
2	How likely is it that Jon's behavior might be caused by food or chemical allergies?	1	2	3	4	5
3	How likely is it that Jon's behavior is caused by modeling his parents' behavior?	1	2	3	4	5
4	How likely is it that Jon is in control of his behavior?	1	2	3	4	5
5	How likely is it that Jon's behavior might be caused by stressful circumstances in his life?	1	2	3	4	5
6	How likely is it that Jon's behavior might be caused by the way he was raised?	1	2	3	4	5
7	How likely is it that Jon's teacher is to blame for his behavior?	1	2	3	4	5
8	How likely is it that Jon's behavior might be caused by watching violent TV or playing violent video games?	1	2	3	4	5
9	How likely is it that Jon's behavior might be caused by his own bad character?	1	2	3	4	5
10	How likely is it that Jon's behavior might be caused by a genetic or inherited problem?	1	2	3	4	5
11	How likely is it that Jon's behavior might be caused by lacking discipline in the home?	1	2	3	4	5
12	How likely is it that Jon's parents do not exercise enough control over his behavior?	1	2	3	4	5
13	How likely is it that Jon's parents are to blame for his behavior?	1	2	3	4	5

APPENDIX D

Subscales

Biological blame

1. How likely is it that Jon's behavior might be caused by a chemical imbalance in the brain?
2. How likely is it that Jon's behavior might be caused by a genetic or inherited problem?
3. How likely is it that Jon's behavior might be caused by food or chemical allergies?

Parental blame

1. How likely is it that Jon's behavior might be caused by the way he was raised?
2. How likely is it that Jon's behavior might be caused by lacking discipline in the home?
3. How likely is it that Jon's parents do not exercise enough control over his behavior?
4. How likely is it that Jon's behavior is caused by modeling his parents' behavior?
5. How likely is it that Jon's parents are to blame for his behavior?

Psychologically-Oriented Intervention

1. Medication is likely to help Jon with controlling his behavior
2. Psychological services are likely to help Jon with controlling his behavior

Punishment-Oriented Intervention

1. Putting Jon into in-school suspension is likely to help Jon with controlling his behavior
2. Jon's parents providing him with stricter punishment at home is likely to help him with controlling his behavior
3. Timeout will likely help Jon with controlling his behavior
4. Detention will likely help Jon with controlling his behavior
5. Taking away the field trip will likely help Jon with controlling his behavior

Understandable given the circumstances

1. Jon's behavior should not be punished because it is understandable given the circumstances

APPENDIX E

Consequence Scale

Part C: Please answer the following questions. Circle the number that fits best with your opinion:

- 1 - not at all likely
- 2 - not very likely
- 3 - neutral
- 4 - somewhat likely
- 5 - very likely

1	Detention will likely help Jon with controlling his behavior	1	2	3	4	5
2	Putting Jon into in-school suspension is likely to help Jon with controlling his behavior	1	2	3	4	5
3	Timeout will likely help Jon with controlling his behavior	1	2	3	4	5
4	Psychological services are likely to help Jon with controlling his behavior	1	2	3	4	5
5	Jon's parents providing him with stricter punishment at home is likely to help him with controlling his behavior	1	2	3	4	5
6	Taking away the field trip will likely help Jon with controlling his behavior	1	2	3	4	5
7	Medication is likely to help Jon with controlling his behavior	1	2	3	4	5
8	Jon's behavior should not be punished because it is understandable given the circumstances	1	2	3	4	5

APPENDIX F

Vignette

Please carefully read the following:

Jon, a 6-year-old boy (who has been diagnosed with autism spectrum disorder) does not have any friends in school or outside of school. He rarely starts conversations with children his own age, and he does not have an interest in making friends. When he does talk to other students in his class, he does not make eye contact. Jon enjoys organizing his materials, and the materials have to be exactly the same every time. This often takes away from him paying attention in class because he will continue to touch his pencils to make sure that they are lined up correctly. Jon was very excited about attending a fieldtrip at the park that was scheduled for that day. At the last minute, the fieldtrip was postponed to next week due to rain. Jon does not do very well with change, and he suddenly began to cry and yell in class. He yelled so loudly that he started to disturb the other students. The teacher tried to calm Jon down by attempting to distract him with other activities (e.g., coloring). Jon shoved the teacher away violently. Consequently, the teacher called the principal.

