Supplementary material

Supplementary Table 1. Data extraction sheet.

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| Author/Year/Country | Study Design | Population | Concept | Context |
| Sample parent | Age of children(Yr) | Exposure method to Passive Restraint | Ranking Preference | Other BGT | Outcome of Passive Immobilisation | Conclusion | Confounding Factors |
| N | Age(Yr) | Ranking | Mean VAS for acceptanceMean (SD) | Percentage of acceptance (%) |
| Nathan [1]/2022/USA | Retrospective Cohort | 4300 | - | 3–7 | Experiencing the BGT | Rate(Optimal = no need for restraint; Acceptable = only minimal or transient need for restraint; Inadequate = persistent need for restraint of interfering behaviour; | 1. OS2. PI | - | - | 63 | • Parent opted for the use of passive restraint when sedative techniques fail to overcome resistive behaviour in order to complete the treatment. | • Alternative option |
| Patil [2]/2021/India | Cross-sectional | 100 | - | 4–10 | Interview | Questionnaire | 1. TSD2. N2O2/O23. VC4. PI5. GA | 3/5 | - | 61 | • Majority of Indian parents, regardless of their educational status, favour Passive restraint as a behaviour management modality, rather than sedation and GA in uncooperative child• Among the various restraints mentioned in the questionnaire, there is least awareness about papoose board among the higher-middle class parent.• 82% of the parents stated that they had no awareness or knowledge about the various laws governing the use of Passive immobilisation in dentistry | • Uncooperative child• Middle class parent |
| Thirunavakarasu [3]/India/2021 | Cross- sectional | 100 | 30–40 | 6–12 | Photograph | Rating score 1–10 | 1. TSD2. VC3. PR4. HOM5. AR6. PI7. OS8. GA | 8/8 | 1.47 | 14.7 | • Papoose board/pedi wrap was not generally well accepted by the parents.• Most parents (84.5%) responded they would prefer to stop the treatment of an uncooperative child, or to stop and calm the child and then resume treatment (communicative BMT) | • School children |
| Kumar [4]/2021/India | Cross- sectional | 675M: 263F: 412 | - | 4–9 | Audiovisual | 10-point VASLeft: UnacceptedRight: Accepted | 1. N2O2/O22. PI3. OS4. VC5. AR6. HOM7. GA8. PPA9. TSD | 2/9 | - | 19.1 | • Passive restraints had the second highest acceptance rate in this study.• The occupation of parent with majority of skilled, semi-skilled and unskilled worker, resultant of education level plays an important role in the selection and acceptance of passive immobilisation as BMTs. | • Socio-economic |
| Sabbagh [5]/2021/Saudi Arab | Cross- sectional | 132 | - | 2-12 | Experiencing the BMT | Likert scale (Agree/Neutral/Disagree). | 1.N202/022.PI | - | - | Before: 40%After :100% | • Parental attitudes toward N2O sedation and/or PB as BMTs improved after parents experienced BMTs with their children. | • Child Dental Experience |
| Al Zoubi [6]/2021/Germany | Cross- sectional | 100M: 26F: 74 | - |  | Written explanation of BMT and 2 additional photos | Five-points Likert scale1: highly unacceptable5: highly acceptable | 1. PI2. AR3. N2O2/O24. GA | 4/4 | 2.05 (±1.18) |  | • Results from this study indicated that passive restraint was significantly less accepted in the University of Greifswald group than in the Jordan University group (*p* = 0.001).• Parent usually had no actual experience with any technique.• The different outcomes between the two samples from Germany and Jordan are probably due to cultural and socio-economic differences.• Higher parental acceptance of advanced BMT in both groups when the treatment is urgent (*e.g.*, pain or dental trauma).• Cultural background and the urgency of the treatment influence the acceptance of advanced behaviour management techniques in paediatric dentistry. | • Cultural• Socioeconomic differences• Urgency of treatment |
| Al Zoubi [6]/2021/Saudi Arabia | Cross- sectional | 99M: 15F: 84 | - |  | 3/4 | 2.52 (±1.50) |  |
