

FINAL OUTCOMES REPORT

*An evaluation of Caring Families:
A holistic approach for treating families in conflict
EG1201*



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Domestic Violence Prevention Services

September 30, 2010

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EXECUTIVE SUMMARY

Nova Vita Domestic Violence Prevention Services offers individual and group counselling to victims, perpetrators and children impacted by domestic abuse. One issue identified by our clients was the need for programming for parents who share the caretaking responsibilities of their children and struggle with increasing domestic conflict. To address this client need we created the *Caring Families* Program.

The *Caring Families Program* is a 16 week psycho-educational group treatment program for mothers, fathers and their children. The goal of this program is to prevent escalating domestic conflict by building respectful, empathetic parent communication and to support appropriate child centered parenting practices. The desired outcomes for this program are to reduce parental conflict, improve parental relationships at an earlier point in domestic conflict and improve a child's well-being by mitigating a child's exposure to parental hostility.

We have tried to assess program value to the different stakeholders, but did not have the resources to conduct a formal evaluation. Meanwhile, social service agencies referring clients to *Caring Families* have been very positive about its content and outcomes; parents participating in the groups have been very enthusiastic about their involvement; and program facilitators reported positive experiences of working in the program. With the help of the Provincial Centre of Excellence at the Children's Hospital of Eastern Ontario (CHEO) we created an evaluation framework which we partially implemented in this study.

Our overall purpose for creating an evaluation framework (Appendix A) was to eventually evaluate specific client outcomes as well as program process as experienced by community partners, clients as well as group facilitators. In this study, we limited our evaluation areas to one outcome measure for the children and two outcome measures for the parents. We were interested in finding out if after participating in our program; children would experience an increased sense of self efficacy. So our question was "Do children experience an increased self

efficacy by the completion of the program?” For the parents we wanted to find out if participation in our program produced positive changes in their co-parenting relationship. To assess any changes in this area we identified two questions: 1. to what extent do parents increase their child-centered, age-appropriate parenting skills? 2. to what extent do parents improve their attitudes toward each other?

We conducted an extensive literature review to educate ourselves about programs that are similar to the *Caring Families* program. For the purpose of this study we identified three evaluation tools to measure children and parents outcomes. To measure changes in the children’s self efficacy we used the “Multidimensional Scales of Perceived Self Efficacy” by Bandura (1990). From the nine domains of the original scale we chose four domains that we believed to be pertinent to the content of our children’s program. These domains are: “Enlisting Social Resources”, “Meet others’ Expectations”, “Self-Assertive Efficacy” and “Enlisting Parental and Community Support”. To assess change in the parents’ self efficacy regarding their parenting abilities we used the TOPSE (Tool to Measure Parenting Self Efficacy). To measure changes in beliefs about intimate relationships we used the “Inventory of Specific Relationship Standards”. Based on consultation with the author we chose to only use “Part one” of the Inventory and to focus on the two dimensions of “Control” and “Boundaries”.

A total of 34 parents and 15 children participated in the study during the 2009-10 Fall/Winter session of the *Caring Families* program. The data was collected at three points in time. Pre-program data was collected during the intake interview; post program data was collected at the last group session and follow up data was collected three months after the end of the program.

Surprisingly, as a group, children’s perceived self efficacy scores decreased at the post group in the domains of “Enlisting Social Resources” and “Meet Others’ Expectations” and “Enlisting Parental and Community Support” but increased in the domain of “Self

Assertiveness". At the follow up scores increased in all domains except in the domain of "Enlisting Parental and Community Support". Parenting self-efficacy increased at the end of the program for five out of the eight scales. These included emotion, empathy, pressures, self acceptance and learning. At the follow up we saw an unexpected decrease in the scales of emotion, empathy, control, pressures and self acceptance scales. Parents' attitudes toward relationships as it was reflected in the ISRS scores indicated a decrease in both boundaries and control subscales at the post program but an increase in both subscales at the follow up.

Improvements in different areas of children's self efficacy at follow-up can be a sign of improved parental relationships and children's feelings regarding their family situation. Positive changes in parent's self efficacy and improvements in relationship standards scores at post group, are encouraging. Though decreases in scores at follow-up validate the need for continued support and services for families experiencing severe parental conflicts.

More research is needed regarding the effectiveness of *Caring Families* as a treatment model for families experiencing domestic conflict. Changes in self efficacy can be seen as a first step to changing co-parenting dynamics to improve outcomes for children in these families. The next logical step would be to measure the changes in attitude towards the other parent and measure connections between changes in attitudes and changes in quality of the co-parenting relationship.

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Introduction

The Caring Families Program aims to offer a holistic approach to the treatment of families impacted by severe parental conflict. It is a 16-week educational/therapeutic parenting program for mothers, fathers and their children. It is a preventative model that addresses reducing domestic conflict at an earlier stage. The desired outcomes are to improve parental relationships by building respectful empathetic parent communication and to support parents developing appropriate child centered parenting practices. Outcomes for the children are to improve a child's self-efficacy and mitigate a child's exposure to parental hostility.

Program Structure: The program is divided into two 8-week segments. The first eight weeks are separate, concurrent mothers and fathers groups. The second 8- weeks continue the concurrent parent groups and the children attend concurrent age appropriate groups. The groups are two hours in length and are co-facilitated by two counsellors. Nova Vita trains the facilitators through our in-house training program. Group facilitators are given a complete program manual that consists of two sections; the children's curriculum and the parent's curriculum. Both sections include details of the program curriculum, the premise for the curriculum, agenda, purpose of the weekly session, questions to be asked, detailed instructions on how to facilitate the group for each weekly topic, therapeutic processes and all handouts and homework sheets. The manual is available on the "Shared File" folder on Nova Vita computer system and is accessible by all staff. New facilitators read the manual before the start of the first group session. The team meets prior to start of initial group session to discuss any concerns and to answer any questions that new facilitators have about group facilitation. Facilitators also meet as a larger group after weekly sessions to debrief and update program issues. Program facilitators are Nova Vita staff members in addition to staff recruited from Brant Children's Aid Society (CAS) to co-facilitate children's group.

Parent Groups: The educational component teaches empathy skills, child centered parenting, child development, the impact of severe parental conflict on children, the tools of conflict reduction, the use of discipline as opposed to punishment and the use of encouragement as a positive parenting tool. The therapeutic component explores parents' successes, notions of parenting based on family of origin experiences, current parenting practices, beliefs about co-parenting, and areas of recurring parental conflict. Parents use homework to practice co-parenting skills, develop safety plans to deal with their anger/upset at the other parent and/or the children and explore future parenting challenges.

Children's Groups: Children learn they are not responsible for parental conflict and how to keep themselves safe in the midst of severe conflict. The children are taught about bullying, how to connect to people who are safe, how to deal with their feelings concerning conflict, and address self-esteem issues. They learn how to confidently communicate their needs and how to respect themselves and others.

Program evaluation: For the purpose of the Pilot study we identified the following evaluation questions: Do children experience increased self efficacy? To what extent do parent(s) increase child-centered, age-appropriate parenting skills? To what extent do parent(s) improve their attitudes towards each other? Participants were parents who have either voluntarily accessed the program or been referred by another agency to take this program because of severe parental conflict. The sample pool consisted of 31 fathers, 26 mothers and 17 children who completed intake interviews. Families participating in the program lived in Brantford and surrounding area. Some parents were separated, others were divorced and others were still together. Families came into the program from different sources; CAS, Office of the Children's Lawyer, the court, self referrals and Nova Vita referrals. Nineteen fathers, 20 mothers and 15 children attended the program. Out of these attendees we had 19 males, 15 females and 14 children agree to participate in the study. We did not have a control group as it

is considered unethical to deny clients any services that can potentially be of help to them. We understand that this is a limitation.

Linkages were established due to the design of the Caring Families program and Nova Vita's working partnerships with our community organizations. Many CAS clients were referred to the program. In addition, CAS workers co-facilitate groups, giving them the opportunity to train in domestic violence and in the issues of children witnessing abusive parental relationships. This program collaborates also with local children's mental health treatment organizations such as; Contact Brant, Woodview Children's Centre and St Leonard's Community Services. These agencies, along with Office of the Children's Lawyer, support the program through referrals and the provision of staff facilitators. Probation & Parole services provided referrals and ongoing client support as some of the fathers and a few of the mothers were charged with perpetrating domestic violence. Other key stakeholders were kept informed of the evaluation process and the outcomes – our local Children's Services Committee at Contact Brant and at the Brant Network for Children and Youth (formerly CCYDS), with information shared at the committee and interagency level and informally between agency workers. We also share this information with the Board of Directors, staff, our clients, our community partners and Ministry funders. We prepared a report for our stakeholders and this information was included in our annual report for public consumption.

Literature Review

Interparental conflict can often lead to relationship disruption, family separation and poor parenting practises thus creating the potential for short term as well as long term adverse emotional and behavioural challenges in children (Carlson, 2000; Kitzmann, Gaylord, Holt, and Kenny, 2003). Furthermore, children who witnessed conflict and or violence between their parents have been found more likely to experience behavioural as well as emotional problems (Carlson, 2000). Interestingly, Kitzmann, Gaylord, Holt & Kenny, 2003 found that children who

were exposed to interparental violence as well as physical abuse did not show significantly worse outcomes than children exposed only to interparental violence, suggesting that violence anywhere in the family may be sufficient to disrupt child development.

Furthermore, Carlson (2000) pointed out that researchers have found that children and adolescents exposed to marital violence are more likely to normalize and approve the use of violence to resolve interpersonal conflicts. The content, frequency and duration of the discord have been found to play a significant role in determining the impact that parental conflict and violence have on children. Of special interest to us were findings regarding the content of parental conflict. Conflict that involved the children has been found to be more distressing to the children than other types of parental discord (Cited from Carlson, 2000). This information is pertinent to the premise of the *Caring Families* program where we educate the parents about the importance of leaving the children out of the conflict and not involving them in any way. The parents learn alternative methods to conflict resolution where the children do not have to be used as messengers, bargaining chips, confidants or therapists.

