Brief Report: Learning to Parent: A Survey of Parents in an Urban Pediatric Primary Care Clinic

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Objective: To survey parents bringing children to an urban pediatric primary care clinic about (1) how they learned parenting skills, (2) role of the clinic in teaching parenting, (3) helpfulness of information sources, and (4) preferred modalities for teaching.

Methods: A total of 108 adults completed an oral survey in clinic, consisting of open-ended questions, yes/no endorsements, Likert ratings, and demographic questions.

Results: The majority reported learning to parent from their families or “by just doing it.” Talking with professionals was rated as very helpful. Most had parenting questions. Almost half wanted information regarding specific developmental/behavioral issues, while only 8% wanted medical information. Most felt they could talk with clinic professionals about concerns but fewer had done so. Modality preferences were reported.

Conclusions: Inner-city parents value working with primary care providers to improve knowledge of developmental/behavioral issues. Results have implications for the anticipatory guidance process, content of information provided, and the training of pediatric healthcare providers. We determined preferences for information delivery.

Key words: primary care; inner-city parents; parenting education; anticipatory guidance.

The concept of primary care calls for “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community” (Donaldson, Yordy, Lohr, & Vanselow, 1996, p. 1). Partnering with parents to optimize a wide range of health care outcomes over a substantial period of time is a central characteristic of primary care pediatrics. One such important outcome is children’s development and behavior. Parents often turn to pediatricians for help in addressing a variety of child-rearing, family, and behavioral concerns (Angeli, Christy, Howe, & Wolff, 1994; Hickson, Altemeier, & O’Connor, 1983; Klar & Coleman, 1995). Many times these developmental or parenting concerns are the major reason for pediatric visits even though that may not be evident. Despite the prevalence of behavioral issues, many parents do not tell pediatricians their greatest concerns about their child’s developmental and behavioral problems (Hickson et al., 1983), although parental reports have been found to be generally accurate indicators of developmental (Glascoe, Altemeier, & MacLean, 1988) and emotional problems (Glascoe, MacLean, & Stone, 1991). Reasons for parents not ex-
pressing problems to their pediatricians may include impediments such as the physician not speaking the same language as the family, long clinic waiting periods, or lack of physician communication, empathy, comfort with topic, time, and educational materials (Fulginiti, 1984; DeSantis & Thomas, 1992).

Anticipatory guidance has long been used to address developmental and behavioral changes in children. The goal has been to educate and prepare parents for predictable changes in their children so they can keep their children healthy and maintain a safe environment in which caregivers foster further development and provide age-appropriate discipline (Green, 1994). Parents also have relied on nonmedical sources of information to guide their actions (Young, Davis, Schoen, & Parker, 1998). Sleep and bedtime issues, feeding problems, toilet training, and oppositional behavior in preschool and school-age children are among the many challenges of parenting that have been addressed through parent training books. Books, handouts, magazines, videotapes, web sites, television, and radio shows have been designed to address general and specific elements of parenting (Glascoe, Oberklaid, Dworkin, & Trimm, 1998). Even children’s books have incorporated messages to parents about managing difficult situations (e.g., The Berenstain Bears Get the Gimmies).

Not all parents have ready access to such materials for economic as well as educational reasons. Cultural and subcultural issues may also affect the acceptability of certain parenting concepts or techniques (McGoldrick & Giordano, 1994). Stickler, Salter, Broughton, and Alario, (1991) found that parents living in high external stress conditions (including single-parent families, living in urban areas, maternal education below the high school graduate level) had different worries about their children than lower stress, less urban parents. The higher stress urban mothers more frequently listed chemical dependency, depression, suicide or homicide, finances, child abuse, delinquency, and unwanted pregnancy, although health concerns and basic parenting issues were no different. Although evidence for relative preference of parents for various methods of teaching is sparse, Black and Tei (1997) found that teaching videotapes showing speakers of similar demographics to a young, African American audience were more effective than tapes with the similar message delivered by white professionals. In order to better address the needs of inner-city, generally minority, parents and children, who attend a primary care continuity clinic at a major teaching hospital, parents were surveyed in this study about how they learned to be parents, the role of the clinic in teaching, and what informational sources have been helpful to them. They were also asked to express their preferences for various methods of clinic-related future education regarding parenting and child development.

Method

Site. An urban pediatric primary care clinic (one of the continuity experiences for pediatrics residents) was the location of the survey. At this clinic, approximately 85% of visits are paid for by Medicaid and 10% are self-pay. Approximately 80% percent of the patients are African Americans.

Participants. A convenience sample of 117 adults, bringing a child or children to a well-child visit were asked to participate. Of these, 115 (98%) agreed to participate and 108 (92%) completed the survey. The appointments were distributed across days of the business week.

