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EVALUATION OF A PARENTING GROUP COMPONENT

by

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies for acceptance, a thesis entitled, "Evaulation of a Parenting Group Component" submitted by Ruanna-Marie Jane MacDougall in partial fulfillment of the requirements for the degree of Master of Social Work.

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ABSTRACT

The Parenting Group Component Within the Child Abuse Program at Alberta Children's Hospital: A Program Evaluation

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This study was a formative program evaluation of the Parenting Group Component within the Child Abuse Program at Alberta Children's Hospital. The purpose of the study was to determine whether or not the Parenting Group Component was successful in achieving its predetermined objectives.

Using multiple indicators, this study examined the effect of the Parenting Group Component. Further, it explored the relationship between selected sociodemographic characteristics of the group participants and three measures of the dependent variables.

Results indicate that only one of the four Parenting Group Component objectives was successfully achieved. However, the group participants and facilitators were very satisfied with the overall Parenting Group Component. There were some sociodemographic characteristics of group participants which had significant effects on measures of the dependent variables. The findings highlight the need for future evaluation of the Parenting Group Component.

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DEDICATION

To those that hold a special place in my heart

My Family

Mom, Dad, Peter, Lorna, Malcolm, Iain,

Dwayne, Rhea, David, Carlos, and Steven

My Best Friend

Larry

whose continual love, encouragement and support strengthens me.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

Chapter 1

INTRODUCTION

Child abuse is not a recent phenomenon. Its occurrence in past times is reflected in early historical records (Ross, 1980). The prevalence of child abuse in the past and at present has encouraged researchers to continue the study of child maltreatment in an attempt to better understand the many facets involved in this phenomenon. Various programs have been implemented across the country with the hope that all children will eventually have the opportunity to be raised in a home free from violence.

Child abuse or maltreatment, in the broadest sense, encompasses such terms as child physical abuse, child sexual abuse, and child neglect. In this report, child maltreatment will address only child physical abuse and child neglect. These terms are often difficult to define as they vary over time, across cultures, within social groups and within the context they are viewed (Gambrill, 1983). Therefore, amidst the literature it is difficult to derive an all encompassing definition of these terms.

Helfer (1982) defines child abuse and neglect as any

interaction or lack of interaction between the child and his/her caregiver which results in non-accidental harm to the child's physical and/or developmental state. Child abuse and neglect are therefore, both physically and psychologically damaging. Acts of abuse include such bodily violence as beating, squeezing, shaking, lacerating, burning, exposure to excess heat and cold, and psychological trauma such as sensory overload with light, sound, pain, and itching (Williams, 1980). Verbal insults, accusations, or indoctrination are also viewed as psychological traumas of child abuse.

Types of child neglect include failure to provide cleanliness, medical care, clothing, emotional stimulation and "failure to thrive due to maternal deprivation" (Halperin, 1979; Kempe & Helfer, 1980). The term "maternal deprivation" is a descriptive term referring to the lack of empathetic, sensitive awareness and response to an infant by its primary caregiver (Kempe & Helfer, 1980). Several authors highlight the importance of distinguishing between abuse (acts of commission that result in harm) and neglect (acts of omission that have negative effects) due to the differences that have been found in abusive and neglecting families (e.g., Disbrow, Doerr, & Caulfield, 1977; Kimball, Stewart, Conger, & Burgess, 1980).

As can be seen, the definitions of child abuse and neglect are vague and, therefore leave room for much discretion at various levels. For example, the typical ambiguous nature of child abuse/neglect legislation permits wide discretion on the part of the courts and professionals to impose their own definitions (Gambrill, 1983). Definitional problems further complicate the task of estimating the frequency of child maltreatment, determining possible causes, identifying characteristics of victims and perpetrators, selecting intervention programs, and evaluating the effectiveness of intervention (Giovannoni & Becerra, 1979; Sweet & Resnick, 1979).

There is general agreement that the reported incidence of child abuse and neglect is an underestimate of the true prevalence and regardless of the definition employed, statistics show the problem has a high frequency of occurrence (Gambrill, 1983). The prevalence and high occurrence of child maltreatment highlights the importance of continuing research in order that children be ridden from the violent milieu of child abuse and neglect.

Purpose of Study

This study was a formative program evaluation of the

Parenting Group Component within the Child Abuse Program at Alberta Children's Hospital. Program evaluation is a research processes aiming to determine how successful a social program is in fulfilling its mission (Raymond, 1985). Therefore, program evaluation is concerned with the extent to which a social program succeeds in reaching its predetermined objectives (Suchman, 1967).

Based on the current literature of child maltreatment, and consistent with the philosophy of the Child Abuse Program, four target factors relevant to child maltreatment were predetermined and subsequently transcribed into measurable Parenting Group Component objectives. Using multiple indicators, this study examined the extent to which the four objectives of the Parenting Group Component were successfully achieved.

In order to gain an understanding of the complex, multifaceted nature of the science of child maltreatment, Chapter Two broadly reviews and critiques the current literature regarding the theories, factors, and intervention programs pertaining to child maltreatment. Chapter Three provides an overview of the Parenting Group Component including the basis for its development, its goal and objectives and its weekly contents. A discussion of the methodology employed

in this study appears in Chapter Four. Chapter Five reports the findings, and a summary and discussion are included in Chapter Six.

Chapter 2

LITERATURE REVIEW

The phenomenon of child maltreatment is complex and multifaceted. The following report is intended to provide an overview of the science of child maltreatment and to illustrate the link between present knowledge and the various intervention and prevention programs currently established to reduce or alleviate the problem of child abuse and neglect. Four main topics will be discussed. They include: (1) models for viewing child abuse and neglect, (2) theoretical limitations, (3) factors contributing to child maltreatment, and (4) intervention and prevention program efforts.

The discussion exemplifies the fact that the theoretical base for the study of child maltreatment is weak and that the etiology of child abuse is, at present, still uncertain. In turn, program administrators are faced with the difficulty of determining which facets of the problem to address and the best way of doing so. Further, due to complete lack of evaluation or lack of sound evaluation efforts, it is not clear whether or not most of these programs successfully achieve their stated aim which is to,

in some way, prevent or alleviate child maltreatment.

MODELS FOR VIEWING CHILD ABUSE AND NEGLECT

Attempts to more clearly understand child abuse and neglect have been ongoing and are presented in the literature as theoretical models of child maltreatment. Recognizing that child maltreatment has been explored from many angles gives insight into the complexity and multifaceted nature of the maltreating milieu.

Traditionally, child maltreatment has been explored from one of two theoretical perspectives; that is, the psychiatric or medical model (Kempe & Helfer, 1972) and the social systems model (Belsky, 1980). More recently a third model, the transactional model, has been utilized.

Psychiatric or Medical Model

The psychiatric model focuses on pathological characteristics of the parents that are thought to explain maltreatment (Kempe & Helfer, 1972; Martin & Beezley, 1976). Parental characteristics frequently found include distorted perceptions of the nature of childhood (an expectation to be cared for by the child), problems dealing with aggressive

impulses, impulsivity, rigidity, low self-esteem, and a history of being abused and neglected (Gambrill, 1983).

The psychodynamic approach to child maltreatment is rooted in traditional views whereby personality is an expression of intraindividual forces including drives, traits, impulses and motives (Kazdin, 1975). Freud's psychoanalytic theory solidified the intraindividual or medical model by focusing on the psychoanalytic factors which primarily determine behavior. Therefore, the inner world of the individual is the cause of the deviant behavior, thus, treatment is through dynamically oriented therapy and/or medication (Biller & Solomon, 1986). The major theme of the psychiatric model is that social factors are neither necessary or sufficient to account for child maltreatment. Factors such as poverty, unemployment, lack of education and other demographic variables are considered secondary because psychodynamic researchers have found that child maltreatment occurs in families where social stresses such as poverty do not exist (Biller & Solomon, 1986). Therefore, causes of maltreatment focus on the individual (Spinetta & Rigler, 1972).

Social Systems Model

The social systems model explains the phenomenon of child abuse through emphasizing the stressful environmental conditions and the cultural values which guide adult-child interaction (Garbarino, 1981; Gelles, 1973; Gil 1970). The social systems perspective can be divided into two components: (1) the sociocultural perspective, and (2) the social situational perspective. Although both models focus on external environmental factors which influence the family, the unit of analysis are different. The sociocultural model emphasizes cultural differences influencing parent-child interaction, whereas the social situational perspective emphasizes the neighborhood and family interactional patterns (Parke & Collmer, 1975).

Seeming contradictory to the psychological model, social systems theorists argue that the social context is both a necessary and sufficient factor in child maltreatment. Both components of the social systems theory (the sociocultural and the social situational) share a common component; that is that the social environment is an important medium in influencing behavior.

Sociocultural Model

The major theme of the sociocultural model of child maltreatment is that the levels of violence accepted within a culture are reflected in the levels of violence towards children. For example, in Sweden the rate for child abuse is approximately one-fifth of the rate in the United States and physical violence towards children is very uncommon (Garbarino, 1981; Tietjen, 1980). Similarly, in China and Japan, physical punishment is not used as a method of common discipline, and the rate of child abuse in Japan and China is notably low (Goode, 1971; Sidel, 1972).

Gil (1970) suggests that a broad range of factors must be addressed when dealing with child maltreatment including society's basic philosophy about its citizens; the nature of the political, social and economic circumstances within the society; and the quality of human relations that are shaped by social factors. Therefore, a restructuring of society, particularly of resource distribution, is necessary in order that child maltreatment be eliminated.

Social Situational Model

The social situational model of child maltreatment

discusses patterns of sociological and contextual variables at various interactional levels (Garbarino, 1976; Gelles, 1973; Klaus & Kennel, 1970; Minuchin, 1974). Three factors are included in the social situational model: (1) ecosystem factors, (2) microsystem factors, and (3) factors related to infant attachment.

The ecosystem level identifies factors within the social structure which hinder the developing person through the immediate setting in which that person is found (Belsky, 1980). Economic hardship and neighborhood characteristics are examples of ecosystem factors. Garbarino's (1981) research was instrumental in understanding effects of ecosystem factors. He argues that the neighborhood is the key factor to child maltreatment; that is, both the economic and social resources determine the likelihood of child maltreatment. High-risk neighborhoods were characterized as "socially impoverished" such that they included young, inexperienced mothers who where less communicative, less self-sufficient, had fewer provisions for the child's care, and were less likely to use social and professional services (Garbarino & Sherman, 1980). Because the "socially impoverished" family is also financially impoverished, they suffer from an irresolvable sense of isolation from potential support networks. There are few opportunities for

these people with the extended family and they must rely primarily on their own family unit to resolve problems and deal with crisis. The resulting stress caused from the community isolation is said to contribute to child maltreatment (Garbarino, 1981).

Microsystem-level research addresses the family as a context for abuse and includes variables such as family size, infant behavior, marital relationships, and behavioral interaction patterns between family members. The family environment, and the internal dynamic processes of family members, exist in a constantly changing network of relationships which, in turn, affect the behavior of the individuals with the family (Minuchin, 1974).

Several researchers have investigated child maltreatment at the microsystem-level. For example, it has been found that abusive families interact less frequently and more negatively on both verbal and physical dimensions than control families (Burgess & Conger, 1978); have more disorganized households; use a broad, haphazard manner of discipline; and maintain conflictual behavioral expectancies from their children (Burgess, 1979; Elmer, 1979; Frodi & Lamb, 1980b; Patterson, 1982; Young, 1964).

In addition to the eco- and micro-subsystem factors within the social situational model, infant attachment is considered to be an important factor in the theoretical base of child maltreatment. Parent-infant relationships have been explored in order to determine whether or not the relationship will effect latter abusive behavior (Ainsworth, 1980).

Several authors suggest that parent-infant relationships exert a profound effect on the infant's emotional and cognitive development and on the latter caregiver behavior (e.g., Bowlby, 1969; Klaus & Kennell, 1970). More specifically, Klaus and Kennell (1970) suggest that bonding between mother and infant can be hampered and permanently altered by factors such as infant illness, prematurity, developmental disabilities, and early separation especially after birth. It is argued that when the bonding processes is interfered with in these ways, higher rates of child maltreatment may occur. More recently, the investigations by several authors have clearly demonstrated deficits in attachment, and in emotional and self-concept development among maltreated infants (Bretherton & Waters, 1985; Schneider-Rosen, Braunwald, Carlson, & Cicchetti, 1985; Schneider-Rosen & Cicchetti, 1984).

Although research based on attachment theory suggests that attachment can be a factor in child maltreatment, it is not clear to what extent the lack of a secure parent-infant attachment is an antecedent or a consequence of maltreatment. Egeland and Vaughn (1981) criticize the attachment theories noting many methodological limitations in the current research including inaccurate bonding measurement instruments.

Transactional Model

A third major model for investigating the phenomenon of child abuse has recently developed as a result of the deficiencies found in the psychiatric and social systems models. It is referred to as the interactional or transactional model. This model suggests that child maltreatment is a result of a large number of interacting influences and represents developmental outcomes from a continuum of potential outcomes (Chibucos, 1980). Authors attending to the interactionist perspective stress the importance of investigating child maltreatment from the joint perspective of the adult, child, and environmental characteristics (Frodi & Lamb, 1980a,1980b; Vietze, Falsey, Sandler, O'Connor & Altermeier, 1980).

The transaction model focuses on multivariate causation and the need for more individualized and specific assessment procedures. While concentrating on contributions from several theoretical perspectives, the model attempts to integrate various causal factors into a comprehensive theoretical framework. The objective, therefore, is to encourage the development of multivariate models that investigate multiple causation rather than emphasizing a single set of variables.

THEORETICAL LIMITATIONS

The theories currently established to investigate the science of child maltreatment can be said to be weak; that is, each has shortcomings in terms of providing a base for future study and practice endeavors. It is important, therefore, to be aware of these shortcomings in order that future research be directed towards generating and solidifying a sound theoretical base in the study and practice of child maltreatment.

The Psychiatric or Medical Model

Although the psychiatric model has predominated studies of child maltreatment, efforts to establish a reliable

character profile of abusive parents have been relatively unsuccessful (Garbarino, 1980). Attempts by medical model researchers to isolate a distinct set of personality characteristics specific to abusive parents have also been unsuccessful. In addition, a number of methodological flaws have been noted in the research endeavors. Psychiatric judgments are neither reliable or valid and are strongly influenced by personal values. The hypothesis are usually based on clinical observations and the samples of abusive parents can not be generalized to the population of maltreating parents (Rosenthal & Louis, 1981). Further, Gelles (1979) stresses that studies are usually ex post facto; that is, they are based on already identified cases. No research has been able to predict rates of child abuse and neglect based on psychiatric profiles. In most instances, control and comparison groups are absent in psychodynamic investigations.

Since the psychiatric model has been relatively unsuccessful in producing desired results, there has been an evolution of alternative research studies. It is difficult to determine whether or not the psychiatric model has not been truly successful because of inadequate research methods or because of an invalid theoretical base. Perhaps a psychiatric profile has not been produced because it does

not exist, or perhaps research methodology has been too simplistic in its approach to develop such a profile (Biller & Solomon, 1986).

Social Systems Model

The social systems perspective tends to address specific variables such as family structure, education, income and neighborhood characteristics that can be directly related to child abuse. Therefore, the foundation of the social systems model can be said to be sound to the extent that it effectively connects sociocultural and social situational variables to child maltreatment. Rutter (1979) notes, however, that although it is clear that such factors are associated, it is also clear that these factors alone do not provide a sufficient explanation for child abuse and neglect.

The social systems model suffers from similar methodological limitations as does the psychiatric model (e.g., few control and comparison groups). As well, although the research focuses on specific social system variables, demographic data is often not included which may act as contributing or intervening factors. These includes such variables as family composition, socio-economic status,

geographical location, ethnicity and/or religion. Further, detailed characteristics of the parents and child often go unmentioned (Gelles, 1979).

The final critism of the social systems model is that by focusing on social and environmental conditions, this model leaves little room for intraindividual factors even though the psychiatric profile is presently unreliable (Biller & Solomon, 1986). Researchers who explore the ways in which the environmental and social factors interact with the internal psychological processes may provide useful insight into present understanding of the etiology of child abuse and neglect.

Transactional Model

Given the limitations presented by the psychiatric and social systems theories, it may be premature to introduce a multiple regression prediction model of child maltreatment (Biller & Solomon, 1986). Data currently available may not be valid and/or reliable enough to attempt such a research endeavor. It is intended, however, that analysis of interactional variables will provide new ideas concerning methods of targeting and integrating relevant factors into a comprehensive theoretical framework (Vietze et al., 1980).

FACTORS CONTRIBUTING TO CHILD ABUSE AND NEGLECT

Consistent with the current theories of child abuse and neglect, a number of factors relating to child maltreatment have been identified. These factors can be categorized into two main areas: (1) parental factors, and (2) child factors. Ecological factors, which are of equal importance, have been integrated into the discussion of both the parental factors and child factors.

Parental Factors

Research exploring the parental factors contributing to the maltreatment of children has focused on demographic, sociological, and psychobiological variables.

Both age and sex have been found to relate to child abuse and neglect. Gil (1970) and Justice and Justice (1976) found that in most cases, parents who were identified as abusive to their children were between the ages of twenty and forty. The important factor may not be the parents' age when the abuse is identified, rather, the parents' age when the child was born. In a reanalysis of Gil's (1970) study, Kinard and Klerman (1980) investigated the parents' age at the birth of their first child. They found that 38 percent

of the mothers in Gil's sample were teenagers when their first child was born, in contrast to only 17.5 percent of the general population. Although Gil (1970) found no relationship between age and child maltreatment, Kinard and Klerman argue that an association may exist which warrants further investigation.

Socioeconomic factors may play a role in the suggested relationship between child maltreatment and age. Pelton (1978) found a strong relationship between socioeconomic factors such as poor housing, low educational achievement, and unemployment and child maltreatment. Bolton, Laner, and Kane (1980) noted that teenage parents experience financial difficulties and other hardships. Social support is also related to socioeconomic factors (Garbarino, 1980) and thus, both the absence of social support systems and networks may heighten the stress and risk of child maltreatment for these young parents.

In attempting to relate the sex of the perpetrator to abusive behavior, Biller and Solomon (1986) warns that most studies have failed to control for variation in family structure, and in many instances it is difficult to determine clearly who perpetrated the abusive act. Paulson and Blake (1969) investigated the relationship between the sex

of the adult and the sex of the child. They found that biological fathers were equally abusive to both their sons as their daughters whereas mothers more frequently abused their daughters. In another study, mothers were found to abuse their children under the age of two years three times more frequently than fathers did (Silver, Dublin, & Lourie, 1971).

A number of authors have associated socioeconomic variables with child abuse and neglect. The basic premise is that socioeconomic factors cause stress for parents and in turn, the risk of child maltreatment increases. Some of the socioeconomic factors associated with child maltreatment include high rates of premarital conception, high unemployment, insufficient education, inadequate housing, high mobility, high degree of household disorganization, and low job satisfaction (e.g., Belsky, 1980; Gil, 1970, 1979).