Interparental conflict within the context of domestic violence

When abuse is present in a relationship there will always be an imbalance in the power and control that each of the partners has in that relationship. The abuser attempts to maintain control by exerting power tactics in different areas of the relationship. It is important to think about how this imbalance can impact conflict dynamics. To understand interparental conflict, Goodman, Bonds, Sandler et al. (2004) proposed three main types of interparental conflict within the context of divorce and separation; legal conflict, interpersonal conflict and attitudinal conflict. In intimate partner abuse, interpersonal and attitudinal conflicts remain more salient and may at times lead to criminal charges. Goodman et al. noted that interpersonal conflict can include verbal disputes, physical violence, and badmouthing. Attitudinal conflict on the other hand refers to the parents' anger and hostility toward their ex-partner. This includes their

negative attitude toward their ex-partner in their parenting role. If one thinks about conflict on a continuum; one end of the continuum represents minimal resolvable conflict and the other represents severe irresolvable conflict. Partners who are in an abusive relationship are further along the continuum towards severity and inability to resolve conflict.

Several researchers reported that interpersonal conflict between parents negatively impacts children's emotional and cognitive functioning. This increases the risk of children developing externalizing as well as internalizing disorders (Davies & Cummings, 1994; Grych & Fincham, 2001). Even though research regarding the impact of attitudinal conflict on children is limited; there are ample reports regarding the impact of such conflict on the partner relationship. Foran and Smith Slep (2007) developed and tested a self report measure to detect unrealistic relationship expectations that are hypothesized to play a role in expressing anger and aggression towards the other partner. They hypothesized that the degree to which the expectations are unrealistic for the particular couple may increase the impact of the conflict on the couple. Foran and Smith, Slep found that focused perfectionism (unrealistic expectations) rather than other forms of general irrational beliefs differentiated aggressive from non aggressive partners. Therefore, we can conclude that negative attitude of the ex-partner can lead to toxic interaction patterns between the ex-partners which eventually can lead to interparental conflict that contributes to further maladjustment in children.

Baucom, Epstein, Rankin and Burnett (1996) set out to create an assessment tool to examine relationship standards for the three relationship dimensions of boundaries, control-power and investment and the role that they play in relationship functioning. The authors suggested that boundaries refer to the degree of independent functioning as opposed to sharing between partners. Minuchin (1974) suggested that if boundaries between partners are either too rigid or too diffuse, then there is potential for relationship dysfunction (Cited from Baucom et al). The second dimension refers to the amount of power-control that partners believe should be

exercised by each partner in the relationship. The third dimension involves the degree of investment in the relationship that each partner believes should be exhibited. The resulting tool was called the *Inventory of Specific Relationship Standards (ISRS)*.

Using the ISRS Baucom et al. (1996) reported that spouses' actual standards were significantly correlated with degree of marital adjustment. While the correlation was not strong, extreme standards and discrepancies between the two partners' standards were less highly related with marital adjustment. The authors noted that extreme standards did not mean that partners will have marital discord. The impact of the extremeness depended on whether the extreme standards were relationship focused or not. More specifically, relationship focused extreme standards were positively correlated with marital adjustment.

Differences in standards between spouses negatively correlated with marital adjustment. However, it is important to note that discrepancies in standards also do not always lead to problems between couples. Baucom and et al (1996) suggested that while couples can have standards for what their relationship should be like, in reality, they may behave differently, recognizing that their standards are unrealistic in their own relationship. On the other hand, inflexibility about standards can lead to conflict and distress in the relationship.

Holtzworth-Munroe and Stuart (1994) used a prepublication version of the ISRS and found no differences in relationship standards between maritally violent men and maritally non-violent men. However they reported that relative to men who are not distressed, distressed husbands endorsed more dysfunctional standards and assumptions in their relationships. Specifically, distressed husbands were less likely to believe that partners should share a great deal with one another and that only one spouse should make the decisions in a relationship.

While interparental conflict can happen between any couple, partners who are experiencing domestic violence are at a higher risk of experiencing violent interparental conflict. Based on the above discussion, it is reasonable to suggest that to successfully affect change in

interparental conflict where partner abuse is an issue, boundaries and power and control imbalances in the relationship need to be removed. When reviewing the literature on family conflict one might become discouraged by the many reports of negative outcomes, yet several researchers continue to identify protective factors that promote resilience and adaptive coping in both adults and children. Feinberg (2002) offered the perspective that a co-parenting relationship is an important and potentially modifiable influence on parenting and child outcomes, as well as a mediator of other factors such as marital conflict. Pedro-Caroll, Nakhnikian and Monte (2001) noted that timely interventions for people who are experiencing stressful life changes can provide important protective benefits.

Treatment and prevention programs can be either directed at parents or children. There are several theoretical approaches to intervention programs aimed at helping families of divorce and separation. Behavioural family interventions (BFI) focus on promoting a child's development and self esteem by changing dysfunctional parenting practices, interpersonal relationships and interaction patterns (parent-parent and parent-child) that are considered to be risk factors for the development of problem child behaviour (cited from Turner & Sanders, 2006). The curriculum of such programs usually utilizes active learning methods through role playing and real life practise with feedback from facilitators. On the other hand, non-behavioural programs focus on teaching the parents affective communication skills and target increasing parent responsiveness to and understanding of their children's developmental needs.

One of the most popular behavioural family intervention programs is the Triple P Positive Parenting Programs developed by Sanders in Australia. This program targets the parenting skills of parents of children who are at a high risk of developing emotional and behavioural problems. Typically, parents are taught to increase positive interactions with children and to reduce coercive and inconsistent parenting practices. The program is offered at the following levels: Enhanced BFI (EBFI), standard BFI (SBFI) and self-directed BFI (SDBFI). Families who

are least likely to benefit from BFI are those in which parenting problems are complicated by other forms of adversity, including low income, single parenthood status, marital conflict, parental mood disturbance, and high levels of stressful life events (Webster-Stratton & Hammond, 1990 cited from Sanders et al., 2000).

Furthermore, shelter based treatment for children who witnessed parental violence often focus on working with the mothers and the children but does not give consideration to the role that the father plays in the family dynamics. It is important to remember that marital conflict and relationship violence does not stop once the parents are separated. The parental conflict might look different after the separation but it will not necessarily stop. At Nova Vita we have observed that after separation parental conflict often revolves around co-parenting issues and the children find themselves caught in the middle. This often leads to the children believing that they are to blame for the conflict and creates feelings of guilt, sadness and confusion.

Accordingly programs geared towards parents have separated behavioural from non-behavioural approaches. They either utilized active learning methods through role playing and real life practise with feedback from facilitators or have focused on teaching the parents affective communication skills and targeted increasing parent responsiveness to and understanding of their children's developmental needs. Intervention programs that target children usually attempt to create a group environment that is supportive so children can share their experiences, create common bonds, clarify misconceptions, and learn skills that enhance their capacity to cope with the stressful changes resulting from family conflict (Pedro-Caroll, Nakhnikian and Monte, 2001).

Developing the capacity to cope with stressful and difficult situations is strongly related to self-efficacy. Self-efficacy refers to an individual's sense of competence regarding his or her ability to successfully execute a behaviour required to produce an outcome (Bandura, 1977). *The Caring Families program* combines behavioural and non-behavioural methods by teaching

program participants the skills needed for healthy conflict resolution and providing them with the information and resources needed to create healthy family interactions between parents, parents and children and siblings. This approach fills the gap present in treatment programs for families inflicted with violent parental conflict thus increasing the chance of healthy development and decreasing the chance of behavioural and emotional problems in children.

Methodology

A pre-test/post-test design was used with children's self efficacy and parent's self efficacy and attitude towards boundaries and control in a relationship as the outcome measures. The study was conducted in 2009/2010.

Participants

A convenience sample of parents and their children ages five to 16 who were attending the *Caring Families* program participated in the study. Participants were parents and their children who have either voluntarily accessed the program or been referred by another agency to take this program because of severe parental conflict. The sample pool consisted of 31 fathers, 26 mothers and 17 children who completed intake interviews. Families participating in the program lived in Brantford and surrounding area. Some parents were separated, others were divorced and others were still together. Families came into the program from different sources. Some families were recommended to attend by their CAS worker. Three families were referred by the Office of the Children's Lawyer, one family was ordered by the court and the rest came into the program voluntarily. Nineteen fathers, 20 mothers and 15 children attended the program. Out of these attendees we had 19 males, 15 females and 14 children agree to participate in the study. We did not have a control group as it is considered unethical to deny clients any services that can potentially be of help to them. We understand that this is a limitation that affects the internal validity of our study.

The research project was explained to the participants during the intake interview. An information sheet was provided to them outlining the research and its purpose (Appendix2). The participants signed a consent form during the intake if they agreed to participate. They completed the pre-test surveys at the completion of the intake. For child participants, we obtained the consent of both parents (Appendix C). Parents' intakes were completed in September and October 2009 and children's intakes were completed in December of 2009.

Tools

We used three measures in this study. *Multidimensional Scales of Perceived Self Efficacy (CPSE)*, *The Inventory of Specific Relationship Standards (ISRS)* and the *Tool to Measure Parenting Self Efficacy (TOPSE)*.

To measure changes in the children's self efficacy we initially considered using the Perceived Self Efficacy measure by Cowen et al (1991). Due to several challenges that we were not able to resolve and feedback from the Centre's review team we decided to utilize the "Multidimensional Scales of Perceived Self Efficacy" by Bandura (1990) instead. From the nine domains of the original scale we chose four domains that we believed are pertinent to the content of our children's program. These domains are: "Enlisting Social Resources", "Meet others' Expectations", "Self-Assertive Efficacy" and "Enlisting Parental and Community Support". Each domain had four items which the children had to rate by putting a circle around the star that best showed how well they feel they can do the things that were mentioned in each statement. The stars represented the following options: not well at all, not too well, well, very well and extremely well. When scoring the results we converted the ratings to numerical values ranging from 1 representing not well at all, to 5 representing extremely well; the higher the score the higher the level of a child's self efficacy. For younger children staff who was administering the questionnaire read the questions to the children and circled the answers as

the children chose the star. The wording of the scale was also modified to meet the comprehension and reading levels of the children participating in the study (Appendix D).

