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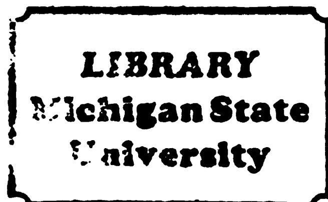

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# DROP-IN CENTERS: WHO USES THEM AND WHY

By

Karen Irene Young

A THESIS

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

MASTER OF ARTS

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# ABSTRACT

## DROP-IN CENTERS: WHO USES THEM AND WHY

By

Karen Irene Young

An exploratory study was conducted with a sample of 60 parents (55 females and 5 males) at a drop-in center in Lansing, Michigan. Five research questions designed to provide detailed information about parents using the services of the drop-in center were investigated. Pertinent information was gathered with the Participant Information Form, the Parental Attitude Questionnaire, the Structured Interview, the Participant Satisfaction Survey, and the Program Register. Although there is reason to believe that the sample may not be representative of the larger parent population at the drop-in center, the results revealed that overall participation in services was low. The respite child care service, however, was used more frequently than the parent support group and education services. Additionally, correlational analyses suggested that three "risk factors" associated with child abuse and neglect may be present among the parents in the sample.

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# CHAPTER I

## INTRODUCTION

The changing nature of the American society from an extended family network to a nuclear family unit has increased the difficulty of childrearing for many parents. Parents who are typically least likely to be able to meet the needs of their children are those who live in geographical or psychological isolation from their own families (Colletta & Gregg, 1981, Colletta, 1979; Egeland & Brunquell, 1979; Gelles & Cornell, 1985; Michigan Department of Social Services, 1984). In these instances, extended family is no longer available to provide parents with services such as respite from child care and emotional support. Furthermore, isolated parents may also lack proper parenting skills and appropriate knowledge about child development and may have difficulty understanding their childrens' needs and behavior (Frank & Rowe, 1981; Kadushin & Martin, 1981; Steele & Pollock, 1968).

The family drop-in center is a child abuse and neglect prevention program created in response to the growing concern for the welfare of children whose parents may be experiencing social isolation, unmanageable stress, and who may be in need of child development information, peer support, or respite child care. The drop-in center is a place where families can go at their own convenience to receive

assistance when they need it. The types of activities and services available to families through involvement in a drop-in center vary from center to center. For example, educational and vocational training, career guidance, job placement, stress management, physical fitness programs, arts and crafts, and crisis assistance are among the activities and services offered. In addition to these activities and services, there are three areas of focus for most drop-in centers: 1) provision of respite child care service, 2) competency enhancement (e.g., providing parent education classes to increase self-esteem and knowledge about child development), and 3) social support (e.g., getting parents involved in a variety of social activities, widening their circle of acquaintances, providing information and referrals to community resources).

Although the drop-in center concept has become a popular manner in which to facilitate the development of positive family relationships and prevent the onset of dysfunctional interactions, particularly child physical abuse and neglect, a review of the pertinent literature has revealed that there is a paucity of information available describing their functioning, the services they provide, and the population(s) they serve.

In an attempt to assist in the amendment of this deficiency in the literature, several research questions were formulated and posed to participants of a Lansing, Michigan based drop-in center. For example, are the social support (i.e., peer support groups), parent education, and respite child care services positively related to such

parent variables as parenting attitude, available social support, residential stability, life stress, and satisfaction with drop-in center services?

A variety of research has been conducted that has assessed the effects of social support on parents, particularly mothers. For example, the total amount of social support received by mothers was found to be positively correlated with the frequency of appropriate maternal behavior (Colletta & Gregg, 1981); and several studies have indicated that maternal support functions as a buffer in the mother-child relationship and in the stimulation of the child (Adamakos et al., 1986; Egeland & Brunquell, 1979; Pascoes, Loda, Jefferies, & Earp, 1981). Additionally, the work by Adamakos et al. (1986), Cobb (1976), and Henderson (1980), supports the contention that the provision of social support acts as a moderator or buffer of life stress.

Research on the effects of parent education on parenting attitude and childrearing techniques has shown that through training, parents can increase their knowledge about the emotional and physical development of children and learn more effective parenting skills such as nonpunitive approaches to discipline (e.g., Frank & Rowe, 1981; Kadushin & Martin, 1981; Resnick, 1985).

While a plethora of information is available that documents the positive relationship between social support and parent education on a variety of parent variables, very little information is available concerning the relationship between the provision of respite child

care on parent variables.

The other research questions investigated in this study focused on who the consumers of services were, their frequency of program participation and services most and least often utilized, reasons for utilizing the drop-in center, and satisfaction with services rendered.

Before proceeding further, it would be helpful to briefly describe the manner in which the forthcoming material is organized. First, child abuse and neglect prevention strategies are discussed. Second, various definitions of child abuse and neglect are reviewed as well as incidence data. Third, several etiological explanations of child abuse and neglect are presented along with methods of intervention. Fourth, the implications for research are specified. This is followed, finally, by a description of the methodology, results, and discussion sections.

Prevention

Drop-in centers and other community programs that attempt to positively affect the parenting attitudes and value systems of individuals in the general population or a specific group of individuals within the population considered to be "at risk" are becoming increasingly popular as methods to reduce the incidence of child abuse and neglect. One reason for the popularity of these primary and secondary preventive efforts is that they appear to be a more positive way in which to deliver services and, in the long run, may be a more cost effective method of service provision as compared to more traditional after-the-fact treatment and rehabilitative

efforts (tertiary prevention).

The definitions of each of these three prevention concepts as they are typically defined in the child abuse and neglect literature will be presented next. The need for precise explanations is paramount as there are probably as many differing definitions of these concepts as there are disciplines that utilize them (Bloom, 1980).

Primary prevention services attempt to reduce the occurrence of child abuse and neglect by influencing attitudes, behavior, and knowledge through the provision of services to all members of a general population.

Secondary prevention services are designed to decrease the probability that child abuse and neglect will occur in a group acknowledged to be "at risk."

Tertiary prevention services are designed for the treatment of individuals who have abused or neglected a child and those who have been abused or neglected. Treatment services are primarily rehabilitative.

As increasing number of primary and secondary prevention programs are established the goal is that they will supplant the need for after-the-fact medical/psychological treatment, legal services, social services, and rehabilitation provided through tertiary prevention strategies. However, until recently, primary and secondary prevention programs have had to compete with tertiary prevention programs for federal and local dollars. Tertiary prevention usually won due to the pressing need to treat the vast number of children who have already

fallen victim to abuse and the adults who inflicted their injuries. Now, with the advent of Children's Trust Funds and federal legislation, more money is available to direct primary and secondary preventive efforts toward parents, other individual caretakers, and children to decrease the incidence of child abuse and neglect.

As of 1987, 38 Children's Trust Funds have been established in as many states. The most common types of prevention programs offered by these states were reported in a survey of the Governors initiated in 1986 by two members of the House of Representatives Select Committee on Children, Youth, and Families George Miller, California and Dan Coats, Indiana. It was found that approximately 50% of the states with Trust Funds offered parent education and 41% provided prenatal and perinatal services to high risk women and teenagers and their infants. Other prevention programs offered by several states focused on respite child care, crisis nurseries, and early screening for developmental disabilities. The authors also found that states were coming to recognize that removing children from their parents should only be a last resort; 18 states provided family preservation services, while 22 and 17 states, respectively, allocated higher funding to homemaking and parent aid services (reported in Select Committee on Children, Youth, and Families: House of Representatives, 1987).

Despite increases in the number and types of primary and secondary prevention services available, a 1982 review of the literature on child abuse prevention programs revealed that the authors in 85% of

the articles failed to evaluate whether the programs were effective in reducing abuse. Evaluation that has been conducted has yielded inconclusive evidence at best (e.g., Gray, Cutler, Dean, & Kempe 1979; Gabinet, 1979; Siegel, Bauman, Schaffer, Saunders, & Ingram, 1980).

Although every parent has the potential to abuse a child at some time (Michigan Department of Social Services, 1984) factors may exist that place certain parents at greater risk and thus, in greater need for prevention services. For example, parents who are socially isolated, who experience unyielding stress, and who lack proper child development knowledge and child care skills should have access to resources that will assist them in strengthening not only their parenting abilities but also their self-esteem. With this in mind, many child abuse prevention programs attempt to change any negative attitudes and behavior parents may have concerning child development and childrearing, reduce feelings of isolation, and improve coping skills. When parents attend parent education classes, participate in peer support groups etc., they have the opportunity to become empowered with the knowledge necessary to help them replace ignorance and inappropriate expectations with positive parenting skills. It is hoped that individuals so empowered will begin to feel better about themselves and, thus, become more effective as parents (Wallach & Weissbourd, 1979). In the words of Vincent J. Fontana, "...Good parenting is the best medicine for the disease of child abuse" (Fontana, 1980 p. 54).

Definitions of Child Abuse and Neglect

The seminal work "The Battered Child" by R. E. Helfer and C. H. Kempe (1968) brought child abuse into the open and gave it credence as a social phenomenon. Their definition of abuse was limited to purposefully inflicted injuries, via physical assault, that could be diagnosed based on their medical and physical symptoms. This initial definition of child abuse was narrow in the sense that it limited abuse to the actual, willful, or intentional physical injury inflicted upon the child by a parent or caregiver. As the battered child syndrome gained more recognition as a social problem, the definitions of child abuse were subsequently expanded to include acts or inactions that impede the normal development of the child.

The definition adopted by The National Center on Child Abuse and Neglect (Public Law 03-237) attempted to go beyond a definition of abusive action resulting in diagnosable injury to also include nonphysical acts, mental injury, and negligent treatment. A comprehensive approach taken to analyze and broadly define child abuse has been advocated by Gil (1973). He defined child abuse as: "Any act of commission or omission by individuals, institutions, or society as a whole, and any conditions resulting from such acts of inaction, which deprive children of equal rights and liberties and/or interfere with their optimal development" (p. 7).

With the inclusion of neglect into the definition, however, discrepancies have arisen in the statistical compilation of abuse rates. In many instances, acts of commission are not distinguished

from acts of omission and this leads to spurious accounts of the actual number of child abuse cases reported yearly. The term "child maltreatment" (an all encompassing term) was advocated by many in the field of child abuse (Fontana, 1980; Garbarino, 1977) as a way to circumvent the confusion raised by the separate terms of abuse and neglect.

Not only is there a lack of agreement concerning the definition of abuse, but in most instances, clear evidence of how an injury was inflicted is difficult to determine; the most common injuries (cuts, broken limbs, bruises, etc.) can appear to be caused by accidents. However, physical examinations, a review of the child's medical history, and interviews with both child and parents, may reveal pertinent information that can aid in distinguishing abuse from accident.

Incidence

Prior to the enactment of mandatory reporting laws in all 50 states, Gil's 1967 national survey of the prevalence of child abuse revealed that 6000 valid cases had been reported (Gil, 1970). States ranged in cases reported from none to 3500. Extrapolating from the responses of a representative sample of 1520 adults, Gil concluded that between 2.53 and 4.07 million children were actually abused each year -- roughly between 13.3 and 21.4 incidents of abuse per 1000 persons in the United States (figures based on a total population of 110 million adults).

Nearly ten years after Gil's survey the findings of two

independent studies, one conducted by Burgdorf (1980) for the National Center on Child Abuse and Neglect and the other by the American Humane Association (1980, reported in Belles & Cornell, 1985) reported child abuse and neglect figures that ranged from 625,000 (10.5 per 1000 children) to 788,844, respectively. The American Humane Association (1984) documented the number of reported cases of abuse and neglect in 1982 to be 929,310 -- an increase of 123% since 1976 when incidence data were first gathered by the American Humane Association. A more recent report conducted by Westat, Inc. (1988) for the National Center on Child Abuse and Neglect, stated that countable cases of abuse and neglect increased from 625,100 in 1980 to 1,025,900 in 1986.

Abusive and damaging acts directed toward children are manifest in a variety of ways, the most publicized of which is physical abuse. At the extremes, physical abuse ranges from spanking, slapping, and shoving to fracturing of limbs and skulls, and death. Although physical abuse receives the bulk of public attention, only 26% of the total number of reported cases of maltreatment in 1982 was categorized as physical abuse. Neglect was by far the most common manifestation of abuse (43%).

Based on information obtained from The National Center on Child Abuse and Neglect, the American Humane Association, the National Study of Child Neglect and Abuse, and various researchers between the years 1976 and 1979, Kadushin & Martin (1981) reported that " ...the more typical physically abused child is a school-aged child who has sustained minor physical injury not requiring medical attention of any

kind. The child was abused by one of the biological parents, the report of abuse having been made most frequently by friends, relatives, or neighbors. The child lives in a low-income household, from which he is not removed" (p. 11).

It is a widespread belief that child abuse is a phenomenon confined to those with lower socioeconomic status. To the contrary, abuse is manifest among the wealthy as well as the poor. Abuse knows no boundaries. It transcends race, religion, level of intellect and afflicts children of all ages (Alvy, 1975; Fontana, 1980; Gelles & Cornell 1985; Steele & Pollock, 1968).

With the broadening of the definitions of child abuse and the upsurge in services provided on the state and local levels (e.g., crisis lines, hot lines, hiring additional social workers to investigate reports of abuse) it is difficult to determine if child maltreatment is actually on the rise or if the figures reflect the increase in official reporting (Gelles & Cornell, 1985). Taking this dilemma into consideration, along with the fact that there are a variety of ways in which child abuse is reported by state (e.g., jurisdictions with higher rates of abuse tend to report by family -- counting the abused child _and_ his/her siblings -- rather than by individual child), caution must be taken when interpreting incidence data.

Although different sources report different figures of child abuse, abuse does exist and a substantial number of children are victimized each year. The absence of accurate incidence data has not

deterred the search to identify and explain the cause(s) of abuse.

## Etiology Of Child Abuse and Neglect

There are two major explanations for the etiology of child abuse. One is the psychopathological model that states that individuals who abuse are "sick" and in need of psychiatric treatment. The other major theory of causation is the situational stress model that emphasizes the fact that everyday problems of living, crisis events, and social isolation can lead to impulsive and abusive actions on the part of the parent when their threshold of tolerance has been reached. Other explanatory models of abuse to be discussed include theories of causation that focus on the childhood history of the abusing parent; the child as a contributor to the abuse event; dysfunctional familial interactions; and abuse as the result of multiple risk factors.

