Outcome Evaluation of Parents Anonymous®

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EXECUTIVE SUMMARY

Parents Anonymous® is a mutual support self-help group aimed at strengthening families and reducing child maltreatment. The purpose of the study was to assess whether parents' participation in Parents Anonymous® was associated with child maltreatment outcomes and with their change in risk and protective factors. In the quantitative segment of the evaluation, 206 parents new to Parents Anonymous® were interviewed at three times. Change in study measures was assessed in the short term (one month) and in the long term (six months). In the qualitative segment, 36 parents from Spanish-language Parents Anonymous® groups in two states were assessed with semi-structured, in-person interviews. Additional qualitative data was collected through group observations and focus groups.

QUANTITATIVE FINDINGS

Parents who continue in Parents Anonymous® showed improvement on eight measures while parents who stopped attending meetings showed improvement on one measure.

Overall, parents who continued attending meetings through the study period improved on eight of the sixteen measures including improvement on six measures in the short term and seven measures in the long term. Parents who stopped attending meetings after the first interview indicated significant change on just one measure in the short term and none in the long term.

Parents showed a strong pattern of reduction in child maltreatment outcomes over time.

In the most important set of measures, short and long term change was found on three of the four child maltreatment outcomes: parenting distress, parenting rigidity, and the use of psychological aggression when disciplining their children.

Parents showed a consistent pattern of improvement over time on risk factors, but less improvement on protective factors.

Parents indicated a reduction in four of six risk factors measured, including life stress, drug and alcohol use, and psychological aggression among intimate partners.

Better adherence to the Parents Anonymous® model, which stresses mutual support and shared leadership, seemed associated with higher child maltreatment outcomes but did not differentiate parents on risk or protective factors.

When classified by demographics and background characteristics, a wide variety of parents showed at least some improvement and certain types showed very consistent improvement.

Groups that showed the most consistent improvement included women, high school graduates, help-seekers, and parents with a child protective services (CPS) history. Conversely, men, parents with less than a high school education, parents with a history of substance abuse, and parents under a mandate to attend Parents Anonymous® showed improvement on the least number of scales.

QUALITATIVE FINDINGS

Suffering from isolation, mental health issues, stress and dysfunctional family life when they began attending meetings, the parents studied now enjoy more social support, better parenting practices, greater satisfaction with parenting, higher family functioning, and a higher sense of their own worth and capabilities. The impact of participation in Parents Anonymous® went beyond parenting practice to include emotional support and friendship outside of meetings.

Parents particularly credited the emphasis in Parents Anonymous® meetings on confidentiality and respect, mutual support and shared leadership with their willingness to share, explore and resolve their personal problems.

SUMMARY

Parents Anonymous® seems to be a promising program for the reduction of child maltreatment. For a wide range of parents, Parents Anonymous® seems to be associated with many of the beneficial outcomes it is intended to effect. The current study, which used a national sample, measures based on published standardized scales, and methods informed by a prior process evaluation (Wordes, et al., 2002), revealed improvement on child maltreatment outcomes in parents with a wide variety of demographics, background characteristics, and needs. Improvement was indicated at both one month and six month follow-ups to the initial data collection. Qualitative interviews with a separate group of Parents Anonymous® participants provided similar evidence that Parents Anonymous® seems to be associated with the beneficial outcomes it is intended to effect. Further, with nearly every study participant reporting they planned to continue attending, Parents Anonymous® enjoys a loyal and enthusiastic following.

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CHAPTER 1. INTRODUCTION AND LITERATURE REVIEW

For the past several decades, the predominant approach to reducing and preventing child maltreatment has been government intervention at federal, state and local levels. Child protective services remove children from their families if they are in danger of abuse and neglect. Parents at risk of maltreating receive home visits and/or parent education. These programs reach relatively few families and are underfunded (Horton, 2003).

New approaches that are based on family strengthening programs are now a major focus of intervention and prevention of maltreatment. The goals of such interventions are to reduce factors in families that may increase the risk of maltreatment, to increase the factors that could protect children from the experience of victimization, and to improve outcomes for individuals and families. Numerous studies have shown that maltreating parents are often socially isolated, have smaller peer networks, and have less contact with and receive less help from their families. The extent to which interventions foster supportive social and emotional bonds between at-risk parents and others will likely increase the long-term effectiveness of any such efforts to promote more nurturing parenting (Belsky, 1993). Strategies such as helping parents improve interactions with their children, providing parents with problem-solving skills, raising self-esteem and emotional functioning, and increasing knowledge about child development may contribute to positive parental practices and child well-being (National Research Council, 1993).

One promising program incorporating the new approaches to address child abuse and neglect is Parents Anonymous®. Parents Anonymous®operates a national network of parent-led, professionally facilitated, community-based groups. The first national study of Parents Anonymous®, a one-time survey of 613 Parents Anonymous® participants, showed that the program was effective in decreasing risk factors for child abuse and neglect. Study findings

showed a decline in physical and verbal abuse and an increase in self-esteem, social support, and knowledge of child development among parents attending Parents Anonymous® (Behavior Associates, 1976). Berkeley Planning Associates had similar findings in another investigation of Parents Anonymous® (Lieber & Baker, 1977). Another study (Cohn, 1979) involving case manager assessments of changes in parental behavior and attitudes, found that those who participated in Parents Anonymous® were significantly more likely to have resolved their problems compared to those not participating in Parents Anonymous®.

The effectiveness of Parents Anonymous® has been attributed to the shared leadership-mutual support model whereby confidentiality is maintained and parents can discuss their issues in a non-judgmental environment (Blizinksy, 1982; Levine, 1988; Nix, 1980; Reissman & Carroll, 1995; Thompson, 1995; and Yoak & Chester, 1985). Other studies have reported improvements in parents' self-esteem, coping mechanism, child development knowledge, problem solving ability, and decreases in parents' abusive behavior, impulsiveness, inappropriate expectations of themselves and their children, and social isolation (Alexander, 1980, Borman and Lieber, 1984; Hunka, O'Toole, and O'Toole, 1985; Savells and Bash, 1979).

The current study. The Office of Juvenile Justice and Delinquency Prevention (OJJDP) promotes Parents Anonymous® as a Family Strengthening Program to prevent juvenile delinquency. The OJJDP selected the National Council on Crime and Delinquency to conduct an evaluation. The evaluation consisted of a process evaluation (Wordes, et al., 2002) followed by the outcome evaluation reported here.

This document represents the findings from the three-year outcome evaluation. The evaluation had two segments, an extensive quantitative survey of new Parents Anonymous® parents and a more limited, qualitative survey of ongoing Parents Anonymous® parents. The

methods and results of each are presented in different chapters of this report. The overall goals for the outcome evaluation were to:

- Assess the effectiveness of the Parents Anonymous® programs and their different structures in preventing and treating child abuse and neglect.
- Assess differences between families that continue in Parents Anonymous® and those that do not.
- Investigate which factors and/or circumstances either contribute to or detract from the effectiveness of the Parents Anonymous® program.
- Identify effective techniques for monitoring program outcomes that might be adapted for ongoing self-assessment of local Parents Anonymous® programs.

Before describing the methods and findings of this outcome evaluation, we will first summarize the current understanding of child maltreatment and its relationship to other social problems. We will then discuss current intervention strategies, which will lead into a discussion of the structure and aim of Parents Anonymous® and this evaluation.

Extent of Child Maltreatment

Each year more than 3 million children are reported as abused or neglected in the U.S. and each day 3 children die as a result of this abuse. The following is a brief summary of recent child maltreatment data available from the National Child Abuse and Neglect Data (U.S. Department of Health and Human Services, 2006).

Child Protective Services Investigations and Abuse Victims. The number of child abuse investigations by U.S. child protective services (CPS) has increased over the last decade. According to National Child Abuse and Neglect Data, over 3.5 million children received an investigation by CPS agencies in 2004, at a rate of 47.8 per 1,000 children which is an increase

of 32.4% from 1990 (36.1 per 1,000). Of these, approximately 872,000 cases[1] were substantiated with a corresponding victim rate of 11.9 per 1,000 children, a decrease of 11.2% from 1990 (13.4 per 1,000 children). The majority of these children were first-time victims (74.3%). These substantiated cases in 2003 are detailed below by type of maltreatment, demographics, and fatalities.

Types of Maltreatment. Neglect represents the largest type of abuse[2] (62.4%) followed by physical abuse (17.5%), sexual abuse (9.7%), emotional abuse (7.0%), and medical neglect (2.1%). One in ten children experienced "other" types of maltreatment including abandonment, congenital drug addiction, or threats of harm to the child.

Gender and Age of Victims. Child victims were slightly more likely to be girls (51.7%) than boys (48.3%). With respect to age, younger children were more at risk for child maltreatment. The child victim rate by age were 16.1, 13.4, 10.9, 9.3, and 6.1 per 1,000 children for birth to 3, 4-7, 8-11, 12-15, 16-17 age groups, respectively.

Race and Ethnicity of Victims. About one-half of victims were Whites (53.8%), one in four of victims were African-Americans (25.2%), and one in six victims were Latinos (17.0%)

The highest rate of victimization occurred among African-Americans (19.9 per 1,000 African American children in the general population) followed by Pacific Islanders (17.6), American Indians/Alaskan Natives (15.5), Whites (10.7), Latinos (10.4) and Asians (2.9).

Fatalities from Child Maltreatment. Among the substantiated cases, over 1,000 child deaths were attributed to child abuse and neglect. The majority of these children are under six years of age and almost half involved infants under one year.

[1] The count of victim is a report-based count and is a duplicate count of cases.
[2] These maltreatment type percentages total more than 100% because children who were victims of more than one type of maltreatment were counted for each type.

Long-term Consequences of Child Maltreatment

Child maltreatment has detrimental effects on the physical, psychological, cognitive, and behavioral development of children (National Research Council, 1993). While maltreatment can profoundly and gravely impact the immediate lives of individual victims, it is also linked to long-term, negative societal impacts. In a longitudinal study of 1,000 youths, Smith and Thornberry (1995) found that youth maltreated in childhood were more likely than those who were not to experience low academic performance (33% vs. 23%), drug use (43% vs. 32%), mental health problems (32% vs. 18%) and, among females, teen pregnancy (52% vs. 34%).

The following studies have shown that childhood victimization increases the likelihood of delinquency, adult criminality, and violent criminal behavior.

- Widom (1998) found that 49% of victims followed for over 20 years had been arrested, compared to 38% of a matched control group. Victims of maltreatment were also more likely than others to be arrested for violent crimes – 18% vs. 14%, respectively.
- Smith and Thornberry (1995) found that 45% of maltreated youths were subsequently arrested, compared to 32% of subjects who were not maltreated.
- Zingraff and colleagues (1993) found that maltreated children had higher rates of juvenile court referrals than comparison groups. These effects were only observed for general delinquency and status offenses, not for violent and property offenses.
- Many studies have associated men's battering (Hotaling and Sugarman, 1986) with violence in the family of origin (i.e. either observing or being the victim of violence). Though violence in the family of origin is not universal among all batterers (Gondolf, 1996), it has been reported as high as 75% (Fitch & Papantonio, 1983).

Financial Burden of Child Maltreatment. The societal economic costs of the consequences of child maltreatment are profound. The financial costs of child maltreatment are the direct or immediate cost as well as indirect cost related to the long-term consequences of child maltreatment. The direct costs are money spent on child welfare services, judicial and law enforcement, health, and mental health services. These costs are numerous including

hospitalization, medical services, CPS, police investigation, foster care, out-of-home placement services, family preservation, rehabilitation and treatment programs. In 1998, the federal government spent $4.5 billion on major child welfare programs, including child welfare services, foster care, adoption assistance, and family preservation and assistance, excluding Medicaid (National Clearinghouse on Child Abuse and Neglect Information, 2003). The Federal government's share of this expenditure is less than half, while state and local government pay for the remainder of the cost.

Indirect costs are expenditures incurred by programs addressing special education, mental health, substance abuse, teen pregnancy, welfare, domestic violence, homelessness, juvenile delinquency and adult crimes, not to mention loss in productivity associated to incarceration, unemployment, or death (National Clearinghouse on Child Abuse and Neglect Information, 2003).

Accurate measure of the total cost is difficult to attain; however, one conservative estimate was $94 billion annually or $258 million each day in the U.S. (Fromm, 2001). Direct cost accounts for more than $24.3 million annually while indirect cost is nearly three times that of direct cost amounting to more than $69.5 million annually.

Etiology of Child Maltreatment

Numerous studies have examined the etiology of child maltreatment. Several key risk factors have been identified, although the research is far from complete.

Rather than focusing only on a singular risk factor such as parental characteristics or disorder to explain child maltreatment, an ecological-transactional model that describes how cultural, community, and family factors interact with characteristics of the individual to influence outcomes for maltreated children is a more relevant approach (Cicchetti and Lynch, 1993). This

model assumes that child maltreatment occurs when multiple risk factors[3] outweigh protective factors[4] (Cicchetti and Carlson, 1989) and that risk and protective factors are not static but change over time as the context in which they exist changes. In other words, child maltreatment results from complex interactions of variables over time.

Briefly, this ecological-transactional model can be viewed as having four levels: 1) the individual level, that is, individual child and parent characteristics; 2) the family microsystem, which includes the family environment, parenting styles, and interactions among family members; 3) the community or exosystem, which consists of the community in which the family lives, parent's workplace, school, and peer groups of family members, social support networks, accessible services, and other socioeconomic factors such as family income, employment, and job availability; 4) the macrosystem, which contains the general values and beliefs of the culture. Finally, the following risk and protective factors are viewed interactively in the context of individual, family, community, and societal factors.

Risk Factors: Individual Level

Child Characteristics. Associations between child characteristics and risk of maltreatment can illuminate the dynamics involved in maltreatment but should not be construed as or used to justify "victim-blaming." Younger children appear most likely to experience maltreatment (Benedict, White, and Cornely, 1985; Powers & Eckenrode, 1988). The reason for this could be that younger children are less able to defend themselves, they spend more time with their caregivers, and they are more susceptible to injury. Children with disabilities or mental retardation are more likely to be abused compared to those without developmental disabilities (Crosse, Kaye & Ratnofsky, 1993; Schilling & Schinke, 1984). Prematurity and low birth weight

[3] A risk factor is a variable associated with increased risk of child maltreatment.
[4] A protective factor is a variable that is associated with decreased risk of child maltreatment.

has also been associated, though inconsistently, to maltreatment (Herrenkohl & Herrenkohl, 1983; Lynch & Roberts, 1977; Starr, 1982). Families with children who require more attention and care may face obstacles to appropriate attachment and bonding and therefore put the children at greater risk of abuse (Understanding Child Abuse and Neglect, 1993). Female children and adolescents are more likely than their male counterparts to suffer sexual abuse (Finkelhor, 1994).

Researchers have attempted to distinguish between child characteristics that trigger abuse and those that maintain and perpetuate maltreatment. Child characteristics may play a greater role in the latter (Ammerman, 1991; Wolfe, 1985). For example, sexually abused children may learn sexualized behaviors that put them at risk for continued abuse.

Demographic Factors of Parents. Demographic factors such as being single, having less education, high parity (having given birth to a greater number of children), and large family size have been associated with child maltreatment (Understanding Child Abuse and Neglect, 1993).

Parental Substance Abuse. The link between substance use or abuse and child maltreatment is frequently cited. Data from child protective caseloads suggest that 40% of confirmed child abuse cases involve substance abusers and that 67% of parents involved with the child welfare system need alcohol and other drugs treatment (CWLA, 2001). Similarly, children living in a family with substance abuse are about three times at greater risk for abuse and more than four times at greater risk for being neglected compared to their counterparts (CWLA, 2001). Further, research consistently shows a strong relationship between substance abuse and child maltreatment recurrence. In California, for example, among families investigated by CPS at least one time in 1995, the rate of recurrence over the next two years was 14.3% when the secondary

caregiver[5] abused alcohol or drugs, compared to 8.3% when he or she was not a substance abuser (Children's Research Center, 1998).

However, presence of other social and economic variables such as poverty and culture may confound the analysis of the relationship of substance abuse and child maltreatment. For example, although alcohol use is often cited as a main risk factor in the etiology of child maltreatment, its precise relationship to child maltreatment remains unclear (Widom, 1992). More needs to be known about the effects of alcohol, its co-occurrence with other problem behaviors and drug use, the context which lead to or sustain child abuse, and cultural factors that mitigate or exacerbate the associations between alcohol use and aggression (Abram, 1990; Fagan, 1990; Pernanen, 1991).

Mental Health. Parents with unaddressed mental health problems may be at greater risk for mistreating their children. Data from the national Women Co-occurring Disorders and Violence Study showed that current mental health symptoms were the strongest predictor of mother's potential for child abuse (Rhinehart, Becker, Buckley, Dailey, Reichardt & Graeber, et al., 2005). Several studies suggest that depressed mothers are less likely to meet their children's basic needs (Kotch, 1999; Zuarvin, 1988). In one retrospective risk study, the recurrence rate for child neglect was 35.6% when the primary caregiver had a current or past diagnosed mental health condition. In comparison, only 15.4% of families with no such history experienced recurrence within two years (Children's Research Center, 1998).

[5] The primary caregiver is the adult most responsible for a child or, if two parents/guardians live with the child, the alleged perpetrator of the original abuse. The secondary caregiver is the adult most responsible for the child beyond the primary caregiver and may or may not be the alleged perpetrator of the original abuse.

Risk Factors: Family Level

Parenting Skills. Parents who lack basic knowledge of parenting skills, have negative attitudes toward their child's behavior, have unrealistic expectations of developmentally appropriate behavior, or simply lack knowledge of effective child management practices may be more likely to maltreat their children (Understanding Child Abuse and Neglect, 1993; Daro, 1994). For instance, abusive parents tend to view their children as more aggressive, intentionally disobedient and less intelligent while other people do not hold the same opinion (Mash, et al., 1983; Reid at al., 1987). Young parents who lack emotional maturity, adequate coping skills, and knowledge about child development may be less prepared for the challenges of parenthood, all of which increases their risk for child abuse (Dukewich, Borkowski & Whitman, 1996).

Family Functioning. Although family disruptions are common in families of abused children, it is unclear whether this contributes to the abuse or is a consequence of abuse. Some studies show that parents in these households tend to be less warm and supportive, less satisfied in their marriage, and more aggressive and violent than their non-abusive counterparts (Fagan and Browne, 1990; Rosenbaum and O'Leary, 1981; Rosenberg, 1987; Straus, 1980). Further, often there is more than one victim of abuse in these families (Faller, 1988). Neglectful families tend to be chaotic and unpredictable, exhibit frequent fluctuations of household members, and be disconnected from other families, friends and community (Understanding Child Abuse and Neglect, 1993). In addition, sexual abuse often occurs in families where the victim is estranged, the mother is absent, ill, or neglectful, the family is socially isolated, there is lack of supervision for the child, and there are unusual sleeping arrangements (Finkelhor, 1984; Wyatt, et al., in press)

Intergenerational Violence. While significant research has been devoted to examining intergenerational violence, the results are far from definitive; a research gap remains. For instance, research suggests that physical aggression is learned behavior supported by decades of studies that show abused children can later become abusive parents (Altemeier, et al., 1984; Dubowitz, et al., 1987; Gaines, et al., 1978; Herrenkohl & Toedtler, 1983; Smith and Hanson, 1975; Whipple and Webster-Stratton, 1991). However, these studies' may be methodologically flawed in that they are retrospective and lack consistent definitions of abuse (Belsky, 1980; Cicchetti and Rizley, 1981; Jayaratne, 1977; Kaufman and Zigler, 1987; Starr, 1988; Widom, 1989). Moreover, some retrospective studies generally show higher rates of intergenerational violence when compared to prospective studies (Understanding Child Abuse and Neglect, 1993).

Social Isolation. Social isolation and limited social ties have been linked to increased risk of child abuse. Maltreating parents were often observed to have smaller peer networks (Disbrow, et al., 1977; Polansky, Gaudin, Ammons, & Davis, 1985; Starr, 1982); have diminished relationships with relatives (Zuravin & Greif, 1989; Polansky, Chalmers, Buttenwieser & Williams, 1981); feel lonely (Milner & Wimberley, 1980; Polansky, et al., 1985); be socially isolated (Kotelchuck, 1982; Whipple & Webster-Stratton, 1991); and be less likely to have a telephone (Dubowitz, et al., 1987). Parents who lack childcare and have fewer chances of getting out of the home and away from parenting are at greater risk for abusing their children (Guterman, 2000). Single parents may feel overburdened and stressed with child responsibilities contributing to increased likelihood of child maltreatment (Understanding Child Abuse and Neglect, 1993) Several researchers suggest looking at social isolation in the context of the larger social environment (i.e. poor and dangerous neighborhoods), while others favor examining individual problems as the root causes of such isolation (Horton, 2003).

Intimate Partner Violence. Domestic violence and child abuse often go hand in hand and their coexistence is well documented (Daro & Cohn, 1988; Dykstra & Alsop, 1996; English, 1998; Ross, 1996). In one California risk study, households with one or more episodes of domestic violence within the past year were twice as likely (17% vs. 8.7%) to experience subsequent physical abuse of children than households without a history of domestic violence (Children's Research Center, 1998). More than half (59%) of mothers of children hospitalized for injuries from child abuse have been physically abused by their male partners (Schecter & Edleson, 1994).

Risk Factors: Community and Societal Level

Poverty. Although child maltreatment is reported across the socioeconomic spectrum, it is disproportionately reported among poor families. According to data from the Third National Incidence Study of Child Abuse and Neglect (Sedlak & Broadhurst, 1996), children living in households with annual incomes below $15,000 were 15 times more likely to be abused and over 44 times more likely to be neglected then those in families with annual incomes above $30,000. Children living in poverty were more than 22 times more likely to die or be seriously harmed from maltreatment. Research indicates family poverty to be the strongest factor associated with child abuse and neglect (Horton, 2003). However, it is unclear whether this link is due to greater stress that these families experience and other risk factors or the result of overreporting due to greater scrutiny of these families by social service agencies. Parents living in poverty may be neglectful due to not being able to provide properly for their children. Further, poor parents may not have the adequate resources to help them cope with stressful situations. Some parents may lose control and act out on their children, while others may become more depressed or feel less competent (Pelton, 1994). While numerous studies have specifically shown the association

between unemployment and child maltreatment (Krugman, et al., 1986; Gabinet, 1983; Gelles and Hargreaves, 1981; Whipple & Webster-Stratton, 1991), the process by which this occurs has not been clearly identified.

Self-reports using the Conflict Tactics Scale have indicated that lower socio-economic status is a risk factor for violent behaviors toward children (Straus, 1980; Gelles and Straus, 1988). Further, child neglect in particular appears to be most prevalent among the most impoverished (Giovannoni and Billingsley, 1970; Pelton, 1981; Wolock and Horowitz, 1979, 1984). Despite these associations, questions still remain regarding why all poor families are not at equal risk for maltreatment and why maltreatment occurs among families that are not poor. Other poverty related risk factors include lack of adequate health care and fragmented social services.

Neighborhood Safety. Child abuse rates were found to be higher in poor neighborhoods with fewer social resources than in similar neighborhoods where social resources were reportedly higher. It was found that in high risk neighborhoods, parents were more likely to use resources for crisis intervention, but not for prevention. In contrast, residents of lower risk neighborhoods made better use of resources, perceived a higher quality of living, and reported healthier living environments (Garbarino and Crouter, 1978; Garbarino and Sherman, 1980). Garbarino and Kostelny (1992) discovered in their research that neighborhood disorganization attributed to differences in child maltreatment rates in neighborhoods with similar socioeconomic characteristics. More research is needed to understand the processes by which neighborhood conditions affect family behaviors and child maltreatment.

Society. Some societal factors that may contribute to child abuse and neglect include social acceptance of violence against children, such as spanking and harsh physical discipline,

and a societal priority for family privacy and non-interference by outsiders on parenting issues (Myers, et al., 2002).

Protective Factors

Not all children with risk factors become victims of child abuse. Researchers and practitioners are increasingly interested in finding protective factors within children and families that reduce risks of child abuse. Similar to risk factors, protective factors can be categorized into child factors, parent and family factors, and social and environmental factors.

Protective Factors: Child Level. The key type of protective factor related to children is healthy social and emotional development (Horton, 2003). Specific examples of child protective factors include good health, intelligence, hobbies or interests, positive peer relationships, easy temperament, high self-esteem, a positive disposition, active coping style, good social skills, and a balance between seeking help and autonomy. The development of cognitive skills, social competence, mental health, and general well-being of young children is dependent on the social and emotional developmental process. Specifically, children need to develop social skills in order to interact and make friends with other children. Children also need to develop their emotional competence, which will enable them to identify and express their feelings, as well as have empathy for others (Shonkoff & Phillips, 2000). Emotional development is further associated with linguistic development and cognitive capacities, psychological well being, and mental health (Hyson, 1994; Shonkoff & Phillips, 2000). Finally, children's social and emotional development is affected by the quality of their primary relationships (i.e. parents or caregivers). Children whose primary relationships are disrupted or limited are prone to having developmental problems, such as speech and language delays, difficulties in regulating their emotions, anxiety, depression, or other behavioral disorders (Koplow 1996; Yoshikawa & Knitzer, 1997). While

difficult child behaviors do not directly cause child maltreatment, they may precipitate conflicts in parent-child relationship, including physical abuse (Shonkoff & Phillips, 2000; Ammerman, 1991).

Protective Factors: Parent Level. Parent level protective factors include secure attachment with children, parental reconciliation with their own childhood abuse (when applicable), high parental education, and parental resilience. Belsky and Vondra (1989) contend that an individual's developmental history and personality are the most important determinants of parental behavior since these can affect how parents respond to a difficult child or interpersonal conflict. Another example of resiliency is how individuals respond to childhood abuse (i.e., whether they later abuse their own children). Egeland, Bosquet, and Chung's (2002) review of the literature on intergenerational maltreatment reports that non-abusive parents are more likely to have had an emotionally supportive relationship with an adult in childhood, be in a healthy adult relationship, and/or have had therapy during adolescence or early adulthood. Several authors found similar phenomena. These researchers, as well as clinicians, attribute these parents' ability to create loving relationships and have empathy with other adults and their own children to the parents' ability to process and cope with their own childhood trauma and pain. Parents who are able to do so are less likely to repeat the experience with their own children (Egeland, Bosquet & Chung, 2002; Fraiberg, Adelson & Shapiro, 1975; Rogosch, et al. 1995; Steele 1997). Both research on child maltreatment and adult resiliency stress the importance of having caring and supportive relationships, personal and professional, as a way for parents to develop the psychological capacities required to form healthy relationships with their children (Horton, 2003). Parents who were not well loved or supported in childhood generally experience difficulties in understanding that their young children are dependent on them and need their love.

They react to this dependency with anger and frustration, which can result in abuse (Frazier, et al., 1996).

Horton's review of the research on protective factors shows that social connection is another factor affecting parental behavior. It is not just the existence of a social network but rather the quality of this network that makes a difference in preventing child abuse and neglect. Some of the qualities of these networks that differentiate maltreating from non-maltreating parents include interdependence, trust, reciprocity, flexibility, perceived adequate support (e.g., emotional, personal, and tangible support), received supportive resources in the past, church affiliation, and support within neighborhood (Coohey, 1996; Beeman, 1997; Runyan, et al. 1998).

Seagull (1987) argues that there is no research evidence to suggest a causal relationship between establishment of social connections and preventing child maltreatment per se because the research is methodologically and conceptually flawed. However, there is evidence to show that abusive parents are typically socially isolated as a result of their psychological and social skills deficiencies which prevent them from forming supportive relationships.

Knowledge of child development and parenting is another source of protection against child abuse and neglect. Child maltreatment occurs when parents do not have an understanding of child development. Parents who abuse their children have unrealistic expectations of children's abilities and react negatively to their behaviors. Harsh discipline or abuse can be sparked by difficult periods in child development such as colic, night waking, separation anxiety, testing out behavior, poor appetite, or resistance to toilet-training (Reppuci, Britner & Woolard, 1997).

Protective Factors: Family Level. Family protective factors include supportive family environment, household rules and monitoring of the child, stable relationships with parents, family expectation of pro-social behavior (Child Welfare Information Gateway, 2004).

Protective Factors: Social Level. Finally, social and environmental factors that may protect children from child abuse include middle to high socioeconomic status, access to health care and social services, stable parental employment, adequate housing, family participation in religious faith, good schools, and other adult mentors or role models outside of the family.

Latino-specific Literature Review and Background

Population figures. The Latino population in the U.S. has grown 48% from 22.4 million to 42.7 million in the last 15 years making them the largest ethnic minority group at 14% of the total U.S. population (U.S. Census, 2006). The majority of Latinos living in the U.S. are of Mexican origin (66%), followed by Central and South Americans (14.3%), Puerto Ricans (8.6%), and Cubans (3.7%) (Ramirez & de la Cruz, 2003). Nearly half of all Latinos reside in California or Texas, at 35% of the population of each state (U.S. Census, 2006). Since most Latinos are foreign born (53%), many are monolingual Spanish-speakers. Nearly 10% of U.S. households use predominantly Spanish; among this group more than 50% say they are bilingual (U.S. Census, 2006). The median household income for Latinos in 2005 was $35,967 with one in five families living at poverty level and below (U.S. Census Bureau News. 2006).

Latinos also represent the youngest population in the country. In 2005, 33.9% of Latinos were under the age of 18 compared to 21.6% for non-Latino Whites (U.S. Census, 2005). The median age of Latinos was 27.2 years compared to 36.2 years for the population in general (U.S. Census, 2006). Latinos are expected to comprise 29% of the youth population by 2050 (Brindis,

et al., 2002). Currently, there are 9.5 million Latino families and of these nearly two-thirds (63%) have children under 18 years of age (U.S. Census. 2006).

Latino-focused research. Little research has been done with respect to child maltreatment in the Latino population (Kenny & McEachern, 2000; Fontes, 2002; Behl, et al., 2001). Korbin (1991) argues that there is very limited cross-cultural information on child abuse and neglect. Based upon their review and analysis of 1,133 articles published between 1977 and 1998, Behl, et al. (2001) found that only 6.7% of the papers examined ethnicity. Among these, Latinos comprised only 7% of the child maltreatment research samples while Whites comprised 56% and African Americans 20%, respectively.

Fontes (2002) points out that the literature on child abuse and Latinos is not only "inadequate" but also "contradictory." For instance, some researchers fail to distinguish between poverty and culture (Ards, Chung, & Myers, 1998), treat Latino as a homogenous group by aggregating the ethnic groups in their analysis (Fontes, 1995), and may include reporting biases (Zayas, 1992). Other researchers add that cultural competency is vital for educators, health care providers, or professionals working in the increasingly diverse U.S. population (McIntyre & Silva, 1992; DeBord & Ferrer; Fontes, 2002).

Latino-specific Risk and Protective Factors. Since child maltreatment is linked with characteristics of the family, and the family is an especially critical social unit for Latinos (Clutter & Nieto, 2001), understanding the Latino family culture is key to promoting the welfare of Latino children. From this framework, there are some risk and protective factors particularly relevant to Latino families

Immigration and Isolation. Immigrant Latinos are likely to encounter multiple struggles when they leave their home countries for the U.S. First, many Latino immigrants come to the

U.S. alone and without their families and losing this main support system can be a tremendous stress and lead to isolation, all of which might increase child abuse potential (Ortega, 2000; Gracia & Musitu, 2002). Researchers have identified that abusive parents tend to have less social support and interactions, feel more isolated, and less likely to hold positive attitudes towards their community or neighborhood (Bethea, 1999; Ortega, 2000; Gracia & Musitu, 2002). Latinos are especially dependent on the extended family, which include not only blood relatives but also close friends (including godparents to their children), as well as those sharing the same household (Crosson-Tower, 2002). Moreover, Latino parents tend to rely primarily on their family members for help in child caregiving; they are less likely to leave their children to professional caretakers even when the professionals can provide better care (Fontes, 2002). However, these strong family ties are likely to be broken due to immigration (Ortega, 2000). With increased isolation and decreased social support, immigrant Latino families may be at risk for child maltreatment.

Acculturative Stress. With many Latinos being foreign born, adaptation to their new country is necessary through a process of acculturation. Acculturation is the "process whereby the attitudes and and/or behaviors of persons from one culture are modified as a result of contact with a different culture" (Moyerman & Forman, 1992). The process of acculturation can be extremely stressful to Latino immigrants as they may experience marginalization, segregation, employment problems, oppression, and poverty (Ortega, 2000). Based on their clinical study on over 100 Latino psychiatric patients, Thoman and Suris (2004) found that acculturation and acculturative stress are predictors of psychological distress and life functioning. Parental stress and psychopathology are recognized as risk factors for child maltreatment (Bethea, 1999; Child Welfare Information Gateway, 2004)

Cultural Conflicts. Similar to many other immigrant groups, Latino immigrants living in the U.S. are likely to encounter conflicts in values, beliefs, attitudes, interpersonal relations, and behaviors including parenting practices. Bornstein & Cote (2004) contend that parenting practices are highly influenced by parenting cognitions, which are "believed to be adopted from one's culture of origin" as opposed to being "the product of individual deliberation." These researchers also suggest that parenting cognitions tend to withstand drastic transformation like immigration and are "among the most resistant to change." In other words, practices concerning discipline and training for the child are passed down as "cultural knowledge" over generations (Fontes, 2002). Research has shown that cultural conflicts can increase parents' stress level, generate conflicts between husband and wife, between parents and children, and even avert immigrant parents from accessing child welfare services (Bornstein & Cote, 2004; Wituk et. al., 2000; Crosson-Tower, 2002). Therefore, cultural conflicts can be critical risk factors threatening children's welfare. A brief review of a few parenting beliefs and practices among Latinos follows.

Respect, Obedience, and Hierarchical Order vs. Individualism and Egalitarianism. Traditional Latino families are organized around a "hierarchical order" whereby the father represents the head of family and absolute authority (Crosson-Tower, 2002; Clutter & Nieto, 2001; DeBord & Ferrer; Fontes, 2002). This phenomenon can be referred to as "machismo," which describes the father's pride, demand for respect, honor, and power at home (Crosson-Tower, 2002). As Latino culture emphasizes respect and obedience toward authority figures, Latino parents tend to be more authoritarian and strict and "expect their children to follow orders" (Zayas, 1992). Therefore, Latino families may experience conflicting values when they emigrate to the U.S. since the culture in the U.S. is more characterized by values of

individualism and egalitarianism rather than hierarchical order. This cultural conflict may increase child maltreatment potential in two ways. First, when immigrant Latino fathers encounter acculturative stress or social barriers in the host country and display their frustration and anxiety onto their children or partners through the use of violence, they may justify their use of violence or abusive behaviors with "machismo" (Office on Child Abuse and Neglect, 2003). Second, when communication and expectation between Latino parents, who strive to maintain their traditional authoritarian culture, and their children, who may embrace the U.S. values of individualism and egalitarianism, becomes strained due to differences in acculturation levels (i.e. intergenerational conflicts), Latino parents might exercise more severe punishments onto their children when they disobey in order to uphold the hierarchical family structure (Wituk et. al., 2000). Thus, the value conflicts between authoritarian Latino culture and egalitarian U.S. culture could increase both family tension and parents' abuse potential.

Child Discipline versus Child Protection. Another similar cultural practice associated with Latino value of respect and obedience is Latino parents' comparatively harsher disciplines for their children when they misbehave or disobey (McIntyre & Silva, 1992; Fontes, 2002). McIntyre and Silva (1992) noted that depending on the cultural variance, what is determined as proper discipline in one culture may be defined as child abuse in another. Meanwhile, Wissow (2001) argues that "nearly half of U.S. parents use physical punishment for child discipline" and "professional groups in the U.S. have not agreed on whether parents should be uniformly counseled not to use physical punishment." Whether physical punishments constitute child abuse depends on their frequency and severity (Fontes, 2002). Even so, research has indicated that harsh physical punishments can injure the child and result in child abuse (Fontes, 2002). Bacchar and colleagues (1997) also found that physical punishment is associated with children's

deficiencies in social and psychological developments even after controlling for socioeconomic status and parental bonding.

Poverty. According to the 2001 Census, while at 14% of the U.S. population, Latinos were disproportionately represented among those living in poverty (21.8%) (U.S. Census Bureau News, 2006). Further, approximately 28% of Latino children lived in poverty compared to10% of non-Latino White children (Fass & Cauthen, 2005). Poverty is one of the "most frequently and persistently noted risk factors for child abuse" (Bethea, 1999). It is unclear how poverty is linked to child maltreatment. Family socioeconomic status has frequently been identified as an important factor correlated to child maltreatment potential cross-culturally (Zambrana & Capello, 2003; Parke et. al., 2004; Bethea, 1999; Child Welfare Information Gateway, 2004). A family's socioeconomic status can directly influence parental stress level, family members' access to health care and other resources, living standards, and child development (Zambrana & Capello, 2003; Parke et. al., 2004; Ortega, 2000; McLoyd, 1998). Zambrana and Capello (2003) have concluded that "families at economic disadvantages, who are disproportionately represented among Latino families, are more likely to have their children removed and placed in foster care and more likely to have parental rights terminated."

High Teen-Pregnancy Rates. While the total teen birth rates in the U.S. have declined since 1991, birth rates among Latina teens have been the highest since 1995, exceeding that of African Americans (Child Trends Databank, 2003). The 2002 birth rate for Latina teens ages 15 to 19 was 83.4 per 1,000, compared to the national average of 43.0 per 1,000, and about 51% of Latina teens become pregnant at least once before they reach age 20 (The National Campaign to Prevent Teen Pregnancy, 2006). While young Latinas are less likely to engage in sex than other girls, they are less likely to use birth control or have an abortion once pregnant, contributing to

their high teen birth rates (Dunifon, 1999). Bethea (1999) argues that parents' emotional immaturity, which is often closely related to their actual ages, is a risk factor for child maltreatment. Teenage mothers are more likely to be single parents, receive public assistance, have higher rate of school drop outs, have less stable employment, and lack social support (Dunifon, 1999). Other research also found that the children of adolescent mothers, compared to the children of mothers aged 20 or 21, are more likely to have low-birth weights, be born prematurely, and be at greater risk for various developmental problems (Fact Sheet: The Children of Teen Parents, 2001), all of which are risk factors for child maltreatment (Child Welfare Information Gateway, 2004). Although adolescent parents may not be a risk factor for child abuse per se, young teens are less prepared for the demands of parenthood.

Familism and Extensive Family Ties. For Latinos, the notion of familism or familismo, the attitudes, family structures, and behaviors that operate within a family system (Coohey, 2001), usually goes beyond the nuclear family to include both extended family and close friends (DeBord & Ferrer, 2000; Clutter & Nieto, 2001). In Latino culture, the family provides its members with a sense of self-identity, feeling of belonging, and support system in times of need. In other words, with strong collective orientation and sense of responsibility for one another, Latino family members endure and celebrate life events together. As researchers have repeatedly reported the connection between child maltreatment and social isolation (Gracia & Musitu, 2002), the extensive social ties in Latino families can hence be perceived as a protective factor for preventing child abuse and neglect.

Children as Blessings Cultural Value. In Latino cultures, being a parent and particularly a mother is highly honored (Fontes, 2002). According to Florsheim, et al., (2003), positive concepts toward having children and smoother transition to parenthood help reduce parenting

stress and child abuse potential. Increasing or promoting the value of children has gradually become a new protective strategy to prevent child maltreatment (Bethea, 1999). Therefore, respecting children is a protective factor for child abuse.

Prevention and Intervention Approaches

Intervention strategies fall into a range of prevention programs addressing populations at differential risk for maltreating their children. These programs can generally fit into three categories: primary, secondary, and tertiary prevention.

Primary prevention programs are those directed to the generalized population regardless of child abuse risk (Oates, 1996). These programs include such things as providing home visits by nurses to all postpartum mothers and parenting classes offered to new parents as well as programs addressing more systemic societal problems such as poverty.

Secondary prevention programs are those directed towards populations identified as being at risk of maltreating their children. At-risk individuals may be characterized by living in extreme poverty, being socially isolated and lacking support systems, and having limited parenting knowledge and skills, etc. These factors may operate either in isolation or in combination and produce a range of "risk levels."

Tertiary programs attempt to prevent recurring abuse and, generally, are directed to those already known to child protective services agencies. Interventions directed toward this population may involve a range of programs, from counseling to temporary removal of victims from the home and, if necessary, termination of parental rights and criminal prosecution of the perpetrator.

Current Responses to Child Maltreatment

Although prevention is key to reducing child maltreatment, little research has been done to examine the effectiveness of prevention programs. Most intervention programs focus on the victims or the perpetrators with few programs working at the primary prevention level to prevent child maltreatment from occurring. In any case, prevention and intervention of child maltreatment has been addressed on many levels such as family support, health services, therapy, legal, community-based, and policy level. A brief summary of some current responses to child maltreatment follows.

Health Services. Screening by health care professionals has been instrumental in detecting suspected cases of child abuse. Health care workers identify, treat, and report cases to CPS and other authorities. Although specific requirements may differ by states, training, continuing education, and guidelines by professional medical groups help to improve the process of detection and treatment by the health care staff. Evaluations of training programs have been limited to health care worker's knowledge of child abuse and behavior and have excluded changes in care and referral for children.

Therapy. Therapy is thought to be appropriate for victims of abuse, children who witness violence, or adults who were abused as children. The particular therapeutic approach applied depends on the age of the victim, type of abuse, and other related factors. Some treatment program for young and school children include therapeutic day care, group counseling, and playgroups. For sexually abused children, interventions include individual, group, or family therapy, again depending on the circumstances of the case such as the relationship of the victim to the perpetrator. A recent rise in services for adults abused as children has coincided with the recognition of the need for such services since some victims may not be identified until later in

life when related problems surface. Limited or no assessments of program effectiveness have been conducted for many of these interventions.

Legal issues and the role of public agencies. Mandatory reporting of suspected child abuse exists in all 50 states in the U.S. (Smith, 2006). Mandatory reporting of child abuse is limited to certain professionals or personnel in most states including health care providers, mental health care providers, teachers and other school personnel, social workers, day care providers, and law enforcement personnel. In many states, clergyman and film developers are required to report suspected cases of abuse as well. Some states have mandates for *all* citizens. These laws are meant for early detection before serious injuries occur, stopping abuse if it has occurred, increasing the safety of the victims by alleviating the need to self-report, and increasing coordination between legal, health care and social services. A failure to report can result in criminal and civil liability. Confidential privileges vary for clergyman and attorneys (Smith, 2006). All states also have a hotline for reporting child abuse and neglect (Smith, 2006).

Child protection service agencies have the challenging task of not only substantiating suspected cases of abuse but also deciding the appropriate response and treatment, balancing the safety of the child and goal of keeping the family together. Therefore, services can vary depending on the needs of the families. Whether child protection service agencies have been effective at reducing rates of child abuse and neglect is not known since little research has been done in this arena.