Gil (1970) and Pelton (1978) argue that there is a social class affiliation in abusive families noting the strong relationship between economic hardship and child maltreatment. Steele and Pollock (1968) and Parke and Collmer (1975), on the other hand, suggest that child maltreatment is an affliction of all social classes and that child abuse is reported more frequently in lower income

families due to their more extensive use of social service programs. Thus, the increased contact with human service professionals increases the likelihood of detection.

The nature of the parents' own child-rearing history has also been explored. Parents are said to have had disastrous childhood experiences and to have been abused as children (Kempe & Helfer, 1980; Melnick & Hurley, 1969). As well, it has been suggested that many abusing parents have had violent adult role models (Green, Gaines, & Sandgrund, 1974).

Emotional deprivation is another characteristic often associated with abusive parents (Belsky, 1980; Spinetta & Rigler, 1972). It is hypothesized that the absence of being mothered (emotional deprivation) leads to a role reversal whereby a mother needs to be nurtured by her child. At different times in a child's life, children will want to please their parents and will comfort them in a nurturing manner. It is when this becomes extreme, usually in the form of an expectation, that a child's development is hampered. Furthermore, when this role reversal requires and trains the the child to assume the responsibility for his or her parents' errors, the child feels guilty and is convinced that he/she is to blame for such things as the parents' in-

ability to handle crises and finances. The ability to separate one's own responsibility from that of another is a learned function that develops in all children who are reared more normally (Kempe & Helfer, 1980).

Lack of nurturance, another common characteristic of abusive and neglectful parents, includes lack of empathy and warmth in the parent' own upbringing. Because the parents lack empathy in their own upbringing, Belsky (1980) hypothesizes that the victim's pain during the abusive act does not inhibit the parents behavior since inhibition depends on feelings of empathy.

It has been suggested that abusive or neglectful parents have unrealistic expectations of their children (e.g., Burgess & Conger, 1978; Spinetta, 1978; Spinetta & Rigler, 1972). They implement culturally accepted norms for raising their children with an exaggerated intensity and at an inappropriately early age (Cooke & Bowles, 1980). Lack of knowledge about the normal stages of child growth and development is considered to contribute to the unrealistic expectations that abusing parents place on their children (Spinetta & Rigler, 1972). If parents have incorrect notions about the norms for and the meaning of behavior, they may become inappropriately angry when their infant or child

fails to engage in expected behavior, thus contributing to maltreatment.

Effective parenting practices include protecting young children from accidents. Neglecting a child's safety is a component of general parental neglect. Parents can neglect a child's safety in two ways. First, they may fail to teach essential safety to young children; for example, the dangers of crossing the road. Second, they may fail to take safety measures in the home; for example, leaving medicines or caustic substances within reach of young children (Falconer & Swift, 1983). Serious injuries may result from lack of judgment, such as when a parent allows a one-year-old child to be burned by a hot water heater because, the parent says, "I told her it was hot" (Kempe & Helfer, 1980).

It can be assumed that lack of knowledge of child developmental stages, and inappropriate child expectations is closely related to neglecting a child's safety. For example, parents who do not realize that a one-year-old child does not fully comprehend the difference between hot and cold will expect that the child is fully capable of running their own bath-water thus, the previous ignorance with respect to child developmental stages accounts for neglecting the child's safety rather than purposefully neglecting

to check the water temperature.

Many abusive and neglecting parents also have few formal and informal social support systems and are often socially isolated (Falconer & Swift, 1983; Holder & Moore, 1980). This includes having fewer contacts with family, neighbors and the community (Garbarino, 1977; Parke & Collmer, 1975; Polansky, Chalmers, Buttenweiser, & Williams, 1979). Young (1964) reported that many of these parents experience difficulty in developing and continuing relationships outside the immediate family. They tend to solve problems and particularly crisis, alone. Wahler (1980) reported that abusive and neglecting families are insular. He also found that punitive behavior towards the child was less on the days in which the parental contacts with friends was high. Conversely, on days when parental contact with friends comprised a low number of extrafamily exchanges, the tendency toward child-directed punitive behavior was much higher.

Garbarino (1980, 1982) states that the most important aspect of a social environment is the degree to which it encourages parents to be "socially connected" and discourages parents from becoming "socially isolated". He believes that the social environment protects people from their vul-

nerabilities and daily stresses whereas a socially impoverished environment feeds personal vulnerabilities and contributes to daily stress. In turn, socially impoverished parents are placed at a higher risk for child maltreatment.

It has been suggested that social isolation will have additional effects; that is, parents who abuse or neglect their children will lack effective parenting models, and lack the information and feedback concerning more positive parenting behavior (Gambrill, 1983). Without appropriate social contacts, abusive and neglectful parents may never be exposed to alternative child management techniques.

Although many studies indicate that the isolation experienced by maltreating parents is social, a more recent examination indicates that the isolation is psychological rather than social. Thompson in his study at the West End Creche in Toronto, Canada (1983), found that families had multiple contacts outside the family however, the mothers perceived themselves as being alone, and without support and adequate nurturing. This perception may be rooted in the parent's own upbringing or in other psychosocial and physical stresses being experienced.

Abusive and neglectful parents often display negative

attitudes towards their children (Milner & Wimberly, 1980). Explanations for the prevalence of these attitudes are only grounded weakly in the literature leaving much room for speculation. Spinetta (1978) reports that abusive mothers differ significantly from nonabusive mothers in their tendency to attribute malevolent intentions to their children and to become angry and upset with them. According to Patterson (1982) and Reid, Taplin, and Lorber (1981), this is an important part of the processes leading to abuse. In a more recent study, Bousha and Twentyman (1984) found that neglectful mothers displayed fewer total interactions with their children than did either the control or abusive mothers and, as might be expected, the abusive mothers displayed lower rates of interaction than the control mothers. From their study, it was also found that abusive mothers displayed a relatively stable and frequent pattern of aggression rather than aggressive outburst tendencies. The preferred interactional style was negative and they displayed aversive behaviors for all situations rather than just for resolving differences and administering discipline.

In addition to the negative attitudes displayed through aversive interactional style, parents have displayed personality variables such as frustration of dependency needs (Melnick & Hurley, 1969), an inability to face life's daily

stress (Heins, 1969), feelings of inadequacy about being a parent and/or parental inability to fulfill the expected roles of parenthood (Fontana, 1964; Silver, 1968; Steele & Pollock, 1968). As well, some abusers may be psychotic, pervasively angry, depressed, passive-aggressive, impulsive, have identity role problems and/or be compulsive disciplinarians (Zalba, 1967). Abusers tend to be of lower intelligence and demonstrate immaturity and self-centeredness (Cochrane, 1965; Delaney 1966; Simpson, 1967).

Several authors highlight the importance of examining the family structure and characteristics of the marital relationship in determining factors related to child maltreatment. Burgess & Conger (1978) compared interaction in two-parent, single-parent and control families by observing each family member while engaging in cooperative tasks, competitive tasks, and discussion tasks. Abuse and neglect had been reported in the experimental groups. Lower rates of interaction occurred in the two-parent abuse and neglect family as compared to the control group, however, these differences were heightened in the single-parent families. In single-parent families twice the level of negative verbal and physical behaviors were exchanged compared to two parent families. In one hour, there were 30 more coercive parent-child engagements in single-parent families than in two-

parent families.

The work of Biller and his colleagues (see Biller & Solomon, 1983) over the past few years focuses on paternal deprivation as a form of child maltreatment. Before this time, little attention had been paid to the incidence of paternal neglect, uninterest, and rejection, which affect more children than actual physical and sexual maltreatment. His major thesis is that "children who are paternally deprived by having an absent father or a neglectful or non-involved father in a two-parent family are more likely to suffer from maltreatment by their mothers than are those whose fathers and mothers have a cooperative relationship" (Biller & Solomon, 1986, p. 2).

Marital conflict and tension has been found to be an important factor associated with child abuse (Gelles, 1979). Steinmetz (1977) reported that when partners use aggressive methods to settle disputes between themselves, parents tend to use similar methods to discipline their children. Reid et al. (1981) suggests that programs that focus specifically on the parent-child interaction may have limited effectiveness unless the intervention also assists parents in acquiring more positive conflict resolution skills.

Other family members may play a passive role in initiating or condoning the abusive act (Patterson, 1976, 1982). For example, if one parent does not react to the other parent abusing the child, it may indicate approval of the act, thus influencing the likelihood of further violence. As well, one sibling may be responsible for initiating negative behavior with other siblings or family members may demand parental resources causing additional stresses and frustrations.

Child Factors

Research pertaining to child maltreatment generally supports the theoretical notion that characteristics of the child tend to increase the likelihood that the child will be maltreated and that the abuse and neglect the child experiences has both physical and psychological consequences for the his/her development.

Differences in temperament exist even in early infancy that are predictive of hostile mothering patterns during the first year of life. Three temperament styles appear quite relevant in identifying children who may be particularly vulnerable to maltreatment; that is, the difficult child, the slow to warm up child, and the easy child (Thomas,

Chess, & Birch, 1968). The 'difficult' child displays characteristics such as irregular biological functions, and nonadaptability. The 'slow to warm up child' displays characteristics such as inconsistent mood patterns and slow adaptation to new stimuli. These children are said to to be at greater risk of maltreatment than the 'easy' child who will have regularity in bodily functions, be quick to adapt to new stimuli and generally display positive mood patterns.

Hyperactivity, age of the child, presence of developmental disabilities, prematurity, birth order and low birth weight have also been attributed as being related to child abuse and neglect (Elmer & Gregg, 1967; Friedrich & Boriskin, 1976; Gil, 1970; Klein & Stern, 1971). As well, Finkelhor (1979) found that children resulting from unwanted pregnancies and step-children are more likely to be the victims of abuse. Although authors do not agree at what age a child is more at risk for abuse and neglect, Gelles (1979) suggests that the most dangerous period is from 3 months of age to 3 years.

Extensive data has been collected on the behavior of children who have been identified as being abused and/or neglected. Biller and Solomon (1986) suggests that the information collected grossly underscores the negative impact

that severe abuse and neglect has on the psychological and social functioning of the child. Martin (1980) proposes that not all physically maltreated children show basic handicaps in cognitive functioning, but even those who are very intelligent often display deficits in academic performance, have social and emotional developmental deficiencies, and serious problems regarding their own self-concept. As well, abused and neglected children are more likely to have low self-esteem, a limited capacity to experience pleasure, and display depressive and/or hyperaggressive behaviors. Further, these children have been found to display patterns of emotional detachment, withdrawal, and lack of ability to maintain a healthy reciprocal intimate relationship (Martin, 1980; Polansky, Chambers, Butterweiser, & Williams, 1981; Williams & Money, 1980).

It is extremely difficult, when discussing characteristics of the child, to differentiate between cause and effect. The question that arises is: are the developmental deficiencies characteristic of the child the result of, or the cause for, abuse? Certainly, child characteristics that are correlated to abuse such as mental retardation should not justify child maltreatment. Rather, correlations between child characteristics and child maltreatment should guide researchers in investigating relevant causes of family

stress and associated social-situational variables.

INTERVENTION AND PREVENTION

Prevention of child abuse and neglect is commonly discussed at three levels: primary, secondary and tertiary prevention. Helfer (1982) defines the three categories of child abuse prevention.

Primary prevention includes any program or maneuver that focuses attention on preventing child abuse and neglect from ever occurring to an individual. The individual, in most cases, is an infant. As well, primary prevention includes a social subset; that is, the program or maneuver is developed or implemented to produce a radical change in societal structure which will lead to prevention of child abuse and neglect by impeding its occurrence. For example, by ridding society of unemployment and poverty, or on a smaller scale, to alter health and public education programs, a large number of people would be impacted upon, thereby preventing child abuse and neglect from occurring.

Secondary prevention is defined as any program or maneuver which is directed towards individuals or groups who are considered to be functioning in a very high risk

environment. The purpose of secondary prevention is to prevent child abuse and neglect from occurring to the individual's offspring. In order to prevent child abuse and neglect from occurring in the next generation, secondary prevention programs, for example, may focus on parents who have already been identified as having been abused or neglected as children.

Tertiary prevention focuses on preventing child abuse and neglect from occurring again, once a case has been identified. In essence, it is any program or maneuver which is implemented after-the-fact. An example of a tertiary program is the protective services of child welfare whereby programs or maneuvers are implemented after a incident of abuse or neglect has been reported. The purpose then, is to prevent the recurrence of the abuse or neglect incident.

There is some overlap between the terms intervention and prevention. Recently, Meirer (1985) has purposefully combined the terms at the primary, secondary and tertiary levels noting that prevention does not just happen, even at the primary level, since some active intervention and change must occur within the child, adult and environment to reduce the risk of maltreatment from ever occurring.

The theoretical limitations, discussed previously, hinder the development of preventive and remediative programs (Zigler, 1980). Uncertainty exists as to which treatment variables are most effectively targeted under particular conditions. Because the social systems model is still a relatively recent development, the initial conclusions are not experimentally verifiable to the extent that they can clearly be translated into effective social programs (Albee, 1980). According to Biller and Solomon (1986) the social systems model exhibits a conceptual advantage over the psychiatric model in terms of prediction and prevention. The psychiatric model directs intervention to the dynamically oriented psychotherapy which is considered by other theorists to be unreachable and unchangeable whereas intervention within the social systems perspective focuses on the environmental variables which are considered to be observable and measurable. The interactive model suggests that intervention must take place at various levels and include variables related to the child, the adult and the environment.

In this section intervention-prevention program contributions designed from various approaches and theoretical perspectives will be presented. They have been categorized into five major areas: (1) programs focusing on treatment

of the child, (2) milieu and family programs, (3) programs focusing on the parent, (4) community programs, and (5) programs for societal and political change. The focus of a program may be on any one of the particular areas outlined, or a program may include several components each of which focuses on a different aspect of child maltreatment in an attempt to contribute to a comprehensive intervention-prevention program. For program designers, a knowledge of the broad spectrum of program approaches is important in order that the most appropriate approach is selected to meet the needs of the client population.

Programs Focusing on the Treatment of the Child

Historically, therapy and counseling programs for child maltreatment have addressed the needs of the abusing parents (Herzberger, Potts, & Dillon, 1981). More recently, an interest in the child's development and environment have led to the establishment of programs which focus specifically on the child. Programs for children, usually fall into the primary or secondary preventative category and include such things as play, art and dance therapy for children, visitors in the home, infant developmental strategies, and programs designed specifically for adolescents (e.g., Bavolek, Kline, McLaughlin, & Publicover, 1979; Castle, 1977; Meirer, 1985;

Smith, 1979).

Another approach to treatment of the child, similar to the ones above, focuses on early childhood educational programs. It is suggested that programs for children such as daycares, nursuries and playschool should be broadened to include the special needs of children who are raised in families where abuse and/or neglect are apparent (Bean, 1971).

Given that the child will be a focal point in a program for the treatment of the child, it is important to educate human service practitioner to effectively intervene with the child in abuse issues. McFadden (1987) provides an analysis of the specific areas and methods for effective counseling of abused children.

McQuiston and Kempe (1980) support the notion of therapeutic intervention programs outside the home for preschool, school-age and adolescent children who have experienced or are at-risk for abuse. They emphasize that the treatment goals and modalities for a given program must be in accordance with the child's age, level of development, role within his or her family, his or her level of social interaction, ego strengths, verbal accessibility, and physi-

cally handicapping conditions. Further, Kraizer (1986) expresses concern that if preventative programs for children are not designed specifically towards the needs and developmental capabilities of the child, more damage to the child may be created; that is, children may be more fearful, mistrustful, and insecure after the program than before (Kraizer, 1986).

The psychiatric model has influenced child intervention programs such that emphasis has been on variables such as ego development, self-concept, and other characterological structures. Cognitive-behavioral strategies have not been as readily applied to intervention with children as they have with adults. As well, methodological difficulties exist with treatment modalities for children. More specifically, studies offer subjective assessment of treatment outcomes, fail to use comparison groups, and do not control for confounding variables such as unrepresentative sampling and observer bias (Biller & Solomon, 1986).

Although a large number of programs exist for the child as the center of the intervention program, few programs offer an empirical analysis of treatment effects. Therefore, much effort is needed in the future to provide programs for children whereby reliable and valid outcomes can be measured

rather than relying on descriptive summaries by the clinicians.

Milieu and Family Programs

Family programs may be derived from a number of theoretical perspectives and thus, focus on various facets of family intervention. Included in this discussion will be the programs that focus on family-oriented outreach and advocacy endeavors; programs that focus on outpatient services; programs that focus on the enhancement of the parent-infant bond; and programs utilizing a multidisciplinary team approach.

It has been suggested that intervention with abusive families usually requires more outreach and service availability than any other forms of treatment (Beezley, Martin, & Alexander, 1976). Family-oriented outreach and advocacy programs can be viewed as secondary and tertiary preventative measures for child maltreatment.

Outreach endeavors include supportive approaches within the family home by various mental health professionals within a variety of broad programs. For example, the Family Development Study in Boston is a descriptive case-control

study of families whose children exhibit the effects of pediatric social illnesses such as child abuse, accidents, ingestions, and failure to thrive. The program has two components: the Parent Education Program and the Family Advocacy Component. The Family Advocacy Program has two goals; that is, to provide services to families being followed in order to assure that they receive help with problems expressed during the course of extensive interviews, and to develop a new mode of intervention for working with families in which a child's illness is symptomatic of a disturbance in family functioning (Daniel & Hyde, 1975). Other outreach endeavors are discussed by Birenbaum (1974), and Morse, Hyde, Newberger and Reid, (1977).

A number of outpatient programs are also prevalent in the literature. These could be considered to be milieu therapy programs. Two popular programs are the Parents' Center Project in Boston (Galdstone, 1975) and the Bowen Center in Chicago (Holmes & Kagle, 1977).

The purpose of the Parents' Center Project (Galdstone, 1975) is to provide concurrent treatment to children and parents while maintaining the integrity of the family unit. It is based on the psychodynamic model and offers weekly group parent meetings and a therapeutic day care for

children. The parent meetings encourage parents to discuss personal concerns such as marital and relationship problems, and early childhood issues. More specifically, the parent groups focus on the intraindividual concerns that interfere with the parenting processes.

The Bowen Center Project in Chicago (Holmes & Kagle, 1977) is another example of an outpatient milieu program. This program, as well, is based on the psychodynamic model and therefore, focuses on object relations, impulse control, and other aspects of ego-functioning. In general, the program provides treatment to parents, services to children, and consultation to other related agencies.