| Seangpadsa [7]/2020/Thailand | Cross- sectional | 200M: 41F: 159 | 22–50 | 2–5 | Video (in random order) | 100 point VASLeft: UnacceptedRight: Accepted | 1. TSD2. VC3. PPA4. N2O2/O25. PI6. AR7. OS8. GA | 2/8 | 74.53 ± 23.8 |  | • Passive immobilisation is useful for a young child undergoing some short dental procedures where pharmacological approaches are limited or not available.• Passive immobilisation was viewed as a safe, protective, and effective technique by studied parents. | • Preschool children |
| Mirmoeini [8]/2020/Iran | Quasi-experimental | 162 | - | 3–7 | Questionnaire (pre intervention), Writing report, oral and visual (film presentation)(Post Intervention) | Questionnaire | 1. PPA2. VC3. AR4. PI5. HOM6. GA | 5/6 | Pre (92.13)Post (53.27) | - | • Lowest acceptance toward passive immobilisation due to the parental concerned regarding emotional problems and harm to the child.• Informing by visual presentation is the most effective method for increasing parental acceptance of passive immobilisation technique. | • Presentation methods |
| Al Zoubi [9]/2019/Germany | Cross-sectional | 136M: 41F: 95 | - | - | Written definition and photos in clinic in one standard order (passive restraint, active restraint, nitrous oxide sedation, GA) | 5 points Likert scale.1: highly unacceptable5: highly acceptable | 1. PI2. AR3. N2O2/O24. GA | 4/4 in both normal treatment and emergency treatment | - | Normal Treatment: 19.9%Emergency Treatment: 37.8% | • Passive restraint was rated as the least acceptable technique for normal treatment (19.9%) and even with a marked increase in acceptance for emergency situations it remained a rather unacceptable technique (37.8%).• A recent review pointed out that the use of passive restraint should be limited to specific emergency situations for a short duration of time. In this case, the dentist should clarify the technique to the parents before using it• The order of the techniques presented was found to affect the perception of the parents to the technique as when passive restraint was shown last, it was rated less acceptable than when it was shown first | • Emergency Treatment• Subconscious comparison to the previous treatment as the survey presented in one standard order |
| Martinez[10]/2019/USA | Cross-sectional | 136M: 28F: 108Hispanic: 62Non Hispanic Black: 38Non Hispanic white: 36 | 19–49 | <18 | Video (Lawrence) | 15 point VASLeft: AcceptedRight: Unaccepted | 1. TSD2. VC3. AR4. PI5. N2O2/O26. OS7. GA | Hispanic: 3/7Non Hispanic Black: 7/7Non Hispanic white: 7/7 | Hispanic: 42.1 (30.4)Non Hispanic Black: 62.6 (31.5)Non Hispanic white: 55.3 (35.2) | - | • Both white and black parents accepted all techniques except for passive restraint, while Hispanic parents accepted passive restraint• Differences in acceptance of behavior management techniques exist between Hispanic, non- Hispanic white, and non-Hispanic black parents, which suggest that practitioners should take into account cultural differences when electing to use them.• Parents of different backgrounds show differences in parenting styles. | • Parental ethnic/race background |
| Mokhtar[11]/2019/Malaysia | Cross-sectional | 55M: 25F: 30 | - | 3–5 | Video (1.5–2 min each BMT) | 100 point VASLeft: UnacceptedRight: Accepted | 1. TSD2. VC3. PPA4. N2O25. PI6. AR7. GA | 5/7 | 19.257 | - | • Majority of parent with pre-school age children preferred least aggressive techniques instead of passive immobilisation. | • Pre-school children |
| Mokhtar[12]/2019/Malaysia | Cross-sectional | 76M: 17F: 59 | - | 4–7 | Audio-Visual demonstration (94 sec) | 100 point VASLeft: UnacceptedRight: Accepted | 1. PI | - | - | 63.2% of respondents agreed that PB was an effective BMT65.8% of our respondents would permit PB placement to be used on their children. | • The demonstration video of Papoose Board usage was performed in a positive and stress-free environment, which may lead to PB acceptance among the respondents• Age of the parents was the only determining factor that influenced parents’ willingness toward the use of Papoose Board where older parents were more receptive toward PB than their younger counterparts | • Method of presentation |