### Parent Focus

*Personality characteristics*. Professions that have traditionally considered intrapsychic conflicts and a childhood history of abuse to be major causes of child abuse include medicine, psychiatry, and clinical psychology. Personality characteristics such as severe depression, low frustration tolerance, aggressive reactions to stress, low self-esteem, impulsivity, dependency, and immaturity, have all been implicated as negative factors that trigger abusive actions (Boisvert, 1972; Davidson, 1977).

The development of psychological profiles has been advocated as a method that could be utilized to differentiate abusers from

nonabusers. The profile would be comprised of personality characteristics believed to be common to abusers. Although factors such as depression, impulsivity, and immaturity have been associated with abuse, no uniform personality profile of abusers has yet emerged. If, however, differences do indeed exist among caregivers along these dimensions, then the profile could be used to predict which individuals are at risk to abuse. Several individuals in the child abuse and neglect field are opposed to this type of prevention strategy (e.g., Alvy, 1975; Gelles & Goldstein, reported in Brodner, 1977). According to Alvy (1975), the strategy would deflect attention away from other viable causes of child abuse while continuing the age old practice of blaming the individual. An even more serious disadvantage of the psychological profile would be the slew of legal and moral issues certain to arise as a result of individuals being diagnosed as true-positives as well as false-positives. Gelles and Goldstein (reported in Brodner, 1977) also expressed skepticism about this type of approach. In their view, little faith can be placed in psychological profiles based on research in which 1) unrepresentative samples and no control groups were used, 2) the authors on the subject disagree about the personality characteristics possessed by abusive parents, and 3) the designs and explanations of the characteristics are generally of an anecdotal and ex post facto nature.

There also exists a prevalent myth in American society that only individuals suffering from mental illness or psychiatric disorder are capable of inflicting abuse upon another family member (Gelles &

Cornell, 1985). This myth survives into the 1980's even though it has been found that less than 10% of all family violence (i.e., child abuse, spouse abuse, elder abuse) is perpetrated by individuals who are "sick" (Garbarino, 1983; Gelles, 1976; Helfer, 1970; Straus, 1980). It would then appear that since the likelihood of being injured (e.g., slapped, physically assaulted, beaten, killed) is greater within the family home than out in the general public (Gelles & Cornell, 1985) that the vast majority of abusers are family members who are not psychologically impaired. For example, demographic characteristics of reported families compiled in The Highlights of Official Child Neglect and Abuse Reporting 1982 document (American Humane Association, 1984) revealed that at least 77% of the perpetrators of abuse were also the child's caregiver. Caregiver was defined as "an adult who has full time responsibility for a child and would not include, for example, babysitters or teachers" (p. 7). In the majority of instances, the caregiver was the child's parent. The average age of the perpetrator was 31.2 years; 38.6% were male and 61.4% were female; 69% were White, 19.7% were Black, 9.2% were Hispanic, and 2.1% comprised the 'other' category.

Parental history of abuse. Parents who themselves were abused, either physically or emotionally, as children not only manifest many of the negative personality characteristics described above, but they may also have unrealistic expectations about what children are capable of doing at certain stages of development (Boisvert, 1972). The lack of parenting knowledge may stem from the fact that many abusive

parents were, as children, deprived of learning what a successful family relationship should be like because their parents were poor role models (Michigan Department of Social Services, 1984). It should be made clear that individuals who were abused or treated harshly as children do not automatically grow up to be abusers themselves. Belief in the deterministic statement that they will can have two deliterious effects on the victims of abuse (Gelles & Cornell 1985). First, they may avoid marriage and conceiving children because they believe themselves to be "preprogrammed" for abusive behavior. Second, social workers, physicians, emergency room personnel etc., may be more apt to label a child's injury as resulting from abuse if they are aware that a parent experienced abuse as a child.

Both disturbances in parental personality and a history of abuse and/or neglect place parents at greater risk for abusing their own children and an intergenerational cycle of abuse may be perpetuated when no one in the cycle is treated.

Child Focus

Child characteristics. Several child characteristics that may place children at greater risk for abuse have been reported in the literature. For instance, infant temperament. Individual differences in reactivity and self regulation that are assumed to have a constitutional basis (Elster, McAnarney, & Lamb, 1983) have been cited as factors that may predispose infants to be the victims of abusive behavior, particularly those who are perceived by their parents as temperamentally difficult (Friedrich & Boriskin, 1976). Most studies

of temperament have assessed newborn behavioral characteristics either through indirect or direct methods. The two most widely used of these methods, maternal self report and the Brazelton Neonatal Behavior Assessment Scale, have both been criticized. For instance, if temperament has a constitutional basis, it appears then that subjective measurement (e.g., via maternal self-report) is contraindicated. However, Sameroff (reported in Elster, McAnarney, & Lamb, 1983) has also asserted that the Brazelton (an objective measure) may have poor psychometric properties when used to assess individual differences.

Other child characteristics cited in the literature that may predispose children to abuse include very young age (Gil, 1970; Davidson, 1977), physical and mental handicaps (Belsky, 1980; Gil, 1970), being born a male (Davidson, 1977), prematurity (Belsky, 1980; Gil, 1970), being designated as temperamentally difficult or hyperactive (Gil, 1970; Davidson, 1977). At the same time, however, there are data that refute the aforementioned findings. For example, a study that examined the variables of prematurity, delivery complications, and the presence of physical anomalies found them unrelated to subsequent ineffective maternal parenting (Egeland & Vaughn, 1981).

Although the data are mixed, many (e.g., Belsky, 1984; Brodner, 1977; Kadushin & Martin, 1981) have come to agree that characteristics that make children difficult to care for play a role in molding the quality of parental care they receive.

## Family Interaction Focus

In general, the existing parent-child research and literature decidedly devotes more attention to the parent variable in the explanation and understanding of child abuse while focusing to a much smaller extent on the child variable. This unidirectional orientation is, however, slowly beginning to give way to an approach that emphasizes the child's role in actively directing the course of events. More specifically, bidirectionality in the parent-child relationship characterizes "...child behavior as an antecedent to parents' behavior, [and] not solely as a consequence of parent behavior" (Kadushin & Martin, 1981, p. 48). The next two sections will focus briefly on the literature that centers on the child's influence in determining parental behavior and on the child's contribution to the bidirectional interaction associated with physical abuse.

Child's influence on parental behavior. As was mentioned earlier, many researchers believe that characteristics of the child, whether they be inherent or environmentally derived, will influence how the caregiver responds. Kadushin and Martin's 1981 literature review highlighted studies that supported the hypothesis that children are instrumental in shaping the behavior of their caregivers. It was found, for example, that infants who failed to initiate such behavior as eye contact, smiling, following, and visual fixation were viewed less positively by their primiparous mothers than infants who engaged in such behavior (Robson & Moss, 1970, p. 54); parents whose children

were unresponsive, not adaptable, unpredictable, irritable, and who had irregular eating, sleeping, and elimination patterns found "...the role of parenting unrewarding. They [felt] inadequate, impatient, and burdened" (Thomas, Chess, & Birch, 1963, pp. 54-55); foster mothers behaved quite differently with a series of foster children who were in their care over a period of time. It was posited that the foster mother reacted "in response to the unique individual differences the child brought to the relationship" (Yarrow, 1963, pp. 56-57); and overactive children were believed to be more deserving of severe discipline than children who exhibited lower activity levels (Stevens-Long, 1973, p. 59).

Bidirectionality and the child's contribution to physical abuse. The research cited above demonstrates the reciprocity that occurs within parent-child relationships in general. This same type of mutual exchange is also specifically manifest within the child abuse interaction. An increasing number of researchers espouse this point of view (Belsky, 1980; Brodner, 1977; Kadushin & Martin, 1981). The basic consensus is that abused children should no longer be viewed as the passive recipients of their caregivers damaging actions but that their own behavior, in many instances, actually provokes caregivers to act in a hostile fashion. For example, a child who is viewed as "different" (e.g., hyperactive, temperamentally difficult, handicapped) has a strong influence on his/her caregiver's behavior (Belsky, 1980; Davidson, 1977; Gil, 1970). The caregiver in this situation must be tolerant of frustration more frequently and for

longer periods and is more apt to resign to impulse or temper which leads to abusive behavior and the cycle of child behavior and caregiver abuse continues (Brodner, 1977).

Various other studies have suggested that premature and low birth weight infants are at greater risk for abuse as a result of the disruption that occurs in the bonding process when they are kept in the hospital following their mothers' return home. These children also require more care once they are brought home and are thus perceived by their mothers as more demanding (Kadushin & Martin, 1981).

Situational Stress Focus

When society targets children as the legitimate recipients of physical force many parents and caregivers believe that it is permissible to displace the negative emotions (e.g., anger, disappointment, and frustration) that arise from a variety of stresses onto children.

A 'stress factor' as defined by the American Humane Association (1984) is "a factor or condition [that] is perceived... to produce stress, tension, and problems within the family" (p. 10). These can include health problems, crisis events (e.g., death in the family), social isolation, single-parent households, economic living condition problems, and family interaction problems (Garbarino, 1983; Gil, 1970; Light, 1973).

Stress may lead parents to misinterpret the signals of their children. They may incorrectly perceive the nature of their

childrens' cries if they are less tolerant of adversive stimuli and stress may also cause them to respond improperly and impulsively.

Many parents who experience pregnancy at an early age (e.g., adolescents) may be bombarded simultaneously with a variety of situational crises such an as unplanned pregnancy, parenthood, and possibly marriage. Because this stress manifests itself during the early stages of their own development, many young parents are unequipped to handle it. The impact of these stresses, however, becomes even greater when psychological immaturity is coupled with isolation from family and friends (Fontana, 1980).

Several studies have found that a higher incidence of abuse occurs within poverty stricken communities (Garbarino, 1983; Gil, 1970, 1973). The higher incidence, however, may be the result of residents having to deal with a greater amount of daily stress and not their socioeconomic status. Garbarino (1977) asserted that it is the unmanageability of the stress that leads to abusive behavior. He also noted, however, that the unmanageability is the result of the disparity between the level of stress and the availability of social support systems.

Social support. Conceptually, social support is seen as a moderator or buffer of life stress (Adamakos et al., 1986; Cobb, 1976; Henderson, 1980). It has been identified by Cobb (1976) as "information leading the subject to believe that he is cared for and loved, esteemed and a member of a network of mutual obligations" (p. 300). A host of individuals (e.g., relatives, neighbors, friends,

professionals and paraprofessionals in the community) can be described as socially supportive in that they may facilitate an individual's ability to cope with stress. However, there may be differences in the amount and kind(s) of support (e.g., emotional support, practical assistance, advice and information, companionship) these individuals provide. For example, research has identified social support network members who perform in the capacity of "support specialists" or "support generalists" (e.g., Bogat et al., 1985; Gottlieb, 1981; Lowenthal & Haven, 1968; Miller & Ingham, 1976). Support specialists offer a single, unique kind of support to an individual. Their assistance is sought when specific knowledge in a particular area is required. Support generalists, on the other hand, may provide an individual with unlimited support in a variety of different areas.

It has long been advocated that one of the factors necessary for the maintenance of mental health is the receipt of social support (Elster, McAnarney, & Lamb, 1983). Researchers have only recently, however, explored the effects social support has on parental behavior (Cochran & Bassard, 1979; Hirsch, 1980). For example, Colletta and Gregg (1981) found a positive correlation between total amount of social support and the frequency of appropriate maternal behavior. The results of another study conducted by Colletta (1979) of low- and middle-income single mothers and middle-income married mothers of preschool-aged children indicated that the social support available to them from their spouse, relatives, and friends predicted the extent to which they demonstrated maternal restrictiveness and punitiveness.

Several studies utilizing samples from both rural and urban populations have also provided evidence for the function of maternal support in buffering stress in the mother-child relationship and in the provision of stimulation to the child (Adamakos et al., 1986; Egeland & Brunquell, 1979; Pascoes, Loda, Jefferies, & Earp, 1981).

Improving the social networks of isolated parents is not always advantageous. Too much input from a spouse, relatives, and friends can become stressful (Belsky, 1984). Social networks work best when network members are able to provide support when it is desired.

Social isolation is the product of the interplay between the individual and the environment (Garbarino, 1977). Thus, social isolation results both from a lack of available social supports and also from failure to take advantage of supports that are available. The potential for abuse is greater when parents have no family and friends to turn to when stressful situations arise. Family and friends may also serve as role models who practice proper childrearing techniques. Abusive parents who are socially isolated may not have an opportunity to learn these proper techniques and thus continue to use violence when they encounter stressful situations (Gelles & Cornell, 1985). Studies have also revealed that caregivers who abuse are distrustful, withdraw from society (Elmer, 1967), and actively discourage their children from forming relationships outside the family unit (Young, 1964). This anti-social behavior is viewed as abnormal in American society.

## Ecological Focus

Character defects, economic factors, crisis events, social isolation, child behaviors, disturbed intra-family relationships, physical impoverishment etc., have all been implicated as factors causing child abuse. But an ecological model holds that abuse is more likely the result of two or more of these factors in combination.

According to Garbarino (1977), the interaction of parental history, social structure, and historical change provides much information about the "contexts and processes" that generate and perpetuate child abuse in general and child maltreatment in particular. He asserted that "there is no 'pure context-free' development" (Garbarino, 1977 p. 722).

Belsky's ecological model of child maltreatment (1980) is a multifactorial causation model in which abuse and neglect are conceptualized as the product of multiple risk factors. The integrated model is comprised of four levels of analysis and is based on the work of two individuals, Tinbergen and Bronfenbrenner. The first level, ontogenic development, considers for example, disturbances in parental personality, parental history of child abuse and/or neglect, and parents' lack of knowledge, and inappropriate attitudes concerning child rearing. The microsystem, or the second level of analysis, focuses on the family setting and all of the dysfuctional interactions that occur among family members (e.g., marital discord, a temperamentally difficult child, scarce household resources). The third level, or the exosystem, considers social

isolation from formal and informal supports, unmanageable stress, and unemployment. Finally, the forth level of analysis is the macrosystem. Here, cultural beliefs and values play a significant role in influencing the events that occur within the micro- and exosystems (e.g., the sanctioning of physical force to control childrens' behavior).

According to Belsky, "not only does this framework emphasize the potentially causative role that each of these factors (i.e., individual, familial, community, and cultural) may play in child maltreatment, but it also explicitly recognizes their interaction in the etiology of child abuse and neglect" (p. 330).

As has been revealed in this section, there exists a variety of explanations concerning the etiology of child abuse. Although the psychopathological model and the situational stress model are the most widely accepted of the causative explanations, convergence toward one model has yet to occur. This lack of agreement may be the result of the complexity of the child abuse phenomenon. The ecological model, however, may prove to be the most promising of the causative explanations since it explicitly takes the issue of complexity into consideration by advancing that abuse is most likely the result of more than one risk factor.