As discussed earlier, the attachment theory highlights the importance of bonding between the parent and the child and researchers suggest that deficits in parent-child attachment may be associated with child maltreatment. Programs have been developed which specifically emphasize the importance and subsequent strengthening of the parent-child bond. One such program is the Blosser Home for Children in Marshall, Montana (Wood, 1980). Parents and children live together in an apartment setting and through a series of interventions such as individual and group counseling, child care classes, recreation, and lifeskills

classes, abusive parents are enabled to develop emotional bonds with their children. Given that the program is based on the attachment theory, the program's objectives include fostering an emotional connection between the parent and the child, and instructing the parents in more effective parent-child interactions (Wood, 1980).

The Prenatal-Early Infancy Project in New York (Olds, 1980) can also be included in this category although the focus is not primarily on the bonding concept. Rather, the program offers a wide range of services to first-time mothers in an overall attempt to improve the mothers' childbearing success and childbearing competencies. It is a home-based program and services include emotional support and information about birth, and fetal and infant development. As well, the program encourages family and friends to offer encouragement and support to the mother.

The multidisciplinary approach for both secondary and tertiary prevention of child abuse and neglect has also been utilized. There is wide acceptance in the literature that the use of multidisciplinary teams to diagnose, plan and evaluate the treatment for all persons influenced by an abusive situation have the potential for preventing child abuse (Beswick, 1979; Frommer, 1979; Martin, 1976). These

teams have been established in hospitals and community-based protective service departments in the recent past and include workers from a variety of disciplines. One of the primary purposes of the multidisciplinary team is to reduce the fragmentation of the service delivery system. Hochstadt and Harwicke (1985), in a recent study of the multidisciplinary team at La Rabida Children's Hospital and Research Center in Chicago, found that the multidisciplinary team can make significant contributions to the follow-up care of abused and neglected children.

In addition to the establishment of concrete teams, educational programs in the forms of audio and visual packages, and reference articles are utilized to enable professionals from various disciplines to become aware of child abuse/neglect issues, thus enabling a large number of professionals to acquire knowledge and skills in order to better service the individuals and families involved with child maltreatment (e.g., College of Human Ecology, 1976; Kalisch, 1973).

Although the number of milieu and family programs is large and varied, little is known about the effectiveness of these programs as outcome data is often absent, therefore programs are difficult to evaluate (Biller & Solomon, 1986).

As well, given that programs include such a vast array of treatment services, overall evaluation becomes an extensive effort. Biller and Solomon (1986) suggest that initially it may be helpful for evaluators to investigate the contribution of each component before offering general statements about the overall effectiveness of the program. This would hold true for all the programs offered and not specifically the family and milieu examples provided in this section.

Programs Focusing on the Parent

Indeed, the largest number of programs existing have been developed to deal most specifically with parents who abuse and neglect their children or who are at risk for abusing and neglecting their children. Parents are seen to be the front-line workers in dealing with their children and thus, education and training for the paraprofessional parent is seen to be essential. In general, parenting programs can be said to be behaviorally oriented; that is, they focus upon the involvement of the child's natural parent or parents and upon creating changes in their behavior. These programs are designed from a social systems perspective and therefore, recognize that the social context is both a necessary and sufficient factor in child maltreatment. Behavioral programs involve training parents in the following

three areas: (1) effective child-management skills, (2) altering emotional reactions, and (3) adapting other behavioral tendencies.

Child-Management Training Programs

The emphasis of acquiring more effective child management skills has long been an integral part of behaviorally oriented programs. The type of training and the methods used vary to a great degree including the location of training, the means of instruction, participants involved, and length of the program. Similarly, the training programs vary in terms of the components used. For example, whether or not rewards are offered to parents for positive behavior, the number of trial rehearsals, and the clarity of the format for learning new skills varies amongst programs. Regardless, of the methods and components used, the aim of child management programs, in the broadest sense, is to increase positive interaction with parents and their children by altering parental behaviors.

A program offered by Wolfe, Sandler and Kaufman (1981) is one example of a behaviorally-oriented program. It consisted of eight weekly 2-hour group meetings plus eight weekly home sessions. Group treatment included three

components. The first component, instruction in human development and child-management, involved having the parents read "Parents Are Teachers" (Becker, 1971), watching filmstrips on human development and a discussion of behavioral principles as applied to parenting. The second component, problem solving and modeling of appropriate child management, involved having the parents view a videotape of common child management vignettes and through discussion, find appropriate resolutions to the problem situations. In the third component, self control, parents were taught deep muscle relaxation and were instructed, via audiotape, in impulse-control procedures that could be applied to their individual problem situations. Individual training involved a psychology graduate student visiting the family in the home once a week to help parents implement new techniques. Pretest and postest measures were employed and a follow-up was conducted after 10 weeks. In addition, child welfare reports were reviewed after one year and it was found that these families had not been involved in child abuse investigations. Sixteen family units, composed of at least one adult and one child per unit, were used for the study. Results of this study suggest that competency-based training resulted in improvements in parent effectiveness as measured by observations of parenting skills in the home, parental reports of child-behavior problems, and caseworker reports

of family problems.

Reid (1981) provides another example of a behaviorally-orientated approach. In this program parents learned alternatives to the use of physical punishment by utilizing such methods as time out and ignoring in an attempt to decrease inappropriate behavior as well as methods to teach children prosocial skills. The purpose of the program was to increase the use of family management practices through such things as consistent contingencies, negotiating compromises, managing crisis and problem solving.

Further examples of behaviorally oriented programs are demonstrated by Crozier and Katz (1979), Denicola and Sandler (1980), Sandler, Van Dercar, and Milhoun (1978), Wolfe and Sandler (1981).

Changing Emotional Reactions

Behaviorally-oriented programs not only focus on training parents in effective child management practices but often include strategies to change parents emotional reactions. This includes program components which address such aspects as anger control (Ambrose, Hazzard & Haworth, 1980), tension headaches (Campbell, O'Brien, Bickett &

Lutzker, 1982), aversion towards the child (Gilbert, 1976), desensitization to loud noises (Sanford & Tustin, 1973), and relaxation therapy (Denicola and Sandler, 1980).

Other Approaches Used

A number of additional behaviorally-oriented approaches have been utilized in order that interaction between parents and their children will become more positive. Some of the more specific training includes focusing on aspects such as communication training (Jeffery, 1976), assertion training (Lutzker, 1983), negotiation training, (Stein, 1978) and marital counseling (Azrin, Naster, & Jones, 1973). Lutzker (1983) describes Project 12 Ways which addresses a wide variety of concepts. Some of them include helping families acquire more leisure time activities, self-control strategies for weight and smoking reduction, and job finding techniques. Gambrill (1983) notes that although factors such as nutrition, child safety, and social isolation are commonly considered to be related to child abuse, few behavioral programs have devoted attention to this area.

The actual degree to which the use of behavioral methods are successful in decreasing child maltreatment is still uncertain. Studies exploring the value of behavioral

methods are hampered by one or more flaws which limit the conclusions that can be drawn. These flaws include such things as anecdotal reports, single case studies, and group experimental or quaisi-experimental studies in which there is a planned-comparison group. Because most studies use an AB design, there is no evidence that intervention was responsible for the change that took place in the client (Gambrill, 1983). In addition, McAuley and McAuley (1977) criticize behavioral programs noting the lack of responsiveness to the multiple factors that may have to be considered in decreasing child maltreatment. This is illustrated by the use of a small number of sessions to attempt to decrease a very complex problem. In terms of prevention, Resnick (1985) notes that a change or improvement in parental competencies cannot be interpreted as prevention unless it is accompanied by some change in the incidence of the target disturbance among the population of interest. Therefore, future prevention research should be directed at longitudinal methodologies which can more clearly identify the link, if any, between the short-term competency-related outcomes and long-term, prevention outcomes.

In addition, or in conjunction with the behavioral training that relies on observable behavioral change, educationally oriented programs and self-help programs exist that

assume that consciousness raising among parents will create change.

Educational programs may be designed to prevent child abuse at either the primary, secondary, or tertiary levels. Some educational approaches which have be utilized include the use of television for adult education (Flannery, 1980), a "crash-course" in childhood for adults (Helfer, 1978), a "warm line" for the education of young parents (Adkins, 1978), and manuals such as "Parentmaking" which offers a practical guideline for teaching parent classes about babies and toddlers (Rothenberg, Hitchcock, Harrison, and Graham, 1983). Little empirical evidence is available to determine the value of these types of programs in decreasing child maltreatment.

Finally, self-help groups have been important in the intervention of child maltreatment (Collins, 1978). Parent self-help groups focus on consciousness raising as a change processes (Biller & Solomon, 1986). Parents Anonymous is an example of a popular self-help group which has been established since 1969. The program involves weekly group sessions where parents can "talk about their behavior toward their children, their values, anger, hurt feelings, experiences growing up and any other issues that may result

from a parent abusing or neglecting a child" (Seals, 1980, p. 39). The group is facilitated by a parent who has successfully completed participation in a Parents Anonymous group as well as another person knowledgeable about the issues and concepts surrounding child maltreatment. This self-help program stresses utilization of a social learning model to account for behavior change such that parents learn new, normative response patterns to a stimulus which is the child (Collins, 1978). The self-help group described by Paulson and Chaleff's (1973), on the other hand, emphasizes the use of the cathartic processes whereby parents are encouraged to cleanse their emotional pain through discussion and disclosure. The role of the group leaders in this program is to act as surrogate parents to the younger participants.

Although self-help groups have existed for a number of years, Biller and Solomon (1986) warns that there are severe limitations concerning the conclusions that can be drawn from from either of the above investigations as neither offered data concerning outcome variables, nor was there presentation of follow-up data. He suggests that longitudinal analysis of treatment effects must be included in sound evaluation efforts.

Organization of the Community

Thus far, the intervention-prevention discussion has examined programs which focus on the child, the milieu and family, and the parents. The community is the fourth major intervention-prevention program focus. Not only must a community have services available for parents who abuse and neglect their children, but residents, including professionals, must be aware of the community needs in order that persons in need can be recognized and appropriately referred to the service programs. Heightening community awareness, and instilling a sense of community responsibility in community members can be fundamental step in primary prevention of child abuse and neglect (Helfer, 1982). Community members, informed about the characteristics and circumstances of child abuse and neglect, can be instrumental in identify child abuse and neglect cases. In turn, secondary and tertiary preventative programs can be developed and modified to meet the specific community needs.

Queens Group and Family Services Unit in New York city provides an example of a community based program (Gentry & Brisbane, 1982). The unit focuses on community collaboration in preventing child abuse and community outreach to distribute information on strategies and techniques for

reducing child abuse. The program utilizes social workers, and peer counselors (parents including some who have previously abused their children) to work with parents in various church and community groups. Services provided include self-help techniques, mutual aide, recreational services, parent education, group counseling, and crisis intervention (Gentry & Brisbane, 1982). Other projects (e.g., Barry, 1982) have been implemented in order to stimulate mobilization of resources for child abuse and neglect at the community level and to channel public and professional concerns regarding child abuse into constructive action.

The above examples are somewhat suggestive that a community agency must be at the for-front of organizing and motivating preventive measures against child abuse and neglect. Indeed, this may most often be the case, however, community motivation should not be misconstrued to appear as some type of radical action by an agency. Rather, heightening community awareness can lead to members being more sensitive to the needs of abusive parents and their children. For example, Coolsen (1983) suggests that supportive policies and practices on the part of the employers, workers, and local communities can greatly help to reduce the level of stress in two-parent working families and single parent families, and can serve to prevent child

abuse. Techniques such as structuring of work hours on a flexible time basis, job-sharing, and part-time employment can help parents to more adequately meet their children's needs. Further, schools which provide before-and-after programs enable parents to feel more secure about their children, thus reducing stress.

The use of volunteers can clearly be included in a discussion of community child abuse prevention programs. Volunteers are deemed as valuable resources at all three levels of prevention.

Specific programs have been developed which enable volunteers to acquire the knowledge and skills necessary to assist in the prevention of child abuse. Programs may be agency based, that is; specifically designed in accordance with the agency mandate, or they may have a broader community focus such that the programs encourage community members to volunteer their time and services to families where child abuse is a concern (e.g., College of Human Ecology, 1977; Martenson, undated; Thomas, undated).

The school system, an integral part of all communities, is viewed by several authors as a primary child abuse and neglect prevention center. Prevention in the school is

through teaching children basic interpersonal skills as well as providing specific information about child-rearing and child abuse and neglect. "An education for parenthood program in a school setting might be the only opportunity many adolescents have to learn accurate child development information and positive child-rearing strategies. Schools can be the institutions that break the cycle of abuse by helping adolescents change their attitudes about child rearing and by providing young people with some of the knowledge and skills lacking in abusive parents" (Marion, 1982, p.575).

The role of the family life educator may be critically important. Family life educators must recognize that the high incident of abuse in society is based, in part, on societal acceptance of coercive discipline and therefore, it is only by teaching positive alternative discipline strategies to future parents that the cycle of violence will be helped (Marion, 1982). A large number of school curriculum and programs have been developed with the primary aim of educating young persons before they become parents (e.g., Broadhurst, 1975; Marion, 1982; Riggs & Evans, 1979). Finally, Erickson, McEvoy, & Colucci (1984) have recently published a guidebook to provide educators, human service workers and community leaders with strategies and school

programs for prevention child maltreatment. Included in the guidebook are strategies to effectively deal with parents, school boards, and the legal system in what may be a frustrating and challenging change effort.

In addition to curriculum of the family life nature within the school, other programs have been developed which are utilized for a broader audience. For example, the URSA Institute (1978), offers a ten-unit parenting curriculum designed to increase awareness of the effect of personal interactions on a child's development and to promote a better understanding of the stages of child development. Potential audiences for this program include expectant parents, parents identified as abusive or neglectful, high school and college students and staff members in service programs.

Finally, secondary and tertiary programs have been designed for use with school children. The primary purpose of these types of programs is to help children; that is, to identify cases of child abuse and make children aware that child abuse is a serious and repeated injury and not a form of normal discipline. Community resources are often addressed in order that these children and families can be helped (e.g., Newberger & Newberger, undated).

Societal and Political Change

Within the social systems model lies those who believe that child maltreatment is rooted in societal factors which encourage abuse and neglect and it is only through radical alteration and restructuring of society, particularly resource distribution, that child maltreatment will decrease (Gil 1970). The societal factors include socially sanctioned use of force in child rearing, and stresses such as unemployment and poverty, that may decrease parental ability to control anger and frustration. Proposals and program efforts have, therefore, been set forth which are based on the premise that the societal structure and political framework could, if changed, make major differences in the method in which children are dealt with in our communities (Gil 1976; 1977).

SUMMARY

Although the study of child abuse and neglect is not a recent one, there is still no all-encompassing definition or description of the nature of child maltreatment to which this phenomenon can be explained. Child maltreatment has been viewed from a number of theoretical perspectives in efforts to more clearly understand the characteristics and

factors which might be attributed to abusive and neglectful behaviors. It is argued, however, that the unitary nature of present theories has hindered the integration of key elements of each model into a larger conceptual framework (Zigler, 1980). Despite theoretical and methodological limitations in the literature to date, several characteristics and factors contributing to child maltreatment have been identified. These studies have provided the foundation for intervention and prevention programs which have been established and implemented in order to address the very complex and multifaceted problem of child maltreatment.

Intervention and prevention programs are numerous and target a variety of social, psychological and ecological variables. Programs, in general, are designed and implemented in order that child abuse and neglect can be prevented in some way. It is not clear, however, to what extent these various program efforts are successful in achieving their specific, predetermined objectives.

The occurrence and high prevalence of child abuse and neglect in society today calls for continued research efforts in an attempt to more fully understand and remedy the complex and devastating problem of child maltreatment. Regardless of the many current limitations in the study of

child maltreatment, it is imperative that the programs presently being implemented to alleviate child maltreatment be designed so that they can be evaluated using reliable and valid outcome measures. Human service professionals and paraprofessionals must recognize that sound program evaluation is not only a responsibility and form of accountability to their clients and community, but a basis for successful future child abuse and neglect intervention and prevention program endeavors.

The Parenting Group Component within the Child Abuse Program at Alberta Children's Hospital (the unit of analysis in this study), is one of many Components designed to contribute to the alleviation of child maltreatment. As stated previously, Biller and Solomon (1987) suggests that it may be necessary to evaluate components within a program in order to determine overall effectiveness, rather than to attempt to evaluate an entire multifaceted program.

Gambrill (1983) emphasizes that one of the major flaws in determining program effectiveness is the fact that programs are often vaguely described. Chapter Three provides a detailed description of, and rational for the Parenting Group Component within the Child Abuse Program at Alberta Children's Hospital. This is an important and

critical step in a program evaluation as program goals and objectives are identified, and a detailed description of intervention is provided.

Chapter 3

THE PARENTING GROUP COMPONENT

The following four major sections are contained within this chapter: (1) an overview of the organization in which the Parenting Group Component is contained, (2) the goals, objectives, and activities of both the Child Abuse Program and the Parenting Group Component, (3) a weekly overview of the Parenting group Component activities, and (4) a summary. A structured outline of a program, which includes a clear description of the program objectives, is necessary before undertaking any program evaluation. This not only allows the reader to visualize the program or component in relation to the overall organization, but it provides a logical link between the mission of the agency, the mission of the program, and the subsequent establishment of clear, measurable component goals and objectives.

ORGANIZATIONAL OVERVIEW

The Alberta Children's Hospital

Located in Calgary, Alberta, the Alberta Children's Hospital is a regional health center serving children and

their families. The Alberta Children's Hospital supports the health needs of children and caregivers through diagnosis, assessment, and treatment; prevention, research and education; and optimum utilization of community health care resources and programs. The philosophy of the Alberta Children's Hospital is to treat the whole child; that is, to treat the child within the context of the family without separating the child's illness from other aspects of his/her environment.