| Hill [13]/2019/USA | Prospective Cohort | 266M: 47F: 218 | 21–46+ | 1–16 | pictorial and written description of passive immobilization technique | 4-Point Likert Scale | 1.PI | - | - | Willing to consentAfrican American: 86%Hispanic: 84%Asian: 50%Caucasian: 23.8% | • Caregiver’s race/ethnicity impacts their willingness to accept passive immobilization as a means of behaviour management for their child’s dental treatment.• African American and Hispanic caregivers were initially more willing to consent, while Asian and Caucasian caregivers were initially less willing to consent.• A written and pictorial explanation of the passive immobilization technique changes caregiver’s attitudes about the technique and makes them more likely to consent to the use of the technique, regardless of the racial/ethnic group. | • Race and ethnicity• Method of presentation |
| Varshitha [14]/2019/India | Cross-sectional | 100M: 48F: 52 |  |  | videotapes with explanation pictures | QuestionnaireAccept/unaccept | 1. TSD2. AR3. PI4. PPA5. N2O2/O26. GA | 6/6 | - | 69% of population unaccepted the usage of passive restraints.Among 31% accepted: 11%-Papoose Board12%-mouth Props4%-Pedi-wrap4%-Straps | • Passive restraint was the least accepted. Parental acceptance of the stabilization device used with conscious sedation depended on the way it was presented by the dentist; positive explanations.• Any such intervention must follow an important parental policy that is informed before we perform. | • Parent with urban area |
| Desai [15]/2019/India | Cross-sectional | 300 |  | A: 2–5B: 6–9C: 10–13 | Video (11 min) with explanation | 100 point VASLeft: UnacceptedRight: Accepted | 1. TSD2. PR3. MOD4. VC5. HOM6. PI7. AR8. OS9. N2O2/O210. GA | 6/10 | A: 19 (±7.04)B: 15.8(±8.67)C: 14.9(±6.59) | - | • Pharmacological BMT such as nitrous oxide sedation and oral sedation techniques were preferred over the aggressive management techniques.• Parents also stated that the videos helped to improve their understanding and broaden their outlook. This showed that parents were more receptive for the techniques once they were educated about the need for their use.• Acceptance of Passive immobilisation is higher in parent with younger age group children due to uncooperativeness | • Different Age group of child |
| Gupta [16]/2019/India | Cross-sectional | 100M: 64F: 36 | 20–40 | 3–622 spl need child | Powerpoint presentation | 100 point VAS0: Unaccepted100: Accepted | 1. VC2. TSD3. PR4. PI5. MOD6. HOM7. AR8. OS9. N2O2/O210. GA | 6/10 | - | 42.0 | • Changing attitudes toward acceptability of behaviour management techniques may be attributed to changes in parenting styles over the past years. A recent study reported parents are more overprotective and less likely to set limits on children’s behaviour | • Mouth prop |
| Taran [17]/Turkey/2018 | Cross-sectional | 142 |  | 3–12 | Video | 3 Point Likert scale0: Not applicable1: Applicable if needed2: Applicable | 1. TSD2. VC3. PR4. PPA5. OS6. GA | - | - | 16.9 | • The preferences toward protective stabilization (*p* = 0.007) and general anaesthesia (*p* = 0.015) were associated with parental dental anxiety• Parents with moderate anxiety seem to prefer protective stabilization if needed (*p* = 0.003),• Cultural differences have been reported to affect parenting styles. | • Parenting style (authoritative)• Parental anxiety |
| Al Daghamin [18]/2017/Saudi Arabia | Cross-sectional | 405M: 127 F: 278 | 20–50 | 7–9 | Video | VAS (0–10)0: completely opposed10: completely accepted | 1. TSD2. N2O2/O23. PI4. VC5. HOM6. OS7. AR8. GA9. PPA | 9/9 | 4.59 (±3.171) | - | • Acceptance of Passive immobilisation was the least as the studied parents were professionally qualified and higher educated. | • socioeconomic status |
| Acharya[19]/2017/India | Cross-sectional | 50 | 20-40 | 3-6yo | Power point presentation | VAS is a 100-mm horizontal line100 (L): “completely acceptable”0% (R): “completely unacceptable” | 1. TSD2. PR3. MOD4. GA5. N2O2/O26. PI7. OS8. VC9. AR10. HOM | 6/10 | - | 42% Passive R (Mouth Prop) | • In the present study, parents received explanations on the various behaviour management techniques intended to be used by the dentists involved in the research, what may be the reason why parents showed general acceptability toward various behaviour management techniques | • Mouth Prop |