Child fatality teams have been set up in many states to review deaths of children. Police, attorneys, health care professionals, child protection services, coroners, and medical examiners gather to review data and information on the case in the hope of obtaining precise cause of death leading to more successful prosecutions and preventing future abuse. One study found that these

review teams were useful in detecting death from child maltreatment and sudden infant death syndrome (Luallen, 1998).

Other legal responses include arrest, prosecution, and mandatory treatment for offenders. Prosecution rates vary and are dependent on "seriousness of the abuse, the strength of evidence, whether a child would make a competent witness, and whether there are any viable alternatives to prosecution. For example, a little over half of sexual abuse cases were accepted by prosecutors in one study (Cross, Whitcomb & DeVos, 1995). Court mandated treatment is controversial among researchers. Some argue that without it, there is no compulsion to undergo treatment; however, successful treatment is more likely among those who volunteer to undergo such treatment.

Family Support. Family support programs generally consist of parenting education, home visitation, and family preservation services. Most programs that provide training in parenting are aimed at high risk families or families with abused children. Parents learn about child development and parenting skills to help them with their children's behavior. Unfortunately, few of these programs have been evaluated in terms of reduction in child maltreatment but rather changes in parental competence and skills, mental health and interaction with their child.

Similarly, home visitation programs provide information, support and other services to families in their home at varying frequencies from weekly or bimonthly for 6 months to 2 years. Some of the identified benefits include enhancement of parenting skills, parents' coping abilities, and emotional support.

Family preservation programs are short-term (few weeks to months) and intense (10 to 30 hours per week) and designed for families experiencing child abuse with the intention of keeping

the family together and preventing victims from being placed outside of the home. Services provided are tailored to the needs of the families such as therapy, rent subsidies, food, or shelter. Evaluations of this type of program have been limited and findings have been inconsistent because programs offer a wide variety of services and few studies have included a control group. However, it is suggested that while such programs may help to prevent removing children from their homes in the short-term, deeper family issues which are at the root of the problem are not addressed adequately.

Family Strengthening Programs

No single strategy is sufficient to reduce the incidence of child abuse and neglect. While prevention of child maltreatment requires a multitude of approaches, family strengthening programs remains one vital strategy to addressing child maltreatment. Many child advocates recognize that it would make sense to enhance protective factors that focus on parenting, family dynamics, and family stability. For instance, the National Resource Center for Community-Based Child Abuse Prevention is advocating enhancing the following protective factors and the types of program activities that would promote such factors.

Nurturing and Attachment. Teach parents how to respond appropriately to their children's basic needs, learn ways to stimulate brain development, and develop a positive and secure attachment with their child.

Parental Resilience. Teach parents skills for managing crisis and day to day challenges of family life, achieving economic self-sufficiency, and managing the physical, emotional and cognitive impact of stress.

Knowledge of Parenting and Child Development. Teach parents about child development, how to recognize if their child needs special help, how to promote healthy

development, and developmentally appropriate and culturally-relevant discipline and guidance methods.

Social Connections. Provide parents with opportunities to engage informally with others parents and child caregivers.

Concrete Support in Times of Need. Provide families with opportunities to receive concrete support by way of receiving necessary information and community referrals.

Mutual Support Self-Help Groups

One setting which may be appropriate to facilitating the promotion of family protective factors is the self-help mutual support group. The provision of mutual support is a promising intervention strategy that can be provided for primary, secondary or tertiary prevention populations. Mutual support is described as a process which promotes a psychological sense of community; provides an ideology that serves as a philosophical antidote; provides an opportunity for confession, catharsis, and mutual criticism; provides role models; teaches effective coping strategies for day-to-day problems; and provides a network of social relationships" (Levine & Perkins, 1987). It is characterized by the reciprocating roles of participants rather than the subordinate position often typifying the professional helping relationship. Research suggests that strategies relying solely on costly professional therapy, unaugmented by other supportive or remedial services, will offer less opportunity for success (Cohn & Daro, 1987).

Program Evaluation. As stated earlier, there are many pathways to child abuse and neglect. Maltreatment arises due to a transactional process of characteristics between parents and children, and the contexts in which they live. As such, evaluation of programs designed to

prevent maltreatment need to address not only "what works" but "what works for whom, when, and under what conditions." Few programs have been evaluated from such a perspective.

Prevention programs like Parents Anonymous® that promote the safety and well-being of children and families hold potential for lessening the suffering experienced by children and greatly reducing these costs. The importance of such programs speaks to the need for rigorous evaluation to measure their potential benefits.

Parents Anonymous® and the Current Evaluation

Parents Anonymous® strives to eliminate risk factors such as parents' unrealistic expectations of children, parents' negative attitudes toward their children, low parenting competence while enhancing protective factors such as increased self-esteem, increased parenting skills, and social support. Further, Parents Anonymous® strengthens families through helping parents with the following:

- Creating healthy parent-child relationships;
- Providing positive discipline methods;
- Monitoring and supervision of their children;
- Learning to advocate for children; and
- Being proactive toward seeking information and support.

Parents Anonymous® Organizational and Group Structure. Parents Anonymous® has three organizational levels. The national organization, Parents Anonymous®, Inc., accredits regional community-based organizations, which, in turn, operate local Parents Anonymous® groups. Parents Anonymous® also has a presense outside of the U.S., though the focus of the current study was domestic groups only.

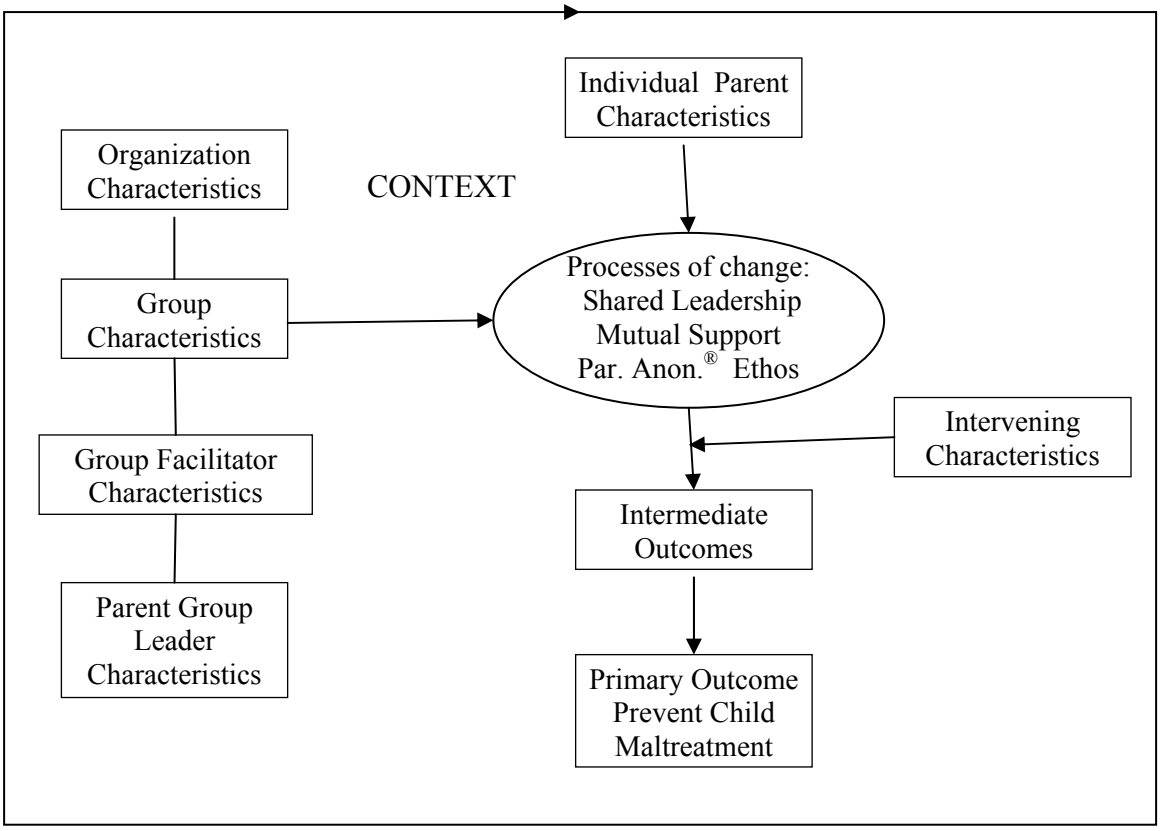
Weekly Parents Anonymous® meetings are co-led by a professionally trained Group Facilitator and a Parent Group Leader. The Parent Group Leader is a parent selected by the other

parents in the group and who receives training in the Parents Anonymous® model. All parents attending groups are considered Parent Leaders (though for clarity this term is not used in the text of this report) by virtue of their ongoing leadership over their own progress in addressing their issues and their contribution to the shared leadership that is an essential element of the Parents Anonymous® model. Meetings are free of charge. Some groups offer a concurrently held Parents Anonymous® Children's Program, which help the children of parents meeting in Parents Anonymous® groups build self-esteem and learn problem-solving and social skills.

Theoretical Underpinnings of Parents Anonymous®. Understanding the theoretical underpinnings of the Parents Anonymous® model allowed the researchers to define and develop measurement approaches for the "processes of change" (see Figure 1.1). In the process evaluation (Wordes, et al., 2002), with the help of leaders from the national organization of Parents Anonymous®, NCCD deduced that there are four central precepts or theoretical underpinnings to the Parents Anonymous® model. First, Parents Anonymous® promotes positive change for parents through mutual support—that is, parents provide and receive support to and from other parents. Second, parents must feel ownership of the program so that they can participate fully and enhance their self esteem. This notion is embodied in the term "parent leadership." Third, to the extent that this ownership is held by both staff and parents, and among all parents, "shared leadership" is said to exist. Fourth, Parents Anonymous® Ethos are a set of beliefs, values, and mores such as anonymity, confidentiality, and a commitment to bettering oneself and improving the lives of one's children. Underlying these key constructs is the notion that parents are in the best position to help parents, and in doing so, help themselves. This has been termed the "helper-therapy principle" (Riessman, 1995).

Evaluation Heuristic. The research questions for the outcome evaluation are based on the heuristic developed by NCCD for understanding the process evaluation (see Wordes, et al., 2002). The process evaluation found that implementation of Parents Anonymous® programs is

Figure 1.1. Evaluation Heuristic



shaped by many contingencies, events and external forces, as well as by explicit policy and program decisions made by the national and regional organizations and groups. The research questions addressed three general issues. First, a theoretical model was developed to identify whether differences in organizational, group, Group Facilitator, Parent Group Leader, and individual member characteristics are associated with the main constructs of parent leadership, shared leadership, mutual support and ethos, and hence, how the Parents Anonymous® model is implemented. Second, in the presence of the core constructs of parent leadership, shared leadership, mutual support and ethos, is there a reduction of risk factors (e.g. isolation, parental

stress, adult-adult conflict) and/or enhancement of protective factors (e.g. social support, parenting competence, family functioning) (intermediate outcomes)? Third, is there an association of change in intermediate outcomes and intervening factors (e.g., substance use, mental health, domestic violence) with final outcomes (i.e., reduction and/or prevention of child maltreatment)?

CHAPTER 2. QUANTITATIVE METHODS

For the quantitative segment of the evaluation, a longitudinal research design was implemented. Individual and group level data collection included a Group Facilitator Assessment, a Group Assessment, and an extensive telephone interview with individual Parents Anonymous® participants. The methodology used in the quantitative segment of the study will be described here and the quantitative findings in the next chapter.

Sampling

A two-tiered sampling strategy was used: group level and individual level. A multi-layered process was required in order to establish a sample of groups and of individual parents to be studied. Key steps of this process are described in more detail below, but, in summary, it proceeded as follows: The Parents Anonymous®, Inc. national office provided descriptions and contact information for all active groups across the country. Of these, eligible groups were contacted via each group's Group Facilitator. Interested Group Facilitators completed the Group Facilitator Assessment. Groups whose Group Facilitator and members agreed to participate were assessed with the Group Assessment questionnaire at two time points. These Group Facilitators then recruited individual parents as they began attending Parents Anonymous® meetings. Individual parents from participating groups who agreed to participate were assessed with the individual interviews at three time points. Data collection began in August, 2003.

Group selection. In the process evaluation (Wordes, et al., 2002), it had been shown that certain easily collected group characteristics were related to model implementation (i.e., presence of a parent group leader). These characteristics were used to screen and then stratify the selection of groups to increase the likelihood of selecting both low and high model implementation

groups.

Group eligibility. There were a total of 524 active Parents Anonymous® groups across the U.S. at the onset of this evaluation. The Parents Anonymous® national office provided group descriptions and current status to assist in determining eligibility for the study. Forty-four percent of the groups were not eligible for the study for the following reasons: groups in prison or other adult or juvenile detention facility; teen parent groups; children-only groups; groups outside of the 48 contiguous states and Alaska; groups that serve parents of children in out-of-home placement or parents living in a treatment facility; groups that serve adult survivors of childhood abuse; groups with no new members; closed groups; groups which refused to participate in the study; and open but inactive groups. All qualified organizations were contacted in order to describe the study and to seek approval for study participation.

NCCD evaluation staff contacted the Group Facilitators both by telephone and by mail to solicit their participation. The Group Facilitators' participation was voluntary. All participating Group Facilitators received an in-depth training session via the telephone on participant recruitment and group survey administration. Group Facilitators also completed the Group Facilitator Assessment. Once groups had been selected to participate in the study, Group Facilitators were asked to administer the Group Assessment.

Individual participant recruitment. Group Facilitators approached newcomers to Parents Anonymous® and explained to them the goals and incentives of the study. Individual participation was voluntary, and participants were asked only once to participate. Group Facilitators gave interested parents an information packet that explained their rights and responsibilities as research participants. Research staff reviewed this material again with the parents when they were contacted for formal enrollment into the study.

Interested parents were asked to provide their name, address, telephone number, number of children under 18 living with them, and number of times they have attended a Parents Anonymous® group on a contact information form. This form was either mailed back with a stamped, self-addressed envelop provided by NCCD or parents would give the form back to their Group Facilitator. Parents could also call NCCD's toll-free number and enroll directly into the study.

Individual eligibility. To be eligible for the study, participants 1) must have been at least 18 years of age; 2) must have been living with at least one of their children at the time of recruitment; 3) must have had at least one child between the ages of birth and 17 at the time of recruitment; 4) must not have attended more than five Parents Anonymous® meetings during the month prior to the recruitment date; and 5) must not have been to a Parents Anonymous® group more than five times during the year prior to the recruitment date. Eligibility was determined upon receipt of the contact information form or through enrollment over the telephone. Eligible parents who sent their contact information forms by mail were called at the telephone number they provided within one week. Ineligible parents were notified by telephone.

Informed consent. An informed consent was obtained over the telephone prior to administering the survey. Participants were made aware that the information collected was to be used for research purposes, that their names would not be revealed, that they had the option to end their participation at any time, and that their decision to participate will in no way affect their involvement in Parents Anonymous®. They were informed they would be compensated $50, $75 and $100 after completion of the first, second, and third interview, respectively. This consent process was tape recorded.

Scheduling and contact number. The first telephone interview was scheduled during

this initial telephone call. For each interview, participants could call the toll-free telephone number, or be called by an interviewer at a telephone number provided by the participant. Participants were mailed their compensation checks within 48 hours after completing each interview to the address they provided.

Retention. Retention was maintained by having consistent communication with each participant throughout the study. Specific strategies to maintain high levels of retention included: 1) a toll-free number was available to participants for questions, rescheduling interviews, or changing their contact information; 2) a thank you letter and incentive check were sent after each interview reminding participants of their next interviews; 3) a reminder card and letter were sent before interviews; and 4) several reminder calls were made in between interviews. The latter approach was particularly important between the second and third interview when five months elapsed between interviews.

INSTRUMENTS

Group Facilitator Assessment Instrument

Parents Anonymous® Group Facilitators completed a brief questionnaire, the Group Facilitator Assessment. The assessment collected information about the Group Facilitator themselves, such as education background and the nature of their position (volunteer, paid, Parents Anonymous® staff person) and about the group, such as whether child care was available during the meetings. No information was collected on the extent of Parents Anonymous® Group Facilitator training received.

Group Assessment Instrument

A short, anonymous and confidential survey was given to all consenting parents in participating Parents Anonymous® groups. Group Facilitators administered Group Assessments

during group meetings at two time points, at the start of the study and approximately six months later. Constructs included in the survey were parent leadership, shared leadership, mutual support, instrumental support, and brief demographics. These surveys were developed in both English and Spanish and designed to measure factors related to the theoretical philosophy of the Parents Anonymous® model and to identify variations in implementation amongst different groups. The primary purpose of the Group Assessment was to assess each group's level of model implementation, that is, the combined levels of mutual support and shared leadership. No individual identifying information was collected for the Group Assessment and therefore data from the first and second administrations were not matched by individual.

Mutual Support. Maton's mutual support scale was used (Maton, 1988). The scale measures support provided (5 items) and support received (4 items) using a Likert scale (0="Not at all accurate" to 4="Completely accurate") with statements such as "At most meetings, I attempt to help others with their problems," or "Members regularly reach out and provide emotional support to men." The reliability of the provide support subscale was .82. The reliability of the receive support subscale was .73.

Leadership. A leadership scale was developed to assess a variety of leadership tasks that take place in Parents Anonymous® groups. The scale included 23 items, each of which was a leadership task such as "Made coffee for the group?", "Opened a group meeting?", "Been a role model for parents?". Participants were asked to consider their entire experience with Parents Anonymous® and, for each item, choose up to three response options: "I have done this," "Another parent has done this," and "A staff person has done this." Two subscales were generated corresponding to the three response options: parent leadership and shared leadership. Each subscale had a possible range of 0 to 23.

Parent Leadership. The purpose of the parent leadership subscale was to assess the extent to which parents in the group undertook the leadership tasks listed on the scale. Scale scores for parent leadership were generated by tallying *one* point for each item where respondents indicated "I have done this" *and/or* "Another parent has done this." The parent leadership group score was the average of each group member's parent leadership score. The reliability of the parent leadership subscale was .93.

Staff Leadership. The purpose of the staff leadership subscale was to assess the extent to which staff members (usually the Group Facilitator) undertook the leadership tasks listed on the scale. Staff leadership scores were calculated by tallying one point for each item where respondents indicated "A staff person has done this." The reliability of the staff leadership subscale was .93. The staff leadership group score was calculated as the average of each group member's staff leadership score.

Shared Leadership. Shared leadership scores for each group were generated using the ratio of the average parent leadership over the average staff leadership. The higher the resulting value the more that staff and parents share leadership, while the lower the value the more that staff bears most of the responsibility for leadership.

Individual Interview Questionnaire

A telephone interview was conducted with individual Parents Anonymous® participants at three time points—baseline (Interview 1), one month later (Interview 2), and again six months from the initial interview (Interview 3). All project participants were tracked over time regardless of whether they continued their involvement with Parents Anonymous®.

The structured one-hour telephone interview instrument covered domains in five categories: 1) demographics and background characteristics; 2) child maltreatment outcomes,

including parenting distress, parenting rigidity, and psychological or physical aggression in disciplining; 3) risk factors including parental stress, life stress, physical or emotional violence between intimate partners, substance abuse; 4) protective factors, including quality of life, social support, parenting sense of competence, nonviolent discipline tactics, family functioning; and 5) experiences with Parents Anonymous®. The interview instrument was finalized after consulting with an advisory team, which included researchers specializing in measurement issues for Latino populations and Parents Anonymous® Parent Group Leaders who ensured the cultural and context appropriateness of the interview instrument.

The instrument had English and Spanish-language versions. Both were pilot tested. Interviewers were full-time NCCD employees and interns. Interviewers received a formal training on interviewing techniques and protocol. Regular meetings were held to discuss interviewing challenges and successes. Bilingual staff administered the Spanish-language interview when the parent so requested.

Demographics and background information. Basic demographic information was collected from each participant including: age, gender, race/ethnicity, marital status, monthly income, government financial assistance, educational level, and employment status. Information was also gathered about participants' children (e.g., number of children, first name of children, age, relationship to respondent, number of children living at home) and other adults living in the home (e.g., how many other adults in the home, relationship to the child). For parents with more than one child, the name of the children was used to randomly select one child to be the "Target Child" for certain items and scales that required the parent consider just one child in their responses.

Child Maltreatment Measures. Key measures of child maltreatment outcomes assessed

in the individual interview included four scales: parenting distress, parenting rigidity, and psychological aggression and physical aggression when disciplining children. These four measures, based on published scales with proven reliability and validity in child maltreatment research, were chosen as the primary outcome measures in the current study.

Parenting Distress and Parenting Rigidity. Two subscales from the revised version of the Child Abuse Potential Inventory (CAPI; Milner, 1986) were used to screen parents for their risk of child maltreatment. The CAPI was designed to measure aspects or factors of a parent's parenting style and psychopathology that may be associated with increased likelihood of child abuse. The subscales used measured two of these factors: 36 items for parenting distress (e.g., "I find it hard to relax," "I often feel afraid") and 14 items for parenting rigidity (e.g., "a home should be spotless," "children should stay clean"). As indicated in the CAPI manual (Milner, 1986), the parenting distress factor represents personal adjustment problems that can increase likelihood of child abuse including "a pattern of feeling frustrated, sad, lonely, depressed, worried, worthless, rejected, misunderstood, and angry." The parenting rigidity factor represents strictness in the parent's attitudes towards the appearance and behavior of children. Children should always be neat, obedient, respectful, quiet, and "seen and not heard;" the home should be spotless and orderly. Parents with high rigidity believe children need strict rules and, it is reasoned, are more likely to aggressively enforce those rules in ways that may be abusive. Participants responded to each item on a 2-point Likert-type scale (1= "agree" and 2= "disagree"). The parenting distress subscale had a reliability of .95 at Interview 1, 2 and 3. The parenting rigidity subscale had a reliability of .83 at Interview 1, .85 at Interview 2, and .84 at Interview 3.

Psychological and Physical Aggression Toward Children. Scales adapted from the

revised version of the (15-item) Parent-Child Conflict Tactics Scale (CTSPC) were used to measure the frequency (0= "never" to 5= "more than four times a week") of psychological and physical aggression in the last month (Strauss, et al., 1996). These measures do not necessarily measure abuse but rather a tendency towards aggression and potential maltreatment.

The psychological aggression scale measures "verbal and symbolic acts by the parent intended to cause psychological pain or fear" in the child (e.g., "Swore or curse at," "Threatened to spank or hit, but did not actually do it"). All five items from the published psychological aggression scale were used and had a reliability of .54 at Interview 1, .67 at Interview 2, and .68 at Interview 3.

The physical assault scale measures instances of actual physical contact with the child in rising degree of severity, from "Spanked on bottom with bare hand" to "Slapped on the face, head or ears". The four items in the physical assault scale used in the current study are taken from the corporal punishment subscale of the published physical assault scale. They represent relatively minor physical acts which have traditionally been acceptable forms of disciplining or, at least, are not necessarily illegal The four items had a reliability of .59 at Interview 1, .55 at Interview 2, and .41 at Interview 3.

(A 2-item subscale assessing neglect, e.g., "Had to leave child home alone, even when you thought some adult should be with him/her," had a reliability of .19 at Interview 1, -.09 at Interview 2, and .49 at Interview 3. Low reliability values did not justify including this subscale in any analyses.)

Risk Factor Measures. Measures of risk factors included five scales: parental stress, life stress, emotional violence between intimate partners, physical violence between intimate partners, and substance abuse.

Parenting Stress. A scale containing 34 items of the Parenting Stress Index: Short Form was used (Abidin, 1995). The published scale was changed from a 5-point Likert-type scale to a 4-point Likert-type scale (1= "strongly agree" to 4= "strongly disagree"). Example items include "I don't enjoy things as I used to.", "My child often does things for me that makes me feel good.", "My child generally wakes up in a bad mood." Just the total stress scale, no subscales, was used. The scale measures the stress a parent is feeling specifically regarding parenting and interactions with their child. A higher score indicates higher parenting-related stress; such stress is associated with a higher risk of dysfunctional parenting behaviors developing. The 34-item parenting stress scale had a reliability of .91 at Interview 1, .94 at Interview 2, and .93 at Interview 3.

Life Stress. A 12-item scale was used to measure general (not parenting-specific) life stress based on a published 4-point Likert-type scale (0= "not a problem" to 3= "very much a problem") (Kanner, Coyne, Schaefer, & Lazarus, 1981). A higher score represents more stress. Respondents were asked how much of a problem the certain issues had been in the last month—food, shelter, bills, family, death, pregnancy, alcohol, drugs, work, friend, violence, etc. This scale had a reliability of .69 at Interview 1, .70 at Interview 2, and .74 at Interview 3.

Emotional Violence and Physical Violence Between Intimate Partners. An adapted version of the Straus Conflict Tactics Scale was used to measure the frequency of psychological and physical attacks between participants and their partners (dating, cohabiting or married) in the last month (Straus, et al., 1995). These measures are sometimes referred to as emotional or physical domestic violence. The measure used a 4-point scale (0= "never" to 3= "often") with eleven items such as: "Called you names?", "Ridiculed or criticized you?", "Pushed or shoved you?", "Hit you with a fist?" This scale was only completed by parents who reported being

romantically involved with someone in the month prior to the interview. The 6-item subscale assessing emotional aggression had a reliability of .88 at Interview 1, .89 at Interview 2, and .85 at Interview 3. The 5-item subscale assessing physical aggression had a reliability of .74 at Interview 1, .33 at Interview 2, and .68 at Interview 3.

Alcohol and Drug Use. An 8-item scale adapted from the Short Michigan Alcoholism Screening Test (SMAST; Selzer, et al., 1975) and the Drug Abuse Screening Test (DAST; Skinner, 1982) was used to assess the extent of problems (if any) participants had related to alcohol and drug use. Participants gave yes or no responses to statements such as "Do you feel you are a normal drinker?", "Are you able to stop drinking [or using drugs] when you want to?", "Have you ever neglected your family or missed work because of your use of drugs?" The reliability of the 4-item SMAST scale was .57 at Interview 1, and .66 at Interviews 2 and 3. The reliability of the 4-item DAST scale was .85 at Interviews 1 and 2, and .86 at Interview 3.

Protective Factor Measures. Measures of protective factors included six scales: quality of life, general social support, emotional and instrumental social support, parenting sense of competence, nonviolent discipline tactics, and family functioning.

Quality of Life. A 9-item scale was used to measure quality of life with respect to feelings about one's life overall, self, personal safety, amount of fun and enjoyment, family responsibilities, life accomplishments, independence and freedom, emotional and psychological well-being, and use of leisure time (Andrews & Withey, 1976). Respondents used a 5-point Likert-type scale (1= "extremely dissatisfied" to 5= "extremely satisfied"). The reliability of this scale was .86 at Interview 1 and .89 at Interviews 2 and 3.

Social Support. Social support was measured using a 7-item scale adapted from the Norbeck Social Support Questionnaire (NSSQ) (Norbeck, Lindsey, & Carrieri, 1981).

Participants were asked to consider the people who provided them with personal support or who are important to them and "fairly regular parts" of their lives and indicate how much of three types of support those people provided: emotional support ("How much do these people make you feel liked or loved?", "How much can you confide in these people?"), instrumental support ("If you need to borrow $10, a ride to the doctor or some other immediate help, how much can these people usually help?", If you were confined to bed for a couple of weeks, how much can these people help you?"), and general support ("These people are available for support when I need them", "I never feel isolated or alone", "I would like to have more support from my friends and family"). Higher scale scores indicated more social support. The subscales for emotional and instrumental support, which used a 4-point Likert-type scale (0=none to 3=a lot), were combined into one subscale that had a reliability of .56 at Interview 1, .67 at Interview 2, and .72 at Interview 3. The subscale for general support used a 3-point Likert-type scale (0=not true to 2=very true) and had a reliability of .51 at Interview 1, and .47 at Interviews 2 and 3.

Parenting Sense of Competence (PSOC). A 16-item scale was adapted from the Parenting Sense of Competence Scale (Gibaud-Wallson, et al., 1978) to assess parental self-esteem (also referred to as parenting sense of competence), which is defined as how confident participants were with regard to parenting and child behavioral issues and how much satisfaction they received from parenting. Parents were asked to respond to a 4-point Likert scale (1= "strongly agree" to 4= "strongly disagree") to statements about parenting (e.g., "I am a fine model for a new parent," "Childcare problems are easily solved," "I'm not sure if I'm doing a good job," "I feel like I'm being controlled."). A high score indicates a high sense of parenting self-esteem. The PSOC scale had a reliability of .81 at Interview 1. Four items were removed from the scale due to low item-total correlations, ranging from .08 to .33. The remaining 12-item

scale had a reliability of .83 at Interview 1 (corrected item-total correlations from .33 to .66), .84 at Interview 2, and .83 at Interview 3.

Nonviolent Discipline Tactics. Another scale adapted from the revised version (15-item) of the Parent-Child Conflict Tactics Scale (CTSPC; Strauss, et al., 1996) was used to measure the frequency (0= "never" to 5= "more than four times a week") of four nonviolent discipline tactics considered to be alternatives to corporal punishment ("Explained why something was wrong," "Gave child something else to do instead of what he/she was doing," "Put child in a 'time out'," "Took away privileges or grounded"). A higher score indicated more nonviolent or "positive parenting" techniques were used in disciplining children. The 4-item subscale assessing nonviolent discipline had a reliability of .67 at Interview 1, .72 at Interview 2, and .70 at Interview 3.

Family Functioning. Family relationships were assessed using a 14-item scale based on the McMaster Family Assessment Device (Epstein, et al., 1983). The family functioning scale used a 4-point Likert-type scale (from 1= "strongly agree" to 4= "strongly disagree") to assess communication, openness, support, problem solving, and sense of closeness and appreciation among family members. Examples of statements include "Appreciation is expressed and accepted," "We avoid discussing our fears and concerns," and "I am proud of my family." A high scale score indicates better family functioning. This scale had a reliability of .93 at Interviews 1 and 2, and .94 at Interview 3.

Data Processing and Analysis

Questionnaires were scanned and read using "Scantron" computer software, producing SPSS data files. SPSS data files were each double checked for accuracy, then merged into a single database for analysis.

Descriptive statistics, histograms, frequency distribution, and examination of outliers were conducted for all variables. Regression analyses assessing scale score change over time and the differential influence on variability in scale score change by parent and group characteristics were conducted, but found few significant findings. Therefore, planned higher order analyses were not conducted. Instead, a series of bivariate analyses—t-tests, Pearson correlations, and chi-squares—are presented.

In order to facilitate pairwise comparisons and simplify interpretation, demographic and background variables were coded as binary whenever possible. The demographics and background characteristics used in the core analyses are a subset of all the characteristics assessed in the full interview (see Table 3.1 in Chapter 3, Section IV). Through statistical correlations and theoretical considerations, this subset was found to effectively represent the parent sample while reducing the total number of possible comparisons in analyses to a manageable number. When a significant ($p<.05$) Levene's Test for Equality of Variances was found, the unequal variance t-test ("adjusted t-test") was used. Instrument reliability was measured with Cronbach's alpha.

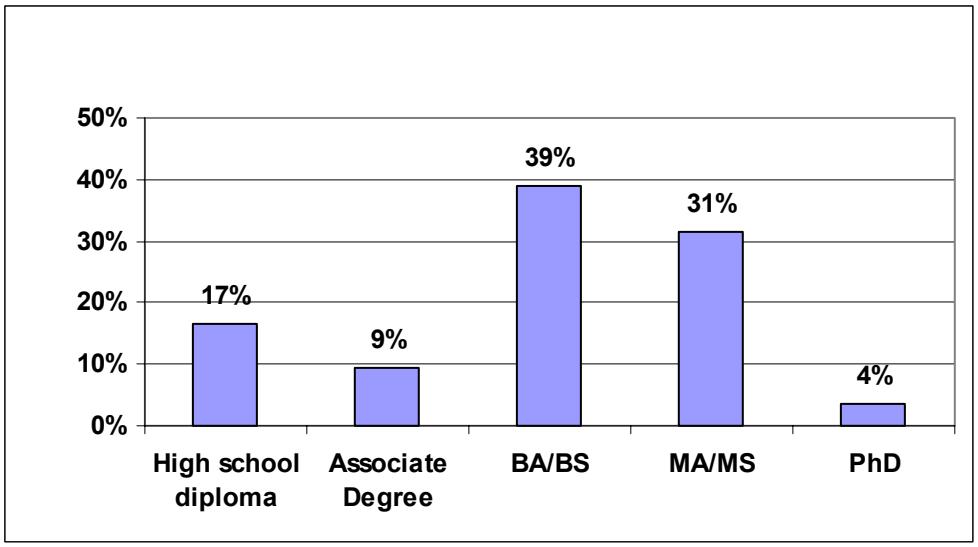
CHAPTER 3. QUANTITATIVE STUDY FINDINGS

The quantitative findings are presented in four parts—the Group Facilitator Assessment findings, the Group Assessment findings, and, for the bulk of the quantitative findings, the Individual Interview Sample Descriptives describe the sample followed by the key analyses for the study, Data Analysis for Research Questions.

I. GROUP FACILITATOR ASSESSMENT FINDINGS

Over 80% of group facilitators had some advanced degree and over a third had a master's or doctorate. Specifically, the highest level of education achieved for 16% (9) of group facilitators was a high school diploma, 9% (5) an Associates Degree, 39% (22) a Bachelors Degree, 32% (18) a Masters Degree, and 4% (2) a PhD (see Figure 3.1).

Figure 3.1. Educational Background of Group Facilitators (n=54)



About 37% (21) of Group Facilitators who reported their employment status were working as volunteers, 30% (17) indicated being paid staff for Parents Anonymous® and 23% (13) were paid a stipend.

About 55% (31) of Group Facilitators indicated that a Parents Anonymous® Children's Program met while the adult group met.

II. GROUP ASSESSMENT FINDINGS

A total of 89 groups participated in the first Group Assessment and 56 groups in the second (follow-up) Group Assessment. A total of 54 groups completed the Group Assessment *and* had group members who participated in the study. Of these 54 groups, 45 completed both the first and second Group Assessment. Nine groups completed the first Group Assessment, but did not complete the second Group Assessment.

Since there were statistically significant differences in the group aggregate data for the first and second Group Assessment, within group responses were averaged across the two time points for those groups who completed both.

The Group Assessment sample thus consisted of 583 respondents representing 54 groups. The average number of respondents per group was 10.8 (sd=6.5) with a range of between 2 and 32 per group. Since questionnaires were not linked to individual parents and it was not possible to determine which, if any, parents completed both the first and second Group Assessment, the group member characteristics described below include a certain amount of redundancy, that is, individual parents counted twice. However, the key data collected from the Group Assessment, the leadership and support information, does not have redundancy since scores for those measures represent either findings from just the first Group Assessment or an average of the first and second Group Assessment.

Group Member Characteristics

Group Demographics (Age, Gender, Race). Group members ranged in age from 17 to 74. The average age of group members was 35.4 years (sd=10.0). Group members were 83% female and 17% male. About 31% indicated being African American, 58% were white, 6% were Latino, 5% were American Indian, and 3% reported being multiracial or other races.

Group Income. Almost two-thirds of the group members earned less than $25,000 annually. About 43% (230) of group members indicated that their annual family income was less than $15,000, 21% (113) between $15,000-24,999, 16% (84) between $25,000-34,999, 15% (78) between $35,000-49,999, 4% (20) between $50,000-75,000, and about 2% (8) over $75,000.

Group Children. On average, group members had 2.7 (sd=1.5) children per family, with a range from one to eleven children. About 22% (125) indicated having only one child, 30% (174) had two children, 24% (136) of had three children, 15% (87) had four children, and 9% (51) indicated having five or more children.

Group Attendance and CPS. On average, group members reported having attended about 40 meetings (sd=75), with a range from 1 to 500 meetings.

About 23% (134) of group members indicated that they had been investigated at some point by child protective services (CPS). Sixteen percent (92) had had a CPS caseworker, and about 12% (71) had had a child removed from their home.

About 29% (166) of group members were required to attend Parents Anonymous® meetings. Of this group of 166, 30% (49) had a judge or court order to attend group meetings, 39% (64) were required to attend because of child protective services, and 4% (7) indicated that their probation officer required them to attend Parents Anonymous® meetings. About 27% indicated some other public entity mandated their attendance.

In addition, about 25% (40) indicated that they would not be attending Parents Anonymous® meetings if not required to attend, 30% (48) indicated that they were not sure if they would attend Parents Anonymous® if not required to attend, and 46% (74) said they would be attending meetings even if they were not required to attend.

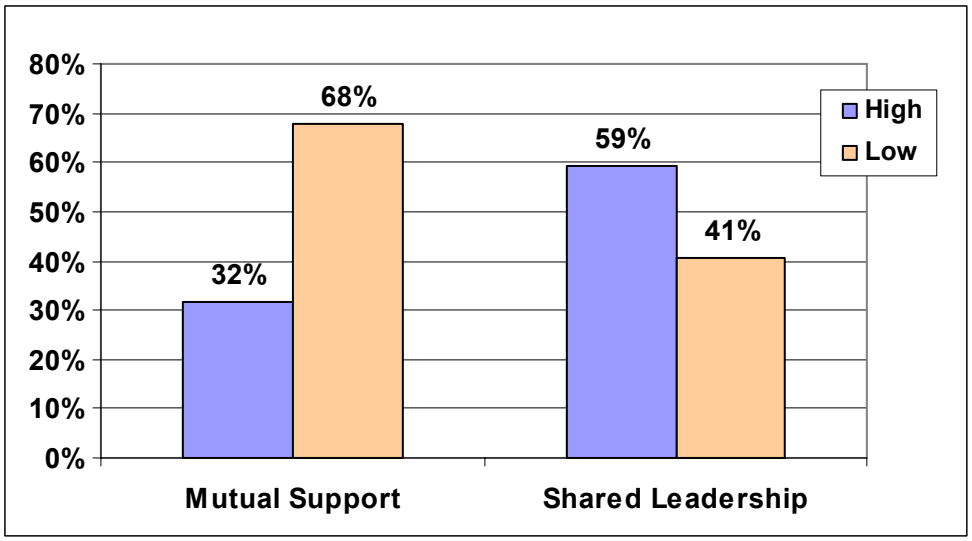
Model Implementation

Model Implementation was calculated using the Mutual Support and Shared Leadership scales.

Mutual Support. The Mutual Support scale (Maton, 1988) consisted of two subscales, one assessing the amount of support parents provide to other group members, and one assessing the amount of support parents receive from other group members. After coding, each subscale had a possible range of 0 to 4 (0="Not at all accurate", 4="Completely accurate") with a higher score indicating a more supportive group environment. A score for each of the two subscales was calculated for each of the 54 groups by averaging the scores of each group's respondents. Groups scores for the Provide Support subscale ranged from 1 to 3.7 (mean = 2.9; sd=.46). Groups scores for Receive Support Subscale ranged from 2.2 to 3.7 (mean = 2.9; sd=.33).

To assess *mutual* support, groups who scored a 3 or higher (representing, on average, the two uppermost responses on the Likert scale) on both the Provide and Receive subscales were considered high support groups. About 32% (17) of groups were identified as high mutual support and 68% (37) were low mutual support (See Fig. 3.2).

Figure 3.2. Group Mutual Support and Group Shared Leadership: High vs. Low (n=54)

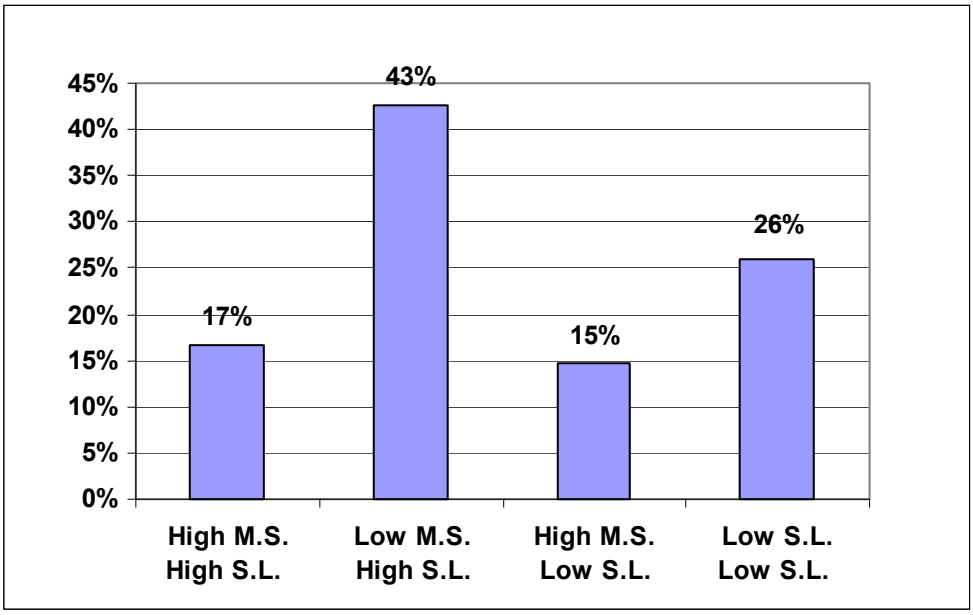


Shared Leadership. The shared leadership ratio was used to differentiate groups with high and low shared leadership. Groups with a shared leadership ratio equal to or above 0.75 were considered high shared leadership and groups with a ratio below 0.75 were considered low shared leadership. About 59% (32) of groups were identified as high shared leadership, and about 41% (22) of groups were identified as low shared leadership.

Group Model Implementation. Groups with high mutual support and high shared leadership were designated high model implementation groups. Figure 3.3 shows the breakdown for group implementation. About 17% (9) of groups fit the criteria of high model implementation. About 58% (31) of groups were identified as low mutual support and high shared leadership (23) or high mutual support and low shared leadership (8). Finally, about 26% (14) of groups were identified as low mutual support and low shared leadership and fit the criteria for low model implementation. A three-level group implementation variable was created to analyze model implementation by comparing groups that had high implementation (high mutual support and high shared leadership; n=9), medium implementation (high mutual support

but low shared leadership, or vice versa; n=31), or low implementation (both low mutual support and low shared leadership; n=14).

Figure 3.3. Group Model Implementation* (n=54)



* M.S. = Mutual Support, S.L.= Shared Leadership

III. INDIVIDUAL INTERVIEW SAMPLE DESCRIPTIVES

A total of 232 new Parents Anonymous® participants from 54 groups across 19 states were interviewed at all three time points. (Of the 242 parents who completed the first interview, 10 parents did not complete further interviews and thus are not included in the sample for this report.) Twenty-six of the 232 parents who completed all interviews were deemed ineligible and were excluded because they had attended more than 5 meetings prior to the first interview.