To measure changes in perceived parenting self efficacy, we used the TOPSE; a tool to measure parenting self efficacy (Appendix E). The TOPSE is a multi-dimensional instrument of 64 statements within 8 scales, each representing a distinct dimension of parenting: Emotion and affection, Play and enjoyment, Empathy and understanding, Control, Discipline and boundary setting, Pressure, Self-acceptance, Learning and knowledge. Each dimension has six statements that the parents had to rate on an 11-point Likert scale where 0 represents completely disagree and 10 represents completely agree. The scale contains positively and negatively worded items and the responses are summed to create a total score; the lower the score, the lower the level of parenting self-efficacy.

To measure changes in relationship standards we used the *Inventory of Specific Relationship Standards III (ISRS)* by Baucom et al. (1996). The Inventory is a 48 item measure that assesses couples' standards for marital relationships, that is, what they believe their own marital relationship should be like. With each of the 48 items on the ISRS, the respondent provides three pieces of information: (a) the individual's actual standard for how the marriage should be in terms of that item; (b) the respondent's statement of satisfaction with how that standard is currently being met in the relationship; and (c) the respondent's expression of how upset he or she becomes when that standard is not met. For the purpose of our study we used only the first part of the Inventory focusing on participants' relationship standards with regards to subscales of Boundaries and Control (Appendix F). Each subscale has 12 items to be rated by the respondent on a scale of one to five with 1 representing never and 5 representing always. All of the items are scored in the same direction; therefore, there is no need to reverse scores for any of the items in summing up to obtain subscale scores. Scores on either extreme of the scale indicate a negative trend in personal relationship standards. For example a score of 1 in

the boundaries dimension indicates that the person believes that partners should be totally independent off of each other and never share thoughts, feelings and actions. On the other hand, a score of 5 could indicate that the person has no sense of independence and believes that partners should always think, feel and act the same.

Data Collection

Data were collected over a 12-month period in 2009-2010. Prior to the recruitment of parents, the researcher met with program facilitators and explained the purpose of the study and how to use each of the measures that were to be used in the study. Facilitators of the parents' groups were part of the team that developed the evaluation framework for the program and were already familiar with all the measures. The children's groups facilitators were new to the research and were given the opportunity to ask questions and get clarifications as needed. They were also a valuable source of feedback regarding the challenges that came as a result of our first attempt to administer the children's self efficacy measure. Based on their feedback we made further modifications to the measure and how it is will be administered during the Full Evaluation study in 2010/2011.

The pre-group data for the parents were collected in September of 2009 during their intake interviews. The children's data was collected in December 2010. Post-group data for both children and parents were collected in April and May of 2010. In hindsight, we realized that for us to obtain a true sense of the children's pre group levels of self efficacy, we should have administered the measure in September of 2009 at the same time as their parents. The fact that we administered the measure eight weeks after the parent's program started might have impacted the children's results. More about this will be discussed in the conclusions section.

Due to the nature of the population that we work with, we experienced some attrition from pre to post group. We faced further challenges in our efforts to gather the follow up data three months after the completion of the program. Despite our offer to complete the

questionnaire with clients by phone, we continued to experience attrition in our rate of responses. As a result, the number of participants' responses fluctuated greatly. For the Children's measure one male had no pre group data and another male had no post group data. Four females and 2 males had no follow up data. For the TOPSE four females had no pre group data, 3 had no post group data and 6 had no follow-up data. Similarly, four males had no pre group data, five had no or incomplete post group data and 14 had no follow up data.

Program facilitators were very supportive of the study and encouraged parents to complete the questionnaires at each stage of the data collection. A number of facilitators felt that the TOPSE was time-consuming to complete, particularly for parents with low literacy skills. Although parents who dropped out of the *Caring Families* program did not complete the questionnaires at the end of group, there were some parents who completed the program but still did not fill out the questionnaires at the end of group. Table 1 shows summary statistics for all participants at baseline, end of group and follow-up.

	CPSE		TOPSE		ISRS	
	Male	Female	Male	Female	Male	Female
Pre group	5(83%)	8(100%)	15(79%)	11(73%)	13(72%)	12(80%)
Post group	5(83%)	8(100%)	14(74%)	12(80%)	14(78%)	13(86%)
Follow-up	4(66%)	4(50%)	5(26%)	9(60%)	5(28%)	9(60%)

Table 1

Data Analysis

The data were analysed using Excel. Independent samples t-tests were conducted to determine if there were differences in self-efficacy scores of participants in terms of mean change in scores from baseline to end of program and from end of program to the three month follow-up. None of the increases or decreases in means were statistically significant.

Results

Demographic data was collected for all program participants (n=41). The majority of attendees (75%) participated in the study. Out of all the research participants there were seven families where both parents and at least one of the children were attending the program. Eighty seven percent of couples in these families were separated or divorced. Out of the remaining couples who participated (n=4), three couples were separated and their children were under the age of 5; too young to attend the program and one couple (the mother did complete the questionnaires) attended but their children were not able to attend due to scheduling conflict. Four mothers attended without their partners/ex-partners and four fathers attended without the participation of their partners/ex-partners. In the case where one of the parents did not attend the children did not participate in the program. All children who participated in the *Caring Families* program and the research had both parents attending. Forty four percent (n=15) of adult participants and 57% (n=14) of the children participants were females. A 26% drop out rate (n=4) for male participants was noted. Ethnicity was not represented in our sample as 100% of our sample was white. The age range of the parents was not calculated, but that of the children ranged from 5 to 16 years. The number of children in the family ranged from 1 to 4. No demographics were collected regarding educational or employment background of the parents. For the purpose of this study no statistical analysis was performed to evaluate statistical significance of the demographic data as it pertains to differences in pre, post and follow-up means.

CPSE

The comparison of pre and post- test total means for the Children's Perceived Self Efficacy scores reflected a decrease in self efficacy regarding three out of the four categories that were measured (see Figure 1). Total means for the "Enlisting Social Resources" category decreased from 3.48 ($SD = 0.93$) at the pre-test to a mean of 3.44 ($SD = 0.91$) at post-test. Similarly, the total mean for "Meet others' Expectations" decreased from 3.87 ($SD = 0.77$) at the pre-test to a mean of 3.56 ($SD = 0.97$) at the post-test. Finally, the total means for the category of "Enlisting Parental and Community Supports" also decreased from a mean of 3.33 ($SD = 1.17$) at the pre-test to a mean of 3.25 ($SD = 1.30$) at the post-test. Conversely, a positive change was observed in the total means for the category of "Self Assertiveness" when comparing the pre and post-test results. Pre-test total means increased from 3.31 ($SD = 0.80$) to a mean of 3.33 ($SD = 1.14$). Follow- up results also indicated an increase in the mean from both pre and post-tests in the three categories of "Enlisting Social Resources", "Meet others' Expectations" and "Self Assertiveness". The values of the means and the standard deviations at the follow up were 3.5 ($SD = 0.94$); 4.0 ($SD = 0.70$) and 3.46 ($SD = 1.05$) respectively. A decrease was noted at the follow-up for the category of "Enlisting Parental and Community Supports" with a mean of 3.21 and a standard deviation of 0.89.

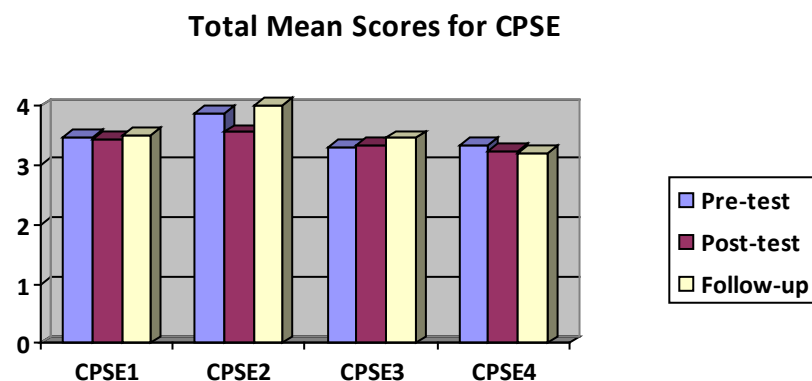


Figure 1

A comparison between males' and females' scores indicated a different pattern of change in self efficacy between the genders. For males there was a decrease in perceived self efficacy from pre-test to post-test in the three categories of "Enlisting Social Resources", "Meet Others Expectations", and "Enlisting Parental and Community Support". Pre-test means were 3.55 ($SD = 1.23$), 3.85 ($SD = 0.81$) and 3.7 ($SD = 1.22$) respectively. Post-test means had values of 3.25 ($SD = 1.26$), 3.85 ($SD = 1.31$) and 3.2 ($SD = 1.38$), respectively. The mean for perceived self efficacy in self assertiveness increased from 3.45 ($SD = 0.62$) at the pre-test to a mean of 3.6 ($SD = 1.29$) at the post-test (see Figure 2). This pattern of change is similar to the total scores when combining scores for both males and females.

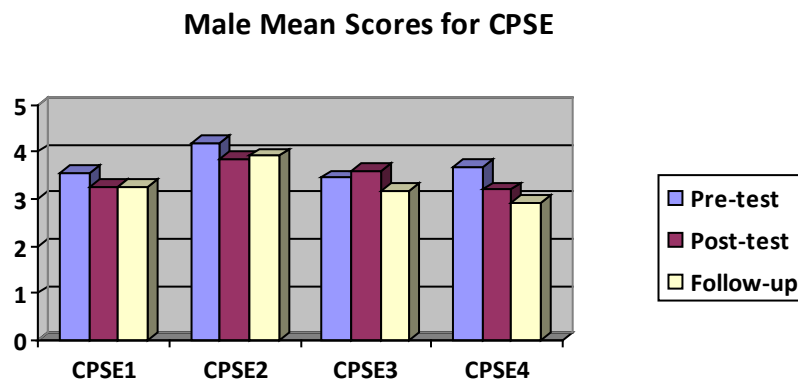


Figure 2

Females' scores on the other hand present differently (see Figure 3). At the post- test females showed an increase in self efficacy in the categories of "Enlisting Social Resources" and "Enlisting Parental and Community Resources". Pre- test scores for the first category increased from a mean of 3.44($SD = 0.74$) at the pre-test to a mean of 3.55 ($SD = 0.70$) at the post- test. The scores for the final category increased from a mean of 3.09 ($SD = 1.14$) at the pre -test to a mean of 3.28 ($SD = 1.25$) at the post-test. A decrease in the scores was noted for the second and third categories of "Meet others' Expectations" and "Self Assertiveness". Pre-

test mean scores for the first category were 3.66 ($SD = 0.74$). At the post-test, a score of 3.38 ($SD = 0.76$) was noted. Scores for the self efficacy regarding self assertiveness decreased from 3.33 ($SD = 0.91$) at the pre-test to a score of 3.16 ($SD = 1.06$) at the post-test.