| Patel [20]/USA/2016 | Cross-sectional | 105M: 20F: 85 | 23–67 | - | Video Tape | 100mm Visual Analogue ScaleL: Completely acceptableR: Completely unacceptable | 1. PI2. AR3. OS4. GA | 4/4 | - | 44.4 ± 39.4 | • Passive immobilization was rated as the least acceptable technique among those tested• However, parents watching passive immobilization first were not influenced by other management techniques and, therefore, may not have rated it as unacceptable as parents who watched passive immobilization last. | • Randomisation presentation of method |
| Jafarzadeh [21]/2015/Iran | Cross-sectional | 54M: 18F: 36 | 23–68 | - | Videotape | 100 mm Visual Analogue ScaleL: Completely disagreeR: Completely agree | 1. TSD2. VC3. PI4. HOM5. AR6. OS7. GA | 6/7 | 35.11 (±25) | - | • Use of passive restraint devices was ranked the second least accepted technique with a significantly different mean score of attitude• Parents still have negative attitude towards aggressive physical techniques | • Videotape by Lawrence |
| Paryab [22]/2014/Iran | Prospective Cohort | 90M: 0F: 90 | - | 3–6 | VerbalWrittenVideotape | 5 point Likert Scale | 1. AR2. PI3. HOM4. OS5. GA | 5/5 |  | 37.8% | • None of the methods for presenting information had any preference over the other in behaviour management, though it seems that verbal presentation has to be performed by the dental team alongside the other forms in presenting information. | • Method of presentation |
| Boka [23]/2014/Greece | Cross- sectional | 229University106Private 123M: 60F: 169 | 28–59 | 3–12 | Video with an introduction to each BGT in Greek, explaining the techniques one by one | Acceptance Scale 0–100: opposed10-unopposed | 1. TSD2. N2O2/O23. PI4. VC5. HOM6. OS7. AR8. GA9. PPA | Overall8/9Universiti clinic8/9Private clinic9/9 | Overall4.21 (±3.84)Universiti clinic5.99 (±3.25)Private clinic2.67 (±3.71) | - | • University clinic parents had lower income and educational level and rated passive restraint, oral sedation and general anaesthesia higher than those at the private practice. | • Different clinic set up (Income and educational level different) |
| de castro [24]/2013/Brazil | Cross- sectional | 8040 disabled40 non disable | - | 3–10 | Photo with standardize description and order | Categorical score of unacceptable, somewhat acceptable, acceptable, totally acceptable | 1. VC2. TSD3. PR4. N2O2/O25. PI6. AR7. GA | Group A5/7Group B:2/7 | - | Group A27.5% acceptableGroup B55% acceptable | • In this study, there was a statistically significant difference (*p* < 0.05) of parental acceptance of the protective stabilization with a restrictive device by Group with disability compared to Group without disability• Parent with children that showed uncooperativeness, involuntary movement and mental developmental delay were more tolerant toward passive immobilisation. | • Presence or absence of a disabling condition |
| Tsuchihashi [25]/2012/Japan | Cross sectional | 50F: 50 | - | 3–5 | Observe their own child using the passive immobilisation device | QuestionnaireYes/No | 1. PI | - | - | Before: 81% consentedAfter: 96% consented | • Almost all mother thought that their decision to allow passive restraint was appropriate and willing to have their child treated under Passive restraint if it would be necessary in the future | • Pre-school Children• Treatment restoration and root canal treatment |
| Elango [26]/2012/India | Comparative study | 204102 Parent with healthy102Parent with Special need | - | 3–15 | videotape | 100mm Visual Analogue ScaleL: Completely unacceptableR: Completely acceptable | 1. TSD2. CE3. PR4. PI5. MOD6. OS7. AR8. GA9. VC10. HOM | Group A: 4/10Group B: 5/10 | Group A: 10.68Group B15.15 | Group A: 89.32Group B: 84.85 | • Parents of special children were less accepting to techniques than the parents of healthy children, but significant differences were obtained only for some BMTs. Thus, having a disabled child might be a factor influencing the parental rating | • Presence or absence of a disabling condition• Mouth prop |