Given these diverse etiological explanations of child abuse, various intervention strategies have been designed, based on the premises of their respective theories, to help parents break the cycle of child abuse and neglect and/or prevent the cycle from ever

beginning.

## Child Abuse and Neglect Intervention Strategies

Just as the most widely accepted etiological theory of child abuse focuses on the abusive parent, the most widely accepted form of treatment for abuse is individual therapy (e.g., psychotherapy) for the parent. There are, however, methods of intervention that take the needs of the abused child into consideration (e.g., the family systems intervention). Although individual therapy for parents and the family systems intervention will not be discussed, other interventions that focus on the parent, child, situational stress, and an interplay of risk factors will be presented.

### Parent Focused Interventions

Parent education. Most people think that parenting is instinctual and requires no formal training. It is this ignorance of proper parenting skills that leads many parents to abuse their children (Frank & Rowe, 1981). Steele and Pollock (1968) commented on the unrealistic expectations many parents have for their children by stating that they "...Expect and demand a great deal from their infants and children. Not only is the demand for performance great but it is premature, clearly beyond the ability of the infant to comprehend what is wanted and to respond appropriately. Parents deal with the child as if he were much older than he really is." As a result, abuse may be greater in homes where there are inappropriate expectations and demands made on children. To offset the occurrence

of abusive behavior stemming from this apparent lack of knowledge, competency enhancement programs have been designed and implemented to teach high risk parents about the physical and emotional development of children (Frank & Rowe, 1981).

One such program, Parent Effectiveness Training, has been incorporated into many abuse prevention services to increase the parents' knowledge of alternative methods of discipline. Childrearing skills are taught that emphasize nonpunitive interactive and disciplinary approaches. The program model is based on the premise that abusive parents who have limited child development information are in need of positive parenting training since they were not exposed to effective parent role models as children (Kadushin & Martin, 1981).

Competency enhancement programs have yet, however, to prove themselves as a viable strategy for the prevention of child abuse and neglect (Rosenberg & Reppucci, 1985). Although evaluation of several programs has demonstrated the short-term enhancement of parenting skills and child development knowledge (Resnick, 1985), no evaluation research is available to support a connection between short-term competency enhancement and long-term prevention of child abuse and neglect (Resnick, 1985; Rosenberg & Reppucci, 1985).

Child removal. The controversy concerning the removal of a child from an abusive environment is not a recent phenomenon. Many of the early pioneers in the field of child abuse and neglect (e.g., Helfer, 1970; Steele & Pollock, 1968) recognized the trend of increasing reliance on separating the abused child from the abusive parent and

placing him/her in a foster home as the intervention of choice. Although in many instances separation is absolutely necessary, it does not allow for any of the issues surrounding the parent's abusive behavior to be resolved. The separation will only be temporary and a decision as to whether the child should be returned to parental custody will have to be made. If during the interim no advances are made to assist the parent in coming to terms with their actions the pattern of abuse will more than likely continue to manifest itself within future parent-child interactions.

## Child Focused Intervention

**Traditional casework.** In instances where child abuse has been substantiated, the bulk of the protective caseworker's attention is focused on the family. Although many caseworkers recognize that the abused child is in need of individual treatment, their large caseloads, coupled with their desire to effect the greatest amount of change, leads them to direct the majority of their attention to the family (Holleman, 1983). It is for these reasons that most caseworkers have come to rely on foster care to solve the child's problems.

## Situational Stress Interventions

As alluded to earlier, the situational stress model is one of the two major theories that attempt to explain the etiology of child abuse. According to this view, the lives of many child abusers are marked by poor housing conditions, social isolation, marital and family discord, financial stress, single-parenthood, etc. Once a

potential abuser's threshold of tolerance has been surpassed, overwhelming feelings of rage, anger, and frustration are typically displaced onto a defenseless child.

A variety of interventive approaches are available to help reduce much of the stress that encroaches upon the family unit in order to strengthen its ability to cope with the remaining stress. For example, the family can obtain assistance from facilitative services such as, traditional casework, paraprofessionals, child care services (such as drop-in centers), and self-help organizations.

Traditional casework. Via information obtained through interviews and naturalistic observation, the social worker is instrumental in deciding whether a child may be safely left in the care of parents, left at home -- provided some other responsible person is there to provide protection, or must be removed from the care of the parent and placed in a foster home in the custody of juvenile court or child protective services (Steele & Pollock, 1968).

As was mentioned previously, criticisms have been directed at caseworkers for focusing the bulk of their energies and resources toward the abusive families while neglecting the individual treatment needs of the child (Helfer, 1970; Holleman, 1983; Steele & Pollock, 1968).

Paraprofessionals. Instead of putting dollars into services like psychiatric care for abusive parents, Helfer (1970) proposed that a "plan for protection," that endeavors to make the home safe for the child to return to, be designed and implemented. This strategy

provides abusing parents with "substitute" mothers (i.e., parent aides) who "...begin to attack the wall of isolation that surrounds the parents." This is accomplished by the parent aides assisting parents in developing friendships and teaching them how to ask for and accept help from others (e.g., the parent aide, spouse, friends, relatives, and neighbors). If the parent aide is successful, the child can start returning to the home approximately three to six months into the intervention (it usually takes that long to get parent aides accepted by and meaningfully involved with the parents).

Child care services. Innovations in "shared parenting" offered through crisis nurseries, drop-in centers, and day care facilities have allowed many parents to find temporary relief from unrelenting child care that might otherwise lead to abuse.

Crisis nurseries (or protective daycare centers) operate on a 24-hour, 7-day-a-week basis. Children are accepted at the nursery for short-term care at all hours in an effort to spare them from any potentially abusive situations. That is, these facilities are typically used by caregivers who consider their children to be a source of anxiety and frustration. Most nurseries accept a maximum of five to seven children with a maximum residential stay of 48 or 72 hours. This service is available as an alternative to foster care placement of children who are at great risk for abuse. Although the effectiveness of crisis nurseries in re-establishing family stability has not as yet been empirically demonstrated, there are some researchers who believe that it is beneficial (e.g., Crittenden,

1983).

Drop-in centers allow parents to receive respite from child care for a few hours any day the center is in operation. Centers tend to vary, however, in terms of their intake procedure and requirements. Some require that reservations be made in advance before children can be dropped off and others operate on a first-come-first-served basis. Many centers place a limit on the number of hours of respite a child may receive while others do not. Once children are accepted into the facility some programs require parents to participate in a predetermined number of parent support services and activities (e.g., peer support groups, parent education classes). Other centers require that the parents themselves volunteer one or more hours of their time in the service of the center at a later date, while those centers that have a large reserve of community volunteers usually do not require parental participation. Due to the nature of both the crisis nursery and the drop-in center, the potential for parental misuse of the facilities as a convenience rather than as a respite haven has to be monitored (Kadushin & Martin, 1981).

Self-help organizations. Self-help groups such as Parents Anonymous provide parents with an effective adjunct group treatment resource. Participation is primarily voluntary but for approximately seven percent of abusing parents it is involuntary (Kadushin & Martin, 1981).

Parents Anonymous was established in California in 1971 with the assistance of a social worker. Membership is estimated to be near

8,000 in some 800 chapters nationwide. The socially supportive atmosphere helps to reduce the social isolation many abusing parents experience. This, in turn, facilitates the parents' receptiveness to learn about more positive behavior alternatives that are socially acceptable (Collins, 1978, reported in Kadushin & Martin, 1981). Parents Anonymous is also concerned about the treatment needs of the abused children. As summarized by Kadushin and Martin (1981): "treatment involves offering education, role modeling, support, clarification and a variety of concrete services within a constructive limit-setting context, in an empathic, warm, noncondemnatory relationship..." (p. 25).

Ecological Intervention

The ecological interventive approach holds that child abuse and neglect stems not from one etiological source but from two or more sources. Therefore, the resulting interactions of the various risk factors that are present at each of four levels of analysis (i.e., the individual, familial, community, and cultural) make intervention implementation difficult.

## Implications for Research

The available literature indicates that child abuse and neglect may result when parents feel burdened by the responsibility of around-the-clock child care, lack appropriate knowledge about child development, possess negative parenting attitudes, and are psychologically and/or geographically isolated from both formal and

informal support networks (Boisvert, 1972; Colletta & Gregg, 1981; Colletta, 1979; Crittenden, 1983; Egeland & Brunquell, 1979; Frank & Rowe, 1981; Gelles & Cornell, 1985; Kadushin & Martin, 1981; Michigan Department of Social Services, 1984; Steele & Pollock, 1968). Although a variety of programs aimed at parents and children attempt to counteract these potential abuse and neglect "risk" factors, some are more well known than others and are widely described in the literature. Unlike, for example, the literature describing perinatal coaching programs for first-time mothers, an organized body of knowledge describing drop-in centers is practically nonexistent. To help remediate this situation, five research questions designed to provide detailed information concerning the functioning of a drop-in center, the services provided, and the population(s) served were formulated and posed to participants of the Family Growth Center (FGC), a drop-in center whose interventions are focused on the parent (e.g., parent education classes) and situational stress (e.g., parent support groups and respite child care). The research questions were 1) Who uses the services offered at the FGC? 2) Which FGC services do parents use and how often? 3) What reasons do parents give for using FGC services? 4) How satisfied are parents with the services received from the FGC? and 5) What is the relation among the three service types (i.e., respite child care, parent support groups, and parent education) and five parent variables (i.e., available social support, parenting attitude, life stress, residential stability, and satisfaction with FGC services)?

# CHAPTER II

# METHOD

## Sample and Procedures

The subject population for this research project was individuals who were participants at three drop-in center facilities.

The sample of 60 participants came from three Family Growth Center's (FGC) located in Lansing and East Lansing, Michigan. The Downtown Family Growth Center, which is housed within the Central United Methodist Church, is located in downtown Lansing. The Mt. Hope Neighborhood Family Growth Center, also located in Lansing, is housed within the Bethlehem Lutheran Church. The East Lansing Family Growth Center is housed within the University United Methodist Church and is located in East Lansing.

The Family Growth Center provides services not only to "high risk" parents, that is, parents who are experiencing social isolation, stress, and lack support networks, but those who are more well-functioning are also eligible to receive services. The services offered to parents include parent education, parent support, information and referral to needed services, and respite (or drop-in) child care. Involvement in community activities such as these is one manner in which the program attempts to reduce the parents' feelings of isolation and stress, build support networks, and enhance their knowledge about children and their healthy development. No

restrictions are placed on parent participation in any of the activities (i.e., participation is unlimited). One restriction, however, does exist for children participating in the drop-in child care component: only children between the ages of two weeks and six years may participate. Although unlimited drop-in child care is provided, the children are taken on a first-come-first-served basis each day the center is in operation until capacity is reached.

The recruitment process began with the researcher obtaining a complete list of all FBC program participants from the FBC Program Director. This list, comprised of 417 names, included all parents who were registered at the FBC between January of 1987 and March of 1988. During the month of April 1988 14 new participants were registered into the FBC program. Their names were obtained and added to the original list (N = 431), in this manner the list remained current and up-to-date. No new participants who were registered into the program after April 1988 were included in the study. A stratified research design was used to categorize the 431 names based on length of program participation. To determine the length of time each of the participants had been receiving FBC services the amount of time from January 1987 to the month the researcher would visit the parent (i.e., either March, April, or May 1988) was calculated. Using increments of three month periods, the length of FBC participation was categorized as follows: 0-3 months, 4-6 months, 7-9 months, 10-12 months, and 13-15 months. By the end of April 1988 there were 80 parents who had been participating between 0-3 months, 49 between 4-6 months, 57

between 7-9 months, 71 between 10-12 months, and 174 between 13-15 months. The number of parents in each category was divided by 431 (the total population size). The resulting percentage was then multiplied by 60 (the sample size) to determine the number of parents to be randomly sampled from each category. For example, 80 ÷ 431 = 18.6%, .186 × 60 = 11. As a result, there were 11 parents randomly sampled from the 0-3 month category, 7 from the 4-6 month category, 8 from the 7-9 month category, 10 from the 10-12 month category, and 24 from the 13-15 month category. The sample of 60 participants is proportional to the population distribution in terms of length of program participation. Since the data collection period spanned over three months (i.e., March through May of 1988) the length of program participation category for 154 of the 431 participants had to be upgraded (i.e., transferred to the next higher category) when data collection entered a new month. For example, if a parent was originally assessed as having been an FBC participant for 6 months as of March 1988 (i.e., in the 4-6 month category), but was not randomly selected for participation in the study in March, her/his length of participation was upgraded to 7 months (i.e., to the 7-9 month category) when the random selection process began for April 1988. In this way, length of program participation remained accurate up until the time of the researcher's visit. It should be noted that since 13-15 month is the highest category that all participants who were originally placed in this category or who were upgraded to this category will always remain in this category.

To prepare the names on the FBC participant list for the random selection process each of the names were numbered from 001 to 431. Only participants whose three digit identification number was selected from the random numbers list was approached for participation in the study.

Each randomly selected FBC participant was mailed a letter (see Appendix A) that 1) briefly described the research project and 2) informed them that they would receive a telephone call from the researcher that would further detail the research project as well as their role as a participant and provide answers to any questions they had.

During the telephone call (see Appendix B for the script that was used), the individual was told that the purpose of the research was to get a better idea of the people who used drop-in centers, to find out why they were used, what services were used, and to determine their satisfaction with service delivery. Following this discussion, each individual was informed that an immediate reply was not necessary -- they would have 24 hours to make a decision. Those who desired this extra time were re-contacted by telephone after the designated period and asked for a decision. When additional questions arose, they too were answered. In most instances, participants did not want the extra time to make a decision as they were able to give the researcher an immediate response. After the individual agreed to participate, a time was scheduled for the researcher to visit to conduct the interview and administer the questionnaires. While at their home, the

research project was explained once more, questions answered, the consent form was discussed and signed (see Appendix C), the Structured Interview conducted (see Appendix D), and the Participant Information Form (see Appendix E), the Parental Attitude Questionnaire (see Appendix F), and the Participant Satisfaction Survey (see Appendix G) completed, in this order. When any individual declined participation, either before or after being given 24 hours notice, their name was discarded from the participant list and another name was randomly selected from the list.

Participants in the study were also tracked over a four week period. The tracking procedure consisted of keeping a weekly program register on each participant and her/his child(ren). Specifically, the Program Register form documented all FGC services utilized by the family and frequency of use during each of the four weeks prior to data collection (see Appendix H).