Diagnostic, Assessment, and Treatment Centre

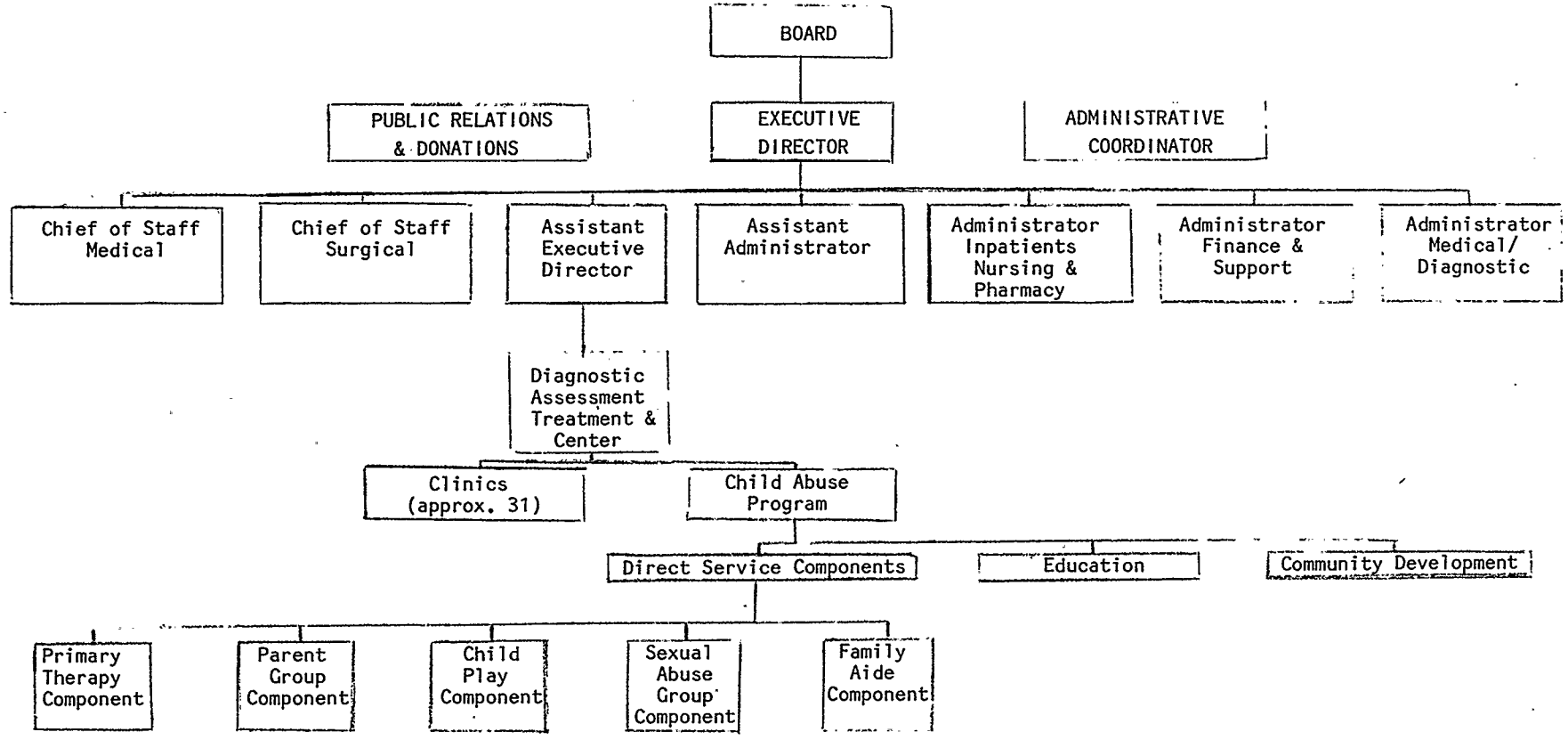
On an outpatient basis, the Alberta Children's Hospital offers approximately 31 various clinics and programs. These clinics and programs make up the Diagnostic, Assessment, and Treatment Center (D.A.T.) within the Alberta Children's Hospital (see Figure 3.1). Consistent with the overall Hospital mission, workers within the D.A.T. Center treat psychosocial problems which are considered to interfere with medical treatment or with a child's ability to function in the wider environment.

The Child Abuse Program

The Child Abuse Program is one of the many programs

FIGURE 3.1

ALBERTA CHILDREN'S HOSPITAL
ORGANIZATIONAL OVERVIEW*



* Not inclusive: illustrates only relevant components

operating under the auspices of the D.A.T. Center at Alberta Children's Hospital (see Figure 3.1). It is multidisciplinary and includes Pediatrics, Social Work, Psychology, Nursing, Psychiatry, and Recreation/Child Life.

The Parenting Group Component

The Parenting Group Component is one of five direct service components of the Child Abuse Program (see figure 3.1). It was initiated in 1976 as a treatment component to supplement and complement the individual therapy parents receive.

The component serves parents (single or as couples) from the Calgary and surrounding region whose children are between the ages of 0-6 years and whose parenting style has been assessed to:

1. contribute to physical abuse to their children;
2. place them at severely high risk of being abusive/neglectful to their children;
3. contribute to non-organic failure to thrive.

The above criteria clearly excludes sexual abuse from the Parenting Group Component. Sexually abusive parents are referred to other Calgary treatment agencies while non-offending parents of young, sexually victimized children are

seen in individual or group therapy by the Alberta Children's Hospital Child Abuse Program staff.

There are four ways in which parents may be considered for acceptance into the Parenting Group Component: (1) self-referral, (2) community referral, (3) referral from a therapist outside the hospital, and (4) referral from a therapist within Alberta Children's Hospital. Regardless of the type of referral, all group participants must have a primary therapist and be involved in individual therapy.

The Parenting Group Component is conducted one evening a week (two hours) for a total of ten weeks and is primarily staffed by a Social Worker (M.S.W.), and a Registered Nurse. More recently a Staff Nurse (B.Sc.) has been assisting the facilitators in a training position. Responsibility for implementation of the Component is shared equally amongst the three facilitators. Other facilitator tasks include all the pre-group preparatory work such as interviewing prospective participants, sending pre-group notices to participants, booking conference rooms for the evening sessions, and ensuring that necessary video equipment and materials are procured.

Before entering the Parenting Group Component, perspec-

tive participants engage in an intake interview with one of the three facilitators at which time an assessment is completed (see Appendix A). Parents must be prepared to attend meetings regularly and must be perceived by the intake worker as able to derive benefit from the program. A consent form is signed by each participant prior to the commencement of the sessions (see Appendix B).

Children's Play Component

Paralleling the Parenting Group Component of the Child Abuse Program is the Children's Play Component (see Figure 3.1). The Children's Play Component provides an opportunity for the children of group participants to engage in periods of free and structured play under the supervision of a Recreation/Child Life worker. Operating during the same hours as the Parenting Group, parents escort their child(ren) to the playroom before attending the Parenting Group sessions and return to the playroom after the session to take their child or children home. This component is important to the Parenting Group Component for four reasons:

1. it provides an opportunity for parents first to observe their children at play (see activity 5a in Figure 3.2) and then to interact with their children (see activity 9a in Figure 3.2) as part of their learning experience.

2. it provides motivation for parents to attend Group sessions; that is, parents have an evening away from the home setting without needing to worry about childcare. Children who enjoy the Play Component may often persuade their parents to attend.

3. it provides a means of monitoring the condition of the children for signs of physical and psychological abuse.

4. for assessment and treatment purposes, it provides a link between parent and child so that comparisons can be made between the progress of the parent and the behavior of the child.

GOALS, OBJECTIVES AND ACTIVITIES

CHILD ABUSE PROGRAM

Goal

The goal of the Child Abuse Program is to alleviate child abuse.

Objectives

The objectives of the Child Abuse Program as presently stated are:

1. To provide appropriate assessment to referred families.

2. To provide appropriate treatment to referred families.

3. To provide appropriate follow-up to referred families.

4. To coordinate the activities of the agencies and organizations in Calgary, Alberta, pertaining to the problem of child abuse.

5. To provide current information concerning child abuse; and

6. To promote awareness of the child abuse problem in the region served by the Alberta Children's Hospital.

Referrals for child abuse assessment, treatment and case consultation are accepted from any source in Calgary and the surrounding regions with the following three criteria as guidelines:

1. child physical abuse
2. child sexual abuse
3. medical aspects of child neglect

Child physical abuse for the purpose of the Child Abuse Program is defined as physical injury which violates the statutes regarding childcare in Alberta. Child sexual abuse is defined as the involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, to which they are unable to give consent, or that violate social taboos of family roles (Kempe & Helfer, 1980). The term medical aspects of child neglect is defined as the failure of a parent to provide medical treatment for suspected or diagnosed physical conditions of a child except in those cases in which religious beliefs proscribe a doctor's care (Halperin, 1979).

THE PARENTING GROUP COMPONENT

Following from the second objective of the child abuse Program -- to provide appropriate treatment to referred families -- the Parenting Group Component was established to supplement and complement individual therapy.

One of the deficits of some abusive and neglectful parents, as identified in the literature in Chapter Two, is that they lack appropriate skills in child-rearing and that their attitudes, expectations, and understanding of the normal growth and development of children set them apart from non-abusive parents (Cooke & Bowles, 1980 & Halperin, 1979). Consistent with the literature and the second objective of the Child Abuse Program, the goal of the Parenting Group Component was established.

Goal

> The goal of the Parenting Group Component is to optimize child-rearing practices among group participants.

Objectives

The literature in Chapter Two indicated that parent-child interactional patterns among abusive and neglectful parents are dysfunctional in certain specific ways.

However, it is exceedingly difficult to determine if behavior is modified in the home under natural conditions or as a result of a change agent such as group therapy. Techniques for observing families in the home are still being developed and, at present, are expensive and time consuming. Thus, many parent educators have turned to attitude questionnaires to obtain relevant cues about likely changes in performance although it is clearly acknowledged that attitudes, or psychological sets, and behavior are not identical and do not change at the same time. Nevertheless, there is a reasonable basis for assuming that a change in attitude toward child-rearing practices will result in a change in parent-child interactional patterns (Radin & Glasser, 1972). On this basis, Objective One was established.

Objective 1:

To change participants' attitudes about child-rearing in the desired direction.

In order to achieve the first objective, one instrumental objective needs to be achieved. Parents need to know what behaviors are associated with "normal" child developmental stages to enable them to interact appropriately with their young children. Without this

knowledge, for example, maltreating parents may expect adult behavior from their children and may punish them inappropriately when these expectations are not fulfilled. Conversely, some parents have excessively low expectations of their children and therefore do not permit activities appropriate to the child's developmental stage (Cook & Bowles, 1980; Halperin, 1979). On this basis, Instrumental Objective One(a) was established.

Instrumental Objective 1a:

To increase participants' knowledge about the developmental stages of children, birth to six years.

In addition to having dysfunctional interactional skills, many abusive and neglecting parents also have few social support systems. The social isolation of many parents who abuse and neglect their children and the ramifications of social isolation has been emphasized in the literature. Gambrill (1983) notes that although many studies report the social isolation of involved families, few devote attention to this area during intervention. In particular, studies using a group format (Ambrose et al., 1980; Wolfe et al., 1981) do not specifically speak of efforts to utilize new contacts amongst parents as a method of enriching interactions outside of the group. Based on the

literature regarding the social isolation of abusive and neglectful parents, Objective Two was established.

Objective 2:

To expand participants' perceptions of their social support systems.

As was discussed in the literature in Chapter Two, neglecting a child's safety is a component of general parental neglect and can be neglected in various ways. Not only is the health of the child protected by knowledge and implementation of safety in the home, but it has been suggested that putting away breakable objects and having an area where children can make a mess can decrease punitive interactions between parents and children (Jeffery, 1976). Based on the literature regarding child safety, Objective Three was established.

Objective 3:

To increase participants' knowledge on how to protect young children from accidents.

Activities to Attain Objectives

One of the most widely used treatment modalities in the field of child maltreatment is group therapy (Kempe & Helfer, 1980). In the literature, the use of filmstrips,

and structured discussion and interaction are amongst the many various teaching techniques considered to contribute to effective learning (Gambrill, 1983). Kadushin (1985) has observed that people learn best if they are actively involved in the learning processes. Teachers ensure greater active involvement in the learning processes if they encourage and provide the opportunity for students to question, discuss, object, and express doubt. Based on this, the facilitators of the Parenting Group Component have chosen to use films, discussion and presentations as teaching techniques in their program. Figure 3.2 provides a comprehensive ten-week overview of the activities which constitute the Parenting Group Component.

In order to achieve the aforementioned objectives, specific activities have been selected and will be discussed accordingly in this section. The activities are outlined as they pertain to attainment of each of the objectives.

Objective 1:

To change participants' attitudes towards child-rearing in the desired direction.

Instrumental Objective 1a:

To increase participants' knowledge about the developmental stages of children, birth to six years.

The activities chosen by the facilitators to achieve Instrumental Objective One(a) are:

1. Weeks 1-4 inclusive and Week 6:
   A series of educational films is shown on the developmental stage of children, birth to 6 years (Humbel, Dailey, Low, Courtois, & Katadotis, 1973, 1974, 1978).

   Week 1: Child - Part 1 The Newborn
   Week 2: Child - Part 2 (first year of life)
   Week 3: Child - Part 3 (the busy toddler)
   Week 4: Child - Part 4 (age 3-4 years)
   Week 6: Child - Part 5 ((age 5-6 years)
   (see activities 1a, 2a, 3a, 4a, and 6a in Figure 3.2).

2. Weeks 1-4 inclusive and Week 6:
   The film is discussed immediately following each week's showing. The discussion involves relating the film content to participants' personal experiences.
   (see Activities 1b, 2b, 3b, 4b, and 6b in Figure 3.2).

3. Weeks 5 and 9: Play Period

   Week 5: Participants view their children through an observation window during a period of free play. The Recreation/Life Worker leads the group in a discussion of the importance of play at every stage in a child's life, birth to 6 years. (see Activities 5a and 5b in Figure 3.2).

   Week 9: Participant's interact with their children in the playroom during a period of structured play, supervised by the Recreation/Child Life Worker and trained volunteers. (see Activity 9a in Figure 3.2).

Each film in the "Child" series (Humbel et al., 1973, 1974, 1978) portrays one developmental stage. Viewing the entire series allows participants to gain an overall knowledge of a child's developmental stages. The ensuing discussion enables participants to expand upon and clarify

points raised in the film and to discuss feelings surrounding the issues. Kadushin (1985) stresses the importance of providing the explicit opportunity to utilize and apply the knowledge which teachers and facilitators seek to teach. Therefore, in the Parenting Group Component participants are first taught child developmental stages and are then provided with an opportunity to apply this knowledge in interactional situations.

Objective 2:

To expand participants' perceptions of their social support systems.

Halperin (1979) has stated that group sessions allow parents to share their innermost fears and frustrations with others whose experiences have been parallel. Because the group members are in various stages of developing appropriate parenting styles and behaviors, they learn both from others' failures and successes. General discussion in the group session is expected to provide an environment conducive to open communication whereby group members are encouraged to support each other.

The activities selected to achieve Objective Two are:

1. Weeks 1-9 inclusive:
   Sharing of ideas and feelings through weekly discussion regarding the strengths and limitations of each participant's parenting abilities. (see Activities 1b through 8b in Figure 3.2).

2. Week 7:
   A film entitled "Cradle of Violence" (Bar Films, 1977). This exercise is followed by a discussion on how it feels to be a parent. (see Activities 7a and 7b in Figure 3.2).

3. Week 8:
   Presentation on specific community resources which may be available to participants to provide them with both direct assistance and social support. A discussion follows the presentation. (see Activities 8a and 8b in Figure 3.2).

Objective 3:

To increase knowledge about how to protect young children from accidents.

The following activities have been selected to achieve Objective Three:

1. Week 8:
   Film - Growing Up Safely (Crawley Films Ltd., 1965.) (see activity 8c in Figure 3.2).

2. Week 8:
   Discussion regarding the concepts introduced in the film. (see activities 8d and 8e in Figure 3.2).

Figure 3.2

WEEKLY OVERVIEW OF ACTIVITIES

Week Prior to Group Commencement:

1. Intake/Pre-Screen Interviews for prospective Parenting Group Component participants.
2. Completion of the Pre-Group Intake Form (see Appendix A).
3. Administration of the following Pretests:
   i. Inventory of Attitudes on Family Life and Children (see Appendix D).
   ii. Child Development Questionnaire (see Appendix E).
   iii. Provision of Social Relations scale (see Appendix F).

Week 1:

1a. Film: Child - Part 1
The Newborn (30 minutes)
1b. Discussion about getting off to a good start with your child.
1c. Coffee Break (half way through the session).

Week 2:

2a. Film: Child - Part 2
The First Year of Life (30 minutes)
2b. Discussion focused on the first year of life.
2c. Coffee Break (half way through the session).

Week 3:

3a. Film Child - Part 3
Coping With a Busy Toddler (30 minutes)
3b. Discussion focused on the toddler stage.
3c. Coffee Break (half way through the session).

Week 4:

4a. Film: Child - Part 4
Children Aged 3-4 Years (30 minutes)
4b. Discussion focused on children aged 3-4 years.
4c. Coffee Break (half way through the session).

Figure 3.2 (continued)

Week 5:

5a. Observation of participants' own children in the playroom.
5b. Discussion focusing on the importance of play in a child's life.
5c. Coffee Break (half way through the session).

Week 6:

6a. Film: Child - Part 5
Children Aged 5-6 Years (30 minutes)
6b. Discussion focusing on children aged 5-6 years.
6c. Coffee Break (half way through the session).

Week 7:

7a. Film: Cradle of Violence
This film is designed to explore feelings associated with child-rearing (15 minutes).
7b. Discussion focusing on what it feels like to be a parent.
7c. Coffee Break (half way through the session).

Week 8:

8a. Presentation on Community Resources (conducted by one of the group facilitators).
8b. Discussion on the various community resources available and of interest to group participants.
8c. Film: Growing Up Safely
Reviews the developmental stages of children and provides a guide for helping parents protect their child from accidents (30 minutes).
8d. Discussion focused on child safety.
8e. Coffee Break (half way through the session).
8f. Quiz on Child Safety (see Appendix G).

Week 9:

9a. Interaction between participants and their children in the playroom.
9b. Posttest: Inventory of Attitudes on Family Life and Children.
9c. Posttest: Child Development Questionnaire.
9d. Posttest: Provision of Social Relations scale.
9e. Coffee Break (halfway through the session).

Figure 3.2 (continued)

Week 10:

10a. Film: Child Behavior = You
10b. Discussion focused on Parenting.
10c. Discussion focusing on comments, issues, and concerns. (Verbal evaluation of the Parenting Group Component).
10d. Completion of the Parent's Evaluation of Parenting Class form (see Appendix I).
10e. Coffee and donuts served. Informal social interaction between group facilitators and group participants.
10f. Measuring instrument outcomes are shared with group participants as appropriate.

SUMMARY

This chapter introduced the Parenting Group Component within the Child Abuse Program at Alberta Children's Hospital by illustrating the relationship of the Component to the overall Hospital organization, the purpose and objectives of the Component, and the specific weekly activities comprising the Component. Chapter Four discusses the methods and procedures employed for carrying out the formative program evaluation of the Parenting Group Component.

Chapter 4

METHODOLOGY

This chapter discusses the research methodology and the procedures used in this program evaluation of the Parenting Group Component. The major topics in this chapter include: (1) the setting, (2) the duration, (3) the participants, (4) instrumentation, (5) reliability and validity, (6) data collection procedures, and (7) ethical considerations.

SETTING

The setting for the Parenting Group Component is the Alberta Children's Hospital located in Calgary, Alberta. More specifically, the Parenting Group sessions are held in a conference room, complete with a one-way audio system and observational window, located within the hospital. The Child's Play Component is also located within the hospital, however a separate room is used; one which is equipped with various free and structured play toys.