APPENDIX G

Informed Consent Form: Participant's Copy

IRB
INSTITUTIONAL REVIEW BOARD
 Office of Research Compliance,
 010A Sam Ingram Building,
 2269 Middle Tennessee Blvd, Murfreesboro, TN 37129



INFORMED CONSENT – RESEARCHERS’ DISCLOSURES

(Part A – Participant’s Copy)

Study Title	<i>Beliefs about Children with Problematic Behavior</i>	Office Use
Principal Investigator	Kristen Nelson Howton	<i>IRB ID: 19-104</i>
Faculty Advisor	Dr. Mary Ellen Fromuth - MaryEllen.Fromuth@mtsu.edu	Approval Date: 8/6/18
Contact Information	Kristen Nelson Howton - kh6h@mtmail.mtsu.edu	Expiration Date: N/A

Dear Participant,

On behalf of the research team, Middle Tennessee State University (MTSU) would like to thank you for considering to take part in this research study. You have been contacted by the above identified researchers to enroll as a participant in this study because you met its eligibility criteria.

This consent document describes the research study for the purpose of helping you to make an informed decision on whether to participate in this study or not. It provides important information related to this study, possible interventions by the researcher(s) and proposed activities by you. This research has been reviewed by MTSU’s internal oversight entity - Institutional Review Board (IRB)- for ethical practices in research (visit www.mtsu.edu/irb for more information).

As a participant, you have the following rights:

- You should read and understand the information in this document before agreeing to enroll
- Your participation is absolutely voluntary and the researchers cannot force you to participate
- If you refuse to participate or to withdraw midway during this study, no penalty or loss of benefits will happen
- The investigator MUST NOT collect identifiable information from you, such as, name, SSN, and phone number
- The researcher(s) can only ask you to complete an interview or a survey or similar activities and you must not be asked to perform physical activities or offer medical/psychological intervention
- Any potential risk or discomforts from this study would be lower than what you would face in your daily life

After you read the following disclosures, you can agree to participate in this study by completing “Part B” of this informed consent document. You do not have to do anything further if you decide not to participate.

1. What is the purpose of this study?

You are being asked to participate in a research study to explore how individuals believe a child who exhibits problem behavior should be handled and perceptions about what is causing the problem behavior.

2. What will I be asked to do in this study?

After reading this informed consent, if you decide to participate you will initial the boxes on the “Part B - Researcher’s Copy” of the informed consent form indicating your agreement to participate in the study. You will keep “Part A – Participant’s Copy” for your records. If you do not wish to participate, then you can hand me this form and you are free to leave. If you choose to participate, you will be asked to provide your basic demographic information, which will include gender (Male, Female, Prefer not to disclose/Other), age (18 to 21 years old, 22 to 25 years old, 26 to 29 years old, and 30 years old and over), and race/ethnic group (Caucasian/White, African-American/Black, Prefer not to disclose/Other.). Next you will read a brief vignette about a child. You will then be asked to read several statements and rate the extent to which you agree with each of them.

How many times should I participate or for how long?

The surveys will take less than 30 minutes to complete. You will only participate in this study one time.

3. What are the risks and benefits if I participate?

Your participation is absolutely voluntary and the researchers cannot force you to participate. There is less than minimal risk for participating in this study. If you refuse to participate or if you withdraw midway during this study, no penalty or loss of benefits will happen. Any potential risk or discomforts from this study would be lower than what you would face in your daily life. Additionally, there is no direct benefit to you for participating. The benefit of this study to science is the increased understanding of the beliefs about children who exhibit problem behavior. In compensation, you will receive one research credit for participation.

4. What will happen to the information I provide in this study?

The surveys will be kept secured for 3 years in a locked location in Dr. Mary Ellen Fromuth's office in Jones Hall Room 222 separate from your informed consent. All information that is provided will remain anonymous.

5. What will happen if I refuse to participate and can I withdraw if I change my mind in the middle?

Participating in this project is voluntary, and refusal to participate or withdrawing from participation at any time during the project will involve no penalty or loss of benefits to which you might otherwise be entitled. You will still receive your research credit.

6. Whom can I contact to report issues and share my concerns?

You can contact the researcher(s) by email (Kristen Nelson Howton – kh6h@mtmail.mtsu.edu or Dr. Mary Ellen Fromuth - MaryEllen.Fromuth@mtsu.edu or 615-898-2548). You can also contact the MTSU's Office of Research Compliance by email – irb_information@mtsu.edu. Report compliance breaches and adverse events by dialing 615 898 2400 or by emailing compliance@mtsu.edu.