Table 1 shows the status of each FGC participant over the three months of data collection. Reported are 1) the total number of FGC participants registered in each length of program participation category, 2) the total number approached (i.e., those randomly selected to receive a letter and telephone call), 3) the total number of interviews completed (i.e., those that agreed to participate in the study), 4) the total number of interviews not completed and the reason they were not completed, 5) the total number whose length of program participation category required upgrading prior to the start of the next data collection month, and 6) the total number remaining in the

Table 1

Status of Parents Approached During Each Month of Data Collection

| Month | Length of Participation at the FBC | | | | |
|---|---|---|---|---|---|
| | 0-3mth | 4-6mth | 7-9mth | 10-12mth | 13-15mth |
| FBC Parents Available to Participate (N = 417) | | | | | |
| March | | | | | |
| Registered | 66 | 49 | 57 | 71 | 174 |
| Approached | 0 | 5 | 4 | 2 | 5 |
| Completed | 0 | 1 | 2 | 1 | 4 |
| Not Completed | 0 | 4 | 2 | 1 | 1 |
| Reason Not Completed: | | | | | |
| a. not interested | 0 | 0 | 0 | 0 | 0 |
| b. no telephone | 0 | 0 | 2 | 1 | 0 |
| c. moved | 0 | 4 | 0 | 0 | 0 |
| d. three telephone calls | 0 | 0 | 0 | 0 | 0 |
| e. canceled visit | 0 | 0 | 0 | 0 | 1 |
| Upgraded | 24 | 26 | 18 | 35 | - |
| Remaining in Selection Pool | 42 | 18 | 35 | 34 | 169 |

Table 1 (cont'd.)

| Month | 0-3mth | 4-6mth | 7-9mth | 10-12mth | 13-15mth |
|---|---|---|---|---|---|
| | Length of Participation at the FBC | | | | |
| FBC Parents Available to Participate (N = 415) | | | | | |
| April | | | | | |
| Registered | 56 | 42 | 61 | 52 | 204 |
| Approached | 13 | 10 | 6 | 14 | 29 |
| Completed | 4 | 1 | 4 | 1 | 6 |
| Not Completed | 9 | 9 | 2 | 13 | 23 |
| Reason Not Completed: | | | | | |
| a. not interested | 4 | 5 | 2 | 6 | 8 |
| b. no telephone | 3 | 2 | 0 | 0 | 3 |
| c. moved | 0 | 1 | 0 | 5 | 8 |
| d. three telephone calls | 1 | 1 | 0 | 2 | 4 |
| e. canceled visit | 1 | 0 | 0 | 0 | 0 |
| Upgraded | 13 | 8 | 15 | 15 | - |
| Remaining in Selection Pool | 30 | 24 | 40 | 23 | 175 |

Table 1 (cont'd.)

| Month | Length of Participation at the FBC | | | | |
|---|---|---|---|---|---|
| | 0-3mth | 4-6mth | 7-9mth | 10-12mth | 13-15mth |
| FBC Parents Available to Participate (N = 343) | | | | | |
| May | | | | | |
| Registered | 30 | 37 | 48 | 38 | 190 |
| Approached | 11 | 10 | 4 | 11 | 24 |
| Completed | 7 | 5 | 2 | 8 | 14 |
| Not Completed | 4 | 5 | 2 | 3 | 10 |
| Reason Not Completed: | | | | | |
| a. not interested | 3 | 2 | 1 | 1 | 1 |
| b. no telephone | 0 | 0 | 0 | 1 | 2 |
| c. moved | 1 | 2 | 1 | 0 | 5 |
| d. three telephone calls | 0 | 1 | 0 | 1 | 1 |
| e. canceled visit | 0 | 0 | 0 | 0 | 1 |
| Upgraded | - | - | - | - | - |
| Remaining in Selection Pool | 19 | 27 | 44 | 27 | 166 |

participant selection pool at the end of the month (i.e., the total number available for random selection during the next data collection month).

As can be seen in Table 1, there were a total of 417 parents participating at the FBC when data collection began during the fourth week of March 1988. Although 16 participants were approached to ascertain their interest in participating, only eight interviews were completed. By chance, none of the identification numbers for parents in the 0-3 month category were randomly selected during the month. At the end of March it was necessary to upgrade the length of program participation category for 103 participants. A total of 401 FBC participants remained in the selection pool for the start of April.

There were 14 new participants registered into the FBC program in April. This increased the total number available in the selection pool to 415 during the month. While 72 participants were approached, 16 interviews were completed and 56 were not completed. Length of program participation category was upgraded for 51 participants. There were 343 FBC participants in the selection pool for the start of May. No new participants who became involved with the FBC after April were included in the study.

During May 60 participants were approached. From this number, 36 interviews were completed and 24 were not completed. At the end of the data collection period (i.e., May 1988) there were 283 FBC participants who had not been randomly selected to participate in the study.

Figures from the preceding monthly tables were compiled and are presented in Table 2. In addition, percentages reflecting the rate of participation for each length of program participation category is reported. The rates ranged from 28% to 57%. To determine whether the variation in these percentages was significant a chi square test was performed. The result was not significant. This finding, then, suggests that there is no relationship between type of participant (i.e., parents approached in the five length of program participation categories) and their rate of participation in the study.
Over the course of the recruitment phase, telephone calls were placed to 148 randomly selected parents. Fifty-nine percent ($n$ = 88) either declined participation or could not be contacted for a variety of reasons. More specifically, 33 parents stated that they had no interest in participating; 27 had moved and left no forwarding telephone number and/or address; 11 were eliminated when they could not be contacted after three attempts were made by telephone; 14 parents without telephones were excluded when they failed to contact FBC staff about their interest in participating per the instructions on the letter they received; and 3 canceled scheduled interviews.

Instruments and Scales

There were five instruments used in this study: the Participant Information Form, the Parental Attitude Questionnaire, the Structured Interview, the Participant Satisfaction Survey, and the Program Register. The first two instruments were created by the Michigan Children's Trust Fund (1986) for use in monitoring child abuse and neglect prevention

Table 2

Compiled Three Month Totals and Participation Rates

| | Length of Participation at the FGC | | | | |
|---|---|---|---|---|---|
| | 0-3mth | 4-6mth | 7-9mth | 10-12mth | 13-15mth |
| FGC Parents Available to Participate (N = 431) | | | | | |
| Approached | 24 | 25 | 14 | 27 | 58 |
| Completed | 11 | 7 | 8 | 10 | 24 |
| Not Completed | 13 | 18 | 6 | 17 | 34 |
| Reason Not Completed: | | | | | |
| a. not interested | 7 | 7 | 3 | 7 | 9 |
| b. no telephone | 3 | 2 | 2 | 2 | 5 |
| c. moved | 1 | 7 | 1 | 5 | 13 |
| d. three telephone calls | 1 | 2 | 0 | 3 | 5 |
| e. canceled visit | 1 | 0 | 0 | 0 | 2 |
| Participation Rate | 46% | 28% | 57% | 37% | 41% |

programs. The Structured Interview was adapted from the Maternal Interview created by Newberger, Hampton, Marx, & White (1986). The remaining two instruments were created by the researcher for use in this study. No reliability information is available for any of the instruments.

The Participant Information Form elicited demographic information from the participants such as age, race, primary source of income, amount of family income, and whether the parent is presently expecting a child.

The Parental Attitude Questionnaire elicited the participants' feelings about being a parent and the childrearing techniques generally used.

The Structured Interview is a 40 minute interview. Parents were asked a variety of questions such as who were the people they felt they could turn to in times of need (social supporters), level of formal education completed, the length of time they have resided in their present community, and questions about their perceptions of their childrens' behavior (i.e., only children who were enrolled in drop-in child care at the FGC).

The Participant Satisfaction Survey elicited the parents' degree of satisfaction with the FGC services, reasons for service use, and inquired as to which aspects of the program they found most and least beneficial.

Although the Program Register was not a participant instrument, it was used by the researcher to document all FGC services utilized by

the participants and their children and the frequency of service usage that occurred over the four week tracking period.

Embedded within the instruments are five parent variables of interest for this research project: available social support, parenting attitude, life stress, residential stability, and satisfaction with FBC services. These variables were operationalized by the following scales:

The Available Social Support Scale documented the number of individuals who provided parents with each of four types of social support, the number of individuals reported as providers of three types of support (this is an extrapolated item, that is, derived from parents' responses to other social support questions), recent involvement in social functions, and membership in groups and organizations. The seven items of this scale were presented to the parents in a fill in the blank format. See Appendix I for a listing of the available social support scale items as well as the items for the other four scales.

The Parenting Attitude Scale assessed how the parents felt about their parenting ability, the discipline technique(s) used, and their relationship with their children in a variety of areas. There are six items on this scale. The items were presented in a multiple choice format with responses ranging from strongly agree to strongly disagree on a five point likert-type scale.

The Life Stress Scale elicited information from parents concerning the number of their children who had been enrolled in drop-in child

care at the FBC and their subjective rating of the amount of stress that results from particular behaviors exhibited by their second and third youngest children who were enrolled in drop-in child care. Parents indicated their perceived degree of life stress by responding to the 12 items of this scale either by filling in the blank or selecting the best suited response (i.e., strongly agree to strongly disagree) from a five point likert-type scale.

The Residential Stability Scale elicited information concerning the number of times parents had moved from one residence to another in the past year and their length of residence in the Lansing area. The two items on this scale required parents to respond using a fill in the blank format.

Finally, the two items of the Satisfaction Scale documented the parents' satisfaction and/or dissatisfaction with FBC services and their feelings about recommending the FBC to others. Each of these items was presented in a fill in the blank format.

Prior to computing the reliability of the five scales, the items appearing on each scale were prepared for scale inclusion in the following manner. First, the responses of several scale items were re-coded in order that low scores indicated that parents 1) had many socially supportive individuals in their life (available social support items), 2) had a good attitude about parenting (parenting attitude scale items), 3) had a low amount of stress in their daily life (life stress scale items), 4) were long-time residents of their present neighborhood (residential stability scale items), and 5) were

satisfied with the services they received at the FGC (satisfaction scale items). High scores on the response sets indicated the opposite of the low scores. Second, a Z-score transformation was performed on all items in order to standardize the items with different observed scales to the same scale. The transformed items have a mean of 0 and a standard deviation of 1. No items were discarded due to lack of variance.

Reliability

Items were selected for each of the five scales after multiple reliability analyses indicated that they were the most appropriate. That is, their corrected item-total correlations were at least .25 (the critical value for a sample of 60 at the .05 level of significance) and the spread between the highest and lowest corrected item-total correlations within a scale did not exceed .30. Cronbach's alpha was then computed on the scales to determine the degree of internal consistency among them.

Standardized item alphas for the scales ranged from .52 for the residential stability scale to .94 for the life stress scale (see Table 3). Table 4 shows the intercorrelations of all the scales with reliabilities appearing in the diagonals. No scale correlated with another at the .01 level of significance or higher, indicating that each are measuring different constructs.

To assess test-retest reliability six of the 60 parents in the sample were randomly selected to complete the Participant Information Form, the Parental Attitude Questionnaire, and the Participant

Table 3

Parent Variable Scales and Psychometric Properties

| Corrected item-total correlation | Items comprising the scale | Standardized item alpha |
|---|---|---|
| | Available social support ($n$ = 60) | .90 |
| .81 | 1. number of emotional supporters | |
| .72 | 2. number of practical assistance supporters | |
| .78 | 3. number of advice and information supporters | |
| .83 | 4. number of companionship supporters | |
| .61 | 5. number of social supporters repeated three times | |
| .51 | 6. number of social functions attended in the past month | |
| .67 | 7. number of groups and organizations parent belongs to | |
| | Parenting attitude ($n$ = 55) | .81 |
| .68 | 1. When dealing with my children, I feel in control of my emotions most of the time. | |
| .57 | 2. I feel comfortable with the way I discipline my children. | |
| .42 | 3. I am able to take a break from my children when I need it. | |
| .56 | 4. I enjoy the time I spend alone with my children. | |
| .73 | 5. I think I'm doing a good job as a parent. | |
| .45 | 6. I feel like my children have a good feeling about themselves. | |
| | Life stress ($n$ = 57) | .94 |
| .96 | 1. number of children who are (were) enrolled in drop-in child care at the Family Growth Center? | |

Table 3 (cont'd.)

| Corrected item-total correlation | Items comprising the scale | Standardized item alpha |
|---|---|---|
| .66 | 2a. attention span of second youngest child who is (was) enrolled in drop-in child care | |
| .75 | 2b. attention span of third youngest child who is (was) enrolled in drop-in child care | |
| .74 | 3a. activity level of second youngest child who is (was) enrolled in drop-in child care | |
| .76 | 3b. activity level of third youngest child who is (was) enrolled in drop-in child care | |
| .70 | 4a. behavioral disposition of second youngest child who is (was) enrolled in drop-in child care | |
| .76 | 4b. behavioral disposition of third youngest child who is (was) enrolled in drop-in child care | |
| .67 | 5a. Does second youngest child who is (was) enrolled in drop-in child care throw temper tantrums? | |
| .79 | 5b. Does third youngest child who is (was) enrolled in drop-in child care throw temper tantrums? | |
| .74 | 6a. Does parent spank second youngest child who is (was) enrolled in drop-in child care? | |
| .74 | 6b. Does parent spank third youngest child who is (was) enrolled in drop-in child care? | |
| .68 | 7. Sleep pattern of third youngest child who is (was) enrolled in drop-in child care. | |
| | Residential stability ($n$ = 60) | .52 |
| .35 | 1. number of times parent has moved from one residence to another in the past year | |
| .35 | 2. length of residence in the Lansing area | |

Table 3 (cont'd.)

| Corrected item-total correlation | Items comprising the scale | Standardized item alpha |
|---|---|---|
| | Satisfaction (*n* = 58) | .75 |
| .61 | 1. In general, how do you feel about the services that were provided by the Family Growth Center? | |
| .61 | 2. Would you recommend the Family Growth Center to others? | |

*Note.* See Appendix I for the exact wording of the scale items, as well as other items that appear on the research instruments that did not qualify for scale inclusion.

Table 4

Intercorrelations Between Parent Variable Scales

| Scale | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| FSC Parent Participants (n = 60) | | | | | |
| 1. Available Social Support | .90 | | | | |
| 2. Parenting Attitude | .26 | .81 | | | |
| 3. Life Stress | -.14 | .05 | .94 | | |
| 4. Residential Stability | .25 | .26 | .09 | .52 | |
| 5. Satisfaction | .29 | -.03 | -.19 | .11 | .75 |

Note. Internal consistencies appear in the diagonals.

