

**DOMESTIC VIOLENCE PREVENTION EFFECTIVENESS IN THE UNITED
STATES AIR FORCE**

A Thesis

by

JENNIFER MICHELLE HALL

Submitted to the Office of Graduate Studies of
Texas A&M University
in partial fulfillment of the requirements for the degree of

MASTER OF SCIENCE

May 2005

Major Subject: Health Education

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ABSTRACT

Domestic Violence Prevention Effectiveness

in the United States Air Force. (May 2005)

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In 2000, the Department of Defense task force estimated roughly 8.8 in every 1,000 military children were victims of some form of maltreatment. In response to the rising incidence of child maltreatment in the military the United States Air Force, in accordance with the Child Abuse Prevention and Treatment Act of 1974, developed the New Parent Support Program (NPSP). The NPSP is a primary maltreatment prevention program for military or dependent parents who have children under the age of three. The formal goals of the program are to decrease potential for family maltreatment, enhance parent role adaptation, increase problem-solving skills and increase knowledge of child growth and development.

Literature has indicated that parental stress is a viable indicator of the potential for child maltreatment. The NPSP uses two quantitative instruments sensitive to parental stress levels, the Family Needs Screener and Parenting Stress Index, to indicate the progress of NPSP participants. The purpose of this study was to evaluate the success of the NPSP at decreasing the potential for maltreatment. Through secondary data analysis, the study examined pre- and post test scores on the PSI for participants in order

to assess whether parental competence, attachment and role restriction scores improved after completion of the program. The study also examined the scoring for any occurrence of racial or rank disparities.

The results of the secondary data analysis showed no significant improvement in overall PSI, parental competence, role restriction scores or attachment scores. The study found racial or rank differences in the FNS scores even though the majority of participants were Caucasian, low ranking, enlisted personnel. The study did not find racial or rank differences in PSI scores. The study results suggest, based on PSI scores, the NPSP does not significantly lower the parental stress, thus lowering the potential for maltreatment. According to the literature, which confirms prevention methods such as home visitation and parent education have been successful in other prevention programs, the NPSP should have the potential to be an effective prevention. Additional research and outcome analysis is necessary to determine which aspects of the program are ineffective and require modification.

DEDICATION

First, thanks to my Heavenly Father- through Him all things are possible. For my family- thanks for all your support and love, you have given me far more than you'll ever know.

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CHAPTER I

INTRODUCTION

Domestic violence is an aspect of health and safety that has become increasingly recognized as a worldwide social threat within the past few decades. Domestic violence, or family maltreatment, is defined as an act by a member of a family or household against another member of the family or household that is intended to result in physical harm, bodily injury, assault, or sexual assault or a threat that reasonably places the member in fear of imminent physical harm, bodily injury, assault, or sexual assault (DOD, 1997). The United States Department of Justice estimated, in 2001, there were between 960,600 and three million incidents of domestic violence in the United States (DOD, 2004). In 2002, an estimated 2.6 million referrals concerning the maltreatment of children were made to Child Protective Services across the United States.

The Children's Bureau of the U.S. Department of Human Services reported in 2001, an estimated 896,000 children were determined to be victims of child abuse or neglect. Children aged birth to three years had the highest rates of victimization at 16.0 per 1,000 children. American Indian and African American children reported the highest rates of victimization, more than twice the rates for Caucasian children (DHHS, 2000). In 2002, children younger than one year accounted for 41 percent of maltreatment fatalities while children younger than 4 years accounted for 76 percent of

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fatalities. One-third of child maltreatment fatalities were associated with neglect, one quarter with physical abuse and the remaining were associated with a combination of the abuse and neglect (DHHS, 2000). One or both parents were involved with approximately 80 percent of all child maltreatment fatalities, closely followed by non-parent caretakers (DHHS, 1995).

Healthy People 2010, a federally supported set of targeted health objectives for the nation, set two initiatives for the reduction of child maltreatment and related fatalities. Initiative 15-33a for Healthy People 2010 is to reduce the maltreatment of children to 10.3 per 1,000 children under the age of 18. Initiative 15-33b is to reduce child maltreatment fatalities to 1.4 per 100,000 children under the age of 18 years (DHHS, 2000). In 2002, the reported rate of abuse and neglect per 1,000 children in the national population was 12.3, a decrease since the 1990 rate of 13.4. 1,400 child fatalities due to abuse and neglect were reported in 2002, a rate of 1.98 children per 100,000 children in the general population.

The cost of child maltreatment may be delineated into categories of direct and indirect cost. The direct costs for the maltreatment of children include such medical services as hospitalization provided to treat abuse-related injuries, child protective services, police investigations, foster care, and family treatment programs. In 1998, the federal government expended an excess of 4.5 billion dollars for child welfare programs (DHHS, 2002). Indirect costs include the long-term economic consequences of child maltreatment such as special education, mental health services, homelessness, juvenile delinquency, and adult criminality along with lost productivity, long-term

unemployment or death. Indirect costs are more difficult to assess due to the wide variability of services provided, however Healthy People 2010 estimated in 1995, the cost of domestic violence in entirety was estimated at more than \$224 billion per year (DHHS, 2000). It is estimated employers lose three to five billion every year for increased medical costs associated with battered workers and United States businesses lose an additional \$100 million in lost wages, sick leave & absenteeism (AIDV, 2001).

The United States military is the largest employer in the country and deploys active duty members to almost every corner of the globe. The military community is a unique population in that while diverse, it is closely knit by a form of employment that has a considerable impact on the lives of the workers and their families. In 2000, escalating media attention concerning military domestic violence became a primary concern for the Department of Defense. In the summer of 2002, the Department of Defense formed a task force to combat domestic violence in the Armed Forces.

The Department of Defense estimated in 2001, 18,000 reported cases of spouse abuse occurred involving military personnel. Of the reported cases, 11,000 were substantiated giving a substantiated aggression of rate of 16.5 per 1000 military personnel (DOD, 2002). Since 1989, the Central Army Registry alone has reported 61,827 substantiated cases of spouse abuse, 5,772 subsequent cases and 3,921 reopened cases. For domestic violence involving children, the Department of Defense task force estimated in 2000, roughly 8.8 in every 1,000 military children were victims of some form of maltreatment (McCarroll et al., 2000). Fatal violence against children is not as

common within the military community as non-fatal violence, however the incidence is still higher than the objectives set by Healthy People 2010 (McCarroll et al., 2000).

In response to the rising incidence of child maltreatment, the United States Air Force, in accordance with the Child Abuse Prevention and Treatment Act of 1974, developed the Child Advocacy Program Regulation (McCarroll et al., 1999). The regulation allowed for the creation of the Family Advocacy Program, a collection of primary and secondary prevention programs designed to prevent family maltreatment within the Air Force. In 1985, The Family Advocacy Program was directed by the Department of Defense to provide a series of programs designed to meet specific domestic violence prevention initiatives. Social outreach workers were recruited by the military to assess community needs, develop prevention service programs, plan and coordinate prevention initiatives, develop community partnerships and increase the awareness of the military community (NPSP, 1999).

The Air Force Family Advocacy Program developed the New Parent Support Program (NPSP) in 1986 in response to the Department of Defense Healthy Parenting Initiative. The NPSP is a multi-dimensional education program designed to prevent the maltreatment of dependent children through clinical intervention and parental skill enhancement training. Interventions focus on the building of knowledge and skills that new parents require to form healthy relationships, and the provision of safe, nurturing communities for children and families (DOD, 1997). The NPSP is a voluntary service offered to active duty members who have children aged birth to three years. With the primary objective to empower USAF families, the goal statement of the NPSP is to

“decrease potential for family maltreatment, enhance parent role adaptation, increase problem solving skills and increase knowledge of child growth and development” (NPSP, 1999). As shown in Figure 1, the logic model for program included intermediate, proximal and distal outcomes in order to evaluate both short-term and long-term change.

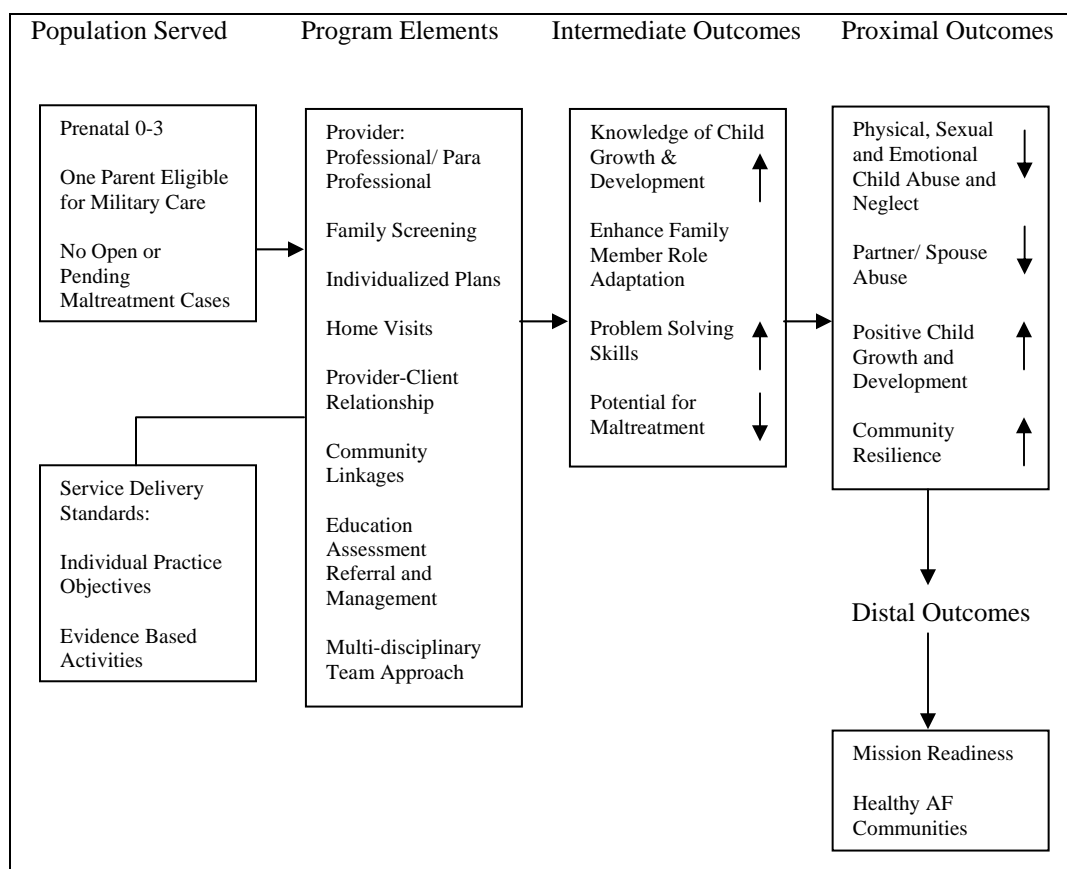


Figure 1 New Parent Support Program Logic Model

Program interventions were developed using the theories of Social Cognitive, Social Capital, Social Networks and Social Support Community Building and Organization, and the Natural Helper Model.

Statement of the Problem

The study is designed to evaluate the effectiveness of a child maltreatment prevention program implemented by the United States Air Force in response to the rising incidence of domestic violence. In 2000 the Department of Defense reported 12,098 cases of reported spousal domestic violence (Department of Defense, 2002). Also in 2000, roughly 8.8 in every 1,000 military children were victims of domestic violence (McCarroll et al., 2000). In the past decade, many studies, though often unsubstantiated, have suggested that the incidence of domestic violence within the United States military is higher than in the civilian population (Mollerstrom et al., 1995; Duggan et al., 1999; McCarroll et al., 2000). The United States Air Force has only recently begun to evaluate the success of the violence prevention programs and little literature exists concerning program effectiveness. What literature does exist has provided conflicting opinions as to the success of interventions such as the New Parent Support Program.

In 1985, the USAF Family Advocacy Program began to focus on a Department of Defense initiative to prevent family violence (McCarroll et al., 1999). The New Parent Support Program is one of the preventative services developed to meet that initiative. The following thesis study will examine the effectiveness of the NPSP concerning the prevention of child maltreatment. Specifically the study seeks to determine the following:

1) Does the NPSP decrease the potential for child maltreatment?

Did participants report a decrease in pre-program parenting stress scores after completing the program?

Racial Differences: Were there any differences in pre-program parenting stress scores vs. post-parenting stress scores specific to race or ethnic group?

Rank: Were there any differences in pre-program parenting stress scores vs. post-parenting stress scores specific to occupation rank?

2) Does the NPSP increase the parenting skills of participants?

Did the 6-month evaluation of program participants show an improvement in parenting competence scores, from the pre program test?

Did the 6-month evaluation of program participants show an improvement in role restriction scores, from the pre-program test?

Did the 6-month evaluation of program participants show an improvement in attachment scores, from the pre-program test?

The potential importance of the study may be justified by three reasons. First, by examining pre and post program outcome measures, the study will determine the success of the primary NPSP program goal to reduce the potential for child maltreatment for program participants. The use of validated quantitative instruments, such as the PSI, for evaluating parental training skills will allow the study to determine if change has taken place from pre-program participation to program completion. Little literature exists that examines the effectiveness of the NPSP and much of what does exist has come from within the military itself, or from civilian parties with a potential bias for or against

military programs. The study will contribute to the literature as an objective evaluation of program success. The study results may be utilized, either by military or civilian services, to enhance existing programs or create new interventions.

Secondly, the study will determine any racial and rank differences concerning the success of the NPSP goals and objectives. By examining raw data scores from the measurement instruments used by the program, it will be possible to identify any racial or rank disparities that exist in the FNS or PSI scores. Lastly, the study provides an empirical analysis of the literature concerning child maltreatment prevention intervention. Within the literature, qualitative and quantitative measures used by the NPSP, specifically the PSI and HOME inventory (Abidin, 1995; Bradley, 1994) have been utilized to determine similar outcomes in a variety of child maltreatment prevention programs. These same measures have also been utilized to determine if parenting education and skill-building efforts have been successful. Through the examination of the literature, it will be possible to determine if similar child maltreatment prevention programs confirm the expected outcomes of the NPSP.

Purpose and Objectives

The purpose of the study was to evaluate the effectiveness of the New Parent Support Program, through the analysis of pre-program and post-program outcome measures. Data was attained through a secondary data analysis of outcome measures retained by the United States Air Force. The measures examined attitude and behavior changes reported before and after the completion of the program. The hypotheses of the study are as follows:

1) Participants of the New Parent Support Program will show decreased potential for child maltreatment six months after program completion regardless of race or educational level.

2) The New Parent Support Program domestic violence education positively affects parenting skills six months after program completion regardless of race or educational level.

3) There will be no racial or rank disparities for Family Needs Screener scores.

Historical Background to the Study

The introduction of the Family Advocacy Program to the United States Air Force in 1974 was the first effort made by the federal government to address the prevention of family violence within the military. Since that time, the Family Advocacy Program has expanded to include a variety of prevention programs such as the New Parent Support Program. While there is limited literature available evaluating the effectiveness of the Armed Forces program interventions, some available research has shown that the programs created by Family Advocacy are effective for the prevention of family violence (Brewster et al., 2002; Mollerstrom et al., 1992; Mollerstrom et al., 1995; McCarroll et al., 2000).

The evaluation of family violence prevention programs has only recently begun to be addressed by the Air Force. Brewster et al. (2002) found, in an evaluation of the Family Advocacy Program, after completing programs offered such as marital therapy, anger management training, individual therapy and domestic conflict containment training, domestic offenders often decreased their incidence of spousal abuse. The

programs indicated were not found however to have produced positive changes for either individual achievement motivation or child maltreatment issues. Brewster concluded that while the Family Advocacy Programs produced successful outcomes for spousal abuse, they did not produce similar outcomes for child maltreatment.