This section reports a detailed description of the full sample of 206 parents in three parts:

- **Demographics** (age, education, marital status, number of children, etc.);

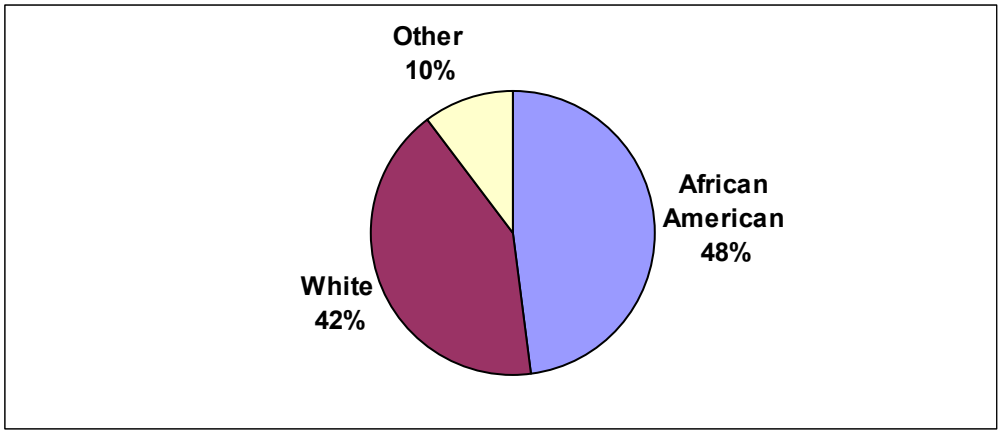
- **Background characteristics** (other caregivers in the household, health history, history of substance abuse, help-seeking behaviors, mandated attendance, etc.);
- **Parents' experience with Parents Anonymous®** (reasons for attending Parents Anonymous®, attendance, perceived impact of Parents Anonymous®, attitude toward Parents Anonymous®, etc.).

When comparative analyses were made for Section III, significant and non-significant findings are reported in order to give a complete picture of the sample. Significant findings are indicated as such. Section IV will then report the analyses addressing the research questions with an emphasis on only the statistically significant findings, though non-statistically significant trends will also be reported.

Demographics

Age, Gender, & Race. The parents in the sample ranged in age from 19 to 62 years with an average of 35 (sd=9.8). (To qualify for participation parents had to be at least 18 years of age.) Most participants in the study were females (91%). About 48% (99) were African American, 42% (86) white, 4% (9) Latino, 2% (5) American Indian, and 3% (7) reported being multiracial or other races (See Fig. 3.4).

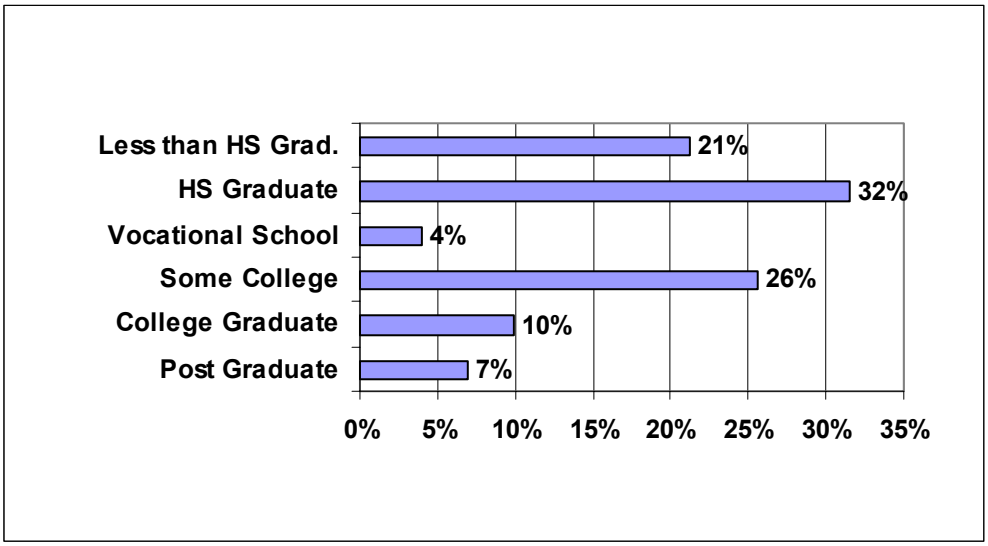
Figure 3.4. Race (n=206)



Education. Approximately 21% of participants (43) indicated not having graduated from high school. Thirty-two percent (64) were high school graduates. About 26% (52) reported having some college education and 10% (20) indicated completing college. Seven percent (14) of participants indicated pursuing a post graduate education. About 4% (8) of parents reported attending technical or vocational schools (See Fig. 3.5).

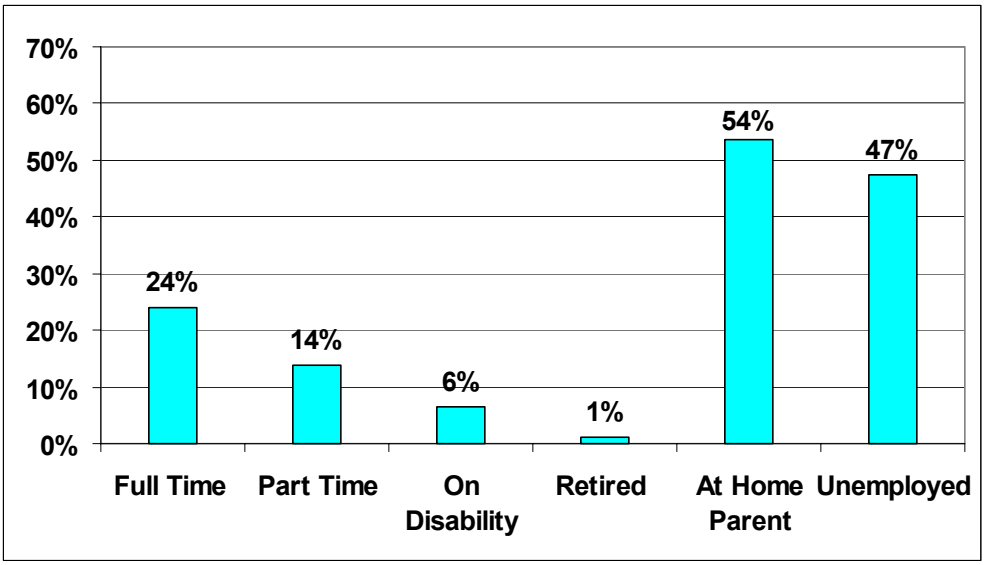
A binary education variable was created that differentiated participants who had graduated from high school (79%; 158) and those who had less than a high school education (21%; 43). Participants who indicated that they had attended technical or vocational schools were included in the group of high school graduates.

Figure 3.5. Educational Status (n=206)



Employment. More than 47% (96) of participants indicated they were currently unemployed. About 24% (49) of participants indicated that they were working full-time, and 14% (28) were working part-time. About 6% of participants were receiving some sort of disability compensation (13) or were retired (2). About 54% (109) of participants identified themselves as at-home caregivers (See Fig. 3.6).

Figure 3.6. Employment Status (n=206)*

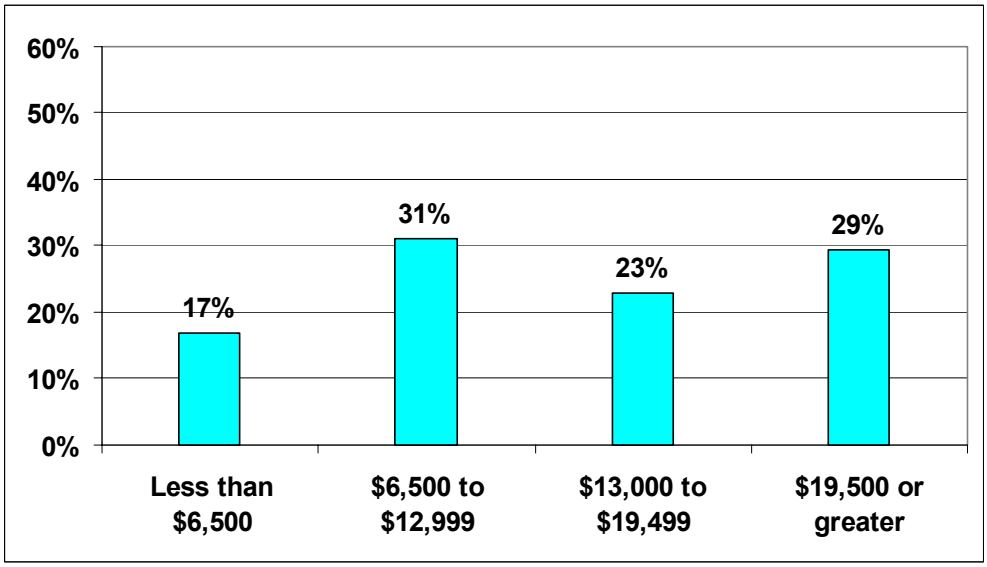


*Respondents could indicate more than one response.

Income. Monthly incomes ranged from $0 to $7,400. The average monthly income was $1,486.83 (sd=$1,281.29). The median monthly income was $1,138. Total monthly income included the income that participants earned from their employment as well as any financial assistance they were receiving.

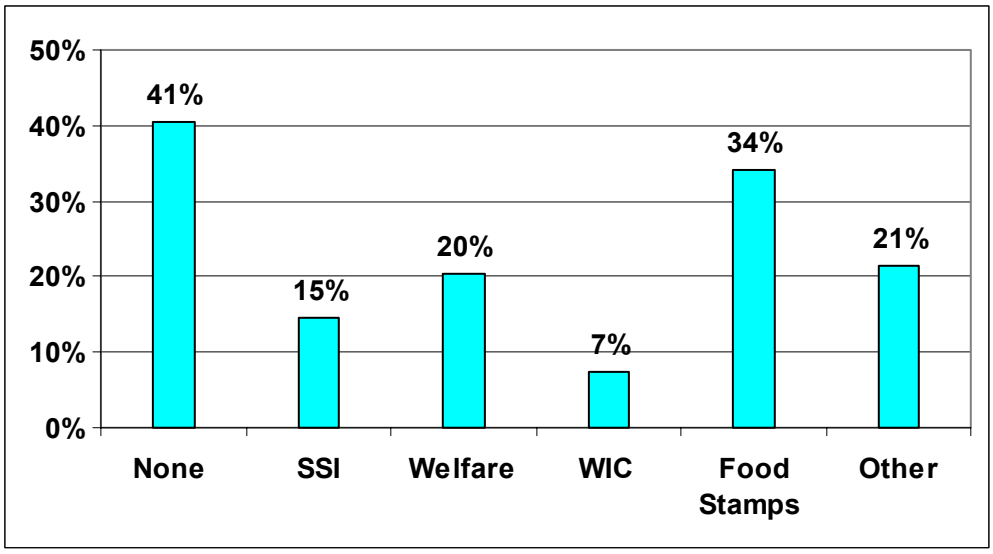
A binary variable was created which categorized participants into two groups: participants who earned more than $13,000 annually (52%; 103) and participants who earned $13,000 or less annually (48%; 94) (See Fig. 3.7). The 2003 Federal Poverty Guideline, sometimes referred to as the poverty level, for a family of two was $12,120 and for a family of three was $15,260 (USDHHS, February 7, 2003).

Figure 3.7. Yearly Family Income (n=197)



Financial Assistance. Approximately 60% (122) of participants indicated that they were receiving financial assistance. Of this group of 122 participants who indicated receiving financial assistance, 57% (70) reported receiving Food Stamps, 34% (42) received welfare in the form of Aid to Families with Dependent Children (AFDC), Aid to Dependent Children (ADC) and/or Temporary Assistance for Needy Families (TANF), 25% (30) indicated receiving Social Security Disability Insurance, and 12% (15) indicated receiving assistance through Women, Infants and Children (WIC) (See Fig. 3.8).

Figure 3.8. Financial Assistance (n=205)*

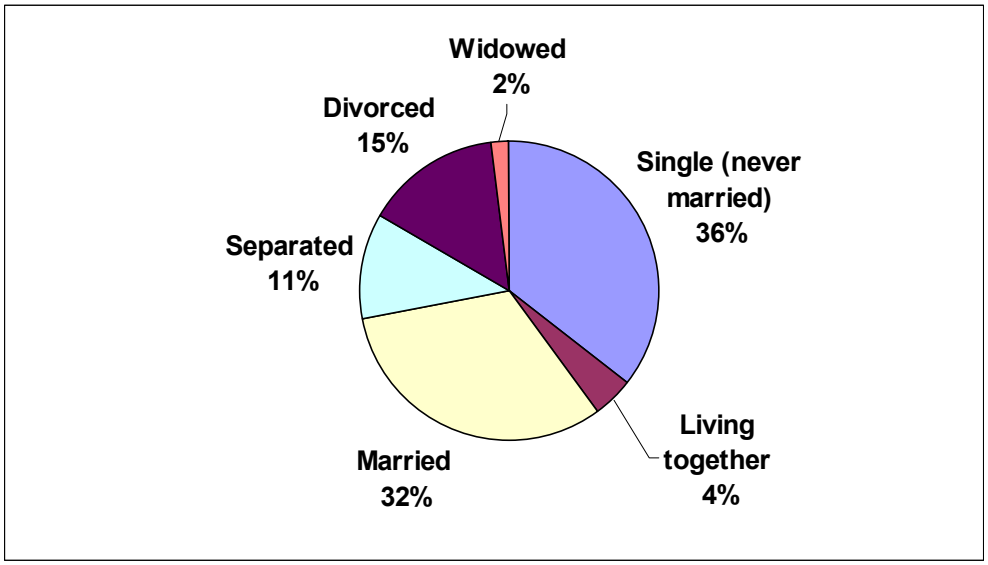


*Respondents could indicate more than one response.

Financial assistance ranged from $10 to $3,000 monthly. The average parent who indicated receiving financial assistance estimated that they got about $564.13 a month (sd=$485.26). The median amount of financial assistance was $462.50. About 86% (101) of participants who received financial assistance described it as 'very important' to the well-being of their family.

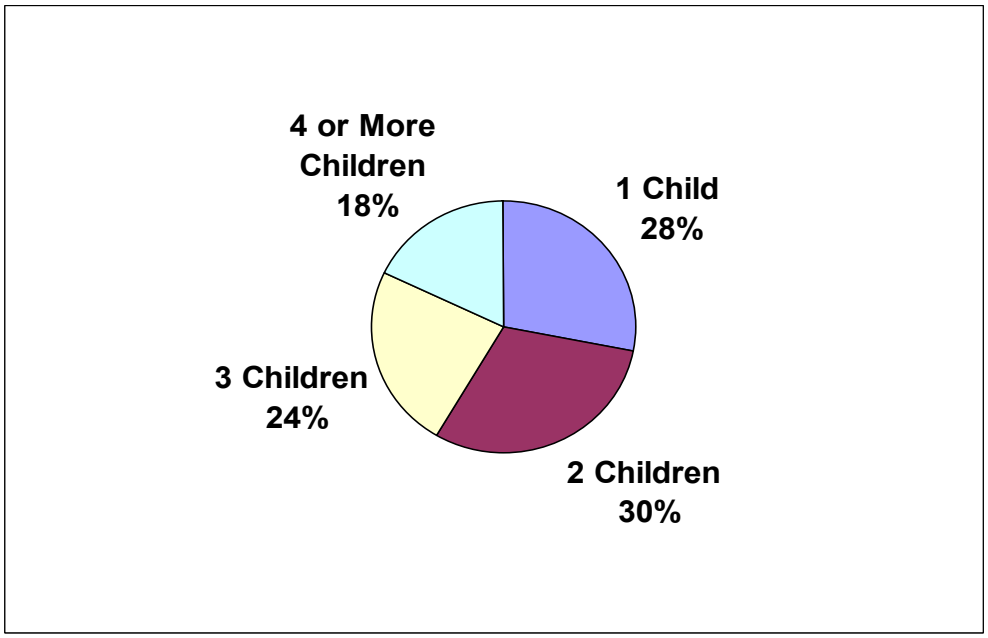
Marital Status. About 36% (72) of participants indicated that they were single and had never been married. About 32% (65) of participants were married and 4% (9) indicated living with their partner, but not being married. Fifteen percent (30) reported being divorced and another 11% (23) indicated being married, but separated. About 2% (4) reported being widowed (See Fig 3.9).

Figure 3.9. Marital Status (n=203)



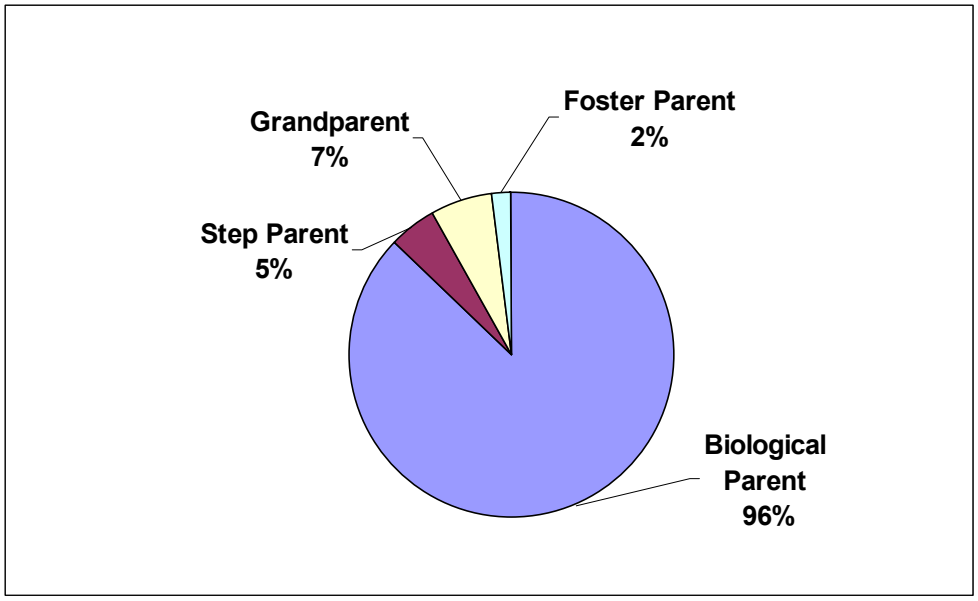
Number of Children. Parents reported having between one and eight children with an average of 2.5 children (sd=1.39). About 28% of participants (58) indicated having one child, 38% (62) indicated having two children, 24% (49) indicated having three children, and 18% (37) indicated having four or more children (See Fig. 3.10).

Figure 3.10. Number of Children (n=206)



Relationship to Children. Ninety-six percent (197) of participants indicated that they were the biological parent of the child or children in their care, 5% (11) a step-parent, 2% (3) a foster parent, and 7% (14) a grandparent (see Fig. 3.11).

Figure 3.11. Participant's Relationship to Children (n=206)*



*Respondents could indicate more than one response.

Background Characteristics

Children's Special Needs. One interview item asked participants which special needs their Target Child had, if any, and a second item asked which special needs their other children had, if any. (Participants could indicate more than one response when asked what special needs their children had.)

About 37% (77) of participants indicated that their Target Child had some sort of special needs issues: 14% (29) learning disabilities, 13% (26) hearing and speaking deficiencies, 13% (26) mental health needs, 9% (18) physical health needs, 6% (12) developmental disabilities, 3% (6) vision impairments, and 2% (4) physical mobility impairments.

About 27% (56) of participants indicated that they had at least one child, other than their Target Child, that had some sort of special needs issues: 14% (29) mental health needs, 12% (24) hearing and speaking deficiencies, 11% (23) learning disabilities, 9% (18) developmental disabilities, 7% (14) physical health needs, 4% (9) physical mobility impairments, and 3% (7) vision impairments.

A binary variable was created categorizing participants as having at least one special needs child or having no special needs children. Half of participants (103) reported having at least one child in their family with special needs issues. Of these, 23% (47) indicated that only their Target Child had a special need, 13% (26) indicated that they had a child with special needs other than their Target Child and 15% (30) indicated that both their Target Child and another child had special needs.

Other Adults in the Household. About 59% (121) of participants indicated that they were living with other adults. Of these 121 participants who indicated living with at least one other adult, 50% (60) reported living with the biological parent to the Target Child. About 11% (13) identified the other adult as a step-parent, and 38% (45) indicated that the other adult was a grandparent.

Other Caregivers in the Household. About 74% (43) of the participants who indicated living with another adult other than the biological parent (61) indicated that they consider this other adult a caregiver for their children.

A variable was created by combining those participants who indicated that they live with the biological parent of the Target Child (60), and those participants who live with another adult (not the biological parent/guardian) who they consider to also be a caregiver (43). After

combining these two variables, half of the participants (103) were single caregivers and half (103) had multiple caregivers in their homes.

Previous Exposure to Abuse. About 50% (102) of participants had been in a prior relationship where they had experienced emotional or psychological abuse. About two-thirds (68) of these respondents indicated that they were living with the perpetrator at the time the abuse occurred. Five percent (5) reported that this abuse was currently occurring, 13% (13) that this abuse occurred in the last year, and 80% (84) that this abuse occurred more than one year ago.

About 39% (79) of participants had been in a prior relationship where they had experienced physical violence or abuse. About 77% (61) of these respondents indicated that they were living with the perpetrator at the time the abuse occurred. Four percent (3) reported that this abuse was currently occurring. About 8% (6) reported that this abuse occurred in the last year. About 88% (70) of participants indicated that this abuse occurred more than one year ago.

Alcohol Abuse. About 10% (20) of participants reported having had issues with alcohol at some point in their lives (see Fig. 3.12). Only 1% (2) of participants indicated that they had experienced alcohol-related issues in the month prior to their first interview.

Of this group who reported having issues with alcohol, 75% (15) had attended a self-help group, 60% (12) had attended individual or group therapy, 20% (4) had called a hotline or helpline, 75% (15) had talked to friends or family, 40% (8) had talked to a religious figure, 70% (14) had read published information, and 40% (8) had asked for help from a professional for their alcohol-related problems (see Fig. 3.13).

Figure 3.12. Substance Abuse and Health History (n=206)

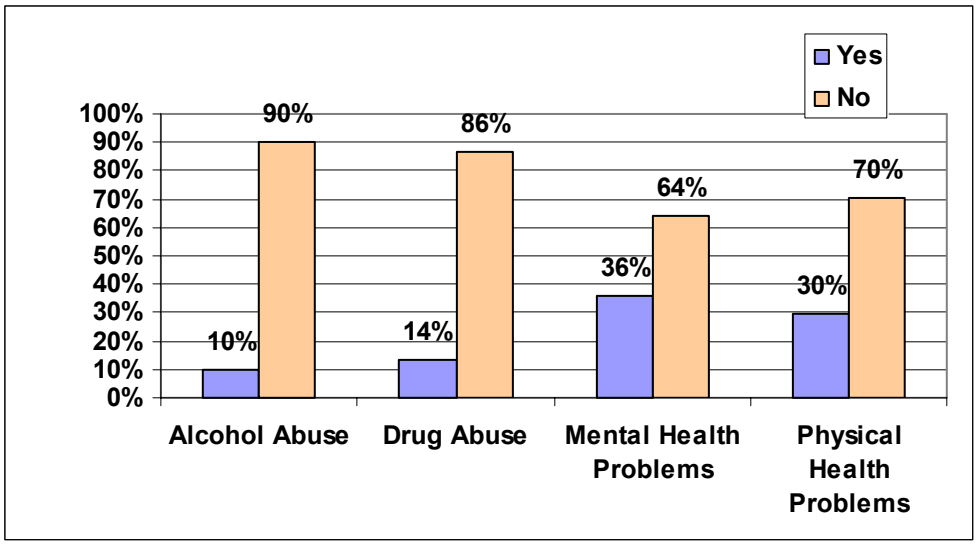
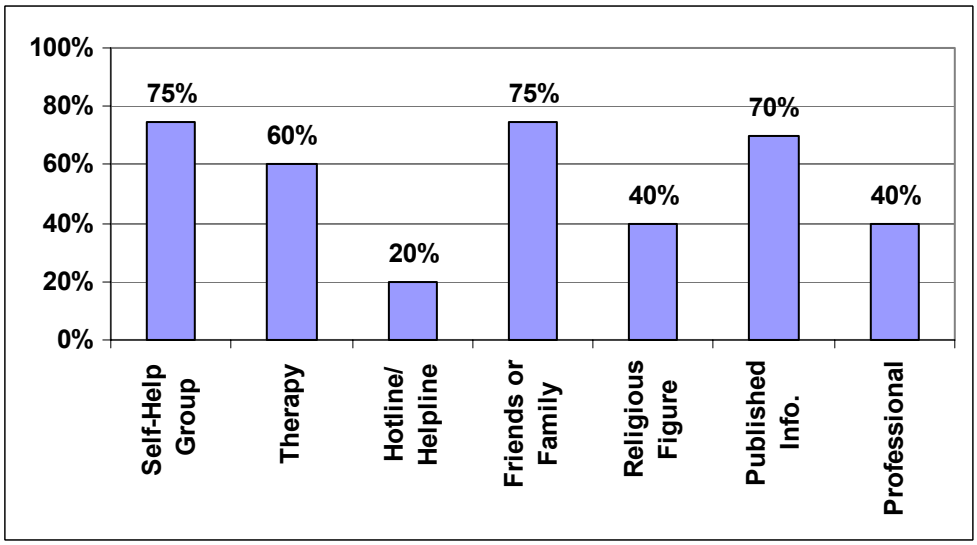


Figure 3.13. Methods of Getting Help with Alcohol Abuse (n=20)*



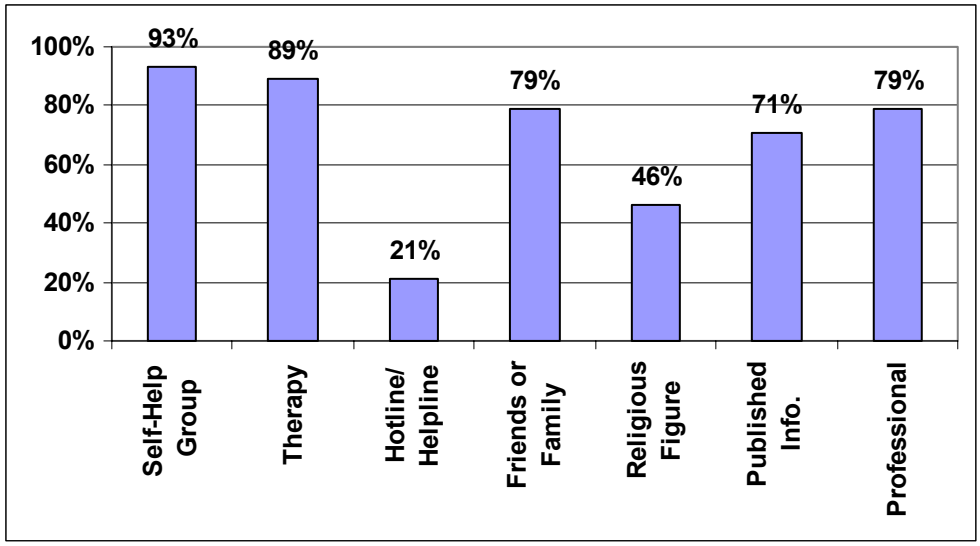
*Respondents could indicate more than one response.

Drug Abuse. About 14% (28) of participants reported having drug related issues at some point in their lives (see Fig. 3.12). Two percent (3) of participants indicated that they had experienced drug-related issues in the month prior to their first interview.

Of this group who reported having issues with drugs, 93% (26) had attended a self-help group, 89% (25) had attended individual or group therapy, 21% (6) had called a hotline or

helpline, 79% (22) had talked to friends or family, 46% (13) had talked to a religious figure, 71% (20) had read published information, and 79% (22) had asked for help from a professional for their drug-related problems (see Fig. 3.14).

Figure 3.14. Methods of Getting Help with Drug Abuse (n=28)*

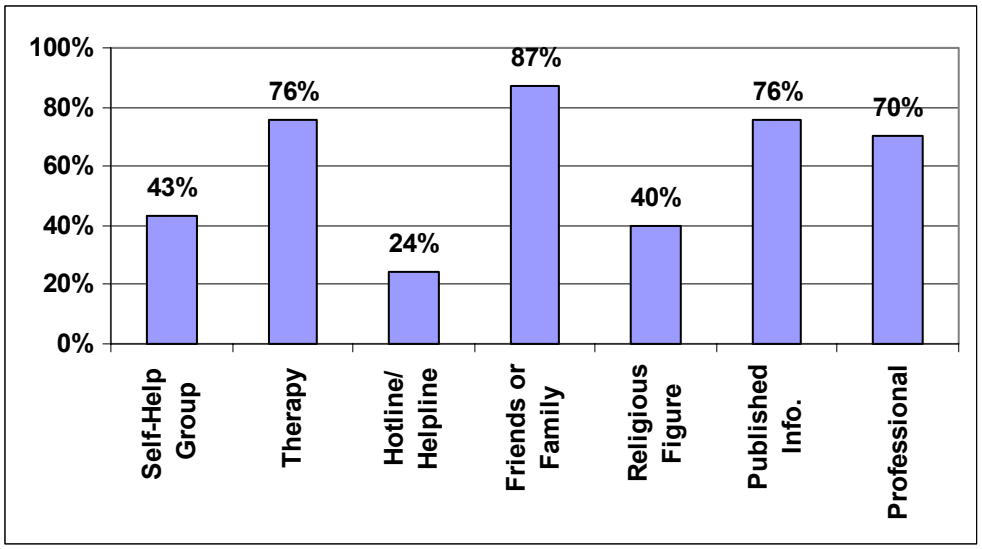


*Respondents could indicate more than one response.

Alcohol or Drug Abuse Combined. A binary variable was created combining the alcohol- and drug-related questions. Eighteen percent (18%; 37) of participants indicated having a problem with alcohol (9), drugs (17) or both (11) at some point in their lives.

Mental Health Issues. About 36% (74) of participants reported having mental health related issues at some point in their lives (see Fig. 3.12). Of this group who reported mental health issues, 43% (32) attended a self-help group, 76% (56) attended individual or group therapy, 24% (18) called a hotline or helpline, 87% (64) talked to friends or family, 40% (29) talked to a religious figure, 76% (55) read published information, and 70% (51) asked for help from a professional to get help with their mental health related issues (see Fig. 3.15). Sixteen percent (33) of participants indicated that they had mental health related issues in the month prior to their first interview.

Figure 3.15. Methods of Getting Help with Mental Health Issues (n=74)*

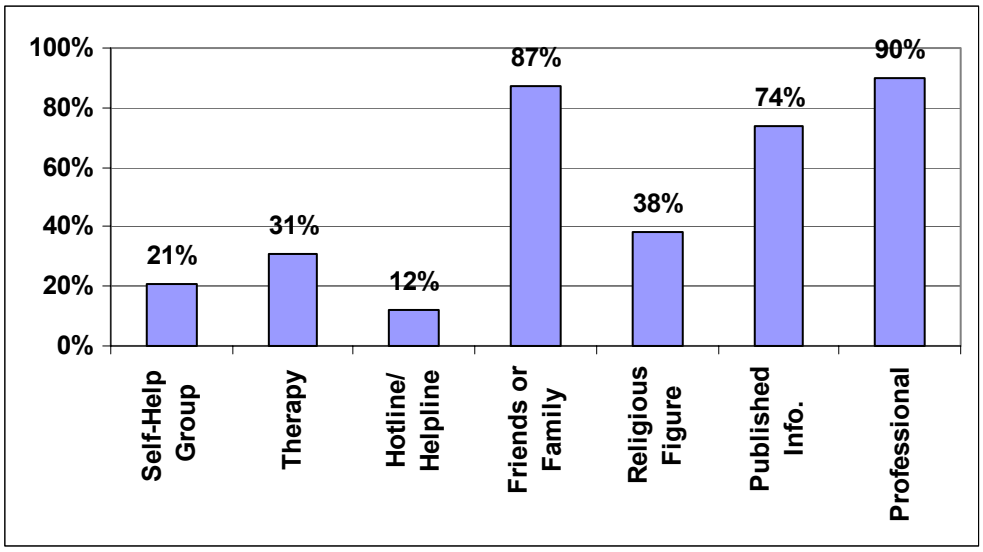


*Respondents could indicate more than one response.

Physical Health Issues. About 30% (61) of participants reported having physical health related issues at some point in their lives (see Fig. 3.12). Of this group who reported physical health issues, 21% (13) attended a self-help group, 31% (19) attended individual or group therapy, 12% (7) called a hotline or helpline, 87% (53) talked to friends or family, 38% (23) talked to a religious figure, 74% (45) read published information, and 90% (55) asked for help from a professional to get help with their physical health related issues (see Fig. 3.16). Eighteen percent (36) of participants indicated that they had physical health related issues in the month prior to their first interview.

Mental or Physical Health Issues Combined. A new variable was created combining the mental and physical health related questions. Forty-nine percent (101) of participants indicated having a mental health problem (40), a physical health problem (27) or both (34) at some point in their lives.

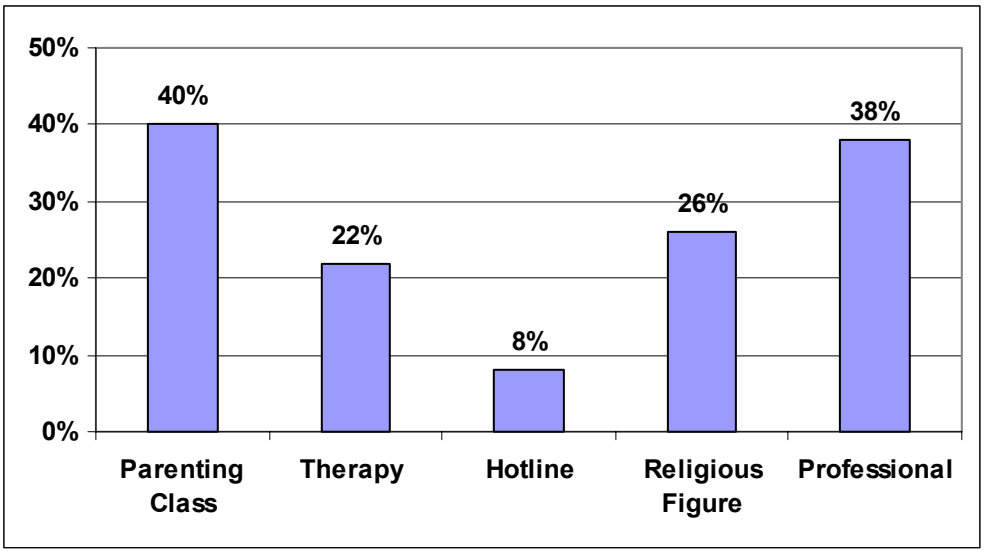
Figure 3.16. Methods of Getting Help with Physical Health Issues (n=61)*



*Respondents could indicate more than one response.

Prior Help Seeking Behaviors. About 40% (83) of participants had attended some sort of parenting class, other than Parents Anonymous®, to get help deal with their parenting issues (see Fig. 3.17). About 82% of participants who had attended parenting classes were "extremely satisfied" (33) or "satisfied" (35) with the information they learned. Twenty-two percent (45) had attended individual or group therapy to get help with their parenting issues. About 75% of participants who had attended therapy were "extremely satisfied" (15) or "satisfied" (17) with it.

Figure 3.17. Prior Help Seeking Behaviors for Parenting Issues (n=206)*



*Respondents could indicate more than one response.

About 8% of participants (17) had called a hotline to get help with parenting issues. About 71% of participants who had called a hotline were "extremely satisfied" (6) or "satisfied" (6) with the help they received from the hotline. About 26% (53) of participants sought help from a religious figure to help them deal with their parenting issues. About 77% of participants who had sought help from a religious figure were "extremely satisfied" (15) or "satisfied" (26) with the help they received. About 38% (78) had seen a professional, such as a caseworker or doctor, to deal with their parenting issues. About 74% of participants who had seen a professional were "extremely satisfied" (25) or "satisfied" (33) with the help they received.

A new binary variable was created by combining these help seeking behaviors to identify participants who had sought out help in the past for their parenting issues. About 72% (148) of the participants had sought out some sort of help to deal with their parenting issues prior to attending Parents Anonymous®.

Child Maltreatment. Five percent of participants (11) had reported themselves to child protective services at some point in their lives. Only one participant had self-reported in the

month prior to their first interview. About 23% (48) of participants had been reported to child protective services by someone else at some point in their lives. Of this group who had been reported to CPS, seven of them (16%) had been reported in the month prior to their first interview.

Combined, a total of 56 (27%) parents had either been reported to CPS (45) or had self-reported to CPS (8). Three of these indicated both being reported by someone else and self-reporting. Allegations leading to these reports included neglect (30), physical abuse (15), sexual abuse (5), and emotional abuse (3). Some respondents provided multiple responses indicating that allegations against them were for more than one reason. Of the 56 with CPS allegations, 22% (11) resulted in charges, 73% (37) were dropped as unsubstantiated, and 6% (3) were still pending. (Five parents did not report the outcome of the allegation.)

Required Attendance. About 15% (30) of participants indicated that they were required to attend Parents Anonymous® meetings. Of this group, 50% (15) had been mandated to attend by a judge; 40% (12) had been mandated to attend by child protective services or other child-related social services; 7% (2) had been mandated to attend as a condition of probation; and 3% (1) had been mandated to attend by another, unspecified entity. About 67% (20) of this sample reported that there was a formal court order requiring them to attend Parents Anonymous®.

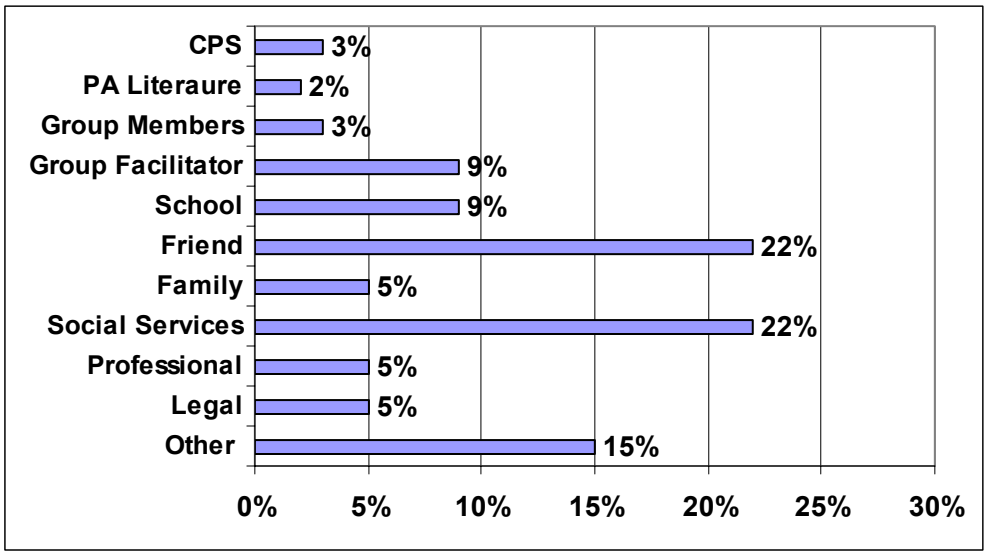
Of the 30 mandated parents, 60% (18) reported having a CPS allegation against them at some point. Of these 18, 35% (6) were charged, 53% (9) unsubstantiated, and 12% (2) pending (with one case missing data).

Parents Anonymous® Involvement

Finding Out about Parents Anonymous®. Participants found out about Parents Anonymous® groups through a variety of manners (see Fig. 3.18). About 3% (6) were informed

about Parents Anonymous® through child protective services. Another 5% (11) heard about Parents Anonymous® through other legal agencies. About 5% (10) heard about Parents Anonymous® from a mental health professional or medical personnel. Twenty-two percent (45) of participants heard about Parents Anonymous® from social services or other community agencies. About 5% (10) were told about Parents Anonymous® from a family member, and 22% (44) from a friend. About 9% (18) of participants heard about Parents Anonymous® from their child's school or teacher. About 9% (19) of participants found out about Parents Anonymous® from the Group Facilitator, 3% (5) from other Parents Anonymous® group members and 2% (3) from Parents Anonymous® literature. About 16% (32) of participants indicated that they heard about Parents Anonymous® from "other" sources, such as from their work, word of mouth, flyers, their children's playgroups, television or newspaper postings, outreach events, and from religious figures.

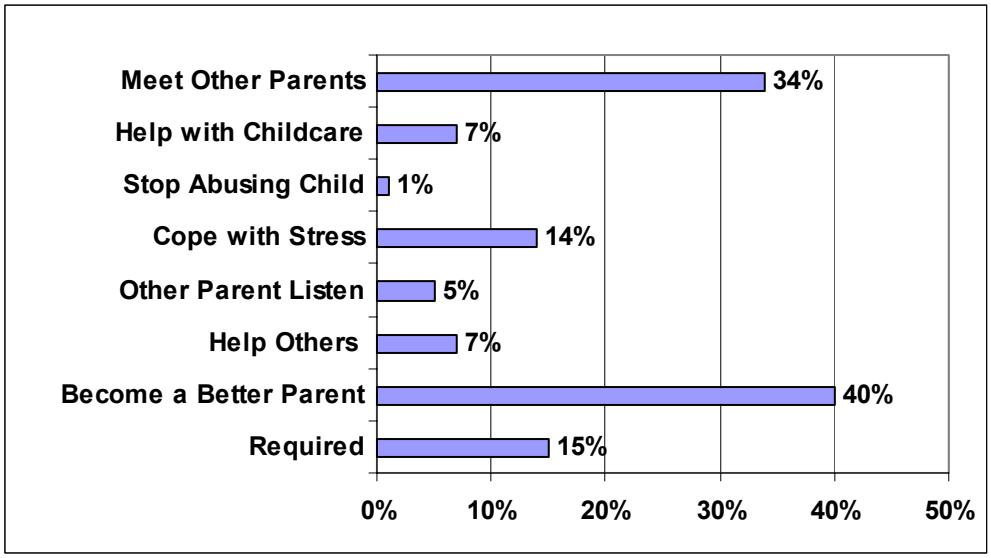
Figure 3.18. How Participants Found Out About Parents Anonymous® (n=206)



Reasons for Attending. Participants reported a variety of reasons for deciding to attend Parents Anonymous® meetings. Thirty-four percent (70) of participants wanted to meet, talk or socialize with other parents. About 40% (82) of participants wanted to become a better parent.

About 7% (14) of participants indicated that they joined so that they could help other parents. About 5% (10) of participants decided to join because they wanted other parents to listen to them. Fourteen percent (28) wanted help to cope with stress. One percent (2) wanted to stop hurting their children. About 7% (14) wanted help with childcare and about 15% (30) were required to attend (see Fig. 3.19).