Satisfaction Survey a second time. The time interval between the first and second administration of these measures ranged from five to seven days. Reliability was calculated using the percent exact agreement method. With this method, reliability equals the sum of the total number of items on the measure, minus the sum of the number of disagreements (i.e., discrepancies in parent responses from the first to the second administration of the measure), divided by the total number of items on the measure. The resulting test-retest reliability ranged from .73 to .84 with an average reliability of .79.

In addition, the Structured Interviews of seven randomly selected parents were coded both by the researcher and an assistant. The resulting test-retest reliability (also assessed using the percent exact agreement method) ranged from .92 to 1.00 with an average reliability of .98.

# CHAPTER III

# RESULTS

## Descriptive Results

To be presented in this section are the findings from the five research questions that were investigated in this study as well as information concerning the social support system of the parents in the sample, their degree of connectedness to their community, attitudes about their relationship with their child(ren), and child development knowledge.

1. Who uses the services offered at the FBC? As Table 5 indicates, nearly all of the parents in the sample are white females (80% and 91.7%, respectively); most of whom are between the ages of 30 and 37 (56.7%). These parents have, on the average, two children. Eighty-five percent have at least one child under the age of five years and 13.3% are presently expecting another child. Over half are married (68.3%) and 90% have no extended family and/or friends residing in their household. The majority of the parents have attended college (78.4%) with the modal response being a completion of four years of higher education. Nearly fifty percent are employed in the workforce, either part-time or full-time. Seventy percent reported themselves, spouse, or both as the primary source of the family income, and family income for 58.3% ranged from $801.00 to over

Table 5

*Demographic Characteristics*

| Variable | *n* | Percent |
|---|---|---|
| **Length of participation** | | |
| 0-3 months | 11 | 18.3 |
| 4-6 months | 7 | 11.7 |
| 7-9 months | 8 | 13.3 |
| 10-12 months | 10 | 16.7 |
| 13-15 months | 24 | 40.0 |
| **Presently participating** | | |
| Yes | 29 | 48.3 |
| No | 30 | 50.0 |
| Missing | 1 | 1.7 |
| **Gender** | | |
| Female | 55 | 91.7 |
| Male | 5 | 8.3 |
| **Race** | | |
| Asian | 5 | 8.3 |
| Black | 3 | 5.0 |
| Hispanic | 3 | 5.0 |
| White | 48 | 80.0 |
| Missing | 1 | 1.7 |

Table 5 (cont'd.)

| Variable | n | Percent |
|---|---|---|
| Age | | |
| 18-21 | 4 | 6.7 |
| 22-25 | 7 | 11.7 |
| 26-29 | 8 | 13.3 |
| 30-33 | 18 | 30.0 |
| 34-37 | 16 | 26.7 |
| 38-41 | 4 | 6.7 |
| 42 and older | 3 | 5.0 |
| Number of children | | |
| One | 21 | 35.0 |
| Two | 21 | 35.0 |
| Three | 13 | 21.7 |
| Four | 3 | 5.0 |
| Five | 1 | 1.7 |
| Missing | 1 | 1.7 |
| Number of children under age five | | |
| Zero | 9 | 15.0 |
| One | 28 | 46.7 |
| Two | 18 | 30.0 |
| Three | 5 | 8.3 |
| Presently expecting a child | | |
| Yes | 8 | 13.3 |
| No | 52 | 86.7 |

Table 5 (cont'd.)

| Variable | n | Percent |
|---|---|---|
| Marital status | | |
| Single | 8 | 13.3 |
| Separated | 5 | 8.3 |
| Divorced | 6 | 10.0 |
| Married | 41 | 68.3 |
| Size of household | | |
| Two | 10 | 16.7 |
| Three | 12 | 20.0 |
| Four | 22 | 36.7 |
| Five | 12 | 20.0 |
| Six or more | 4 | 6.7 |
| Educational level | | |
| Less than high school | 3 | 5.1 |
| High school graduate | 9 | 15.0 |
| Some college | 18 | 30.0 |
| College graduate | 29 | 48.4 |
| Missing | 1 | 1.7 |
| Number of extended family/friends residing in home | | |
| Zero | 54 | 90.0 |
| One | 4 | 6.7 |
| Two | 1 | 1.7 |
| Four | 1 | 1.7 |

Table 5 (cont'd.)

| Variable | n | Percent |
|---|---|---|
| Employment status | | |
| Unemployed | 31 | 51.7 |
| Part-time or Occasional | 18 | 30.0 |
| Full-time | 11 | 18.3 |
| Primary source of income | | |
| Employment of self, spouse, or both | 42 | 70.0 |
| Parents | 2 | 3.3 |
| Public assistance | 11 | 18.3 |
| Other | 4 | 6.7 |
| Missing | 1 | 1.7 |
| Family income | | |
| Under $500/month | 12 | 20.0 |
| $501 to $800/month | 11 | 18.3 |
| $801 to $1,100/month | 9 | 15.0 |
| $1,101 and Over/month | 26 | 43.3 |
| Missing | 2 | 3.3 |
| How parent learned about the FGC | | |
| Friend | 29 | 48.3 |
| Relative | 4 | 6.7 |
| Co-worker | 1 | 1.7 |
| Professional in the community | 8 | 13.8 |
| Acquaintance | 2 | 3.3 |
| Brochure/pamphlet | 10 | 16.7 |
| Other | 4 | 6.7 |
| Missing | 2 | 3.3 |

$1,101.00 per month.

Additional demographic information reveals that parents in the study were most commonly referred to the FBC by a friend (48.3%) or they learned about the services through a brochure or pamphlet (16.7%). At the time the researcher visited each parent half reported that they were no longer actively receiving services at the FBC. Though not formally documented in the research, parents gave a variety of reasons for their inactivity at the FBC. For example, children had reached the age at which they were ineligible to receive drop-in child care (age six), lack of time due to enrollment in higher education courses, taking a part-time or full-time job, scheduling conflicts, the inconvenience of the first-come-first-served drop-in child care policy.

In sum, it appears that the primary consumers of FBC services tend to be white females who are married, well educated, between the ages of 30 and 37 with an average of two children. Their monthly family income ranged from $801.00 to over $1,101.00 and many, though not the majority, are employed either on a part-time or full-time basis. At the time of data collection half of the parents in the sample indicated that they were not currently participating in the services at the FBC.

2. Which FBC services do parents use and how often? The FBC services investigated for this project were respite (or drop-in) child care, parent education, and parent support group. Frequency of service use was documented in two manners. The first was based on

parent report and the second on the actual attendance records kept by the FBC staff. Eighty percent of the parents reported that they had not used the parent support group service at all during the four week period prior to the researcher's visit. Additionally, of the 12 parents who did indicate support group attendance, the average number of sessions attended was four. The zero usage figure reported by most parents closely approximates the support group attendance figures documented by the FBC staff. Their records showed that 86.7% of the parents had not attended any of the support group sessions during the previous four weeks. Of those who had, the average number attended was three.

Ten parents reported participating in an educational class during the designated four week time period. They had attended an average of five classes during the previous month. This compares to the 83.3% who had received no form of parent education. The FBC records substantiated parent reported use of parent education classes: 18.3% (_n_ = 11) had attended an average of five classes.

Twenty-eight parents reported that their children had used the respite child care service during the last four weeks. The average number of visits was four. Again, FBC records corroborated the respite child care attendance figures reported by the parents: 26 parents brought their children to the respite child care program approximately three times each.

The _total_ number of FBC services parents used during the designated period ranged from zero for 51.7% of the parents to 19 for

1.7% of the parents, according to FBC records. The average number of services used was three.

In sum, of the three FBC services investigated in this study, the respite child care service was used most frequently by parents over the designated four week period while the parent support group service and parent education classes were seldom used. Additionally, usage figures for each of the three services as reported by parents and as documented by the FBC staff were nearly identical.

3. What reasons do parents give for using FBC services? The reasons parents gave for registering for services were broken down into seven general categories: self-improvement, respite, child-related, practical assistance, emotional support, task completion, and quality of service. Before proceeding to an examination of the results, it should be noted that parents were allowed to give multiple responses to the four items querying this research question. As a result, the reported percentages do not add to 100%.

Thirty-nine percent of the parents mentioned self-improvement as the reason they initially began to use services at the FBC (e.g., to attend FBC parent education classes); 38% were in need of respite (e.g., to give themselves a break from their children and vice versa); 38% gave child-related reasons (e.g., to give children an opportunity to play with other children); and 30% sought practical assistance (e.g., needed a child care provider).

Examination of specific services revealed that parents became involved in the support group service to obtain emotional support

(25%) and to improve themselves, for example, by taking the advice offered by other parents (16%). Forty percent of the responding parents, however, indicated that they had never participated in an FBC parent support group. The major reason given by 55% of the parents for participating in the parent education classes was self-improvement (e.g., to learn better parenting skills). Thirty percent reported no past or present involvement in an FBC parent education class. All indicated that they had used the respite child care service at one time or another. A variety of reasons were given for using this service. Twenty-two percent reported that they used the service when they attended an FBC class; 43% used it truly for respite, that is, they left their children with a child care provider when they needed a break from the children or vice versa; 52% focused on the child-related benefits of the service (e.g., it gave the children an opportunity to play with other children); 13% needed someone to care for their children while they completed tasks such as, running errands and keeping appointments; finally, 31% commented the quality of the service (e.g., high quality, inexpensive, and reliable).

As indicated above, parents began using the FBC, in general, and the parent support group service, parent education classes, and respite child care service, in particular, for a variety of reasons. For many, self-improvement was an important factor that motivated them to participate at the FBC as well as the opportunity to provide more play experiences for their children and to receive respite from child care.

4. How satisfied are parents with the services received from the FGC? Examination of responses to the question, "In general, how do you feel about the services that were provided by the Family Growth Center?" revealed that the majority of the parents were either very satisfied (71.7%) or somewhat satisfied (21.7) with the services they had received. The dissatisfaction some parents expressed about the FGC focused, for the most part, on the manner in which it was operated. For example, many thought that the three centers should be open for longer hours and on more days and that the first-come-first-served drop-in child care policy was too inconvenient. Also, 96.7% indicated that they would recommend the FGC to others. See Table 6 for a list of areas in which parents felt that the FGC had been helpful and not helpful to them.

In sum, even though some of the parents cited areas at the FGC that they believed needed improvement (e.g., various operational policies) most were satisfied with services and stated that they would recommend the FGC to others.

Additional Descriptive Information

The remainder of this section will focus on the additional descriptive information obtained on the sample (i.e., their social support network, degree of connectedness to the community, attitudes about parent-child relationships, and child development knowledge) as well as the findings from the fifth research question that was investigated in this study.

Parents were asked to respond to four social support items

Table 6

Service Areas Reported by Parents as Helpful and Not Helpful

| Area | % Helped | % Not Helped |
|---|---|---|
| FBC Parent Participants ($n$ = 60) | | |
| Drop-in child care | 82 | 5 |
| Child care/child development skills | 43 | 10 |
| Social interaction/support with other parents | 43 | 12 |
| Understanding child's needs and abilities | 40 | 8 |
| Worries about parenting | 38 | 12 |
| Recreational outlet | 33 | 17 |
| Difficulties handling my infant/child | 28 | 13 |
| Continuing education | 15 | 18 |
| Other | 13 | 3 |
| Developing job skills/finding a job | 7 | 30 |
| None of the above | 0 | 40 |

*Note.* These items were presented as two questions in a multiple choice format, therefore, the percentages do not add to 100%.

designed to examine various characteristics of individuals they designated as support network members. Investigation of these items indicated that the average number of emotional supporters named was six. These emotional supporters are those individuals who parents believed would listen to their troubles, comfort them, and share their life experiences with them. Forty percent of the emotional supporters named were friends and 40% were relatives. Over half of the parents had one person living in their home whom they categorized as an emotional supporter. Additional information about the people named as emotional supporters included: 78.3% were female, the average age of the youngest named emotional supporter was 27.4 years, and 55 years was the average age of the oldest named emotional supporter.

The average number of practical assistance providers was five. Relatives (43.3%) were most often named as the people parents turned to when they needed someone to perform services such as running errands, babysitting, and lending money. Friends provided these services for 40% of the sample. Fifty percent of the parents had no practical assistance providers living in their households and 45% had one person so designated residing in their home. Females were named by 68.3% of the parents as providers of practical assistance and the average ages of the youngest and oldest named practical assistance providers were 29 and 52 years, respectively.

Advice and information providers are those individuals who give advice on how to solve problems as well as give suggestions on where to get needed information. The average number of advice and

information supporters reported was four. Friends (43.3%), relatives, (23.3%), and professionals in the community (11.7%) were the people most frequently named as advice and information providers. Further investigation revealed that 45% of the parents had only one advice and information supporter living in their home. Nearly 65% of advice and information providers were female. The average age of the youngest named advice and information provider was 31 years, with the oldest provider having an average age of 52 years.

Parents reported having an average of five individuals in their lives with whom they spent time engaged in activities such as talking, shopping, and going to the movies. Friends (36.7%) and relatives (36.7%) were most often named as companionship supporters. Almost 54% indicated that two companionship supporters lived in their household and 33.3% reported having none residing with them. Additionally, females were most often named as companionship supporters (76.7%) and the average ages of the youngest and oldest named companionship supporters were 23 and 46 years, respectively.

Twenty percent of the parents reported knowing one person who made their lives more difficult (i.e., a negative supporter), while 23.3% named no one to this category. The average number of negative supporters named was two. The most frequently named negative supporters were relatives (46.7%). Nearly 57% stated that no negative supporters lived in the family home. Females were named as negative supporters more often (41.7%). The average age of the youngest and oldest named negative supporters was 15 and 45, respectively.

In sum, the investigation of the parents' social support network revealed that most were able to name at least one individual as a provider of positive support in each of the four social support categories and at least one individual in the negative support category. Both the positive and negative supporters tended to be characterized as female, relatives or friends, and of various ages.