| de leon [27]/2010/spain | Cross sectional | 50M: 16F: 34 |  | 3–13 | Video in standard order | Scale 0–100: completely opposed10: completely accepted | 1.TSD2. N2O2/O23. PI4. VC5. HOM6. OS7. AR8. GA | 7/8 | - | 10% | • Parents still have a low opinion of the passive immobilisation and levels of acceptance remain very low. The socioeconomic level of parents affects their acceptance of papoose board. | • Socioeconomicstatus |
| Marshall [28]/2008/USA | Cross sectional | 85 |  | 2.7–19 | Experiencing the BGT | Survey acceptance by ye/no/uncertain | 1. PR2. TSD3. PI4. AR5. MP6. N2O2/O27. OS8. GA9. DIS | 9/9 |  | 54 | • The stabilization device was used for 25 children, with a dentist-reported calming effect noted for 5 (20%).Parents’ acceptance of a stabilization device used on their children was 95%, significantly higher than the 40% acceptability reported by parents of children who were not treated with that device (*p* < 0.001) | • Autism• Experience |
| Oliviera [29]/2007/Brazil | Cross sectional | 227 | - | <15 | Video | Rate Accept/not accept | 1. AR2. PI3. OS4. GA | 2/4 | - | 55.9 | • The parents who were more likely to accept passive physical restraint had a child aged between 9 months and 4 years and had previous experience with physical restraint. | • Children with Intellectual Disability |
| Eaton [30]/2005/USA | Cross sectional | 46M: 8F: 38 | 22–53 | - | Video Tape by Lawrence *et al*. | 100mm Visual Analogue ScaleL: Completely acceptableR: Completely Unacceptable | 1. TSD2. N2O2/O23. PI4. VC5. HOM6. OS7. AR8. GA | 7/8 | 49.7 (±32.1) | - | • Aggressive physical management techniques (passive restraint and hand-over-mouth) appear to be less favourably accepted. | • Video tape from Lawrence |
| Kupietzky [31]/2005/Israel | Comparative study | 60 | - | - | Audiovisual | Survey yes/no or acceptable/unacceptable | 1. PI2. N2O2/O23. AR4. GA | - | - | Neutral explanation: 10%Positive explanation: 69% | • Parents who received a positive explanation regarding the PB showed higher acceptance levels than parents who received a neutral, noncommittal explanation | • Positive explanation versus neutral explanation |
| Peretz [32]/1999/Israel | Cross sectional | 104 | 25–52 | 2–13 | Verbally explain | Questionnaire | 1. VC2. AR3. PI4. OS | 3/4 | - | 31 | • Detailed explanations and witnessing children during dental treatment may raise parents’ tolerance level toward aggressive management techniques. | • Detailed explanation• Witness their own children |
| Scott [33]/1998/USA | Case control | 52M: 6F: 26 | - | - | Videotape by Lawrence | 100mm Visual Analogue ScaleL: acceptableR: Unacceptable | 1. TSD2. VC3. N2O2/O24. OS5. GA6. AR7. HOM8. PI | Explanation: 8/8No Explanation: 7/8 | Explanation: 70.4 (±8.7)No Explanation: 60.6 (±9.1) | - | • No single behaviour management technique was rated completely acceptable by all parents in either of the groups which may be attributed by smaller population in our study. | • With and Without explanation• Hispanic Parent |
| Brandes [34]/1995/USA | Prospectivecohort | 8040 disabled40 non disableM: 6F: 74 | 22–71 | - | Written Description of BGT with and without rationale1A: Parent non disabled, not informed1B: Parent non disabled, informed2A: Parent disabled, not informed2B: Parent Disabled, informed | 100mm Visual Analogue ScaleL: acceptableR: Unacceptable | 1. PI2. HOM3. OS4. GA | 1A: 4/41B: 4/42A: 2/42B2/4 | 1A: 58.5 (±32.9)1B: 5.5(±40.0)2A: 33.0 (±32.5)2B36.2 (±33.7) | - | • Parent with disabled children were more willingness to use techniques to accomplish needed care, perhaps because of their experience working with other providers or therapists or their own approaches to functioning in daily life with a disabled child. | • Presence or absence of a disabling condition• BGT with and without rationale |
| Allen [35]/1995/USA | Comparative study | 120 | - | 2–8 yo | Video 1 with explanationVideo 2 without explanationWritten presentationOral presentation | Five point likert scale5 (stronglyagree) to 1 (strongly disagree). | 1. TSD2. N2O2/O23. PI4. VC5. HOM6. OS7. AR8. GA | Vid 1: 6/7Vid 2: 6/7Written: 5/7Oral:7/7 | - | Well informedVid 1: 80%Vid 2: 87%Written: 63%Oral: 90%ConsentedVid 1: 50%Vid 2: 53%Written: 60%Oral: 57% | • Handing parents a written form to read independently and sign, or having them watch videos depicting the techniques do not appear to be adequate to ensure that parents are well informed and likely to consent• The results of this investigation suggest that an interpersonal (oral) delivery of information to parents about each technique is most likely to result in parents who feel well informed and who are likely to provide written consent. | • Different presentation method |