Figure 3.19. Reasons for Attending Parents Anonymous® (n=206)



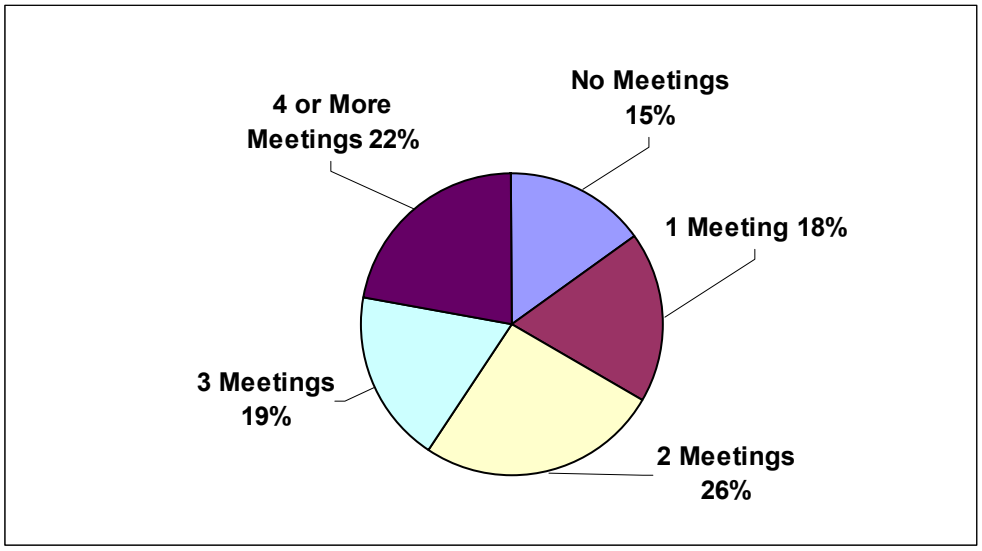
*Respondents could indicate more than one response.

Group Attendance. Before their first interview, participants attended between 1 and 5 meetings. On average, participants attended 2.5 (sd=1.29) meetings prior to their first interview. About 55% (113) of participants attended two or less meetings prior to their first interview. About 45% (93) of participants attended three to five meetings prior to their first interview. (In order to focus on parents new to Parents Anonymous®, eligibility for study analysis was limited to parents who had attended no more than five meetings prior to their first interview.)

Participants attended between 0 and 13 meetings between Interview 1 and Interview 2; on average, participants attended 2.4 (sd=2.01) meetings in that period . About 15% (31) of participants did not attend any meetings. About 18% (37) attended one meeting. Twenty-six

percent (53) attended two meetings. About 19% (38) attended three meetings and 22% (45) attended 4 or more meetings (see Fig. 3.20a).

Figure 3.20a. Attendance Between Interview 1 and Interview 2 (n=206)



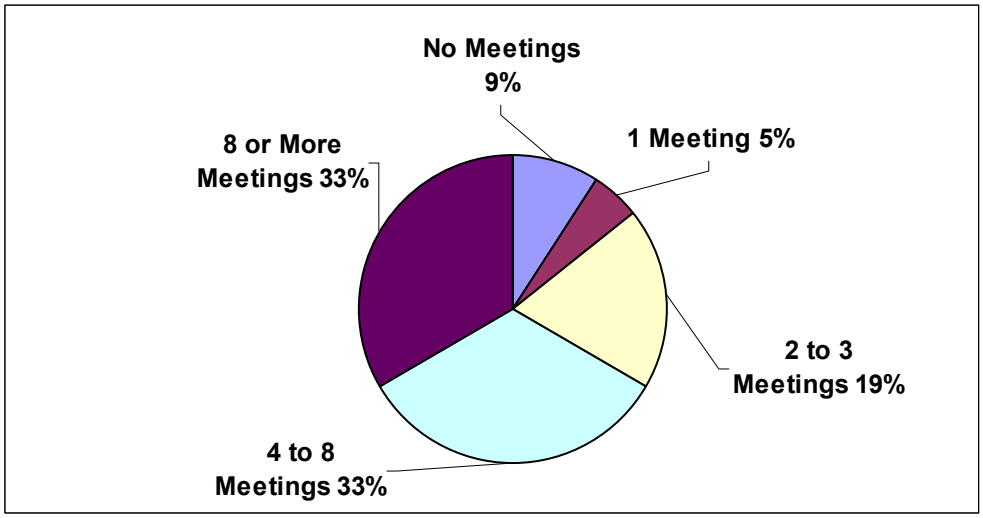
Participants who attended less than 2 meetings between their Interview 1 and Interview 2 were asked to explain why they had not attended more often. About 12% (9) of participants indicated that their meetings had been cancelled. About 21% (16) said they were too busy. About 13% (10) had transportation difficulties. Nine percent (7) stopped attending due to illness. Twelve percent (9) stopped attending meetings because of conflicts with their work schedules. About 8% (6) reported having childcare issues. Furthermore, about four percent (3) stopped attending because they did not fit in, and they disliked the meetings.

Attendance ranged from 0 to 30 meetings between Interview 2 and Interview 3; on average, participants attended 6 (sd=7.05) meetings in that period.

Attendance ranged from 0 to 36 meetings between Interview 1 and Interview 3; on average, participants attended 8.4 (sd=8.05) meetings in that period. On average, participants attended about 1.4 (sd=1.35) meetings per month from Interview 1 to Interview 3. About 9%

(18) of participants did not attend any meetings, 5% (10) attended one meeting, 19% (39) attended two to three meetings, 33% (68) attended four to eight meetings and 33% (68) attended 9 or more meetings (see Fig. 3.20b). (See Chapter 4, Section IV of this report for further discussion of attendance figures as they pertain to parents who continued attending Parents Anonymous® meetings through the study period versus those who stopped attending.)

Figure 3.20b. Attendance Between Interview 1 and Interview 3 (n=206)*



* May not add to 100% due to rounding.

Parent Group Leaders. At Interview 2, 8% (16) of participants indicated that they were their groups' Parent Group Leader. About 45% (57) of participants who were not already Parent Group Leaders mentioned that they wanted to become one. At Interview 3, 11% (22) of participants were Parent Group Leaders and 30% (54) of participants who were not already Parent Group Leaders mentioned that they wanted to become one.

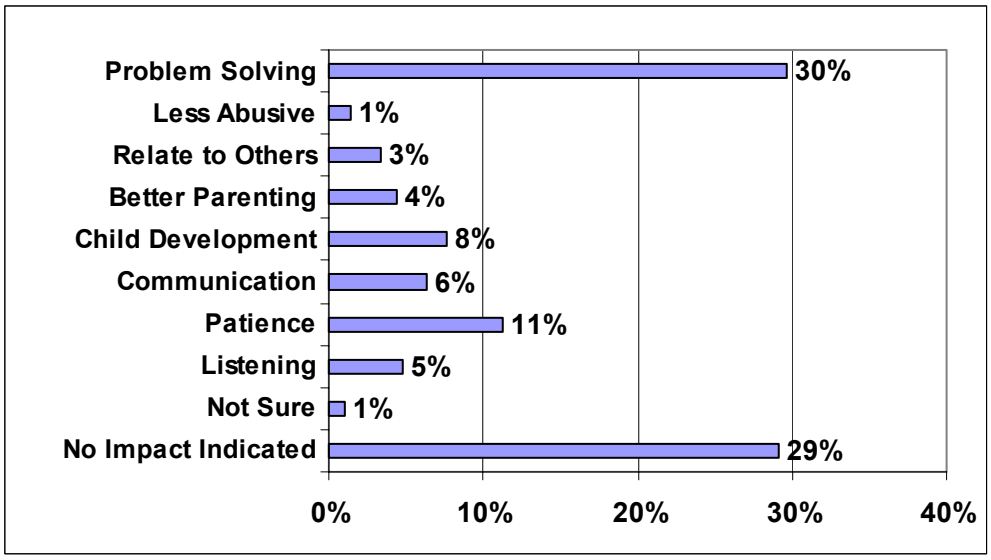
Self-Reported Impact of Parents Anonymous® Attendance

Ninety-six percent (197) of participants felt that Parents Anonymous® provided them with the services needed to raise healthy children. About 77% (157) of participants formed relationships with other Parents Anonymous® group members and 72% (113 of 157) of these

indicated that they saw other members outside of group meetings. About 77% (156) of participants felt that parenting had become easier as a result of their participation in Parents Anonymous®. (See Chapter 4, Section IV of this report for further discussion of self-reported impact of and attitude towards Parents Anonymous® attendance as they pertain to comparisons of parents who continued attending Parents Anonymous® meetings through the study period and parents who attended no meetings after their first interview.)

Impact on parenting. About 71% (146) of participants reported that attending Parents Anonymous® meetings had changed the way they parent (See Fig. 3.21). When these 146 participants were asked to describe in their own words how their parenting had been impacted, 43% (61) reported that through meeting attendance they improved their problem solving skills and learned new parenting and discipline ideas and methods; 16% (23) became more patient when dealing with childcare problems; 11% (16) learned more about topics related to child development and how to relate to different stages in their child's growth; 9% (13) improved their ability to speak with their children more effectively; 7% (10) became more understanding of their children and more open to listening to them; 5% (7) helped them relate their own experiences to what other parents are going through and realized that they are not alone when dealing with problematic issues. About 2% (3) felt that attending Parents Anonymous® helped them act less abusively with their children. About 6% (9) of parents indicated that Parents Anonymous® helped them become a better parent in general.

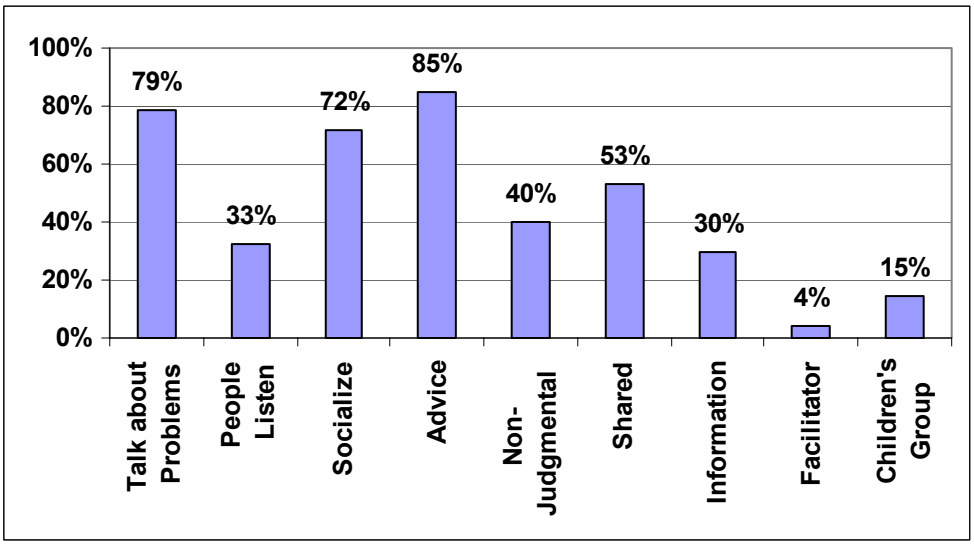
Figure 3.21. Impact of Parents Anonymous® (n=206)



Parents' Feedback about Parents Anonymous®

Positive Feedback about Parents Anonymous®. In each of the three interviews, participants reported what they liked and what they disliked about attending Parents Anonymous® meetings. Their open-ended responses were coded into categories. The change in these responses over the course of the study are reported in the next sections. In this section, responses for each participant were combined from the three interviews in order to assess what positive and negative feedback the parents reported at least once through the course of the study (See Fig. 3.22).

Figure 3.22. Positive Feedback about Attending Parents Anonymous® Group: Reported at Lease Once by Parents in their First, Second or Third Interview (n=206)*



*Respondents could indicate more than one response.

Over time, 79% (162) of participants reported, at least once, that they liked to attend meetings so that they could talk about their problems, 33% (67) liked that other parents listened to their problems. About 72% (148) of participants reported, at least once, that they like to attend meetings so that they could socialize with other parents. This response includes comments from respondents about how they enjoyed meeting and talking with other parents. Many group members liked how group meetings allowed them the opportunity to meet with other parents with similar backgrounds going through common problems and to get a break from watching their children.

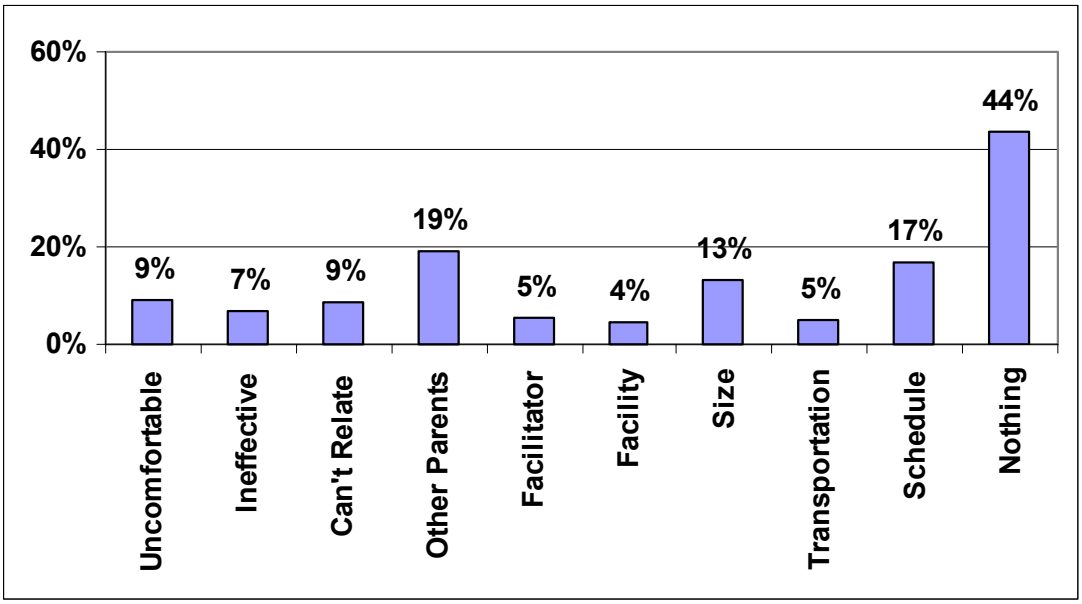
About 85% (175) of participants reported, at least once, that they enjoyed attending meetings to problem solve with other parents and to share advice. About 40% (83) of participants reported, at least once, that groups were non-judgmental. The "non-judgmental" response refers to the respondents' perception that other parents and the Group Facilitator do not criticize them for the problems and issues that they bring-up and discuss during meetings.

About 53% (110) of participants reported, at least once in the three interviews, that they liked how there was a "shared sense of purpose" with other group members. This response included comments from parents indicating they felt camaraderie with the other parents in their group, received a lot of support, even felt like the group was their extended family. About 30% (61) of participants reported that they liked the information that was provided to them at meetings. The "information" response included parents who specifically said they felt their parenting competence had grown, and that they learned a great deal from attending groups, especially about specific topics important to them such as adolescence, autistic children, violence, or community resources.

About 4% (9) of participants specifically mentioned that they liked their Group Facilitator. Lastly, about 15% (30) of participants liked how their group meetings also included a separate, simultaneously occurring children's group. The "children's group" response includes compliments from parents about how they could bring their children with them to meetings. "Children's groups" allow parents to attend group meetings while their children are under structured supervision.

Negative Feedback about Parents Anonymous®. Participants also reported negative feedback about their involvement with Parents Anonymous® (see Fig. 3.23). About 9% (19) of participants indicated that they felt uncomfortable at group meetings. The "uncomfortable" response included comments about how something in the group process made parents uneasy to the point they did not feel like sharing, and did not feel that attending was helpful (e.g., the topics were too personal, they felt others were judging them, or felt others had talked about them outside of the group).

Figure 3.23. Negative Feedback about Attending Parents Anonymous® Groups: Reported at Lease Once by Parents in their First, Second or Third Interview (n=206)*



*Respondents could indicate more than one response.

About 7% (14) of participants felt that Parents Anonymous® groups were ineffective. The "ineffective" response included parents who thought the group was not helpful to them, usually for a specific reason such as they needed more objective information or they were not sure what the purpose of the group was. About 9% (18) of group participants indicated that they could not relate with other group members. The "can't relate" response included parents who felt they felt alienated from and could not relate to the other parents because, for instance, the other parents had older children than they did, the other parents were mostly ordered by a court to attend Parents Anonymous®, or the other parents were too interested in drug issues.

About 19% (39) of participants had some issues with the other parents in their group. For instance, the "other parents" response included complaints about the topics of discussion that group members would bring up, how long they took to express themselves, their approach to

parenting, the quality of their advice (e.g., too broad, too harsh, etc.), or their general attitude (e.g., unfriendly, judgmental, late arriving, etc.).

About 5% (11) of group members indicated, at least once, that they disliked the Group Facilitator. The "facilitator" response included complaints about the Group Facilitator. For instance, Group Facilitators were not able to effectively organize and hold meetings, provide relevant topics of discussion or control the flow and pace of group meetings.

About 4% (9) of participants reported, at least once, that they disliked their groups' facilities. The "facility" response included parents who commented that they did not like something about the facility or the Parents Anonymous® process, such as inadequate childcare, no food offered, or the meeting space was too small. About 13% (27) of participants reported that they disliked the group's size. The "size of group" response included complaints about group meetings being either too crowded to focus and allow for everyone to be heard or too small to facilitate a good discussion.

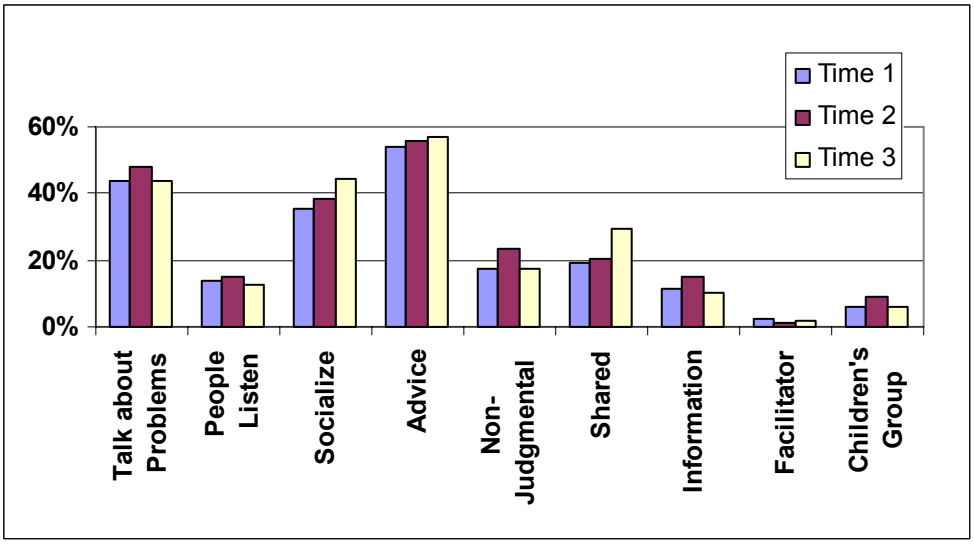
About 5% (10) of participants disliked their group because of transportation issues. The "transportation issues" response included complaints about the meeting location, and how parents had difficulties attending meetings, either because the parent no longer had the means of transportation because they moved, or because the location was too distant. About 17% (35) of parents reported, at least once, that they disliked their group's schedule. The "schedule" response included complaints about the time that meetings were held. For instance, the day and time were inconvenient, the meetings were not held often enough, or there were not enough groups in the area.

About 44% (90) of participants reported, at all three interviews, that there was nothing for them to dislike about their group. These parents could not think of any areas where they felt that Parents Anonymous® provided unsatisfactory services.

Changes in Positive Feedback About Parents Anonymous® Over Time. In a number of areas, participants' feedback about Parents Anonymous® changed as they continued to attend more meetings (see Fig. 3.24). (All of these changes over time were assessed for statistical significance using t-tests; significant findings of $p<.05$ are indicated where appropriate.)

The percentage of participants who indicated that they like to attend Parents Anonymous® so that they can talk about their problems changed from 44% (90) at Interview 1, to 48% (98) at Interview 2, and back to 44% (90) at Interview 3. The percentage of participants who indicated that they like to attend Parents Anonymous® because other parents listen to their problems changed from 14% (29) at Interview 1, to 15% (31) at Interview 2, and down to 13% (26) at Interview 3.

Figure 3.24. Changes in Positive Feedback of Parents Anonymous® Over the Three Interviews (n=206)*



*Respondents could indicate more than one response.

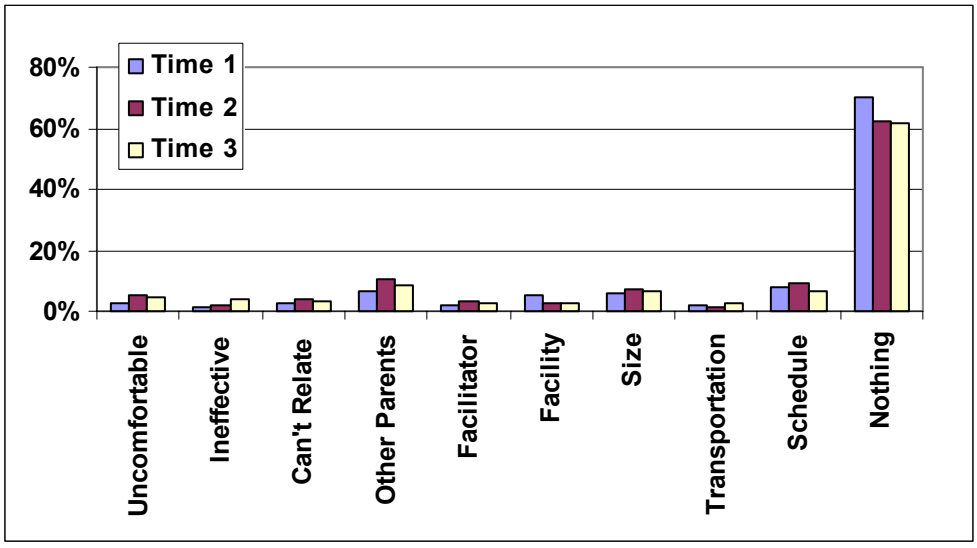
The percentage of participants who indicated that they like to attend Parents Anonymous® so that they can socialize with other parents changed from 35% (73) at Interview 1, to 38% (79) at Interview 2, and to 44% (91) at Interview 3. The percentage of participants who indicated that they like to attend Parents Anonymous® so that they could problem solve with other parents changed from 54% (111) at Interview 1, to 56% (118) at Interview 2, and to 57% (117) at Interview 3.

The percentage of participants who indicated that they like to attend Parents Anonymous® because other parents are non-judgmental changed from 18% (36) at Interview 1, to 23% (48) at Interview 2, and back to 18% (36) at Interview 3. The percentage of participants who indicated that they like to attend Parents Anonymous® because of a shared sense of purpose changed from 19% (40) at Interview 1, to 20% (42) at Interview 2, and to 30% (61) at Interview 3. The percentage of parents endorsing this item was statistically greater at the third interview compared to the first interview ($t=2.49$, $df=205$, $p=.014$). The percentage of participants who indicated that they like to attend Parents Anonymous® because of the information provided changed from 11% (23) at Interview 1, to 15% (31) at Interview 2, and down to 10% (21) at Interview 3. The percentage of participants who indicated that they like to attend Parents Anonymous® because of its children's group changed from 6% (13) at Interview 1, to 9% (42) at Interview 2, and back to 6% (12) at Interview 3.

Changes in Negative Feedback About Parents Anonymous® Over Time. The percentage of participants who indicated that they disliked attending Parents Anonymous® meetings because they felt uncomfortable changed from 3% (6) at Interview 1, to 5% (11) at Interview 2, and back down to 4% (9) at Interview 3 (see Fig. 3.25). The percentage of

participants who indicated that they disliked attending Parents Anonymous® meetings because they are ineffective changed from 2% (3) at Interview 1 and Interview 2 (4), to 4% (8) at Interview 3. The percentage of participants who indicated that they disliked attending Parents Anonymous® meetings because they could not relate with other parents changed from 3% (6) at Interview 1, to 4% (8) at Interview 2, and back down to 3% (7) at Interview 3.

Figure 3.25. Changes in Negative Feedback of Parents Anonymous® Over the Three Interviews (n=206)*



*Respondents could indicate more than one response.

The percentage of participants who indicated that they disliked attending Parents Anonymous® meetings because they did not like the other parents changed from 7% (14) at Interview 1, to 10% (21) at Interview 2, and down to 9% (18) at Interview 3. The percentage of participants who indicated that they disliked attending Parents Anonymous® meetings because they did not like the Group Facilitator changed from 2% (4) at Interview 1, to 3% (7) at Interview 2, and back down to 2% (5) at Interview 3.

The percentage of participants who indicated that they disliked attending Parents Anonymous® meetings because of the group's facility (the site and/or meeting space) changed

from 1% (1) at Interview 1, to 2% (5) at Interview 2 and Interview 3. The percentage of participants who indicated that they disliked attending Parents Anonymous® meetings because of the group size changed from 6% (12) at Interview 1, to 7% (15) at Interview 2 and Interview 3 (14). The percentage of participants who indicated that they disliked attending Parents Anonymous® meetings because of transportation issues changed from 2% (4) at Interview 1, to 1% (2) at Interview 2, and to 3% (6) at Interview 3. The percentage of participants who indicated that they disliked attending Parents Anonymous® meetings because of the group's schedule or meeting times changed from 8% (16) at Interview 1, to 9% (19) at Interview 2, and down to 7% (14) at Interview 3.

The percentage of participants who indicated that there was nothing to dislike about Parents Anonymous® meetings changed from 70% (145) at Interview 1, to 62% (126) at Interview 2 and Interview 3 61% (127). There was a statistically significant difference between the first and third interview ($t=-2.58$, $df=205$, $p=.011$).

IV. DATA ANALYSIS FOR RESEARCH QUESTIONS

Reported as a series of Findings, this section addresses the original research questions from the study proposal:

1. Do people who participate in Parents Anonymous® groups improve their parenting behaviors and/or reduce the amount or severity of child maltreatment? (See Finding 1.)

2. Are there differences in child maltreatment outcomes among different types of participants? (Finding 3.)

3. Is Parents Anonymous® able to reduce the potential risk factors for child maltreatment (e.g., isolation, normative acceptance of abuse)? (Finding 2.)

4. Is Parents Anonymous® able to increase the potential protective factors thought to influence child maltreatment (e.g., supportive relationships, positive discipline methods, knowledge of child development)? (Finding 2.)

5. For which types of parents is Parents Anonymous® more effective at reducing risk factors and enhancing protective factors? (Finding 3.)

6. How do characteristics of the group or process impact risk and protective factors? (Finding 5 and 6.)

7. How do characteristics of the group or process influence child maltreatment outcomes? (Finding 4.)

8. What characteristics distinguish parents who continue to participate and those that do not? (Finding 7 through 9.)

The analyses in this section included only those parents who continued attending Parents Anonymous® meetings through the six-month study period (n=188). The single exception is the analysis of those parents who continued and those who stopped attending meetings (Findings 7-9), which includes the full study sample of N=206.

Much of this section discusses change in study measures over time. "Short term" is the one month between the first and second interview. "Long term" is the six months between the

first and third interview. Much of the analysis is based on the parent characteristics listed in Table 3.1.

In order to answer the research questions using the most reliable methods, this section emphasizes statistically significant ($p<.05$) findings, though non-statistically significant trends are also reported. The appendix at the end of the report, including Appendix Tables A-1, A-2 and A-3, gives all the related statistics including means and standard deviations for all scales at each interview and the possible range of each scale score. The appendix text parallels the text in this section but includes all t-test statistics. For clarity, methodological considerations as they relate to each set of analyses and findings are included in this section, some of which are redundant with the methods section above. Finally, Chapter 6 below includes discussion and interpretation of these findings.

Table 3.1. Parent Characteristics: Background Variables Used in the Analysis

	TOTAL		Continuing Parents		Drop-outs	
	N=206		n=188		n=18	
	%	(n)	%	(n)	%	(n)
Gender						
Female	91%	(187)	90%	(169)	100%	(18)
Male	9%	(19)	10%	(19)	0%	(0)
Race						
African American	48%	(99)	49%	(92)	39%	(7)
White	42%	(86)	42%	(79)	39%	(7)
Other	10%	(21)	9%	(17)	22%	(4)
Education						
Less than HS	21%	(43)	23%	(43)	0%	(0)
Graduated HS	79%	(158)	77%	(142)	100%	(16)
Income						
Less than $13,000 per year	48%	(94)	49%	(88)	35%	(6)
$13,000 or more per year	52%	(103)	51%	(92)	65%	(11)
Child with special needs (1 or more)						
No	50%	(103)	49%	(92)	61%	(11)
Yes	50%	(103)	51%	(96)	39%	(7)
Caretakers in the household						
No other caretakers	50%	(103)	51%	(95)	44%	(8)
Other Caretakers	50%	(103)	50%	(93)	56%	(10)
Physical or mental illness history						
No	51%	(105)	51%	(96)	50%	(9)
Yes	49%	(101)	49%	(92)	50%	(9)
Alcohol or drug abuse history						
No	82%	(169)	80%	(152)	94%	(17)
Yes	18%	(37)	19%	(36)	6%	(1)
Help-seeking behavior for parenting						
No	28%	(58)	29%	(54)	22%	(4)
Yes	72%	(148)	71%	(134)	78%	(14)
History of CPS Allegations						
No	73%	(150)	73%	(137)	72%	(13)
Yes	27%	(56)	27%	(51)	28%	(5)
Mandated attendance						
No	85%	(171)	85%	(156)	83%	(15)
Yes	15%	(30)	15%	(27)	17%	(3)

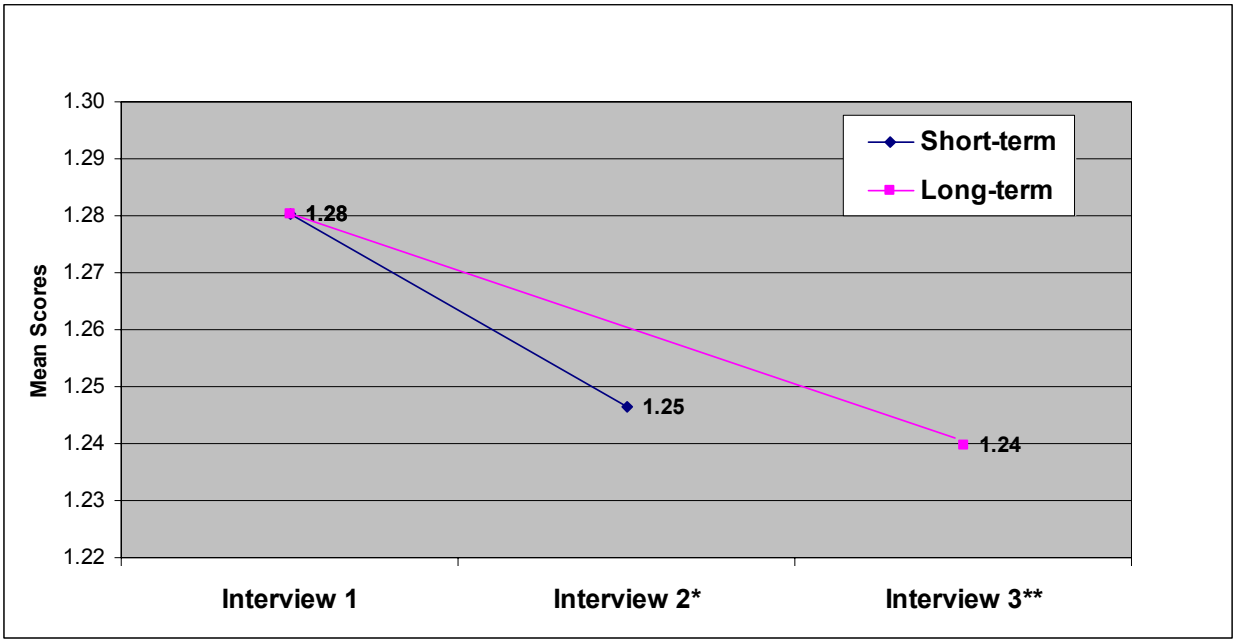
Pairs may not add to 100% due to rounding.

Finding 1. Overall, parents who participated in Parents Anonymous® indicated a reduction in child maltreatment outcomes in both the short and long term.

When analyzing all the parents as a single group (n=188), statistically significant change was found on three of the four child maltreatment outcomes (see Figures 3.26, 3.27, 3.28 and Table 3.2). In both the short and long term, parents reduced their parenting distress, their parenting rigidity, and their use of psychological aggression toward their children.

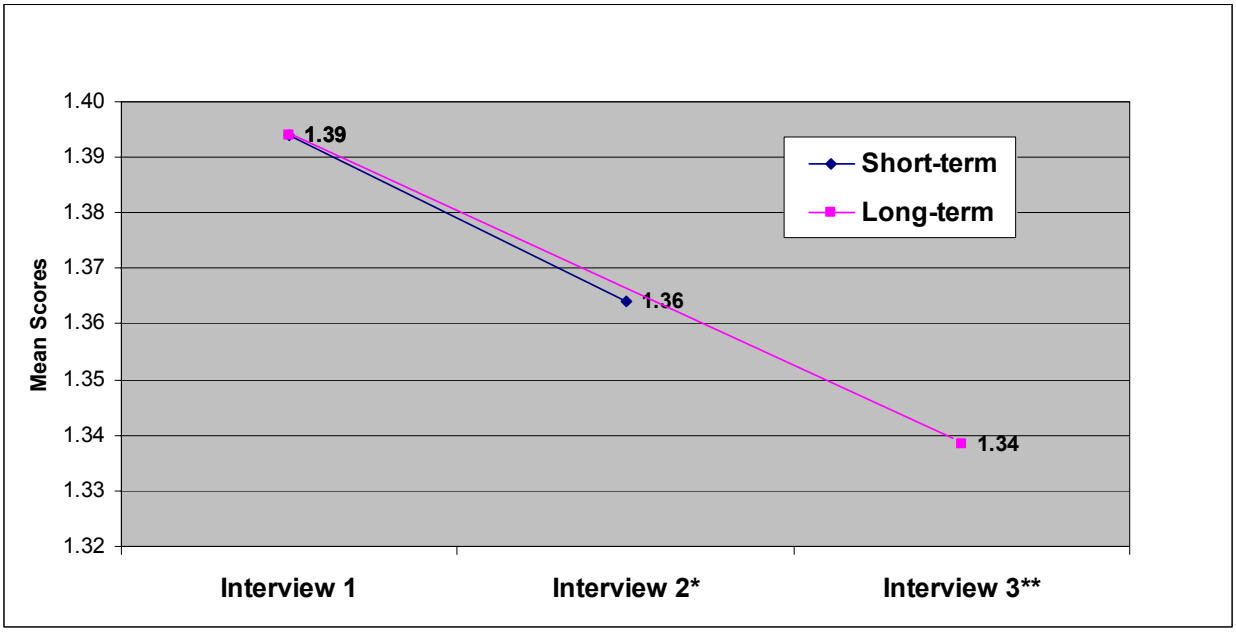
Overall, there was no evidence of statistically significant change on the use of physical aggression in either the short or long term, though the trend was for parents to report less physical aggression over time (see Figure 3.29). T-tests run to assess change in physical aggression over time for *only* those parents who, at the first interview, reported using physical aggression at least "once a month or less" (as opposed to "never") found statistically significant improvement in both the short and long term.

Figure 3.26. Parenting Distress Change Over Time (n=188)



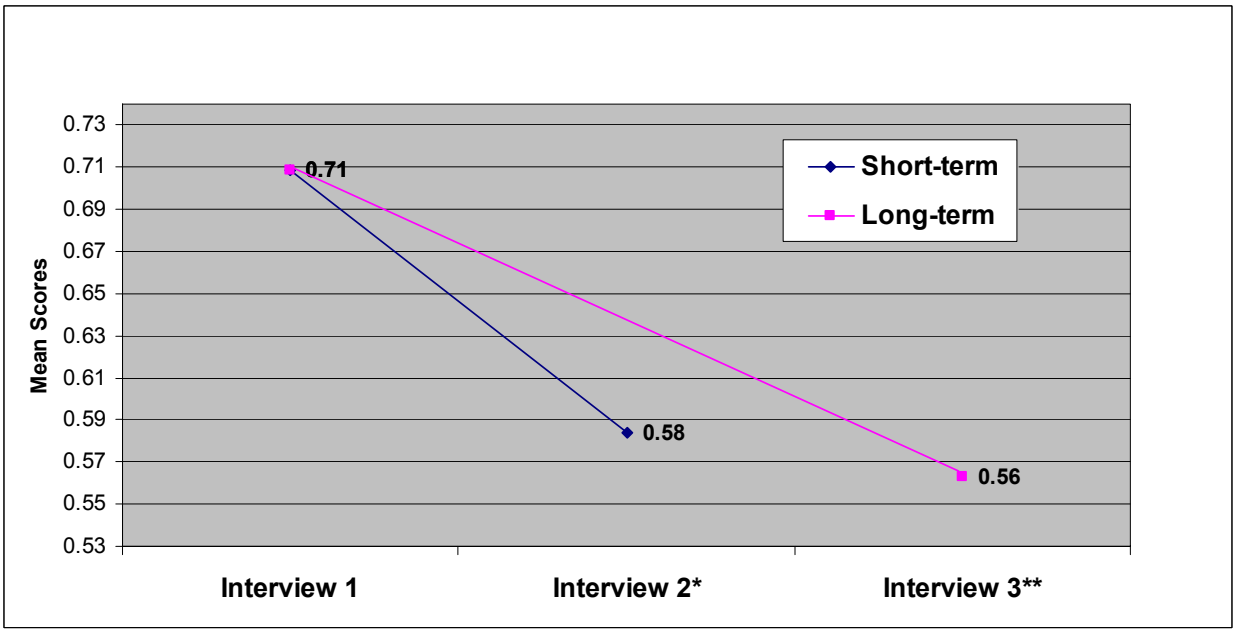
* Short-term change Interview 1 to Interview 2 (t=3.41, df=187, p=.001)
**Long-term change Interview 1 to Interview 3 (t=2.86, df=187, p=.005)

Figure 3.27. Parenting Rigidity Change Over Time (n=188)



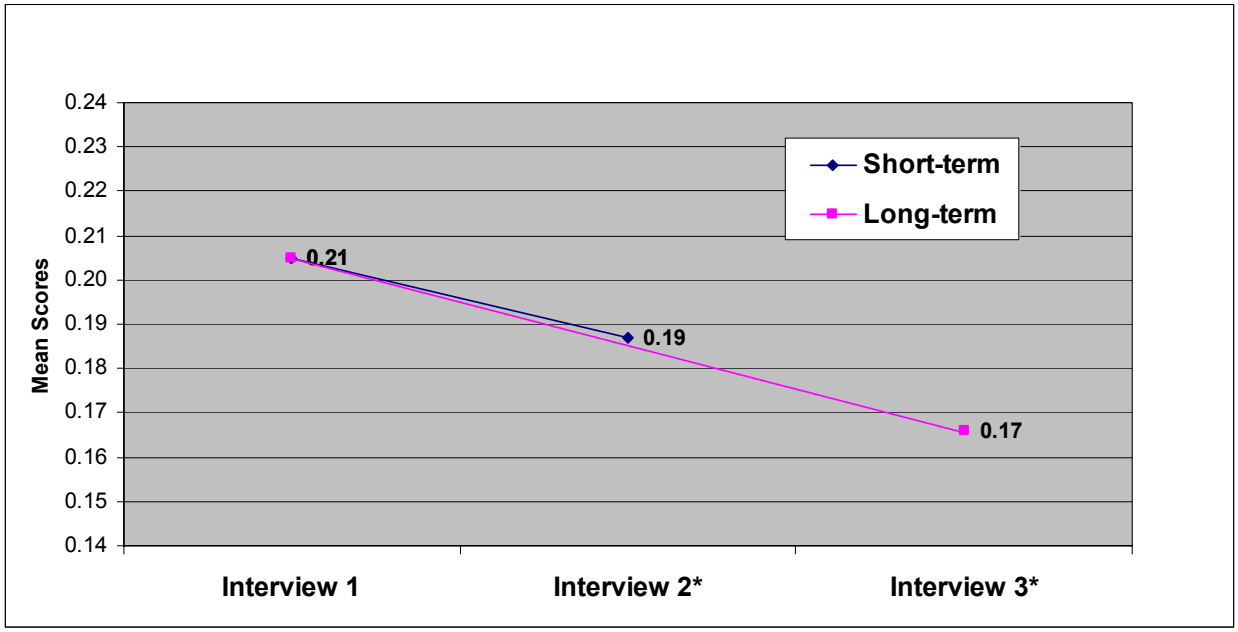
* Short-term (t=2.54, df=187, p=.012)
**Long-term (t=4.27, df=187, p=.000)

Figure 3.28. Psychological Aggression Change Over Time (n=188)



* Short-term (t=2.82, df=186, p=.005)
**Long-term (t=3.31, df=184, p=.001)

Figure 3.29. Physical Aggression Change Over Time (n=188)



* No statistically significant change.

CPS Allegations. A fifth measure of child maltreatment outcomes was CPS allegations. Forty-eight (23%) parents indicated having a CPS allegation against them anytime prior to the first interview. Overall, for parents who reported any CPS contact, the charges were substantiated for 21% (10), dropped for 72% (34), and still pending at the time of interview for 6% (3).

Eight parents reported a CPS allegation against them specifically in the month prior to the first interview, five for neglect and three for physical abuse. Of these eight, two were still pending and all but one of the rest were dropped. One neglect charge—for leaving the child alone—was upheld with the father placed on probation and asked to attend parenting classes.

Three parents reported having a CPS allegation against them in the month prior to the second interview. Two of these involved neglect—in one case the children had head lice—and both were eventually dropped. The third case self-reported herself for being neglectful and

emotionally abusive to the children due to stress; the charge was substantiated and the mother received help with her children once a week and had to periodically report to her caseworker.

Five parents reported having a CPS allegation against them in the month prior to the third interview. Two of these involved neglect and were deemed unsubstantiated. The other three allegations were for physical abuse: one case, directed at the interviewee's fiancé, was eventually dropped; the outcome of one case was still pending; and the last case, for striking her 11-year-old's bottom, was substantiated with the mother asked to attend a parenting class.

There were too few parents reporting CPS involvement—especially with substantiated allegations—during the course of the study to justify using CPS allegations as an outcome variable or to reliably interpret trends. Besides small sample size, another factor prohibiting analysis was that all CPS information was self-reported by participants and participants seemed unsure of the nature or outcome of their cases in many instances. (CPS allegations prior to the first interview were used as predictor variables in certain analyses.)