Procedures. Interviewers, dressed in street clothes, approached adults to explain the project and ask for their consent while the parents waited in the clinic examination rooms with their children. Parents were told that the interview would not prolong their clinic visit, and interviewers left immediately if a medical staff member came to the room. Unfinished surveys were completed whenever possible during the next waiting interlude. Most survey interviews required less than 10 minutes. Surveys were read to the parents, who responded orally, with a model of the response scale visible to the respondents during relevant questions. No incentives to participate were offered. This protocol was approved by the Institutional Review Board.

Measures. Adults completed an oral survey specifically developed for this project. It consisted of (1) open-ended questions regarding how they learned to “take care of and raise” their children; (2) ratings of listed sources of information about “taking care of and raising” their children on a 1–5 Likert scale; (3) open-ended questions regarding child-rearing topics the adults would like to know more about; (4) Likert ratings of the role of the clinic in teaching parents about raising children; and (5) yes/no questions to indicate preferences for possible methods of delivery of parenting information in clinic.
opmental stages, discipline in general); (4) specific medical/health topics, 8% (e.g., a particular disease or syndrome, teeth care); (5) general parenting issues, 6% (how to stay patient, get time alone); and (6) 20% had no such topics.

**Table II.** Percentage of Respondents Endorsing Modalities of Future Clinic Teaching (N = 108)

<table>
<thead>
<tr>
<th>Type of clinic teaching</th>
<th>% Responding Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Papers to take home</td>
<td>87</td>
</tr>
<tr>
<td>Videos to watch in clinic</td>
<td>85</td>
</tr>
<tr>
<td>Magazines for waiting room</td>
<td>79</td>
</tr>
<tr>
<td>Books to borrow</td>
<td>77</td>
</tr>
<tr>
<td>Just talking</td>
<td>77</td>
</tr>
<tr>
<td>Classes</td>
<td>76</td>
</tr>
<tr>
<td>More time with doctor</td>
<td>55</td>
</tr>
<tr>
<td>More time with nurse</td>
<td>55</td>
</tr>
<tr>
<td>Don’t care</td>
<td>6</td>
</tr>
<tr>
<td>Don’t want clinic to do this</td>
<td>2</td>
</tr>
</tbody>
</table>

Percentages do not equal 100% because some respondents gave several answers to the question. Each percentage represents the number of times a certain response was mentioned out of the total number of 108 participants.

**Source of Parenting Skills.** A majority of the participants (87%) felt they learned how to be a parent from their own family, usually from their mother. Almost half of the participants learned how to parent from their own experience “just by doing it” (46.3%). A large number of caregivers learned how to be parents from other people (26%) or from babysitting (18.5%).

**Helpfulness Ratings of Sources of Parenting Information.** After obtaining spontaneous listings of answers to the above question, researchers asked for ratings of helpfulness (on a Likert scale of 1 to 5, where 5 is “helps a lot”) of the methods parents listed and other sources of parenting information. The participating caregivers reported that talking to health professionals was very helpful relative to other methods in learning how to be a parent (M = 3.9). Talking to relatives (M = 3.8) and remembering how one was raised (M = 3.6) were also helpful. In contrast, according to these caregivers, some possible sources of information were not helpful, such as listening to radio programs. Table I shows the mean ratings of the sources.

**Wish for More Topics.** Answers to this open-ended question (About which child-raising topics do you wish to know more?) were categorized into six mutually exclusive qualitative categories: (1) specific developmental/behavioral topics, 46% (e.g., toilet training, attention deficit hyperactivity disorder [ADHD], nutrition, tantrums, managing “cussing”); (2) general medical/health topics, 17% (e.g., caring for a child who is sick, illnesses in general); (3) general developmental/behavioral topics, 16% (developmental stages, discipline in general); (4) specific medical/health topics, 8% (e.g., a particular disease or syndrome, teeth care); (5) general parenting issues, 6% (how to stay patient, get time alone); and (6) 20% had no such topics.

**Availability of Parenting Information.** We asked: In what ways would parents like the clinic to make parenting information available? Despite the number of parents who did not feel a need for more information about taking care of and raising their children, only 2% of the respondents did not want the primary care clinic to provide parenting information, while an additional 6% did not have a preference as to how information is presented. Preferences of respondents are shown in Table II.

**Communications with Primary Care Clinic Staff about Parenting.** The majority of respondents reported comfort in asking doctors and nurses in the clinic about parenting (89% and 88%, respectively). A smaller percentage reported that they had, in fact, asked questions of either clinic doctors (51%) or nurses (39%). Of those who had, however, 97% reported that the interchange with doctors was helpful (rated above 3 on 1–5 scale). Similarly, 96% of those who had asked questions of nurses rated the conversation as helpful.