To determine whether support specialists and generalists were present in the parents' support network, their responses to the above social support items were subjected to further analysis. For each parent, the individuals named as providers of the four kinds of support was reviewed. Each individual who was listed as providing only one of the four kinds of support was counted by hand and recorded. These individuals were then designated as support specialists. In addition, individuals who were listed as providers of two, three, and four kinds of support were each counted and recorded. They were designated as support generalists. It was found that 80% of parents named an average of 2.7 network members (range, 1 to 10) as providers of only one kind of support. Nearly 77% indicated that they received two kinds of support from an average of 2 network members (range, 1 to 7); an average of 1.86 network members (range, 1 to 9) were named by 70% as providers of three kinds of support; and 75% reported an average of 2.21 network members (range, 1 to 10) as providers of four kinds of support. These findings revealed the presence of support specialists and generalists in the parents' support networks.

Approximately 67% of the parents reported that they had not moved from their present place of residence during the 12 month period prior to data collection. Almost 64% have resided in the Lansing area for six or more years, and 63.3% believe they are quite aware of agencies and groups in the area that provide services for parents and children.

An investigation of parental perception of the nature of their interactive experiences with their children was also conducted. With the exception of two parents, all reported that they enjoyed the time they spent alone with their children. Nearly 92% felt in control of their emotions when dealing with their children. Almost 22% were concerned about their behavior when angered by their children. Seventy percent reported that there were times when their children demanded too much from them. Ninety-five percent indicated that there were times when they needed a break from child care responsibilities. Sixty-five percent stated that they were actually able take a break from their children when needed. Most of the parents ($n$ = 47) felt overwhelmed to some degree by their children (e.g., 8.3% infrequently, 48.3% sometimes, 8.3% often, and 1.7% all of the time). Nearly 82% felt that they were doing a good job raising their children.

As indicated above, most of the parents reported enjoying interacting with their children and believe that they are doing a good job as a parent. They also acknowledged, however, that there were times when they felt overwhelmed by child care responsibilities and needed to (and were able to) take a break from their children.

In the area of finances, 53.3% of the parents stated that they

needed more money to make ends meet at home and 36.6% reported that they did not have enough money to take good care of their children. Nearly 62% indicated that they had no trouble finding a babysitter and 62% also reported that they did not worry when someone else was taking care of their child(ren). Two-thirds of the parents stated that their mate (spouse, boyfriend, girlfriend) helped out "alot" with their children. Almost 44% reported receiving no child care assistance from family members (both immediate and extended, excluding their mate).

To assess parents' beliefs about child development they were asked a series of questions concerning the age that a child would be capable of handling various tasks and understanding a simple command.

In the area of toilet training, there were 25 parents in the sample (41.7%) who gave responses within the 18 to 24 month range as the optimal age to begin toilet training. Of the remaining parents, 40% stated the range to be 25 to 45 months and 9.5 to 15 months (11.7%).

When asked the age at which a child should know what it means when told "no," 16.7% of the parents stated between seven and eleven months of age; 3.3% thought that a child was capable of understanding this command at age six months; and the majority (71.7%) reported responses between 12 and 36 months.

Fifty percent of the sample stated that a child should be able to sleep through the whole night by six months of age but no later than twelve months. Nearly 19% indicated birth to five months as the age range and 20.1% stated between 15 and 48 months.

When asked at what age a child could stay alone for an hour or so during the afternoon five percent of the parents reported age four (i.e., preschool age); 50.1% stated between age six and ten and a half (elementary school age); and 41.8% reported between the ages of 11 and 14 (junior high school and older).

5. What is the relation among the three FBC service types and the five parent variables? Prior to performing Spearman correlational analyses (a nonparametric test of correlation) to determine the extent to which the three services provided by the FBC (i.e., parent education, parent support groups, and respite child care) were related to the five parent variables of interest (i.e., available social support, parenting attitude, life stress, residential stability, and satisfaction with FBC services), parent reported responses of the frequency with which they used the three services over the past four weeks were re-coded as dichotomous variables. That is, if parents reported that they had used a particular FBC service at least once over the past four weeks they were given a re-coded score of 00. If they reported that they had not used a particular service at all in the past four weeks they were given a re-coded score of 01.

The results presented in Table 7 revealed two significant positive Spearman correlations based on parent report of service use between parent education service usage and satisfaction with FBC services ($p < .05$) and respite child care service usage and available social support ($p < .05$). The former correlation indicates that those parents who use the parent education service more frequently also tend

Table 7

Spearman Correlations Between Service Types and the Parent Variable Scales (Per Parent Report)

| Scale | Service Types | | |
|---|---|---|---|
| | Parent Education | Parent Support Group | Respite Child Care |
| FGC Parent Participants ($n = 60$) | | | |
| 1. Available Social Support | .18 | .02 | .31* |
| 2. Parenting Attitude | -.01 | -.19 | -.09 |
| 3. Life Stress | .08 | -.05 | -.07 |
| 4. Residential Stability | .07 | .09 | .09 |
| 5. Satisfaction | .26* | .11 | .19 |

*$p < .05$, two tailed.

to be more satisfied with the service offerings at the FGC. The latter correlation indicates that those parents who use the respite child care service more frequently also tend to have more social supporters in their support network.

Spearman correlational analyses were also performed on the parent service usage figures reported by the FGC for the four week period prior to data collection. These figures were also re-coded as dichotomous variables (00 = use of at least one service; 01 = no services were used). The results presented in Table 8 revealed that a significant positive relation existed between respite child care service usage and available social support ($p < .01$). This correlation suggests that those parents who were reported (through FGC records) to have used the respite child care service more frequently also tended to have more social supporters in their support network

Although the opportunity existed to find as many as thirty significant relationships between the five parent variables of interest and service usage patterns (based both on parent report and FGC official report), only three were obtained. More specifically, the Spearman correlational analysis performed on parent report of service usage and the five parent variables produced two significant positive correlations while the same analysis based on FGC official report of parent service usage yielded one significant positive correlation. Since the number of relationships obtained is quite small, and could have resulted from chance, any interpretations made must be considered with caution.

Table 8

Spearman Correlations Between Service Types and the Parent Variable Scales (Per FBC Official Report)

| | Service Types | | |
|---|---|---|---|
| Scale | Parent Education | Parent Support Group | Respite Child Care |
| FBC Parent Participants ($n$ = 60) | | | |
| 1. Available Social Support | .04 | -.07 | .37** |
| 2. Parenting Attitude | -.01 | -.06 | -.05 |
| 3. Life Stress | .17 | .07 | -.19 |
| 4. Residential Stability | .07 | -.08 | .22 |
| 5. Satisfaction | .20 | .12 | .23 |

**$p$ < .01, two tailed.

# CHAPTER IV

# DISCUSSION

Parent participation in the three types of services offered at the FSC was investigated. The services were parent support group, parent education, and respite child care. Overall participation in these services was low. During the four week period prior to data collection half the parents reported that they were no longer actively receiving services at the FSC. This reported lack of participation is in agreement with the findings that revealed that 80% of the parents reported that they had not participated in the parent support group service (FSC official report indicated that 86.7% had not attended) and 83.3% stated that they had not taken part in any form of parent education (per FSC report, this figure is 81.7%) during the designated four week period. In contrast to the relatively inactive usage patterns for the above two services, parents were more actively involved in the respite child care service. Nearly 47% reported that they had used the service at least once during the designated four week period (FSC report revealed a supporting figure of 44%). Parent report and FSC official report of service usage was significantly, positively correlated ($p < .05$ for parent support group attendance and $p < .001$ for both parent education and respite child care participation).

Inquiries into the reasons why parents use (or used) FBC services revealed a variety of responses. These included self-improvement (e.g., to enhance their knowledge of children and parenting), to receive respite from child care, child-related reasons (e.g., to give the children an opportunity to play with other children), practical assistance (e.g., needed low cost child care), to receive emotional support (e.g., through the parent support group), task completion (e.g., running errands and doing housework while children were in respite care), and for the high quality of service provided by FBC staff.

Although the vast majority of the parents were either very satisfied or somewhat satisfied with the services they had received, many also expressed that they would like to see the FBC's three center locations open for longer hours and on more days during the week and wanted staff to change the procedure for admitting children into respite child care (i.e., revise the first-come-first-served policy). Additionally, nearly 100% indicated that they would recommend the FBC to others.

Parents named a total of 514 individuals as providers of social support. The average number of supporters comprising their support network was 8.5 (range, 2 to 20). More specifically, in the areas of emotional support, practical assistance, advice and information, and companionship it was found that the average number of supportive individuals named by parents was 5.5, 4.7, 4.1, and 4.9, respectively. When these figures are compared with the findings from other studies

investigating support network size it appears that the average number of individuals named is of adequate size. For example, a general survey of the social support networks of 1531 individuals was conducted by Marsden (1987). In response to the question querying the number of support individuals with whom subjects had discussed "matters of importance" within the past six months it was found that they named an average of three individuals and their responses ranged from zero to six.

Although a focus on quality, as opposed to quantity, may be a better way to assess the potency of support network relationships, the child abuse and neglect literature indicates that small networks that do not provide various kinds of support may place parents at greater risk to abuse their children (Barbarino, 1977; Belles & Cornell, 1985; Powell, 1980).

The results of the correlational analysis that was performed (to determine what relations, if any, existed between the five parent variables of interest and the three FBC services) revealed that frequency of respite child care service usage (per parent report as well as FBC official report) was significantly positively correlated with available social support ($p < .05$ per parent report and $p < .01$ per FBC official report). This suggests that less frequent use of the respite child care service was significantly positively related to having fewer available social supporters. An individual's social support network may be inadequate when there are few friends, family, etc., with whom to interact. This is especially true if some of the

supporters in the small network do not provide more than one kind of support. In support of this contention, it was found that a subsample of parents ($n = 28$) had support networks comprised of fewer than 8.5 members (8.5 was the average network size for the entire sample). In addition, 14 in this subsample had support networks in which 50% or more of the members were support specialists (i.e., providers of one kind of support). However, only one-third of these support specialists provided practical assistance (e.g., respite from child care). Although these findings indicated that some parents have small support networks and do not have access to supporters who provide services like child care, 56 parents (93.3%) failed to identify the FBC as a source of practical assistance. Additionally, nearly 54% reported that they had not used the FBC respite child care service over the designated four week period prior to data collection. Since a lack of available social support and failure to take advantage of available social support have been found to be related to social isolation (Garbarino, 1977) and social isolation has, in turn, been found to be related to child abuse and neglect (Garbarino, 1977), parents who isolate themselves from agencies and individuals who could help them alleviate some of the stress they may be feeling may be at greater risk to abuse their children if their threshold of tolerance is surpassed (Garbarino, 1977; Gelles & Cornell, 1985).

Finally, a significant positive correlation was found to exist between parent reported use of the parent education service and satisfaction with FBC services ($p < .05$). This correlation suggests

that a low rate of participation in the parent education service is related to less satisfaction with all services offered at the FBC. It is only natural to assume that not all parents will have a high regard for the FBC for various reasons, therefore, their lower rate of participation can be understood. However, approximately 84% of the sample reported that they had not attended a parent education class during the four week period prior to data collection and within this percentage group there may be parents with poor parenting attitudes and inadequate child development knowledge. Evidence in support of this contention was found in parents' responses to various questions querying their parenting attitudes and knowledge of child development. For example, concerning parenting attitudes, 93.3% ($n$ = 56) agreed or strongly agreed that parenting is a tough job; 76.7% ($n$ = 46) agreed or strongly agreed that sometimes they did not think that they were doing everything that they can for their children; 30% ($n$ = 18) disagreed or strongly disagreed that they were able to take a break from their children when they need to; 25% ($n$ = 15) disagreed or strongly disagreed that they had a good idea of what children are like at different stages of their development; and 23.3% ($n$ = 14) disagreed or strongly disagreed that they feel that they are aware of agencies and groups in the area that offer services for parents and children. In terms of child development knowledge, 71.7% ($n$ = 43) reported that it was not until a child is between 12 and 36 months that s/he should know what it means when told "No," (7 to 11 months is the optimal age, according to the Princeton Center for Infancy and Early Childhood,

1978); 51% ($n$ = 31) either over-estimated (25 to 45 months) or under-estimated (9.5 to 15 months) the optimal age (18 to 24 months) at which to begin toilet training (Levine, 1973); and 20.1% ($n$ = 12) over-estimated (15 to 48 months) and 19% ($n$ = 11) under-estimated the optimal age (6 to 12 months) at which a child should be able to sleep through the whole night (Levine, 1973). Therefore, if these parents who are in need of the parent education service are not very satisfied with the FBC and have not become involved with other community agencies or individuals (social isolation) who can assist them in changing any misconceptions they may have about the physical and emotional development of children and enhancing their parenting skill, their potential for directing abusive actions toward their children may be greater (Frank & Rowe, 1981; Steele and Pollock, 1968). Although there is no research conclusively linking short-term competency enhancement and long-term prevention of child abuse (Resnick, 1985; Rosenberg & Reppucci, 1985) there are individuals who strongly believe that parents who learn correct information about the abilities and needs of children decrease the risk of abusing their children (Boisvert, 1972; Frank & Rowe, 1977; Michigan Department of Social Services, 1984).

Although three significant correlations were observed between parent use of services (per parent report and FBC attendance records) and the parent variables, the number of relationships is quite small (i.e., 3 out of 30) and could have resulted by chance. When considering the content of the preceding interpretations, then,

considerable caution must be exercised.

## Implications

With the assortment of services offered by the Family Growth Center to Lansing area parents, it was quite surprising to learn that so few of the registered parents were actively participating. While parents made little use of the support group and education services, they more frequently utilized the respite child care service. What reason(s) could explain this obvious inequality in service usage patterns?

Although correlational analysis found that parents who were less satisfied with the overall service offerings at the FGC tended to use the parent education service less often, evidence was also obtained that indicated that the majority of parents were not displeased with the parent education service. There were only two parents in the sample who expressed a concern in this area. In response to the question, "Which Family Growth Center services have you been dissatisfied with and why?", one parent stated that education classes were needed that focused on specific stages of a child's development and the other indicated that more variety was needed in the educational classes offered. There were no negative comments made concerning the parent support group service. Ironically, the vast majority of the responses focused on dissatisfaction with the respite child care service, especially the inconvenience of the first-come-first-served drop-in child care policy.

Additional evidence disputing the notion that parents were

displeased with the support group and educational services, and thus did not participate in them, is that 93.4% reported themselves to be satisfied (either very or somewhat) with the services provided by the FGC.

If parents were not dissatisfied with the parent support group and education services, why then was their overall rate of participation not higher? Two hypotheses may explain these results. One is based on the assumption that the current sample is representative of the larger FGC parent population and the other on the assumption that the current sample is not representative.