Finding 2. Overall, parents who participated in Parents Anonymous® indicated an increase in one protective factor and a reduction in four risk factors.

Risk factors. In the short-term, parents overall indicated a statistically significant reduction in life stress and alcohol use. In the long term, parents overall indicated a statistically significant reduction in their life stress, emotional violence between intimate partners, drug use, and alcohol use. (See Table 3.2.)

There was no evidence of statistically significant change for parental stress when all parents were analyzed together though the trend was for parents to report less parental stress in both the short and long term. T-tests run to assess change in parental stress for *only* those parents

who, at the first interview, scored in the highest 25% of parental stress scores found statistically significant improvement in both the short and long term.

There was no evidence of statistically significant short-term change for intimate partner emotional violence when all parents were analyzed together though the trend was for parents to report a reduction in the short term. T-tests run to assess short-term change in this scale for *only* those parents who, at the first interview, scored in the highest 25% of intimate partner emotional violence scores found statistically significant improvement.

There was no evidence of statistically significant change for intimate partner physical violence when all parents were analyzed together though the trend was for parents to report a reduction over both the short and long terms. T-tests run to assess change in this scale for *only* those parents who, at the first interview, scored in the highest 25% of intimate partner physical violence scores found statistically significant improvement in both the short and the long term.

There was no evidence of statistically significant short-term change for drug abuse when all parents were analyzed together though the trend was for parents to report a reduction in drug use. T-tests run to assess short-term change in this scale for *only* those parents who, at the first interview, scored in the highest 25% of drug use scores found statistically significant improvement.

Protective factors. In the short term, parents indicated a statistically significant increase in their quality of life. (See Table 3.2.) There was no evidence of statistically significant long-term change for quality of life when all parents were analyzed together though the trend was for parents to report improvement. T-tests run to assess change in this scale for *only* those parents who, at the first interview, scored in the lowest 25% of quality of life scores found statistically significant improvement.

There was no evidence of change for statistically significant emotional and instrumental social support when all parents were analyzed together though the trend was for parents to report increases. T-tests run to assess change in this scale for *only* those parents who, at the first interview, scored in the lowest 25% of emotional and instrumental social support scores found statistically significant improvement in both the short and long term.

It should be noted that parents overall indicated a long-term increase in general social support that was approaching significance (p=.056) and the trend was for parents to report increases in both the short and long term. Also, t-tests run to assess change in this scale for *only* those parents who, at the first interview, scored in the lowest 25% of general social support scores found statistically significant improvement in both the short and long term.

There was no evidence of statistically significant change for parenting sense of competence when all parents were analyzed together. The trend was for parents to report a reduction in such competence over time. However, t-tests run to assess change in this scale for *only* those parents who, at the first interview, scored in the lowest 25% of parenting sense of competence scores found statistically significant improvement in both the short and long term.

Parents indicated a statistically significant short-term reduction in the use of nonviolent parenting tactics; the trend was for parents to report a smaller (not statistically significant) decrease in the long term. T-tests run to assess change in non-violent discipline tactics for *only* those parents who, at the first interview, scored in the lowest 25% of that scale found statistically significant improvement in both the short and long term.

There was no evidence of statistically significant change for family functioning when all parents were analyzed together. However, t-tests run to assess change in this scale for *only* those

parents who, at the first interview, scored in the lowest 25% of family functioning scores found statistically significant improvement in both the short and long term.

Table 3.2. Significant (p<.05) Short-Term and Long-Term Improvement (n=188)

	Improvement	
	Short Term	**Long Term**
Child Maltreatment Outcomes		
Parenting Distress	Yes	Yes
Parenting Rigidity	Yes	Yes
Psychological Aggression	Yes	Yes
Physical Aggression		
Risk Factors		
Life Stress	Yes	Yes
Parental Stress		
Domestic Violence – Emotional		Yes
Domestic Violence – Physical		
Alcohol Abuse	Yes	Yes
Drug Abuse		Yes
Protective Factors		
Quality of Life	Yes	
Social Support – Emot & Instrum		
Social Support – General		
Parenting Sense of Competence		
Nonviolent Discipline Tactics	*	
Family Functioning		

Blanks indicate no statistically significant change (p<.05).
*Significant reduction in nonviolent tactics (p<.05).

Finding 3. Parents Anonymous® does not impact all parents in the same way, but seems to be more effective at reducing child maltreatment factors, reducing risk factors, and enhancing protective factors in some types of parents more than other types.

The next step of the analysis was to assess whether patterns of change in child maltreatment outcomes (parenting stress, parenting rigidity, and psychological aggression) and in risk and protective factors were consistent across all parents in the study. *Does Parents Anonymous® impact all parents in the same way? Which types of parents experienced which types of change?*

Methodology. Parents were classified according to background information collected in the first interview, such as demographic variables, history of CPS contact, help seeking behavior, health history, etc. These background variables were all coded as binary so that every parent fell into one of two categories for each variable, for instance, male or female for gender and high school graduate or non-graduate for education (see Table 3.1 above). The sample used for this analysis was n=188; however, on certain characteristics not all participants gave responses. Tables 3.3a and 3.3b show all statistically significant findings and the sample size for each parent characteristic. Tables A-2, A-3 and A-4 in the appendix show the mean and standard deviations for each analysis. These tables can also be used to assess non-statistically significant trends.

Baseline differences. First, baseline differences at the start of the study (first interview) between parents in each of the two categories of the background variables are reported in order to assess whether different types of parents were statistically different on study measures at the onset of the study. Such differences might indicate a greater or lesser need in certain areas as

well as a greater or lesser likelihood of improvement. This part of the analysis used t-tests, in this case comparing the change in scale scores for one category of each background variable to its counterpart, that is, men were compared to women, graduates to nongraduates, etc.

Maltreatment outcomes and risk and protective factors. Second, the two categories for each background variable were analyzed separately in order to assess whether one or the other, or both, categories showed significant change over time on each study measure. In this part of the analysis, t-tests were used to compare scale scores from each interview in order to determine if statistically significant ($p<.05$) change occurred between the first and second interview (short term) and between the first and third interview (long term).

Note that there was no evidence of statistically significant change on the use of physical aggression in either the short or long term for any of the parent characteristics.

Gender

Baseline differences between men and women. At the start of the study, men and women showed statistically significant difference on only one measure: men on average indicated more general social support than women.

Maltreatment outcomes. The one indication of change in maltreatment outcomes for men was in their use of psychological aggression towards their children, which decreased in the short term; that change was not significant in the long term. On the other hand, women showed significant change in both the short and long term on three child maltreatment outcomes: psychological aggression towards their children, parenting distress and parenting rigidity.

Risk factors. Men indicated decreased life stress in the short term and decreased drug use in the long term. Women indicated short- and long-term decreases in life stress and alcohol

use. Women also indicated decreases in emotional domestic violence and drug use in the long term.

Protective factors. Both men and women indicated a decrease in the use of nonviolent discipline tactics in the short term. There was no further evidence of change for men, while women also indicated short- and long term increase in quality of life and general social support.

Table 3.3a. Significant Change (p<.05) on Study Measures by Background Characteristics (n=188)

	Gender		Race			Education		Income		Special Needs Child	
	Female	Male	African American	White	Other	Less than HS	Graduate HS	Low income	High income	Yes	No
N	169	19	92	79	17	43	142	88	92	96	92
	S= Short Term L=Long Term S L= Short & Long Term										
*MALTREATMENT OUTCOMES***											
Parenting Distress	S L		S	L			S L		S L	S L	S L
Parenting Rigidity	S L		L		L	L	S L	L	S L	S L	L
Psychological Aggression	S L	S		S L			S L	S	S L	L	S L
Physical Aggression											
RISK FACTORS											
Parental Stress											
Life Stress	S L	S	S L	S L			S L	S L	S L	S L	S
Domestic Violence - Emotional	L			S L					L		
Domestic Violence - Physical								S			S
Alcohol Screen	S L		L						L		L
Drug Screen	L	L	S L				L		L		S L
PROTECTIVE FACTORS											
Quality of Life	S L			L			S				
Social Support - Emotional & Instrum											L
Social Support - General	S L		L		L		L				
Parenting Sense of Competence			(S)								
Nonviolent Discipline Tactics**	(S)	(S)					(S)	(S)		(S)	
Family Functioning											
Count of scales with short term improvement	*7*	*2*	*3*	*3*	*0*	*0*	*5*	*3*	*4*	*3*	*5*
Count of scales with long term improvement	*9*	*1*	*5*	*5*	*2*	*1*	*6*	*2*	*7*	*4*	*6*
Total scales with any improvement	***9***	***3***	***6***	***5***	***2***	***1***	***7***	***4***	***7***	***4***	***8***

*All significant change (p<.05) listed was "improvement" on the given scale except those in parentheses indicated a significant "worsening."

**See Chapter 6 for a discussion of the interpretation of change over time on Nonviolent Discipline Tactics.

Table 3.3b. Significant Change (p<.05) on Study Measures by Background Characteristics (n=188)

	Other caregivers in the household		Physical or mental illness history		Alcohol or drug abuse history		Help-seeking behavior for parenting		History of CPS Allegations		Mandated attendance	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
N	93	95	92	96	36	152	134	54	51	137	27	156
	S= Short Term L=Long Term S L= Short & Long Term											
*MALTREATMENT OUTCOMES***												
Parenting Distress	L	S	S L			S L	S L	S L	S	S L		S L
Parenting Rigidity	S L		S L	L		S L	L	L		S L		S L
Psychological Aggression	L	S	S L			S L	S L		S L		S L	S L
Physical Aggression												
RISK FACTORS												
Parental Stress	L								L			
Life Stress	S	S L	S L	S L		S L	S	S L	S	S L	S	S L
Domestic Violence - Emotional		L		S		L		L	S			L
Domestic Violence - Physical							S					
Alcohol Screen	L			L	L	S	L	S	S L			S L
Drug Screen	L			S L	S L		S L	L		L		L
PROTECTIVE FACTORS												
Quality of Life	L	S				S			S			
Social Support - Emotional & Instrum.												
Social Support - General	L					S	S			L		
Parenting Sense of Competence				(S)						(S)		
Nonviolent Discipline Tactics**		(S)		(S)		(S)	(S)			(S)		(S)
Family Functioning	(L)			(L)		(L)		(L)		(L)		(L)
Count of scales with short term improvement	*2*	*4*	*4*	*3*	*1*	*7*	*6*	*3*	*6*	*3*	*2*	*5*
Count of scales with long term improvement	*8*	*2*	*4*	*4*	*2*	*5*	*5*	*5*	*3*	*5*	*1*	*7*
Total scales with any improvement	***9***	***5***	***4***	***5***	***2***	***8***	***8***	***6***	***7***	***5***	***2***	***7***

*All significant change (p<.05) listed was "improvement" on the given scale except those in parentheses indicated a significant "worsening."
**See Chapter 6 for a discussion of the interpretation of change over time on Nonviolent Discipline Tactics.

Race

Baseline differences between races. At the start of the study, various group differences were found between the three ethnic categories. Each group was compared to the other ethnic groups, that is, African Americans were compared to all non-African Americans, whites were compared to all non-whites, and parents in the Other category were compared to African Americans and whites.

African Americans indicated more parenting rigidity but less parenting distress than non-African Americans. They also reported more issues with drugs. Conversely, African Americans indicated higher quality of life, less life stresses, less parenting stress, less emotional domestic violence, more emotional or instrumental social support, higher sense of parenting competence, and higher family functioning than non-African Americans. It should be noted that African Americans indicated more use of physical aggression in parenting than non-African Americans, with the difference approaching significance ($p=.058$).

Parents in the Other race category indicated less emotional and instrumental social support as well as less problems with drugs than parents in the other ethnic groups.

At the start of the study, whites indicated more parenting distress, but less parenting rigidity than non-whites. There was no evidence that whites were different from non-whites on aggressive discipline tactics. Compared to non-whites, whites reported lower quality of life, more parenting stress, less parenting sense of competence, more emotional domestic violence and lower family. Whites also indicated fewer problems with drugs than non-whites.

Maltreatment outcomes. African Americans decreased their parenting distress in the short term and their parenting rigidity in the long term, but showed no change on their use of aggressive tactics. Whites improved in both the short and long term on psychological aggression and in the long term on parenting distress, but showed no change in parenting rigidity. The Other race category improved only on parenting rigidity in the long term. It should be noted that decrease in parenting rigidity for the Other group was approaching significance in the short term ($p<.051$).

Risk factors. African Americans and Whites both showed patterns of change on risk factors. African Americans indicated a decrease in alcohol use in the long term and short- and long-term decreases in life stresses and drug use. Whites indicated short- and long-term decreases in life stresses and emotional domestic. There was no evidence of short- or long-term change in risk factors for parents in the Other race category.

Protective factors. Each ethnic category showed limited long-term change in protective factors, but no improvement in the short term. African Americans indicated a short-term reduction in parenting sense of competence. Whites indicated an increase in quality of life in the long term. An increase was found in long-term general social support for African Americans and the Other category.

African Americans also indicated *decreased* parenting sense of competence in the short term, but an increase in general social support in the long term. It should be noted that in the short term African Americans showed increase approaching significance in general social support ($p=.059$) and decreases approaching significance in parenting sense of competence ($p=.054$) and nonviolent discipline tactics ($p=.053$).

Education

Baseline differences between high school graduates and nongraduates. At the start of the study, parents who had not graduated from high school indicated more parenting rigidity than those who had graduated.

Maltreatment outcomes. Non-graduates showed no short term change, but decreased their parenting rigidity in the long term. Graduates indicated short- and long-term decreases in three measures: use of psychological aggression, parenting distress and parenting rigidity.

Risk factors. There was no evidence of short- or long-term change on risk factors for parents who did not graduate from high school. Parents who did graduate from high school indicated a decrease in drug use in the long term and a decrease in life stresses in the short and long term. It should be noted that graduates indicated short- and long-term decreases approaching significance in problems with alcohol (p=.059 and p=.052).

Protective factors. There was no evidence of short- or long-term change on protective factors for parents who had not graduated from high school. On the other hand, high school graduates indicated an increase in their quality of life in the short term, a decrease in their use of nonviolent discipline tactics in the short term, and an increase in general social support in the long term.

. It should be noted that parents who had graduated from high school showed an increase approaching significance for quality of life (p=.051) and a decrease approaching significance in family functioning (p=.052) in the long term.

Income

Baseline differences between parents who earn more than $13,000 and those who earn less than $13,000. At the start of the study, parents who made less than $13,000 indicated more parenting rigidity and drug issues than parents who made $13,000 or over.

Maltreatment outcomes. Parents whose annual income was less than $13,000 decreased their use of psychological aggression in the short term and decreased their parenting rigidity in the long term.

Those who made more than $13,000 improved in the short and long term on parenting distress, parenting rigidity and psychological aggression.

Risk factors. Parents reporting annual income of less than $13,000 indicated decreases in life stresses in the short term and long term and in physical domestic violence in the short term.

Parents earning $13,000 or more indicated decreases in life stress in the short and long term. Parents earning $13,000 or more also indicated long-term decrease emotional domestic violence, alcohol use. It should be noted that parents earning more than $13,000 annually showed short-term decrease approaching significance in alcohol use (p=.058).

Protective factors. There was no evidence of short-term or long-term change in protective factors for parents reporting income of $13,000 or more. Parents reporting income of less than $13,000 indicated a short-term decrease in nonviolent parenting tactics.

Children with special needs

Baseline differences between parents with and without special needs children. At the start of the study, parents of children with special needs and those without were significantly different on several measures. Parents with at least one special needs child indicated more parenting distress, parenting rigidity, parenting stress, life stress, and emotional domestic violence. They also indicated lower quality of life, general social support, parenting sense of competence, and family functioning.

Maltreatment outcomes. Parents with at least one special needs child and parents without a special needs child indicated similar patterns of change in maltreatment outcomes. Parents with special needs children showed short- and long-term reduction in parenting distress and parenting rigidity and reduced their use of psychological aggression in the long term. Parents without any special needs children showed short- and long-term reduction in their psychological aggression and parenting distress. They also reduced their parenting rigidity in the long term.

Risk factors. Having or not having special needs children did not substantially differentiate parents with regard to change in risk factors, as both types of parents showed significant change. Parents who reported having at least one special needs child indicated decreased life stresses in the short and long term.

Parents who reported having no special needs children indicated decreased life stresses, physical domestic violence, and drug use in the short term. They indicated decreases in alcohol and drug use in the long term.

Protective factors. Having or not having special needs children did not substantially differentiate parents on change in protective factors. Parents with at least

one special needs child indicated decreased use of nonviolent discipline tactics in the short term, but showed no evidence of change on protective factors in the long term. It should be noted that parents with special needs children reported an increase approaching significance for quality of life in the short term (p=.058).

There was no evidence of short-term change in protective factors for parents who reported no special needs children. Parents with no special needs children indicated an increase in emotional and instrumental social support in the long term.

Other caregivers in the household

Baseline differences between parents with and without other caregivers. At the start of the study, parents who had other adults in their household who assisted with parenting duties indicated higher family functioning than parents without other caregivers at home.

Maltreatment outcomes. Parents who had at least one other adult in their household to help with parenting duties decreased their parenting rigidity in the short term and long term. They also showed long-term decrease in both their parenting distress and psychological aggression.

Parents who did not have another caregiver in the household improved in the short term on parenting distress and psychological aggression. They indicated no evidence of long-term change on child maltreatment outcomes.

Risk factors. Both parents with and without other adult caregivers at home were impacted on risk factors. Parents with no other adult caregivers in their household to help with parenting indicated a decrease in emotional domestic violence in the long term and a decrease in life stresses in the short and long term.

Parents with another adult caregiver in their household indicated a decrease in life stresses in the short term and long-term decreases in parental stress, drug use and alcohol use.

Protective factors. Parents with other adults at home to assist with parenting showed some long-term change in protective factors but no short-term change, while parents without such assistance showed the opposite, no long-term but some short-term change. Parents with no other adult caregivers in their household to help with parenting indicated a short-term increase in their quality of life and a short-term decrease in their use of nonviolent discipline tactics.

Parents who did have other adult caregivers in their household indicated long-term increases in quality of life and general social support, and a long-term decrease in family functioning.

Health history

Baseline differences between parents with and without histories of health problems. At the start of the study, parents with histories of physical or mental health issues indicated greater potential for child maltreatment compared to parents without prior health issues. Compared to parents who reported no prior mental or physical health problems, parents with prior health issues indicated higher parenting distress, psychological aggression, life stress, parenting stress, and emotional domestic violence. They also indicated lower quality of life, parenting sense of competence, and family functioning.

Maltreatment outcomes. Parents who reported a history of either mental health or physical health problems indicate short- and long-term reduction in parenting distress ,

parenting rigidity, and their use of psychological. Parents who reported no history of mental or physical health problems indicate a long-term decrease in parenting rigidity.

Risk factors. Parents who reported a history of mental or physical illness indicated decreases in life stresses in both the short and long term.

Parents who reported no history of illness indicated short- and long-term decreases in life stresses and drug use. They also indicated decreased emotional domestic violence in the short term and decreased alcohol use in the long term.

Protective factors. There was no evidence of short- or long-term change in protective factors for parents reporting a history of mental or physical illness. However, there was some change for parents without histories of illness. Parents who reported no history of illness indicated short-term decreases in the use of nonviolent discipline tactics. They also indicated decreases in their parenting sense of competence in the short term and their family functioning in the long term.

History of alcohol or drug problems

Baseline differences between parents with and without histories of alcohol or drug problems. At the start of the study, parents with histories of alcohol or drug issues indicated higher parenting rigidity and lower sense of competence in parenting than parents without abuse histories.

Maltreatment outcomes. Parents with a history of drug or alcohol abuse did not indicate change in maltreatment outcomes. There was no evidence of change in either time period on parenting distress, parenting rigidity or aggressive tactics for parents reporting prior alcohol or drug issues. Conversely, those who did not report alcohol or

drug issues showed short- and long-term reduction in their use of psychological aggression, parenting distress and rigidity.

Risk factors. Parents who reported a prior history of alcohol or drug abuse indicated a decrease in drug use in the short and long term and a decrease in alcohol use in the long term.

Parents who reported no prior history of substance abuse indicated a decrease in alcohol use in the short term, a decrease in emotional domestic violence in the long term and a decrease in life stresses in the short and long term. It should be noted that parents with no history of alcohol or drug abuse showed decrease approaching significance in emotional domestic violence in the short term ($p=.053$).

Protective factors. There was no evidence of short- or long-term change in protective factors for parents who reported prior histories of alcohol or drug abuse.

However, there was evidence of change for parents without substance abuse histories. In the short term, parents who reported no substance abuse history indicated increased quality of life, increased general social support, and decreased use of nonviolent discipline tactics. In the long term, parents who reported no substance abuse history indicated lowered family functioning.

Help seeking behavior

Baseline differences between parents who did and did not seek parenting help prior to Parents Anonymous®. At the start of the study, parents who had histories of help seeking behavior indicated greater issues with alcohol and drugs than those who had not sought help.

Maltreatment outcomes. Help-seeking behavior for parenting issues did not substantially differentiate these parents. Short- and long-term reduction in parenting distress was found for both parents who had and who had not sought formal help for their parenting issues prior to joining Parents Anonymous®. Both types of parents also showed reduction in their parenting rigidity in the long term. However, parents who had not sought help did not change their psychological aggression while parents who had sought help reduced their use of psychological aggression in both the short.

Risk factors. Parents who reported seeking help for parenting issues prior to attending Parents Anonymous® indicated short-term decreases in life stresses and physical domestic violence, long-term decrease in alcohol use, and short- and long-term decrease in drug use. Parents who reported not seeking help for parenting issues prior to attending Parents Anonymous® indicated decreased life stresses in the short and long term, decreased problems with alcohol in the short term, and decreased emotional domestic violence and drug use in the long term.

Protective factors. Parents who had sought help for their parenting issues indicated an increase in general social support and decreased use of nonviolent discipline tactics in the short term. There was no evidence of long-term change on protective factors for parents who had sought help.

There was no evidence of short-term improvement on protective factors for parents who reported they had never sought out formal help for their parenting issues before attending Parents Anonymous®. Those who had not sought help showed lowered family functioning in the long term.

History of CPS contact

Baseline differences between parents with and without a history of CPS contact. Compared to parents without CPS histories, parents reporting prior CPS contact indicated higher quality of life but they also indicated more parenting distress, psychological aggression, life stress, parenting stress and a lower sense of their parenting competence, and lower family functioning.

Maltreatment outcomes. Change was experienced by both those parents with and without a CPS history. Parents reporting prior CPS contact indicated reduced parenting distress in the short term and reduced use of psychological aggression in both the short and long term.

Those reporting no prior CPS contact indicated short- and long-term reduction in parenting distress and rigidity, but did not show any change in their aggressive tactics.

Risk factors. Parents with CPS histories showed a broader pattern of change on risk factors than those without CPS contact. Parents who reported prior contact with CPS indicated short-term decreases in life stresses, emotional domestic violence, and alcohol use. Parents reporting prior CPS contact also indicated decreases in parental stress and alcohol use in the long term. It should be noted that parents reporting prior CPS contact showed short-term decrease approaching significance on physical domestic violence ($p=.057$).

Parents who reported no prior contact with CPS indicated decreased drug use in the long term and life stresses in the short and long term.

Protective factors. Parents reporting prior contact with CPS indicated increase in their quality of life in the short term, but showed no other change in protective factors.

Parents reporting no prior history with CPS indicated decreased use of nonviolent discipline tactics in the short term and increased general social support in the long term. Parents with no prior CPS history also indicated decreased sense of parenting competence in the short term and decreased family functioning in the long term.

Mandated attendance

Baseline differences between parents mandated to attend Parents Anonymous® and those not mandated. Compared to parents attending Parents Anonymous® of their own accord, parents required to attend Parents Anonymous® indicated more parenting rigidity, lower sense of competence in parenting, and lower family functioning.

Maltreatment outcomes. Both parents required to attend Parents Anonymous® and those not required to attend showed improvement in maltreatment outcomes. The 27 parents required to attend Parents Anonymous® reduced their use of psychological aggression in both time periods but there was no evidence of change on parenting distress or rigidity. Parents not required to attend improved in the short and long term for psychological aggression, parenting distress and parenting rigidity.

Risk factors. Parents required to attend Parents Anonymous® indicated a decrease in life stresses in the short term. There was no evidence of long-term change in risk factors for parents required to attend. Parents not required to attend Parents Anonymous® indicated short- and long-term decreases in life stresses and problems with alcohol. Parents not required to attend also showed decreases in emotional domestic violence and drug use in the long term.

Protective factors. There was no evidence of short- or long-term change in protective factors for parents required to attend Parents Anonymous®. Parents not required to attend Parents Anonymous® indicated less use of nonviolent discipline tactics in the short term and *lower* family functioning in the long term. It should be noted that parents not required to attend Parents Anonymous® showed an increase approaching significance in quality of life in the short term (p=.051).

GROUP IMPLEMENTATION

Methodology. As described above, central to the Parents Anonymous® model are the notions of mutual support (parents exchanging advice and support with other parents) and shared leadership (parents demonstrating ownership of the group process by sharing leadership duties with the Group Facilitator). Group implementation level was calculated based on the shared leadership and mutual support scales administered in the Group Assessments. High implementation groups showed both high shared leadership and high mutual support. Middle implementation groups showed high shared leadership or mutual support but not both. Low implementation groups showed low shared leadership and low mutual support.

Parents' individual interview data was matched with the aggregate data from their group's Group Assessment; six parents were members of groups who did not complete the Group Assessment so they are not included in these analyses. T-tests measured change over time in all study measures for each level of implementation separately.

Finding 4. Parents in groups which had a higher level of implementation of the Parents Anonymous® model showed consistent pattern of change on child maltreatment outcomes.

Parents in groups at the high level of model implementation indicated a statistically significant reduction in parenting rigidity in the short term and long term and a long-term reduction in their use of both psychological aggression and physical aggression. (See Table 3.4.) Non-statistically significant trends for parents in the high implementation groups showed short- and long-term improvement for parenting distress and a short-term *increase* in psychological aggression towards children.

Parents from groups in the middle level of model implementation indicated statistically significant short- and long-term reduction in parenting distress and parenting rigidity. Non-statistically significant trends for parents in the middle implementation groups showed short- and long-term improvement for psychological and physical aggression towards children.

Parents in groups with the lowest level of implementation improved on only one measure; they indicated a statistically significant reduction in parenting distress in the short term. Non-statistically significant trends for parents in the low implementation groups showed short- and long-term improvement for psychological and physical aggression towards children, long-term improvement in parenting distress, and short-term improvement but long-term *worsening* of parenting rigidity.

Finding 5. Parents in each of the three levels of group implementation of the Parents Anonymous® model showed at least some change on risk factors. There was no clear differentiation between the levels.

Parents from groups in the high implementation category indicated a statistically significant reduction in alcohol use in the short term and in life stress in the long term. (See Table 3.4) Non-statistically significant trends for parents in high implementation groups showed short- and long-term improvement in all other risk factors with the exceptions of short-term parental stress and emotional violence between intimate partners which each rose somewhat.

Parents from middle implementation groups indicated a statistically significant reduction of drug problems in the long term, a reduction of intimate partner emotional violence in the short term, and a reduction in life stresses in both the short term and long term. Non-statistically significant trends for parents in the middle implementation groups showed short- and long-term improvement in all other risk factors.

Parents attending groups in the low implementation category indicated a statistically significant reduction in life stresses in the short term and a reduction of drug abuse problems in the long term. Non-statistically significant trends for parents in the low implementation groups showed short- and long-term improvement in all other risk factors.

Finding 6. Parents in groups which had the lowest level of implementation of the Parents Anonymous® model showed improvement on protective factors, while those in the middle and high implementation groups showed no change.

There was no evidence of statistically significant change in protective factors among parents from groups in the middle or high implementation category. (See Table 3.4.) (The long-term increase in quality of life for parents in middle implementation groups was approaching significance, p=.053.) Non-statistically significant trends for parents in the high implementation groups showed short- and long-term improvement in quality of life, emotional/instrumental social support and parenting sense of competence; reductions were found for general social support, nonviolent tactics and family functioning. Non-statistically significant trends for parents in the middle implementation groups showed short- and long-term improvement in quality of life, and general and emotional/instrumental social support; reductions were found for parenting sense of competence, nonviolent tactics and family functioning.

Parents from groups in the low implementation category indicated statistically significant change on three protective factors. They showed evidence of short-term increase in quality of life and a short-term and long-term increase in general social support. They also showed a statistically significant short-term *decrease* in nonviolent discipline tactics in the short term. Non-statistically significant trends for parents in the low implementation groups showed *worsening* in all other protective factors except for a short-term improvement in emotional/instrumental support.

Table 3.4. Significant Short and Long-Term Improvement in All Measures by Group Implementation (n=182)

	Group Implementation		
	Low	**Middle**	**High**
% (n)	24% (43)	67% (122)	9% (17)
	S= Short Term L=Long Term		
Child Maltreatment Outcomes			
Parenting Distress	S	S L	
Parenting Rigidity		S L	S L
Psychological Aggression			L
Physical Aggression			L
Risk Factors			
Parental Stress			
Life Stress	S	S L	L
Domestic Violence - Emotional		S	
Domestic Violence - Physical			
Alcohol Abuse			S
Drug Abuse	L	L	
Protective Factors			
Quality of Life	S		
Social Support – Emotional & Instrumental			
Social Support - General	S L		
Parenting Sense of Competence			
Nonviolent Tactics	**		
Family Functioning			

**Significant (p<.05) short-term reduction in nonviolent tactics.
Blanks indicate no statistically significant change.

CONTINUING PARENTS VS. PARENTS WHO DROPPED OUT

Of the total sample (N=206), 18 parents did not attend any meetings after the first interview (see Table 3.1 above). (These 18 parents were not included in the analysis except in this section.) This group of 18 parents had attended from 1 to 5 meetings prior to the first interview (mean=2.2, sd=1.34), a similar number of pre-study meetings as the rest of the sample. This group of n=18 and the continuing group of n=188 were analyzed and compared in a number of ways in order to answer the questions: *What characteristics distinguish parents who continue in Parents Anonymous® and those who do not.*

Finding 7. Parents who continued to attend meetings and those who stopped attending were not different on background characteristics or on any study measures at the start of the study.

Chi-squares showed no evidence of any differences on background characteristics between parents who continued to attend Parents Anonymous® meetings and those who did not attend any meetings between the first and last interview.

Also, t-tests showed no evidence of differences between parents who continued attending and those who did not on first interview scores on any of the sixteen study measures (four child maltreatment outcomes and twelve risk and protective factors).

Finding 8. Parents who continued to attend showed improvement on a far greater number of measures than those who stopped attending.

Of the total of sixteen measures, parents who did not attend meetings after the first interview indicated significant change on just one measure in the short term (a reduction in life stresses) and on no measures in the long term. In contrast, the group

who continued indicated significant improvement on a total of eight measures: six measures in the short term and seven measures in the long term.

Finding 9. Though not statistically significant, it appeared that those who continued to attend meetings reported a more positive attitude towards Parents Anonymous® than those who stopped attending.

The sample size for these items was too small to justify statistical comparison of the continuing and dropout groups on their attitude about their experience with Parents Anonymous®. However, as shown in Figures 3.29 and 3.30, the 188 parents who continued to attend reported more positive and less negative feedback than those who dropped out. The group who continued attending endorsed nearly every category of positive feedback more often than those who stopped attending, especially for talking about one's own issue, having someone to listen, and sharing a sense of purpose with the group. The factor those who discontinued liked the most about Parents Anonymous®—and was endorsed 13% more often by those who did not continue versus those who did—was socializing.

Similarly, the group who stopped attending endorsed nearly every category of negative feedback more often than those who continued, especially for feeling too uncomfortable to share in meetings, problems with the Group Facilitator, and feeling Parents Anonymous® was ineffective.

Figure 3.30. Positive Feedback of Parents Who Continued in Parents Anonymous® and Parents Who Stopped Attending at First Interview (N=206)

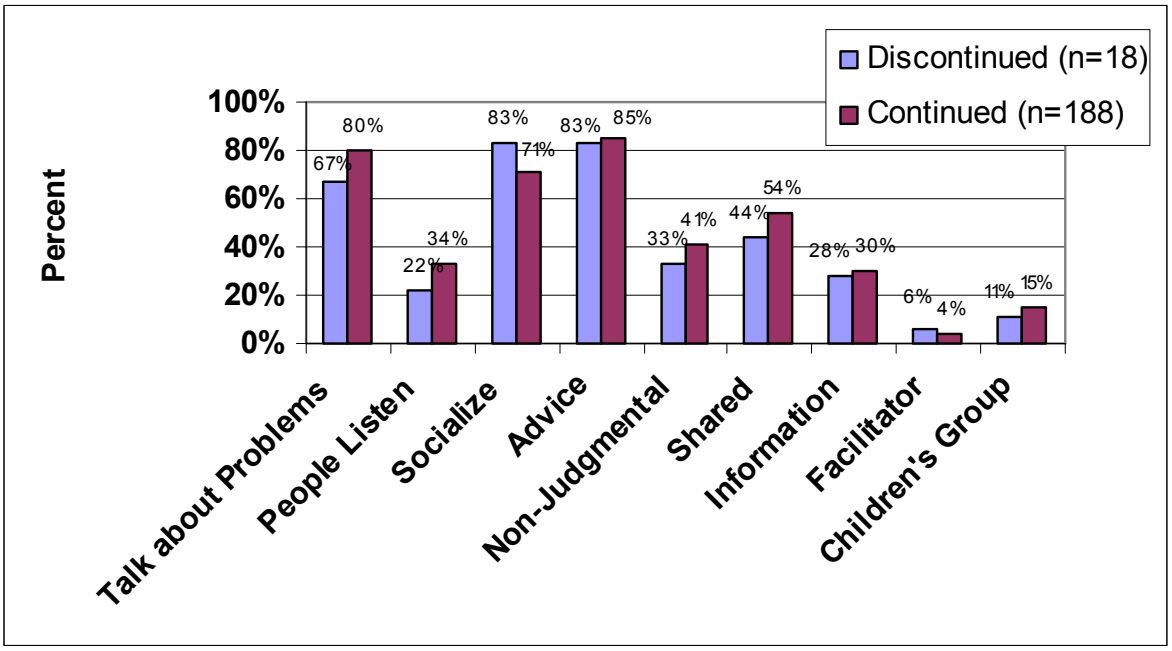
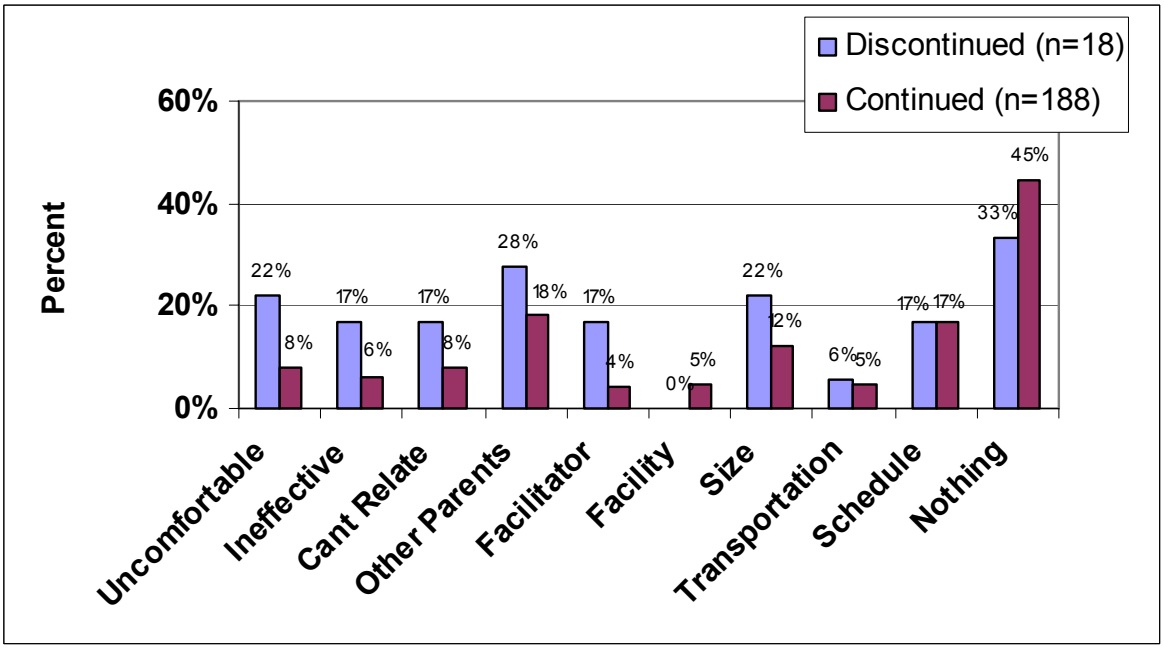


Figure 3.31. Negative Feedback of Parents Who Continued in Parents Anonymous® and Parents Who Stopped Attending at First Interview (N=206)



CHAPTER 4. QUALITATIVE METHODS

For the qualitative segment of the outcome evaluation, data were collected with four Spanish-speaking groups in California and Utah. Data collected included group observations, in-person qualitative interviews, and focus groups.

The qualitative study with Spanish-speaking groups was carried out to gather in-depth information about the experiences of Spanish speaking Parents Anonymous® participants. Recruiting Spanish speaking participants proved very difficult for a number of reasons including closure of groups, changes in staff, and inconsistent group attendance. Because of these reasons, collecting more in-depth data on a smaller sample of participants was a more appropriate research method. A total of 36 (24 Utah, and 12 California) participants from three groups were assessed with qualitative interviews. The same three groups and one other group were included in group observations and focus groups.

Qualitative Data Collection

Group observations, in-depth interviews, and focus groups were conducted with participants of four Spanish-speaking groups in California and Utah. These groups were chosen based on the number of attendees; history, stability, and structure of the groups; administrative support and cooperation from Group Facilitator and Parent Group Leader; and recommendation from Parents Anonymous® Inc. staff, specifically the Director of Research, and various Program Coordinators and Group Facilitators.

Group Observations. Permission to observe groups was obtained from group participants by the Group Facilitator several weeks prior to observing the group and again

upon arriving to observe the group. Research staff answered any questions by participants before starting the observation. Bilingual research staff attended and observed one group meeting in Los Angeles, California and one in Midvale, Utah. Our staff were trained to collect the following information from each group: 1) Basic information such as characteristics of group meeting, parents, Group Facilitators and Parent Group Leaders; 2) Flow information such as structure of the group, availability of food, use of time clock, breaks, and flow of discussion; 3) Content information regarding what happens during group meetings, specifically mutual support, parent leadership, shared leadership, types of issued discussed, and tone of meetings; 4) Group history information particularly how long parents have attended the group, how long the group has been in existence, how long the Group Facilitator has been coordinating the group, and how the group got started; and 5) Any comments parents make to each other or to the Group Facilitator.

In-depth Interviews. Group Facilitators and Parent Group Leaders recruited and scheduled interviews with current and past Parents Anonymous® members. The interviews took place in the participant's homes for those in California and at their group meeting places for those in Utah. The interview instrument was pilot tested for linguistic and cultural appropriateness. Interviews took about an hour and a half, were tape recorded, and were conducted in Spanish. Research staff obtained written consent from each parent and compensated them $25. The interviews focused on determining the background of the participants, their experiences with Parents Anonymous® (e.g., attendance, what happens during a group meeting, how they feel about talking about parenting issues with other people, how they benefit from the meetings, what kind of

support they receive from the meetings, what they like and dislike about the meetings), what else they do to get help with parenting, and other life concerns.

Focus Groups. As an addendum to the qualitative data collection, two focus groups were conducted with the goal of learning how people in the Latino communities feel about research and what would make it easier for them to participate in research studies. The following information was obtained from participants: 1) Whether they had been involved in a research study before and what that experience was like; 2) What they think of when they think about research; 3) What are the main reasons for not participating in research studies; 4) What are some ways to make it easier for them to participate in a research study; and 5) What they think the benefits are to participating in a research study. Group Facilitators and Parent Group Leaders assisted with recruiting current and past Spanish speaking Parents Anonymous® members. Snow ball sampling was used by asking parents to invite their Spanish-speaking family members and/or friends if recruitment is low. There were 11 and 21 focus group participants in California and Utah, respectively. Each focus group was conducted in Spanish, taped recorded, and took about 1.5 hours. Participants were compensated $25 each for their participation. Staff trained in facilitation moderated the groups while other staff assisted in writing notes, audio recording and logistical support.

Analysis Strategy

This qualitative evaluation was guided by a two-part research question: *Are the elements of the Parents Anonymous® model demonstrated in the groups* and, if so, *is the model associated with the intended outcomes for individual parents*, namely more social support, less isolation, better parenting practices, and generally better satisfaction with

parenting. To answer these questions, qualitative analysis of in-depth interviews, group observations, and focus groups included thematic analysis procedures in which coding of comments and quotes were categorized by topic area. Themes and patterns were identified and documented and thematic relationships considered.

CHAPTER 5. QUALITATIVE STUDY FINDINGS

This chapter presents the findings of the qualitative data collection for Spanish-language Parents Anonymous® groups. As described above in the methods chapter, 36 parents (24 in Utah and 12 in California) from 3 Spanish-language groups were assessed with semi-structured, in-person interviews. The same three and one other group were represented in group observations and focus groups. All of the parents interviewed were immigrants from Latin American countries. Their immigrant status sets them apart from other parents to a certain extent, mainly as related to isolation and access to services, but their issues and concerns are much the same as all parents involved with Parents Anonymous®.

Findings are presented in four parts: 1) the background of the parents interviewed and their reasons for first attending Parents Anonymous®, 2) the meeting process, 3) the implementation of the Parents Anonymous® model and philosophy, and 4) the impact of participation in Parents Anonymous® on the lives of these parents. Lastly, some challenges facing the Parents Anonymous® groups studied are discussed. Group observation findings are included with the interview findings. Focus group findings are presented in a separate section at the end of this chapter.

This qualitative evaluation was guided by a two-part research question: *Are the elements of the Parents Anonymous® model demonstrated in the groups* and, if so, *is the model associated with the intended outcomes for individual parents*, namely more social support, less isolation, better parenting practices, and generally better satisfaction with parenting. Sections two and three below address the first part of this question and sections three and, especially, four address the second part. Though much detail will be

presented below, in summary it was found that the Parents Anonymous® was demonstrated in the groups and that the parents had experienced the intended outcomes.