Follow-up scores for females show a change in the positive direction when compared to both pre and post-test scores, thus indicating an increase in self efficacy in all four areas of the measure. The mean scores and standard deviations for each of the categories were 3.69 ($SD = 0.67$), 4.06 ($SD = 0.63$), 3.69 ($SD = 0.83$) and 3.44 ($SD = 0.83$) respectively.

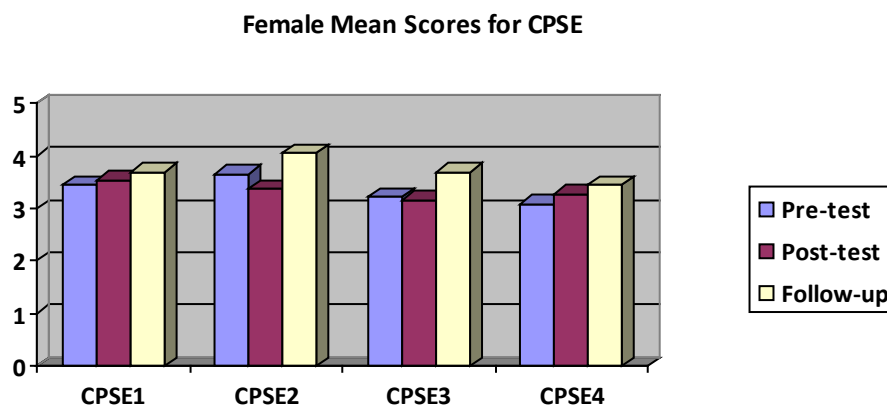


Figure 3

ISRS

In examining the data from the Inventory of Specific Relationship Standards (ISRS) at the different stages of the “pre-test”, “post-test”, and “follow-up”, several results were found to be noteworthy. When looking at the “Control” dimension of the measure, during the pre-test males averaged a mean score of 4.31 ($SD = 0.69$). This mean score decreased to 4.03 ($SD = 0.70$) at the post-test. Additionally for males, the mean score for pre-test for the “Boundaries” dimension was 3.94 ($SD = 0.85$) whereas post-test results also showed a decreased mean of 3.65 ($SD = 0.97$). When examining the follow-up data, researchers noted an unexpected increase in male mean scores for both control and boundaries, from the time of pre-test as well

as the time of post-test. The male mean score at the time of follow-up for beliefs about control, in comparison to the abovementioned scores, was 4.70 ($SD = 0.43$). Likewise, the male average for beliefs about boundaries increased to 4.42 ($SD = 0.62$) (see Figure 4).

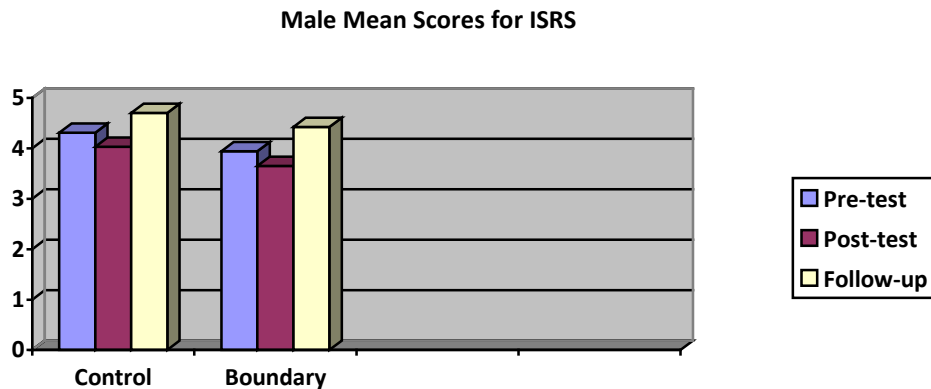


Figure 4

As with males, the average mean score for females in terms of beliefs about control decreased from 4.41 pre-test with a standard deviation of 0.65 to 4.31 ($SD = 0.67$). Unlike the males, however, who presented a decrease in mean scores from the pre-test to post-test portions of the study in regards to boundaries, the female mean score increased from the pre-test mean of 3.80 ($SD = 0.84$) to the post-test mean of 3.94 ($SD = 0.76$). Also unlike the males' averages at follow-up time which saw significant increases, the females' averages reveal a decrease in average scores for beliefs about both control and boundaries. The follow-up portion of the study revealed that females' beliefs about control decreased to a mean score of 4.26 ($SD = 0.50$). Females' beliefs regarding boundaries also saw a decrease in mean scores from the time of post-test, however an increase from the time of pre-test to 3.89 ($SD = 0.47$) at the time of follow-up (see Figure 5).

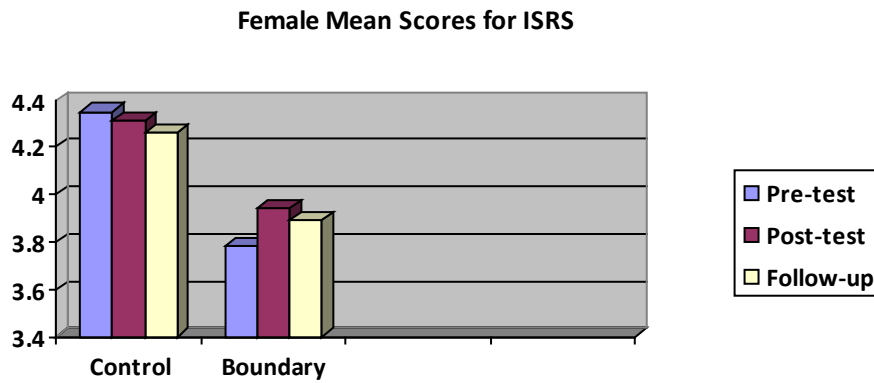


Figure 5

In looking at total scores – combining male and female scores – a pattern emerged in beliefs about both control and boundaries (see Figure 6). This pattern shows a decrease in mean scores from the time of pre-test to post-test scores, and an increase in follow-up scores as compared to both pre and post-test scores. The total pre-test mean score for beliefs regarding control, 4.36 ($SD = 0.67$), decreased to a post-test mean score of 4.17 ($SD = 0.69$). The follow-up mean score, as mentioned, increased to 4.44 ($SD = 0.47$). The total pre-test mean score of 3.87 ($SD = 0.85$) for beliefs regarding boundaries likewise decreased in the post-test average, resulting in a mean score of 3.79 ($SD = 0.87$). Similarly, the follow-up score increased as compared to pre and post-test averages to a total mean score of 4.11 with a standard deviation of 0.53.

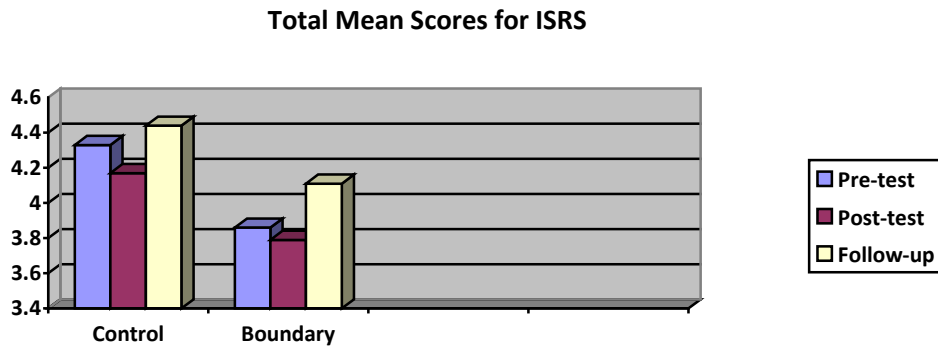


Figure 6

TOPSE

When looking at the pre and post-test data for both males' and females' scores combined (see Figure 7), an increase in the scores of the "Emotion & Affection" category, "Empathy & Understanding" category, "Pressures" category, "Self- Acceptance" category and the "Learning & Knowledge" category was noted. The mean scores increased from 9.14 ($SD = 0.77$) to 9.19 ($SD = 1.05$) in the first category thus indicating a possible improvement in parent's self efficacy towards their ability to identify, express and discuss emotions and feelings with their children. As for the parents' perceived self efficacy in terms of showing empathy and understanding towards their children, a change in the mean scores is reflected in the increase from a mean of 8.81 ($SD = 1.04$) to a mean of 8.9 ($SD = 0.91$). The parent's scores in the category of "Pressures" indicate a possible increase in self efficacy with regards to the parents' confidence in their ability to meet the challenges and the pressures that can present themselves during parenting. The scores increased from a mean of 7.67 ($SD = 1.96$) to a mean of 7.76 ($SD = 1.88$). Comparably the scores for perceived self efficacy regarding self acceptance as a parent and ability to seek and obtain knowledge needed for problem solving also improved. The mean scores increased from 8.97 ($SD = 0.95$) to 9.1 ($SD = 0.84$) and 8.80 ($SD = 1.24$) to 8.92 ($SD = 1.17$) respectively.