A study by three of the leading researchers of military domestic violence also examined the effectiveness of the Family Advocacy Program for the prevention of child maltreatment (Mollerstrom et al., 1995). The study evaluated the program offered at 44 Air Force facilities in the United States. The services evaluated by the study included: family therapy, structured parenting training, general parenting education and individual therapy. The majority of program participants indicated the classes had been useful and 78.8% reported an improvement in attitudes towards domestic violence. This report was confirmed by 82.6% of spouses of the participants, who reported that the family situation had significantly improved. The future risk of maltreatment was significantly reduced from a pre-program mean of 2.21 to a post-program mean of 2.01 on a four-point scale. The study concluded the evaluation of the Family Advocacy Program indicated positive outcomes from the program intervention offered, although further research is called for.

Definition of Terms

Child Emotional Abuse - Behavior on the part of the offender that contributes to low self esteem, undue fear or anxiety, or damage to the victim's psychological well being. Included are: active, intentional berating, disparaging remarks, or other abusive behavior towards the victim that affects adversely the psychological well being of the victim as well as the passive or passive-aggressive inattention to the victim's emotional needs, nurturing or psychological well-being (DOD, 1987).

Child Maltreatment- Occurrence(s) of child neglect, physical, sexual or emotional abuse.

Child Neglect - Neglecting to provide a victim with nourishment, clothing, shelter, health care, education, supervision or contributing to a failure to thrive, when able and responsible to do so (DOD, 1987).

Child Sexual Abuse - The employment, use, persuasion, inducement, enticement or coercion of any child to engage in, or having a child assist any other person to engage in, any sexually explicit conduct (or any simulation of such conduct) or the rape, molestation, prostitution, or other such form of sexual exploitation of children, or incest with children. All sexual activity between an offender and a child, when the offender is in a position of power over the child, is considered sexual maltreatment (DOD, 1987).

Community Capacity - The ability of a community to bring its members together to meet their needs and goals, jointly solve problems, reinforce prosocial norms, provide opportunities for meaningful participation, provide and express support respond to

external threats, maintain stability and order and create a psychological sense of connection or belonging (NPSP, 1999).

Core Objectives - The key NPSP instruments used with all families receiving home visits. These are the HOME, PSI and ASQ. Additional measures are used when answers on the Family Needs Screener or the PSI indicate there are potential specified concerns for the family (NPSP, 1999).

DOD - Department of Defense - An executive branch of government, created in 1949, designed to provide United States military forces needed to deter war and to protect the security of the country.

Domestic or Family Violence - An act by a member of a family or household against another member of the family or household that is intended to result in physical harm, bodily injury, assault, or sexual assault or a threat that reasonably places the member in fear of imminent physical harm, bodily injury, assault, or sexual assault, but does not include defensive measures to protect oneself; or abuse by a member of a family or household toward a child of the family or household (Texas Code Section 71.01).

Family Advocacy Program - In accordance with the Department of Defense initiative 6400.1, a support program designed to prevent and treat child and spouse abuse within the United States military through multiple interventions (DOD, 2004).

Family Needs Screener – Questionnaire, developed by the University of New Hampshire, to screen prospective participants of the USAF NPSP in order to determine their level of need and the appropriate level of intervention (NPSP, 1999).

Family Service Plan – A comprehensive outline of care delivered in order to attain expected outcomes (NPSP, 1999).

Healthy People 2010 - A governmental initiative first published in 1980, designed to improve the health of the people of the United States through federal, state and local intervention.

Home Observation for Measurement of the Environment (HOME) - “an observational measure the quality of the home environment as it pertains to the child” (NPSP, 1999). Test-retest reliability studies show moderate to high stability with coefficients of .27. Studies conducted with this measure have yielded a standard error of measurement that ranged from .89 to 1.1 for the individual subscales and 2.6 for the total score. Internal consistency reliabilities ranged from .44 to .89 for subscales and were .89 for the total score. Inter-rater agreement levels have been reported at least 85% (Bradley, 1994).

NPSP - New Parent Support Program - A child maltreatment prevention intervention developed by the United States Family Advocacy Program in 1986.

Primary Prevention - Any intervention designed for the purpose of preventing child abuse before it occurs (Browne, 1995).

PSI - Parenting Stress Index- A measure of child, parent and situational characteristics associated with the presence of parenting stress and dysfunctional parenting (Abidin, 1995). The PSI is a 101-item quantitative instrument for the

identification of clinical risk factors associated with child abuse. Alpha reliability coefficients are reportedly 0.95 (Abidin, 1995)

Substantiated Abuse Case - A case that has been investigated and the preponderance of available information indicated that abuse had occurred. This means that the information that supported the occurrence of abuse was of greater weight or more convincing than the information that indicated that abuse did not occur (DOD, 1987).

Unsubstantiated Abuse Case - An alleged case that has been investigated and the available information was insufficient to support the claim that child abuse and/or neglect did occur (DOD, 1987).

Limitations of the Study

The first limitation of the study was the provision of data for analysis. The study was based upon a secondary data analysis of outcome measures supplied by the United States Air Force. The research was dependent on what information was provided and it is possible that all data potentially available was not accessible due to security limitations by the Air Force. Any information deemed sensitive by the Family Advocacy program at Brooks Air Force Base was not made available, therefore a complete examination of the New Parent Support Program methodology was not possible.

Secondly, program participants were often enrolled in the NPSP on a voluntary basis. Although the program is offered, child maltreatment offenders are not necessarily required to attend. It is reasonable to assume, therefore, that many of the voluntary

program participants were low-risk offenders before program completion. A lack of significant change may indicate participants less likely to incur a high potential for child maltreatment regardless of program participation.

Third, the Family Advocacy Program has only recently begun to collect outcome measures for the New Parent Support Program. The relatively small number of participant outcome measures available for analysis may not represent the whole of the military population. The lack of a civilian control group for comparison also prevents the NPSP outcomes from being generalized to non-military populations.

As the Air Force continues to collect outcome measures and repeat data analysis, it will enable studies of program evaluation to be more thorough. The NPSP uses a variety of assessment tools to gauge participant progress. Instruments such as the HOME inventory and the Ages and Stages Questionnaire would have given a more complete assessment of participant attitude and behavior change. The PSI and FNS scores alone do not completely justify the determination of success or failure of the NPSP.

Study Delimitations

The study had two primary delimitations. First, the data used in the study was limited to the United States Air Force due to the availability of data from the New Parent Support Program. Brooks Air Force Base in San Antonio, Texas is responsible for the analysis of all domestic violence reports for the United States Air Force. Due to the close proximity of the base to the researcher, the Air Force was the only branch of the armed forces considered for evaluation. Due to the selection of one military branch, data

results may not be generalized to the Army, Navy or Marines. Secondly, the PSI outcome measures requested by the study were restricted to those participants who had been given a six-month post-program evaluation. Pre-program data for those participants who had not completed the program or who had rejected the post-program six-month evaluation were not considered due to the desire for complete data sets.

Overview of the Study

The purpose of the study was to determine the changes in attitudes and behaviors of the participants in the New Parent Support Program, through the analysis of pre-program and post-program outcome measures. Chapter II will review relevant literature concerning the use of parental education and skill-building programs to decrease the incidence of child maltreatment. Chapter III will provide an explanation of study methods and procedures. The results of the secondary data analysis will be presented in Chapter IV. Chapter V will be concerned with the examination and discussion of the analysis findings. The implications of the study findings, as well as suggestions for future research will also be addressed in the final chapter.

CHAPTER II

LITERATURE REVIEW

The efficacy of parenting programs designed to prevent child maltreatment has been extensively documented within the literature. This literature review will be concerned with two aspects of those programs. The articles identified as potentially eligible for this literature review were acquired through a bibliographic search of the Medline database. First, the literature review will examine programs similar to the NPSP that utilized parental education and skill-building, as well as similar theoretical foundations, in order to decrease the potential for child maltreatment. The theoretical basis behind the New Parent Support Program was multi-dimensional with aspects of Social Cognitive, Social Capital, Social Networks and Social Support Community Building and Organization and the Natural Helper Model.

Secondly, the theory that parental stress, as a modifiable variable, is directly related to the incidence of child maltreatment will be examined through the literature review. In 1994, a national survey of 224 home visiting programs found the most often reported determinants of program success was the improvement of parenting skills, parental coping mechanisms such as stress management, and social and emotional development of the child (Wasik & Roberts, 1994). Many programs, similar to the NPSP, utilize the Parenting Stress Inventory (PSI) to measure changes in parental stress as an outcome of parental education. The quantitative measure by the PSI of parenting skills and attitudes towards the parent-child relationship enables the NPSP to clearly evaluate the success of program objectives.

Literature Review

Cowen and Reed

Child abuse literature has identified children with developmental disabilities as a vulnerable population for maltreatment (Abiden, 1995; Westcott & Jones, 1999).

Cowen and Reed conducted an evaluation of respite care programs, targeting children with developmental disabilities, with the primary goal of the prevention of child maltreatment (Cowen & Reed, 2002). The respite care programs used, as a comprehensive approach for the prevention of child maltreatment for at-risk and special needs children, are provided to children at environmental, biological, and developmental risk. Respite care interventions are intensive, in-home programs administered through public health nurses. The conceptual framework of the respite program includes individual (parent & child), familial, social, and cultural factors, emphasizing the level of stress within a family unit as the variable most influential on the risk of maltreatment. Within the program, parents were provided the opportunity to receive parenting information, social support, positive role modeling, and information regarding alternative community resources and agencies.

The evaluation conceptual framework, derived from the theory stress and social support are key variables in determining if child maltreatment occurs, were as follows: increased stress will be associated with an increase in the odds of maltreatment occurring; increased social support will be associated with a decrease in the odds of maltreatment occurring, and as stress and social support are the key variables, other variables will not be significantly related to maltreatment. The evaluation was

accomplished by comparing pre-program and post-program Parenting Stress Inventory (PSI) scores. The PSI instrument, used to measure the amount of personal, life and parent-child relationship stress, has three domains of parent, child and total stress. An analysis of 87 family PSI scores through multiple regression and bivariate correlations revealed that although pre-test and post-test total stress scores were above the “high stress” range of 260, there was a significant decrease in stress from pre-test to post-test ($t = 3.27, p = .0016$). A decrease in post-test measurement was also reported for both the parent domain ($t = 3.55, p < .001$) and child domain ($t = 2.2, p = 0.03$) scores. The reported incidence of child maltreatment during and after the intervention also decreased. Bivariate relationships were found between maltreatment during enrollment and social support, father’s health, PSI Life Stress, mother’s health, income, and service level. Life stress was found to be positively related to maltreatment and social support, negatively related.

The authors concluded, “Parenting stress significantly decreased following respite care interventions resulting in a decreased risk for the development of dysfunctional parental behavior”. The respite care program was determined to be an effective and appropriate intervention to decrease parental stress and thus decrease potential for child maltreatment. The study was extremely thorough in conceptual framework, hypotheses and data analysis. As a control group was not utilized in the study, it is not possible to determine if the findings may be generalized to the population as a whole. The study is relevant to the NPSP evaluation in many ways including the voluntary nature of the evaluation. The use of public health nurses to provide clinical

and social skill building for the parent-child relationship is similar to the role of the NPSP social worker. The use of the PSI by the authors to determine the program effectiveness risk is directly proportional to the evaluative study of the NPSP. The PSI scores are utilized in both studies to determine if a significant decrease in parental stress occurs between pre-program and post-program intervention. The hypothesis parental stress is directly related to the risk of maltreatment is the foundation of both programs. The respite care program evaluation concluded as PSI scores decreased from pre to post-program intervention, the respite care program was successful. The NPSP program will be similarly gauged as effective or ineffective due to the PSI scores of program participants.

Cerny and Inouye

The purpose of the Cerny and Inouye evaluation of Hawaii's Joint New Parent Support Program (JNPSP) was to determine if the program effectively reduced the potential for maltreatment, and to identify demographic characteristics that correlate with abuse (Cerny & Inouye, 2001). Similar to the Air Force New Parent Support Program, the JNPSP was developed by the Army to serve families who have been identified as high risk for child maltreatment. The JNPSP is an early pre-natal individualized home visitation intervention focusing on the empowerment of the parents through education, bonding and social support. Participants are visited bi-monthly by a community health nurse until the child is one year of age. Although participation is voluntary, less than 5% of women deemed as high risk for abuse refuse JNPSP services. The program utilizes the Child Abuse Potential (CAP) inventory as a tool for screening

and outcomes evaluation. In 1992, The JPSP was credited with the reduction of military child maltreatment in Hawaii to 1.77 (per 1,000) as compared to the 6.2 worldwide military maltreatment rates.

The evaluation hypothesis was the potential for abuse by mothers would decrease within a 16-month period of home visit interventions. The authors also expected to find statistical confirmation that single parenting and marital problems influence in potential for abuse. The study utilized a one-group pre- and post-test comparison method.

Criteria for inclusion in the study as “high risk” included the following factors: unrealistic expectations of children, lack of support, high stress, marital problems, single parenthood, poor parenting imprint, negative attitude toward pregnancy, social isolation, inappropriate coping skills, history of spouse abuse, or a history of emotional, physical, or sexual abuse. The 142 participants were primarily young, Caucasian women of relatively low socioeconomic status. All mothers completed the CAP inventory within the first three home visits and again at the completion of program services. Statistical analysis was completed using the *t* test and ANOVA.

The signal detection cut-off of the CAP inventory for the risk of child abuse is 166. 46% of the program participants scored higher than 166 on the CAP pre-test, with a mean score of 257. After 16 months of home visitations the mean score fell to 137 ($p < .001$). CAP subscales found that loneliness, distress, rigidity, unhappiness, and problems within the parent and the families significantly decreased at the end of the study ($p < .001$). Ego strength significantly increased indicating high self-efficacy, knowledge and parental confidence. The only sociodemographic differences found in the study were

mothers who had past or present psychological problems, relationship problems or spouse abuse were more likely to score higher on the pre-CAP inventory.

The authors concluded the JNPSP significantly decreased the potential for child abuse and neglect through the home visitation intervention. Study limitations included the lack of a control group and the inability to generalize these findings to non-military populations. The NPSP is exceedingly similar to the JNPSP in design, program intervention and outcome assessment. While the NPSP does not use the CAP inventory but a variety of screening and outcome measures, the use of home visitation and a similar parental education curriculum allow for outcome comparisons to be made. The reduction of the potential for child maltreatment by the JNPSP lends validity to the interventions currently under evaluation for the NPSP. Similar successful outcomes may be expected from the NPSP.

Wesch and Lutzker

Wesch and Lutzker conducted a five-year evaluation of an ecobehavioral program for the treatment and prevention of child abuse and neglect (Wesch & Lutzker, 1991). The program, Project 12-Ways is an in-home intervention using such techniques as parental-child training, basic skill training, problem solving and stress reduction in order to reduce the potential for child maltreatment. 232 families participating in Project 12-Way between June of 1980 and December of 1985 were considered for evaluation. A sample of 625 families, referred to the state for at risk behavior, was randomly selected for a comparison sample. Demographic and treatment program data, along with outcome data such as goal attainment or the removal of children from the home, were

examined as primary variables. Data concerning child placement, adoption and abuse were compared between the two samples across three points in time: pre-treatment, treatment and post-treatment performance through Chi-Square analysis.