First, there are two types of parent populations eligible to receive services at the Family Growth Center, those parents considered to be at risk to abuse (e.g., isolated from formal and informal support networks, experiencing a great deal of stress) as well as those who are more well-functioning (e.g., individuals who already have at least adequate parenting and coping skills but may need periodic assistance when crises arise). If the current sample is representative, the low service usage figures could lead one to conclude that many of the parents in the present sample fall into the "more well-functioning" category and, as a result, they have no need to participate at the Family Growth Center on a more regular basis. If this were the case, it might imply that the FGC is serving a population that can manage without its services rather than a population truly in need of on-going services.

Second, if the obtained sample is not representative, the low

service usage figures may not reflect the actual pattern of service usage for a truly random sample of F&C participants. There is support that this latter hypothesis may be the more appropriate of the two from which to make statements about the data.

For example, there were 148 telephone calls placed to parents during the recruitment phase of this study. Fifty of these parents declined participation (a 34% rejection rate) and 38 (26%) could not be contacted for a variety of reasons (e.g., moving and leaving no forwarding address or telephone number). It is unclear how, or even if, these parents who were eliminated from the study would have changed the demographic composition of the sample and service usage pattern had they been included. However, due to the fairly high rejection rate and inability to make contact with many of the parents, it is best to demonstrate caution and assume that the current sample may be different from the actual F&C parent population.

Additional support for the hypothesis that the current sample may not be representative comes when their demographic characteristics are compared to those of participants in other drop-in center programs.

As reported previously, the vast majority of parents in the current sample were married, white, females between the ages of 30 and 37. On the average, they had two children, one of whom was under the age of five. They were college educated or had some college experience. A large percentage reported themselves, spouse, or both as the primary source of the family income and their family income was $1,101.00 and over per month. Unfortunately, only limited demographic

information (i.e., race, family type, and income) was available concerning the actual population served by the Family Growth Center. The existing demographic information does, however, indicate that like the sample the majority of the parents who utilize FGC services are white (53%, N = 339 families) and married (50%, N = 419 individuals). In addition, nearly 30% are single women (N = 419 individuals) who are the sole heads of their households and based on a family size of three, 77% (N = 308 families) had a monthly income under $1,255.00.

However, based on the researcher's experience monitoring child abuse and neglect prevention programs similar to the Family Growth Center, it can be said that the current sample and the larger FGC parent population do not fit the description of the parents who typically utilize the services of these kinds of agencies. For example, comparison of the demographic characteristics of the Family Growth Center sample in the current study with those of eight drop-in centers funded by the Michigan Children's Trust Fund (the child abuse and neglect prevention funding agency that the researcher is affiliated with) during fiscal year 1986-87 revealed some differences. Serving a total of 821 parents, the CTF data revealed that 54% of the parents served were black, 40% were white, and 10% comprised the "other" category. Based on responses from 40% of the parents, it was found that for 54% their primary source of income was public assistance and the monthly income for 69% was less than $800.00. A much larger percentage of teenage mothers were represented in the CTF sample than in the sample of the current study. This could be one

reason to explain why nearly 67% of the parents were single mothers and why 26% had less than a high school education. The average age of the parents was 25 and 50% had more than one child.

In conclusion, the present study was an attempt to make information available concerning one type of child abuse and neglect prevention program -- the drop-in center -- since there is very little information in the child abuse and neglect literature describing its functioning, the services offered, and the population(s) served.

Methodological deficiencies, however, interfered with the full achievement of this goal. Specifically, the current sample may not be representative of the larger population from which it was attained.

In order to remediate the short-comings of the present study, a second research study should be conducted at the Family Growth Center. The research methodology of the second study should concentrate on obtaining a random and representative sample. This is imperative if one seeks to make statements about the data that are generalizable to the larger Family Growth Center parent population (or other similar drop-in center populations). It would also be helpful if data (i.e., demographic information) could be obtained from the parents who decline participation. This information could then be compared to the sample to determine whether there are differences between those who consent to participate and those who do not. Finally, acquiring a sample larger than 60 would greatly increase the precision of the obtained population estimates.

Although the current sample may not be representative of the

larger FGC parent population, a wealth of information was revealed about them concerning who they are, the services they use, the reasons for service use, and their satisfaction with services received.

Also investigated were the relations that exist between five parent variables and parent service usage patterns. Several of the Spearman correlational analyses suggested that some of the parents in the sample may be experiencing social isolation, stress, and have inadequate child development knowledge. These three factors have each been implicated in the literature as potential contributors to events of child abuse (Boisvert, 1972; Frank & Rowe, 1981; Garbarino, 1977; Gelles & Cornell, 1985; Michigan Department of Social Services, 1984). Since only small percentages of parents had participated in the three FGC services over the four week period prior to data collection, it is hoped that those who were not currently participating, but who are in need of services, will return to the FGC or seek other community resource agencies or support individuals to help them 1) reduce their feelings of stress in order that they not take their frustrations out on their children, 2) enhance their knowledge and understanding about child development so that inappropriate expectations about what children are capable of doing will not lead to abuse, and 3) widen their social support network and increase involvement in community activities in order to reduce feelings of social isolation which may lead to abuse when one is not able to compare one's thoughts, feelings, and behaviors to those of other's.

Future Directions

Although the drop-in center concept is gaining more popularity as a child abuse and neglect intervention strategy, the paucity of information on the topic in the child abuse and neglect literature indicates that more research is needed. Not only is research needed that describes how various drop-in centers function, the types of services they offer, and the population(s) they serve (as was the case in the current exploratory study), but that which assesses the efficacy of the different service types and evaluates the extent to which participation in services effects the long-term prevention of child abuse and neglect is also needed.

The importance of designing and conducting evaluation studies with these kinds of objectives is evident in wake of the finding reported in a 1982 review of child abuse primary and secondary prevention programs (reported in Select Committee on Children, Youth, and Families: House of Representatives, 1987). It was found that authors in only 15% of the articles actually evaluated the degree of impact prevention programs had on reducing child abuse. And in the majority of the studies that have evaluated impact, the general consensus is that no conclusive evidence has yet been obtained that clearly shows that prevention programs reduce the incidence of child abuse (e.g., Gray, Cutler, Dean, & Kempe, 1979; Gabinet, 1979; Siegel, Bauman, Schaffer, Saunders, & Ingram, 1980). Even though these findings may be discouraging, continued effort in the area of evaluation will eventually reveal to child abuse and neglect prevention researchers

and program staff whether interventions such as those offered by drop-in centers are having the desired effect on the population(s) receiving services.

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# APPENDICIES

## APPENDIX A

## LETTER INTRODUCING THE RESEARCH PROJECT

Hello!

My name is Karen Young and I'm a graduate student at Michigan State University. Toni Landick, the Program Director at the Family Growth Center, has made it possible for me to do a research project on a topic that I'm very interested in. What's that topic you may ask? Well, it's getting to know who the people are who participate in the activities at the Family Growth Center! In particular, I'm interested in getting a better understanding of the people who use the Family Growth Center, the services that they use, and the reasons they are used.

To help me answer these questions all you would have to do is allow me to spend one hour with you -- enough time to complete an interview (34 questions) and for you to fill out two questionnaires (one is 22 questions and the other is 15 questions).

I will be contacting you by telephone in a few days to explain the research project in more detail and answer any questions you may have about it. Both Toni and I invite you to participate, we think it's a worthwhile project! Thanks in advance for your time and consideration.

Karen Young
Michigan State University

P.S. If your telephone is out of service or your number is unlisted, just let Toni know (as soon as possible) that you are interested in the project and ask her to contact me -- we'll set up other arrangements.

## APPENDIX B

### TELEPHONE SCRIPT

"Hello, my name is Karen Young and I'm a graduate student at MSU conducting a research project in conjunction with the Family Growth Center. I'm being given the opportunity to speak with parents who use the Family Growth Center to find out more about them, the services they use, and their satisfaction with services received. Toni Landick, the Program Director at the Family Growth Center, provided me with your name, your telephone number, and your address. You probably have already received a letter briefly describing this project in the mail recently?"

[Regardless to whether the prospective participants have received the letter (sometimes the mail runs slow or an incorrect address was used) the following is said]:

"I can tell you more about the project if you think you might be interested in participating."

[If they are not interested, I thank them for listening and say goodbye. If they are interested, the following is said]:

"As I said, the purpose of the project is to gather information about the parents in the Lansing area who use the Family Growth Center. Some of the questions focus on your family life and your relationship with your child(ren), others focus on the services you have used at the Family Growth Center, how often you have used them, and your satisfaction with them. The way I would obtain this information is by coming to your home and asking you to fill out two questionnaires, one is 22 questions and the other is 15, and conducting an interview with you. All of this would take between 45 minutes and one hour to complete. If you have some interest, but would like more time to think about it, I could call you back tomorrow -- you do not have to give me an answer right now."

[If the prospective participant consents to participate in the project, a day and time is set for the researcher to come out to their home].

## APPENDIX C

## CONSENT FORM

Participation in drop-in center activities is becoming very popular with many parents in your area. Through program participation parents such as yourself are given the chance to become involved in activities like parent support and parent education classes and receive services such as child care. In order to get a better understanding of the types of people who use drop-in centers, the services that are used, and the reasons for use, you will be asked to take part in an interview and complete two questionnaires. An example of the types of questions you will be asked include: your attitude about parenting, the types of stresses you have faced (or are facing) in your life, who the people are who you can count on in times of need, the ages of family members, and your satisfaction with the services of your drop-in center. The interview will take forty (40) minutes to complete and the two questionnaires will take a total of twenty (20) minutes to complete.

1. I hereby acknowledge that the details of this research study have been explained to me and I understand what my role as a participant will be.

2. I understand that I may withdraw my consent to participate at any time without penalty.

3. I understand that my decision to participate will not effect the services I receive from the drop-in center.

4. I understand that all information gathered and all research results will be kept in strict confidence and my identity will remain anonymous. Upon request, summary results of the study will be made available to me.

I freely give my consent to participate in this project and to allow all information gathered to be used as part of a research study being conducted by Karen Young (telephone number) at Michigan State

University.

date
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participant's signature

date
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parent's/guardian's signature if under 18

date
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researcher's signature

## APPENDIX D

## STRUCTURED INTERVIEW

1. Who are the people who live in your household? Only tell me their initials and also give their sex, age, and relationship to you.

| Initials | Sex | Age | Relationship |
|---|---|---|---|

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________
8. ____________________
9. ____________________
10. ____________________

2. What was the last grade you completed in school?

   Actual number of years: __ __.__yrs

3. Are you currently employed?

   1 = no
   2 = part-time or occasional
   3 = yes

4. What is your marital status?

1 = single
2 = separated
3 = divorced
4 = widowed
5 = married

5. How many times have you moved during the past year?

Actual number of moves: __ __

************************************************************************
In the next four questions I'm going to ask you about the people who provide you with different kinds of support. For each question you can name up to 10 people or none at all. You can also name any of the same people over in any of the four questions. Again, only give their initials and also give their sex, age, and relationship to you.

6. Of the people you know -- friends, relatives, neighbors, co-workers, professionals, acquaintances -- who provides you with emotional support? That is, who are the people who listen to your troubles, share their life experiences with you, and who comfort you?

7. Of the people you know, who provides you with practical assistance? That is, who are the people who do things for you like run errands, babysit, and lend you money?

8. Of the people you know, who provides you with advice and information? That is, who are the people who give you suggestions on how to solve your problems and tell you where to get needed information?

9. Of the people you know, who provides you with companionship? That is, who are the people who spend time with you doing things like talking, shopping, and going to the movies?

| Initials | Emo Sup | Prac Assis | Advice Info | Compan | Sex | Age | Rel |
|---|---|---|---|---|---|---|---|
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10. Of the people you know, who makes life more difficult for you? You can name up to ten people or none at all. You can also name any of the same people you gave in the other questions.

Initials Sex Age Relationship

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. ______________________________

6. ______________________________

7. ______________________________

8. ______________________________

9. ______________________________

10. ______________________________

11. How many times did you go to church in the last month?

    Actual number of times: __ __

12. How many times did you go to a social function in the last month?

    Actual number of times: __ __

13. How many times did you go to an educational function in the last month?

    Actual number of times: __ __

14. How many times did you go to a political function in the last month?

    Actual number of times: __ __

15. How many groups or organizations do you belong to?

    Actual number of organizations: __ __

************************************************************************

Now I would like to ask you some questions only about your child(ren) who is (are) enrolled in the drop-in child care at the Family Growth Center:

16. How many of your children are (were) enrolled in drop-in child care at the Family Growth Center?

    Actual number of children enrolled: ____

    What are their initials? ___ ___ ___ ___ ___ ___

17. Does this (these) child(ren) have any physical handicaps?

    1 = no
    2 = yes

18. In general, does your child(ren) go to sleep and wake up at about the same time everyday?

| 1 | 2 | 3 |
|---|---|---|
| no regular pattern (time varies by 1-2 hours) | sometimes | regular pattern within 1/2 hour |

| | Initials | Response | | Initials | Response |
|---|---|---|---|---|---|
| Child #1 | ______ | ______ | Child #4 | ______ | ______ |
| Child #2 | ______ | ______ | Child #5 | ______ | ______ |
| Child #3 | ______ | ______ | Child #6 | ______ | ______ |

19. Can your child(ren) amuse him/themselves for 1/2 hour or so playing with a toy or game or does he/they indicate a need for attention or a new activity after several minutes?