INVESTIGATOR's SIGNATURE Kristen Nelson Howton	FACULTY ADVISOR's SIGNATURE Mary Ellen Fromuth, PhD	DATE
NON-IDENTIFIABLE PARTICIPANT ID# _____		

Confidentiality Statement:

All efforts, within reason, will be made to keep the personal information in your research record private but total privacy cannot be promised, for example, your information may be shared with the MTSU IRB. In the event of questions or difficulties of any kind during or following participation, you may contact the Principal Investigator as indicated above.

For additional information about giving consent or your rights as a participant in this study, please feel free to contact our Office of Compliance at (615) 898 2400.

Compensation:

In compensation, you will receive one research credit in your General Psychology course for participation.

Study-related Injuries:

MTSU will not compensate for study-related injuries.

Exemption Criteria:

Participants will be restricted to undergraduate students who are enrolled in a General Psychology course and who are at least 18 years old.

This study was submitted to the MTSU IRB – an internal oversight entity to oversee research involving human subjects. The IRB has determined that this investigation consists of lower than minimal risk and it is exempt from further IRB processes based on the criteria: *“Category 5 - Research conducted by or approved by agency heads.”*

Note to the Participant

You do not have to do anything if you decide not to participant in this study. But if wish to enroll as a participant, please complete “Part B” of this informed consent form and return it to the researcher. Please retain the signed copy of “Part A” for your future reference.

APPENDIX H

Informed Consent: Researcher's Copy

IRB

INSTITUTIONAL REVIEW BOARD

Office of Research Compliance,
010A Sam Ingram Building,
2269 Middle Tennessee Blvd, Murfreesboro, TN 37129



(Part B – Researcher's Copy)

Study Title	<i>Beliefs about Children with Problematic Behavior</i>	Office Use
Principal Investigator	Kristen Nelson Howton	<i>IRB ID:19-104</i>
Faculty Advisor	Dr. Mary Ellen Fromuth - MaryEllen.Fromuth@mtsu.edu	Approval Date: 8/6/18
Contact Information	Kristen Nelson Howton - kh6h@mtmail.mtsu.edu	Expiration Date: N/A

You have been contacted by the investigator(s) because the researchers believe you meet the eligibility criteria to participate in the above referenced research study. Be aware that you must NOT be asked by the investigator(s) to do anything that would pose risk to your health or welfare, such as:

- Identifiable information – name, phone number, SSN, address, College ID, social media credentials (Facebook page, Twitter, etc.), email, identifiable information of closest relatives and etc.
- Physical activities – like exercise studies
- Medical intervention – testing drugs, collection of blood/tissue samples or psychological questions
- Nothing risky – any proposed activity that would expose you to more risk than what you would face on a day to day basis is not approved by the IRB

However, you can do the following:

- Withdraw from the study at any time without consequences
- Withdraw the information you have provided to the investigators before the study is complete

- Ask questions so the researcher must explain the procedures used in the research verbally.

The investigators must give you enough time to ask any questions. Once you have had a chance to read “Part A” (Participant’s Copy), indicate your acceptance by checking the appropriate boxes:

- | | NO | YES |
|--|--------------------------|--------------------------|
| ➤ I have read investigator(s)’ disclosure (Part A) for the above identified research | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ The researcher(s) explained the procedures to be conducted verbally | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ I understand each part of the interventions and all my questions are answered | <input type="checkbox"/> | <input type="checkbox"/> |
| ➤ The researcher(s) gave me a signed copy of the disclosure page (Part A) | <input type="checkbox"/> | <input type="checkbox"/> |

By initialing below, I give my consent to participate in this study. I understand that I can withdraw from the study at any time without facing any consequences.

X

_____ **NON-IDENTIFIABLE PARTICIPANT ID#** _____
 Participants Initials Date

Initial this copy and return it to the researcher and retain Part A for your reference in case you have questions or you wish to get in touch with the researcher or with the MTSU IRB

APPENDIX I
Debriefing Form

Please keep for your own use.

Dear Participant,

Perceptions of parents of children with problematic behavior have largely been unstudied. Previous research suggests that parents sometimes feel that they are to blame for their child's behavior (e.g., Grey, 1993; Neely-Barnes, Hall, Roberts, & Graff, 2011; Portway & Johnson, 2010; Werner & Shulman, 2014). Indeed, parents have been blamed in the past for their child's mental disorder (e.g., Bettelheim, 1967). Furthermore, the previous research suggests that providing a diagnosis to a child with a disorder caused participants to believe that the child should receive less punishment when he or she engages in problem behavior (e.g., Berryessa, 2016). The purpose of this study is to address the lack of research regarding perceptions about the cause of problematic behaviors and how they should be handled. This study is evaluating whether respondent gender of the participant impacts these views. Please do not share any details from this study with other classmates or faculty to help ensure that the results of this study are valid.