DURATION

The Parenting Group Component was conducted every Wed-

nesday evening beginning at 18:00 hours and ending at 20:00 hours. It commenced on January 3, 1988 and terminated on March 16, 1988 for a total of ten sessions. Prior to commencement of the Parenting Group sessions (mid-December, 1987), a letter was sent to prospective participants inviting them to participate in an intake interview and informing them of the research component of this particular Parenting Group Component (see Appendix C). Intake interviews and initial data collection were scheduled to take place in the week prior to session commencement (January 4, 1988 to January 12, 1988). Specific details of intake procedure and data collection are discussed in the Implementation section.

PARTICIPANTS

Participants of the study were those parents who attended the Parenting Group Component from January 13, 1988 to March 16, 1988. These parents met the criteria for entrance into the program (discussed previously in Chapter Three). Therefore, the participant profile was within the following parameters:

1. Their parenting style had been assessed to:
    i. contribute to physical abuse of their children;
    ii. place them at severely high risk of being abusive/neglectful to their children;

iii. contribute to non-organic failure to thrive.

2. At least one of their children was between the ages of 0-6 years.

3. They were from Calgary, Alberta or the surrounding region served by the Alberta Children's Hospital.

4. They had an individual or family primary therapist.

5. They were perceived by the Parenting Group Component facilitators during an intake assessment to be able to derive benefit from the group sessions.

All of the Parenting Group Component participants cooperated in the study for a total thirteen subjects. A comprehensive sociodemographic description of the 13 group participants is presented in Table 4.1.

As can be seen from Table 4.1, the majority of the participants were between the ages of 18-25 years (mean = 26.8), were predominantly females, and either married or living common-law. Half of the participants had an educational level below grade twelve. The majority were unemployed and indicated they were experiencing financial difficulty. In addition, the participants had one or two children living at home with the majority having one child. The mean age of the eldest child (Child Number One) was 43.7 months while the mean age of the second or youngest child (Child Number Two) was 34.0 months. Most of the eldest

TABLE 4.1

Sociodemographic Variables of Group Participants

Characteristics	Percentage	No. of Cases
Age		10
(mean = 26.8; S.D. = 7.4)		
under 18 years	----	
18-25 years	60.0%	
26-35 years	30.0%	
36-45 years	10.0%	
Gender		13
male	30.0%	
female	70.0%	
Marital Status		13
single	38.5%	
married or common-law	61.5%	
Educational Level		10
post-secondary	10.0%	
grade twelve	40.0%	
below grade twelve	50.0%	
Employment Status		13
student	15.4%	
employed	38.5%	
unemployed	46.2%	
Financial Difficulty		13
yes	61.5%	
no	38.5%	
No. of Children Living at Home		13
more than two	-----	
two	46.2%	
one	53.8%	
Age of Child Number One		13
(mean = 43.5; S.D. = 20.2)		
less than 24 months	-----	
24-48 months	69.3%	
49-72 months	23.1%	
older than 72 months	7.7%	

Table 4.1 (continued)

Sociodemographic Variables of Group Participants

Characteristics	Percentage	No. of Cases
Age of Child Number Two (mean = 34.0; S.D. = 20.8)		6
less than 24 months	33.3%	
24-48 months	33.3%	
49-72 months	33.3%	
older than 72 months	-----	
Gender of Child Number One		13
male	69.2%	
female	30.8%	
Gender of Child Number Two		6
male	100%	
female	----	
Visits with Relatives		13
1 per month	7.7%	
1 per week	15.4%	
less than 1 per month	76.9%	
Visits with Friends		13
1 per month	----	
1 per week	15.4%	
less than 1 per month	84.6%	
Visits with Neighbors		13
1 per month	30.8%	
1 per week	15.4%	
less than 1 per month	53.8%	
Social Community Involvement		13
yes	15.4%	
no	84.0%	
Children Ever Separated From You For Longer Than One Week		13
yes	30.8%	
no	69.2%	
Attendance		13
5 or more sessions	70.0%	
less than 5 sessions	30.0%	

children were females while all of the second children were males. In terms of social contacts, the majority of participants visited with their relatives, friends, and neighbors less than once per month, and had no social community involvement. Most of the participants had never been separated from their children for longer than seven days. Finally, the majority of the participants attended five or more of the Parenting Group Component sessions.

INSTRUMENTATION

The instruments used to measure the objectives for this study were directly linked to the Parenting Group Component objectives. This section describes the measurement instruments utilized and notes the specific objective to which the instrument pertains.

Inventory of Attitudes on Family Life and Children

This 36-item questionnaire, designed by Radin and Glasser (1965), is a revision of the original 115 item Parental Attitude Research Instrument (PARI) for measuring child-rearing attitudes by Schaefer and Bell (1958). (see Appedix D). The thirty-six statements are evaluated on a four-point Likert-type forced choice scale from strongly agree to

strongly disagree. Responses are scored with 4, 3, 2, or 1 points with highest point score for strongest agreement. Lower scores reflect a more positive attitude toward family life and children (minimum score equals thirty six).

The Inventory of Attitudes on Family Life and Children was selected to measure the first objective of the Parenting Group Component discussed in Chapter Three -- to change participants' attitudes toward child-rearing in the desired direction. Although observations in the home are most often perceived as more revealing of pervasive behavioral patterns than responses to questionnaires, there are indications that the responses on the Inventory of Attitudes on Family Life and Children can fairly accurately predict how nurturant the mother would be if she were observed in the home (Radin & Glasser, 1972). Therefore, use of this instrument is suggested for researchers who wish to gain valid information about maternal child-rearing practices with limited time and funds.

Child Development Questionnaire

This is 40-item questionnaire designed to measure the respondents knowledge of child development milestones (see Appendix E). It requires the respondent to rate the age

when a child is most likely to first demonstrate various developmental abilities (e.g., ability to roll over, climb stairs, cut with scissors etc.; Mash, 1980). Developmental abilities are divided into four categories: (1) motor skills, (2) communication skills, (3) self-help skills, and (4) miscellaneous skills. Ten possible age categories are given for each item (e.g., 0-6 months, 6-12 months, etc.). Scoring is based on a predetermined norm. For each question, a normative response scores zero. In each of the four categories, two scores will be obtained: (1) a total number of responses greater and less than the norm, and (2) a sum of the age categories greater and less than norm. Scores above the norm indicate latter expectations from the child and scores below the norm indicate early expectations from the child.

The Child Development Questionnaire was selected to measure Instrumental Objective One(a) discussed in Chapter Three -- to increase participant's knowledge about the developmental stages of children, birth to six years. Measuring parents knowledge of child developmental milestones has been used as an indicator of parents' unrealistic expectations of their children (Steele & Pollock, 1968). Although Azar, Robinson, Hekimian and Twentyman (1984) argue that operationalizing "unrealistic expectations" by

parents' knowledge of developmental milestones may not be optimal, they and other authors (e.g., Twentyman & Plotkin, 1982) have found that knowledge of developmental milestones is an important determinant of unrealistic expectations (either earlier or later) and, in turn, maltreating behavior.

Provision of Social Relations Scale

The Provision of Social Relations scale (PSR) is a 15-item measurement instrument designed to measure two components of social support (Turner, Frankel & Levin, 1983). (see Appendix F). The first component, family support, is revealed through Item Numbers 4, 7, 10, 11, and 14. The second component, friend support, is revealed through Item Numbers 1, 2, 3, 5, 6, 8, 9, 13, and 15. The PSR is scored by reverse-scoring items 7 and 15 and then summing the item scores on each of the components to get a score for that component. A total score is obtained by summing the scores on the two components. Lower scores reflect more social support.

The PSR was specifically chosen to measure Objective Two of the Parenting Group Component discussed in Chapter Three -- to expand participants' perceptions of their social

support systems. The PSR is one of the few instruments that explores the environmental variable of social support (or, at least, the respondent's perceptions) which is a key element for assessment and intervention in many clinical approaches (Corcoran & Fisher, 1987).

Child Safety Quiz

This 5-item, multiple choice quiz is a data collection instrument designed by the Parenting Group Component facilitators to measure the respondent's knowledge of child safety (see Appendix G). Each of the five questions has four possible answers and the respondent is asked to select the best answer. There is only one correct answer. Scoring the Child Safety Quiz involves marking the answers to the quiz as either right or wrong. The respondent receives a score out of the total five questions.

The Child Safety Quiz was designed specifically to measure Objective Three of the Parenting Group Component discussed in Chapter Three -- to increase knowledge on how to protect young children from accidents. Because no other measurement instrument could be located to specifically measure this objective, the Parenting Group Facilitators designed the Safety Quiz.

Other Data Collection Instruments

In addition to the measurement instruments specifically selected to measure the Parenting Group Component objectives, three other data collection instruments were utilized in this formative program evaluation. They include the Facilitator Feedback Report, the Parent's Evaluation of Parent Class form, and the Parent Pre-Group Intake form. These instruments were designed by the Parenting Group Component facilitators.

The Facilitator Feedback Report is a recording instrument designed to collect qualitative data regarding the facilitator's perceptions on each of the Parenting Group Component participants (see Appendix H). It consists of short summaries of the facilitators perceptions (including the Recreation/Child Life facilitator) of each of the participants with regard to such matters as participant participation, participant reaction to information, participant's physical and emotional state, and any other general concerns or perceived improvements. The information collected on this form is communicated to the appropriate primary therapist either immediately (if it is regarded as urgent) or as a part of a final written summary which is routinely sent to each participant's primary therapist upon

completion of the ten group sessions.

The 8-question Parent's Evaluation of Parenting Class form is designed to collect both qualitative and quantitative data on participant's perceptions of the overall Parenting Group Component (see Appendix I). It includes eight variables; three ratio-level variables, two dichotomous variables and three variables which involve having the participants comment on specific aspects of the component.

The three ratio-level variables are measured by having the participants rate how helpful the Parenting Group Component was, how clearly they perceived the material to be presented and how satisfying the overall program was for them. To measure each variable, a 5-point scale was used.

The two dichotomous variables on this form require that participants indicate whether or not they would recommend the Parenting Group Component to a friend and whether or not they wished to have a follow-up group after termination of these sessions.

Finally on this form, parents were asked to write their comments regarding the sufficiency of detail provided in the

Parenting Group Component, the most significant aspects of the Component, and the ways in which they would like to see the Component improved.

The Parent Pre-Group Intake form is a 12-item instrument is designed for assisting with pre-group intake assessment. Sociodemographic data is also collected on this form (see Appendix A). Therefore, it provides the basis for an initial intake assessment and enables the facilitators to construct a sociodemographic profile of perspective participants.

Qualitative data was also collected during each Parenting Group Component session by the researcher (myself) through utilizing both observation (40% of the sessions) and participant observation (60% of the sessions). The use of participant observation as opposed to observation was a random choice made exclusively by the group facilitators at the beginning of each session. Information recorded included the number of group participants in attendance on the particular evening, the group facilitators in attendance on the particular evening, and a specific recording of session content.

RELIABILITY AND VALIDITY

Three of the four measurement instruments used to measure the objectives of the Parenting Group Component have been assessed for reliability and validity. A discussion of reliability and criterion-related validity for the Inventory of Attitudes on Family Life and Children (Appendix D) can be found in Radin and Glasser (1972) and further, in Schaefer & Bell (1958). Mash (1980) discusses the validity and reliability of the Child Development Questionnaire (Appendix E). A discussion of the reliability and validity of the Provision of Social Relations scale (Appendix F) can be found in Corcoran and Fisher (1987) and further, in Turner et al., (1983). The Safety Quiz (Appendix G) was not assessed for reliability and validity, however it is believed to have high face validity.

DATA COLLECTION PROCEDURES

Utilizing the aforementioned instruments to measure the degree of attainment of the Parenting Group Component objectives, data was collected using various research procedures. These procedures were included in Figure 3.2 in Chapter Three. For each of the seven data collection instruments, the procedures are outlined.

Inventory of Attitudes on Family Life and Children

To determine if there was a significant difference between participant's attitudes towards child-rearing before and after participation in the Parenting Group Component, the Inventory of Attitudes on Family Life and Children was administered on a pretest-posttest basis (see Number 3 and 9b in Figure 3.2).

Child Development Questionnaire

To determine if there was a significant difference between participant's knowledge of child development before and after the Parenting Group Component, the Child Development Questionnarie was administered on a pretest-posttest basis (see Number 3 and 9c in Figure 3.2).

Provision of Social Relations Scale

To determine if there was a significant difference between participants' perceptions of their social support systems before and after the Parenting Group Component, the Provision of Social Relations Scale was administered on a pretest-posttest basis (see Number 3 and 9d in Figure 3.2).

Child Safety Quiz

To determine participants' level of knowledge on how to protect young children from accidents, the Safety Quiz was administered immediately following the specific Parenting Group session on child safety (see Number 8f in Figure 3.2).

Facilitator Feedback Report

In order to collect weekly data regarding the facilitators' perceptions of each of the Parenting Group participants, the Facilitator Feedback Report was completed at the end of each weekly session (see Appendix H).

Parent's Evaluation of Parenting Class Form

To determine the participant's overall impressions of the Parenting Group Component, the Parent's Evaluation of Parenting Class form was administered during the final session of the Component (see Number 10d in Figure 3.2).

Parent Pre-Group Intake Form

For assessment purposes, and in order to determine sociodemographic characteristics of Parenting Group

participants, the Parent Pre-Group Intake form was administered prior to commencement of the group sessions (see Number 1 in Figure 3.2).

As discussed previously, the Parenting Group Component was specifically designed in order that data collection could easily be accommodated into the regular weekly plans (see Figure 3.2 in Chapter Three). As well, it was assumed in this design that participants would attend a scheduled pre-group interview and all the subsequent sessions in order that administration of the measurement instruments could remain consistent. Due to differing factors, the nature of implementation of the measurement instruments varied.

In order to obtain pretest scores, the Inventory of Attitudes on Family Life and Children (Appendix D), the Child Development Questionnaire (Appendix E), and the Provision of Social Relations scale (Appendix F) were planned to be administered on an individualized basis by the researcher or one of the group facilitators prior to commencement of the Parenting Group sessions. At this time, the Parent Pre-Group Intake form (Appendix A) was also scheduled to be completed. Due to factors such as participants canceling interviews and facilitator time restrictions, the instruments were not all administered on an individualized basis

nor were they administered prior to commencement of session one. Four of the 13 participants (31%) completed the above measurement instruments in a personal interview and nine (69%) were completed in a group interview. Eleven of the 13 participants (85%) completed the above measurement instruments prior to commencement of session one and two participants (15%) completed the above instruments prior to commencement of session two.

In order to obtain posttest scores, administration of the Inventory of Attitudes on Family Life and Children, the Child Development Questionnaire, and the Provision of Social Relations scale were scheduled for session nine. The seven participants who attended session nine (54%) completed the above measurement instruments during this session. One participant (8%) completed the above measurement instruments in the following session (session ten) and five of the participants (38%) completed the above instruments during a personal interview (home visits) with the researcher as soon as possible following termination of the Parenting Group Component (all five were completed within 21 days of group termination).

The Child Safety Quiz (Appendix G) was administered, as scheduled, in session eight at which time six participants

(46%) were in attendance. Given that the Safety Quiz pertained only to session eight, this instrument was not administered to those participants who did not attend that session.

The Facilitator Feedback Report (Appendix H) was completed by the group facilitators and the Recreation Life Coordinator at the end of each weekly session as scheduled in the Parenting Group Component design.

The Parent's Evaluation of Parenting Class form (Appendix I) was scheduled to be administered during session ten. Seven of the group participants (54%) were in attendance during session ten and completed the form at that time. Five of the participants (38%) completed the form during a personal interview (home visits) with the researcher as soon as possible following termination of the Parenting Group Component (all five were completed within 21 days of group termination). One participant (8%) could not be contacted in order to complete this form.

Prior to commencement of each evening session, the researcher was asked by the group facilitators either to participate in the group or to observe the group through a one-way mirror. Regardless of the method utilized, quantitative

data regarding program content was collected during each session.

ETHICAL CONSIDERATIONS

Prior to commencement of this Parenting Group Component, participants were informed in a letter about the research component which would be implemented (see Appendix C). Participation in this project was, therefore, voluntary. Each participant completed a Consent Form before attending their first session (Appendix B). Prior to administering any of the measurement instruments, the researcher verbally explained to the participants the purposes and processes of this formative program evaluation and emphasized the concept of confidentiality. Upon completion of the Parenting Group Component, the researcher verbally thanked all participants for their cooperation in the study.

Approval to proceed with this formative program evaluation was granted by the Faculty of Social Welfare Ethics Committee at the University of Calgary, the Conjoint Areas Research Ethics Committee at the University of Calgary, and the Alberta Children's Hospital Research Committee (see Appendices J, K, and L, respectively).

SUMMARY

This chapter discussed the methods and procedures employed for the program evaluation of this Parenting Group Component. In chapter Five, the data analysis and findings from this evaluation are reported.

Chapter 5

RESULTS

This chapter reports the findings of the evaluation of the Parenting Group Component. It includes the following five major sections: (1) data analysis, (2) measures of the dependent variables, (3) sociodemographic variables, and (4) a summary.

DATA ANALYSIS

Data collected from all the instruments was entered into STAT PAC by the researcher. Data was analyzed in the following four ways:

1. The student's t-test was used to compare the mean scores of three of the dependent variables (attitudes towards child-rearing, child development knowledge, and social support) before and after the independent variable (the Parenting Group Component) was introduced.

2. Descriptive statistics (percent scores) were used to measure the success of the dependent variable (participants' knowledge on how to protect young

children from accidents) after introducing the independent variable (session on child safety).

3. Descriptive statistics (distributions) as well as a data summary were used to assess participants' and facilitators' overall impressions of the Parenting Group Component.

4. The Pearson product-moment correlation coefficient was employed to explore the relationships between the sociodemographic variables and three dependent variables (attitudes towards child-rearing, knowledge of child development, and social support).

MEASURES OF THE DEPENDENT VARIABLES

As discussed previously in Chapter Four, seven data collection instruments were utilized in this study. Six of these instruments were used to measure the effectiveness of the Parenting Group Component, and the seventh instrument was used to collect sociodemographic data.

Using the Inventory of Attitudes on Family Life and Children, the Child Development Questionnaire, and the Provision of Social Relations scale, scores were obtained on

a pretest-posttest basis to measure participant's attitudes towards child-rearing, knowledge of child development, and perceptions of social support, respectively. Table 5.1 illustrates the findings for each of these variables.

The fourth instrument used to determine program effectiveness was the Child Safety Quiz which measured participants' knowledge on how to protect young children from accidents. These findings are also discussed in this section.

Finally, the Facilitator Feedback Report and the Parent's Evaluation of Parenting Class form were used to collect data on the facilitator and participant perceptions of the overall Parenting Group Component. Results from both of these instruments are discussed in this section and table 5.2 illustrates the findings from the Parent's Evaluation of Parenting Class form.