Results determined that 56% of pretreatment families and 42% of the comparative sample had an incidence of abuse, child placement or adoptions occur. Post treatment 31% of the intervention families and 25% for the comparative sample. Across the three conditions, the findings were statistically significant with $p < .01$. Child abuse recidivism remained constant in the intervention group and rose with the comparative sample. Authors concluded, as families in the Project 12-Way were more likely to be problematic than the comparative sample, the reduction in maltreatment recidivism was significant and consistent with program variables. The authors admitted that the integrity of each sample was uncertain, as the numerous variables that affect the structure and function of a family were not possible to constantly monitor, for example, during the course of the intervention some families had all their children removed from the home which effectively lowered the rate of recidivism. Furthermore, it is difficult to compare the 12-Way evaluation results to the child maltreatment literature due to differences in the defining of dependent variables.

The 12-Way program is similar to the NPSP as the intervention focuses on in-home observation and training of parental skills. Variables such as stress management, multiple setting behavioral management, home safety and problem solving are aspects of the 12-Way program that are used to decrease the potential for future child maltreatment. The results of the 12-Way evaluation are significant as the emphasis of parent-child

interaction to decrease parental stress and potential for child maltreatment is comparative to NPSP methods. Due to the similarities the reduction in recidivism for child maltreatment for NPSP participants may be theorized to decrease post-treatment as well.

Holden and Banez

The conceptual framework of the NPSP assumes the theory that parenting stress is directly related to the potential for child maltreatment. A study conducted by Holden and Banez examined the relationship between parenting stress and the incidence of child abuse (Holden & Banez, 1996). Participants in the study were 47 couples receiving treatment for child maltreatment through community programs. More than half of the participating couples had been referred the community programs due to past incidences of physical child abuse, the others referred due to the incidence of child neglect or sexual abuse. Participants were given both the Child Abuse Potential Inventory (CAP) and the Parenting Stress Index (PSI) at the onset and completion of program treatment. Regression analysis was conducted to determine if parenting stress was related to the potential for child abuse. A factor analysis was also conducted in order to derive factors contributing to Parental Domain Stress

The authors found high parental stress was significantly correlated with child abuse potential ($p < .0001$). The second order factor analysis found that depression, social isolation and sense of competence were identified with emotional and parenting competence. Health, spousal relationship and restriction of role was identified with interpersonal and health stressors. Parental attachment was identified as the third factor.

Factor one, emotional and parenting competence was found to be significantly correlated with child abuse ($p < .0001$).

Study conclusions found maltreating parents showed higher levels of child abuse potential and child related parenting stress than did non-maltreating parents. For both groups, parenting stress was shown to be a significant predictor of abuse. The parental sense of competence was the variable found to be the most significant contributor to parental stress. The non-perpetrating parents reported high levels of child-related distress, therefore suggesting that both non-perpetrating and perpetrating parents be targeted equally within maltreatment prevention programs. The study, while presenting strong quantitative data analysis, is limited in that the study sample was not contrasted with a control sample, producing correlational rather than causal results. Also, as the PSI and CAP are self-administered, relying on data from the participants' point of view, the results may not have been clinically accurate.

The Holden and Banez study is significant to the evaluation of the New Parent Support Program as the results support the hypotheses of the NPSP logic model. The model assumes parental stress, as a significant contributor to child abuse, must be a focus of intervention in order to reduce the potential for child maltreatment. The results of the study indicate parenting stress does contribute to the potential for child abuse, thus lending theoretical validity to the NPSP intervention effort. The use of the Parenting Stress Index to measure parental stress is also another validation of the NPSP choice of parenting stress measurement.

Duggan, McFarlane and Windham

Duggan et. al. conducted a three-year evaluation of Hawaii's Healthy Start Program (HSP) in order to assess the impact on the incidence of child abuse and maltreatment for participating families (Duggan et. al, 1999). The HSP is a paraprofessional, home visitation-based intervention for families determined to be at risk for child maltreatment. The goal of the HSP is to identify vulnerable families before stressors, lack of knowledge and social isolation potentially give rise to abuse and neglect of infant children. The study was designed to answer four questions: (1) How well does performance conform to the HSP model? (2) How successful is the program in achieving desired outcome for parents and children? (3) How does the fidelity of program implementation influence outcomes? (4) How do benefits compare with direct and influence program costs?

Participants for HSP services are generally identified as "at-risk" by the presence of one or more of 15 indicators in the maternal medical records. The "at risk" indicators range from the paternal unemployment to a history of maternal depression. When record reviews determine an individual to be at risk, an early identification worker then contacts the parent(s) to arrange for voluntary home visitation. The home visitation program seeks to provide problem-solving skills and access to community services as well as child health promotion through parenting education, modeling of effective child-parent interaction, and the ensuring of a source for pediatric primary care. By building family trust and promoting effective parenting, the HSP suggests child abuse and neglect will

be effectively prevented. The home visitation programs set 6 months goals for family retention and engagement, services delivered and quality of care.

The two-year report of a continuing three-year evaluation consisted of three study groups: the HSP group consisting of 373 families, the main control group consisting of 270 families and the testing control group consisting of 41 families. Participants in the HSP and main control group were followed throughout the three-year evaluation and the testing control group was interviewed at the end of the evaluation to determine if the study's intensive data collection influenced outcomes. The HSP and main control group were relatively similar at baseline testing. 35% of fathers and 23% of mother in the HSP group were identified as very high risk for child maltreatment at base line compared to 40% of fathers and 25% of mothers in the main control group. Home visitors reported an average of 13 visits in the infant's first year.

The conceptual framework of the HSP relates to the linkage of families with community resources, parental life course, home environment, parenting behavior and attitudes, child health and development, and child maltreatment. The outcomes chosen for evaluation followed the HSP conceptual framework. Data was collected through maternal interviews, observation of the home environment, observation of mother-child interactions, child development testing and child protective services reports. The evaluation found after two year of services, the HSP group was less likely to use nonviolent approaches to discipline, experience less stress ($p=.08$), and express more confidence in their parenting skills ($p=.03$). Parental stress was shown to directly affect the level of parenting confidence, or efficacy, The incidence of child maltreatment

differed between the control group and the HSP group only during the first year, in which the control group was more likely to have been reported to social services for neglectful behavior.

The authors did state the relation of the incidences of child maltreatment to the HSP intervention did have two limitations. First, the reporting of child maltreatment is rare, especially with large sample sizes. Also, the potential for reporting bias was high as maltreatment in an intervention group may be reported more often simply as the intervention group was under more surveillance than the control. The evaluation found parental competence and self-efficacy were positively promoted by the HSP, thereby decreasing parental stress. The theory parental stress directly affects the incidence of child maltreatment is supported by the study. The NPSP and the HSP program are similar in that the programs both attempt to increase parenting competence and decrease parental stress through education and home visitation. The preliminary conclusion by the Duggan et. al. evaluation suggests such programs are successful in the prevention of child maltreatment.

Olds, Henderson, Chamberli and Tatelbaum

The evaluation of a program designed to prevent child abuse and neglect through home visitation is the focus of the study by Olds, Henderson, Chamberlin, and Tatelbaum (Olds, Henderson, Chamberlin, & Tatelbaum, 1997). The study was preempted by the comparison of four controlled child abuse prevention programs. Although the results of the program comparisons showed mixed results for the effectiveness of child abuse prevention, the use of home visitation to encourage behavior

change was a common intervention. A randomized clinical was conducted by the authors in order to determine if home visitation within prevention programs effectively reduced the incidence of child abuse and neglect. The study consisted of four treatment conditions. Group One was determined to be the control group with no services provided. Participants in Group Two were provided prenatal and well-child care. Group Three participants were provided with nurse home visitation during the 9-month pregnancy. Group 4 participants received the nurse home visitation during pregnancy and during the first two years of the child's life. The home visitation consisted of parental education of infant and toddler needs, stress management, the building of familial social support, and connection to community support services.

400 hundred women, identified as at-risk for potential child maltreatment due to age, socioeconomic status or marital status, were enrolled in the study. Participants were all first-time parents. The home visitation nurses, to evaluate the quality of the home environment and parent-child interactions, used the Home Observation for Measurement of the Environment (HOME). A core statistical model using covariate analysis and linear regression was used to evaluate statistical data, using a significance level of .10. At the study completion, all participants were screened through the state social services in order to determine if child abuse or neglect had been reported.

Data analysis determined women who were provided nurse home visitations (Groups 3 and 4) felt a significantly greater sense of control over their lives ($p = .04$). During the first two years of children's lives, 20% of the participants at the greatest risk for abuse (teenagers, unmarried, low SES) who had not received the home visits reported

abuse or neglect of the child compared to 4% of their counterparts who did receive the home visits ($p = .07$). As the number of risk factors for abuse such as the maternal sense of control increased in the comparison group, the incidence of abuse and neglect increased however for the groups who received home visits, the incidence of abuse remained low regardless of risk factors. Home visited women reported happier infants, less parent-child conflict, low use of child restriction and punishment and higher developmental quotients.

The authors concluded the results of the data analysis suggested home visitation was effective at preventing child abuse and neglect. They cautioned statistical bias in the reporting of study findings. Objective measure of environment and parental education by the home visitation nurses is subject to human error and personal bias. Also, parental observation of the child's temperament and behavior may be attributed to multiple causes such as genetic predisposition and may not be directly attributed to program intervention efforts. The addition of home visitation to the provision community services did seem to effectively decrease the risk of child abuse and maltreatment by study participants. The study conclusions stated home visitation positively affected infant crying behavior, maternal conflict with the child, provision of appropriate play materials and the use of punishment or restriction. These findings were not only supported by the statistical analysis of the HOME inventory, but also by the incidence of abuse and neglect reported by state social services, emergency room records, and child developmental test scores.

The Olds et. al. study is relevant to the NPSP as the HOME inventory is the observational measure used by social workers in the NPSP intervention. As the NPSP has just begun the process of evaluation, program administrators were unable to provide the HOME data in addition to the PSI data for evaluation. The use of home visits in order to educate program participants and encourage behavior change is central to provision of the NPSP intervention. The study found home visitation had a positive effect on the prevention of child abuse and maltreatment, therefore the NPSP may be expected to have similar results from visitation. In the future when the NPSP has made available the HOME data, it will be useful to evaluate the effects of the home visitations on program outcomes as the Olds et. al study has done.

Thompson and Grow

Thompson and Grow evaluated the success of a practical parenting program for poor and middle-income families (Thompson & Grow, 1993). The Common Sense Parenting Program, based on social learning principles, is designed to teach child management skills to parents through individualized home visitation, modeling and role-playing, and family management education. The assumption parental stress due to economic, environmental and behavioral factors is directly related to the incidence of child abuse serves as the theoretical foundation for the program intervention. The 8-week intervention is hypothesized to reduce parental stress, and reduce the potential for child abuse and neglect. 34 parents were recruited for the evaluation study. Participants completed outcome measures before, immediately after and 3 months following the completion of the Common Sense program. A problem-solving inventory, and self-

report inventory were used to measure changes in attitude and behavior. Participants were differentiated into two subgroups as low-income or middle income. The majority of the participants were Caucasian and half were single parents. Parent-child conflict was identified as the main reason for program participation, either through an outside organization referral or a personal referral. Outcome measures used were the Eyeberg-Child Behavioral Inventory (ECBI), the Parent Attitude Test, and the PSI. Analysis of eight dependent outcome measures was done by ANOVA

Data analysis showed no significant differences between income groups. Parental reports of child behavior, parental attitudes, and problem-solving skills improved significantly from pre-program to post-program measures. No significant changes were reported from immediate outcomes to 3-month outcomes. Seven out of eight of the dependent outcome measures showed significant improvement including number and frequency of child behavior problems, parental home attitude, parental adjective checklist, parental behavior, personal control and problem-solving confidence. These improvements were maintained for the 3-month follow-up measures. The sample size for the study was small, and no information was provided as the incidence of maltreatment and abuse prior to and following the program intervention. The participants all had finished high school and many had some college education. It would be inadvisable to generalize the results of this study to the entire low-income population, as the sample was not demographically representative. The authors identify the need for future research in order to isolate the variables of the intervention that directly affect the potential for child abuse or maltreatment.

The Common Sense Parenting Program is similar to the NPSP as the reduction and management of parental stressors is thought to decrease the likelihood of child abuse and maltreatment. The program outcomes show intensive in-home efforts to relieve parental stressors may successfully modify attitudes and behaviors that are maintained over time. Future plans of the NPSP include the follow-up of program participants 3-months after the completion on the intervention in order to determine if change is maintained. The Thompson and Grow study shows parental attitudes and behavior change may be expected to be maintained after program completion.

Pianta, Egeland and Erickson

The Pianta, Egeland and Erickson evaluation of the Mother-Child Interaction Research Project (MCRIP) specifically seeks to identify an integrative model of the antecedents of child maltreatment (Pianta et al., 1989). Through a review of the literature, the authors found parental social-cognitive and affective processes are directly tied to the perception of the parent-child relationship and care-taking behaviors. While numerous potential variables that may contribute to the parent-child relationship have never been comprehensively studied, the authors found parental vulnerability to the environment and to child-induced stress were the constant and common determinants in the literature of child treatment. A multi-factorial perspective for child behavior, environment and parental response was required to assess the effect of child maltreatment prevention efforts.

The MCIRP is a prospective, longitudinal study of 267 women and children considered at high risk for child maltreatment due to low socioeconomic status.

Participants were primarily young, single and uneducated and 86% of the children were unplanned pregnancies. The assessment measures began at the birth of the child and continued through early elementary education. The HOME inventory, along with the Life Stress Scale and several other assessment instruments were administered during the last trimester of pregnancy, at birth, and from 3-64 months of age. Data analysis was conducted using ANOVA and linear regression.

The authors found maltreating mothers were found to have high levels of anxiety, aggression, and defensiveness which, when combined with environmental stressors, increased the likelihood of child maltreatment. A continuity or cyclical pattern of maltreatment was found as 75% of the mothers maltreating their children at 12 months were found to have a high incidence of maltreatment at 64 months. Neglectful and maltreating households were found to have poor scores on the HOME inventory and high scores on the Life Stress Scale. The study authors found the maltreating mothers who were no longer maltreating their children by the age of 64 months were more personable and outgoing ($p = .037$), tended to be more mature and less reactive to feelings and emotions ($p = .065$), and were more realistic and practical in problem solving ($p = .017$) than the maltreating mothers. Many of the mothers who were no longer maltreating had been involved in maltreatment prevention programs using education and social support to modify their parental styles.

The authors concluded maternal psychological characteristics play a critical role in the determination of high and low risk parents. High levels of stress and low social support for those mothers who were emotionally stable did not necessarily increase the

risk of child maltreatment. The psychological health of the parent may often have been less modifiable due to childhood experiences, family history of abuse, etc. The coping ability of the parents therefore, may have been a modifiable variable for those parents experiencing unstable psychological characteristics. A limitation of the study is the study was primarily concerned with a population considered “high-risk” of low socioeconomic status, and little social support. Program participants may have been more vulnerable to the impact of stress than peers in a more positive environment and results therefore, may not be generalized to the entire population.

The importance of this study, relevant to the NPSP evaluation lies in the theoretical support of the NPSP hypotheses. The program assumes that stress is a modifiable contributor to the risk of child abuse and maltreatment. Support for this hypothesis is found within the Pianta, Egeland and Erickson study as the authors identified numerous studies, through literature review, that reached the conclusion that parental stress is directly related to the risk of maltreatment. The study supports the use of the PSI, a measure of parental stress, to predict the potential for future child maltreatment.