On the other hand, the parent's self efficacy regarding their parenting abilities in the areas of "Play & Enjoyment", "Control", and "Discipline & Setting Boundaries" seemed to decrease at the post-test. The mean scores decreased from 9.34(*SD* = 0.77) to 9.21(*SD* = 0.58); 8.05 (*SD* = 1.29) to 7.86 (*SD* = 1.35) and 8.5 (*SD* = 1.16) to 8.19 (*SD* = 1.72) respectively.

Follow up scores showed a decrease in the mean with the exception of the three categories of "Play & Enjoyment", "Discipline & Setting Boundaries" and "Learning & Knowledge". Follow up mean scores increased to 9.38 (*SD* = 0.58), 8.5 (*SD* = 0.84) and 9.05 (*SD* = 0.84).

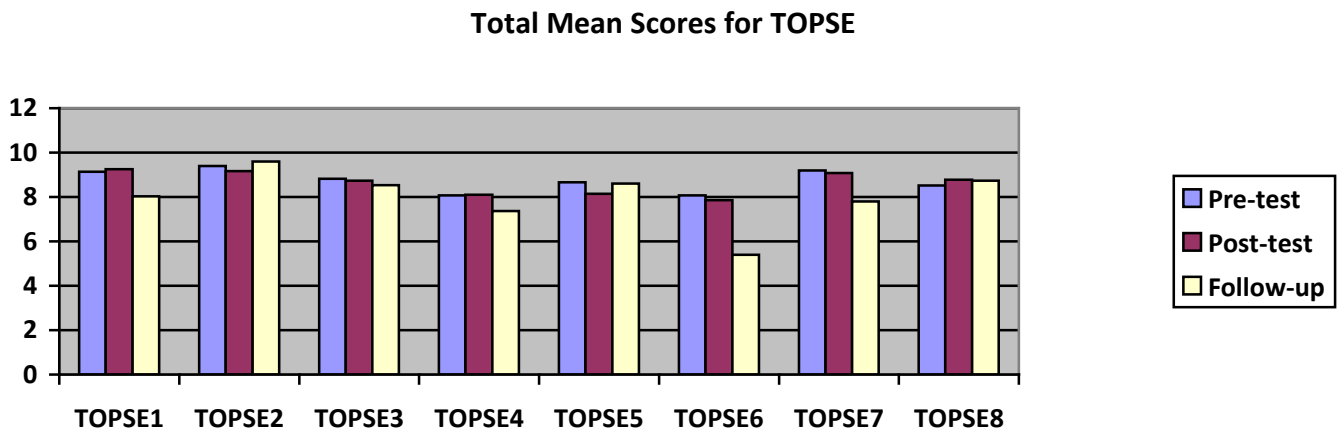


Figure 7

When examining the results of males (see Figure 8) and females (see Figure 9) separately, both males and females showed a decrease in the mean score from pre to post-test in the categories of "Play & Enjoyment", and "Discipline & Boundary setting". The mean scores for males were 9.4 (*SD* = 0.71) and 8.66 (*SD* = 1.18) at pre-test and decreased to 9.17(*SD* = 0.72) and 8.14 (*SD* = 1.53) at post-test while the female scores were 9.26 (*SD* = 0.85) and 8.29 (*SD* = 1.14) at pre-test and decreased to 9.25 (*SD* = 0.43) and 8.25 (*SD* = 0.97) at post-test. For the remainder of the categories the increase in the mean scores for males reflected an

improvement in the fathers' self efficacy towards their abilities to identify, express and discuss emotions with their children; to have a sense of control as a parent and to have confidence with regards to learning and knowledge of parenting. The means increased from 9.14 ($SD = 1.31$) to 9.25 ($SD = 1.01$) for "Emotion & Affection"; 8.07 ($SD = 1.48$) to 8.10 ($SD = 1.41$) in "Control" and 8.52 ($SD = 1.45$) to 8.77 ($SD = 1.44$) in "Learning & Knowledge". Females' scores on the other hand reflected a decrease in the mothers' self efficacy in the above mentioned areas of parenting. The mean scores decreased from 9.14 ($SD = 0.77$) to 9.11($SD = 1.10$) in "Emotion & Affection"; from 8.02 ($SD = 1.02$) to 7.58 ($SD = 1.29$) in "Control" and from 9.18 ($SD = 0.97$) to 9.10 ($SD = 0.86$) in "Learning & knowledge".

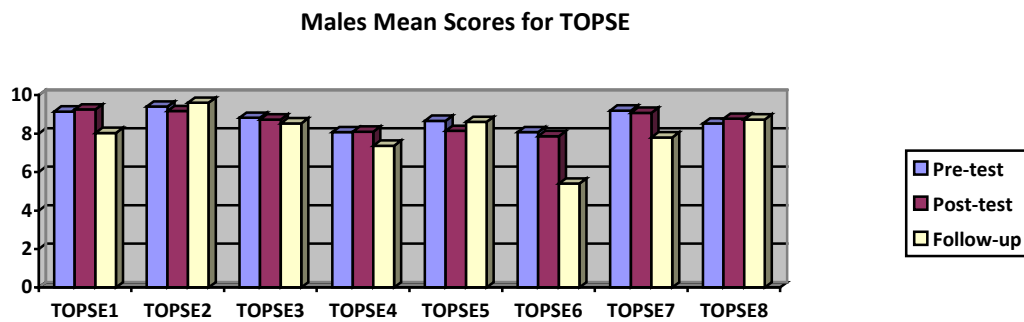


Figure 8

Finally while males self efficacy seemed to decrease in the categories of "Empathy & understanding" with a pre-test mean score of 8.82 ($SD = 1.08$) and a post-test mean score of 8.73 ($SD = 1.0$); "Pressure" with a pre-test mean score of 8.07 ($SD = 1.81$) and a post-test mean score of 7.86 ($SD = 1.81$) and "Self -Acceptance" with a pre=test mean score of 9.19 ($SD = 0.82$) and a post-test mean score of 9.08 ($SD = 0.89$), Female mean scores increased with pre-test scores for each of the above categories at 8.8 ($SD = 0.99$); 7.14 ($SD = 2.17$) and 8.67 ($SD = 1.14$) respectively and post-test mean scores at 9.11 ($SD = 0.79$); 7.65 ($SD = 1.95$) and 9.11 ($SD = 0.79$) respectively.

Females Mean Scores for TOPSE

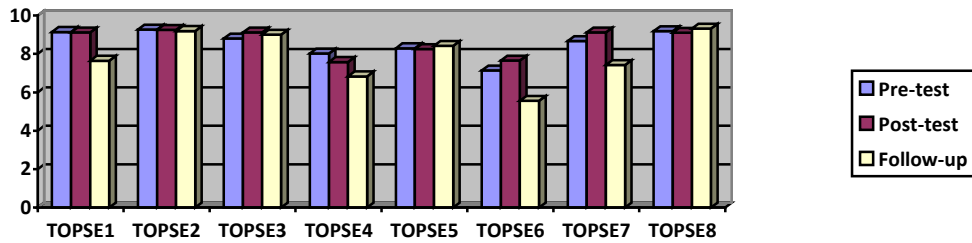


Figure 9

Follow up results reflected a decrease in both fathers' and mothers' self efficacy in the areas of "Emotion & Affection", "Empathy & Understanding", "Control", "Pressures" and "Self Acceptance". The fathers' mean scores decreased at the follow-up as compared to both pre and post-test mean scores. The follow-up mean scores were 8.03 ($SD = 3.15$), 8.53 ($SD = 0.88$), 7.37 ($SD = 3.13$), 5.4 ($SD = 4.25$) and 7.8 ($SD = 3.51$) respectively. On the other hand the decrease in the mothers' scores as compared to the pre and post-test mean scores were only in "Emotion & Affection" with a follow-up mean score of 7.64 ($SD = 3.62$); "Control" with a mean score of 6.83 ($SD = 2.77$); "Pressures" with the lowest mean score of 5.56 ($SD = 4.07$) and "Self Acceptance" with a score of 7.42 ($SD = 3.07$). The mothers' follow-up mean scores for "Empathy & Understanding" increased to a score of 9 ($SD = 0.95$) from a score of 8.8 ($SD = 0.99$) at the pre-test and decreased from a score of 9.11 ($SD = 0.79$) at the post-test. The high standard deviations are reflective of the small number of respondents in the follow-up stage. Self Efficacy in "Play & Enjoyment" increased for the males to a mean score of 9.6 ($SD = 0.68$) as compared to both pre and post-test mean scores. On the other hand, mothers' self efficacy regarding play and enjoyment in parenting decreased at the follow-up to a score of 9.19 ($SD = 0.49$) as compared to both pre and post-test mean scores.

Fathers' follow-up Scores for "Discipline & setting Boundaries" ; 8.6 ($SD = 0.75$) reflected a slight decrease as compared to pre-test mean scores but an increase as compared to post-test scores. Mothers' follow-up scores regarding self efficacy in disciplining and setting boundaries showed an increase from both pre and post-test scores with a mean of 8.42 ($SD = 0.92$). Similarly, the mothers' follow up mean scores in learning and knowledge increased to a mean score of 9.31 ($SD = 0.73$) as compared to both pre and post-test results. Finally, the fathers' follow up mean scores in learning and knowledge increased to a score of 8.73 ($SD = 0.96$) as compared to pre-test scores but showed a decrease when compared to post-test scores.

Discussion & Interpretation

The conclusions of this study suggest that *Caring Families* has the potential to assist parents in learning to reduce levels of conflict and relational dysfunction to help create healthy atmospheres for their children. As evidenced by the results of the "pre," "post," and "follow-up" ISRS questionnaire, changes in belief systems about the importance of control and boundaries in relationships were reported by participants of the program. Decreases in levels of importance that both fathers and mothers gave to control in a relationship, point to the possibility that the program impacted the dynamic of power and control in what previously was an abusive relationship. Unfortunately, lack of statistical power prevents us from concluding that differences in means are attributed to program participation.