Inventory of Attitudes on Family Life and Children

One score was obtained from the Inventory of Attitudes on Family Life and Children which was utilized to measure group participants' attitudes towards child-rearing (see Appendix D). A difference of 2.69 was found between the mean

pretest and posttest scores indicating a positive change in participants' attitudes towards child-rearing. Although this difference was not statistically significant, the standard deviation indicates that posttest scores were considerably more centralized around the mean than the pretest scores.

Child Development Questionnaire

The Child Development Questionnaire was utilized to measure change in participants' knowledge of child development (see Appendix E). In each of the four categories, two scores were obtained: the total number of responses greater and less than the norm, and the sum of the age categories greater and less than the norm. Four total scores were obtained on the Child Development Questionnaire. They include the total number of responses less than the norm, the total sum of the age categories less than the norm, the total number of responses greater than the norm, and the total sum of the age categories greater than the norm.

As can be seen from Table 5.1, the positive differences between pretest and posttest mean scores were minimal. Negative differences were also found. The positive differences were not significant, indicating that participants'

knowledge of child development did not change significantly after introducing the independent variable -- the Parenting Group Component.

Provision of Social Relations Scale

The Provision of Social Relations (PSR) scale was used to measure participants' perceptions of social support (see Appendix F). The PSR categorizes social support into family support and friend support. Differences in the pretest and posttest mean scores were negative and no significant differences were found following the implementation of the Parenting Group Component.

Child Safety Quiz

The Child Safety Quiz was employed, using a posttest-only design, to measure participants' knowledge on how to protect young children from accidents (see Appendix G). Six (46%) of the Parenting Group Component participants attended the session on child safety (N = 6). The mean score on the Child Safety Quiz was 80 percent. A score of 80 percent was considered to be an indicator of successful objective achievement by the group facilitators.

Table 5.1

Pretest and Postest Scores for the Inventory of Attitudes on Family Life and Children, the Child Development Questionaire, and the Provision of Social Relations Scale

Measure	Average (S.D.) Pre		Post		Difference
Inventory of Attitudes on Family Life and Children					
Total	92.5	(12.3)	89.9	(6.9)	2.69
Child Development Questionnaire					
Motor Skills					
above/below[1]	3.4	(1.9)	3.7	(2.2)	-0.31
above/below[2]	4.7	(2.7)	4.0	(2.6)	0.69
Communication					
above/below[1]	4.5	(1.2)	4.8	(1.8)	-0.31
above/below[2]	5.5	(1.6)	6.5	(2.6)	-1.00
Self Help					
above/below[1]	2.9	(1.0)	2.6	(1.2)	0.24
above/below[2]	3.5	(1.6)	3.3	(1.6)	0.15
Micellaneous					
above/below[1]	4.4	(1.3)	4.5	(1.5)	0.08
above/below[2]	7.4	(2.7)	6.7	(2.9)	0.69
Total					
below[1]	6.1	(4.4)	5.3	(4.6)	0.77
below[2]	8.2	(6.0)	7.0	(7.4)	1.15
above[1]	9.0	(4.1)	9.9	(3.0)	-0.85
above[2]	12.8	(5.9)	13.2	(4.9)	-0.39
Provision of Social Relations					
Family	15.5	(7.1)	16.5	(6.4)	-1.00
Friend	19.7	(6.7)	21.5	(6.4)	-1.77
Total	35.2	(9.9)	38.0	(9.0)	-2.76

[1] total number of responses greater or less than the norm.
[2] sum of the age categories greater or less than the norm.

Facilitator Feedback Report

The facilitator feedback report collected quantitative data to measure the group facilitators' perceptions of participants' overall progress in the Parenting Group Component (see Appendix H). In general, the program facilitators were pleased with the participants' responses to the Parenting Group Component. They felt that the majority of participants benefited from involvement in the program particularly in terms of their attitudes towards child-rearing. This was evidenced through the apparent lack of enthusiasm displayed by most of the participants at the onset of the Parenting Group Component compared to the enthusiastic nature of many of the participants after the ten Component sessions.

In addition, the findings reported on this form, which were specific to each group participant, were communicated immediately after the group session to the respective primary therapist if a matter was perceived to be urgent. In order to attain confidentiality, specific findings will not be discussed. However, urgent matters includes such things as a participant perceived by the facilitators to be severely depressed, under the influence of substances or, for various reasons, to be having extreme difficulty in the

home environment. Regardless of whether or not an urgent matter is communicated to the primary therapist, a summary letter regarding each participant was composed at the end of the ten-week session and sent to the respective primary therapist. Information contained in the letter was generally summarizing and included comments on attendance, attitude, specific contributions made by the participant to the group and any other concerns or comments which were considered by the facilitators to be useful to the primary therapist.

Parent's Evaluation of Parenting Class

Recall from Chapter Four that the Parent's Evaluation of Parenting Class form included eight variables; three ratio-level variables, two dichotomous variables and three variables which involved having the participants' comment on specific aspects of the component (see Appendix I).

Using distributions, the results from the three ratio-level variables and the two dichotomous variables appear in Table 5.2.

As can be seen from Table 5.2, one participant (8.3%) indicated that the Component was not at all helpful. Two

TABLE 5.2

Distributions of Responses to
Parent's Evaluation of Parenting Class

Variables	Percentage	N
Component Content		12
Not at all helpful	8.3%	
A little helpful	17.7%	
Somewhat helpful	25.0%	
Very helpful	50.0%	
Extremely helpful	-----	
Clarity of Material Presented		12
Not at all clearly	-----	
A little clearly	8.3%	
Somewhat clearly	16.7%	
Very clearly	75.0%	
Extremely clearly	-----	
Satisfaction with Component		12
Not at all satisfied	16.7%	
A little satisfied	-----	
Somewhat satisfied	8.3%	
Very satisfied	75.0%	
Extremely satisfied	-----	
Recommend Component to a Friend		12
yes	91.0%	
no	8.3%	
Prefer a Follow-up to this Component		11
yes	63.3%	
no	36.7%	

participants (16.7&) indicated that the group was a little helpful. Three (25%) of the participants indicated that the Component was somewhat helpful and six participants (50%) reported that the group was very helpful.

One participant (8.3%) indicated that the material was presented a little clearly. Two participants (16.7%) indicated that the material was presented somewhat clearly and nine participants (75%) believed that the material was presented very clearly.

Two participants (16.7%) were not at all satisfied with the Parenting Group Component. One participant (8.3%) was somewhat satisfied with the group and nine participants (75%) were very satisfied with the group.

Eleven participants (91.7%) indicated that they would recommend the group to their friends and only one participant (8.3%) indicated that they would not recommend the group to their friends. Seven participants (63.3%) indicated that they would like to have some type of follow-up group after termination of this parenting group although specific ideas were not discussed. Four participants (36.7%) indicated they would not like a follow-up to this group.

This form also required participants to write their comments regarding the sufficiency of detail provided in the Parenting Group Component, the most significant and helpful aspects of the Component, and ways in which they would like to see the Component improved.

Five (42%) of the participants indicated that they did not feel sufficient detail was provided in each of the Parenting Group Component sessions. Four (33%) of the participants indicated there was sufficient detail provided; and the remaining three (25%) indicated that only some sessions provided sufficient detail. Some of the participants who indicated that sufficient detail was provided expanded their comments noting that they were able to realize both the positive and negative aspects of their parenting style, and that the knowledge of the facilitators greatly enhanced this learning processes.

The majority of participants who indicated that there was not sufficient detail gave reasons for answering in this way. The reasons have been summarized and include: (1) the sessions were not held to the topic content designed for the specific evening session, (2) specific participants continually monopolized the discussions, (3) participants did not feel they were benefiting from the content, (4) too much

attention was paid to personal, individual matters as opposed to general matters, and (5) participants wished for information more relevant to the age of their child.

When asked to comment on the most significant and helpful aspects of the Parenting Group Component, two participants (16%) indicated that nothing at all was significant or helpful. Ten (83%) of the participants commented on the most significant and helpful aspects of the Component. In general, these aspects include: (1) those sessions which discussed the age categories in which their children are a part, (2) the discussion/communication aspect which allowed participants to share ideas and concerns with other parents who are experiencing similar difficulties, (3) the discussion aspect at which time child behavior management techniques were sometimes addressed, and (4) the movies as a teaching aide.

Finally, in commenting on how they wished to see the Parenting Group Component improved, one participant (8%), indicated that there should be no improvement made in the Parenting Group Component as it was useful in its present form. Other participants indicated areas in which they wished to see improvement. These have been summarized and include: (1) including more child behavior management

techniques, (2) emphasize the age categories of children whose parents are participants, (3) include more observation and interaction time between parents and their children, and (4) hold more closely to the topic matter outlined for the specific evening session.

SOCIODEMOGRAPHIC VARIABLES

The sociodemographic data collected in this study was based on the sociodemographic variables currently identified in the literature which have been recognized as contributing to the risk or incident of child maltreatment. Using the Pearson product-moment correlation coefficient, seventeen sociodemographic variables were correlated with the participants' scores on three of the four measures of the dependent variables: the Inventory of Attitudes on Family Life and Children, the Child Development Questionnaire and the Provision of Social Relations scale. These findings are reported in Table 5.3.

Age of the Participant

The first sociodemographic variable selected to determine the level of association with the dependent variables was a ratio-level variable which denoted the age of the

TABLE 5.3

Pearson Product-Moment Correlations between Sociodemographic Variables and Three Dependent Variables
(N = 13)

Sociodemographic Variables	Attitudes Towards Child-Rearing	Knowledge of Child Development	Percetions of Social Support
1. Age of Participant	-.31	-.22	-.26
2. Gender of Participant	-.16	-.17	.40
3. Marital Status	-.16	.09	.09
4. Educational Level	-.43	.05	.62[1]
5. Employment Status	.83[3]	.24	-.43
6. Financial Difficulty	.20	.23	.39
7. No. of Children Living at Home	-.49[1]	.19	.15
8. Age of Child #1	-.50[1]	-.24	-.08
9. Age of Child #2	.11	-.66	-.76[1]
10. Gender of Child #1	-.47	-.26	-.23
11. Gender of Child #2	.00	.00	.00
12. Visits with Relatives	.23	-.15	.16
13. Visits with Friends	.04	.25	.23
14. Visits with Neighbors	-.12	.48[1]	.69[3]
15. Social Community Involvement	-.02	-.31	-.18
16. Child/Parent Separation	-.38	-.21	-.40
17. Attendance	-.54[2]	-.37	.04

[1] $p < .10$; [2] $p < .05$; [3] $p < .01$

participant at the onset of the program.

As can be seen from Table 5.3, weak, negative associations were found between the age of the participant and their attitudes towards child-rearing, knowledge of child development and perceptions of social support. In other words, as age increased participants' attitudes towards child-rearing became more positive, their knowledge of child development improved, and their perceptions of social support were expanded.

Gender of the Participant

The second sociodemographic variable selected to determine the level of association with the dependent variables was the gender of the participant. A dichotomous variable was created for participant's gender which involved assigning a value of 0 to those participants who were male and a value of 1 to those participants who were female.

As can be seen from Table 5.3, weak, negative associations were found between the participants' gender and their attitudes towards child-rearing and knowledge of child development. This indicates that female participants' had more positive attitudes towards child-rearing and a broader

knowledge of child development than did male participants. A weak, positive correlation was found between the gender of the participant and their perceptions of social support. In other words, female participants perceived themselves to be more socially isolated than did male participants. These associations, however, were not statistically significant.

Marital Status

The third sociodemographic variable selected to determine the level of association with the dependent variables was the marital status of the participant. A dichotomous variable was created for marital status which involved assigning a value of 1 to those participants who were single and a value of 2 to to those participants who were legally married or living in a common-law arrangement.

As can be seen from Table 5.3, a weak, negative association was found between marital status and participants' attitudes toward child-rearing. Couples, therefore, tended to have more positive attitudes towards child-rearing. Weak, positive associations were found between participants' marital status and both their knowledge of child development and perceptions of social support. Single people tended to have less knowledge of child development and perceived them-

selves to be more socially isolated. These associations, however, were not statistically significant.

Educational Level

The fourth sociodemographic variable selected to determine the level of association with the dependent variables was the educational level of the participants. Dummy variables were created which involved assigning a value of 1 to those participants who had not achieved a grade twelve education, a value of 2 to those participants who had completed grade 12, and a value of 3 to those participants who had attended a post-secondary educational institute for at least one year.

As can be seen from Table 5.3, a weak, negative association was found between the educational level of the participants and their attitudes towards child-rearing. Higher levels of educational achievement reflected more positive attitudes towards child-rearing. A weak, positive association was found between the participants' educational level and their knowledge of child development indicating that participants with higher educational achievement knew less about child development. The above findings, however, were not statistically significant. A positive association

was found between the participants' educational level and their perceptions of social support (r = .62, p < .10). In other words, higher educational achievement reflected increased perceptions of social isolation.

Employment Status

The fifth sociodemographic variable selected to determine the level of association between the dependent variables was the employment status of group participants. Dummy variables were created which involved assigning a value of 1 to those participants who were employed, a value of 2 to those participants who were unemployed and a value of 3 to those participants who were students.

As can be seen from Table 5.3, a strong, positive association was found between the participants' employment status and their attitudes towards child-rearing (r = .83, p < .01). Therefore, being employed reflects more positive attitudes towards child-rearing. A weak, positive association was found between employment status and knowledge of child development, and a weak, negative association between employment status and participant's perceptions of social support. Thus, being employed reflects more knowledge of child development and increased perceptions of social

support. These two associations were not statistically significant.

Financial Difficulty

The sixth sociodemographic variable selected to determine the level of association between the dependent variables was a nominal-level variable which denoted the participant's perception of their financial circumstances. A value of 0 was assigned to those participants who did not perceive themselves to be experiencing financial difficulty and a value of 1 was assigned to those participants who perceived themselves to be experiencing difficulty.

As can be seen in Table 5.3, weak, positive associations were found between the participants' perceptions of financial difficulty and measures of the dependent variables. This indicates that those participants who were experiencing financial difficulty had more negative attitudes towards child-rearing, less knowledge of child development, and perceived themselves to be more socially isolated. These associations, however, were not statistically significant.

Number of Children Living at Home

The seventh sociodemographic variable selected to determine the level of association between the dependent variables was a ratio-level variable denoting the number of children living at home at the onset of the Parenting Group Component sessions.

As can be seen in Table 5.3, a negative association was found between the number of children living at home and the participants' attitudes towards child-rearing (r = -.46, p < .10). Therefore, the greater the number of children living at home, the more positive the participant attitudes towards child-rearing. Weak, positive associations were found between the number of children living at home and both the participants' knowledge of child development and their perceptions of social support. Thus, the greater the number of children living at home, the less participants know about child development; and the greater the number of children living at home, the less social support participants perceive. These findings, however, were not statistically significant.

Age of Child Number One

The eighth sociodemographic variable selected to determine the level of association between the dependent variables was a ratio-level variable denoting the age of the eldest child in living at the home of the participant at the onset of the Parenting Group Component sessions.

As can be seen from Table 5.3, a negative association was found between the age of Child Number One and the participants' attitudes towards child-rearing ($r = -.50$, $p < .10$). Therefore, as the first child becomes older, attitudes towards child-rearing improve. Weak, negative correlations were found between the age of Child Number One, and both participants' knowledge of child development and perceptions of social support. Thus, as the first child becomes older, knowledge of child development improves and participants' perceive themselves to have more social support. Both of these findings were not statistically significant.

Age of Child Number Two

The ninth sociodemographic variable selected to determine the level of association between the dependent variables a ratio-level variable denoting the age of the

youngest child living in the home of the participant at the onset of the Parenting Group Component sessions.

As can be seen from Table 5.3, a weak, positive association was found between the age of Child Number Two and the participants' attitudes towards child-rearing. As the age of the second child increases, attitudes toward child-rearing become more negative. A weak, negative association was found between the age of Child Number Two and participants' knowledge about child development. As the second child becomes older, knowledge of child development improves. Both of these findings were not statistically significant. A strong, negative association was found between the age of Child Number Two, and the participants' perceptions of social support ($r = -.76$, $p < .10$). This indicates that as the second child becomes older, participants' perceive themselves to have more social support.

Gender of Child Number One

The tenth sociodemographic variable selected to determine the level of association between the dependent variables was a nominal-level variable denoting the gender of the eldest child living at home at the onset of the parent-

ing group sessions. Dummy variables were created which involved assigning a value of 0 to male children and a value of 1 to female children.

As can be seen from Table 5.3, weak, negative associations were found between the gender of Child Number One and the measures of the dependent variables. A first child who was female reflected a more positive attitude towards child-rearing, increased knowledge of child development and increased perception of social support. None of the associations were statistically significant.

Gender of Child Number Two

The eleventh sociodemographic variable selected to determine the association between the dependent variables was a nominal-level variable denoting the gender of the youngest child living at home at the onset of the Parenting Group Component. Dummy variables were created and were assigned the same values as in the previous section.

The gender of Child Number Two was, coincidentally, all males in this sample of participants. Therefore, there was no association between the gender of Child Number Two and the dependent variables.

Visits with Relatives

The twelfth sociodemographic variable selected to determine the level of association with the dependent variable was an ordinal-level variable denoting the number of visits the participants experienced with immediate relatives. Dummy variables were created which involved assigning a value of 1 to those participants who experienced less than one visit per month, a value of 2 to those participants who experienced one visit per month, and a value of 3 to those participants who experienced at least one visit per week with immediate relatives.

As can be seen from Table 5.3, weak, positive associations were found between the number of visits with relatives and both attitudes towards child-rearing and perceptions of social support. Therefore, as the number of relative contacts increased, participants' attitudes towards child-rearing and perceptions of social support became more negative. A weak, negative association was found between the number of visits with relatives and participants' knowledge of child development indicating that as contact with relatives increased, knowledge of child development improved. These associations were not statistically

significant.

Visits with Friends

The thirteenth sociodemographic variable selected to determine the level of association with the dependent variable is similar to the variable discussed above (visits with relatives). It is a ratio-level variable denoting the number of visits participants experienced with their friends. Friends are considered to be persons with whom the participant feels comfortable with, attached to, and supported by. The values assigned to the dummy variables were identical to those discussed above; that is, a value of 1 to those participants who experienced less than one visit per month, a value of 2 to those participants who experienced one visit a month, and a value of 3 to those participants who experienced at least one visit per week with friends.

As can be seen from Table 5.3, weak, positive associations were found between the participants' visits with friends and measures of the dependent variables. Thus, as contact with friends increased, participants' attitudes toward child-rearing became more negative, knowledge of child development decreased and perceptions of social support decreased. These associations were not statistically

significant.

Visits with Neighbors

The fourteenth sociodemographic variable selected to determine the level of association between the dependent variables was the number of visits participants experienced with neighbors. Neighbors are considered to be persons who live near the participants but who are not considered, by the participants, to be friends (as defined in the previous section). Visits with neighbors was a ratio-level variable and values for the dummy variables were identical to those outlined in the previous two sections; that is, a value of 1 for those participants who experienced less than one visit per month, a value of 2 for those participants who experienced one visit per month, and a value of 3 for those participants who visit with their neighbors at least once per week.