Lutzker, Bigelow, Doctor and Kessler

Lutzker, Bigelow, Doctor & Kessler evaluated Project SafeCare, a child abuse and neglect program for families, with children under the age of 5 years, reported to be at risk for child maltreatment (Lutzker, Bigelow, Doctor & Kessler, 1998). The introduction of development-ecological and transactional theories in order to explain the causal factors of child abuse, have produced eco-behavioral programs such as Project

SafeCare. The program focuses on the family, the individual, the environment and culture as the primary factors that influence the family dynamic, constantly influencing behavior and attitude. The treatment strategies of Project SafeCare such as direct observation, behavioral assessment, behavior analysis, and therapy procedures are implemented within a co-behavioral context in order that learned skills may be implemented within the individual families' social ecologies. The program offers parent-child training, stress reduction, basic skill training of the children, money management, home safety, home cleanliness, single-parent training, infant health care, nutrition, and marital counseling.

Evaluation participants were comprised of two groups: the control was an at-risk group referred from a local hospital maternity center, and the target population was an abuse/neglect group referred from the Department of Children and Family Services. 116 families participated in the project evaluation. The control and target groups were closely matched for age of the children and geographic location. 64% of project participants were Hispanic, 28% African American, 7% African American and 1% Indian. An in-home counselor visited the families to train the parents in areas of childcare, home safety and parent-child bonding for 6 total sessions. Role-playing, modeling and practice with feedback were used along with the completion of a health manual. The Child Abuse Potential Inventory (CAP), the Beck Depression Inventory (BDI), Parenting Stress Index (PSI), Eyeberg Child Behavior Inventory (ECBI) and the Parental Anger Inventory (PAI) were used for the evaluation of Project SafeCare.

The evaluation of the four-year Project SafeCare program utilized a longitudinal design within a constructed control group. The dependent variable for data analysis was post-contact abuse recidivism rates. The department of social services screened all participants in order to determine if recidivism had occurred. Reliability observations were conducted for all of the data collected for analysis, including verification of social services reports of abuse and maltreatment. The authors found the target group from Project SafeCare was significantly more likely than the control group to have suppressed abuse recidivism ($p < .01$). Based on these findings, authors concluded families who completed the program were less likely to be involved in recidivistic child abuse and neglect.

Limitations of the study include the fact that in order to create demographically similar comparison groups, there was non-random assignment to the target and control groups. Non-random assignment therefore limits the study's applicability to the population. Again, the limitations inherent in the reporting of child abuse are relevant in this study, as not all child maltreatment is always reported to the state social service departments. Some of the participant families had their children removed from their care during the four-year program, thus lowering the possibility of abuse recidivism. The study contributed to the literature further credibility that in-home interventions, family-based services are effective for reducing child abuse and neglect. The use of stress management within the intervention in order to improved parenting efficacy, is again used to reduce the likelihood of abuse as it is in the NPSP.

Cowen

The Bavolek Nurturing Program (BNP), a parenting education intervention, was the subject of the next evaluation (Cowen, 2001). The theoretical framework of the BNP is based on the premise that positive change in the parent must be attained before the parent-child relationship can be modified. The intervention focuses on the remediation of four parenting constructs, typically associated with maltreating parents. These constructs are: inappropriate parental expectations, inability of the parents to be empathetically sensitive to the needs of the child, strong parental belief in the value of punishment, and role reversal. The program goals require cognitive changes in the parents within the first five years of the life of the child. Participants are taught parenting techniques such as communicating effectively, developing empathy and handling stress and anger. The intervention utilizes both group training and individualized home visitations. Outcomes are assessed using the Adult-Adolescent Parenting Inventory (AAPI). The AAPI, developed from known parenting and childrearing practices of neglectful and abusive parents, is a 32-item questionnaire designed to assess parenting attitudes and behaviors. Reliability of the AAPI is approximately .76.

The one-year program evaluation was conducted by matching the pre- and post-program AAPI scores for 15 county interventions. The 191 evaluation participants, primarily Caucasian, were either self-referred or court referred. The participants were differentiated as high risk or low risk, primarily by sociodemographic factors such as income and employment status. Evaluation of the pre-test AAPI scores determined the

majority of program participants had very low scores associated with maladaptive parenting practices. Score comparison found positive, significant attitude and behavior change occurred in the areas of parental expectations ($p < .0001$), lack of empathy ($p < .0001$), belief in corporal punishment ($p < .0001$), and role reversal ($p < .0001$).

The primary limitation of the Cowen study is the absence of a control group. Secondly, although 600 families were originally identified as eligible for evaluation, the sample size of the evaluation was considerably smaller. There was also no differentiation in scores from those participants who were self-referred and those who were court referred. Finally, any additional social support services provided to participants were not considered during the evaluation. The authors concluded the evaluation findings supported the theory that interventions targeting parenting adaptive skills and childrearing practices are important in child maltreatment prevention. The use of home visitation to reinforce educational interventions was again utilized in the BVP study, as it is in the NPSP. The BVP study is another that supports the NPSP theory that intensive parenting education, including stress management skills, is an effective method of child maltreatment prevention.

Peterson, Tremblay, Ewigman and Saldana

The Peterson, Tremblay, Ewigman, & Saldana study concerned the development, implementation and evaluation of a multi-component, selected primary- prevention program to reduce the potential for child maltreatment (Peterson, Tremblay, Ewigman, & Saldana, 2003). The authors anticipated the program would decrease the potential for child maltreatment based on seven hypotheses. The seven outcomes hypotheses on

which the program was based supposed the program would: increase parenting skills, increase awareness of behavior management interventions, development of accurate beliefs, reduction of erroneous beliefs, acceptance of responsibility for the child, nurturing skills, and increased self-efficacy. The conceptual prevention model assumed high beliefs, parental role, parental efficacy, maternal role, and affect (reduction in erroneous beliefs) would lead to developmental awareness, adaptive parenting behaviors and sustained, successful parenting.

Study participants were recruited through the Women, Infants and Children program. Participants were selected if they were Medicaid eligible, had less than two years of college and had children between 18 and 48 months of age. Participants were differentiated into a treatment (n=61) and a control group (n=58) using stratified random sampling. Multiple questionnaires, some developed by the study authors specific to the identified outcome measures, were used in order to measure parental attitudes, beliefs and behaviors. The measures were completed by the treatment group pre-intervention and again at a one-year follow up. Intervention techniques included 15 weeks of attitude and behavior modification using cognitive restructuring such as role-playing, Socratic dialogue, modeling and discussion. Every week, a home visitor would visit each family to provide social support, individualize the curriculum, encourage familial support, and answer questions.

The participant pre- and post-intervention measures were analyzed using one-way ANOVA, MANOVA, and chi-square for each of the seven expected outcome hypotheses. Data from the one year follow up determined that the knowledge of

appropriate interventions, parenting beliefs, parent affect and parental self-efficacy showed significant and sustained improvement for the treatment group compared to the control group ($p < .0001$). The study authors found the intervention significantly reduced the use of harsh discipline, and parental knowledge and confidence increased. Notable in this study is the apparent sustainability of the intervention as outcomes continued to be positive after the intervention had ended.

Study limitations included a small sample size, non-random selection of participants as well as potential bias introduced by financial compensation for participants. Any possible effects outside the program influencing attitudes and behaviors were also not controllable and therefore may have had influences that were unaccounted for. The study findings, specifically that parental education and self-efficacy building appear to reduce the potential for child maltreatment, is relevant to the evaluation of the NPSP which assumes similar hypotheses. The Peterson, Tremblay, Ewigman, & Saldana study may be added to the literature that supports the intervention methods and educational goals of the NPSP.

Rodriguez and Green

The Child Abuse Potential Inventory (CAPI) has been recognized in the literature as the leading instrument to evaluate the risk of child abuse by incorporating constructs that have been linked to abusive parenting. Poor ego-strength, erroneous beliefs concerning appropriate child-hood behavior, stress, and poor parenting skills have all been linked to abusive parental behaviors (Rodriguez & Green, 1997; Peterson, Tremblay, Ewigman & Saldana, 2003). According to the Rodriguez and Green study,

the level of stress experienced by parents encompasses several factors such as marital conflict and depression. Parents experiencing greater stress exhibited a higher frequency of controlling, abusive, and punitive parenting behaviors (Rodriguez & Green, 1997). The Rodriguez and Green conducted a study to determine if PSI scores positively correlate with CAPI scores, thus validating that stress is a reliable indicator of abuse potential.

The study was based on three hypotheses: PSI scores would positively correlate with CAPI scores, anger expression scores would positively correlate with CAPI scores, and that PSI scores and anger expression scores would provide the best prediction for CAPI abuse scores. The study consisted of 84 participants (65 female and 19 male) with children under the age of two years, recruited through local schools. Participants had a mean age of 38.08 and the majority was Caucasian. Participants completed the PSI, CAPI abuse scale, and the State-Trait Anger Expression Inventory (STAXI). Analyses was conducted using hierarchal multiple regression. The correlation between the PSI and CAPI was significant and positive ($r = .52, p < .001$) confirming the first hypotheses. The correlation between the CAPI and STAXI was also significant ($r = .44, p < .001$) indicating that the tendency to express anger was correlated with abuse, confirming the second hypothesis. The PSI and STAXI scores, therefore, confirm the third hypothesis in that both scales give a reliable predication of the CAPI scores.

Study limitations include the potential bias by the sample, as those who responded to the study were more likely to be involved and motivated parents which may not be representative of the population. As the study population was presumably

non-abusive, results may not be generalized to an abusive sample. The authors concluded the study shows the PSI and STAXI instruments are valid predictors of abuse potential. Participants who reported high stress and high anger levels were more likely to also report parental characteristics associated with abuse. The Rodriguez and Green study is significant to this evaluation as the NPSP utilizes the PSI inventory as a screening and program outcome measure. The instrument is used to gauge participant progress during the program intervention and it is used as an indicator of child abuse potential. The NPSP educational curriculum emphasizes stress management skills in order to decrease the potential for abuse. The Rodriguez and Green study validated the use of the PSI as a screening instrument and as an outcomes assessment predictor of child abuse.

Summary of Literature

Chapter II has presented the evaluation of child maltreatment prevention programs similar to the New Parent Support Program. The use of the Parenting Stress Index for outcomes assessment was also examined in the literature review. The literature indicated child maltreatment prevention programs through methods utilized by the New Parent Support Program are successful. The analysis of the literature indicated a strong correlation between programs emphasizing stress management skills through home visitation, and the successful prevention of child maltreatment. High parental stress levels were shown to correlate positively with the potential for child maltreatment. The PSI, along with other instruments utilized by the NPSP, was frequently utilized to identify parental stress levels and to evaluate post-intervention stress reduction

outcomes. The literature provides support for secondary data analysis of the New Parent Support Program outcome measures in order to determine if the program is an effective intervention for parenting skill- building and the reduction of child maltreatment. The literature also supports the use of the Parenting Stress Index as an adequate measure of parental stress and thus an accurate predictor of the potential for child maltreatment.

CHAPTER III

METHODS

Introduction to Methods and Procedures

The proposals for the study were reviewed and approved by the Institutional Review Board of Texas A&M University (Appendix B). The purpose of the study is to evaluate the success of the NPSP by the analysis and comparison of a pre- and post-intervention outcome measures. Participating families are determined as high-risk or low risk by the Air Force Family Needs Screener. Families who are determined to be low risk are offered parental education and community-based resources such as stress management and family health promotion programs. Families who are determined to be high risk and are referred for home visit intervention and are given multi-dimensional parental assessment tests during the first home visit. The program participant flow diagram is shown in Appendix C.

Nurses and social workers are utilized for the home visitation in order to provide a clinical assessment of the environment. The primary assessment tests (Appendix A), including the Family Needs Screener, Parenting Stress Index (PSI) and the Home Observation and Measurement of the Environment (HOME) are given to the participants before the program intervention and again every six months until program completion. The instruments are then given six months after program completion in order to measure long-term change. The Ages and Stages Questionnaire (ASQ), an additional quantitative instrument is administered multiple times during the intervention determined by the child age milestones. Based on the scoring of these assessment tests, a Family Service

Plan (FSP) is developed by the Family Advocacy Treatment Manager. Each family is assigned a team consisting of clinicians, social workers, program assistants and a treatment manager. Goals, objectives activities, and outcomes are developed and referrals for specialized services, such as substance abuse, are incorporated into the individualized intervention.

The four goals of the NPSP are as follows: to enhance healthy families, increase family member role adaptation, increase problem solving skills and increase knowledge of child growth and development. As the program is tailored to the needs of each family, interventions include such programs as nutrition education, infant attachment and bonding, home safety, infant care and home environment. The team provides clinical and social training in such areas as life management skills, medical system access, basic first aid skills, and the dynamics of family violence. Program completion is determined by participant request or the completion of program criteria. The United States Air Force provided pre- and post-intervention PSI index scores in a SPSS data file. Pre-intervention Family Needs Screener scores were also provided along with demographic information such as age, rank, and race.

Research Instruments

Parenting Stress Index

The PSI was designed as a screening instrument to evaluate the extent to which a parent experiences stress in childrearing. Designed to be used by parents with children under the age of twelve, to date there have been approximately 200 studies that have utilized the Parenting Stress Index for measurement purposes. The 101-item PSI

extracts information through a 5-point Likert-type continuum ranging from “strongly agree” to “strongly disagree”. The PSI questions are written at a fifth grade reading level and take approximately 20 minutes to administer. The stress measures are categorized into Parent Domain, Child Domain and an optional 19-item Life Stress Domain. A Defensive Response Scale is also used in the measurement of the PSI in order to identify parents who are attempting to avoid a high score. The PSI is ideally used as an initial screening tool to identify potential areas of stress between a parent and a child.

The Parent Domain is divided into seven subscales (depression, restriction of role, attachment, sense of competence, social isolation, relationship with spouse and parental health) and emphasizes stress as a consequence of the parenting process. A high score in the Parent Domain scale suggests the existence of stress within parental functioning. High scores in the subscales of depression, attachment, sense of competence and parental health indicate the presence of emotional and or physical pathology and low motivation in fulfilling the role of the parent. High scores on restriction of role indicate the presence of negative stress due to feelings of entrapment by the parent. High scores on social isolation and relationship with spouse indicate the absence of sufficient social support.

The Child Domain reflects the existence of characteristics of the child that make the fulfillment of the parenting role difficult. The domain is divided into six subscales (child adaptability, acceptability, demandingness, mood, hyperactivity/distractibility and reinforces parent) and a high score indicates that the child is not viewed as a source of

positive reinforcement for the parent. The Total Stress Score is obtained by combining the Parent and Child Domain scores. Higher scores on the subscales and the Total Stress Score indicate not only the presence of parental stress, but also the risk or presence of dysfunctional parenting behaviors and/or behavioral problems of the child.

The alpha reliability coefficients measuring the internal consistency of each domain score and subscales have been reported to range from .70-.95 (Abidin, 1995). Test-retest studies have shown consistent and factorial stability in reported PSI scores (Heinze & Grisso, 1996). The discriminate validity of the PSI has also been a focus of reliability and correlational tests. The PSI has been found to be sensitive to treatment interventions, and future behavioral or parents and children can be predicted from high scores (Heinze & Grisso, 1996). Abidin reported abusive parental behaviors, parental distress, parental and marital dissatisfaction, and low social support are related to high scores on the PSI. Defensiveness and neglectful parental behaviors are related to lower scores (Abidin, 1995).