PARENTS' BACKGROUND PRIOR TO JOINING PARENTS ANONYMOUS®

Thirty women and six men were interviewed for the qualitative segment of the study. Fourteen of the mothers stayed at home with their children full-time while 16 worked; all of the men worked. Thirty-one parents indicated parenting or their children as their current greatest concern in their life. None of these parents were required to attend Parents Anonymous®.

The Parents Anonymous® group members described particularly difficult life situations. They discussed the stresses of moving to a new country, leaving family behind, deaths of close family members, divorces, and histories of violence. In addition to a difficult and dangerous trek across the U.S. border for some, parents reported adjustment problems once they reached the U.S., such as language barriers, feeling alone in a strange place, not knowing how to access basic services, and lacking a legal status in this country. Given the considerable length of time the parents had been in the United States, ranging from five to 35 years, they discussed long-lasting difficulties and struggles. These issues will be discussed under the following headings: isolation, mental health, stress, and parent-child interaction and parent competency.

Parental Isolation

Parents reported feeling very isolated and alienated prior to joining Parents Anonymous®. Parental isolation was rooted in a variety of factors, including being new immigrants, not knowing English very well, loss of extended family support, fear of

deportation, not knowing how to access services, not having a driver's license, and familial issues such as separations and divorces.

Loss of support of extended family. By moving to the U.S., these parents often lost a crucial form of support – their families. Thirteen parents specifically mentioned leaving their family behind. Parents said even if they still maintained contact with family members back home, that they could not rely on them to the same extent as before. A mother expressed this loss:

> I've have to face really difficult situations [since moving to the U.S.] on my own. I say on my own because my mother, my father, my family are all in Mexico, and I always relied on my mother. And I'm not going to get on a phone to worry her, to tell her my problems when I'm far away… when she asks me, 'How are you?' I try to say 'Good, everything's good.

This isolation was magnified among stay-at-home mothers. Though these women expressed satisfaction with their choice to stay at home, the complete focus on their children and home, at the expense of other activities, resulted in their feeling isolated and alone. A mother reported "I prefer to stay at home [but] I feel bad because sometimes I get so frustrated always staying home."

Lack of help from partner and familial structure. Some mothers complained that they were not getting help with the children from their male partner. Twenty-seven of the 36 parents interviewed had a spouse or live-in partner and some couples attended Parents Anonymous® together. Many women lamented that their husbands saw their role within the family as that of provider, leaving the day-to-day responsibility of caring for the children to the mother. Some women described finally reuniting with their husbands, after years apart, only to find them unloving or uninterested in fulfilling their family

duties. As such, these women felt overwhelmed, even "trapped," by their household responsibilities. As one mother said:

> If the husband doesn't help it's even more stressful…I think that's why many women are depressed. One finds herself alone, without family, and without the complete support of the husband because the husband goes to work and he thinks that's his role in the family…and he doesn't realize that in the home they are also his children and that he needs to help with the kids.

Other parents felt alone because they may be living alone, which is not common in their own country. A father described his divorce:

> I've felt so bad sometimes, a bit depressive, because I'm alone. Even if I see my children it feels really bad to come home and eat alone, sleep alone, not be with somebody who receives you at night or tells you 'goodbye' in the morning.

Some parents reported becoming increasingly isolated during the adjustment period when they first came to the U.S. due to difficulties in communication, their inability to drive, and the fear of deportation.

Mental Health

For many parents, isolation was compounded with depression. Nearly half of the parents reported that they had suffered from depression. Many mentioned feeling overwhelmed and alone before joining Parents Anonymous®. Parents reported symptoms of depression, including sporadic crying spells, suicidal thoughts, a debilitating lack of motivation, and lethargy. One mother spoke of living in a haze for the first six months after she arrived in the U.S. She said could not make sense of what was happening to her, and did not know how or whom to ask for help.

> People would come and tell me that they had seen me at the school where I pick up my kids and they had called out my name and even shook me and I wouldn't respond. I didn't remember that happening. They would

> ask me what was wrong and I would start to cry, but I would always say that I was fine.

A Mexican woman in her forties described how the combination of elements came together--moving to a new culture, not knowing where to find basic services, increasing isolation, increasing depression, and the impact on her family:

> Once I got here [to the US] I entered into a total depression because this felt like chaos. I didn't know any Latinos, everybody spoke English. My culture changed completely from Latina to English. I was in this depression and I tried to find services. I had birth control for three months and I couldn't find anywhere to get more birth control. And I ended up pregnant and well I became more depressed because of the pregnancy. I didn't know how my daughters would react. I wanted to adapt to the culture of the state, to the people, to the way of life. After [giving birth] there were moments I remember I would look at the freeway and I would think of going to a bridge and letting myself fall. I thought about that a lot in those moments. So then the problems with my husband began because I wasn't adapting to life here. I cried all the time and he would get mad because I would cry; he didn't insult me or hit me but he would leave all the time, never be home, and that was worse because I would be alone with my daughters. I didn't drive, I didn't have a car, I lived shut in our home.

Stress

According to parents, feeling alone and without support added additional stress to their already stressful lives that for some had negative results for their children.

Work-family balance. As a counterpart to the issues faced by stay at home mothers, parents reported that entering the workforce presented a new set of difficulties. Working parents' described having stressful jobs and difficulties balancing work and family responsibilities. Parents detailed physically demanding jobs such as construction work, hotel cleaning or factory work, all of which required long hours away from their family with little flexibility. They recognized there were repercussions for their children. For instance, one woman blamed her son's drug addiction on the many hours she spent at

work and away from him. She described the pain of hearing her son tell her she had not been there for him when he needed her and added:

> I came to [the US] with one purpose, to work work work, and still now I am a person who is trying to break the rule of the clock. Usually the clock guided my life, no time for family, for me, for nothing. I only wanted to make money to give my children the best or what I felt they needed to have. As such I have one son who got involved with drugs.

Financial stresses. Financial security was a concern for some parents, particularly for single parents who indicated they had problems with meeting the basic needs such as food, paying rent and household bills. One group member said he had difficulty attending the meetings "because I didn't have the money for gas." One single parent confided:

> I think my problems with my children also came from my stress related to money…You know how it is, when one is alone, one has to have enough money for the supermarket, for bills, for rent, and it was quite difficult for me.

Expectations of parenting. Among the parents interviewed, having children and caring for them was more challenging than they imagined and led to many frustrations. Parents described realizing that having children did not mean they knew how to *be* parents. They did not know what to expect from their children or how to discipline them. As one mother who was overwhelmed once she had children said:

> When there are children [your house] is totally disorganized. And there is no way to know how to be a mother. One might have an idea but when you have a kid you don't know what to do. It was a bit stressful for me; I wanted everything to be intact. If I left my son sitting there I wanted him to stay there, and I wanted everything to be done perfectly. And he was a baby and I would get very mad at him, and maybe spank or yell loudly.

Parent-Child Interaction and Parenting Competency

The combination of difficult transitions, stressors, isolation, and attendant emotional problems, had repercussions for parenting, especially for parents lacking basic skills and confidence.

Life difficulties affecting parenting. The stresses that these parents were experiencing appeared to influence parents' interaction with their children. Parents described that they felt overwhelmed and did not know where to turn for help. They, in turn, directed their anxieties and frustrations toward their children. A mother of two young children explained, "You bottle things up for so long and all of your family is in Mexico that you keep everything inside and it comes out as shouting towards your children even if you don't intend for that to happen." Another mother described her behavior toward her children:

> So then I arrived [in the US] depressed, for many reasons. I decided I needed help because sometimes I shouted at my kids. It must have been the move, I don't know, but I didn't used to be like that. I adored my children. I didn't scream at anybody. The [move] did make me very nervous and I yelled at everybody. I didn't want to yell at my children.

Another mother commented,

> I was tough, I was cruel, I was drastic as a mom. I was very strict. I exaggerated about cleaning. And [my daughters] left my house very young…and one was already pregnant. So I think it had a lot to do with how I acted, because I think they were sick of me. I even got to the point of mistreating them, both verbally and physically. So I was a very tough mom, perhaps because of the problems I went through. I took out my frustrations on them because I had nobody else to take them out on.

Limited parenting options. Parents interviewed said they fell into patterns of yelling and physically disciplining their children. Some attributed their aggressive behavior to be a reaction toward their current life situation. Parents also reported that they

did not know other ways to discipline their children beside what their own parents had done with them. A mother revealed that "In Mexico it is custom that punishment is a spanking and naturally one brings that with them. Because that's how one was raised, and one learns to repeat what was done by one's parents."

Despite having been raised with aggressive discipline, some parents felt that they acted wrongly. As one mother revealed, "I knew inside that it wasn't okay, because every time I did it [my son] cried, and I would cry more than him."

Nevertheless, simply recognizing that it "wasn't okay" was not sufficient in creating a behavioral change. Eva said she realized that her current parenting efforts were inappropriate, but she did not know of appropriate alternatives. Without other adults or professionals to turn to, she eventually asked her son "How do you want me to be as a mother?" Hoping to compensate for her past behavior, Eva became over-protective; she gave her son anything she thought he might need until she realized that she was not allowing him to develop confidence and initiative and, in fact, "was doing him harm." She explained:

> I wouldn't let him run because I didn't want him to fall; I wouldn't let him do anything for himself. I became depressed when I realized that all the other kids would run and play. When my child was in the second grade he got on top of a slide and he started to cry because he didn't know how to slide down.

Soon after the incident on the slide, Eva sought help from a psychologist who referred her to Parents Anonymous®. Other parents reported they were in similar predicament but unclear how to remedy it.

THE MEETING PROCESS

The following section uses information gathered during parent interviews, focus groups and group observations to describe the Parents Anonymous® group meeting process.

How parents heard about Parents Anonymous®. Parents said they heard about the group through professionals at their children's school or health clinic, or informal network such as spouses, friends, family, relatives, and even complete strangers. Others saw the program advertised in after-school programs, schools, or health clinics.

Attendance in Parents Anonymous®. The length of participation varied widely from three weeks to over seven years. All the parents said they attended the weekly meetings regularly. One mother mentioned proudly that in four years, she had only missed four meetings. Occasionally, work obligations prevented some parents from attending the meeting.

Characteristics of Parents Anonymous® meetings. Parents Anonymous® meetings shared significant similarities across groups. At the start of the meeting, parents introduced themselves, for example, "We give our name, where we come from, how much time we have been coming to the group, and how it's helped us." Then, parents are reminded of the group rules, such as confidentiality and mutual respect. As one father commented:

> When everyone's presented themselves, then we tell them that what is discussed here is confidential, nothing gets out. The [Parent Group Leader] will tell them to be punctual so that they can get in the rhythm of being punctual every week.

Generally, the topics discussed during group meeting stemmed from issues that group members currently faced. Most of the meetings observed or described did not have

pre-assigned topics (per the Parents Anonymous® model). As a parent described, "We discuss things that people want to discuss because they are [currently] experiencing it." Parents shared particular issues or problems they were facing. Sometimes, if a parent had shared an issue at a past meeting, others would ask if there had been a resolution. Similarly, older attendees might ask newer members to share their experiences and the reason they had come to the group.

Occasionally, guest speakers were invited to speak on topics of interest to the members, such as child personality types and strategies for parents to control their anger. One of the groups observed had invited speakers every other meeting. After the presentations, parents asked questions and shared personal stories related to the topics presented. They discussed how to apply the lessons learned in their own lives. Additionally, they discussed topics or issues they were experiencing not related to the presentation. The Group Facilitator mentioned that in the next meeting, they would discuss how the new information and strategies they had learned had been implemented, and how these needed to be adjusted to better suit their individual children.

Role of the Group Facilitator. Overwhelmingly, parents spoke highly of their Group Facilitator. One mother said:

> [The Group Facilitator] is very kind, and I aspire to have her confidence, to speak like her. I think she's a really good person who inspires a lot of trust. She speaks very well, very beautifully, is a really good person, very humble. I see her as very strong; she doesn't seem to act her years, like a grandmother. She seems very active. Also, her studies make a big difference.

The most valued roles of the Group Facilitator as described by the parents were to give professional opinions, to organize the meetings and invite guest speakers, to provide

informational resources, and, for some Group Facilitators, to provide assistance outside of meetings.

Parents described the Group Facilitators as essential in presenting new parenting practices to the group members. Parents felt if they simply shared their own practices with each other, especially if they came from similar cultural backgrounds with similar disciplining techniques, it would be difficult to introduce new ideas to the group.

Some Group Facilitators had a professional background in psychology or social work. Parents said they trusted and admired their Group Facilitator particularly because of their professional background. Such perception makes parents more receptive to learning new parenting ideas and techniques from the Group Facilitator. A mother said:

> Her knowledge as a professional is different than our knowledge, we always wait for her commentary as a professional because it's on the mark, every time she talks, we say, 'yes, it's true, it's true, I hadn't thought about it in that way.'

In addition to introducing parenting techniques, Group Facilitators supported parents in many other ways. Some parents reported that their Group Facilitator made themselves available to the parents outside of group meetings. As one mother said, "she tells us, 'if you guys want it, I'm available to talk,' and gave us her phone number to talk to her, like if you are very sad or something she will hear you out." Another mother said her Group Facilitator (a licensed therapist) counseled her and her husband outside of the group meetings, and helped them begin to rebuild their marriage. Finally, Group Facilitators, according to the parents, often kept themselves informed of community events, and brought in new resources and speakers to the group. A parent described the speakers:

> People come in to share about their expertise…people from the police department, a really friendly detective. He was really helpful for example, because we come here and don't realize what can harm our children, right? Like gangs and they explained to us, brought us drawings of gang symbols, [told us] about drugs. People have come to teach us to take care of our banking, so that we aren't surprised by everything. Also people from the school district came and [child protective services taught us about] how one can fall into violence, because here people's kids have gotten taken, and if they come and explain we have an idea of how to behave ourselves.

Parent Group Leaders. Parent Group Leaders were another important element of the Parents Anonymous® structure. Parent Group Leaders were often referred to as "mother leader" by group members. Because the groups had more women than men, Parent Group Leaders were more likely to be women. Depending on the group, Parent Group Leaders took on a variety of responsibilities such as arranging the room before the meeting, calling every parent before the meeting to remind them to attend, keeping a record of attendance and members' contact information, and, between meetings, calling to check in on parents who were having a particularly difficult time. A Parent Group Leader described her routine:

> I have made it a habit to call before our meetings. I call them and I ask them how they are doing. Sometimes when I know someone's problem is a little more heavy, that they need a word of encouragement or just to know that there's someone here. I'll call them at any moment during the week and if they say, 'I'm not doing well,' then we'll talk.

Parent Group Leaders may be responsible also for finding information or resources and sharing this with the group. A Parent Group Leader, for instance, mentioned attending a few sessions of Alcoholics Anonymous because he wanted to make sure Alcoholic Anonymous was worth recommending to other parents. As a parent said, "The mother

leader is always making sure to get out the information about upcoming things and to remind everyone of meetings."

Resources. Official Parents Anonymous® literature was scarce according to parents at sites visited by the research team. Most parents received a Parents Anonymous® folder with information about the group when they first began attending. Some groups shared Parents Anonymous® videos and pamphlets with their members. If the facility where the meeting was held had the proper equipment, the group would watch the video in the meeting.

Parents generally felt Parents Anonymous® should provide more informational material. As a mother said:

> Well, it's like there aren't a lot of resources, right? [The Group Facilitator] tries to gives us photocopies of some articles that she finds that can help us. And well anytime there's a class on anything, like cancer or something, she always brings us the information so that we can go. We don't really have information packets; the only thing we have is the purple packet they give us when we go for the first time.

Though official Parents Anonymous® material is limited, parents reported that Group Facilitators and Parent Group Leaders would share information such as articles related to parenting or life in the U.S., information on community events, employment opportunities, listings for publicly available classes on topics of interest, and other resources, as well as invite guest speakers. A Parent Group Leader described using her limited English to translate some English-only information packets sent by Parents Anonymous® into Spanish. As a mother said, "Well, in terms of actual materials there isn't much, but I think we take advantage of the little we have."

PARENTS ANONYMOUS® MODEL AND PHILOSOPHY

Parents expressed the need to discuss and share their worries with others, as well as to find practical solutions to their dilemmas. This need was what led most of them to start attending Parents Anonymous®. However, they also discussed feeling hesitant about sharing their life stories with strangers. Parents credit the emphasis in Parents Anonymous® meetings on confidentiality and respect, mutual support and shared leadership with their willingness to share their personal problems and explore solutions to their personal problems. In fact, there was evidence that all of the key aspects of the Parents Anonymous® model—mutual support, parent leadership, shared leadership, and personal growth—had been implemented and were playing important roles in the groups observed and in the satisfaction of individual parents with their involvement in Parents Anonymous®.

Mutual Support

A key component of the Parents Anonymous® model is mutual support: promoting positive change by allowing parents to provide support to *and* receive support from other parents. As reported above, parents described suffering from severe loneliness, without their families and other sources of support nearby. Parents reported that the support they received both during group meetings and outside of meetings was very important in their improved sense of competence as parents as well as feeling more fulfilled as individuals. The impact of participation in Parents Anonymous® went beyond parenting practice to include emotional support and friendship outside of meetings. In fact, many reported that they came to think of the other parents in their groups as their

extended family, effectively serving as proxies for the families they had left behind when coming to the US.

The mutual support format of Parents Anonymous® seems to help ensure that parents stay active within their group. There was evidence that there were benefits received from both the receiving and giving of support in the context of Parents Anonymous® meetings. There is a self-perpetuating aspect, as well as a sort of obligation implied, in this arrangement—in order to keep receiving these benefits and in order to continue to have the benefit of the other parents' trust, each parent needs to continue to invest in the process and to participate. There was evidence that parents recognized this need for them to actively participate or, at least, to follow the group norms in order to keep the group functioning, although they also seemed to value not being forced to participate in any given instance and to maintain their autonomy from the group.

This section is split into various aspects of mutual support that arose in the qualitative data collection, including sharing, the role of past behavior, emotional support, the benefits of giving as well as receiving support, and building a sense of community and family.

Sharing of experiences and building parenting competency. In the process of sharing their stories, parents offer and receive support. Each meeting's conversation topics are determined by the issues raised by the parents. During this process, parents learn to seek out information from other parents. In return, helping others provided an added incentive for parents to share their experiences and take an active role in the meetings. Parents learned from the experiences of other parents. A mother said she liked

discussing her worries with other parents because "they weren't only going to listen but also offer input." Another one stated:

> [Listening to the problems of others] helps me because I hear their problems and the advice they get. And I know that one day I will be in those situations and I will know how to approach them and how to react.

Parents learn to take an active role in learning about different parenting methods and possible challenges they may encounter with their children. This exchange of experiences helped parents to see that they had a range of options regarding how to interact with their children – they were not limited to the parenting practices of their own parents. A mother described the need to be open to others' point of view:

> No well it's like our culture…we bring with us that mentality of 'things stay in the house and get taken care of there and nothing else.' But if you want to change…you can't do it by yourself. You can't close yourself off, 'no, I'm fine, I'm fine,' and not look at others' point of view…[now] if this doesn't work for me, I'll try that, and if that doesn't work, I'll try something else.

This parent had learned that no one solution fits every situation or every child, and was willing to try a variety of options to find which worked best.

Learning from, but not judging, past behavior. Parents learned from each other's past failures as well as successes. The mother of a preadolescent girl articulated this idea when she said, "When you hear about other people's problems with their children, you say to yourself, 'I'm not going to commit this error."

Furthermore, hearing others' stories helped parents gain perspectives regarding their own issues. By listening to others' problems, parents realized that their own problems were not invincible. Thus they could move beyond feeling overwhelmed and towards figuring out how to approach their problem. As a group member stated:

> I leave [the group] with a different perspective, I leave thinking, 'my problems aren't so big compared to other people, who have huge

> problems.' And I leave happy because I say I'm not going to drown in a cup of water, not for a little problem.

Retaining parental autonomy; group ideas, individual choices. Another aspect of the Parents Anonymous® process valued by these parents was the lack of prescribed recommendations or expectations for their behavior in their own homes. At the end of the meeting, a parent still had to decide for themselves how they would tackle their personal problems. They may be boosted by a range of options suggested by the other parents or Group Facilitator, or that might have occurred to them as the discussion took place, but they are not obligated. Parents listened to others' suggestions, but retained final responsibility for their actions:

> It's like sharing your weight, and at the same time finding an answer which sometimes is within yourself. And they make you look for it, because in this group they don't give you advice, no, they say 'you know, this happened to me, so I would suggest this or I think.' But they are never going to tell you, you must do this. And the fact that each person has their own way of thinking means that you can take a little bit out of each thing you are told that you think will help you.

Parents said the variety of life experiences shared in the group makes it clear that there are more than one disciplinary option, and that parents have to decide which will suit them and their children best. One parent compared her experiences with therapy to her experiences in Parents Anonymous®:

> With the group, I hear different opinions of which I can take the ones I think are best, since therapy is individual it's almost like you have to take everything you are being told…in the group we all have different ways of thinking…and at the end of the day, after they have shared everything, I decide what I want to do.

Parents Anonymous® group participation expanded the range of options from which parents could choose and built their confidence to tackle issues, yet they retained full control of their parenting decisions.

Safe place for emotional support. For some parents, simply having somebody to listen to them made a lot of difference for them. One mother confessed she spent her first meeting crying. Before she could begin to tackle the issues, she needed a place where she could simply express her frustrations and worries:

> Parents Anonymous® helped me because I can let everything out, I can cry. I remember when I started going I would cry and cry and cry…I arrived at the group completely broken down, but having a place to go and speak about these things, to listen, to cry, really helped me, until I got to the point where I was no longer crying.

Another parent commented:

> This is what I wanted, what I had been looking for, somebody to confide in, somebody in whom I could release my worries, somebody who would listen to me.

Gaining from giving. In addition to benefiting from receiving support, parents also gain from providing support to others. One mother reported that attending the meetings "makes me feel good, it makes me feel useful, like I can help others." Parents who described past feelings of inadequacy and depression felt useful when they provided support and advice to others; as a mother said, "Those comments we make and the bad experiences we share, we know it helps other parents." A parent of an adolescent boy reported that although other parents have not had direct experience raising a teenage son, he enjoyed attending the meetings and offering advice to others whose children are just now entering adolescence. He recognized that he was an integral part of his Parents Anonymous® group.

A sense of community. Despite the parents' initial hesitancy to share their lives, in their Parents Anonymous® groups these parents found a new community where they did not feel like outsiders because of their immigrant status or their parenting issues.

This community was made up of individuals in whom they could rely and by whom they could feel supported. As one mother described:

> We Hispanics all have a story, and also we get here [to the U.S.] and many people don't take their lives because they are strong. I have heard some horrible things, and I have heard of people who are about to kill themselves. And I never had those urges. But I did feel so alone, so rejected sometimes, and you get here [to Parents Anonymous®] and you find that there is warmth, that people will listen to you, they will support you.

With such support, parents no longer felt that they were alone in confronting their problems. Furthermore, other parents could provide helpful suggestions on how to tackle different issues. A woman revealed when she worried about not being prepared to deal with her children's impending adolescence, her group had helped her calm those worries by providing her with a ready source of support for when difficulties arose:

> It's very difficult, but with the group it doesn't feel so bad…I think, well, at least during the group I can discuss what's happening and the other parents will share some story that will give me some idea as to what to do.

Various group members expressed that participation in Parents Anonymous® had helped them realize that parents are "all the same." Hearing other parents vocalize similar problems help parents feel at ease with their own. One father of two stated:

> I am sharing with people that have personal problems, and similar to mine. So they are suffering really what I may be suffering. And it feels different because one identifies more with them than with outsiders because outsiders aren't in the same situation. It's a difference, I could say I feel more comfortable or at least more understood within the group than outside of the group.

A sense of family. Parents reported that their Parents Anonymous® support networks and friendships extended beyond the meetings. One group member said:

> If you have a problem but it's not on a Parents Anonymous® meeting day you know you can count on someone to feel some kind of sympathy, it feels very good. There are people that since I met them, they're still there.

> Our kids grow up together, we get together to take them to the park, to take them swimming, or sometimes we just say let's go gossip! We can talk about our problems and the children are happy being together too!

Various parents compared the community they found in Parents Anonymous® to family. "When someone comes in with a problem all of us are with that person and we feel like if it was our family. A lot of us don't have family in this country but we have a lot of family here [in Parents Anonymous®] that cares about us. We're all very united." One mother recalled the first Parents Anonymous® group she joined:

> When I got to Parents Anonymous® I found my mother, my aunt, my grandmother, everybody, because I can tell you that from the group came my best friends. I don't have any family here except for my two boys and my husband. But I tell my mother that I feel like I have my entire family here. I'm not alone, nothing happens to me that [my friends from Parents Anonymous®] won't know about or help me resolve.

Parents supported each other emotionally as well as in practical, non-parenting matters, such as teaching another parent how to drive. They described receiving assistance or helping others with a wide range of activities from car rides to being available to listen to giving food to those facing particularly difficult financial times:

> I remember us working together to get [driver] licenses, I helped because I already had my license…and we began classes, to support each other, cooking classes because we didn't know, well more like I didn't know how to cook.

Most of those friendships and outside assistance began organically, without any particular emphasis on building such relationships discussed during meetings, but Parent Group Leaders reported making a special effort to provide outside support to those that needed it. A mother who used to be a Parent Group Leader described her duty: "During the week [I'd] pay attention to those that seemed to be feeling particularly bad in the

group. During the week I would call them, see how they feel, how they were doing, if they needed anything, and make them feel generally good."

Parents Anonymous® Ethos

The Parents Anonymous® ethos is a set of beliefs, values, and mores such as anonymity, confidentiality, trust, and being nonjudgmental. In group observations and parent interviews it was evident that this ethos is both successfully implemented in the groups studied and valued by group members.

Building trust. In addition to the mutual support offered, parents benefited from clear guidelines and norms that help ensure the personal information they shared would be respected and kept confidential. Despite differences in formats, all the Parents Anonymous® groups visited took very concrete steps to create a safe environment. During meetings, one member would remind the rest of the group of the group's guiding rules, including confidentiality and not giving criticism. A father described the importance of paying attention to the language employed when describing the group norms:

> We don't consider them rules, usually it's a little more difficult that one accepts rules, even the word makes you feel [uncomfortable], you go to a support group because you need help and if they tell you here are the rules, it will make you feel [uncomfortable].

The emphasis placed on the language used was mentioned by several parents as highlighting the extent of the efforts to make parents feel comfortable.

Various parents cited the importance of not being forced to speak. A mother described her hesitancy to share her story with others before joining Parents Anonymous®, "Oh no…I'm not going to go around talking to people, what do they have to know about my life?" Her friend finally convinced her to

attend by promising that she would not have to share her story unless she wanted to. Another mother stated that if she had been forced to speak at her first meeting, she probably would not have returned to the group:

> I was nervous, thinking 'what am I going to say?' and I had so many things on my mind. And, I don't know, it was very comfortable. They said 'you don't have to speak unless you want to, you can just listen.' That's why I wanted to return, I think that if they would have said that I had to speak in that moment I wouldn't have returned.

Groups emphasized a policy of confidentiality, but it took some parents a little bit of time before they could trust the policy. A parent described her early worries about confidentiality:

> I felt a bit of distrust. At the beginning, I would say, 'perhaps what I'm saying they are going to go out and spread,' but that was only at the beginning. I saw that people were sharing problems that were more serious than mine, or more delicate than mine, and they were sharing them. And then I thought that if I wasn't going to say anything about what I was hearing, others wouldn't either. I know they won't speak about my life to others, which gives me the confidence to speak.

She realized that if other parents could trust her with their private stories, she could trust them with hers, and her worries subsided.

"We don't judge." Parents' willingness to share is further limited by shame and fear of judgment. According to the parents in the Parents Anonymous® groups visited, group members were discouraged from criticizing or judging each other. As one father said, "one of the norms is that we do not criticize, we don't judge." In particular, to avoid sounding like they were criticizing, rather than offering advice, parents would describe their own past experiences or what they would do in a certain situation. As a parent said: "Instead of giving them advice, we tell them about times when we were in similar situations and describe what we did in those situations. We aren't going to say 'hey, you

are wrong.'" One mother felt particularly concerned about being judged because she did not want to reinforce stereotypes about Latinos.

> As Hispanics, in particular, we face a bit of discrimination. And we are already in the spotlight a little bit, so I didn't want to be another one of those people that stands out because of her problems, because my son was a drug addict.

> Another parent said it took several meetings before she felt comfortable speaking. She used to think, 'Oh no! What shame, what shame, to admit that I am this way," but then said she realized "that in the group they don't judge you or criticize you."

Feeling free from being judged by others enabled parents to focus on their current problems instead of defending their past behavior. A father described this phenomenon:

> I haven't really known those people for years or for a long time. They don't know me, and so they can give me their opinion and their way of thinking freely, without judging me, without saying 'it's that you always are like this,' or 'you have to do this,' 'your problem is this,' or 'this other thing is really what's the matter with ,' right? People here only give an opinion about the current issue and situation really, not really about you as a person, just the situation. That's what has given me confidence to speak, knowing that this is how it works. And I can be more sincere than to perhaps somebody I know, because it's very hard to be sincere with somebody that you know.

Parents said the group focus on current situations, as opposed to judging past errors. As such, parents were free to discuss their present issues and work constructively towards improving their relationships and behaviors.

Shared Leadership

As encouraged in the Parents Anonymous® model, groups demonstrated shared leadership, divided among the Group Facilitator, Parent Group Leader, and group members.

Parent Leadership. All parents are considered parent leaders and in group meetings, leadership tasks are divided among parents – for example, one parent will

make the coffee before the meeting, while another will help set up the chairs. Parents also learned to help others and take initiative beyond the meetings, such as finding resources or information for another parent. As a mother said, "Many times we leave thinking, 'what can we do to help?'" Parents even took the initiative to find resources that may help somebody else:

> If someone can look for help outside to help with that person's situation, they will locate that help and give it to that person whether it's information or any other thing.

The role of Parent Group Leaders. Parent Group Leaders described their efforts to encourage group members to take on more responsibility and become more active within their groups. One Parent Group Leader decided to open up the opportunity for leadership to someone else. "I was for some time [a Parent Group Leader], but I stepped aside so that others could do it too. They can all be leaders." A Group Facilitator mentioned changing Parent Group Leaders relatively often to ensure that different people had a chance to take part of this leadership opportunity. Parent Group Leaders described ensuring that all group members had the opportunity to give input, and often stated that all parents were leaders; a Parent Group Leader mentioned that "We are all leaders because we are all parents." This statement exemplifies the Parents Anonymous® notion of parent leadership.

Nevertheless, some parents reported that issues had arisen regarding Parent Group Leaders. Because being a Parent Group Leader can be perceived as an honor, issues can arise with other parents regarding the selection. One parent mentioned that in her group, if the Parent Group Leader is absent for any reason, an alternate Parent Group Leader is selected. She said this makes her feel uncomfortable, "It's like saying, well, you couldn't

do it, she or he can, making one feel less. I say that's not right." She feels as if her own abilities are judged negatively when other parents are picked for the role of Parent Group Leader. A mother who used to be a Parent Group Leader added:

> [I] became [a] Parent [Group] Leader, but there were conflicts and people started talking about [me]…There was no point in being a leader if people were going to distance themselves…Being in this group helps us all, so I decided to step down.

Role of Group Facilitators. Group Facilitators said they promote parental leadership throughout the group. As seen in group observations, they acknowledged and gave positive feedback to all the parents that spoke, regardless of whether they disagreed with them. Group Facilitators encouraged shy parents to share their stories, emphasizing that their expertise could help other parents. Furthermore, parents said Group Facilitators made an effort to not differentiate between parents or play favoritism. As a former Parent Group Leader said, "The word is just that, a word-mother leader. In the group we're all the same. Our facilitator doesn't distinguish us at all."

Unfortunately, in some cases parents potentially became too dependent on their Group Facilitator and were not thinking for themselves and acting independently when it comes to resolving their own situation. Indeed, a mother who attended her first Parents Anonymous® meeting years ago experienced the drawbacks of such over-dependence:

> I went for three years, and then yes, when [the Group Facilitator] left…the whole group felt like, like she abandoned us…We felt there couldn't be a group without her…We loved her point of view with her social work background. It's always good to have a professional, right? So when she left we ended the group.

In this situation, parents felt that without the Group Facilitator, their group could no longer exist. Interestingly, in one of the groups visited, a Group Facilitator had left right before our interviews began and these parents were threatening to stop attending the

meetings. A Group Facilitator from another group concerned about such dependency decided to heavily promote parental leadership. In the past, her organization had funded more than one Group Facilitator so they rotate facilitating the different Parents Anonymous® groups to prevent dependency. Now due to funding cuts, she was the only Group Facilitator remaining.

THE IMPACT OF PARENTS ANONYMOUS® PARTICIPATION

Group members credited Parents Anonymous® with improving their relationship with their children, their partners, and the community, and with helping them become more assertive individuals. Among the self-reported benefits reported, sometimes explicit and sometimes implied, were many of the outcomes the Parents Anonymous® model was designed to engender, including greater social support, reduced isolation and improved parenting competency and confidence.

Impact on relationship with children

Parents attributed communication skills, parenting options, self-control techniques, and knowledge about child development they acquired through Parents Anonymous® for their improved relationship with their children. Parents reported that even small efforts they had begun to make, such as making time for their children when they were tired, had resulted in much closer relationships. They realized that parenting was more than providing food and shelter and acting in an authoritative manner. As one mother said,

> [My relationship with my daughter] has changed a lot…She used to never come up to me. She knew not to ask me anything because I was always tired, or said 'not now.' I never wanted to talk. Our relationship has really changed, up to the point that she has even asked me for a date, just the two of us. Before she would never have dared to do that.

Similarly, another mother revealed that "before there would be things [my daughter] wanted to tell me but she wouldn't out of fear, because I would get hysterical, and she tells me we have grown a lot closer because of the program."

Parent-child interaction. At the meetings, parents said they learned about child development and how their own behavior affects their children. Parents seemed more willing to change their behavior after understanding its root causes and consequences. A mother used communication and self-observation tools she learned during the meetings to interpret her past behavior:

> …when you hit somebody you do not have communication, because that is why one hits a child, you are frustrated, due to everything that is going on. I was always crying before coming here.

Parents mentioned learning that children look to their parents' behavior for clues to how they should behave. A mother recalled the moment she realized the impact of her behavior:

> When he [her son] was little he hit all the other little kids, he hit and he hit…and I didn't understand why…and I didn't understand until I came here and I learned that your children are a reflection of you, that he acted this way because I was aggressive with him. Learning that was like a slap in the face, and it hurt me very much because I thought, it's not his fault, it's mine! And I have to fix this.

Armed with this knowledge, this mother could begin to confront the problem. In fact, parents were able to use children's tendency to emulate their parents' behavior to foster positive behavior. A father to two small children was thrilled to learn about behavior modeling–now he could try to positively influence his children's behavior. In an attempt to foster better habits in his young children, he became an avid reader. He joyfully commented, "When I would read, my children would follow my lead!"

Learning about child development appeared to help these parents prepare for changes in their children's behaviors and handle difficult behaviors. One mother was worried about her daughter's rebelliousness:

> I will go to the Group Facilitator and she tells me, 'she is a good girl, she is just going through a rebellious phase where she will do this, this, this, and that,' I'm not saying that she was doing anything serious, but it was things that I couldn't handle, but in reality no longer, I can manage it now.

Parents were also urged to look back at their childhood. One father refers back to his childhood, to remind himself to be more patient:

> I've learned to be more tolerant, to remember sometimes how children feel…because you grow up and forget what it was like to be a kid. And you want your kid to do things exactly like you said…and when we were kids we were the same, or worse.

Though some parents may feel guilty and blame themselves after learning of the impact of their past behavior, most parents tended to use the information as a tool to improve their behavior. One mother was overwhelmed with regret over her treatment of her son and feared that the harm done was irrevocable. She cried as she said:

> I've made a lot of errors as a mother. My biggest worry is my children's' self-esteem, that my oldest son grows up with a low self-esteem because of me. That is my worry; it worries me, not helping him. I think I have lowered his self-esteem and I think that sooner or later that's going to have some consequences…I was so frustrated, it was too much for me that he was always sick and I was alone. It was very difficult and it is one of my biggest regrets…That's why I say that it is my worry that all my behavior will hurt his future. That's why I'm trying to improve now, I'm not sure if I'm still in time to make up for it, what I didn't do before, do now.

Communication. Parents frequently recognized just how little they knew about interacting and communicating with their children before coming to Parents Anonymous®. A mother mentioned that during meetings parents most often asked "about

how to talk to their children." Parents seemed to sense that there was an emotional component missing from their relationship with their children.

Group members mentioned realizing that parenting was about much more than providing shelter and food for their children. They emphasized the importance of communication in creating deeper bonds with their children. As a father described,

> My relationship has improved with my girls, specifically because I listen to them. Sometimes I'll get home after 10 hours of work…of construction, it's heavy…and I just want to eat, take a shower, and go to bed, you know? So you get home and one jumps at you, and then comes the other and the other. So learning to pay attention, listen to them, even if I'm tired, to make them understand that I care. The simple fact of looking over their homework and say "Wow, good job, excellent" instead of telling them "I'm tired, what do you want?" is a big improvement.

Parents said they learned to be aware of the effect their actions will have on their children and to make efforts that help strengthen their relationship with their children instead of alienating them.

A mother mentioned that she had to overcome the idea that satisfying her children's financial needs was a sufficient way of expressing her love for them. Furthermore, she explained that she has learned to have conversations with her children, as opposed to simply yelling and telling them what to do. As a result, the mother believed her children feel more comfortable expressing themselves around her, and that she is providing a model of positive communication. She explained:

> I no longer yell at my children. Before it was really hard for me to talk to them without yelling. Now I can have conversations with them, and not so badly even if they did something pretty serious. I learned that children have the right to speak, to defend themselves…I learned that one has to speak with them and look into their eyes, get down to their level…Before it was very hard for me to hug them, and tell them how much I love them. I felt that with giving them food and a home, it was clear that I loved them. I didn't love them I wouldn't provide for them. But no, I have learned to hug them, and now they have learned how to express their feelings as well.

Parenting options and competency. Group members credited Parents Anonymous® with teaching them a variety of ways to interact with their children. By being exposed to new ideas, parents no longer needed to rely on their own parents' techniques.

Sometimes the techniques they instituted were fairly simple. One mother said she continually struggled with getting her youngest son to take a bath, and she could not understand why. Finally, she shared her issue with the group. One of the other parents asked her "Did you sit down with him and teach him which is the cold and which is the hot water, so he doesn't burn himself?" She had not, and her problem was resolved almost immediately, "I can't believe something so simple, and it hadn't even occurred to me!"

Parents mentioned learning variety of techniques which might not have occurred to them without the group, and which were producing great results. Parents talked most often about new disciplinary techniques. A mother shared her experiences:

> I've learned that instead of a spanking a consequence…So, for example, take away a child's favorite TV program. I also learned "time-out" here, [the techniques] work, and one doesn't feel so guilty for spanking the kids or for insulting them or yelling at them.

One mother found it very difficult to physically discipline her children, but that was the only way she knew how to discipline her children. As such, she often did not discipline them. Despite her repeated threats to give her children a spanking, she could not bring herself to do it. Now she is able to teach her children right from wrong, without threatening to resort to spanking. She says,

> [Parents Anonymous® has] helped me to be a better mother, well, to listen to my children, when they need me, if they behave badly well punish them…before I only yelled…now I discipline them instead of hitting them…because before I would say 'I'm going to hit you' and I wouldn't and I let them go, and now no, I try to punish them.

A young woman expecting another child, said that taking away a favorite toy or activity sometimes "works, but for my oldest it doesn't work all the time. I continue to go to learn how to manage that." Instead of giving up, this woman had learned to open herself to a variety of options. Every child is different and sometimes even the same child will react differently to disciplinary techniques. In addition to learning particular techniques, group members said Parents Anonymous® had taught them that there are a range of disciplinary options for parents to experiment with and explore. They felt the group would support them as long as they were committed to finding solutions without resorting to physical or emotional violence.

Self-control. Parents reported that sometimes they resorted to violence out of anger or frustration. As a result, parents benefited from learning how to control their anger. One mother felt that she learned to control her anger through the techniques that she had picked up from group meetings. As a mother described:

> [Parents Anonymous®] has helped me control myself…because I yell a lot. And they have suggestions on how to control that, and they've put on videos about how to control one's anger. It's helped me to not yell at my

> kids so much, or when I'm really stressed, to remain quiet for a little while and try to let myself relax.

Another mother confirmed the importance of calming down before taking action:

> Because I believe in counting to ten, at least for me it works…Sometimes I count five sets of ten and I'm able to finally calm down. So you have to count to ten before you do anything because if not you may regret what you end up doing.

Parents knew the meetings provided a safe space to discuss their issues and strategize solutions; the promise of this place appeared to help calm some parents when they were faced with difficult situations away from the group. A father said that "[Parents Anonymous®] gives us stability and allows us to be calm when making decisions because we know we have the support here."

Increased Assertiveness and Self-efficacy

Parents credited sharing their stories, taking some leadership responsibilities, and gaining familiarity in their communities with increasing their assertiveness.

Sharing as empowering. Sharing their stories helped parents assert themselves, while alleviating their suffering due to stress, depression, and low self-esteem. Despite having joined Parents Anonymous® four years ago, a mother vividly described her feelings when she finally expressed herself, "I cried, I released my emotions, I released my depression. I felt like something had been lifted off of me." For some parents this "release" enabled them to change their perspective about themselves. A mother was reassured by the Parents Anonymous® philosophy that, "No problem is too small to talk about it." By sharing their stories with others, parents seemed to validate their lives as worthy enough and important enough to share.

This release of depression and emotions freed parents to find solutions. Soon, their mindset could change from passive, as they were overwhelmed by their problems, to more active, as they began to look for, and act out, solutions to their issues. Maria realized that always keeping quiet meant she was unable to tackle any problems.

> At home you can't fix anything. Many times your husband won't help you. Many times you're not heard. Instead of fixing your problems you make it bigger and bigger. The biggest problem is that we stay quiet; we keep all of our problems. We don't know what to do. Now I've come to realize, more than anything that we lived according to myths that we've put on ourselves and that our parents have put on us.

Maria described having living her life believing the myth that she was unworthy, unimportant and thus incapable of facing, let alone fixing, her problems. By realizing that she was capable, she had been able to confront her problems.

Luz reported that Parents Anonymous® helped her confront her bouts of self-loathing,

> I feel a lot more secure. My self esteem is a lot higher because when I first arrived my self esteem had hit rock bottom. I feel very secure with myself now. I feel a lot better!

Benefits of serving as Parent Group Leader. All groups visited had designated Parent Group Leaders, and those who had served in that role reported further benefits. Parent Group Leaders managed the logistics of the group and a range of activities, such as reminding parents about the meetings, writing down the list of new members, and deciding whose turn it is to speak. As Maria said of her first weeks as a Parent Group Leader,

> The first problem I encountered was having to call people on the phone because my self esteem was very low. I had a hard time doing it. I was very nervous. That helped me a lot to have more communication.