Perhaps one of the more interesting findings of the study is seen when comparing "pre" and "follow-up" ISRS scores by gender. Whereas fathers saw a decrease in the importance given to both control and boundaries from the time of "pre" tests to "post" tests, by the time the "follow-up" tests were administered, fathers presented with increased levels of importance given to both boundaries and control not only from the time of "post" scores as one might expect, but also from the time of "pre" scores. Though the exact reason remains unknown, research

suggests that external, as well as internal factors, affect the level of importance individuals give to certain beliefs, and as these factors change over time, so too do the beliefs. If a father, for example, is experiencing legal difficulties resulting in a feeling of powerlessness prior to participation in the group, he is likely to score higher in the category of control – that is, stating high amounts of control are important in a relationship – as he is currently experiencing life without that control. If, over the course of the group, he is not only educated in how to experience life without control, but also he is surrounded both by other fathers who have or are experiencing similar situations, as well as counsellors who encourage and support him, he may feel that control is not as important as he did prior to group. This father learns from other fathers as well as counsellors that it is okay to feel a lack control at times; even though living without a sense of control is unpleasant, it is not as bad as he once believed. At the time of the “post” test, therefore, this father, who has felt encouraged and supported over the past sixteen weeks, will likely have experienced a change in his belief system as he now believes that having control in a relationship is not quite as important as he once thought. Months after those supports are removed, however, if the abovementioned legal circumstances do not change, this father is back to experiencing overwhelming feelings of powerlessness once again, and therefore not feeling any sense of control. He is no longer supported by others with similar experiences, or by counsellors who can assist him in what to do when he has lost some control. His belief system changes, then, to reflect these feelings in that once again he believes that having a sense of control is very important in a relationship.

One should note that unlike parenting programs offered at other counselling agencies, clients participating in *Caring Families* are often referred by another agency, as opposed to voluntarily participating. As such, one could suppose that the position of these parents to be that of a higher perceived self-efficacy than of parents who volunteer for a parenting program, as voluntary parents already believe that they need help. The supposition that parents who are

required to participate in *Caring Families* believe themselves to be good parents and therefore do not need assistance is supported by the TOPSE “pre” test scores indicating high perceived self-efficacy. By the time these same parents completed the “post” tests, and furthermore several months later when the “follow-up” tests were administered, one could argue based on results, that having learned and applied the principles taught in *Caring Families*, they developed a more realistic perception of their self-efficacy. Given that the goal of *Caring Families* is to increase self-efficacy – not merely *perceived* self-efficacy – one could argue that the first step to being able to increase one’s self-efficacy is to have an accurate understanding of perception of one’s own self-efficacy.

Another noteworthy finding is in regards to parents’ perceived ability to handle the pressures associated with being a parent. Parent are asked to rate on the following comments: “It is difficult to cope with other people’s expectations of me as a parent”, “I am not able to assert myself when other people tell me what to do with my child”, “Listening to other people’s advice makes it hard for me to decide what to do”, “I can say ‘no’ to other people if I don’t agree with them”, “I can ignore pressure from other people to do things their way”, and “I do not feel a need to compare myself to other parents.” The total average “pre-test” score for mothers and fathers combined, 7.67, suggests that most parents in the program initially viewed themselves as people who can handle pressures fairly well. At the end of their time in group, parents appeared even more confident of their ability to cope with pressure, averaging a “post-test” score of 7.76. As with the above discussion regarding the fathers’ beliefs about control, it would not be a far leap to suggest that while both groups of mothers and fathers were actively meeting one night every week, they felt supported and encouraged as a parent. Both mothers and fathers were surrounded by other parents who would offer them feedback and advice, as well as counsellors who would listen to, challenge, and encourage them in their current experiences as parents. When that support was no longer present, however, and the pressures of life and parenting

were strongly felt once again, it logically follows that many parents would feel less confident in their ability to handle pressure. If an individual has grown accustomed to some relief from pressure, and one were to remove that relief (or support) from that person, it logically follows that he/she may no longer feel as capable of handling that pressure as the pressure feels greater compared to what he/she had grown accustomed to.

Though test scores indicate only slight variations in children's perceived self-efficacy, researchers have since realized that the timing of when the tests were administered may have skewed the results. As the "pre" test was administered prior to the children's direct participation in the program, it was assumed that the results accurately depicted the perceived self-efficacy. It has since been realized, however, that though the children themselves were not involved in groups, they were in actuality being affected by the material being taught to their parents. If, for example, a child's primary caregiver was taught empathy and was assertively practicing and developing empathetic skills, his or her child would be more likely to enlist that parent's support than prior to that parent learning empathy. It logically follows, therefore, that though the children's "pre" tests were administered prior to their involvement in group, as their parents had been involved in group for eight weeks prior to this testing, the results do not accurately depict children's perceived self-efficacy prior to the participation in *Caring Families*. If all "pre" tests – not only parents, but children also – were administered prior to any family member's participation in group, it is plausible that a greater difference would be seen between "pre," "post," and "follow-up" test scores than is currently the case regarding children's perceived self-efficacy.

It is important to point out that as the parents self efficacy scores decreased at the follow-up in the areas of "Emotion & Affection", "Empathy & Understanding", "Control", "Pressures" and "Self Acceptance, so did the children's scores in the category of "Enlisting Parental and Community Support". This speaks to the importance of having parents who feel

confident and capable and to children feeling confident and secure about their parents' availability to support and nurture them.

Conclusions & Recommendations

As one might surmise from the data collected, *Caring Families* appears to be making a difference in the lives of mothers, fathers, and children. As the data indicates, when parents learn and apply the principles of respectful communication, child-centered parenting, and age appropriate parenting, their self-efficacy is increased. When fathers and mothers' self-efficacy increased, and as they begin to approach parenting from a child-centered mentality, as opposed to conflict, or even other parent-centered mentality, also as indicated by the data, children's perceived self-efficacy also increased as they felt the impact of their parents' positive shift. As mentioned above, though the data indicated that *Caring Families* might have played a role in increasing self-efficacy in children, the first recommendation resulting from this study is to begin administering the "pre" test to all participants, including children, prior to any family member's participation in group. This change will not only provide a more accurate understanding of a child's perceived self-efficacy prior to participation in *Caring Families*, but we also expect it to reveal a more accurate measurement of the increase *Caring Families* creates in a child's self-efficacy.

As mentioned above, whereas multiple factors may account for the changes in "pre," "post," and "follow-up" ISRS and TOPSE results an additional recommendation is that *Caring Families* reviews the need for follow-up services. Data suggested that the greatest amount of positive change occurred in both mothers and fathers when they were actively involved in group. Therefore, if *Caring Families* were able to alter its form slightly to offer support following the completion of the group portion, such as follow-up individual or dyadic counselling, it logically follows that the change that began during the group portion would continue longer and, perhaps even deepen and grow in those individuals.

The final recommendation based on the findings of this study is for further research to continue. Although findings point to the effectiveness of the *Caring Families* program, it is largely unknown why specific changes occurred; further research, involving more qualitative methods such as more regular interviews or questionnaires, could help researchers better understand what makes *Caring Families* effective and why. Furthermore, a qualitative component may assist researchers in recognizing and eliminating lurking variables. With this knowledge, further development of the program could occur, thus increasing the effectiveness of the program and longevity of the change it creates. Greater self-awareness, as will be discussed in the next section, has been a by-product of this research, and therefore counsellors and researchers are more aware of potential lurking variables.

Lessons learned from evaluation activities

As *Caring Families* works with complex issues involving multiple persons, as one might expect, many factors can and will affect those persons as well as the process of learning and applying new principles; as such, in conducting evaluation programs for the purpose of researching the effectiveness of *Caring Families*, a number of these variables were identified. If evaluation activities and research were not being conducted on the program, but rather *Caring Families* was instead simply operating, it is safe to assume that facilitators would not be as vigilant in seeking these variables. Evaluation activities such as self-reporting questionnaires for clients and counsellors often revealed differences in perception regarding the effectiveness of the material.

Differences of perception regarding the effectiveness of the *Caring Families* material, we believe indicates a possible significant variable in that variations in facilitators may possibly be affecting the presentation and reception of material. As each group has different facilitators, though the material counsellors work from remains the same, given differing styles in presentation, it is possible that these differences may affect the results and even the

effectiveness of the material. If, for example, counsellors A and B are facilitating the fathers' group, given that they are unique individuals utilizing specific therapeutic techniques, they will present material X differently than will counsellors C and D, who are facilitating the mothers' group. Though counsellors A, B, C, and D all utilize material X, the differences in each counsellor's personality, therapeutic approach, and even perspective on the material will affect how material X is taught, thus potentially altering how the material is heard and received by participants. Had Nova Vita not conducted research on *Caring Families*, nor allowed counsellors and clients to participate in evaluation activities, it is possible that the way in which counsellor individuation may potentially affect the material might not have been considered. Perhaps the single greatest lesson learned in researching *Caring Families* through counsellor and client evaluation was the importance of developing greater self-awareness and a more critical eye. An awareness of how counsellors presented the material, how clients were hearing and understanding the material, and what could be done differently to further increase the effectiveness of *Caring Families* began occurring as a result of researching the program through evaluation activities. Furthermore, as a result of experiencing the effectiveness of evaluation activities on creating self-awareness, an additional lesson learned is to continue and expand these evaluations.

Impact of evaluation on clients/staff/nova vita

As indicated above, the evaluation process of exploring the effectiveness of *Caring Families* impacted clients, counsellors, and Nova Vita in several ways. For example, as clients understood that Nova Vita was not simply delivering a program, but was also evaluating it, they understood that Nova Vita was making a deliberate effort to listen to their perspectives on the program and to do what they could to improve it.

Another impact the evaluation process had on clients was that it provided them with an opportunity to make their voice heard as they were aware that Nova Vita staff were actively

seeking their opinions and feedback. One participant, for example, stated that though it was a “good course, I wanted more teaching instead of support.” Had there been no evaluation of the program, it is possible that this client, and others like him/her, may not have felt as free to provide such honest feedback. Another client wrote, “it is hard to answer some of these questions – especially the first part – as they are very general. Most situations depend on the factors involved, eg. sharing spending habits could depend on income, how much is being spent, what is being purchased, etc. As for the programme, it has definitely helped our family as the communication between my ex and I is much better.” This client not only provided feedback in regards to the effectiveness of the program, but since he/she knew that Nova Vita wanted to know his/her opinion on the entire program – including the evaluation itself – this individual was given a voice to share an honest evaluation.