The generalizability of the PSI to a variable demographic has also been the focus of study. There have been no demographic variables specifically associated with changes in PSI scores assuming cultural and socioeconomic sensitivity (Abidin, 1995). Demographic factors, such as low income and education, which have been positively associated with high stress, (Holden & Banez, 1996; McCarroll, Ursano & Liu, 2000; Bigras, LaFreniere & Dumas, 1996) may indirectly influence the generalizability of the PSI. Limitations to the studies of reliability and validity include the potential bias of

studying mothers instead of fathers and dissection or variable use of certain subscales and measurements specific to program outcomes.

The NPSP utilizes a 20-question portion of the PSI, specifically those questions pertaining to parental competence, parental attachment and role restriction. These three subscales were selected from the Parent Domain. A score is considered to be significant for the parental competence subscale if it is above 21, meaning the parent may lack child development knowledge or have limited child development skills. A high score may also indicate a lack of acceptance by the spouse or partner. High scores in parental competence are often found for parents with children who have mental or physical disabilities. A score for the second subscale, parental attachment, is significant if the score is higher than 10. A high score may indicate a lack of emotional closeness between the parent and child, or an inability of the parent to empathize with the child. The final subscale, role restriction, is considered significant if the parent score is 20 or higher. A high score for this subscale indicates the need for clinical intervention, as parents will view the presence of a child as a restriction on freedom, or a restriction on maintaining their own identify. Parents may feel great frustration or anger and feel dominated by the needs of the child.

Family Needs Screener

The Family Needs Screener is a preliminary identifier for families at high risk for potential child abuse. Developed by the Family Research Laboratory at the University of New Hampshire, the screener was developed in order to accurately allocate services to NPSP participants. The FNS is based on an analysis of data compiled by the testing

of Air Force families for stress, the evaluation of families participating in preventative programs from the Air Force Family Advocacy Program, and through literature which identified stress as a causal risk factor for family violence (McCarroll, Thayer & Liu, 2000; Mollerstrom, Patchner & Milner, 1995). The screener is unique as stressors and family characteristics typically associated with the likelihood of child abuse are included. The characteristics assessed include demographics, substance abuse history, family of origin violence and abuse, relationship distress, support systems, stressors, self-esteem, depression, and prior family violence.

Demographics refer to the military status of parents, marital status, maternal status (antepartum or postpartum), age, ethnic group and education. Substance Abuse refers to alcoholic consumption patterns for both parents. Family of Origin Violence and Neglect refers to childhood experiences of violence or neglect. Relationship Distress examines the relationship climate between spouses or partners. Support Systems refer to social support available to the parent through the spouse or partner, or through friends. The existence of Stressors refer to pregnancy related stress, or life stress. Self -Esteem refers to parental psychological health and self-value. The Depression variable also screens psychological health and the presence of dysphoria or hopelessness. Prior Family Violence identifies those families with prior maltreatment cases.

Two pilot tests of the screener were conducted in 1999 by the Air Force before the introduction of the instrument into Family Advocacy Programs. The pilot tests included over 700 Air Force families. The data collected provided a baseline “cutting

point” for the identification of high-risk families. The cutting point of ‘9’ was initially established based the preliminary pilot test of 100 families, and confirmed on the second pilot test of 600 families. Teen parents and dependent daughters were classified as automatic high-risk families based on pilot testing. The United States Air Force concluded the pilot tests indicated the screener was found to be successful in differentiating high-risk families from those at low risk for child maltreatment. The Family Advocacy Program is currently conducting a validation study of the Family Needs Screener.

Sample

The study population size consisted of 521 New Parent Support Program participants. As the data analysis was secondary, there was no selection of subjects therefore avoiding potential sampling biases. Of the total sample of participants, 20 cases were fully completed with both pre- and post-test PSI scores. The remaining 501 cases were incomplete as no pre- or post-test scores were recorded, therefore the data in these cases were not considered for analysis.

Participant Demographics and Needs Screening

The rank descriptives of the 20 completed Parental Stress Index cases are shown below in Table 1.

Table 1
Sponsors Rank

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	E-2	1	5.0	5.0	5.0
	E-3	6	30.0	30.0	35.0
	E-4	7	35.0	35.0	70.0
	E-5	4	20.0	20.0	90.0
	E-6	1	5.0	5.0	95.0
	E-8	1	5.0	5.0	100.0
	Total	20	100.0	100.0	

Participants were equitably distributed across ranks as there were no officers in the completed PSI cases and all were enlisted personnel. Table 2 and Table 3 show the breakdown of race for both female and male participants.

Table 2
Maternal Race/Ethnicity

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Asian	1	5.0	5.0	5.0
	Black but not Hispanic	5	25.0	25.0	30.0
	Latino	2	10.0	10.0	40.0
	Caucasian	12	60.0	60.0	100.0
	Total	20	100.0	100.0	

Table 3

Paternal Race/Ethnicity

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Black but not Hispanic	4	15.0	15.0	15.0
Latino	1	5.0	5.0	20.0
Multi Racial	1	5.0	5.0	25.0
Native American or Alaskan	1	5.0	5.0	30.0
Caucasian	14	70.0	70.0	100.0
Total	20	100.0	100.0	

The majority of female and male participants were Caucasian. The assessment of “high needs” and low “needs” participants due to FNS scores is shown below in Table 9.

Potential NPSP participants are given a pre-program assessment packet to differentiate “high needs” families from “low needs” families. The questionnaire given to participants determining needs status is the Family Needs Screener. Participants who score below the cutoff point of ‘9’ are designated as “low needs” and are generally allowed one home visitation by a social worker and access to parenting education information and activities. Participants designated as “high needs” are scheduled for a series of home visits as well as intensive parenting education information and activities. Participants remain in the program until they are discharged by the case social worker, or until they choose to terminate services. The proportion of “high needs” to “low needs” cases is shown below in Table 4.

Table 4

High Needs vs. Low Needs

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Low	1	5.0	5.0	5.0
	High	19	95.0	95.0	100.0
	Total	20	100.0	100.0	

95 percent of the participants completing the first and second PSI tests were classified as “high needs” through the FNS screener. The mean FNS scores for those participants completing the PSI was 8.60, slightly lower than the high needs indicator cutoff of 9.

Data Analysis

The secondary data analysis was conducted with the assistance of SPSS 12.0 software. Demographic data was analyzed using descriptive statistics and bivariate correlational analysis in order to examine population diversity. The paired t-test is used in order to determine if the to see if the means of the two normally distributed interval variables differed from one another. Using an alpha value of .05, a paired t sample analysis was used to determine if FNS and PSI scores were related to race or rank. Paired sample t-tests were also used to analyze pre- and post-test PSI scores.

CHAPTER IV

PRESENTATION OF RESULTS

The hypotheses of the secondary data analysis were as follows:

1) Participants of the New Parent Support Program will show decreased potential for child maltreatment six months after program completion regardless of race or educational level.

2) The New Parent Support Program domestic violence education positively affects parenting skills six months after program completion regardless of race or educational level.

3) There will be no racial or rank disparities for Family Needs Screener scores. Through the secondary data SPSS analysis of pre- and post-PSI scores, the study was able to determine the validity of the stated hypotheses. The analysis method selected for pre- and post-test scoring comparison was the paired samples t-test, used to compare two normally distributed interval variables. The racial and rank disparities data was analyzed using a bivariate correlational analysis, which tested whether the dependent variable (FNS or PSI Scores) differed by the categorical independent variables (race or rank).

PSI Participants

FNS and Racial/Rank Disparities

Potential racial and rank disparities in FNS scores were analyzed through bivariate correlational analysis for the 20 participants. The null hypothesis was group means were equal for each rank category. The alternative hypothesis was group means

were not equal for each rank category. The results for rank comparison are shown below in Table 5.

Table 5

Rank and FNS Scores

		Sponsors Rank	FNS Score
Sponsors Rank	Pearson Correlation	1	-.141**
	Sig. (2-tailed)	.	.005
	N	400	400
FNS Score	Pearson Correlation	-.141**	1
	Sig. (2-tailed)	.005	.
	N	400	400

** . Correlation is significant at the 0.01 level (2-tailed).

At a 95% confidence interval, the Pearson correlation was reported to be -.141 indicating that FNS scores are significantly associated with category of rank and the correlation between score and sponsors rank is significant at .005. The null hypothesis is therefore rejected for this analysis. Analysis of paternal race and FNS scores is shown below in Table 6.

Table 6

Paternal Race and FNS Scores

		FNS Score	Fathers Race
FNS Score	Pearson Correlation	1	.339**
	Sig. (2-tailed)	.	.000
	N	400	400
Fathers Race	Pearson Correlation	.339**	1
	Sig. (2-tailed)	.000	.
	N	400	400

** . Correlation is significant at the 0.01 level (2-tailed).

At a 95% confidence interval, the Pearson correlation was reported to be .339 indicating that FNS scores are significantly associated with paternal race and the correlation between score and race is significant at .000. The null hypothesis is rejected for this analysis. Analysis of maternal race and FNS scores is shown below in Table 7.

Table 7

Maternal Race and FNS Scores

		FNS Score	Mothers Race
FNS Score	Pearson Correlation	1	.217**
	Sig. (2-tailed)	.	.000
	N	400	400
Mothers Race	Pearson Correlation	.217**	1
	Sig. (2-tailed)	.000	.
	N	400	400

** . Correlation is significant at the 0.01 level (2-tailed).

At a 95% confidence interval, the Pearson correlation was reported to be .217 indicating that FNS scores are significantly associated with maternal race and the correlation between score and race is significant at .000. The null hypothesis is rejected for this analysis.

Potential for Child Maltreatment

The literature review has shown that primary maltreatment prevention programs similar to the NPSP often utilize the Parenting Stress Inventory (PSI) to measure changes in parental stress as an outcome education (Cowen & Reed, 2000; Duggan, McFarlane, & Windham, 1999; Holden & Banez, 1996). The use of stress as an indicator of child maltreatment potential was also identified throughout the literature review as a valid indicator (Hegar, Zuravin & Orme, 1994). The NPSP administers the PSI prior to program participation and re-administers before the discharge of the participant from the program or at six-month intervals. The paired sample t-test results comparing pre- and post-PSI scores for the 20 completed cases are shown in Table 8.

Table 8

PSI Pre- and Post-Test Scores

		Paired Samples			
		Mean	N	Std.	Std. Error Mean
Pair	PSI Score 1	45.20	20	14.810	3.312
1	PSI Score 2	42.35	20	11.677	2.611

Table 8 Continued

PSI Pre- and Post-Test Scores

Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	PSI Score 1 & PSI Score 2	20	.440	.052

Paired Samples Test

		Paired Differences				t	df	Sig. (2-tailed)	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	PSI Score 1 PSI Score 2	2.850	14.265	3.190	-3.826	9.526	.893	19	.383

Paired Samples T Test analysis of pre- and post PSI scores does not show significant improvement in overall scores. With a alpha of .05 the correlation between the two tests was .52 and the paired samples significance test was .383. The analysis shows that participants in the NPSP did not significantly decrease parenting stress from pre-test to post-test.

PSI Parenting Skills

The PSI Parent Domain for the New Parent Support Program is divided into three subscales, which are parenting competence, parental attachment and role restriction. High scores on the three subscales indicate not only the presence of parental stress, but

also the risk or presence of dysfunctional parenting behaviors and/or behavioral problems of the child. The first subscale examined was parental competence, shown below in Table 9.

Table 9

PSI Pre- and Post-Test Parental Competence Scores

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	PSI 1 Competence	18.50	20	7.681	1.718
	PSI 2 Competence	17.45	20	6.684	1.495

Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	PSI 1 Competence & PSI 2 Competence	20	.398	.082

Paired Samples Test

		Paired Differences				t	df	Sig. (2-tailed)	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	PSI 1 Competence PSI 2 Competence	1.050	7.924	1.772	-2.658	4.758	.593	19	.560

Data analysis of the pre- and post-PSI parental competence scores showed there was not a significant improvement in scores. Correlational significance between pre- and post-test was .082 and the paired samples significance was .560. The data analysis shows the NPSP did not significantly differ from pre-test to post-test in parenting competence.

Role restriction was the second PSI subscale examined through data analysis.

The results of the analysis are shown below in Table 10.

Table 10

PSI Pre- and Post-Test Role Restriction Scores

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	PSI 1 Role Restrict	16.70	20	4.932	1.103
	PSI 2 Role Restrict	15.10	20	4.745	1.061

Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	PSI 1 Role Restrict & PSI 2 Role Restrict	20	.402	.079

Paired Samples Test

		Paired Differences				t	df	Sig. (2-tailed)	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	1 Role Restrict 2 Role Restrict	1.600	5.295	1.184	-.878	4.078	1.351	19	.192

The results of the data analysis showed the pre- and post-test correlation significance was .79 and the paired sample correlation was .192. Using an alpha of .05, these values are not significant. Participants did not significantly differ in role restriction from pre-test to post-test. The final data analysis examined the pre- and post-test PSI attachment scores for NPSP participants. The results of the analysis are shown below in Table 11.

Table 11

PSI Pre- and Post-Test Role Attachment Scores

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	PSI 1 Attachment	9.80	20	3.874	.866
	PSI 2 Attachment	9.85	20	3.731	.834

Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	PSI 1 Attachment & PSI 2 Attachment	20	.500	.025

Paired Samples Test

		Paired Differences				t	df	Sig. (2-tailed)	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	PSI 1 Attachment PSI 2 Attachment	-.050	3.804	.851	-1.830	1.730	-.059	19	.954

Data analysis of the PSI attachment scale showed a significant correlation between the pre- and post-test scores. The paired sample correlation was .025, which is significant at a alpha of .05. The paired samples test, however, was not significant with a t value of .059 and a significance of .954. The pre- and post-test scores did not significantly differ for attachment.

PSI and Racial/Rank Disparities

Potential racial and rank disparities in PSI scores were analyzed through one-way ANOVA for the 20 participants with completed PSI scores. The null hypothesis was group means were equal for each rank category. The alternative hypothesis was group means were not equal for each rank category. The results for rank comparison are shown below in Table 12.

Table 12

Rank and PSI Scores

		Correlations	
		Sponsors Rank	PSI Score 1
Sponsors Rank	Pearson Correlation	1	.241
	Sig. (2-tailed)	.	.307
	N	400	20
PSI Score 1	Pearson Correlation	.241	1
	Sig. (2-tailed)	.307	.
	N	20	20

The bivariate correlational analysis shows that PSI scores and rank are not positively correlated although they are significantly distributed. The analysis indicates that the PSI

is sensitive to rank or socioeconomic status. The analysis fails to reject the null hypothesis. The analysis for paternal race and PSI scores is shown below in Table 13.

Table 13

Paternal Race and PSI Scores

		Correlations	
		PSI Score 1	Fathers Race
PSI Score 1	Pearson Correlation	1	.329
	Sig. (2-tailed)	.	.156
	N	20	20
Fathers Race	Pearson Correlation	.329	1
	Sig. (2-tailed)	.156	.
	N	20	400

The bivariate correlational analysis shows that PSI scores and paternal race are not positively correlated although they are significantly distributed. The analysis indicates that the PSI is sensitive to race. The analysis fails to reject the null hypothesis. The analysis for maternal race and PSI scores is shown below in Table 14.

Table 14

Maternal Race and PSI Scores

		Correlations	
		PSI Score 1	Mothers Race
PSI Score 1	Pearson Correlation	1	.260
	Sig. (2-tailed)	.	.269
	N	20	20
Mothers Race	Pearson Correlation	.260	1
	Sig. (2-tailed)	.269	.
	N	20	400

The bivariate correlational analysis shows that PSI scores and maternal race are not positively correlated although they are significantly distributed. The analysis fails to reject the null hypothesis.