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| constantly needs new stimulation | short attention span | can amuse himself/ themselves somewhat | occupies self for long periods of time |

| | Initials | Response | | Initials | Response |
|---|---|---|---|---|---|
| Child #1 | ______ | ______ | Child #4 | ______ | ______ |
| Child #2 | ______ | ______ | Child #5 | ______ | ______ |
| Child #3 | ______ | ______ | Child #6 | ______ | ______ |

20. Is the tempo of your child's/childrens' play very active with much movement, or does he/they play quietly, calmly?

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| very quiet | somewhat quiet | somewhat active | very active |

| | Initials | Response | | Initials | Response |
|---|---|---|---|---|---|
| Child #1 | ______ | ______ | Child #4 | ______ | ______ |
| Child #2 | ______ | ______ | Child #5 | ______ | ______ |
| Child #3 | ______ | ______ | Child #6 | ______ | ______ |

21. Would you describe your child(ren) as stubborn or agreeable?

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| very stubborn | somewhat stubborn | somewhat agreeable | very agreeable |

| | Initials | Response | | Initials | Response |
|---|---|---|---|---|---|
| Child #1 | ------ | ------ | Child #4 | ------ | ------ |
| Child #2 | ------ | ------ | Child #5 | ------ | ------ |
| Child #3 | ------ | ------ | Child #6 | ------ | ------ |

22. Does your child(ren) throw temper tantrums?

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| no | rarely | occasionally | constantly |

| | Initials | Response | | Initials | Response |
|---|---|---|---|---|---|
| Child #1 | ------ | ------ | Child #4 | ------ | ------ |
| Child #2 | ------ | ------ | Child #5 | ------ | ------ |
| Child #3 | ------ | ------ | Child #6 | ------ | ------ |

23. Do you ever put him/them in another room or deprive him/them of something as a form of discipline?

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| no | rarely | occasionally | constantly |

| | Initials | Response | | Initials | Response |
|---|---|---|---|---|---|
| Child #1 | ------ | ------ | Child #4 | ------ | ------ |
| Child #2 | ------ | ------ | Child #5 | ------ | ------ |
| Child #3 | ------ | ------ | Child #6 | ------ | ------ |

24. Do you ever spank your child(ren)?

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| no | rarely | occasionally | constantly |

| | Initials | Response | | Initials | Response |
|---|---|---|---|---|---|
| Child #1 | ------ | ------ | Child #4 | ------ | ------ |
| Child #2 | ------ | ------ | Child #5 | ------ | ------ |
| Child #3 | ------ | ------ | Child #6 | ------ | ------ |

25. How many times a week does some other person (besides drop-in center staff) take care of your child(ren)?

1 = never
2 = 1 - 2
3 = 3 - 4
4 = 5 - 7
5 = more than 8 times

26. How long have you lived in the Lansing area?

1 = less than one year
2 = 1 - 2 years
3 = 3 - 5 years
4 = 6 - 10 years
5 = 11 or more years

**********************************************************************
Now I would like to ask you some questions about the problems some people have in their family situations:

27. Are you or anyone else in your family having any particular health or medical problems requiring a doctor's attention?

1 = no
2 = yes

28. Do you feel that you're overwhelmed with your children?

1 = never
2 = infrequently
3 = sometimes
4 = often
5 = all the time

29. On the whole, would you describe your present living situation as happy or unhappy?

    1 = very unhappy
    2 = somewhat unhappy
    3 = so-so, variable
    4 = somewhat happy
    5 = very happy

30. Do you ever lose your temper?

    1 = no
    2 = rarely
    3 = sometimes
    4 = often
    5 = all the time

*************************************************************************

To complete the interview I would like to ask you some questions about children in general:

31. At what age do you think parents should start toilet training?

    Actual age in months: __ __.__mths

32. At what age do you think a child should know what you mean when you tell him no?

    Actual age in months: __ __.__mths

33. At what age do you think a child should be able to sleep through the whole night?

    Actual age in months: __ __.__mths

34. At what age do you think a child can stay alone while you go out for an hour or so in the afternoon?

    Actual age in years: __ __.__yrs

# APPENDIX E

## PARTICIPANT INFORMATION FORM

IN ORDER TO IMPROVE OUR SERVICES FOR PARENTS, WE WOULD APPRECIATE YOUR RESPONSE TO THE FOLLOWING QUESTIONS. PLEASE CHECK THE CORRECT RESPONSE.

Date:__________ Name of Program:__________________________

1. What is your Age:_______

2. What is your Race:

   (1)_____White (4)_____Native American

   (2)_____Black (5)_____Hispanic

   (3)_____Asian (6)_____Other (please specify) ________________

3. What is your primary source of income:

   (1)_____employment of yourself, spouse (or partner), or both

   (2)_____parents

   (3)_____public assistance (welfare, G.A., A.F.D.C.)

   (4)_____other (please specify)_________________________

4. What is your family income:

   (1)_____under $500/month

   (2)_____$501 to $800/month

   (3)_____$801 to $1,100/month

   (4)_____over $1,101/month

PLEASE CONTINUE

5. Are you presently expecting a child?

(1)_____Yes

(2)_____No

6. Are you currently participating in activities at the Family Growth Center?

(1)_____Yes

(2)_____No How long did you participate?______________

THANK YOU VERY MUCH

## APPENDIX F

## PARENTAL ATTITUDE QUESTIONNAIRE

THE FOLLOWING STATEMENTS ARE ABOUT PARENTING AND RAISING CHILDREN. THERE ARE NO RIGHT OR WRONG ANSWERS, ONLY YOUR OPINION. USE THE FOLLOWING RATING SCALE TO INDICATE YOUR DEGREE OF AGREEMENT OR DISAGREEMENT WITH EACH OF THE STATEMENTS BELOW.

Box #1 = STRONGLY AGREE - True most of the time
Box #2 = AGREE - True some of the time
Box #3 = DON'T KNOW - Unable to decide
Box #4 = DISAGREE - Not true some of the time
Box #5 = STRONGLY DISAGREE - Not true most of the time

YOU DECIDE HOW MUCH YOU AGREE OR DISAGREE WITH EACH STATEMENT BY PUTTING AN "X" IN THE BOX UNDER THE STATEMENT OF YOUR CHOICE. USE BOX #3 (DON'T KNOW) ONLY WHEN IT IS ABSOLUTELY IMPOSSIBLE TO DECIDE ON ONE OF THE OTHER CHOICES.

1. When dealing with my children I feel control of my emotions most of the time. [1][2][3][4][5]

2. I feel comfortable with the way I discipline my children. [1][2][3][4][5]

3. Parenting is a tough job. [1][2][3][4][5]

4. There are times when I think my children demand too much of me. [1][2][3][4][5]

5. I am able to take a break from my children when I need it. [1][2][3][4][5]

6. I have a good idea of what children are like at different stages of their development. [1][2][3][4][5]

7. Sometimes I don't think that I am doing everything that I can for my children. [1][2][3][4][5]

8. My family helps me alot with my children. [1][2][3][4][5]

PLEASE CONTINUE

9. I have enough money to take good care of my children. [1][2][3][4][5]

10. When my children make me angry I worry about what I may do to them. [1][2][3][4][5]

11. I worry alot when someone else is taking care of my children. [1][2][3][4][5]

12. I'm confident that I know how to take good care of my children when they're sick. [1][2][3][4][5]

13. I enjoy the time I spend alone with my children. [1][2][3][4][5]

14. At times I need a break from taking care of my children. [1][2][3][4][5]

15. I have enough time for myself. [1][2][3][4][5]

16. My mate (husband, boyfriend, etc.) helps me alot with my children. [1][2][3][4][5]

17. I think I'm doing a good job as a parent. [1][2][3][4][5]

18. I need more money to make ends meet at home. [1][2][3][4][5]

19. I feel that I'm quite aware of agencies and groups in the area that offer service for parents and children. [1][2][3][4][5]

20. I feel like my children have a good feeling about themselves. [1][2][3][4][5]

21. I always have trouble finding a babysitter for my children. [1][2][3][4][5]

22. I have alot of fun with my children. [1][2][3][4][5]

THANK YOU VERY MUCH

APPENDIX B

PARTICIPANT SATISFACTION SURVEY

1. How did you hear about the Family Growth Center?

   1 = friend
   2 = relative
   3 = co-worker
   4 = professional in the community
   5 = acquaintance
   6 = brochure/pamphlet
   7 = other (please specify)______________________

2. Why did you begin to use the Family Growth Center?

   ______________________________________________
   ______________________________________________
   ______________________________________________
   ______________________________________________

3. Why do you (did you) use the parent support group service?

   ______________________________________________
   ______________________________________________
   ______________________________________________
   ______________________________________________

4. How often in the last month have you used the parent support group service?

   Number of times = ______

5. Why do you (did you) use the parent education service?

   ______________________________________________
   ______________________________________________
   ______________________________________________
   ______________________________________________

PLEASE CONTINUE

6. How often in the last month have you used the parent education service?

   Number of times = ______

7. Why do you (did you) use the drop-in child care service?

   ______________________________________________
   ______________________________________________
   ______________________________________________
   ______________________________________________

8. How often in the last month have you used the drop-in child care service?

   Number of times = ______

9. What are the kinds of things you do (did) while your child(ren) is (was) receiving drop-in child care?

   ______________________________________________
   ______________________________________________
   ______________________________________________
   ______________________________________________

10. How often in the last month have you used the recreational services (arts and crafts, field trips, etc.)?

    Number of times = ______

11. In general, how do you feel about the services that were provided by the Family Growth Center? (Check one only)

    ____very dissatisfied
    ____somewhat dissatisfied
    ____no opinion
    ____somewhat satisfied
    ____very satisfied

PLEASE CONTINUE

12. In which of the following areas has the Family Growth Center been helpful to you? (Check one or more)

____drop-in child care
____providing me with a recreational outlet
____difficulties in handling my infant/child
____understanding my child's needs and abilities
____child care/child development skills
____my worries about parenting
____social interaction/support with other parents
____continuing my education
____developing my job skills/finding a job
____other (explain)____________________________________
____none of the above

13. In which of the following areas has the Family Growth Center not been helpful to you? (Check one or more)

____drop-in child care
____providing me with a recreational outlet
____difficulties in handling my infant/child
____understanding my child's needs and abilities
____child care/child development skills
____my worries about parenting
____social interaction/support with other parents
____continuing my education
____developing my job skills/finding a job
____other (explain)____________________________________
____none of the above

14. Which Family Growth Center services have you been dissatisfied with and why?

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

15. Would you recommend the Family Growth Center to others?

____yes
____no
____not sure

THANK YOU VERY MUCH

APPENDIX H

PROGRAM REGISTER

Program Name: ____________________

Service used most over 4 weeks of tracking ________________
Service used least over 4 weeks of tracking ________________

| I. PARTICIPANT DATA | SERVICE WEEK | | | | TOTAL |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | |
| Number of Children Enrolled | | | | | |
| Children's Sex M | | | | | |
| F | | | | | |
| II. SERVICE DATA | | | | | |
| Service One Respite Child Care | | | | | |
| Service Two Parent Sup- port Group | | | | | |
| Serv. Three Parent Educ. | | | | | |
| Other | | | | | |
| Total Number of Services Provided | | | | | |

## APPENDIX I

### ITEMS APPEARING ON THE RESEARCH INSTRUMENTS

#### Available social support (1-7 are scale items)

1. Of the people you know -- friends, relatives, neighbors, co-workers, professionals, acquaintances -- who provides you with emotional support? That is, who are the people who listen to your troubles, share their life experiences with you, and who comfort you?

2. Of the people you know, who provides you with practical assistance? That is, who are the people who do things for you like run errands, babysit, and lend you money?

3. Of the people you know, who provides you with advice and information? That is, who are the people who give you suggestions on how to solve your problems and tell you where to get needed information?

4. Of the people you know, who provides you with companionship? That is, who are the people who spend time with you doing things like talking, shopping, and going to the movies?

5. How many individuals named as supporters were repeated in three support categories? (This is an extrapolated item)

6. How many times did you go to a social function in the last month?

7. How many groups or organizations do you belong to?

8. How many individuals named as supporters were repeated in two support categories? (This is an extrapolated item)

9. How many individuals named as supporters were repeated in four support categories? (This is an extrapolated item)

10. My family helps me alot with my children.

11. My mate (husband, boyfriend, etc.) helps me alot with my children.

12. Are you currently participating in activities at the FBC?

13. How many times did you go to a political function in the last month?

14. How many times did you go to church in the last month?

15. How many times did you go to an educational function in the last month?

16. I feel that I'm quite aware of agencies and groups in the area that offer services for parents and children.

Parenting attitude (1-6 are scale items)

1. When dealing with my children I feel in control of my emotions most of the time.

2. I feel comfortable with the way I discipline my children.

3. I am able to take a break from my children when I need it.

4. I enjoy the time I spend alone with my children.

5. I think I'm doing a good job as a parent.

6. I feel like my children have a good feeling about themselves.

7. I have a good idea of what children are like at different stages of their development.

8. I'm confident that I know how to take good care of my children when they're sick.

9. I have alot of fun with my children.

10. At what age do you think parents should start toilet training?

11. At what age do you think a child should know what you mean when you tell him no?

12. At what age do you think a child should be able to sleep through the whole night?

13. Parenting is a tough job.

14. Sometimes I don't think that I am doing everything that I can for my children.

15. I worry alot when someone else is taking care of my children.

Life stress (1-7 are scale items)

1. How many of your children are (were) enrolled in drop-in child care at the Family Growth Center?

2(a,b). Can your child(ren) amuse him/themselves for 1/2 hour or so playing with a toy or game or does he/they indicate a need for attention or a new activity after several minutes?

3(a,b). Is the tempo of your child's/childrens' play very active, with much movement, or does he/they play quietly, calmly?

4(a,b). Would you describe your child(ren) as stubborn or agreeable?

5(a,b). Does your child(ren) throw temper tantrums?

6(a,b). Do you ever spank your child(ren)?

7. In general, does your child(ren) go to sleep and wake up at about the same time everyday?

8. Does this (these) child(ren) have any physical handicaps?

9. Do you feel that you're overwhelmed with your children?

10(a,b). Do you ever put him/them in another room or deprive him/them of something as a form of discipline?

11. I have enough time for myself.

12. How many of the parent's children were enrolled in drop-in child care over the past four weeks?

13. How many of the parent's male children were enrolled in drop-in child care over the past four weeks?

14. Are you or anyone else in your family having any particular health or medical problems requiring a doctor's attention?

15. On the whole, would you describe your present living situation as happy or unhappy?

16. Of the people you know, who makes life more difficult for you? You can name up to ten people or none at all. You can also name any of the same people you gave in the other [positive support] questions.

17. Does this (these) child(ren) have any physical handicaps?

18. Do you feel that you're overwhelmed with your children?

19. Do you ever lose your temper?

20. I have enough money to take good care of my children.

21. There are times when I think my children demand too much of me.

22. When my children makes me angry, I worry about what I may do to them.

23. At times I need a break from taking care of my children.

24. I need more money to make ends meet at home.

25. I always have trouble finding a babysitter for my children.

Residential Stability (1 and 2 are scale items)

1. How many times have you moved during the past year?

2. How long have you lived in the Lansing area?

Satisfaction (1 and 2 are scale items)

1. In general, how do you feel about the services that were provided by the Family Growth Center?

2. Would you recommend the Family Growth Center to others?

Demographic items

1. Who are the people who live in your household? Only tell me their initials and also give their sex, age, and relationship to you.

2. What was the last grade you completed in school?

3. Are you currently employed?

4. What is your marital status?

5. What is your age?

6. What is your race?

7. What is your primary source of income?

8. What is your family income?

9. Are you presently expecting a child?

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