**Discussion**

Parents see themselves as learning the complex and often difficult task of raising children largely through modeling and a variety of on-the-job-training. A large percentage of the parents in this urban, inner-city clinic would like to know more
about raising their children, addressing behavioral problems, and promoting development, although 20% would not.

The areas in which they reported the greatest desire for knowledge were more often developmental and behavioral than medical or health-related, similar to Hickson et al.’s earlier findings (1983). Of parents who desired more information, more than half wanted to learn about specific developmental or behavioral topics. Since the children were being brought for well-child visits, it may be that the medical concerns were less pressing at the time of interview than they might be at other times. It might also be that parents of children with medical problems are taught more about their child’s specific condition than about raising children in general.

While parents accessed information from a variety of sources, they ranked as very helpful the informative interactions they had with medical care providers. Only a very small minority of parents did not want the primary care clinic to provide information about raising children. Behavioral/developmental topics that parents wanted to learn more about covered a wide range including ADHD; managing undesirable behaviors such as temper tantrums, “cussing,” defiance, and “being stubborn”; the behavioral aspects of “getting a kid to eat”; fears; methods of discipline; helping a child to give up the baby bottle; sibling fights; school readiness; separation; crying; self-esteem; living with teenagers; sex education; and potty training. Other concerns commonly expressed by parents were how to get time alone, how to be more patient, and how to cope with stress. These are not topics necessarily related to psychopathology and have been the “bread and butter” issues of pediatric psychologists in primary care settings.

Although most respondents reported both wanting to know more and feeling comfortable that they could ask primary care clinic staff about behavioral and developmental issues, many of the parents had never asked such a question in clinic. This survey did not address the reasons, but this finding is consistent with previous findings (Hickson et al., 1983). Previous research has suggested that physician behavior largely determines the likelihood of these concerns being addressed (DeSantis & Thomas, 1992; Wissow, Roter, & Wilson, 1994). Training pediatric residents to encourage parents’ inquiry about behavioral issues and teaching effective techniques to respond to behavioral concerns during clinic opportunities deserve to be studied further. Attempts to focus residents on psychosocial issues, however, will be competing with economic and administrative pressures to see more patients in a shorter period of time, especially as capitation becomes a reality for many clinics and practices. As Zuckerman and Parker (1995) and Nazarian (1995) have pointed out, this may call for a reorganization of pediatric practices with many disciplines contributing to addressing the physical, social, emotional, and behavioral needs of children and their families.

Another model for this reorganization is Schroeder’s (1996) idea of integrating pediatric psychologists into private pediatric practices.

Even without reorganization, some parental preferences would be possible to implement. One preference of the parents was handouts, a method Gibbs, Waters, and George (1989) found helpful to increase knowledge. One mother commented that “something to take home reminded [her] of what the doctor said.” Similarly, brochures, books, or recordings to borrow or keep could address some of the needs of the families, but literacy levels, applicability, and cultural relevance would need to be addressed prior to their use. More time with medical staff was endorsed by half of the respondents, but “just talking” about the issues received the endorsement of over three-quarters of the parents. This suggests that the amount of time may not be of as much concern to the parents as what is said during the pediatric visit. Glascoe in several studies (1989, 1991) found that developmental or behavioral screening devices can be useful as a way of stimulating and structuring conversations between parents and primary care physicians. Parents were also open to talking to professionals other than physicians. Additionally, talking to other people and remembering how they had been raised were rated as helpful. This suggests that group well-child discussions in clinic or in the waiting room could also be valuable.

Another parents’ preference was videotapes in clinic. Waiting times in lobbies or examination rooms could be used more productively with little expense after the initial outlay of money for equipment. Alternatively, parenting videos could be provided free of charge to church or public libraries or videotape rental services in an urban clinic’s primary catchment area. Economic concerns do not seem to be a major obstacle to the use of most of the modalities of information delivery preferred by the respondents in this study. Parents’ attitudes do
not pose a barrier either; only a very small percentage of caregivers surveyed felt the clinic should not be educating parents about child-rearing issues.

Because of the narrow segment of the population of parents surveyed, findings may be limited in their generalizability to private practice settings or to clinics with somewhat different demographic representations. On the other hand, the findings are consistent with previous work with other populations, most notably the recent national survey of parents with children under 3 years of age, which found that parents were satisfied with the physical care their children received from physicians and clinics but not the parenting and psychosocial information or support (Young, Davis, Schoen, & Parker, 1998). It is also consistent with the findings of Stickler et al. (1991), which emphasized that stressed, urban parents had many emotional, developmental, and behavioral concerns about their children. The results of this study reveal that these concerns extend to lower socioeconomic, minority urban families and suggest some ways to address them.

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References