Summary

The secondary data analysis of NPSP participant FNS and PSI was concerned with significant change between pre- and post-test scores, and the presence of racial or rank disparities in FNS and PSI scores. Racial and rank disparities were seen in the FNS scores for the entire NPSP population. The mean FNS score varied across ranks and racial groups suggesting that the FNS screener may not be sensitive to race or socioeconomic status. Paired sample analysis of PSI scores showed no significant change between pre-test and post-test total scores, parental competence, role restriction or attachment when using an alpha of .05.

CHAPTER V

CONCLUSION

Review of Purpose and Literature

The purpose of the study was to evaluate the effectiveness of the New Parent Support Program, a multi-dimensional education program designed to prevent the maltreatment of dependent children through clinical intervention and parental skill enhancement training. NPSP interventions focus on the building of knowledge and skills that new parents require to form healthy relationships, and the provision of safe, nurturing communities for children and families (DOD, 1997). The NPSP is a voluntary service offered to active duty members who have children aged birth to three years. The United States Air Force provided data for a secondary analysis of pre-program and post-program outcome measures. The outcome measures examined attitude and behavior changes, specifically parental stress reported before and after the completion of the program. The hypotheses of the study were as follows:

1) Participants of the New Parent Support Program will report decreased potential for child maltreatment six months after program completion regardless of race or educational level.

2) The New Parent Support Program domestic violence education positively affects parenting skills six months after program completion regardless of race or educational level.

3) There will be no racial or rank disparities for Family Needs Screener scores.

A review of the literature indicated child maltreatment prevention programs, utilizing methods similar to the NPSP such as home visitation and parental education are successful. The literature review found a strong correlation between programs emphasizing stress management skills through home visitation, and the successful prevention of child maltreatment. High parental stress levels were shown to correlate positively with the potential for child maltreatment. The PSI, along with other instruments utilized by the NPSP, was frequently utilized to identify parental stress levels and to evaluate post-intervention stress reduction outcomes. The literature provided support for intervention programs such as the New Parent Support Program effective primary prevention for child maltreatment.

Summary and Interpretation of Findings

Paired sample analysis of the completed cases for total PSI scores showed no significant difference between pre- and post-test scores ($p=.383$). The hypothesis that the NPSP decreases the potential for child maltreatment is rejected based on analysis of the PSI scores. The three subscale scores, parental competence, role restriction and attachment, were also analyzed by paired sample analysis. The results of the analysis showed that parental competence ($p=.560$), role restriction ($p=.079$) and attachment ($p=.192$) did not show significant change from pre- to post-test. As 95% of the completed cases were classified as “high needs” due to FNS score, significant change was an expected outcome of the program. The hypothesis the NPSP positively affects parenting skills is rejected based on analysis of the PSI scores. The PSI scores did not show significant disparities when compared across race and rank categories. The racial

and rank (socioeconomic indicator) sensitivity of the PSU has been verified through literature therefore no disparity was anticipated (Abiden, 1995).

Analysis of the demographic data showed the FNS scores varied significantly across race and rank categories for the PSI participant population. Although the FNS has been tested in pilot studies, the Family Advocacy Program is conducting an ongoing validation study screener and no reliability or validity values were available. The disparities found in the bivariate correlation analysis may indicate that the FNS is not racially or rank (socioeconomic indicator) sensitive. An alternative possibility is Caucasian, low-ranking enlisted personnel are more predisposed to high level of parental stress. The majority of the participant population was Caucasian, low-ranking enlisted personnel therefore skewed data may also account for the significant variations found in the FNS.

Discussion

The analysis and interpretation of the total PSI and subscales scores suggests that the NPSP is not effective at reducing parental stress and therefore, reducing child maltreatment. Although the PSI scores did not differ significantly from pre- and post-test, the small sample size of participants who completed both the pre-test and the post-test may have not be representative of the entire participant population. As the validity and reliability of the PSI has been confirmed in the literature, it is reasonable to assume population sample error or program failure rather than instrument error. The absence of data for companion assessments used by the NPSP such as the Ages and Stages Questionnaire and the HOME Inventory, also prevent this study from compiling a

thorough assessment of program success. As the validity and reliability of the PSI has been confirmed in the literature, it is reasonable to assume population sample error or program failure rather than instrument error. In the Family Needs Screener was found to have scoring disparities across racial and rank (socioeconomic indicator) categories. The FNS has not yet been validated by the Air Force therefore it is possible that the instrument is biased against minority and low-income participants. The three hypotheses tested by this study were all rejected. As the NPSP continues to collect outcomes data using a variety of quantitative and qualitative instruments, a more complete evaluation of the program will be possible. Further evaluation of NPSP post-program outcomes is recommended in order to determine if the program decreases the potential for child maltreatment.

Recommendations

Although the analysis of the NPSP was limited by sample size, data availability, and instrumentation there were findings through the analysis that can be considered recommendations for USAF when evaluating the success of the program. First, there is the issue of participant retention. Of the 521 participant cases that were provided, only 20 of the cases were completed. Even allowing for variables such as deployment and reassignment, the over-all completion rate was extremely low. As the NPSP is a voluntary program, program facilitators may want to examine the retention efforts of program administrators.

The second recommendation regards the FNS instrument used by the NPSP for the initial screening process. Although the FNS was not the focus of this analysis, the

independent t sample showed that disparities existed across race and rank demographics. As these disparities did not appear on the PSI demographics analysis, it may be assumed that the FNS may not be culturally or socioeconomically sensitive. If the FNS has been tested for alpha reliability and validity, the results were not made available for this analysis. I would recommend if the FNS has not been tested for reliability or validity, it should be evaluated for both. If the screening instrument for the program, which determines the path that participants take within the program, is not a reliable indicator of needs, then adjustments should be made.

The PSI analysis did not show significant improvement for participants in the analysis. When this study was begun, the USAF coordinators were beginning their own evaluation of the NPSP and results were not yet available. The results of my study are not necessarily an indicator of program failure, but allowing for the established validity and reliability of the PSI, it was surprising that *no* progress was seen in any of the three identified areas. It may be useful to examine the program to see if intervention efforts could be strengthened in order to affect measurable change. Again, as all instruments used to measure progress were not made available for this study, so change may have occurred that was not picked up by the PSI.

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APPENDIX A
FAMILY NEEDS SCREENER AND PSI INSTRUMENTS

DATE ___/___/___
 BASE _____

NPSP ID#: _____

U.S.A.F. Family Advocacy New Parent Support Program Family Needs Screener

1. What is your military status? (PLEASE CIRCLE)

- ① Active Duty Member
- ② Family Member, Spouse
- ③ Retired Military
- ④ Family Member, Daughter
- ⑤ Other (SPECIFY): _____

2. What is the sponsor's military status? (PLEASE CIRCLE)

- ① Active Duty
- ② Retired Military
- ③ Other (SPECIFY): _____

3. What is your marital status? (PLEASE CIRCLE)

- ① Single
- ② Married
- ③ Divorced
- ④ Separated
- ⑤ Widowed

4. What is your current living situation? Are you: (PLEASE CIRCLE)

- ① Living together with your partner/spouse
- ② Living alone (or with children only)
- ③ Living with your parents (or other adults)
- ④ Other living situation (SPECIFY): _____

5. How long have you been living together: _____ Years _____ Months _____ Not Applicable

6. Are you currently pregnant or in the process of adoption? (PLEASE CIRCLE)

- ① Yes
- ② No (GO TO QUESTION 7)

(a) No. of Weeks Pregnant _____

7. Did you have or adopt a baby over the last 12 months? (PLEASE CIRCLE)

- ① Yes
- ② No

DATE ___/___/___

NPSP ID#: _____

8. How many children are living with you? (SPECIFY): _____

9. Do you have any children living with you who are from a prior relationship? (either yours or your partner's) (PLEASE CIRCLE)

- 1 Yes
- 2 No

10. What is your age? _____

11. What is your partner's age? _____ (SKIP IF NOT APPLICABLE)

Ethnic Group

12. Which of these ethnic groups do you and your partner consider yourself? (PLEASE CIRCLE)

1.YOU	2.YOUR PARTNER
1 Pacific Islander	1 Pacific Islander
2 Asian	2 Asian
3 Native Amer. Or Alaskan Native	3 Native Amer. Or Alaskan Native
4 White but not Latino	4 White but not Latino
5 Black but not Hispanic	5 Black but not Hispanic
6 Latino or Hispanic	6 Latino or Hispanic
7 Multi-racial	7 Multi-racial
8 Some other group (SPECIFY): _____	8 Some other group (SPECIFY): _____

Education

13. What is the last year of school that you and your partner completed? (PLEASE CIRCLE)

1.YOU	2.YOUR PARTNER
1 7 th Grade or Less	1 7 th Grade or Less
2 8 th Grade	2 8 th Grade
3 Some High School/GED	3 Some High School/GED
4 High School Graduate	4 High School Graduate
5 Some College	5 Some College
6 College Graduate	6 College Graduate
7 Post-B.A. Training	7 Post-B.A. Training
8 Advanced Degree	8 Advanced Degree

➔ GO TO NEXT PAGE

DATE ___/___/___

NPSP ID#: _____

INSTRUCTIONS: FOR EACH QUESTION, PLEASE READ THE FOLLOWING STATEMENTS AND CIRCLE THE BEST RESPONSE

GO TO QUESTION 17 IF YOU ARE NOT CURRENTLY PREGNANT

	Strongly Disagree	Disagree	Agree	Strongly Agree
14. My partner is very supportive of this pregnancy.	1	2	3	4
15. This is an unplanned pregnancy.	1	2	3	4
16. This is not a good time for me to have a baby.	1	2	3	4

GO TO QUESTION 21 IF YOU ARE NOT CURRENTLY IN A RELATIONSHIP

	1	2	3	4
17. My partner treats me well.	1	2	3	4
18. My partner and I have a very good relationship.	1	2	3	4
19. I wish my partner and I got along better.	1	2	3	4
20. I have thought seriously about ending my relationship with my partner.	1	2	3	4
21. This is a very stressful time for me.	1	2	3	4
22. At times I feel out of control, like I'm losing it.	1	2	3	4
23. Uncontrolled anger can be a problem in my family.	1	2	3	4
24. I only have a few friends/family to help with the baby (my children).	1	2	3	4
25. I feel very isolated.	1	2	3	4
26. I sometimes drink enough to feel really high or drunk.	1	2	3	4
27. I sometimes drink five or more drinks of alcohol at a time, but mostly on weekends.	1	2	3	4

GO TO QUESTION 29 IF YOU ARE NOT CURRENTLY IN A RELATIONSHIP

	1	2	3	4
28. My partner sometimes drinks five or more drinks at a time, but mostly on weekends.	1	2	3	4
29. It is sometimes necessary to discipline a child with a good, hard spanking.	1	2	3	4
30. I can think of a situation when I would approve of a wife slapping a husband's face.	1	2	3	4
31. I can think of a situation when I would approve of a husband slapping a wife's face.	1	2	3	4
32. It is sometimes necessary for parents to slap a teen who talks back or is getting into trouble.	1	2	3	4
33. When I was a child I was spanked or hit a lot by my mother or father.	1	2	3	4

➔ GO TO NEXT PAGE

DATE ___/___/___

NPSP ID#: _____

INSTRUCTIONS: FOR EACH QUESTION, PLEASE READ THE FOLLOWING STATEMENTS AND CIRCLE THE BEST RESPONSE

	Strongly Disagree	Disagree	Agree	Strongly Agree
34. When I was a teenager, I was hit a lot by my mother or father.	1	2	3	4
35. When I was growing up, I saw my mother or father hit or throw something at their partner.	1	2	3	4
36. My parents helped me when I had problems.	1	2	3	4
37. I have unhappy memories of my childhood.	1	2	3	4
38. My parents did not comfort me when I was upset.	1	2	3	4
39. My income is often inadequate for basic needs (rent, food, clothing, transportation, etc.).	1	2	3	4
40. I feel that I have a number of good qualities.	1	2	3	4
41. I feel that I am a person of worth, at least on an equal basis with others.	1	2	3	4
42. I frequently feel as if I am not as good as others.	1	2	3	4
43. I feel I do not have much to be proud of.	1	2	3	4
44. All in all, I am inclined to feel that I am a failure.	1	2	3	4
45. Someone I'm close to makes me feel confident in myself.	1	2	3	4
46. There is someone I can talk to openly about anything.	1	2	3	4
47. There is someone I can talk to about problems in my relationship.	1	2	3	4
48. I have someone to borrow money from in an emergency.	1	2	3	4
49. I have someone to take care of my child/children for several hours if needed.	1	2	3	4
50. I have someone who helps me around the house.	1	2	3	4
51. I have someone I can count on in times of need.	1	2	3	4
52. I usually wake up feeling pretty good.	1	2	3	4
53. I think good things will happen to me in the future.	1	2	3	4
54. There are times when I feel life is not worth living.	1	2	3	4
55. I feel sad quite often.	1	2	3	4
	YES		NO	
56. Have you or your partner been involved in a suspected or verified case of child abuse or neglect?	1		2	
57. Have you or your partner been involved in a suspected or verified case of spouse abuse?	1		2	

END OF QUESTIONNAIRE
Page 4 of 4

THANK YOU

Date ___/___/___

Case ID _____

U.S. Air Force Family Advocacy New Parent Support Program Family Needs Screener Scoring Sheet

Instructions for scoring the USAF Family Advocacy New Parent Support Program Family Needs Screener: Numbered items on the Family Needs Screener instrument correspond to those in the "ITEM" column below. If the person answered the questionnaire item with the responses found next to the items below, place a "1" in the "Score" column. For example, if a person answered question 1 below with either "1" (Active Duty) or "4" (Dependent Daughter), enter 1 on the same line under the "Person's Score" column. If the person answered with any other option, place a 0 in the "Score" column. For items that say "Do not score", or which were omitted by a client, then place a dash as needed. Add the 1's in the "Score" column to obtain the total needs score.

ITEM	Score
1. 1,4 =1	
2. Do not score	
3. 1,3,4,5 = 1	
4. 2 = 1	
5. Less than 1 year=1	
6. Do not score	
7. Do not score	
8. Do not score	
9. "yes" = 1	
10. Less than 20=1	
11. Less than 20=1	
12. Do not score	
13.1 (you)1,2,3 = 1	
13.2 (partner)1,2,3 = 1	
14. 1,2 = 1	
15. 3,4 = 1	
16. 3,4 = 1	
17. 1,2 = 1	
18. 1,2 = 1	
19. 3,4 = 1	
20. 3,4 = 1	
21. 3,4 = 1	
22. 3,4 = 1 (HIGH NEED)	
23. 3,4 = 1 (HIGH NEED)	
24. 3,4 = 1	
25. 3,4 = 1	
26. 3,4 = 1	
27. 3,4 = 1	
28. 3,4 = 1	
29. 3,4 = 1	
30. 3,4 = 1	
31. 3,4 = 1	
32. 3,4 = 1	
33. 3,4 = 1	

ITEM	Score
34. 3,4 = 1	
35. 3,4 = 1	
36. 1,2 = 1	
37. 3,4 = 1	
38. 3,4 = 1	
39. 3,4 = 1	
40. 1,2 = 1	
41. 1,2 = 1	
42. 3,4 = 1	
43. 3,4 = 1	
44. 3,4 = 1	
45. 1,2 = 1	
46. 1,2 = 1	
47. 1,2 = 1	
48. 1,2 = 1	
49. 1,2 = 1	
50. 1,2 = 1	
51. 1,2 = 1	
52. 1,2 = 1	
53. 1,2 = 1	
54. 3,4 = 1 (HIGH NEED)	
55. 3,4 = 1	
56. 1=1 (HIGH NEED)	
57. 1=1 (HIGH NEED)	

TOTAL NEEDS SCORE

★ A High Needs Score is = or > 9;
OR 22, 23, 54, 56 or 57 = 1

Needs Subscales

Category	Total
A. Demographics (1-13.2)	
B. Stress (14-16;21,22)	
C. Relationship Discord(17-20,23)	
D. Support (24,25;39,45-51)	
E. Substance Abuse (26-28)	
F. Violence Approval (29-32)	

Category	Total
G. Family of origin Violence and Neglect (33-38)	
H. Self Esteem (40-44)	
I. Depression (52-55)	
J. Prior Family Violence (56,57)	

Parenting Index

This questionnaire contains 20 statements. Read each statement carefully. For each statement, please focus on the child you are most concerned about, and circle the response which best represents your opinion.