Such responsibility appeared to have prompted her to become more comfortable expressing herself.

Benefits of outside speakers and community events. Group Facilitators and Parent Group Leaders worked hard to invite outside speakers and inform parents about community offerings and events. Such efforts provided both practical benefits, such as learning to recognize drug use or gang activity, how to handle their finances, the pathways to violence among adolescents and adults, as well as more emotional benefits, such as helping parents feel more at home in their new country.

Group members attributed outside speakers with connecting them to the larger community. One mother revealed, "I go [to Parents Anonymous®] because it helps me understand this country." Many of the parents spoke of a desire to get help before discovering Parents Anonymous®. But with a fear of authority, very little experience with available community services, and no prior knowledge of self help groups, parents said they were at a loss.

Furthermore, parents said through Parents Anonymous® they learned they had certain rights. Parents learned what constitute child abuse and domestic violence so that they can recognize when a law is broken, as well as that there are laws that protect them. Parents, for instance, also learned that they could contact the police, whom they previously feared, regardless of their immigration status. This insight was very empowering to victims of abuse. As a mother described,

> I told my husband, if you ever do anything to us [herself or her children], I am not scared, I will go to the police and here they will pick you up, it's not like in our country [where] sometimes they look the other way.

Facilitators and Parent Group Leaders also made every effort to ensure parents knew about relevant community events. These events also helped parents become accustomed to their new community. Opportunities to interact with people outside of their immediate circle, from different backgrounds, helped the parents feel more comfortable and less afraid in their new surroundings. A Parent Group Leader described her experiences attending the annual Parents Anonymous® meeting in Washington, DC: "We go and we speak with the congressmen, so, the important thing is that they don't scare me." This Parent Group Leader felt confident even among seemingly intimidating lawmakers.

Assertiveness Outside of Parents Anonymous®. Parents reported that they also became active in uniting group members for a variety of causes. In one group, parents collected money to keep their groups from closing. In another location, group members were interviewed by a local news station and met with political figures to try to prevent their groups from closing down. During our site visit, some group members were organizing a Parents Anonymous® team for an upcoming cancer walk, while others were teaching group members how to conduct themselves during a protest.

Parents applied this newfound assertiveness to other aspects of their lives. Parents credited their involvement in Parents Anonymous® with giving them the confidence and knowledge to find new jobs, get a driver's license, and get involved in their community. As a mother said,

> This group has helped me grow as a person, as a woman, it's even given me opportunities to help others…I've been lucky in finding this group because it's been a springboard to many paths and opportunities. For example now I'm a volunteer working against cancer. So all this stuff fulfills me, and that's the way that I've learned how to be independent, how to be strong, I know how to make my own decisions and I know what I want. It's made me comfortable in this city and allowed me to get ahead.

Another mother mentioned that every time she accomplished something she was able to lift herself out of her depression a little bit more. She said, "Little by little I started coming out of it [the depression]. I went to school, I got my license, and I got better." Another parent credited Parents Anonymous® with helping her find work in the medical field. She earns her own money and it allows her to stay at home with to tend to her children. One mother mentioned starting her own savings in order to fulfill her professional dreams:

> I'm searching where I can take courses, even if it's the minimum. It's expensive but I'm saving a dollar here and there. I want to succeed! I'm not scared of anything.

Relationship with Partner and Self-satisfaction

Parents indicated that their involvement in Parents Anonymous® had a tremendous impact on their relationship with their partners. They reported learning more about the opposite sex, feeling better about themselves, demanding better treatment, and communicating in more effective ways.

Improving self. Parents discussed the difficult issues they faced before joining Parents Anonymous®, including stress, depression, low self-esteem, and isolation. These difficulties affected how they interacted with their spouses as well as their children. As the parents began to overcome their problems by understanding their root causes and how these problems affected their children and partners, they were able to change their behavior. A mother mentioned that she had to confront issues from her past before she was able to change her behavior:

> I was very jealous with [my current husband]; I wouldn't even let him go to the store by himself. Because my dad left us when we were young, I had children young. I got divorced. [My current husband] now says that if it were not for Parents Anonymous® 'I would no longer be with

> you'…because truly the group helped me realize that it wasn't healthy, they were issues from my past. He wasn't my dad, that figure I missed.

She realized why she was acting so jealous, and as such was able to begin to change her behavior.

Sometimes parents needed to see the impact of their behavior before they could change. One father described having to learn the impact of his alcoholism on his relationship with his family before he was able to improve his behavior. Though his wife's ultimatum was essential in getting him to quit drinking, he described spending time at group meetings discussing his alcoholism with his wife and only then did he see its impact. Having a relatively safe place to communicate allowed the couple to be more open with each other. This father was finally able to listen and understand the impact of his actions. He said:

> I thought it was just some drinks, a fair number of drinks but still, but then I realized…the environment in my house felt horrible, and I was making it this way. And my kids, if we were going out they would ask, 'Is dad coming?' and would not join us if we said I was.

Gender differences. Though the Parents Anonymous® groups are predominantly female, there are a number of male participants. The opportunity for members of each gender to interact was very valuable, according to parents. A father said that by listening to women share their stories, he "learned about their needs, about the way they feel, and how they are affected by a man's decision." A mother shared the female perspective:

> I almost haven't spoken about that [her relationship with her husband] with Parents Anonymous®…but it has helped me…For example, my husband is very serious, very quiet. And one time I heard a couple, in this case the husband told the wife to have patience, that he's quiet…if she asks him 'what's wrong,' and he says 'nothing,' to believe him that sometimes nothing is gong on…And the same thing happened to me, I would ask him [her husband] what was wrong and I felt bad! I would get

> upset, and now I've tried to understand him more, I've tried to accept his silence.

Parents learned about the opposite sex by simply sharing their stories with the group and listening to the other parents. As such, they might be more likely to re-examine how their decisions affects their partner or to be more tolerant of their differences, and not be so quick to get angry or hurt by their partner's actions.

Improved communication, support, and understanding. Parents said they were able to transfer the communication skills they learned to improve their parenting to their relationships with their partners. As such, many were able to improve their relationship with their partners simply by improving their communication skills. A husband shared:

> With my wife, we've learned how to share our differences. Let's say, we've learned how to fight. We've learned up to what level to let our discussion go. We've learned how to speak and compromise without making it into a huge thing, without it becoming the big leagues. We've learned how to talk, a lot of communication which is the most important thing in a relationship.

Couples were able to avoid cycles of escalating violence that were affecting all family members. Furthermore, parents credited their involvement in Parents Anonymous® with teaching them to support each other and work as a team regarding their parenting decisions. As a group member who accompanied his girlfriend to the meetings said:

> She likes [my participation in Parents Anonymous®] because, in addition to the fact that she told me to go, she saw that I liked it. I can tell she doesn't feel so alone because sometimes her son will behave badly and we punish him, 'you can't play,' or something like that, and he'll come to me and say 'won't you let me play?' and I say 'no.' So it makes more sense because we support each other, because sometimes before she'd say 'you can't play' but because I didn't go [to the group] I would say 'let him play, why not?' in front of him.

They succeed in presenting a united front towards the son. Furthermore, as the boyfriend pointed out, his involvement with Parents Anonymous® helped alleviate his girlfriend's feeling of being alone in household matters. Another parent said:

> I like to go to this program, Parents Anonymous®, because it's an hour dedicated specifically to me. It got to the point where I got very desperate with the kids…and perhaps because my husband saw that I was so agitated and that I wanted to do something (get out of the house) he supports me if I need to do something and stays with the kids.

Not every partner, however, was so supportive. One husband did not object to his wife's participation, but he also was not involved hands-on with the parenting himself, and continually put forth excuses for not attending the group. This mother explained:

> [My husband] thinks it's great that I go to the meetings. I've asked him to come but he also puts up work as a pretext, I'll say 'Let's go,' and he'll say 'Next week. I'll tell my boss to let me go.' One day I was late [to the group] because I was waiting for my husband. The next time, I simply didn't wait. I went [alone] and that was better. But he won't tell me, 'Why do you go so much, what do you do?'

Demanding a better life. Parents' increased assertiveness appeared to help them realize that they deserved better treatment and to take action towards changing their situation. A mother of two recalled the difficulty of her situation at home:

> I had problems with my husband who was an alcoholic and I couldn't see an out. I told my husband that if he didn't go to a meeting with me, our marriage would be over.

After only a handful of sessions she was able to gather the courage to set that ultimatum. She realized that she and her husband were responsible for setting examples for their children, and neither were doing a good job at the time. She did not want her children to see his behavior as a result of his alcoholism, nor her acceptance of his behavior. Both husband and wife expressed that their relationship had improved greatly and they are now

both regular Parents Anonymous® attendees. They both said: "If it were not for Parents Anonymous®, we would be divorced."

A group member left her physically abusive husband because he did not change. Now she is divorced but realized that "Living with domestic violence is very sad but a better life can happen and it can be passed down to our children." Similarly, another mother believed she was heading towards a divorce because her husband refused to be affectionate to her children from a previous marriage. She said:

> We've gotten better…in that we don't fight. We don't insult each other…And that's good for the children. They shouldn't have to see that, but I do have it in mind that we are heading towards a separation because I don't think he is going to change.

At least, she felt she succeeded in curbing their fighting, particularly in front of the children. Nevertheless, after giving him many opportunities to change, she seemed resigned to their impending separation. She revealed that Parents Anonymous® helped her see the unacceptability of his behavior towards her children.

The assertiveness and techniques parents learned to improve their relationship with their children, as well as the supportive environment necessary to impart this learning, carried over into other realms – particularly in regards to parents' community involvement, jobs, relationships with their partners and the development of friendships.

CHALLENGES FOR PARENTS ANONYMOUS®: LIMITED RESOURCES

Some challenges faced by Parents Anonymous® groups have already been discussed, including the lack of consistent informational resources, the risk of groups becoming overly dependent on particular Group Facilitators, and conflicts arising over

Parent Group Leaders. The most consistently reported concerns were those related to resources such as child care, facilities, and discontinued groups. Thirteen parents expressed concern about their limited group resources, such as limited child-care, and were particularly worried about the future of their groups.

Child care. One mother reported that sometimes there would not be any child care at all, and it would be difficult to concentrate on the meeting while taking care of her children. A father said the worst part of Parents Anonymous® meetings is that "sometimes there's no one to tend to the children." Even when child care was available, it appeared to be insufficient. A Parent Group Leader described her group's insufficient child-care:

> We need more people to watch our children, because right now we only have one person who is watching children who range in age from a few months to 14, 15 years of age, but we don't have the money.

Various parents complained that children of a variety of ages were all cared for by the same person. During one group observation, one adult watched approximately fifteen children, between six and eleven years old. Those parents that brought younger children said they did not feel comfortable leaving their children under such scarce care. As a result, they brought these children into the meeting, which caused a number of disruptions for the entire group.

Facilities and meeting locations. Furthermore, one of the meeting locations observed was in particularly poor shape. Parents met in a dilapidated school trailer behind an abandoned church. The facility was locked and dirty when parents arrived and there were no materials provided. Saul remarked, "The facility is dirty and there is no TV [for watching parenting videos]. The building isn't maintained very well." Despite

the condition of the site, parents were happy to have a place to meet, as they lost their sponsor and had been forced out of their facility and put on hiatus for several months because they did not have a site to hold meetings. Nevertheless, parents expressed some disillusionment regarding their new location and limited resources. One mother mentioned her disappointment, "There's no TV to watch videos. In the old facility they would bring food once a month, that doesn't happen anymore. Things that are bought are coming out of the parent's pockets." Their previous site offered appropriate child care, occasional snacks for the children, food once a month for parents, and visual aids.

Discontinued groups. The downsizing of Parents Anonymous® groups had already resulted in a decrease in parent attendance. One mother said that because the new site was farther and less conveniently located to public transportation, some of the parents that rode public transportation slowly stopped attending the meetings. At the end of her interview she said sadly, "They have us feeling a bit abandoned."

The groups observed had all struggled with being closed. A mother mentioned that the group is "constantly being threatened. There's a fear that it may be closed permanently or that it needs to shut down whenever the facility closes." Another group we visited had also been closed for almost a year due to lack of funds, and had just started again a few months before our visit. The Group Facilitator said she had trouble getting in touch with all the parents that used to attend the group, partly due to the parents' tendency to move or change numbers, and she told us the current group had considerably fewer people than the old group.

In another city, we were told that there used to be over ten different groups, some that catered to sub-groups such as men or single mothers, and plans to create many more.

However, instead of this expansion, their funding was cut and they were left with three groups. A mother who had left Parents Anonymous® years ago when her Group Facilitator left, realized that she was feeling increasingly stressed and needed to return. Her words speak to the importance Parents Anonymous® attendance played in her life and, unfortunately, to her distress at the lack of space in groups in her area.

> I wanted to return and I realized that there weren't enough funds, and that was like a shock! So I said, 'I better leave the space for somebody new, I've already participated in Parents Anonymous®.' [Then] like three months or two months ago, I said, I *need* to go to a group. I told [the Group Facilitator], 'tell me which group to go to because I need a group, because of my job, because of my kids, everything.' I was very stressed out. I said even if they have me in a little corner I'm going to go, but it really worries me that [Parents Anonymous®] isn't going to grow, that they won't be able to have all those groups they used to have, that there won't be a place to send people to anymore.

Though she was able to eventually find a group, such losses in funding inevitably left some people out. In one city, the reduced number of groups meant some areas were no longer serviced and those parents who could drive had to drive long distances to get to their meetings. Other parents had to give up other after-work activities, such as English classes, because their new group schedule conflicted with those activities. Furthermore, though some parents were able to find a way to keep attending, the reduction in number of groups offered had impact on group memberships.

The inability to provide a clean, spacious, functional facility could have implications on membership. A Parent Group Leader expressed dismay at the lack of introductory packets for new recruits. She also noted the lack of funds for simple snacks or coffee:

> We will make pamphlets that say we serve coffee, snacks, and there are occasions we don't have them, so then in those cases where I know we don't have them, I have taken my time, my money, and I've bought

> them…'cause you might not know but many of these parents come running from work…

The group with the inadequate facility had been shut down for several months, during which time the Parent Group Leader hosted the group, without a Facilitator, in her home. She told us:

> As a Parent [Group] Leader I had suggested we collect money ourselves because I don't want the group to disappear. So we wanted to raise money to pay the Facilitator, because of the need we feel for the program. Our desire to have it [didn't] disappear. We volunteered our own money, but we stopped doing that because we were told it wasn't right. When the group was [at my house] it wasn't Parents Anonymous®. It totally lost its name. I would run around for the parents and run around with the kids. I want to see people happy; my biggest dream is to see Parents [Anonymous®] get larger and larger. I want to see my community get larger and larger. But I haven't been able to bring parents because as I told the Group Facilitator, I need to see resources before I bring parents, I can't bring them somewhere with no resources.

Most of the parents that were interviewed were willing to make the effort to make the group work despite its limitations, even donating their own money or driving long distances to get to their meetings. But it was clear that at some point such resource limitations had an impact on who could be served and on the effectiveness of the groups, as long hiatuses and logistical obstacles hurt the flow and reliability of the group as a trusted place.

FOCUS GROUP FINDINGS: Latino Attitudes Toward Research

The difficulties encountered while recruiting new members of Parents Anonymous® for the Spanish-language longitudinal study highlighted the need to explore effective ways to include more Latinos in investigative research. Therefore, the qualitative segment of the evaluation included two focus groups, one at the Utah location and the other at the California location. Comprised of Parents Anonymous® members, focus group participants were asked about their attitudes and experiences regarding research and their recommendations to help researchers recruit and retain more Latino participants.

The focus groups participants didn't have much experience with formal research, but several recalled being called by surveying telemarketers or approached by door to door census workers. Also, they were all aware of the qualitative evaluation of Parents Anonymous® and some were participating in the interviews. In fact, they may have been unique from others in their community in that their membership in Parents Anonymous® had exposed them to research as well as to the importance of expressing their needs. Their personal investment in Parents Anonymous® may have allowed this group to understand potential benefits of research participation better than other groups—both research related to Parents Anonymous® and other studies. When discussing what makes them different from other parents in regards to feeling comfortable enough to speak to researchers one mother replied, "I think that others are a bit more timid than us (Parents Anonymous® parents) because at least we have these groups but others like to be more hidden and they are more afraid." However, even though they felt they had had more exposure to research than others, they recalled how they felt before participating in

Parents Anonymous®, and several described having to advocate for family members who were too timid to seek out information or medical help because of their immigrant status. Their experiences and comments were, therefore, relevant to the broader topic of Latino participation in research. They felt they could speak not only for themselves but for their family members and community.

Attitudes about Research

A general feeling of apprehension toward participation in research was expressed. All parents who had been approached by researchers felt unsure of participating for various reasons.

Avoiding researchers. Parents mentioned avoiding visitors and telephone calls they thought may be researchers. One mother spoke frankly about using the excuse of not being available.

> In reality, it's not that we don't have time, we put up that pretext so when they call us and they want to interview us we say, 'I don't have time right now.' I don't know why we do it. I tell you because I've done it, but I don't know exactly why.

Negative image. A parent commented on the propensity of publicized data that often portrays Latinos negatively, "I've heard about statistics that we (Latinos) are the poorest population, that's what I've heard."

Experiences Underlying Attitudes

Time. Some parents thought they—as Latino immigrants—may be somewhat unique in that, more than some other potential research participants, they may work longer hours and more often have multiple jobs in order to sustain themselves. They suggested perhaps they really do have less time and that, in any case, researchers should

be sensitive to problems with availability and timing when making initial contact with potential Latino participants.

Language and comprehension of study material. When asked what could keep them from completing paperwork or answering questions one parent mentioned, "I would like for Parents Anonymous® to translate all of its literature." Although this quote is targeting Parents Anonymous®, the lack of translated information is a problem for non-English speakers. The inability to fully comprehend what was being asked was also a complaint mentioned by one parent who had had trouble completing the paperwork for the evaluation visit.

> It's like we get confused. I'm telling you that to answer this [Parents Anonymous®] study's questions, it took me like four weeks, to be able to understand, to answer what they wanted. If I [still] don't understand them, well I just leave it blank.

Recognizing the benefits of research participation. The focus group participants stressed that not knowing how a particular study might benefit them is a major reason Latinos would choose not to participate.

In describing their own willingness to participate in Parents Anonymous® research, these parents demonstrated that Latinos in general would most likely be more interested in research if they understood its potential benefits. One parent recognized how the Parents Anonymous® study participation could mean greater exposure to the community of the true purposes and practices of Parents Anonymous® and thus increase membership.

> It's good because sending people to come and evaluate the group could mean getting our message out and to tell the truth about this because no one is obligated to be here and we're all part of the community. Investigations are very important because you will be able to take this message of what we need here in the community, it's good.

Another parents said:

> I think that this study in particular for us is to bring to light that the Hispanic community is in need of some sort of guidance; a way to introduce us to this culture. A lot of the time we don't know anything just what people tell us. So, the study [may let it be known] that Hispanics are in need but are collaborating and need more support [and] funding.

One parent articulated the importance that potential participants be shown the value of research.

> I tell my husband sometimes that that is why we have to have investigations because we are in a strange country, with a different culture, different ways, and different laws. [My other family members] are very afraid of investigations and studies. I tell them that they are not for bad, they are to learn more about Latinos and to learn how to help us because if we don't talk how are they supposed to help us when we are sick? We need more studies if nothing more than to get to know this country that we are standing on because many times we make many errors because we are uninformed.

Legal status. These parents felt the key reason so few Latino immigrants volunteer to participate in research was their fear of having their legal status exposed. One woman described reluctantly answering questions posed by a census worker and later regretting it due to worries about her legal status and that of her children. She said: "Another time, if I see him in my window I won't open the door, because I get scared."

Another mother spoke nervously about having to answer to the census worker who came to her door.

> I got scared of the census because they asked me my immigrant status. Then because I know that I'm hiding here in this country, he asked me, 'Ok, how many people live in your home? Ok, now how many are legally here?' Oh! And he told me, 'No, it's so that we can build more clinics and schools and more things.' He wanted to make me feel comfortable, but I didn't.

One parent described how suspicious parents are and how it's even kept new people from attending Parents Anonymous® meetings, despite being invited by a co-worker or neighbor with a similar legal status:

> I have invited a lot of people and people will tell me, 'No because they're going to investigate me and put down my name? No!' Even though I explain to them, they still don't want to go because they get scared.

One parent whose job involved hiring new employees recognizes the difficulty people face when questions are posed because she, too, must confront the same issue.

> They get to the question of social security numbers and if you are a resident here. That's when [the interview] ends! It's very difficult to be in that routine because there is always that fear.

One father added, "I think that for parents sometimes we feel, well, I sometimes feel like I'm between a rock and a hard place because we're scared of the police."

Focus Group Recommendations

The implication of these discussions was that despite certain ingrained attitudes and very real concerns about their legal status, it was the largely the responsibility of the researchers to design research projects that took the communities concerns and needs into account and then to adequately explain the research and its potential benefits to the community. The focus group participants gave several recommendations on how researchers could help potential participants overcome their preconceived notions and fears and thereby increase Latino participation in research.

Incentives. Having a clear incentive was something that parents mentioned could attract more Latinos into participating and sharing necessary information for research projects. They felt even small incentives could motivate people to offer their opinions.

Language. Study related materials need to be translated and the language used needs to be basic enough for all readers to understand.

Personal approach. Most parents stressed that face-to-face interactions were key to enticing Latinos into research. A parent commented:

> Us Latinos really like participating face-to-face. We are a very warm community so that way really motivates us. Going door to door and giving that acknowledgement, by looking at someone in the eye and to be able to see who exactly is benefiting from this…I think that will work better.

Another parent agreed:

> There's a trust that you get when you do things face to face…because if we are going to fill out a questionnaire there isn't that trust over the phone. I think it's better in person.

Community members as research staff. Focus group participants felt that having someone from within the community to make contact with them was important. One Parent Group Leader said:

> For me, in order for studies to function, I think that researchers need to be from the same community because it nurtures trust in neighbors and it gets rid of that barrier that they shouldn't be calling. When our parents call others there is no barrier but when we bring people from the outside to do them there's a barrier.

Results dissemination and follow-up. Parents made it clear that once data is gathered, results need to be made available and clear to participants and the community studied. The focus group parents felt that to increase Latino participation in research it was essential to commit to following up with study participants after data collection ceased. One parent said, regarding the Parents Anonymous® evaluation: "Almost all of my peers said they would like to see the results of [the research] and to know the truth about what the next steps will be." Others concurred:

> I would like support. I hope that [researchers] will come to see if promises were kept. I've seen groups where those on top have the privileges and those on the

> bottom continue to be forgotten and continue to live screaming. It would be good for them to be looking out for us.
>
> I would like for there to be a follow-up so that it wouldn't just be this conversation or this visit. Perhaps for [researchers] it would be difficult but perhaps there are other ways to communicate so that it won't be just something spontaneous for [researchers] to come here and there are no follow-ups.
>
> I would think that the information would have to go to [the Group Facilitator] and she would share it with us. She would keep us posted as to what was being found and what was being done for the group. We wouldn't want for [researchers] to come and then not know anything. We should continue communicating.

Practical study results and real benefits for the community. When asked what they would like to see in future studies that include Latinos, focus group participants expressed not simply wanting to hear about what impacts the Latino community, but suggestions as to how to fix some of the problems they encounter. A mother stated,

> Ultimately there are studies that say that children are suffering a lot from diabetes and obesity and those are things that we want to change. Sometimes we don't just want to hear about these problems but we want to hear, 'You know what? If you eat like this and like this, things are going to get better for you.'

When asked how they would prefer to be informed of study results, one parents said "A bulletin, a report, or a notice, to tell us this and that and this is the way it is because…and so on. We want to know that our protests are being heard." Another said: "I would like to see results in the end, maybe exchange phone numbers and give [researchers] the address, so that …we could accomplish something with [the research]."

Focus Group Findings Summary

The focus groups highlighted the problems researchers will continue to encounter if investigative projects don't begin to reflect sensitivity to the nuances of the Latino community. Recommendations for reaching this demographic included the following

- Make extra effort to reach out to potential participants whose preconceptions and fear of exposure are likely to keep them from participating.
- Make clear to potential participants what data will be collected and how the data and personal information will be used. Give clear and valid explanations of any risks.
- Make sure information is understandable, translated if necessary, and participants are guided through any paperwork they may find hard to fill out or answer.
- Describe how participants and their communities will benefit from the research.
- When possible conduct in-person study recruitment and data collection.
- When possible include community members in planning, recruitment and data collection efforts.
- Make efforts to conduct research when convenient for research participants, regardless of work schedules.
- Describe to participants plans for findings dissemination and follow-ups, and follow through on the plans.
- Design projects that address not just problems but possible solutions.

The question of legal status and, therefore, confidentiality is especially important to Latino immigrants. Additionally, focus group participants felt that they were already aware of the issues faced by their community that might be the subject of research and they were most open to research that wouldn't just assess the problems but that would lead to practical information they could use to help *solve* the issues.

CHAPTER 6. DISCUSSION

The results of this evaluation provide evidence that parents are positively affected in a variety of important ways from their experience with Parents Anonymous®. The quantitative analysis indicated that after attending Parents Anonymous® meetings parents indicated less aggression towards their children and less potential for child maltreatment. They also reduced their scores on several important risk factors for child abuse and neglect, including their experience of life stress, drug and alcohol abuse, and intimate partner emotional violence. These statistically significant findings are further supported by non-statistically significant trends showing improvement in physical aggression, parental stress, physical violence between intimate partners, and social support.

These quantitative findings were supported by the open-ended responses in the quantitative questionnaires and by the interviews in the qualitative segment of the study. When asked to describe how attending Parents Anonymous® meetings had affected their lives, parents were convinced of many positive impacts also related to risk and protective factors for child maltreatment—increased parenting skills and confidence, increased social support, even increased self-esteem. Over three-quarters indicated that parenting had become easier since they began attending Parents Anonymous® meetings and almost all reported Parents Anonymous® supplied them what they needed to raise their children well. Parenting-related problem solving, understanding child development, communication skills and developing their own patience were the most commonly expressed improvements these parents felt their Parents Anonymous® experience had given them. Also, over three-quarters of these parents said they had formed relationships with other members and almost all of these spent time with group members outside of

meetings. Further, at the final interview, almost all (96%) indicated they planned to continue attending meetings.

This study builds upon previous evaluations and makes several important contributions. Importantly, it had strengths that differentiate it from most evaluations of child maltreatment interventions. Recently released studies of other parent self-help mutual support programs have not typically used a national sample or scales based on published standardized measures as this study did. This study was also informed by a year long process evaluation (Wordes, et al., 2002) which helped to define research goals and objectives, develop the most appropriate constructs and variables, and target selection and recruitment efforts.

These overall results described are further supported and illuminated by more detailed study findings, including 1) parents who did not continue attending Parents Anonymous® did not show the improvements that continuing parents experienced, 2) when studied separately, a wide variety of parents showed improvement on study measures, 3) short *and* long term improvement was shown, 4) parents with particularly serious needs showed improvement on those needs, 5) there are reasonable explanations for why some measures, such as several of the protective factors, typically did *not* show improvement. These findings will be further described following a discussion of the study sample.

The Parents in the Sample

Why do parents attend Parents Anonymous®? Parents Anonymous® is primarily a grassroots organization with group members recruited through word of mouth. Most parents in the study heard about Parents Anonymous® through family or

friends, their children's' school, or Parents Anonymous® staff or literature. About a third of parents heard about Parents Anonymous® through CPS, social services, or some other professional or legal contact. Fifteen percent were required to attend Parents Anonymous® meetings by social services, a court, or some other public authority.

Parents reported that the key reasons for starting their attendance in Parents Anonymous® included learning to be a better parent, meeting other parents (reducing isolation), and coping with the stresses of parenting and of life in general. Very few indicated they began attending specifically to stop abusive behavior, though the 15% who were mandated presumably had been in contact with CPS or the courts regarding some sort of child maltreatment or because their own behavior indicated a potential risk to their children (16 of 27 mandated parents had had contact with CPS; 6 of those 16 cases were substantiated).

Parents endorsed a range of characteristics of Parents Anonymous® meetings that they particularly valued, including discussing and receiving input about their problems, socializing, sharing a sense of purpose with the other parents, and learning more about child development and parenting. Having other parent members truly listen to their issues and respond without being judgmental were important factors to many parents.

Parents' background and level of need. The sample was mostly female high school graduates, mainly either African American or White. The parents in the sample reported a fair number of needs: half had no other adult caretaker living with them to help take care of their children, half reported having at least one special needs child, half noted a history of physical or mental illness, and a fifth reported a history of substance abuse.

At the start of the study these parents reported little abusive behavior towards their children. Appendix Table A-2 shows that, with a possible score of between 0 and 5, mean scores at the first interview were 0.71 for psychological aggression and 0.21 for physical aggression. Put in terms of frequency, this average score indicates the vast majority of parents used such tactics less than once a month if at all. Also, though about a quarter of participants reported having had a CPS allegation against them at some time prior to the study, only 21% were substantiated.

These parents also began the study at the "healthy" extremes of the risk and protective factors measured. For example, Appendix Table A-3 shows that the life stress, emotional domestic violence, and physical domestic violence scales, each of which had a possible range of 0 to 3, had average scores of 0.5, 0.4, and 0.05, respectively. The means for the risk factors of alcohol and drug abuse were also extremely low. Further, Appendix Table A-4 shows these parents scored high on protective factors at the start of the study. For instance, the means at the first interview for social support were very high. Out of a possible range of scores of 0 to 3, the mean for emotional/instrumental social support was 2.75 (sd=0.39) and, out of a possible 0 to 2, the mean for general social support was 1.47 (sd=0.47).

Despite the high overall averages, there certainly were study participants who *did* show risk or occurrence of maltreatment. However, new Parents Anonymous® parents as a group seem to have relatively low risk of or occurrence of child maltreatment and thus seem to mainly represent a primary prevention population. Importantly, they did generally self-evaluate themselves as needing assistance with the practice of parenting. Almost three-quarters indicated they had sought help for their parenting issues prior to

joining Parents Anonymous® and 85% attended Parents Anonymous® on their own accord.

It should be noted that the sample for the qualitative segment of the study may represent a somewhat higher "risk" group when they started Parents Anonymous®. These parents did not complete the standardized measures, but reported in their interviews that before attending Parents Anonymous® meetings they had many of the risk factors for child maltreatment, including apparently severe stress and depression, isolation (often associated with their immigrant status), misconceptions of what raising children would entail, and dysfunctional relationships with their children. Importantly, they also reported that each of these issues had been ameliorated through their involvement with Parents Anonymous®.

Parents Who Continue Versus Parents Who Stop Attending Meetings

Parents who stopped attending Parents Anonymous® meetings after either the first or second interview showed almost no change over time compared to the strong patterns of positive change shown by the group who continued attending Parents Anonymous® throughout the study period. These findings cannot be explained by pre-study differences as the two groups were not statistically different on any demographics, background characteristics, or study measures at the start of the study, including the number of meetings attended prior to the first interview. This is the strongest evidence this study can offer that the improvements demonstrated over time were largely the effect of the Parents Anonymous® intervention.

Broad Range of Parents Showed Improvement

Parents Anonymous® seems to have at least some positive impact on parents across a broad range of characteristics, especially on measures of child maltreatment and risk of abuse. Table 3.3 shows that when various types of parents, as defined by their demographic and background information, were analyzed separately, all showed improvement on at least one study measure and most showed improvement on a variety of scales.

There were some types of parents who seemed to gain the most positive impact. Women make up the majority of attendees *and* showed the most impact; it is possible that these two findings are not coincidental, that women were more comfortable or otherwise responded better than men to the Parents Anonymous® process. In particular, women showed the most positive change for protective factors of any subgroup. These findings related to gender differences were consistent through various aspects of the analysis, though, with men accounting for just 10% of the sample, a more equally distributed sample may have provided more reliable statistics.

Parents with apparently fewer needs (or lower "risk") showed significant change on more measures than parents with greater needs (higher "risk"), that is, parents with other caregivers at home, high school graduates, earning $13,000 or more, parents with no special needs children and parents with no history of substance abuse showed significant improvement on the most scales of any other subgroups. Interestingly, parents with a CPS history also showed change on a relatively large number of scales. Men, parents who had not graduated from high school, parents with a history of substance abuse, and mandated parents showed the least improvement.

Short and Long Term Improvement

Change in study measures was assessed in the short term (one month) and in the long term (six months). It should be noted that "short term" and "long term" are phrases chosen mainly for clarity and, with regard to time, are relative to this evaluation only. Unfortunately, six months is not an adequate follow-up period to identify all possible effects of the intervention or how effects change over time. Nevertheless, these Parents Anonymous® parents demonstrated significant short term as well as long term improvement. In fact, across all the measures in the study there was somewhat more long term improvement indicated than short term improvement, that is, parents showed improvement in the short term on six and in the long term on seven of the sixteen measures. Further, parents showed *both* short and long term improvement on five measures, which indicates initial one-month impacts were sustained or improved upon over the six-month study period.

The evaluation literature includes many studies in which interventions produced immediate or short term impacts that do not necessarily last over a longer period. It is reasoned that acute needs may show immediate change due to the novelty and intensity of the initial intervention, but that this initial impact may lessen over time as other factors, such as individual differences, consistency of application, or frequency of dosage, play larger mitigating roles in outcomes. Similarly, some measures would be expected to change more readily while others may require a longer intervention period to effect measurable change. Finally, some participants may respond more quickly to the intervention while others may require more extended treatment.

Parents with Particularly Serious Needs Showed Improvement on those Needs

As previously stated, participating parents showed improvement in many but not all study measures. Separate analysis of those measures that did not show improvement overall revealed that the analysis across the entire sample may have hidden the positive impacts experienced by certain parents, specifically those who began the study with the most serious needs. These separate analyses showed that parents with a particularly strong need in a certain area (usually indicated by their being in the "worst" 25% of all parents on that scale) *always* showed improvement in that area even though the overall sample did not. For example, no statistically significant change was found for either general or emotional/instrumental social support. However, when analyzed separately from the full sample, those parents reporting the least social support at the start of the study *did* show significant improvement on those measures in both the short and long term. The same phenomenon was found for short and long term parental stress and physical domestic violence, short term emotional domestic violence and drug abuse, and long term quality of life. Similarly, while no statistically significant change was found for physical aggression toward children when the entire sample was analyzed together, when only those parents who indicated using at least some physical aggression in the first interview were analyzed, significant improvement was found in both the short and long term. Thus those parents most likely to use physical aggression did show improvement on that scale while the sample overall seemed not inclined toward physical aggression coming into the study and thus scores remained statistically flat for the group as a whole.

Similar patterns were found when those parents reporting the lowest levels of parenting sense of competence, nonviolent discipline tactics, and family functioning were

analyzed separately. This is important because the overall trends indicated *decreases* in scores for these three factors, though only to a statistically significant level for short term nonviolent tactics. Such decreases might suggest parents were losing rather than building those protective factors. Yet the parents who started the study in the lowest 25% of all scores for those measures showed improvement in both the short and long term.

Parents Anonymous® seems to provide both targeted and broad-based intervention. There are other possible explanations for the findings related to parents with the most need. For instance, since sampling was targeted toward parents new to Parents Anonymous®, at the time of the first interview many of them may have been in a particular crisis that would be expected to lesson over time, with or without intervention. However, it is also possible such crises would worsen or that new crises would develop, especially over longer periods of time. The overall patterns of change coupled with improvement in particular need areas suggest Parents Anonymous® represents a broad-based approach wherein parents with different types and levels of need can help each other improve both individually and collectively.

Protective Factors

Except for short term quality of life, the protective factors measured in the study did not show statistically significant improvement for the parents as a group or for most subgroups of parents. This is not a surprising result. As with other measures, parents tended to score toward the healthiest extreme on the protective factor scales and thus did not have much room for improvement. It seems that these parents already had a strong base of protective factors and most likely were attending Parents Anonymous® not so much to strengthen their quality of life or social support but to specifically address their

parenting issues. Perhaps more importantly, protective factors generally attempt to measure underlying attitudes and perspectives that are reasonably expected to change only over longer period of times. Risk factor scales, on the other hand, typically attempt to measure mood or specific behavioral change, such as stress or using or not using certain parenting techniques on a daily basis, constructs more likely to change in a matter of weeks or a few months.

Still, as discussed above, when analyzed separately parents with particularly low protective factors at the start of the study often did show some improvement. For example, building social support is a key element of the Parents Anonymous® strategy for reducing child maltreatment. Parents who scored in the bottom quartile of social support did show significant improvement at both the second and third interview. And there was evidence that they highly valued the social support provided by other Parents Anonymous®: 71% of parents' positive feedback regarding their experience with Parents Anonymous® included the social aspect of the meetings and 54% valued the shared sense of purpose they felt with the other parents, a category that included the camaraderie, support, and sense of community they felt they shared with the other parents. Also, the social support garnered from Parents Anonymous® attendance was extremely important to the parents interviewed in the qualitative segment, though many indicated that it took some time for them to grow accustomed to the meetings, to learn to trust the other parents, and to fully embrace the process.

Nonviolent Discipline Tactics. The complex etiology of child abuse speaks both to the difficulty in assessing the effects of interventions as well as the difficulty in measuring and interpreting parental behavior. A case in point is the measure of

nonviolent discipline. This study operationalized nonviolent tactics as a protective factor that was expected to be used more often as the study progressed. As unhealthy forms of disciplining such as psychological aggression and physical aggression are reduced, it was theorized that that the use of positive parenting techniques including nonviolent discipline tactics would supplant the aggression. If that were borne out, scores on nonviolent tactics would be expected to rise over time, but the findings were the opposite. However, it can also be expected that, as risk and protective factors are generally impacted positively and a family begins to function in a generally more healthy way, the need for any discipline, aggressive or not, would be reduced. This alternative explanation is supported by the authors of the scale on which the measure was based (Strauss, et al., 1998). They report that parents use a variety of strategies to address discipline issues and found that nonviolent tactics were significantly correlated with more aggressive tactics, a finding consistent with the current results. It is also important to note that those parents who reported using nonviolent tactics the least, those who scored in the bottom 25% at the first interview, increased their use of nonviolent tactics at a statistically significantly at the second and the third interview. Parents who did not have positive parenting techniques as part of their approach to discipline seem to have learned how to incorporate them through their Parents Anonymous® attendance. For consistency, nonviolent discipline tactics are presented here as they were originally conceived, but it is likely that use of nonviolent tactics is a protective factor in certain cases and a risk factor in others.

Parenting Sense of Competence and Family Functioning. The measures of parenting sense of competence (or parenting self-esteem) and family functioning showed statistically significant decreases for many types of parents, though not for the sample

overall. This may be explained in a number of ways. For instance, it could be that Parents Anonymous® attendance by one family member but not the whole family creates greater tension and less healthy functioning, at least in the short run, until that family member can work to bring the rest of the family up to speed. It could also be that the extent of dysfunction is not recognized by family members until attendance in meetings provides perspective on what is healthy and what is not, which would lead to an initially inflated family functioning score followed by at least a short term decrease. Parents entering Parents Anonymous® may have just come to realize (or were shown by authorities) that there parenting skills needed help and they may be somewhat daunted by the confidence shown by longer term attendees in their groups, both of which could be expected to make parenting self-esteem require a longer time to level and improve.

As reported in the literature review of this report, child maltreatment results from complex interactions of variables over time. Effecting change in maltreatment outcomes requires more than a simple reduction in risk factors coupled with an increase in protective factors, but rather requires consideration of both the level of need in each of these areas as well the interaction of the various factors. In fact, the dynamics are such that improving in one area may be at another's detriment. That is, parents who improve on one scale may actually, if temporarily, worsen on another scale. For example, as parents begin to more proactively address issues which had previously been unattended to, such as substance abuse or adult-to-adult domestic violence, other factors, such as family functioning or social support, may degrade as the family dynamic changes. The current findings are not inconsistent with this possibility. Even if this seesaw phenomenon does not manifest itself, parents need not just their most pressing needs

addressed but also secondary and related needs. It may be that a broad-based approach to family strengthening such as that offered by Parents Anonymous® allows parents to address their most pressing needs at the same time as providing a safety net, buffering the impact of the process of change across other factors. While worsening of certain factors was found over the course of the study, the overall trends were overwhelmingly in the direction of positive change. Parents Anonymous® seems to allow parents to collectively improve their parenting behaviors while also allowing individual parents with different needs to address and solve their personal issues. Higher order analyses of these factors over a longer period of time would illuminate what dynamics are at work in these findings.

Further Discussion of Specific Factors

Baseline scores and magnitude of change. While many scales showed statistically significant improvement over time, the *magnitude* of the change was typically small. As described above, parents tended to score near the "healthy" extremes of most study measures at the time of their first interview. Therefore it could not be expected that great amounts of improvement across the entire sample could be found when, for instance, the group average for social support was nearly at the top of the scale and, likewise, the group average for physical aggression was nearly zero. A related issue is that these "healthy" average scores at the start of the study may indicate the sample mainly came from a primary prevention population. Separate analyses attempted to assess scale score change over time just for those parents with less "healthy" baselines (e.g., those parents in the top or bottom 25% for a given scale) and with particular needs as indicated by their background characteristics (e.g., prior CPS contact); however,

further study is warranted targeting Parents Anonymous® participants associated with secondary or tertiary prevention populations.

Physical aggression towards children. The scale measuring physical aggression was based on a scale similar to the physical aggression subscale of the Conflict Tactics Scale. Parents were informed before each interview that any potential abuse or neglect that arose from their responses would be reported to local CPS authorities; it is always possible that some parents were inhibited in their responses for fear of such action. However, only the lesser forms of corporal punishment, historically socially acceptable and typically not illegal, were included in the study measure. This was done in order to encourage honest responses to the items that *were* included and to interview questions in general as well as to reduce the chances that parents would indeed have to be reported to authorities. In any case, these factors did not seem to limit the validity of the physical aggression measure. A more important factor is that the parents in the study sample did not use much physical aggression towards their children in the first place.

Limitations of the Current Study

Lack of experimental design. The research would have benefited from an experimental design and larger sample size. The complex nature of child maltreatment and its intervention will make it difficult for any design to produce definitive causal relationships, but such efforts would be maximized with randomization of both the treatment group and an appropriate control group that received no Parents Anonymous® or similar intervention. Other limitations related to the lack of an experimental design are discussed below including the attempt to study "new" Parents Anonymous® participants and the lack of true comparison groups.