The impact on counsellors was such that they reported feeling more confident of the material and program as a whole as they felt the research and evaluation provided greater credibility and prestige to the program. Management reported that counsellors became more vigilant in being constructively critical of not just *Caring Families*, but also in other programs run by Nova Vita. In terms of how counsellors were affected on a personal level, many counsellors reported how doing the evaluation made them more aware of not just their own presentation of the material, but also of how effective the material was and how it could be applied in their own relationships. One counsellor stated that both the evaluation and program “enriched my personal life by encouraging me to make changes to my parenting and co-parenting approaches.”

As an organization, Nova Vita was also impacted by the evaluation process in several ways. Evaluating *Caring Families* opened many people’s eyes to the importance of reviewing our programs and actively seeking ways to make them better. As mentioned, staff became more attentive to what was working in programs, what was not working, and why. Yet another

impact was that the evaluation process enabled Nova Vita to seek and obtain resources that will assist in future research. For example, Nova Vita was able to ask local university students for assistance in analyzing data. Nova Vita staff purchased software to assist in statistical analysis and books to educate themselves in research methods. Several staff members also sought out both formal and informal training in how to properly conduct quantitative research and data analysis. The evaluation process challenged Nova Vita staff members to grow professionally in many ways, which will both benefit Nova Vita, but also present and future clients.

Next steps

As stated above, much of the data collected revealed change in the lives of participants of *Caring Families*, however much of the data also reveals differences in means that are not statistically significant. This lack of statistical significance in data does not necessarily indicate a flaw in the program, but instead all evidence points to the small sample size from which the data was collected. One of the next steps in further developing *Caring Families*, therefore, is not only to increase the number of participants, thus broadening the sample size, but also to extend the length of study. By increasing the length of time that the program is studied to a period of several years, as opposed to, for example, a period of one or two sixteen week blocks, the population of participants involved in the research would rise dramatically, thus deepening the pool which to draw data from. This would increase the likelihood of statistical relevance and significance.

As discussed previously regarding the timing of data collection, the research team will administer the “pre” test to all participants prior to any family member participating in the program. By requiring all participants – mothers, fathers, and children – to complete the “pre” test before any groups start, data collected will be more accurate, thus providing more precise measurements of the effectiveness of *Caring Families* in increasing self-efficacy, particularly among children.

To address the issue of uniformity in the presentation of material facilitators need to continue communication with each other as well as management through feedback forms that have already been designed to detect inconsistencies curriculum implementation. Ongoing training in presentation of material, and ongoing counsellor evaluations of both material and of self well also assist in addressing the above challenge.

Research results would gain validity by the inclusion of qualitative research methods, in addition to the currently existing quantitative methods. Quantitative research alone can make for a lot of guesswork on the part of counsellors and researchers as though it remains effective in accurately showing change (i.e. how much change occurred, when the change occurred, etc.), it fails to explain why that change occurred. By adding qualitative components such as interviews and additional questionnaires, researchers will begin to gain an understanding as to why and how the change is occurring. Quantitatively obtained data indicates that *Caring Families* is effectively helping foster change that leads to increased self-efficacy in parents and children alike; by utilizing both quantitative and qualitative research tools, though, researchers will better understand what makes *Caring Families* effective, and therefore be able to increase its effectiveness even further.

Finally, Parents' written and verbal feedback at the follow up leads researchers to believe that there is a need to develop a unique measure that addresses the specific changes in parents' beliefs towards the other parent; his/her value, role and contribution to the life of the children and the family. In hindsight, researchers believe that to truly measure the success of *Caring Families* they need to measure the change in participants' views towards the partner/ex-partner as a parent and not only towards themselves as a parent.

Knowledge Exchange

Community collaborations have already been established due to the design of the *Caring Families* program and Nova Vita's working partnerships within the community. The

Caring Families Program collaborates with the Children's Aid Society (CAS) and many CAS clients are referred to us. CAS workers support their clients throughout the program. Other CAS workers are group facilitators, giving them the opportunity to train in domestic violence and in the issues of children witnessing abusive parental relationships. This program also collaborates with local children's mental health treatment organizations such as; Contact Brant, Woodview Children's Centre and St Leonard's Community Services. These agencies, along with Office of the Children's Lawyer, support the program through referrals and the provision of staff facilitators. Probation & Parole services provide referrals and ongoing client support as some of the fathers and a few of the mothers have been charged with perpetrating domestic violence. While these organizations did not participate in this research, they will be a part of the 2010/2011 data collection by responding to the Referring Agency Satisfaction Questionnaires. We are currently in the process of identifying all referring agencies to gather participants for our "service providers" data part of the study. Potential participants will be contacted at the end of October/beginning of November 2010. While many community partners are aware of our evaluation process, more details will be disseminated during the following months about the specific outcomes of the research and about our experience of implementing the evaluation.

This knowledge exchange activities, we believe supports informed referrals to our program and adds to the community capacity for treatment programs for families experiencing domestic violence. We continue to keep our other key stakeholders informed of the evaluation process and the outcomes – our local Children's Services Committee at Contact Brant and at the Brant Network for Children and Youth (formerly CCYDS), with information shared at the committee and interagency level and informally between agency workers. We share this information with the Board of Directors, staff, our clients, our community partners and Ministry funders. Adjustments have already been made to program curriculum based on client feedback from this study.

With evidence based outcomes we prepared a report for our stakeholders and this information is being included in our annual report and seasonal newsletters to be distributed for public consumption in October 2010. Our final report will also be accessible to our clients and the general public through our website.

With the support of the Centre, the skills and expertise gained from implementing a this research will be an asset to our continued efforts to learn about and implement evaluations of our services and programs. Specifically, *Caring Families* is in its infancy stage and continued monitoring and evaluation will be key to ensuring that it evolves into a solid treatment program for the unique population that our agency services.

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Appendices

Appendix A

Evaluation Matrix: Evaluation of Nova Vita Caring Families Program – Brantford, Ontario

OUTCOME EVALUATION MATRIX

Evaluation Questions	Short-Term Outcomes	Indicator(s)	Source of data	Method to Collect Data & Frequency	Who collects data	When collects data (specify month/year)
1. To what extent do parent(s) increase child-centered, age-appropriate parenting skills?	Increased child-centered, age-appropriate parenting skills	Improved parenting skills scores between baseline and post intervention over the term of the evaluation and maintained at follow up.	Tool to Measure Parenting Self-Efficacy (TOPSE) Available at: http://www.hpherts.nhs.uk/Category.asp?cat=1536 Topics scored:	Administer TOPSE survey to all parent participants at: - PRE: the beginning of the intervention (at intake to obtain a baseline)	Facilitators or staff assigned to administer this	September 2009 March 2010

Evaluation Questions	Short-Term Outcomes	Indicator(s)	Source of data	Method to Collect Data & Frequency	Who collects data	When collects data (specify month/year)
			<ul style="list-style-type: none"> ▪ control ▪ discipline & setting boundaries ▪ self-acceptance (negative score) ▪ learning & knowledge ▪ play and enjoyment ▪ emotion and affection ▪ empathy and understanding ▪ pressures (negative score) 	<p>- POST: the end of the intervention (16th week)</p> <p>- FOLLOW-UP: 3 months after program end</p>		June 2010
2. To what extent do parent(s) improve their attitudes towards each	Increased acceptance of other parent.	Improved relationship expectation scores between baseline and post intervention	Inventory of Specific Relationship Standards - III	Administer the Inventory to all parent participants at:	Facilitator or staff assigned to administer this	

Evaluation Questions	Short-Term Outcomes	Indicator(s)	Source of data	Method to Collect Data & Frequency	Who collects data	When collects data (specify month/year)
other?		over the term of the evaluation and maintained at follow up.		PRE: the beginning of the intervention (intake to obtain a baseline score) - POST: the end of the intervention (16 th week) - FOLLOW-UP: 3 months after program end		September 2009 March 2010 June 2010
3. Do children experience increased self efficacy by the completion of the program?	Increased self efficacy	Improved scores on self efficacy assessment between baseline and post intervention over the term of the evaluation and maintained at follow up.	Child self efficacy questionnaire	Administer questionnaire to all children Grade 4 and above - PRE: the beginning of the intervention (intake to obtain a baseline) - POST: the end of the	Facilitator or staff assigned to administer this	December 2009 March 2010

Evaluation Questions	Short-Term Outcomes	Indicator(s)	Source of data	Method to Collect Data & Frequency	Who collects data	When collects data (specify month/year)
				intervention (16 th week) - FOLLOW-UP: 3 months after program end		June 2010

Appendix B



Nova Vita Caring Families Program Parent Information Letter and Consent Form

Nova Vita Domestic Violence Prevention Services is conducting an evaluation of the Caring Families program. The purpose of the evaluation is to assess the effectiveness of the Caring Families program to determine if it is meeting the needs of the clients.

As a family participating in the Caring Families program, we would like to invite you to participate in the evaluation study. Your participation will involve the completion of questionnaires at the beginning of the program, at the end of your involvement with the program, and at 3 months follow-up. If you choose to participate, a Nova Vita facilitator will give you questionnaires in your group and will call you 3 months after you complete the group to set up a time that is convenient for you to complete the questionnaires. The amount of time required for your participation will be minimal.

We will use the information from the study to determine whether the Caring Families program is helpful in addressing the problems relating to family conflict.

Confidentiality

All the information that you provide will be kept confidential. Your information will be assigned a code and your name will not be used on any of the forms used. The list connecting your name to this code will be kept in a locked file, and when the study is completed, the list will be destroyed. Your name and any personal identifying information will not be used in any report.

Voluntary Participation

Your participation in this evaluation is voluntary. You may choose not to participate or you may withdraw from the study at any time. You will not be penalized in any way if you decide not to participate in this study or choose to withdraw at a later date. There are no known benefits to you that would result from your participation in this study; however, your information will help us understand some of the ways the program can be improved for others.

Contact information

If you have any questions or concerns about this study or if any problems arise, please contact: Gail Quinlan, Director of Counselling Services at 519 -752 -1005 x 220.