Circle the SA if you strongly agree with the statement.

Circle the A if you agree with the statement.

Circle the D if you disagree with the statement.

Circle the SD if you strongly disagree with the statement.

For example, if you sometimes enjoy going to the movies, you would circle A in response to the following statement:

I enjoy going to the movies. SA A D SD

While you may not find a response that exactly states your feelings, please circle the response that comes closest to describing how you feel. **YOUR FIRST REACTION TO EACH QUESTION SHOULD BE YOUR ANSWER.**

Circle only one response for each statement, and respond to all statements.

1. When my child came home from the hospital, I had doubtful feelings about my ability to handle being a parent.

SA A D SD

2. Being a parent is harder than I thought it would be.

SA A D SD

3. I feel capable and on top of things when I am caring for my child.

SA A D SD

4. I can't make decisions without help.

SA A D SD

5. I have had many more problems caring for my child (children) than I expected.
SA A D SD
6. I enjoy being a parent.
SA A D SD
7. I often have the feeling that I cannot handle things very well.
SA A D SD
8. It takes a long time for parents to develop close, warm feelings for their children.
SA A D SD
9. I expected to have closer and warmer feelings for my child than I do and this bothers me.
SA A D SD
10. When I was young, I never felt comfortable holding or taking care of children.
SA A D SD
11. My child knows I am his or her parent and wants me more than other people.
SA A D SD
12. Most of my life is spent doing things for my child (infant).
SA A D SD
13. I feel trapped by my responsibilities as a parent.
SA A D SD
14. I often feel that my child's needs control my life.
SA A D SD
15. Since having this child, I have been unable to do new and different things.
SA A D SD
16. Since having a child, I feel that I am almost never able to do things that I like to do.
SA A D SD
17. It is hard to find a place in our home where I can go to be by myself.
SA A D SD

For the following statements, choose from choices 1 to 5 below.

18. When I think about myself as a parent I believe:

1. I can handle anything that happens
2. I can handle most things pretty well.
3. Sometimes I have doubts, but find that I handle most things without any problems
4. I have some doubts about being able to handle things
5. I don't think I handle things very well at all

19. I feel that I am:

1. A very good parent
2. A better than average parent
3. An average parent
4. A person who has some trouble being a parent
5. Not very good at being a parent

20. How easy is it for you to understand what your child wants or needs?

1. Very easy
2. Easy
3. Somewhat difficult
4. It is very hard
5. I usually can't figure out what the problem is

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Date: ___/___/___
 Client ID#: _____

U.S.A.F. FAP NPSP PARENTING INDEX SCORE SHEET

☛ Most items are scored as follows:

SA, enter a score of 5
 A, enter a score of 4
 D, enter a score of 2
 SD, enter a score of 1

☛ Items 3, 6, and 11 (bolded with an asterisk), are *reverse scored*, and tabulated as follows:

SA, enter a score of 1
 A, enter a score of 2
 D, enter a score of 4
 SD, enter a score of 5

☛ The last 3 items (18-20) are multiple-choice. Score by recording each of the numbers corresponding to the answer chosen (e.g., if "an average parent" is endorsed for item#19, then that item is scored "3").

Item	Score
1.	
2.	
3.*	
4.	
5.	
6.*	
7.	
8.	
9.	
10.	

Item	Score
11.*	
12.	
13.	
14.	
15.	
16.	
17.	
18.	
19.	
20.	

PARENTING INDEX SUBSCALES

For each subscale, **SUM** the items noted:

Competence Items 1-7; 18, 19	Role Restriction Items 12-17	Attachment Items 8-11; 20
Competence TOTAL:	Role Restriction TOTAL:	Attachment TOTAL:
Cutoff Score = 21	Cutoff Score = 20	Cutoff Score = 10

NOTE: Generally, scores higher than the cut off are clinically significant.
 Take into consideration possible defensiveness or need to "look good."

APPENDIX B
TEXAS A&M INSTITUTIONAL REVIEW BOARD

Revised December 15, 2003

Checklist for Human Subject Protocols

The following is a checklist of the items you must provide to the IRB in order for them to approve your research. **Please check and attach all items that apply to your research.**

FOR FULL REVIEW: Attach the **original** and **three** copies of the complete **IRB Protocol**. Submit your paper work to the Office of the Vice President for Research (VPR), Sharon Alderete, 318B Administration Building, MS 1112. Reviewers require a minimum of 15 working days before the IRB meeting depending on workload. Your protocol will be delayed if it is missing any of the required information. If you have any questions after reading the application you can call (979) 458-4067 for assistance. *Allow sufficient time for protocol processing as it may take several months to obtain IRB Approval.*

FOR EXEMPT PROTOCOLS: Attach the **original** and **one** copy of the complete **IRB Protocol**.

NOTICE: All submitted protocols require the following, when applicable.

- Part I: Summary Cover Sheet
- Part II: Protocol Format
- Signature Page
- Conflict of Interest Statement
- Training Certificate(s)

Informed Consent Document (with all elements of consent)

- Consent Form
- Videotape/audio tape release form (if not included in the consent/assent form)
- Information Sheet
- Telephone script for telephone surveys
- Cover Letter for mail out surveys
- Justification for Waiver of Signed Consent (*Required if using an Information Sheet*)
- Assent form if research involves minors, ages 7-17

Note: If consent or assent form is longer than one page, number each page in the format "page x of y" and blank space for date and initial "Date ____ Initial ____". Page #'s will be separate from IRB Application

- Debriefing form (if deception is used)
- Survey/Assessment Instruments
- Recruitment Media/Newspaper Advertisements
- Compensation conditions, schedule of payment
- FDA Form 1572 (for investigators involved in drug or biologic studies)
- Drug or Device Accountability Record

Page ____ of ____

Email irb@tamu.edu or call (979) 458-4067 with any questions regarding this form.

Revised December 15, 2003

**Texas A&M University
IRB Application
Protocol for Human Subjects in Research
Part I: Summary Cover Sheet**

IRB # _____ (Internal use only)

If Requesting Exempt Status, Check Here (Exemp from Full Board Review)
 Please check or provide details on the following information (enter N/A if not applicable)
 New submission Re-submission _____ (IF protocol was disapproved)
 Principal Investigator Name Jennifer Michelle Hall Faculty _____ Staff _____ Graduate Student Undergraduate Student _____
 Department HLTH Mail Stop 4243 Phone (979) 774-9849
 Email jhall41790@aol.com Fax _____
 Is this study part of a Thesis or Dissertation? Yes No _____ If Yes, do you have Committee Approval? Yes No _____

Co-Principal Investigator Name _____ Faculty _____ Staff _____ Graduate Student _____ Undergraduate Student _____
 Department _____ Mail Stop _____ Phone _____
 Email _____ Fax _____

Graduate Committee Chair/Faculty Advisor Name (if student) Steve Dorman
 Department HLTH Mail Stop 4243 Phone (979) 845-1333
 Email sdorman@hlpn.tamu.edu Fax _____

Project Title DOMESTIC VIOLENCE PREVENTION EFFECTIVENESS IN THE UNITED STATES AIR FORCE

Funding Agency _____
 Funding Administrator: RF _____ TAES _____ TEES _____ TAMU _____ TTI _____
 Funding Status: Funded _____ Not Funded _____ Pending _____ (Please attach a copy of Grant Proposal)
 Funding Amount _____

Risk Management Matrix

		Probability That Something Will Go Wrong			
		A Likely to occur immediately or in a short period of time, expected to occur frequently	B Probably will occur in time	C May occur in time	D Unlikely to occur
Seriousness of Risk	I May result in death	5	5	4	3
	II May cause severe injury, major damage or loss, and/or result in negative publicity for the participant involved	5	4	3	2
	III Participation presents a minimal threat to safety, health and well-being of participants	4	3	2	1
	IV No more than minimal risk	3	2	1	1

Red Zone - 4 thru 5 Yellow Zone - 2 thru 3 Green Zone - 1

If your protocol falls in the **Yellow** or **Red Zone** please call (979) 458-3624 for further instructions.

Seriousness of Risk IV Probability That Something Will Go Wrong D
 These three fields must be answer

Activity	Associated Risks	Method to Manage
Secondary data Analysis	None	N/A

Page _____ of _____

Email irb@tamu.edu or call (979) 458-4067 with any questions regarding this form.

Revised December 15, 2003

Objective Estimate of Risk to Subject: None Low Moderate High Will Existing Documents Be Used? Yes No Will Existing Specimens Be Used? Yes No Research Methodology: Qualitative Quantitative Both Gender of Subjects: Male Female Both Estimated Age of Subjects 35 Total Participants (est.) 500

Location of Research: _____

Subjects Recruited From: Psychology Subject Pool Other Subject Pool USAF Data Other TAMU Students Community Women/Fetuses Children Treatment Centers Hospitals Prisoners Schools Others _____**Recruitment Method:** Direct person-to-person contact Telephone solicitation (attach script) Newspaper Advertising (attach ad copy) Posted Notices (attach copy) Letter (attach copy) Other (describe) No Direct RecruitmentCompensation for Subjects Yes No (If Yes, attach regular payment schedule)Deception Used Yes No (If Yes, attach debriefing form)Research/Course Credit for Subjects Yes No **Invasive or Sensitive Procedures:** Yes No Blood Samples Urine Samples Physical Measurements (electrodes, etc.) Stress Exercise Review of Medical/Psychological Records rDNA Other (specify) _____**Sensitive Subject Matter:** Yes No Abortion Learning Disability AIDS/HIV Psychological inventory Alcohol Sex Body composition Suicide Criminal activity Depression Drugs Other (specify) Domestic Violence Data**Use of Video or Audio Taping** None

If yes, answer the following:

Retained Yes No

Length of time retained: _____

Destroy/Erase Yes No

Other _____

Use specified in consent form Yes No **Provisions for Confidentiality/Anonymity** Replies Coded Secure Storage Anonymous Response OR Confidential

(Cannot be both anonymous and confidential)

Requesting waiver of signature on consent form. Yes No If Yes, Attach justification for waiver request. Criteria for waiver request can be found in the Federal Regulation section 45 CFR 46.116 and 46.117 at the following web address: <http://ohrp.osophs.dhhs.gov/humansubjects/guidance/45cfr46.htm#46.116>

Location where consent forms will be filed: _____

(Consent forms must be kept on file for 3 years after the completion of the project. It is best to keep the forms in a campus office in a locked filing cabinet. If you are requesting a waiver of signature on the consent form, this question does not apply to you.)

Do you have any relationship with any or all of the subjects, other than your investigator role? Yes No

If yes, you must explain the relationship in the "Selection of Subjects" section and how you will avoid any type of coercion (doctor-patient, teacher-student, counselor-student, etc.)

Abstract: Please provide a brief statement, in lay terminology, outlining the purpose of this study. (*Why you are doing this research project, and what you propose to learn.*)

The Department of Defense estimated that, in 2000, there were 12,098 cases of reported spousal domestic violence in the United States Armed Forces. As increasing attention was given to domestic violence in the military in 2001, the Department of Defense Task Force called for interventions within the Family Advocacy Program to combat domestic violence. Little peer-reviewed literature exists examining the success of subsequent program interventions designed by the military to prevent spousal and child maltreatment. The purpose of this research is to evaluate one such intervention, the New Parent Support Program (NPSP).

The goal of the NPSP is to prevent maltreatment in military families during pregnancy and from birth to three years through education, support services, parent infant bonding & infant care. Outcome measures, including a post-program follow-up, are given to determine potential attitude and behavior changes. A secondary data analysis of these outcome measures will be conducted in order to evaluate the success of the NPSP and subsequently, the prevention of domestic violence.

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Email irb@tam.u.edu or call (979) 458-4067 with any questions regarding this form.

Revised December 15, 2003

REQUEST FOR EXEMPTION from full IRB review

Some research projects involving human subjects are exempt from full review by the IRB. See the attached sheet on research categories exempt from full IRB review. (*Sensitive topics and subjects such as children or minors, pregnant women and prisoners are not considered for exempt research*).

Basis for Exemption [Please refer to attached "Categories Exempt From Full IRB Review."]
(Do not check unless requesting an exemption from full IRB review.)

Established Educational Settings/Normal Educational Practices(a letter of approval from a school official must be obtained and submitted to the IRB before the study can be conducted)(**studies with children or minors are not exempt**)

Use of educational anonymous tests (cognitive, diagnostic, aptitude, advancement; **attach copy**).

Survey or interview procedures, [**unless** identifying subjects places them at legal or personal risk, and unless survey or procedures deal with sensitive matters of personal behavior]

Observations of public behavior [**unless** identifying subjects places them at legal or personal risk, and unless observations deal with sensitive matters of personal behavior]

Anonymous collection or study of existing documents, records, pathological or diagnostic specimens which are without any identifiers or codes.

Evaluation of agencies and programs for administrative purposes where there was no deviation from standard practice.

Taste and food quality evaluation and consumer acceptance studies.

The U.S. population is becoming increasingly culturally, linguistically, economically, and ethnically diverse. The research needs to make a concerted effort to ensure that research subjects reflect the population demographically, including these groups who have been traditionally under represented. However, it is recognized that the available pool of subjects may preclude having a balanced population. If you cannot use a diverse population in your research, you must justify this action in Part II, A, 1.

NOTE: The IRB makes the final decision whether or not a proposal is exempt from full IRB review.

Please check with the IRB Program Coordinator (979-458-4067). Exempt proposals require an original and two (1) copies of each instrument, i.e., Part A, Part B (with signatures), consent forms, research instrument, recruitment materials, etc. Full IRB review proposals require an original, with signatures, and 3 full copies, including research instrument, consent forms, recruitment materials, etc.

Revised December 15, 2003

Part II:

Part A

I have read the Belmont Report, "Ethical Principles and Guidelines for the Protection of Human Subjects of Research" and subscribe to the principles it contains. In light of this Declaration, I present for the Board's consideration the following information, which will be explained to the subject about the proposed research.