| Havelka [36]/1992/USA | Prospective cohort | 122M: 17F: 105 | 20–57 | - | VideotapeA: With ExplanationB: Without explanationGroup A: Low SES with explanationGroup B: Low SES without explanationGroup C: High SES with explanationGroup D: High SES without explanation | 100mm Visual Analogue ScaleL: Completely acceptableR: Completely Unacceptable | 1. TSD2. N2O2/O23. PI4. VC5. HOM6. OS7. AR8. GA | Group A: 7/8Group B: 7/8Group C: 8/8Group D: 7/8 | Group A: 50.1 (±33)Group B: 47.8 (±37)Group C: 58.2 (±35)Group D: 66.3 (±32) | - | • statistically significant difference was found between the two social statuses (“high” and “low”) for the use of PB with the "low" social status group being more accepting. | • Socioeconomic status (SES)• Videotape with and without explanation |
| Lawrence [37]/1991/USA | Case control | 80M: 21F: 59 | 18–56 | - | VideotapeA: With ExplanationB: Without explanation | 100mm Visual Analogue ScaleL: Completely acceptableR: Completely Unacceptable | 1. TSD2. N2O2/O23. PI4. VC5. HOM6. OS7. AR8. GA | 6/8 | Group A: 8.3 (±1.49)Group B: 34.1 (±2.89) | - | • Parents viewing videotapes with explanations were significantly more accepting of behaviour management techniques than those viewing videotapes without explanations.• Parents reporting greater stress were less accepting of the behaviour management techniques studied. | • Randomised order of the videotape• Video with and without explanation• Parent rate BGT per se and not for their own child• Low to lower middle-class parent |
| Wilson [38]/1991/USA | Comparative study | 60M: 17F: 43 | - | - | Videotape by Lawrence | 100mm Visual Analogue ScaleL: Completely unacceptableR: Completely acceptable | 1. TSD2. VC3. HOM4. AR5. PI6. N2O2/O27. OS8. GA | 7/8 | Single rating :32Group rating: 43 | - | • Small groups of parents viewing BMT tend to rate them as less acceptable than parents viewing the same BMT individually; however, this effect is not significant. The acceptability of the BMT does not appear to be influenced by the distinction of rating the BMT in reference to either "a" child or "their" child. | • Group effect on parental rating |
| Frankel [39]/1991/USA | Cross sectional | 59M: 0F: 59 | - | - | Experiencing the papoose board used to their own child | survey | 1. PI | - | - | • 66%-PB is stressful• 96%-PB is necessary• 90%-give protection• 70%-PB is comfortable• 68%-not negative effect• 86%-PB will be consented | • These results differ from past studies and suggest that parental attitudes can be influenced by the way that proposed dental behaviour management procedures are presented. The 59 mothers who responded to the survey had treatment involving the PB explained to them in a manner that led them to agree to its use. The responses of the mothers themselves provide some clues as to why this positive attitude developed. | • Experience |
| Field [40]/1984/USA | Cross sectional | 67 | - | - | Videotape | Parent were asked to mark each managementtechnique that was acceptable to gain cooperation foreach specific dental procedure | 1. TSD2. VC3. PR4. HOM5. PI6. AR7. Sed8. GA | 7/8 | - | - | • Papoose Board was consistently unacceptable with all dental procedures, but acceptance of this technique was greatest for use with an emergency extraction. | • Different dental procedures |
| Murphy [41]/1984/USA | Cross sectional | 67 | - | 3–5 | Videotape | Rating acceptability by score 0–39 (per quartile)0–9: least acceptable30–39: most acceptable | 1. GA2. PI3. OS4. HOM5. AR6. MP7. VC8. PR9. TSD | 9/9 | 5.1 (±0.97) |  | • Parents with more than one child found Papoose Boards less acceptable than parents with one child. | • Upper middle class parent |

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