Nova Vita Caring Families Program
Consent Form

Consent

I have read the above information regarding my participation in the evaluation of the Caring Families program and have been given the opportunity to ask questions. I give my consent to participate in this evaluation.

Parent signature: _____ Date: _____

Parent signature: _____ Date: _____

_____: _____ Date: _____

Please keep the information portion of this consent form for your records.

Appendix C



Nova Vita Caring Families Program Parent Information Letter and Consent Form

Nova Vita Domestic Violence Prevention Services is conducting an evaluation of the Caring Families program. The purpose of the evaluation is to assess the effectiveness of the Caring Families program to determine if it is meeting the needs of the clients.

As a family participating in the Caring Families program, we would like to invite your child to participate in the evaluation study. Your child's participation will involve the completion of a questionnaire at the beginning of the program, at the end of his/her involvement with the program, and at 3 months follow-up. If you choose to give permission for your child to participate, a Nova Vita facilitator will give your child a questionnaire during their intake, during the final session and will call 3 months after your child completes the group to set up a time that is convenient for you and your child to complete the questionnaire. The amount of time required for your child's participation will be minimal.

We will use the information from the study to determine whether the Caring Families program is helpful in addressing the problems relating to family conflict.

Confidentiality

All the information that your child provides will be kept confidential. Each participant's information will be assigned a code and your child's name will not be identified on any of the forms used. The list connecting your child's name to this code will be kept in a locked file, and when the study is completed, the list will be destroyed. Your child's name and any personal identifying information will not be used in any report.

Voluntary Participation

Your child's participation in this evaluation is voluntary. You and your child may choose not to participate or may withdraw from the study at any time. Your child will not be penalized in any way if he/she decides not to participate in this study or chooses to withdraw at a later date. There are no known benefits to your child that would result from his/her participation in this study; however, your child's information will help us understand some of the ways the program can be improved for others.

Contact information

If you have any questions or concerns about this study or if any problems arise, please contact: Gail Quinlan, Director of Counselling Services at 519 -752 -1005 x 220.



Nova Vita Caring Families Program
Consent Form

Consent

I have read the above information regarding my child’s participation in the evaluation of the Caring Families program and have been given the opportunity to ask questions. I give my consent for my son/daughter _____ to participate in this evaluation.

Parent signature: _____ Date: _____







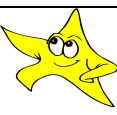




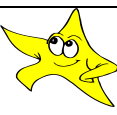




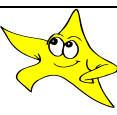



Parent signature: _____ Date: _____

Witness: _____ Date: _____

Please keep the information portion of this consent form for your records.

How well I can do things

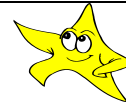
Put a circle around the star that best shows how well you feel you can do things.

<p>1. How well can you get adults to help you when you have problems at home?</p>	 Not well at all	 Not too well	 Well	 Very well	 Extremely well
<p>2. How well can you get a friend to help you when you have problems at home?</p>	 Not well at all	 Not too well	 Well	 Very well	 Extremely well
<p>3. How well can you get adults to help you when you have social problems (problems with your friends)?</p>	 Not well at all	 Not too well	 Well	 Very well	 Extremely well
<p>4. How well can you get a friend to help you when you have social problems (problems with your friends)?</p>	 Not well at all	 Not too well	 Well	 Very well	 Extremely well

5. How well can you live up to what your parents expect of you?



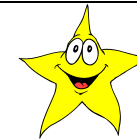
Not well at all



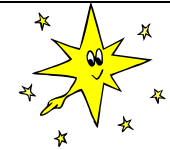
Not too well



Well



Very well

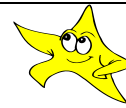


Extremely well

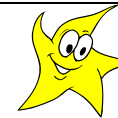
6. How well can you live up to what your teachers expect of you?



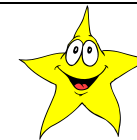
Not well at all



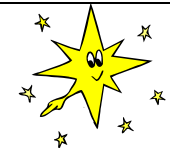
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Well



Very well

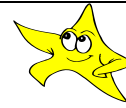


Extremely well

7. How well can you live up to what your peers expect of you?



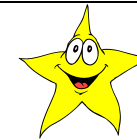
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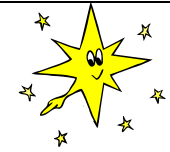
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Well



Very well

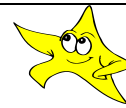


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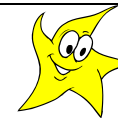
8. How well can you live up to what you expect of yourself?



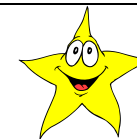
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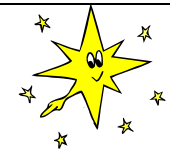
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Well

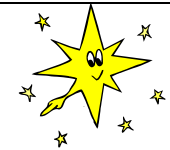
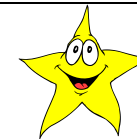
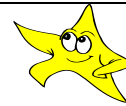






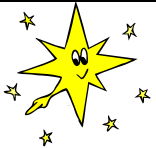
Very well













Extremely well






9. How well can you express your opinions when other family members disagree with you?



	Not well at all	Not too well	Well	Very well	Extremely well
10. How well can you stand up for yourself when you feel you are being treated unfairly?					
	Not well at all	Not too well	Well	Very well	Extremely well

11. How well can you deal with situations where others are annoying you or hurting your feelings?					
	Not well at all	Not too well	Well	Very well	Extremely well

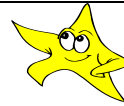
12. How well can you stand firm to someone who is asking you to do something unreasonable or inconvenient?					
	Not well at all	Not too well	Well	Very well	Extremely well

13. How well can you get your parent(s) to help you with a problem?					
	Not well at all	Not too well	Well	Very well	Extremely well

14. How well can you get your brother(s) and sister(s) to help you with a problem?



Not well at all



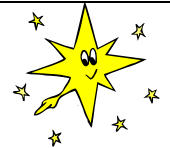
Not too well



Well



Very well



Extremely well

15. How well can you get your parent(s) to take part in a school activity?



Not well at all



Not too well



Well



Very well

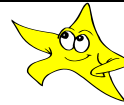


Extremely well

16. How well can you get people outside the school to take an interest in your school (community groups, churches)?



Not well at all



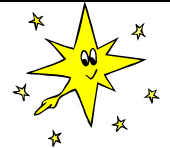
Not too well



Well



Very well



Extremely well

Appendix E

TOPSE Attached to document

ID #
Circle Gender:
Male Female

Inventory of Specific Relationship Standards-III

© Donald H. Baucom, Norman B. Epstein, Lynn A. Rankin, Charles K. Burnett, 1993

This following questionnaire has been adapted from Inventory of Specific Relationship Standards-III

© Donald H. Baucom, Norman B. Epstein, Lynn A. Rankin, Charles K. Burnett, 1993. Modifications were made to accommodate the wide range of relationships that our clients are involved in.

This questionnaire asks about your standards for your marriage/relationship, or what you think your marriage/relationship **should be** like. The way you think your marriage/relationship should be might be different from the way your marriage actually is. Remember, we are interested in what you think your marriage/relationship **should be** like. Below you will find 24 statements that describe standards that people may hold about their relationships. If you are not currently in a relationship, please respond to the questions based on your general expectations regarding marriage/relationship.

Please indicate how often you believe you and your partner should act toward each other in certain ways, as described in the following statements. You have five choices for doing this:

Never	Seldom	Sometimes	Usually	Always
1	2	3	4	5

Simply circle the number beside each item that corresponds to your view. Some of the items ask about parenting and child-rearing. Even if you do not have children, please answer these items based on how you think children should be raised.

Example: Consider the item, *My partner and I should eat our evening meals together*. If you believe that you and your partner should do this most of the time, first you would circle 4 for *Usually*.

1. My Partner and I should have equal say about when we discuss certain positive thoughts and feelings that we have about our relationship. 1 2 3 4 5
2. My partner and I should have equal say about what kinds of leisure activities we do together. 1 2 3 4 5
3. My partner and I should have the same ideas about the values we teach our children. 1 2 3 4 5
4. My partner and I should have equal say about whether we discuss certain negative thoughts and feelings that we have about our relationship. 1 2 3 4 5
5. My partner and I should have equal say about the things we spend our money on. 1 2 3 4 5
6. My partner and I should have equal say on decisions we need to make about friends. 1 2 3 4 5
7. My partner and I should have the same ideas about how to spend our leisure time together. 1 2 3 4 5
8. My partner and I should have the same ideas about how the housework should be done. 1 2 3 4 5
9. My partner and I should value the same qualities in a friend. 1 2 3 4 5
10. My partner and I should have similar religious or philosophical values. 1 2 3 4 5
11. My partner and I should have equal say in job or daily task decisions that affect our relationship. 1 2 3 4 5

12. My partner and I should have equal say on decisions we make about our families (such as, when to visit, lend money, etc.). 1 2 3 4 5
13. My partner and I should have equal say about how our children are raised. 1 2 3 4 5
14. My partner and I should have equal say about how the household is to be run. 1 2 3 4 5
15. My partner and I should have similar spending habits. 1 2 3 4 5
16. My partner and I should have similar values about our jobs or daily tasks (e.g., same amount of ambition, future goals, etc.). 1 2 3 4 5
17. We should have the same attitude about sharing negative thoughts and feelings we have about our relationship. 1 2 3 4 5
18. We should have similar attitudes and values about our sexual relationship. 1 2 3 4 5
19. We should go with our partner when our partner is visiting his/her family. 1 2 3 4 5
-

20. We should have similar ideas about how we share physical affection. 1 2 3 4 5
21. We should agree on how to share our positive feelings about our relationship. 1 2 3 4 5
22. My partner and I should have equal say about when and where we show each other physical affection. 1 2 3 4 5
23. My partner and I should have equal say about the activities connected with our religious or philosophical views we take part in together. 1 2 3 4 5
24. My partner and I should have equal say about the kinds of sexual activities that we share. 1 2 3 4 5