If you would like additional information about this study or your rights as a participant, please feel free to contact me at kh6h@mtmail.mtsu.edu or my faculty advisor, Dr. Mary Ellen Fromuth, at MaryEllen.Fromuth@mtsu.edu. The results from this study will not be immediately available, but arrangements can be made for you to obtain the results of the study once they become available.

I really appreciate you taking the time to participate in my project.

Kristen Nelson Howton
Graduate Student, Clinical Psychology
kh6h@mtmail.mtsu.edu

Mary Ellen Fromuth, PhD
Faculty Advisor, Clinical Psychology
MaryEllen.Fromuth@mtsu.edu

APPENDIX J

Survey

Part A: Please circle the answer that best describes you.

1. **Please identify your gender?**
 1. Male
 2. Female
 3. Prefer not to disclose/Other

2. **Please identify your age**
 1. 18 to 21 years old
 2. 22 to 25 years old
 3. 26 to 29 years old
 4. 30 years old and over

3. **Please identify your race/ethnic group**
 1. Caucasian/White
 2. African-American/Black
 3. Prefer not to disclose/Other

Please carefully read the following:

Jon, a 6-year-old boy (who has been diagnosed with autism spectrum disorder) does not have any friends in school or outside of school. He rarely starts conversations with children his own age, and he does not have an interest in making friends. When he does talk to other students in his class, he does not make eye contact. Jon enjoys organizing his materials, and the materials have to be exactly the same every time. This often takes away from him paying attention in class because he will continue to touch his pencils to make sure that they are lined up correctly. Jon was very excited about attending a fieldtrip at the park that was scheduled for today. At the last minute, the fieldtrip was postponed to next week due to rain. Jon does not do very well with change, and he suddenly began to cry and yell in class. He yelled so loudly that he started to disturb the other students. The teacher tried to calm Jon down by attempting to distract him with other activities (e.g., coloring). Jon shoved the teacher away violently. Consequently, the teacher called the principal.

Part B: Please answer the following questions. Circle the number that fits best with your opinion:

- 1 - not at all likely
- 2 - not very likely
- 3 - neutral
- 4 - somewhat likely
- 5 - very likely

1	How likely is it that Jon's behavior might be caused by a chemical imbalance in the brain?	1	2	3	4	5
2	How likely is it that Jon's behavior might be caused by food or chemical allergies?	1	2	3	4	5
3	How likely is it that Jon's behavior is caused by modeling his parents?	1	2	3	4	5
4	How likely is it that Jon is in control of his behavior?	1	2	3	4	5
5	How likely is it that Jon's behavior might be caused by stressful circumstances in his life?	1	2	3	4	5
6	How likely is it that Jon's behavior might be caused by the way he was raised?	1	2	3	4	5
7	How likely is it that Jon's teacher is to blame for his behavior?	1	2	3	4	5
8	How likely is it that Jon's behavior might be caused by watching violent TV or playing violent video games?	1	2	3	4	5
9	How likely is it that Jon's behavior might be caused by his own bad character?	1	2	3	4	5
10	How likely is it that Jon's behavior might be caused by a genetic or inherited problem?	1	2	3	4	5
11	How likely is it that Jon's behavior might be caused by lacking discipline in the home?	1	2	3	4	5
12	How likely is it that Jon's parents do not exercise enough control over his behavior?	1	2	3	4	5
13	How likely is it that Jon's parents are to blame for his behavior?	1	2	3	4	5

Part C: Please answer the following questions. Circle the number that fits best with your opinion:

- 1 - not at all likely
- 2 - not very likely
- 3 - neutral
- 4 - somewhat likely
- 5 - very likely

1	Detention will likely help Jon with controlling his behavior	1	2	3	4	5
2	Putting Jon into in-school suspension is likely to help Jon with controlling his behavior	1	2	3	4	5
3	Timeout will likely help Jon with controlling his behavior	1	2	3	4	5
4	Psychological services are likely to help Jon with controlling his behavior	1	2	3	4	5
5	Jon's parents providing him with stricter punishment at home is likely to help him with controlling his behavior	1	2	3	4	5
6	Taking away the field trip will likely help Jon with controlling his behavior	1	2	3	4	5
7	Medication is likely to help Jon with controlling his behavior	1	2	3	4	5
8	Jon's behavior should not be punished because it is understandable given the circumstances	1	2	3	4	5