As can be seen in Table 5.3, a weak, negative association was found between the number of visits participants experienced with neighbors and their attitudes towards child-rearing indicating that the greater number of contacts with friends, the more positive the participants' attitudes were towards child-rearing. This finding was not statistically

significant. Positive associations were found between the number of visits participants experienced with their neighbors and both their knowledge of child development (r = .48, p < .10), and their perceptions of social support (r = .69, p < .01). Thus, increased contacts with neighbors reflected less knowledge of child development and decreased perception of social support.

Social Community Involvement

The fifteen sociodemographic variable selected to determine the level of association between the dependent variables is a nominal-level variable denoting the participants' participation in social community activities. Community activities include social groups or self-help groups such as church, community associations, Parents Anonymous, and Alcoholics Anonymous. Dummy variables were created which involved assigning a value of 0 to those participants who were not involved in community activities and a value of 1 to those participants who were involved in community activities.

As can be seen from Table 5.3, weak, negative associations were found between the participants' involvement in community activities and measures of the dependent variable.

Therefore, greater community involvement reflected more positive attitudes towards child-rearing, more knowledge of child development, and increased perceptions of social support. These associations were not statistically significant.

Child Separation

The fifteenth variable selected to determine the level of association between the dependent variables was a nominal-level variable denoting whether or not the participants' child(ren) living at home at the onset of the Parenting Group Component sessions had been separated from them for longer than a week for either hospitalization, separation, divorce, or foster care. Dummy variables were created which involved assigning a variable of 0 to participants who had not been separated from their child(ren) for the above reasons, and a value of 1 to those participants who had been separated from their child(ren) for one or more of the above reasons.

As can be seen in Table 5.3, weak, negative associations were found between participants' separation from their child(ren) and measures of the dependent variable. Therefore, being separated from the child reflected more

positive attitudes towards child-rearing, more knowledge of child development, and increased perceptions of social support. None of these findings were statistically significant.

Attendance

The seventeenth, and final, sociodemographic variable selected to determine the level of association between the dependent variables was a ratio-level variable denoting the number of Parenting Group Component sessions each participant attended.

As can be seen from Table 5.3, a negative association was found between the number of group sessions participants attended and their attitudes towards child-rearing ($r = -.54$, $p < .05$). In other words, attending more sessions improved participants' attitudes towards child-rearing. A weak, negative association was found between the number of group sessions participants attended and their knowledge of child development indicating that attending more sessions improved participants' knowledge of child development. A weak positive association was found between attendance and participants' perceptions of social support indicating that attending more sessions decreased participants' perceptions

of social support. These findings were not statistically significant. Moreover, the association between those participants who attended more than half of the sessions (5 or more sessions), and those that attended less than half (less than 5 sessions) was not statistically significant.

SUMMARY

No significant differences were found between the participants' attitudes towards child-rearing, knowledge of child development, and perceptions of social support after introducing the Parenting Group Component. Participants achieved a successful mean score on the Child Safety Quiz which was used to measure their knowledge about how to protect young children from accidents.

The majority of participants found the group to be very helpful, and the material to be very clearly presented. As well, the majority noted that they were very satisfied with the overall Parenting Group Component, would recommend it to their friends, and would like some type of follow-up group session.

A summary of participants' suggestions was provided regarding the sufficiency of detail, the most helpful

aspects, and the ways to improve the Parenting Group Component.

Relationships were found to exist between selected sociodemographic variables and participants' attitudes towards child-rearing, knowledge of child development, and perceptions of social support. Some of these associations were statistically significant at various levels.

Chapter Six reviews this study and discusses the above findings in relation to the overall purpose of this project. Study limitations and future research considerations are also discussed.

Chapter 6

DISCUSSION AND SUMMARY

In light of the findings reported in Chapter Four, this chapter presents the results as they pertain to the overall purpose of the study. Six sections are included in this discussion: (1) a review of the study including the purpose and methodology, (2) a discussion of the dependent variables, (3) a discussion of the sociodemographic variables, (4) limitations of the study, (5) future considerations, and (6) a summary.

REVIEW

The purpose of this study was to evaluate the Parenting Group Component within the Child Abuse Program at Alberta Children's Hospital. The four Component objectives (dependent variables) were to: (1) change participants' attitudes towards child-rearing in the desired direction, (2) increase participants' knowledge about the developmental stages of children (birth to 6 years), (3) increase participants' perceptions of social support and, (4) increase participants' knowledge on how to protect young children from accidents.

One of the purposes of a program evaluation is to measure the degree to which a social program succeeds in reaching its predetermined objectives (Suchman, 1967). In order to determine the degree to which the Parenting Group Component successfully attained its predetermined objectives, six measures of the dependent variables were used. They included the: (1) Inventory of Attitudes on Family Life and Children, (2) Child Development Questionnaire, (3) Provision of Social Relations scale, (4) Child Safety Quiz, (5) Facilitator Feedback report, and 6) Parent's Evaluation of Parenting Class form. Both qualitative and quantitative data collection methods were utilized.

To determine program success, data was collected and analyzed in three ways. First, a one-group only pretest-posttest design was used to determine if significant differences existed between the participants' attitudes towards child-rearing, knowledge of child development, and perceptions of social support (dependent variables) after introducing the Parenting Group Component (independent variable). Statistics were generated using the student's *t*-test. Second, a posttest-only design was employed to determine the level of knowledge participants' achieved about how to protect young children from accidents and percent statistics were generated. Third, written reports and an evaluative

summary were utilized to determine both the facilitators' and participants' overall perceptions of the success of the Parenting Group Component. Summary reports and percent statistics were generated.

Also relevant in a program evaluation are the reasons why a particular social program fails or achieves success in meeting program objectives (Weiss, 1972a, 1972b). Sociodemographic data analysis provides important information regarding the client population, and may, in turn, suggest reasons why a program does or does not achieve it's desired objectives. The level of association between sociodemographic data and measures of the dependent variables reveals specific information particularly about the participants' suitability for the program, or the programs suitability for the participants. Therefore, sociodemographic data were correlated with three measures of the dependent variables. Statistics were generated using the Pearson product-moment correlation coefficient.

MEASURES OF THE DEPENDENT VARIABLES

Attitudes Towards Child-Rearing

The findings from the pretest-posttest analysis of this

dependent variable indicate that the participants in this Parenting Group Component did not significantly change their attitudes towards child-rearing. The use of this measurement alone suggests that the first objective of the Parenting Group Component -- to change participants' attitudes towards child-rearing -- was not achieved.

Knowledge of Child Development

Findings from the pretest-posttest analysis of this dependent variable indicate that the participants in this Parenting Group Component did not significantly improve their knowledge of child development. The use of this measurement alone suggests that Instrumental Objective One(a) -- to increase participants' knowledge of child development, birth to 6 years -- was not achieved.

Social Support

Results from the pretest-posttest analysis of this dependent variable indicate that the participants in this Parenting Group Component did not significantly expand their perceptions of social support. The use of this measurement alone suggests that the second objective of the Parenting Group Component -- to expand participant's perceptions of

their social support systems -- was not achieved.

Knowledge of Child Safety

The findings from the posttest measuring this dependent variable indicate that participants in this Parenting Group Component did receive a successful mean score on the Child Safety Quiz. The use of this measurement alone suggests that the third objective of the Parenting Group Component -- to increase participants' knowledge on how to protect young children from accidents -- was achieved.

Although the above findings indicate that only one of the four objectives of the Parenting Group Component was achieved, results from the two other measures of the dependent variables (the Facilitator Feedback Report and the Parent's Evaluation of Parenting Class form) cannot be discounted. These data indicated that the majority of participants found the Parenting Group Componet to be very helpful and very satisfying. As well, the group facilitators were satisfied with the Parenting Group Component. Discrepancies between the participant and facilitator reports, and the qualitative analysis implies that no firm conclusions can be drawn about the extent of objective achievement. Rather, this contradiction em-

phasizes that further evaluation is required in order to draw substantative conclusions regarding program effectiveness.

SOCIODEMOGRAPHIC VARIABLES

Significant associations were found between some of the sociodemographic variables and measures of the dependent variables. Rather than using these results to alter the existing program, these findings should be compared in future investigations to determine sociodemographic trends among participants. Identifying sociodemographic trends will provide future direction to the program designers by indicating the specific participant profiles most suited to the existing program. Conversely, aspects of the program may need to be altered to accommodate the needs of the client population. Therefore, future program modification and restructuring should take place based on the sociodemographic trends.

LIMITATIONS OF THE STUDY

Five limitations of this study have been identified. Design and implementation limitations have been alluded to in previous chapters but are discussed in further detail in

this section. Intervention, instrumentation, and sample limitations are also discussed in this section.

Design Limitations

This study would have been enhanced by employing a static group comparison design in order that internal validity effects could have been controlled. Due to time and administrative restrictions, the use of this design was not possible, and a one-group only pretest-posttest design was one design selected. Although all four of the dependent variables would have most appropriately been measured using a one-group pretest-posttest design, only three of the dependent variables were measured in this way. The other dependent variable was measured using a posttest-only design. This limitation could not be controlled for by the researcher as it was believed by Parenting Group Component facilitators that implementation of all measures of the dependent variable at one time (pretest and posttest) would be too burdensome and timely.

Implementation Limitations

Implementation of the measurement instruments was not completed on a consistent basis (e.g., personal interviews

versus group interviews and home interviews versus agency interviews). Although the degree to which this affected the respondents' responses is not known, inconsistent administration of the instruments questions the reliability of the study.

Intervention Limitations

A third limitation may have been in the intervention itself. First, due to various circumstances, not all facilitators were present during each session. This may have had various effects on intervention outcomes. Second, the films utilized in the Component were outdated. Although the content of the films, and the message to be gained from them may presently be accurate, many of participants commented that the outdated films distracted their learning. This too, may have had various effects on intervention outcomes. Finally, the participant observation and observation recording completed each session by this researcher indicated that the Weekly Overview of Activities outlined in Figure 3.2 was not rigidly followed. Thus, intervention outcomes may have been effected.

Instrumentation Limitations

The instruments utilized in this study were lengthy, and some of the participants indicated to the researcher that the questions were difficult to answer due to the clarity and vocabulary. Although the majority of the instruments were tested for reliability and validity as previously discussed in Chapter Four, this is noteworthy as the results may have been hampered by repondents' inability to understand the questions.

Subject Limitations

The final limitation of this study was the number of subjects present in the group available for use in this study (N = 13). The Parenting Group Component generally accepts 12-15 participants for any given group and therefore, group size could not be controlled for. For research purposes, a larger group size would reduce sampling error.

FUTURE CONSIDERATIONS

Given the above limitations, further research is required in order to determine the true effectiveness of the

Parenting Group Component. Results of this study should be utilized as a stepping-stone for future exploration. In doing so, several considerations should be viewed.

First, Gambrill (1983) suggests that one of the flaws of the present research on program effectiveness is that it lacks the use of control and comparison groups. Repeating this study would allow for comparisons to be generated between these results and results obtained in other groups thus, improving the reliability of the conclusions drawn. As well, utilizing a pretest-posttest control group design would better control for internal validity factors. Although a waiting list for subsequent groups was not established at the time this study was conducted, waiting lists are useful control groups.

It would be premature to alter the program objectives or activities based on the findings of this study alone. However, comparing these results with other Parenting Group Component results would guide the program administrators in identifying alternative objectives, or modifying the activities selected to achieve the present ones. In doing so, the present literature regarding program approaches must be considered.

Comments made by the participants on the Parent's Evaluation of Parenting Class must also be given consideration. These findings were summarized in Chapter Five and include both positive and negative suggestions from the parents regarding aspects of the Parenting Group Component. These findings should be considered in conjunction with comparison groups and, in turn utilized to modify or restructure the program.

SUMMARY

The purpose of this study was to evaluate the Parenting Group Component within the Child Abuse Program at the Alberta Children's Hospital. This evaluation found that only one of the four Parenting Group Component objectives was achieved although the group participants stated that the Component was both helpful and satisfying.

Results from this study provide a foundation for future analysis of the Parenting Group Component. Further research is required before substantative conclusions regarding program effectiveness can be made and, in turn, before program modification and restructuring can be implemented.

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APPENDIX A

PARENT PRE-GROUP INTAKE

PARENT PRE-GROUP INTAKE

NAME: _____ SPOUSE OR C/L: _____

ADDRESS: _____ ADDRESS: _____

TELEPHONE #: _____ TELEPHONE #: _____

AGE: _____ AGE: _____

SCHOOL GR. COMPLETED: _____ SCHOOL GR. COMPLETED: _____

OCCUPATION: YES NO OCCUPATION: YES NO
OCCUPATION: _____ OCCUPATION: _____

HOW DID YOU HEAR ABOUT THIS GROUP? _____

1. ATTENDANCE: Do you foresee any problems attending weekly group meetings? Yes No

2. Interest: Why are you interested in attending this group? _____
_____

3. Group Experience: Have you been involved in a group program or group learning before?
No _____
Yes _____ (when) _____
(where) _____
Are you nervous about speaking in a group?
Yes very A little Not at all

4. Support:
(1) Do you have any relatives in Calgary? Yes No
Do you see them once a month? Yes No
Do you see them once a week or more? Yes No

(2) Do you have friends in Calgary now? Yes No
Do you see them once a month? Yes No
Do you see them once a week or more? Yes No

(3) Do you have neighbors that you are friendly with? Yes No
Do you visit with them once a month? Yes No
Do you visit with them once a week or more? Yes No

5. Are you involved with any community organizations or groups such as Church, Parents Anonymous, A.A., etc.?
No _____
Yes (which ones)_____
_____
Do you attend once a month? Yes No
Do you attend once a week or more? Yes No

6. Do you have a family doctor?
No _____
Yes (name) _____
Can you talk to him/her about personal problems? Yes No

7. Are you involved with any other community services right now? Yes No
_____Day Care
_____Counselor
_____Community Health Nurse
_____Social Services (worker)

8. Please give the names and birthdates of all your children.
_____ _____
_____ _____
_____ _____

9. Which, if any, of your children might be involved in our nursery?

Name	Age	Any particular fears, dislikes	Favorite Activity	Food Allergies

10. Have any of your children been separated from you through hospitalization, divorce or foster care?
No _____
Yes (which children, when, and for how long?)
_____

11. Any financial problems? Yes No

12. How alone do you feel most of the time?

Please tell us by making a circle around the number that best shows how you feel.

1	2	3	4	5
very much alone	alone some of the time	there is at least one person I can depend on	close to some people	very close to several people

Name of Child:

Choose one behavior for each child that you are bringing to our nursery that you would like to change:

_____
(1)_____
(2)_____
(3)_____

_____
(1)_____
(2)_____
(3)_____

_____
(1)_____
(2)_____
(3)_____

APPENDIX B

CONSENT FORM

INPATIENT AND AMBULATORY CARE CONSENT FORM

AGREEMENT

THE PURPOSE OF THIS AGREEMENT IS TO:

1) Provide a record of your consent to diagnostic and/or treatment procedures that you and your child will be receiving as a result of admission to Alberta Children's Hospital.
2) Ensure that diagnostic and/or treatment procedures have been explained to both you and your child before actual diagnosis and/or treatment begins.

Please ask any specific questions that you may have regarding the nature of diagnosis and/or treatment or any sections of this form before signing it. You may withdraw or amend your agreement to diagnosis and/or treatment at any time; however, the Hospital urges you to discuss with it, the problems that might lead to such a withdrawal before you take action.

In consideration of the admission and/or treatment by Alberta Children's Provincial General Hospital of

_____
(NAME OF PATIENT)

AS A PATIENT I(WE) THE UNDERSIGNED DO HEREBY AGREE AS FOLLOWS:

PERMISSION FOR DIAGNOSTIC PROCEDURES AND TREATMENTS

1. That I(We) the undersigned do hereby authorize and grant permission to the physician in charge of this case and/or other qualified treatment staff of Alberta Children's Provincial General Hospital to employ such technical procedures and/or treatments as he/they may consider necessary or advisable in the diagnosis and/or treatmnent of this case. I **also understand that any significant changes to the initial approach to the patient's condition will be communicated to me by the appropriate staff.**

   Because of the nature of certain procedures that may be necessary for the proper diagnosis and/or treatment of the patient, additional consent will be sought. Full information on these procedures will be given at the time agreement is sought.

PAYMENT GUARANTEE

2. That I(We) the undersigned do hereby assume responsibility for all hospital charges incurred by or on account of the above named patient in Alberta Children's Provincial General Hospital. These costs would include the standard admission fee charged by all Alberta hospitals, as well as those costs not covered by either the Provincial Medical and Hospital Insurance Plan or my own insurance coverage.

LOSS OF VALUABLES

3. That I(We) the undersigned do hereby understand and agree that Alberta Children's Provincial General Hospital shall not be held responsible for loss of personal belongings or valuables of the above-named patient. The hospital agrees to act in a normally responsible manner in order to minimize the possibility of such loss.

PHOTOGRAPHY

4. That I(We) authorize the Alberta Children's Provincial General Hospital to photograph the above-named patient for: a) internal identification purposes, b) scientific or medical purposes.

DENTAL

5. That I(We) grant permission to the Alberta Children's Provincial General Hospital to perform any necessary dental inspection of the above-named patient.

EXCLUSIONS

6. That I(We) **DO NOT** authorize the following items that relate to Sections 4 or 5 above:

   _____

   _____

I(WE) THE UNDERSIGNED UNDERSTAND THE FIRST FIVE SECTIONS. I(WE) HAVE INCLUDED IN SECTION 6 ANY SPECIFIC EXCLUSIONS THAT I(WE) WISH AND THIS AGREEMENT SHALL BE BINDING UPON ME.

DATED AT THE CITY OF CALGARY, ALBERTA, THIS_____ DAY OF_____ 19____ A.D.

_____ _____
(SIGNATURE OF HOSPITAL STAFF) (SIGNATURE OF PARENT/GUARDIAN/PATIENT)

A GENERAL EXPLANATION OF THE NATURE AND EFFECT OF THE ANTICIPATED DIAGNOSTIC AND/OR TREATMENT PROCEDURES HAS BEEN EXPLAINED TO MY SATISFACTION BY

_____

_____ DATED THIS_____ DAY OF_____ 19____A.D.

_____
(SIGNATURE OF PARENT/GUARDIAN/PATIENT)

I CONFIRM THAT I HAVE GIVEN A GENERAL EXPLANATION OF THE NATURE AND EFFECT OF THE ANTICIPATED DIAGNOSTIC AND/OR TREATMENT PROCEDURES TO THE SATISFACTION OF THE PERSON WHO SIGNED THE ABOVE CONSENT FORM.

DATED THIS_____ DAY OF_____ 19____A.D.