Signature _____

Principal Investigator Jennifer Michelle Hall

1. Selection of Subjects

a. Source and number

Quantitative outcome measures from the New Parent Support Program will be acquired through the Family Advocacy Program at Brooks Air Force Base in San Antonio, Texas. The approximate number of subjects is 200.

b. Method of recruitment and selection

No recruitment is required as data analysis will be from existing documentation gathered by the Family Advocacy Program. The data given to the researcher in this case will have no potential identifiers for any human subject.

c. Ages and gender

Participation in the NPSP is voluntary and available without restriction by gender and age. Since analysis is secondary, no selection of data defined by gender or age is possible.

d. Compensation

Not Applicable due to secondary data analysis

Page ____ of ____

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e. Location and duration of experiment

Location of the Experiment will be in College Station, Texas. Data analysis will be completed within four weeks

f. Specific steps to ensure confidentiality or anonymity of responses of results

The Family Advocacy Program will have no subject identifiers when providing the quantitative data. There will be no possibility for subject identification or contact.

g. The investigator's relationship to subjects

None

2. Purpose of study

The domestic violence prevention programs implemented by the United States Armed Forces have not been extensively evaluated in existing peer-reviewed literature. Since 2001, The United States Family Advocacy Program has designed and implemented a variety of prevention-based domestic violence interventions. The New Parent Support Program (NPSP) is one such intervention that has been given limited peer-reviewed evaluation.

The purpose of this thesis research will be to evaluate the outcomes of the United States Air Force New Parent Support Program (NPSP). The goal of the NPSP is to address the prevention of maltreatment in military families during pregnancy and from birth to three years. The program is a voluntary service offered to interested parents in order to provide preventative support. Mandatory behavioral assessments given to participants in the program include the Family Needs Screener (FNS) and the Home Observation and Measurement of the Environment (HOME) questionnaire. Through these screening questionnaires, participating families are differentiated according to level of risk or need. All families who are assessed to have high needs are asked to take several assessment measures to further assess and evaluate clinical interventions. Outcomes of the NPSP program are measured after six months in order to determine if any maltreatment cases have been reported within the participating families. Evaluation of the Family Advocacy outcomes analysis through these behavioral assessment instruments will enable the researcher to evaluate the success of the NPSP for the prevention of child maltreatment.

Revised December 15, 2003

3. Research procedures

The New Parent Support Program administered a series on mandatory questionnaires to program participants. The Family Advocacy Program has agreed to provide the researchers with quantitative data from the existing program analysis of outcome measures. The data provided will enable the researcher to compare pre and post program attitudinal and behavioral measures. Data will be sent from Brooks Air Force Base in San Antonio, Texas to College Station, Texas for analysis. As no identifiers will be provided and all data given to the research will be secondary, the individual outcome measure instruments will not be provided.

a. Physical/Behavioral Aspects

None

b. Deception of Coersion

None

4. Risks and Benefits to Subjects

a. A description of any potential risks of discomforts to the subject.

None

b. A definition of benefits to the research subject or alternatives for participation in the study.

None

c. Do not include broad benefits to society of potential research benefits to a group as a benefit to the subjects.

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Revised December 15, 2003

Part B.

SIGNATURE ASSURANCE: *(this should be the last page of the protocol application before attachments)*

Principal Investigator/Graduate Student Assurance Statement:

I understand Texas A & M University's policy concerning research involving human subjects and I agree:

1. To accept responsibility for the scientific and ethical conduct of this research study;
2. To obtain prior approval from the Institutional Review Board before amending or altering the research protocol or implementing changes in the approved consent form;
3. To immediately report to the IRB any serious adverse reactions and/or unanticipated effects on subjects which may occur as a result of this study;
4. To complete, on request by the IRB, the Continuation/Final Review Forms.

SIGNATURE: _____ DATE: _____

TYPED NAME: Jennifer Michelle Hall E-MAIL: jhall41790@aol.com

***Faculty/Research Advisor's Assurance Statement:**

I certify that I have read and agree with this proposal, that the PI has received adequate training to perform this research, and will receive adequate supervision while performing this research.

SIGNATURE: _____ DATE: _____

TYPED NAME: Steve Dorman E-MAIL: sdorman@hikn.tamu.edu

*** If the principal investigator is completing this project to meet the requirements of a Texas A & M University academic program, or is a student, both the student's faculty/research advisor and the departmental head should sign the Signature Assurance Sheet.**

****Department Head**

This is to certify that I have reviewed this research protocol and agree that the research activity is within the mission of the Department and appropriate for the responsibilities and assigned duties of the principal investigator.

SIGNATURE: _____ DATE: _____

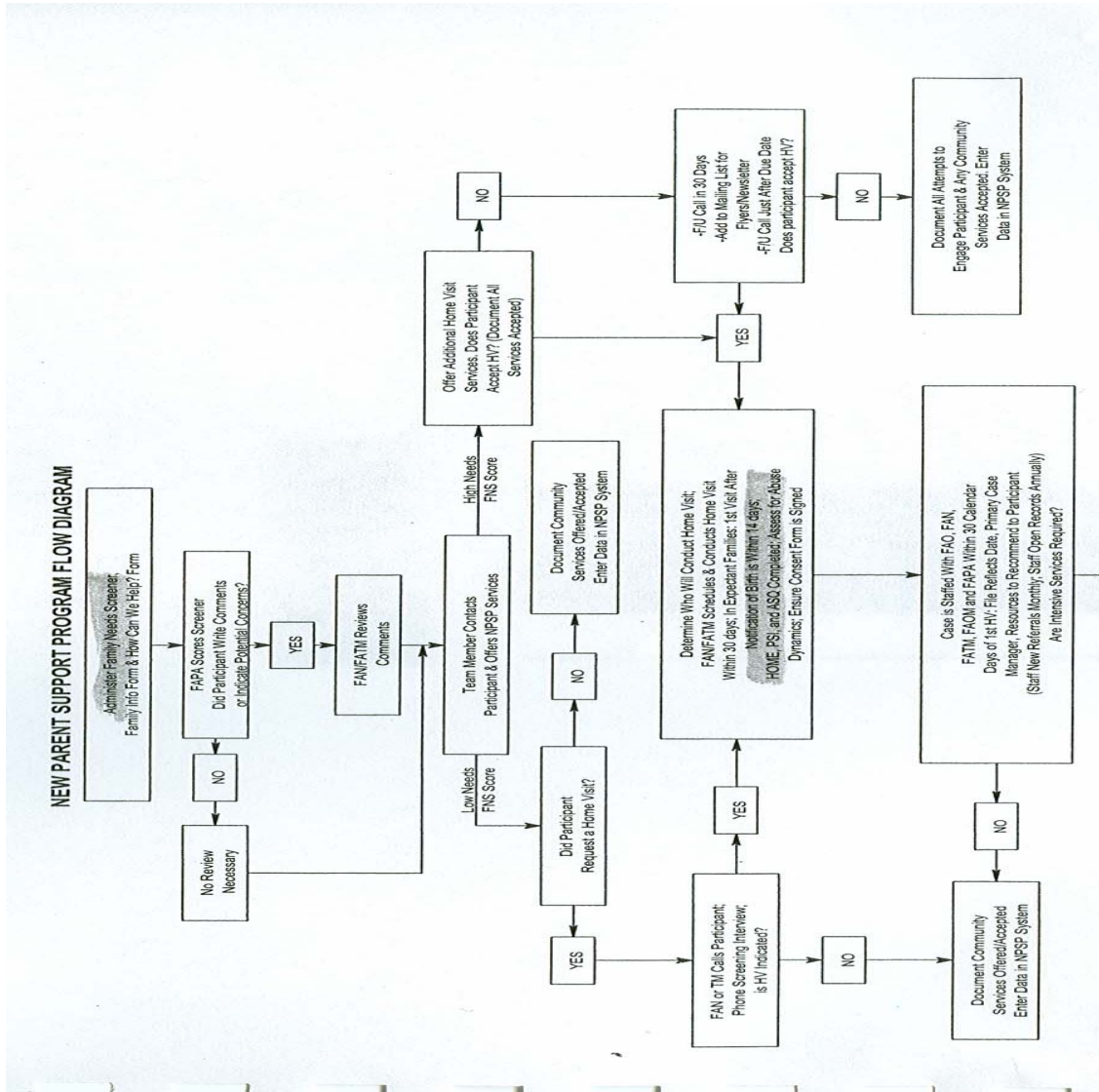
TYPED NAME: Steve Dorman E-MAIL: sdorman@hikn.tamu.edu

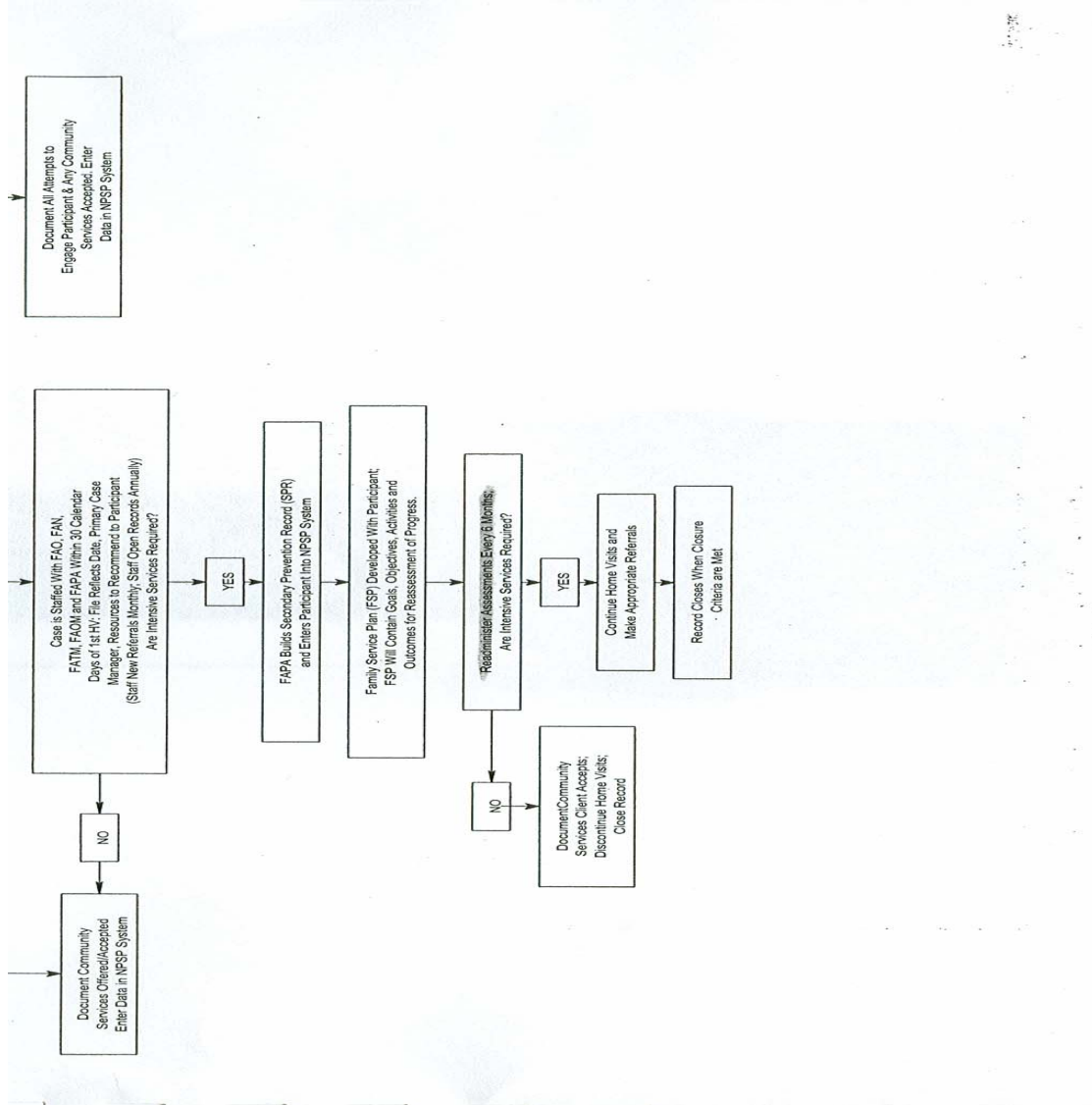
****If the principal investigator is also the Department Head , the College Dean or equivalent should sign the Signature Assurance Sheet.**

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APPENDIX C
PROGRAM PARTICIPANT FLOW DIAGRAM





APPENDIX D
AGREEMENT FOR USE OF USAF DATA

15 April 2004

MEMORANDUM FOR AFMSA/SGOF

FROM: Ms Jennifer Hall

SUBJECT: Agreement for Use of USAF Family Advocacy Program Central Database Data:
The New Parent Support Program

1. This proposal request for secondary data analysis concerns the United States Air Force New Parent Support Program (NPSP). The request for data is directed to Major James Whitworth and Ms. Martha Salas in order that the data recipient, Jennifer Hall may complete a Masters thesis from Texas A&M University. The proposed data analysis will enable Ms. Hall to evaluate the success of the New Parent Support Program as relevant to the thesis topic of domestic violence prevention within the Armed Forces.
2. The data requested will be used solely for the purposes of the completion of the Masters thesis required by Texas A&M University. In accordance with university regulations and Air Force requirements, an Institutional Review Board has been initiated and is currently pending approval. A copy of the approved form will be forwarded to Major Whitworth as soon as it becomes available.
3. The data requested has been collected by the NPSP through the Parenting Index instrument. In order to complete an assessment of the sample population, demographic information requested will be race, gender, age, and rank (and/or status). Data collected from the questionnaires will address two central questions:
 - a) Does the NPSP reduce the potential for family maltreatment?
 - b) Does the NPSP decrease the incidences of physical, sexual and emotional abuse?

Analysis of data collected by the questionnaires concerning parenting skills will enable Ms. Hall to answer the two questions proposed above by comparing pre-program screenings and post-program outcomes follow-ups. Additional variables such as the occurrence of family or child maltreatment reported through the NPSP six-month outcomes follow-up will be considered. No subject identifiers will be requested, assuring complete anonymity and confidentiality.

4. The data acquired will be retained only for the duration of the thesis project. Any external publications related to thesis findings must be approved by the United States Air Force Family Advocacy Program. The completed thesis will be provided to Major Whitworth and Ms. Salas prior to the thesis defense.
5. Upon the receipt of the NPSP data, the IRB proposal and the thesis proposal submitted to Major Whitworth and Ms. Salas will serve as the template for the proposed research. Supervision of thesis research will be by Dr. Steve Dorman, Department Head of Health

15 April 2004

and Kinesiology, Texas A&M University. Ms. Hall will obtain approval from Major Whitworth in the event that the thesis project in any way deviates from the approved proposal. As a representative of Texas A&M University, Ms. Hall will ensure both the security of data received and the appropriate use of.

Jennifer Michelle Hall
JENNIFER MICHELLE HALL
Department of Health and Kinesiology
Texas A&M University

Steve M. Dorman
STEVE DORMAN, Ph.D.
Department Head, Health and Kinesiology
Texas A&M University

Martha Salas
MARTHA SALAS, RN, MBA
New Parent Support Program Manager
Family Advocacy Program
AF Medical Support Agency
Office of the AF Surgeon General

James D. Whitworth
JAMES D. WHITWORTH, Ph.D.
Maj, USAF, BSC
Chief, Family Advocacy Operations and Research
Air Force Medical Operations Agency
Office of the Surgeon General

VITA

Jennifer Michelle Hall was born on Edwards AFB in California on September 12th, 1979. She came to Texas A&M from Colorado Springs, Colorado in 1997. A third generation Texas A&M student, she received her Bachelor of Science in Health in December of 2001. The degree required a three-month internship and she was placed at The University of Texas Medical Branch. Upon graduating from Texas A&M, she became a Research Assistant for the Department of Family Medicine. Jennifer returned to College Station in the fall of 2002 to pursue her Master's Degree in Health. She plans to apply to the University of Texas Physician Assistant program within the next year.

Permanent Address: 8312 Turtle Rock Loop College Station, Texas 77840