_____
(SIGNATURE OF PHYSICIAN/TREATMENT STAFF)

ACH 83 R10/80

APPENDIX C

LETTER OF INTENT

ALBERTA CHILDREN'S HOSPITAL
CHILD HEALTH CENTRE

1820 Richmond Rd. S.W.,
Calgary, Alberta, Canada T2T 5C7

(403) 229-7211

FAMILY RESOURCE PROGRAM

December 10, 1987

Dear Parents:

Welcome to our Parent Group to begin on January 13, 1988. The group will meet weekly for ten weeks.

TIMES:	6:00 - 8:00 each Wednesday Evening
PLACE:	Room 23B - Level 2 - Psychology Department Alberta Children's Hospital 1820 Richmond Road S.W., Calgary, Alberta
PURPOSE:	To provide information to assist you in parenting. Opportunity for discussion and sharing ideas and feelings.
GROUP LEADERS:	Doug McKeague, Betty Kornfeld & Margaret Dolan.

TENTATIVE AGENDA

January 13/88	Film: The Newborn A film and discussion on getting off to a good start with your child.
January 20/88	Film: Child - Part 2 A discussion of the first year of life.
January 27/88	Film: Child - Part 3 How to cope with a very busy toddler. Meet Child Life Worker - Kitty McNab.
February 03/88	Film: Child - Part 4 At 3-4 years children are developing their own personalities and begin to look outside the family.
February 10/88	Observe your own child in the Playroom. A Child Life Worker will join the group to discuss the importance of play in a child's life and to present ways in which we as parents can encourage appropriate play with our children.

February 17/88	Film: Child - Part 5 5-6 year old children need a different kind of learning and association with others.
February 24/88	Film or Parent Puzzle Discussion of how it feels to be a parent.
March 02/88	Film: Growing Up Safely A guide to help parents protect children from accidents from infancy to 10 years of age. Also a good review of all stages of development. Discussion of community resources.
March 09/88	Evaluation.
March 16/88	Film: Child Behaviour = You Discussion and evaluation of the Program. More observation and interaction with your own children in the Playroom.

COFFEE PARTY !!!

There is no charge for the group or for the Children's Play Program which is provided by Recreation/Child Life workers from the Children's Hospital.

As the Program runs in a series, it is very important that you attend each session. It has been our experience in the past that when we have regular attendance, the discussions and learning experience is of much more value to everyone. We hope that getting to know other parents in similar circumstances to yours will be an added bonus for you.

With the assistance of some graduate students, we are planning a special evaluation of this group to assist us in planning future groups that will be of the best possible benefit to new clients. In order to implement this, we ask your cooperation in meeting with one of our students, along with one of the group leaders, at the time of your pre-group interview. You will, at that time, be asked to complete some simple questionnaires and the total interview will take approximately one hour. We will also arrange for some feedback after the study is completed. If you wish to attend the group, please call Barbara at 229-7886 to arrange an appointment for your pre-group interview. The interview will be scheduled for January 5th and 6th between the hours of 9:00 a.m. and 4:00 p.m. Some alternate times will be available if absolutely necessary. Please complete the enclosed intake form and bring it with you at that time. We look forward to hearing from you.

Sincerely,

Betty Kornfeld

Betty Kornfeld, R.N.
Family Resource Program

APPENDIX D

INVENTORY OF ATTITUDES ON FAMILY LIFE AND CHILDREN

INVENTORY OF ATTITUDES ON FAMILY LIFE AND CHILDREN

Parental Attitude Research Instrument
(Glasser-Radin Revision, 1965)

Name: _____ Child: _____

Interviewer: _____ Date: _____

Read each of the statements below and circle the appropriate letter: "A" for "strongly agree", "a" for "mildly agree", "d" for "mildly disagree", and "D" for "strongly disagree".

A	a	d	D
strongly agree	mildly agree	mildly disagree	strongly disagree

There is no right or wrong answer. It is very important to answer according to you own opinion, and all questions must be answered. Many of the statements will seem alike, but all are necessary to show slight differences.

		Agree		Disagree	
1.	A child who is on the go all the time will most likely be happy.	A	a	d	D
2.	Children should be more considerate of their mothers since their mothers suffer so much for them.	A	a	d	D
3.	Children will get on any woman's nerves if she has to be with them all day.	A	a	d	D
4.	Sex is one of the greatest problems to be contended with in all children.	A	a	d	D
5.	Some children are just so bad they must be taught to fear adults for their own good.	A	a	d	D
6.	Children pester you with all their little upsets if you aren't careful from the first.	A	a	d	D
7.	Children would be happier and better behaved if parents would show and interest in their affairs.	A	a	d	D

8.	Children should never learn things outside the home which make them doubt their parents' ideas.	A	a	d	D
9.	Mothers very often feel that they can't stand their child a minute longer.	A	a	d	D
10.	Children are actually happier under strict training.	A	a	d	D
11.	The sooner a child learns to walk the better he is trained.	A	a	d	D
12.	Parents must earn the respect of children by the way they act.	A	a	d	D
13.	A child will be grateful later on for strict training.	A	a	d	D
14.	A mother should do her best to avoid any disappointment for her child.	A	a	d	D
15.	There is usually something wrong with a child who asks a lot of questions about sex.	A	a	d	D
16.	Parents should know better than to allow their children to be exposed to difficult situations.	A	a	d	D
17.	Children who are held to firm rules grow up to be the best adults.	A	a	d	D
18.	A good mother will find enough social life within the family.	A	a	d	D
19.	One of the worst things about taking care of the home is a woman feels that she can't get out.	A	a	d	D
20.	Mothers sacrifice almost all their own fun for their children.	A	a	d	D
21.	A child's ideas should be seriously considered in making family decisions.	A	a	d	D

22.	The trouble with giving attention to children's problems is they usually just make up a lot of stories to keep you interested.	A	a	d	D
23.	There is no good excuse for a child hitting another child.	A	a	d	D
24.	Most children are toilet trained by 15 months of age.	A	a	d	D
25.	Parents who are interested in hearing about their children's parties, dates, and fun help them grow up right.	A	a	d	D
26.	Most children should have more discipline.	A	a	d	D
27.	A mother has a right to know everything going on in her child's life because her child is a part of her.	A	a	d	D
28.	Having to be with the children all the time gives a woman the feeling that her wings have been clipped.	A	a	d	D
29.	When you do things together, children feel close to you and can talk easier.	A	a	d	D
30.	Few men realize that a mother needs some fun in life too.	A	a	d	D
31.	The child should not question the thinking of his parents.	A	a	d	D
32.	Strict discipline develops a fine character.	A	a	d	D
33.	A child soon learns that there is no greater wisdom than that of his parents.	A	a	d	D
34.	When a child is in trouble he ought to know he won't be punished for talking about it with his parents.	A	a	d	D
35.	A child should be taught to avoid fighting no matter what happens.	A	a	d	D

36. A mother should make it her business to know everything her children are thinking. A a d D

APPENDIX E

CHILD DEVELOPMENT QUESTIONNAIRE

CHILD DEVELOPMENT QUESTIONNAIRE

Listed below are descriptions of child behavior. Please read each item carefully and decide <u>at what age you think a child is most likely to first show</u> this ability. Although there is considerable variability among children and even within an individual child, we would like you to think of the average or most common age at which these behaviors appear consistently. For each item, please draw an "X" through the age range at which you think it generally occurs on the age scale below.

For example:

The child rides a tricycle.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

Please complete all items.

1. The child indicates what they want (e.g. food or drink) with one specific word.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

2. The child does up and undoes buttons.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

3. The child shows a preference for using either their right or left hand.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

4. The child drinks from a cup with help.

0-6 mons.	6-12 mons.	12-18 mons.	12-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

5. The child prints their first name.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

6. The child waves bye-bye.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

7. The child walks up stairs without assistance.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

8. The child cuts with scissors.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

9. The child follows objects with their eyes.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

10. The child feeds themselves a cracker.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

11. The child tells their age when asked.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

12. The child raises themselves to a crawling position.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

13. The child knows right from left.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

14. The child stays dry all night.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

15. The child eats solid food.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

16. The child sits without support.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

17. The child rolls over when lying on their back or stomach.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

18. The child feeds themselves with a spoon.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

19. The child walks without holding on.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

20. The child plays patty-cake.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

21. The child uses a knife to cut their meat.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

22. The child ties shoelaces.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

23. The child catches a ball bounced to them.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

24. The child puts their shoes on the correct feet.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

25. The child understands times of day (e.g. morning or evening).

0-6 mons. | 6-12 mons. | 12-18 mons. | 18-24 mons. | 2-3 yrs. | 3-4 yrs. | 4-5 yrs. | 5-6 yrs. | 6-7 yrs. | 7-8 yrs.

26. The child goes about the neighborhood on their own.

0-6 mons. | 6-12 mons. | 12-18 mons. | 18-24 mons. | 2-3 yrs. | 3-4 yrs. | 4-5 yrs. | 5-6 yrs. | 6-7 yrs. | 7-8 yrs.

27. The child understands whether they are a boy or a girl.

0-6 mons. | 6-12 mons. | 12-18 mons. | 18-24 mons. | 2-3 yrs. | 3-4 yrs. | 4-5 yrs. | 5-6 yrs. | 6-7 yrs. | 7-8 yrs.

28. The child correctly names pennies, nickels, dimes, etc.

0-6 mons. | 6-12 mons. | 12-18 mons. | 18-24 mons. | 2-3 yrs. | 3-4 yrs. | 4-5 yrs. | 5-6 yrs. | 6-7 yrs. | 7-8 yrs.

29. The child unwraps gum or candy before eating it.

0-6 mons. | 6-12 mons. | 12-18 mons. | 18-24 mons. | 2-3 yrs. | 3-4 yrs. | 4-5 yrs. | 5-6 yrs. | 6-7 yrs. | 7-8 yrs.

30. The child separates from their mother without a fuss.

0-6 mons. | 6-12 mons. | 12-18 mons. | 18-24 mons. | 2-3 yrs. | 3-4 yrs. | 4-5 yrs. | 5-6 yrs. | 6-7 yrs. | 7-8 yrs.

31. The child tells jokes or riddles.

0-6 mons. | 6-12 mons. | 12-18 mons. | 18-24 mons. | 2-3 yrs. | 3-4 yrs. | 4-5 yrs. | 5-6 yrs. | 6-7 yrs. | 7-8 yrs.

32. The child names the days of the week.

0-6 mons. | 6-12 mons. | 12-18 mons. | 18-24 mons. | 2-3 yrs. | 3-4 yrs. | 4-5 yrs. | 5-6 yrs. | 6-7 yrs. | 7-8 yrs.

33. The child follows simple instructions.

0-6 mons. | 6-12 mons. | 12-18 mons. | 18-24 mons. | 2-3 yrs. | 3-4 yrs. | 4-5 yrs. | 5-6 yrs. | 6-7 yrs. | 7-8 yrs.

34. The child asks to go to the toilet.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

35. The child uses utensils or tools in the way for which they were intended (e.g. cooking or construction).

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

36. The child hops on one foot.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

37. The child rides a bicycle.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

38. The child sleeps through the night without waking.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

39. The child correctly names colors.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

40. The child gives their full name when asked.

0-6 mons.	6-12 mons.	12-18 mons.	18-24 mons.	2-3 yrs.	3-4 yrs.	4-5 yrs.	5-6 yrs.	6-7 yrs.	7-8 yrs.

APPENDIX F

PROVISION OF SOCIAL RELATIONS SCALE

PROVISION OF SOCIAL RELATIONS

We would like to know something about your relationships with other people. Please read each statement below and decide how well the statement describes you. For each statement, show your answer by indicating to the left of the item the number that best describes how you feel. The numbers represent the following answers.

1 = Very much like me
2 = Much like me
3 = Somewhat like me
4 = Not very much like me
5 = Not at all like me

____ 1. When I'm with my friends, I feel completely able to relax and be myself.

____ 2. I share the same approach to life that many of my friends do.

____ 3. People who know me trust me and respect me.

____ 4. No matter what happens, I now that my family will always be there for me should I need them.

____ 5. When I want to go out and do things I know that many of my friends would enjoy doing these things with me.

____ 6. I have at least one friend that I could tell anything to.

____ 7. Sometimes I'm not sure if I can completely rely on my family.

____ 8. People who know me think that I am good at what I do.

____ 9. I feel very close to some of my friends.

____ 10. People in my family have confidence in me.

____ 11. My family lets me know they think I am a worthwhile person.

_____ 12. People in my family provide me with help in finding solutions to my problems.

_____ 13. My friends would take the time to talk over my problems, should I ever want to.

_____ 14. I know my family will always be there for me.

_____ 15. Even when I am with my friends I feel alone.

APPENDIX G

CHILD SAFETY QUIZ

CHILD SAFETY QUIZ

For each of the following questions, please indicate the best answer by circling the appropriate letter. There is only one correct answer to each of the questions. Please answer all of the questions.

1. Which of the following describes a danger common to babies in the first year of life?

   a. choking
   b. suffocating
   c. falling
   d. all of the above are common dangers to babies

2. Which of the following describes a danger common to toddlers?

   a. burns
   b. falls
   c. choking
   d. all of the above are common danger to toddlers

3. What is the first thing you do if you think your child has swallowed something poisonous?

   a. wash your child's mouth out with water
   b. make your child throw up
   c. call the doctor immediately and follow the doctor's orders
   d. make your child drink lots of fluids

4. Which of the following numbers would you dial in case of an emergency?

   a. 911
   b. 711
   c. 511
   d. 411

5. At what age is it safe to leave a child at home alone?

   a. birth to six months
   b. six months to two years
   c. two years to six years
   d. none of the above

APPENDIX H

FACILITATOR FEEDBACK REPORT

REFERRAL SOURCE (Name, Number)	I.P. NAME
PRIMARY WORKER (Name, Number)	D.O.B. A.C.H.
PLEASE [✓] WHEN COMPLETE	GROUP A.M. P.M. DATES

	Pre Group Intake Form	Leaders
	C.A.P. Intake Form	Mother's Name
	Consent for Rx and Release	Mother's Address
	Client Evaluation	Mother's Age, Education, Occupation
	Therapist Evaluation	Father's Age, Education, Occupation
	Follow-Up Letter to Referral Source	Is Partner Attending Group Yes No

PARENT TARGET BEHAVIOURS:

THERAPISTS OVERALL IMPRESSIONS:

PROGRESS RECORD

DATE	SESSION		ATTENDANCE	GOALS OF SESSION	PARENT INVOLVEMENT	ADDITIONAL COMMENTS Note: MAJOR CHANGES EVENTS	CHILDREN'S BEHAVIOR IN GROUP	
	1.		Newborn Age					
	2.		First Year of Life					
	3.		Toddler Years					
	4.		Pre School					
	5.		Play					
	6.		Age 5-6					
	7.		How does it feel? Parents					
	8.		Safety Com. Re-sources					
	9.		Child Behavior You Eval.					

APPENDIX I

PARENT'S EVALUATION OF PARENTING CLASS

PARENT'S EVALUATION OF PARENTING CLASS

1. Can you tell us <u>how helpful</u> you found the content? Please circle the number below to show how you feel about it.

1	2	3	4	5
Not at all helpful	A little helpful	somewhat helpful	very helpful	extremely helpful

2. Was there sufficient detail? Please comment.

3. Can you tell us <u>how clearly</u> the material was presented? Please circle the number below to show how you feel about it.

1	2	3	4	5
not at all clearly	a little clearly	somewhat clearly	very clearly	extremely clearly

4. Please indicate what you found most significant and helpful.

5. How would you like to see the parents' classes improved?

6. Would you like to see a follow up program to this series?

7. Overall, how would you describe how satisfied you have been with the Parenting classes? Please circle one number below.

1	2	3	4	5
not at all satisfied	a little satisfied	somewhat satisfied	very satisfied	extremely satisfied

8. Would you recommend these classes to any of your friends?

APPENDIX J

ETHICAL APPROVAL
FACULTY OF SOCIAL WELFARE

M E M O R A N D U M

Faculty of Social Welfare

The University of Calgary

TO: Lynn McDonald

FROM: Richard M. Grinnell, Jr.

RE: MacDougall and Stothers Proposal

DATE: December 15, 1987

This memo is to confirm that the above two students' proposal (The Parenting Group Component within the Child Abuse Program at the Alberta Children's Hospital) has my approval in reference to ethics. Thus, on behalf of the Faculty's Ethics Committee, I am clearing this proposal for implementation.

If you have any questions in reference to the above matter, please get in contact with me at your earliest convenience.

APPENDIX K

ETHICAL APPROVAL
CONJOINT AREA RESEARCH ETHICS COMMITTEE

THE UNIVERSITY OF CALGARY

INTER·OFFICE

TO: Ruanna MacDougall and Margaret Stothers ✓
Faculty of Social Welfare

FROM: Professor Eric Dodd, Chair
Conjoint Area Research Ethics Committee

DATE: 88/01/14

RE: "The Parenting Group Component Within the Child Abuse Program at the Alberta Children's Hospital."

All ethical concerns have been met by you and I am happy to enclose a copy of the signed institutional certificate. The original certificate has been forwarded to Mr. R. W. Martin, Research Services.

With all good wishes for your most interesting research.

Eric M Dodd

ED/bjp

Enclosure

cc: Mr. Bob Martin, Research Services

Dr. David Hoar, Chairman, Research Committee,
Alberta Children's Hospital, Geriatrics Dept.
1820 Richmond Road S.W.
Calgary, Alberta. T2T 5C7

CERTIFICATION OF INSTITUTIONAL ETHICS REVIEW

This is to certify that the Conjoint Areas Research Ethics Committee at the University of Calgary has examined and approved the research proposal.

by: (Applicant) Ruanna MacDougall and Margaret Stothers

of the Department of: Faculty of Social Welfare

to: (Agency) _____

entitled: "The Parenting Group Component Within the Child Abuse Program at the Alberta Children's Hospital."

(the above information to be completed by the applicant)

Date: Jan 14 / 88 Chair, Ethics Committee Eric M. Todd

APPENDIX L

ETHICAL APPROVAL
ALBERTA CHILDREN'S HOSPITAL RESEARCH COMMITTEE

ALBERTA CHILDREN'S HOSPITAL
CHILD HEALTH CENTRE

1820 Richmond Rd. S.W.,
Calgary, Alberta, Canada T2T 5C7

(403) 229-7211

March 11, 1988

Ms. Ruanna MacDougall
Faculty of Social Welfare
University of Calgary

Dear Ms. MacDougall:

Re: Project 87-27 Parenting Group Component

Please excuse the administrative lapse in not informing you of the present status of the above project with respect to the ACH Research Committee:

I have reviewed the appropriate letter of support and hence the interim approval can be lifted and an official approval granted. I hope this has not been an inconvenience and that your work has been proceeding as expected.

Sincerely,

David I. Hoar, Ph.D.
Chairman
Alberta Children's Hospital
Research Committee Meeting

DIH:sem