Sampling. Though participation was voluntary, the methods used in this study most likely produced a fairly representative national sample of new parents to Parents Anonymous®. The data from the process evaluation indicates the outcome study sample had a somewhat higher proportion of mandated parents and a lower proportion of men then the national Parents Anonymous® data indicates. The mandated parents in the study tended to show less improvement over time than non-mandated parents and less enthusiasm for their Parents Anonymous® experience. It is thus possible that a more representative sample with regard to mandated status may have produced greater improvement than that found in the current sample. The mandated parents *did* show improvement in short and long term psychological aggression, one of the strongest indicators of child maltreatment among the measures used. This may suggest that Parents Anonymous® attendance can have a positive impact on risk behavior even for parents who are not fully invested in their Parents Anonymous® experience.

Mandated parents being overrepresented in the study sample might suggest parents with CPS contact and substantiated allegations were also overrepresented. The proportion of Parents Anonymous® participants nationally with a history of CPS contact was not available. The proportion of parents with a history of allegations against them the current sample was 27%, with approximately 21% of those substantiated, figures that are consistent with national averages. It would be expected that a somewhat greater proportion of parents with CPS contact than the national average would attend a self-help group focused on parenting and child maltreatment issues, so this 5% gap does not seem to suggest the sample used in the study had an unusually high number of such parents or that the study results might have been affected by that factor.

On the other hand, since men showed generally less improvement over time than women, if men are underrepresented in the current sample it could be that less improvement overall may have been found were more men included. Counteracting that possibility is the small subsample of men, since statistical tests lose their ability to identify group differences as sample sizes become smaller.

New parent status. While the current study was meant to focus on only parents new to Parents Anonymous®, parents were already experiencing the impact of Parents Anonymous® at the time of the first interview. Every parent had attended at least *one* prior meeting, since it was only possible to recruit parents once they had attended a meeting. (Study resources—as well as the Parents Anonymous® model—did not allow for prior assignment of treatment versus comparison group status as would have occurred with an experimental design.) And while every attempt was made by research staff to administer the first interview as soon as possible after recruitment, most parents had attended more than one prior meeting by the time of their first interview due to several factors including parents' scheduling issues, inconsistencies in parent reporting of their total attended meetings, and different group meeting schedules (giving parents the opportunity to attend more than one meeting per week). This made it difficult to limit the eligibility cut-off to just one or two meetings prior to the first interview; the cut-off used was five meetings.

This could have affected the baseline scores and ultimate findings in a number of ways. The baseline scores measured at the first interview were likely less extreme than had they been measured before first attending Parents Anonymous®, that is, a certain amount of leveling if not improvement in scores was probably already occurring,

especially among parents who attended 3 or 4 or 5 prior meetings. The fact that improvement on many scales was found between the first and second interview makes it likely that the path to improvement may have already begun for parents who had almost as many meetings prior to the first interview as between the first and second interviews.

Study length. As noted above, the study design would have benefited from a longer final follow-up period, for two reasons. First, many impacts of an intervention such as Parents Anonymous® would be expected to reach statistically significant levels only after a longer period, such as 12 to 18 months. Second, it is of interest to see if improvements experienced by parents are (or are not) sustained over the full course of their participation in Parents Anonymous®, which for many parents is several years. A longer term study would also be able to explore what help Parents Anonymous® can offer parents as they cope with various family events and setbacks. This speaks also to the need for the collection of weekly attendance records. The measure of attendance used in this study—total number of meetings attended between interviews—was not adequate to assess how parents are really using Parents Anonymous®. Some parents seem to attend Parents Anonymous® weekly while others use it less often, on an "as needed" basis or as often as their schedules allow. These different attendance patterns need to be analyzed appropriately to fully understand the differential impact of participation over time.

Comparison groups. The research plan for the study included using Parents Anonymous® dropouts as a quasi-comparison group to those who continued attending meetings throughout the study. This is the main reason parents who stopped attending meetings were still interviewed at each follow-up. The fact that relatively few parents

did in fact dropout was somewhat of a surprise to the researchers and made sample sizes for comparisons between these two groups rather small.

Group implementation. Another quasi-comparison group planned for was group implementation, that is, the level to which the groups adhered to the key Parents Anonymous® model elements of shared leadership and mutual support. Findings in those analyses were equivocal. The assessment tools used to measure group implementation were first used in the process evaluation and were adapted for the outcome evaluation, but are not yet proven as reliable measures of these complicated phenomena. It is possible using different or improved tools to measure high and low implementation was required, though it is not clear that alone would have strengthened group implementation as a differentiating variable. The Parents Anonymous® national office notes that model fidelity, which they continually try to maximize, is subject to many factors not all of which are under its control, including how long the group has been together, the size of the group, and the role of the local organization. They estimate that 80% of existing groups have moderate to high implementation of the Parents Anonymous® model, figures that are consistent with the current study. (Personal communication, Lisa Pion-Berlin, July 13, 2007) Parents Anonymous® national is currently using lessons learned from the current study's Group Assessment to develop ongoing evaluation tools. Despite difficulties in measuring group implementation and despite a lack of a particularly strong statistical pattern for how group level may impact parents differently, the group implementation analysis still shows relevant results. Despite most parents attending groups that were deemed to have only a low or moderate level of implementation, parents across the sample showed improvement. Also, statistically significant improvement was

found in groups with the lowest level of implementation. Benefit to parents can be found at all levels of model fidelity. In the key child maltreatment outcomes of parenting distress and rigidity and aggression towards children, parents from groups with moderate or high implementation levels were more likely to show statistical improvement, indicating efforts to improve group adherence to the Parents Anonymous® model should continue.

Relationships between the quantitative and qualitative data. While the quantitative and qualitative segments seemed to extract generally similar information regarding the impact of Parents Anonymous® attendance on parents' lives, findings for the two segments should not be considered as directly corresponding to one another. The qualitative segment focused entirely on Latinos while the quantitative data had too few Latinos to isolate them in the analyses. Further, the fact that the qualitative sample was all Spanish-speaking immigrants to the U.S. not only sets them apart from the vast majority of the quantitative sample, but may have contributed to the impact of Parents Anonymous® in their lives. That these parents had a major life experience in common and shared many of the problems associated with that experience prior to meeting through Parents Anonymous® probably contributed to the success of those groups. The philosophy and methods of Parents Anonymous® in many ways seemed a perfect fit for these parents and thus their experiences may not be representative of the members of groups nationwide.

Conclusion

Parents Anonymous® is a promising program for the reduction of child maltreatment. The Parents Anonymous® model seems to be broadly based and flexible

enough to address the individual parenting needs of a wide variety of participants. The current study, which used a national sample, standardized scales and methods informed by a prior process evaluation, revealed improvement on child maltreatment outcomes in parents with a wide variety of demographics, background characteristics, and needs. Improvement was indicated at both one month and six month follow-ups to the initial data collection. Qualitative interviews with a separate group of Parents Anonymous® participants provided similar evidence that Parents Anonymous® can be associated with the beneficial outcomes it is intended to effect. Further, with all of the qualitative interviewees and 96% of the quantitative interviewees reporting they planned to continue attending, Parents Anonymous® enjoys a loyal and enthusiastic following.

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APPENDIX – Main Analysis Statistical Information

This appendix closely mirrors the text of Chapter 3, Section 4, but includes the relevant statistics that were removed from the main report for purposes of clarity. Means and t-test statistics are included in the text, while tables A-1 through A-4 show means and standard deviations for all study measures at the three interviews.

Finding 1. Overall, parents who participated in Parents Anonymous® indicated a reduction in child maltreatment outcomes in both the short and long term.

When analyzing all the parents as a single group (n=188), statistically significant change was found on three of the four child maltreatment outcomes (see Figures 3.26, 3.27, 3.28, 3.29 and Table 3.2 in the main text). In both the short and long term, parents reduced their parenting distress, their parenting rigidity, and their use of psychological aggression toward their children.

Overall, there was no evidence of statistically significant change on the use of physical aggression in either the short or long term, though the trend was for parents to report less physical aggression over time (see Figure 3.29). T-tests run to assess change in physical aggression over time for *only* those parents who, at the first interview, reported using physical aggression at least "once a month or less" (as opposed to "never") found statistically significant improvement in both the short (T1 m=0.59 vs. T2 m=0.43, t=3.32, df=64, p=.023) and long term (0.59 vs. 0.36, t=3.30, df=63, p=.002).

Finding 2. Overall, parents who participated in Parents Anonymous® indicated an increase in one protective factor and a reduction in four risk factors.

Risk factors. In the short-term, parents overall indicated reduced life stress (T1 m=0.53 vs. T2 m=0.42, t=5.43, df=187, p=.000) and reduced alcohol use (0.09 vs. 0.06, t=2.29, df=186, p=.023). In the long term, parents overall indicated a reduction in their life stress (0.53 vs. 0.45, t=3.24, df=187, p=.001), emotional violence between intimate partners (0.38 vs. 0.28, t=2.00, df=91, p=.048), drug use (0.13 vs. 0.08, t=3.35, df=186, p=.001), and alcohol use (0.09 vs. 0.05, t=2.49, df=186, p=.014). (See Table 3.2 in the main text and Table A-1 here.)

There was no evidence of change for parental stress when all parents were analyzed together. However, t-tests run to assess change in parental stress for *only* those parents who, at the first interview, scored in the highest 25% of parental stress scores found statistically significant improvement in both the short (2.55 vs. 2.41, t=3.67, df=45, p=.001) and long term (2.55 vs. 2.38, t=4.48, df=45, p=.000).

There was no evidence of short-term change for intimate partner emotional violence when all parents were analyzed together. However, t-tests run to assess short-term change in this scale for *only* those parents who, at the first interview, scored in the highest 25% of intimate partner emotional violence scores found statistically significant improvement (1.26 vs. 0.96, t=2.51, df=24, p=.019).

There was no evidence of change for intimate partner physical violence when all parents were analyzed together. However, t-tests run to assess change in this scale for *only* those parents who, at the first interview, scored in the highest 25% of intimate partner physical violence scores found statistically significant improvement in both the short (0.45 vs. 0.15, t=2.39, df=10, p=.038) and the long term (0.45 vs. 0.15, t=4.22, df=10, p=.002).

There was no evidence of short-term change for drug abuse when all parents were analyzed together. However, t-tests run to assess short-term change in this scale for *only* those parents who, at the first interview, scored in the highest 25% of drug use scores found statistically significant improvement (0.53 vs. 0.32, t=5.14, df=45, p=.000).

Protective factors. In the short term, parents indicated an increase in their quality of life (3.81 vs. 3.88, t=-2.27, df=187, p=.024). These parents also indicated a short-term *reduction* in the use of nonviolent parenting tactics (2.30 vs. 2.11, t=2.58, df=186, p=.011). (See Tables 3.2 and A-1.)

It should be noted that parents indicated a long-term increase in general social support that was approaching significance (p=.056).

There was no evidence of long-term change for quality of life when all parents were analyzed together. However, t-tests run to assess change in this scale for *only* those parents who, at the first interview, scored in the lowest 25% of quality of life scores found statistically significant improvement (2.98 vs. 3.29, t=-4.79, df=48, p=.000).

There was no evidence of change for emotional and instrumental social support when all parents were analyzed together. However, t-tests run to assess change in this scale for *only* those parents who, at the first interview, scored in the lowest 25% of emotional and instrumental social support scores found statistically significant improvement in both the short (2.16 vs. 2.48, t=-4.46, df=41, p=.000) and long term (2.15 vs. 2.44, t=-3.52, df=40, p=.001).

There was no evidence of change for general social support when all parents were analyzed together. However, t-tests run to assess change in this scale for *only* those parents who, at the first interview, scored in the lowest 25% of general social support scores found statistically significant improvement in both the short (0.82 vs. 1.23, t=-6.56, df=46, p=.000) and long term (0.82 vs. 1.28, t=-7.04, df=46, p=.000).

There was no evidence of change for parenting sense of competence when all parents were analyzed together. However, t-tests run to assess change in this scale for *only* those parents who, at the first interview, scored in the lowest 25% of parenting sense of competence scores found statistically significant improvement in both the short (2.55 vs. 2.64, t=-2.25, df=47, p=.029) and long term (2.55 vs. 2.79, t=-6.78, df=48, p=.000).

T-tests run to assess change in non-violent discipline tactics for *only* those parents who, at the first interview, scored in the lowest 25% of that scale found statistically significant improvement in both the short (0.90 vs. 1.18, t=-2.18, df=50, p=.034) and long term (0.89 vs. 1.38, t=-3.74, df=49, p=.000).

There was no evidence of change for family functioning when all parents were analyzed together. However, t-tests run to assess change in this scale for *only* those parents who, at the first interview, scored in the lowest 25% of family functioning scores found statistically significant improvement in both the short (2.46 vs. 2.58, t=-2.23, df=43, p=.031) and long term (2.46 vs. 2.62, t=-2.89, df=43, p=.006).

Table A-1. Overall Short-Term and Long-Term Change on All Measures (n=188)

	First Interview		Second Interview		Third Interview	
	m	sd	**m**	sd	**m**	sd
Child Maltreatment Outcomes						
Parenting Distress	**1.28**	0.26	**1.25***	0.25	**1.24***	0.25
Parenting Rigidity	**1.39**	0.26	**1.36***	0.28	**1.34***	0.27
Psychological Aggression	**0.71**	0.67	**0.58***	0.71	**0.56***	0.66
Physical Aggression	**0.2**	0.39	**0.19**	0.39	**0.17**	0.33
Risk Factors						
Parental Stress	**2.07**	0.4	**2.06**	0.39	**2.03**	0.4
Life Stress	**0.53**	0.4	**0.42***	0.36	**0.45***	0.39
Domestic Violence – Emotional	**0.38**	0.61	**0.33**	0.6	**0.25***	0.44
Domestic Violence – Physical	**0.05**	0.21	**0.02**	0.08	**0.03**	0.15
Alcohol Abuse	**0.09**	0.19	**0.06***	0.17	**0.05***	0.15
Drug Abuse	**0.13**	0.28	**0.11**	0.26	**0.08***	0.23
Protective Factors						
Quality of Life	**3.81**	0.64	**3.88***	0.6	**3.88**	0.61
Social Support – Emot & Instrum	**2.75**	0.39	**2.78**	0.38	**2.78**	0.37
Social Support – General	**1.47**	0.47	**1.52**	0.44	**1.54**	0.46
Parenting Sense of Competence	**2.97**	0.36	**2.95**	0.33	**2.97**	0.32
Nonviolent Tactics	**2.31**	1.14	**2.11***	1.13	**2.18**	1.11
Family Functioning	**3.1**	0.48	**3.08**	0.49	**3.05**	0.48

*Statistically significant change from first interview (p<.05).

Finding 3. Parents Anonymous® does not impact all parents in the same way, but seems to be more effective at reducing child maltreatment factors, reducing risk factors, and enhancing protective factors in some types of parents more than other types.

The next step of the analysis was to assess whether patterns of change in child maltreatment outcomes (parenting stress, parenting rigidity, and psychological

aggression) and in risk and protective factors were consistent across all parents in the study. *Does Parents Anonymous® impact all parents in the same way? Which types of parents experienced which types of change?*

There was no evidence of change on the use of physical aggression in either the short or long term for any type of parent.

Gender

Baseline differences between men and women. At the start of the study, men and women were significantly different on only one measure. Men on average indicated more general social support than women (men=1.65, women=1.45, adj. t=-2.10, df=24, p=.047).

Maltreatment outcomes. The one indication of change in maltreatment outcomes for men was in their use of psychological aggression towards their children, which decreased in the short term (0.66 vs. 0.38; t=2.21, df=18, p=.041); that change was not significant in the long term. On the other hand, women showed significant change in both the short and long term on three child maltreatment outcomes: psychological aggression towards their children (short-term: 0.71 vs. 0.61; t=2.29, df=167, p=.023; long-term: 0.71 vs. 0.58; t=2.84, df=165, p=.005), parenting distress (short-term: 1.29 vs. 1.25; t=3.36, df=168, p=.001; long-term: 1.29 vs. 1.24; t=3.10, df=168, p=.002) and parenting rigidity (short-term: 1.39 vs. 1.36; t=2.61, df=168, p=.010; long-term: 1.39 vs. 1.32; t=4.90, df=168, p=.000).

Risk factors. Men indicated decreased life stress in the short term (0.47 vs. 0.33; t=2.38, df=18, p=0.041) and decreased drug use in the long term (0.25 vs. 0.11, t=2.12, df=18, p=.045). Women indicated short- and long-term decreases in life stress (short-term: 0.53 vs. 0.42, t=4.96, df=168, p=.000; long-term: 0.53 vs. 0.44, t=3.45, df=168, p=.001) and alcohol use (short-term: 0.08 vs. 0.06, t=2.24, df=168, p=.012; long-term: 0.08 vs. 0.04, t=2.43, df=167, p=.016). Women also indicated decreases in emotional domestic violence (0.34 vs. 0.21, t=2.49, df=78, p=.015) and drug use (0.12 vs. 0.07, t=2.71, df=167, p=.007) in the long term.

Protective factors. Both men and women indicated a decrease in the use of nonviolent discipline tactics in the short term (men: 2.25 vs. 1.82, t=2.23, df=18, p=0.028; women: 2.231 vs. 2.15, t=2.07, df=167, p=0.041). There was no further

evidence of change for men, while women also indicated short- and long term increase in quality of life (short-term: 3.79 vs. 3.87; t=2.54, df=168, p=0.012; long-term: 3.79 vs. 3.86, t=-2.01, df=186, p=.046) and general social support (short-term: 1.46 vs. 1.53; t=2.03, df=162, p=0.044; long-term: 1.50 vs. 1.54, t=-2.09, df=163, p=.038).Race

Baseline differences between races. At the start of the study, various group differences were found between the three ethnic categories. Each group was compared to the other ethnic groups, that is, African Americans were compared to all non-African Americans, whites were compared to all non-whites, and parents in the Other category were compared to African Americans and whites.

African Americans indicated more parenting rigidity (AA=1.50, non-AA=1.30, t=-5.76, df=186, p=.000) but less parenting distress (AA=1.23, non-AA=1.33, adj. t=2.84, df=185, p=.005) than non-African Americans. They also reported more issues with drugs (AA=0.19, non-AA=0.08, adj. t=-2.68, df=147, p=.008). Conversely, African Americans indicated higher quality of life (AA=3.96, non-AA=3.67, t=-3.23, df=186, p=.001), less life stresses (AA=0.46, non-AA=0.59, t=2.13, df=186, p=.035), less parenting stress (AA=2.07, non-AA=2.20, t=2.41, df=186, p=.0017), less emotional domestic violence (AA=0.14, non-AA=0.53, adj. t=4.00, df=79, p=.000), more emotional or instrumental social support (AA=2.83, non-AA=2.67, adj. t=-2.87, df=176, p=.005), higher sense of parenting competence (AA=3.03, non-AA=2.92, t=-2.13, df=186, p=.035), and higher family functioning (AA=3.18, non-AA=3.02, t=-2.23, df=186, p=.027) than non-African Americans. It should be noted that African Americans indicated more use of physical aggression in parenting than non-African Americans, with the difference approaching significance (p=.058).

Parents in the Other race category indicated less emotional and instrumental social support (Other=2.50, non-Other=2.77, adj. t=2.21, df=17, p=.041) as well as less problems with drugs (Other=0.04, non-Other=0.14, adj. t=2.94, df=52, p=.005) than parents in the other ethnic groups.

At the start of the study, whites indicated more parenting distress (White=1.34, non-White=1.24, t=-2.88, df=186, p=.005), but less parenting rigidity (White=1.27, non-White=1.49, t=6.29, df=186, p=.000) than non-whites. There was no evidence that whites were different from non-whites on aggressive discipline tactics. Compared to

non-whites, whites reported lower quality of life (White=3.64, non-White=3.92, t=3.11, df=186, p=.002), more parenting stress (White=2.15, non-White=2.00, t=2.35, df=186, p=.020), less parenting sense of competence (White=2.91, non-White=3.02, t=2.14, df=186, p=.034), more emotional domestic violence (White=0.52, non-White=0.24, adj. t=-2.44, df=84, p=.017) and lower family functioning (White=3.01, non-White=3.16, t=2.11, df=186, p=.037). Whites also indicated less problems with drugs than non-whites (White=0.09, non-White=0.16, adj. t=2.03, df=185, p=.043).

Maltreatment outcomes. African Americans decreased their parenting distress in the short term (1.23 vs. 1.20, t=2.84, df=91, p=.006) and their parenting rigidity in the long term (1.50 vs. 1.44, t=3.44, df=91, p=.001), but showed no change on their use of aggressive tactics. Whites improved in both the short and long term on psychological aggression (short-term: 0.70 vs. 0.51, t=3.16, df=78, p=.002; long-term: 0.70 vs. 0.51, t=2.91, df=78, p=.005) and in the long term on parenting distress (1.34 vs. 1.29, t=2.26, df=78, p=.027), but showed no change in parenting rigidity. The Other race category improved only on parenting rigidity in the long term (1.43 vs. 1.29, t=3.05, df=16, p=.008). It should be noted that decrease in parenting rigidity for the Other group was approaching significance in the short term (p<.051).

Risk factors. African Americans and Whites both showed patterns of change on risk factors. African Americans indicated a decrease in alcohol use in the long term (0.09 vs. 0.03, t=3.20, df=90, p=.002) and short- and long-term decreases in life stresses (short-term: 0.46 vs. 0.37, t=3.26, df=91, p=.002; long-term: 0.46 vs. 0.39, t=2.29, df=91, p=.024) and drug use (short-term: 0.19 vs. 0.12, t=2.679, df=90, p=.009; long-term: 0.19 vs. 0.12, t=3.31, df=90, p=.001). Whites indicated short- and long-term decreases in life stresses (short-term: 0.58 vs. 0.45, t=4.22, df=78, p=.000; long-term: 0.58 vs. 0.50, t=2.11, df=78, p=.038) and emotional domestic violence (short-term: 0.53 vs. 0.41, t=2.03, df=48, p=.048; long-term: 0.50 vs. 0.32, t=2.40, df=46, p=.020). There was no evidence of short- or long-term change in risk factors for parents in the Other race category.

Protective factors. Each ethnic category showed limited long-term change in protective factors, but no improvement in the short term. African Americans indicated a short-term reduction in parenting sense of competence (3.04 vs. 2.97, t=2.18, df=90,

p=.032). Whites indicated an increase in quality of life in the long term (3.64 vs. 3.76, t=-2.04, df=78, p=.045). An increase was found in long-term general social support for African Americans (1.50 vs. 1.61, t=-2.24, df=88, p=.028) and the Other category (1.42 vs. 1.58, t=-2.74, df=15, p=.015).

African Americans also indicated *decreased* parenting sense of competence in the short term, but an increase in general social support in the long term. It should be noted that in the short term African Americans showed increase approaching significance in general social support (p=.059) and decreases approaching significance in parenting sense of competence (p=.054) and nonviolent discipline tactics (p=.053).

Education

Baseline differences between high school graduates and nongraduates. At the start of the study, parents who had not graduated from high school indicated more parenting rigidity than those who had graduated (non-graduates=1.51, graduates=1.36, t=3.42, df=183, p=.001).

Maltreatment outcomes. Non-graduates showed no short term change, but decreased their parenting rigidity in the long term (1.51 vs. 1.45, t=2.52, df=42, p=.016). Graduates indicated short- and long-term decreases in three measures: use of psychological aggression (short-term: 0.68 vs. 0.55, t=2.81, df=140, p=.006; long-term: 0.68 vs. 0.54; t=3.12, df=141, p=.002), parenting distress (short-term: 1.27 vs. 1.23, t=3.50, df=141, p=.001; long-term: 1.27 vs. 1.21; t=3.46, df=141, p=.001) and parenting rigidity (short-term: 1.36 vs. 1.33, t=2.36, df=141, p=.020; long-term: 1.36 vs. 1.31; t=3.30, df=141, p=.001).

Risk factors. There was no evidence of short- or long-term change on risk factors for parents who did not graduate from high school. Parents who did graduate from high school indicated a decrease in drug use in the long term (0.12 vs. 0.07, t=2.65, df=140, p=.009) and a decrease in life stresses in the short (0.53 vs. 0.40; t=5.12, df=141, p=0.00) and long term (0.53 vs. 0.45, t=2.61, df=141, p=.010). It should be noted that graduates indicated short- and long-term decreases approaching significance in problems with alcohol (p=.059 and p=.052).

Protective factors. There was no evidence of short- or long-term change on protective factors for parents who had not graduated from high school. On the other hand,

high school graduates indicated an increase in their quality of life in the short term (3.79 vs. 3.86; t=2.185, df=141, p=0.031), a decrease in their use of nonviolent discipline tactics in the short term (2.35 vs. 2.14; t=2.50, df=140, p=0.014), and an increase in general social support in the long term (1.50 vs. 1.59, t=-2.13, df=136, p=.035).

. It should be noted that parents who had graduated from high school showed an increase approaching significance for quality of life (p=.051) and a decrease approaching significance in family functioning (p=.052) in the long term.

Income

Baseline differences between parents who earn more than $13,000 and those who earn less than $13,000. At the start of the study, parents who made less than $13,000 indicated more parenting rigidity (<$13K=1.45, >$13K=1.35, t=2.78, df=178, p=.006) and drug issues (0.18 vs. 0.09, adj. t=2.17, df=134, p=.032) than parents who made $13,000 or over.

Maltreatment outcomes. Parents whose annual income was less than $13,000 decreased their use of psychological aggression in the short term (0.64 vs. 0.51; t=2.12, df=86, p=0.037) and decreased their parenting rigidity in the long term (1.45 vs. 1.41, t=2.13, df=87, p=.036).

Those who made more than $13,000 improved in the short and long term on parenting distress (short-term: 1.29 vs. 1.25, t=3.03, df=91, p=.003; long-term: 1.29 vs. 1.24; t=2.48, df=91, p=.015), parenting rigidity (short-term: 1.35 vs. 1.30, t=3.31, df=91, p=.001; long-term: 1.35 vs. 1.29, t=3.56, df=91, p=.001) and psychological aggression (short-term: 0.81 vs. 0.67, t=2.13, df=91, p=.000; long-term: 0.81 vs. 0.63, t=2.63, df=91, p=.010).

Risk factors. Parents reporting annual income of less than $13,000 indicated decreases in life stresses in the short term (0.54 vs. 0.44; t=3.41, df=87, p=0.001) and long term (0.54 vs. 0.45, t=2.44, df=87, p=.017) and in physical domestic violence in the short term (0.06 vs. 0.03; t=2.23, df=38, p=0.032).

Parents earning $13,000 or more indicated decreases in life stress in the short (0.52 vs. 0.38, t=4.44, df=91, p=.000) and long term (0.52 vs. 0.44, t=2.15, df=91, p=.034). Parents earning $13,000 or more also indicated long-term decrease emotional domestic violence (0.44 vs. 0.27, t=2.40, df=53, p=.020), alcohol use (0.07 vs. 0.03,

t=2.75, df=91, p=.007) and drug use (0.09 vs. 0.01, t=3.74, df=91, p=.000). It should be noted that parents earning more than $13,000 annually showed short-term decrease approaching significance in alcohol use (p=.058).

Protective factors. There was no evidence of short-term or long-term change in protective factors for parents reporting income of $13,000 or more. Parents reporting income of less than $13,000 indicated a short-term decrease in nonviolent parenting tactics (2.28 vs. 1.96; t=2.88, df=86, p=0.005).

Children with special needs

Baseline differences between parents with and without special needs children. At the start of the study, parents of children with special needs and those without were significantly different on several measures. Parents with at least one special needs child indicated more parenting distress (needs=1.37, non-needs=1.19, adj. t=-4.96, df=175, p=.000), parenting rigidity (needs=1.43, non-needs=1.36, t=-2.00, df=186, p=.047), parenting stress (needs=2.21, non-needs=1.92, t=-5.25, df=186, p=.000), life stress (needs=0.66, non-needs=0.39, adj. t=-4.87, df=177, p=.000), emotional domestic violence (needs=0.49, non-needs=0.25, adj. t=-2.06, df=96, p=.042). They also indicated lower quality of life (needs=3.62, non-needs=4.01, adj. t=4.41, df=182, p=.000), general social support (needs=1.34, non-needs=1.60, t=3.76, df=183, p=.000), parenting sense of competence (needs=2.91, non-needs=3.03, t=2.28, df=186, p=.024), and family functioning (needs=3.02, non-needs=3.19, t=2.41, df=186, p=.017).

Maltreatment outcomes. Parents with at least one special needs child and parents without a special needs child indicated similar patterns of change in maltreatment outcomes. Parents with special needs children showed short- and long-term reduction in parenting distress (short-term: 1.37 vs. 1.33, t=2.25, df=95, p=.027; long-term: 1.37 vs. 1.32, t=2.06, df=95, p=.042) and parenting rigidity (short-term: 1.43 vs. 1.40, t=2.17, df=95, p=.033; long-term: 1.43 vs. 1.37, t=2.90, df=95, p=.005) and reduced their use of psychological aggression in the long term (0.81 vs. 0.63, t=2.56, df=93, p=.012). Parents without any special needs children showed short- and long-term reduction in their psychological aggression (short-term: 0.62 vs. 0.48, t=2.46, df=91, p=.016; long-term: 0.60 vs. 0.50, t=2.12, df=90, p=.037) and parenting distress (short-term: 1.19 vs. 1.16,

t=2.60, df=91, p=.011; long-term: 1.19 vs. 1.16, t=2.14, df=91, p=.035). They also reduced their parenting rigidity in the long term (1.36 vs. 1.30, t=3.21, df=91, p=.002).

Risk factors. Having or not having special needs children did not substantially differentiate parents with regard to change in risk factors, as both types of parents showed significant change. Parents who reported having at least one special needs child indicated decreased life stresses in the short (0.66 vs. 0.49, t=5.48, df=95, p=.000) and long term (0.66 vs. 0.55, t=2.84, df=95, p=.006).

Parents who reported having no special needs children indicated decreased life stresses (0.39 vs. 0.34, t=1.99, df=91, p=.049), physical domestic violence (0.03 vs. 0.01, t=2.07, df=46, p=.044), and drug use in the short term (0.14 vs. 0.09, t=2.57, df=90, p=.012). They indicated decreases in alcohol (0.07 vs. 0.03, t=2.40, df=90, p=.019) and drug use (0.14 vs. 0.06, t=4.39, df=90, p=.000) in the long term.

Protective factors. Having or not having special needs children did not substantially differentiate parents on change in protective factors. Parents with at least one special needs child indicated decreased use of nonviolent discipline tactics (2.40 vs. 2.23, t=2.06, df=94, p=.042) in the short term, but showed no evidence of change on protective factors in the long term. It should be noted that parents with special needs children reported an increase approaching significance for quality of life in the short term (p=.058).

There was no evidence of short-term change in protective factors for parents who reported no special needs children. Parents with no special needs children indicated an increase in emotional and instrumental social support in the long term (2.81 vs. 2.88, t=-2.26, df=88, p=.026).

Other caregivers in the household

Baseline differences between parents with and without other caregivers. At the start of the study, parents who had other adults in their household who assisted with parenting duties indicated higher family functioning than parents without other caregivers at home (other caregivers=3.19, no other caregivers=3.01, t=-2.47, df=186, p=.014).

Maltreatment outcomes. Parents who had at least one other adult in their household to help with parenting duties decreased their parenting rigidity in the short term (1.38 vs. 1.33; t=3.15, df=92, p=.002) and long term (1.38 vs. 1.30, t=4.28, df=92,

p=.000). They also showed long-term decrease in both their parenting distress (1.27 vs. 1.21, t=3.46, df=141, p=.001) and psychological aggression (0.71 vs. 0.52, t=3.12, df=90, p=.002).

Parents who did not have another caregiver in the household improved in the short term on parenting distress (0.56 vs. 0.43; t=4.49, df=94, p=0.00) and psychological aggression (0.70 vs. 0.57; t=2.29, df=94, p=0.024). They indicated no evidence of long-term change on child maltreatment outcomes.

Risk factors. Both parents with and without other adult caregivers at home were impacted on risk factors. Parents with no other adult caregivers in their household to help with parenting indicated a decrease in emotional domestic violence in the long term (0.40 vs. 0.17, t=2.08, df=23, p=.049) and a decrease in life stresses in the short (0.56 vs. 0.43; t=4.49, df=94, p=0.00) and long term (0.56 vs. 0.46, t=2.83, df=94, p=.006).

Parents with another adult caregiver in their household indicated a decrease in life stresses in the short term (0.50 vs. 0.40; t=3.53, df=92, p=0.002) and long-term decreases in parental stress (2.03 vs. 1.96, t=2.66, df=92, p=.009), drug use (0.12 vs. 0.06, t=3.13, df=92, p=.002) and alcohol use (0.06 vs. 0.29, t=2.12, df=92, p=.037).

Protective factors. Parents with other adults at home to assist with parenting showed some long-term change in protective factors but no short-term change, while parents without such assistance showed the opposite, no long-term but some short-term change. Parents with no other adult caregivers in their household to help with parenting indicated a short-term increase in their quality of life (3.74 vs. 3.83; t=2.06, df=94, p=0.042) and a short-term decrease in their use of nonviolent discipline tactics (2.22 vs. 1.94; t=2.83, df=94, p=0.006).

Parents who did have other adult caregivers in their household indicated long-term increases in quality of life (3.88 vs. 4.00, t=-2.60, df=92, p=.011) and general social support (1.52 vs. 1.61, t=-1.99, df=91, p=.050), and a long-term decrease in family functioning (3.19 vs. 3.09, t=2.33, df=92, p=.022).

Health history

Baseline differences between parents with and without histories of health problems. At the start of the study, parents with histories of physical or mental health issues indicated greater potential for child maltreatment compared to parents without

prior health issues. Compared to parents who reported no prior mental or physical health problems, parents with prior health issues indicated higher parenting distress (history=1.39, no history=1.18, adj. t=-5.07, df=166, p=.000), psychological aggression (history=0.86, no history=0.56, adj. t=-3.04, df=175, p=.003), life stress (history=0.67, no history=0.39, adj. t=-5.07, df=166, p=.000), parenting stress (history=2.19, no history=1.95, t=-4.21, df=186, p=.000), and emotional domestic violence (history=0.55, no history=0.20, adj. t=-3.17, df=78, p=.002). They also indicated lower quality of life (history=3.60, no history=4.01, t=4.63, df=186, p=.001), parenting sense of competence (history=2.86, no history=3.08, t=4.54, df=186, p=.000), and family functioning (history=2.99, no history=3.2, t=3.13, df=186, p=.002).

Maltreatment outcomes. Parents who reported a history of either mental health or physical health problems indicate short- and long-term reduction in parenting distress (short-term: 1.38 vs. 1.34, t=3.26, df=91, p=.002; long-term: 1.39 vs. 1.33, t=2.89, df=91, p=.005), parenting rigidity (short-term: 1.38 vs. 1.35, t=2.08, df=91, p=.040; long-term: 1.38 vs. 1.32, t=2.78, df=91, p=.007), and their use of psychological aggression (short-term: 0.73 vs. 0.69, t=2.30, df=90, p=.024; long-term: 0.86 vs. 0.66, t=3.06, df=88, p=.003). Parents who reported no history of mental or physical health problems indicate a long-term decrease in parenting rigidity (1.41 vs. 1.35, t=3.27, df=95, p=.002).

Risk factors. Parents who reported a history of mental or physical illness indicated decreases in life stresses in both the short (0.68 vs. 0.53, t=4.40, df=91, p=.000) and long term (0.67 vs. 0.59, t=2.15, df=91, p=.034).

Parents who reported no history of illness indicated short- and long-term decreases in life stresses (short-term: 0.39 vs. 0.31, t=3.20, df=95, p=.002; long-term: 0.39 vs. 0.31, t=2.48, df=95, p=.015) and drug use (short-term: 0.16 vs. 0.07, t=2.62, df=94, p=.010; long-term: 0.12 vs. 0.06, t=3.13, df=94, p=.002). They also indicated decreased emotional domestic violence in the short term (0.16 vs. 0.10, t=2.09, df=48, p=.042) and decreased alcohol use in the long term (0.09 vs. 0.03, t=2.35, df=94, p=.021).

Protective factors. There was no evidence of short- or long-term change in protective factors for parents reporting a history of mental or physical illness. However, there was some change for parents without histories of illness. Parents who reported no

history of illness indicated short-term decreases in the use of nonviolent discipline tactics (2.15 vs. 1.93, t=2.09, df=95, p=.039). They also indicated decreases in their parenting sense of competence in the short term (3.04 vs. 2.97, t=2.27, df=95, p=.026) and their family functioning in the long term (3.20 vs. 3.10, t=2.48, df=95, p=.015).

History of alcohol or drug problems

Baseline differences between parents with and without histories of alcohol or drug problems. At the start of the study, parents with histories of alcohol or drug issues indicated higher parenting rigidity (history=1.49, no history=1.37, t=-2.60, df=186, p=.010) and lower sense of competence in parenting (history=2.87, no history=3.00, t=1.98, df=186, p=.049) than parents without abuse histories.

Maltreatment outcomes. Parents with a history of drug or alcohol abuse did not indicate change in maltreatment outcomes. There was no evidence of change in either time period on parenting distress, parenting rigidity or aggressive tactics for parents reporting prior alcohol or drug issues. Conversely, those who did not report alcohol or drug issues showed short- and long-term reduction in their use of psychological aggression (short-term: 0.68 vs. 0.55, t=2.60, df=151, p=.010; long-term: 0.68 vs. 0.53, t=3.17, df=150, p=.002), parenting distress (short-term: 1.27 vs. 1.23, t=3.33, df=151, p=.001; long-term: 1.27 vs. 1.23, t=-2.62, df=151, p=.010) and rigidity (short-term: 1.37 vs. 1.33, t=2.85, df=151, p=.005; long-term: 1.37 vs. 1.31, t=4.07, df=151, p=.000).

Risk factors. Parents who reported a prior history of alcohol or drug abuse indicated a decrease in drug use in the short (0.52 vs. 0.38, t=2.28, df=35, p=.029) and long term (0.52 vs. 0.30, t=3.84, df=35, p=.000) and a decrease in alcohol use in the long term (0.26 vs. 0.13, t=2.24, df=35, p=.032).

Parents who reported no prior history of substance abuse indicated a decrease in alcohol use in the short term (0.04 vs. 0.02, t=2.81, df=150, p=.006), a decrease in emotional domestic violence in the long term (0.37 vs. 0.23, t=2.48, df=74, p=.016) and a decrease in life stresses in the short (0.51 vs. 0.40, t=5.21, df=151, p=.000) and long term (0.51 vs. 0.44, t=2.65, df=155, p=.009). It should be noted that parents with no history of alcohol or drug abuse showed decrease approaching significance in emotional domestic violence in the short term (p=.053).

Protective factors. There was no evidence of short- or long-term change in protective factors for parents who reported prior histories of alcohol or drug abuse.

However, there was evidence of change for parents without substance abuse histories. In the short term, parents who reported no substance abuse history indicated increased quality of life (3.80 vs. 3.88, t=2.44, df=151, p=.016), increased general social support (1.49 vs. 1.56, t=1.99, df=146, p=.048), and decreased use of nonviolent discipline tactics (2.34 vs. 2.12, t=2.64, df=151, p=.009). In the long term, parents who reported no substance abuse history indicated lowered family functioning (3.12 vs. 3.05, t=1.99, df=151, p=.049).

Help seeking behavior

Baseline differences between parents who did and did not seek parenting help prior to Parents Anonymous®. At the start of the study, parents who had histories of help seeking behavior indicated greater issues with alcohol (help seekers=0.10, non-help seekers=0.05, adj. t=-2.15, df=149, p=.033) and drugs (help seekers=0.16, non-help seekers=0.05, adj. t=-3.37, df=170, p=.001) than those who had not sought help.

Maltreatment outcomes. Help-seeking behavior for parenting issues did not substantially differentiate these parents. Short- and long-term reduction in parenting distress was found for both parents who had (short-term: 1.30 vs. 1.27, t=2.76, df=139, p=.007; long-term: 1.30 vs. 1.26, t=2.13, df=133, p=.035) and who had not (short-term: 1.24 vs. 1.20, t=2.01, df=53, p=.049; long-term: 1.24 vs. 1.19, t=2.20, df=53, p=.032) sought formal help for their parenting issues prior to joining Parents Anonymous®. Both types of parents also showed reduction in their parenting rigidity in the long term (help-seekers: 1.41 vs. 1.37, t=2.91, df=133, p=.004; not help-seekers: 1.35 vs. 1.27, t=3.46, df=53, p=.001). However, parents who had not sought help did not change their psychological aggression while parents who had sought help reduced their use of psychological aggression in both the short (0.76 vs. 0.64, t=2.31, df=132, p=.022) and long term (0.75 vs. 0.59, t=3.26, df=131, p=.001).

Risk factors. Parents who reported seeking help for parenting issues prior to attending Parents Anonymous® indicated short-term decreases in life stresses (0.55 vs. 0.44, t=4.33, df=133, p=.000) and physical domestic violence (0.04 vs. 0.01, t=2.24, df=70, p=.028), long-term decrease in alcohol use (0.10 vs. 0.06, t=2.09, df=133,

p=.039), and short- and long-term decrease in drug use (short-term: 0.16 vs. 0.12, t=2.01, df=133, p=.046; long-term: 0.16 vs. 0.10, t=2.93, df=133, p=.004). Parents who reported not seeking help for parenting issues prior to attending Parents Anonymous® indicated decreased life stresses in the short (0.46 vs. 0.34, t=3.33, df=53, p=.002) and long term (0.46 vs. 0.32, t=3.24, df=53, p=.002), decreased problems with alcohol in the short term (0.05 vs. 0.01, t=2.06, df=52, p=.044), and decreased emotional domestic violence (0.47 vs. 0.25, t=2.22, df=27, p=.034) and drug use (0.05 vs. 0.02, t=2.20, df=52, p=.033) in the long term.

Protective factors. Parents who had sought help for their parenting issues indicated an increase in general social support (1.43 vs. 1.50, t=1.99, df=130, p=.049) and decreased use of nonviolent discipline tactics (2.34 vs. 2.14, t=2.33, df=132, p=.021) in the short term. There was no evidence of long-term change on protective factors for parents who had sought help.

There was no evidence of short-term improvement on protective factors for parents who reported they had never sought out formal help for their parenting issues before attending Parents Anonymous®. Those who had not sought help showed lowered family functioning in the long term (3.16 vs. 3.04, t=2.29, df=53, p=.026).

History of CPS contact

Baseline differences between parentw with and without a history of CPS contact. Compared to parents without CPS histories, parents reporting prior CPS contact indicated higher quality of life (CPS=, non-CPS=, adj. t=2.97, df=186, p=.003) but they also indicated more parenting distress (CPS=1.38, non-CPS=1.24, adj. t=-3.19, df=76, p=.002), psychological aggression (CPS=0.90, non-CPS=0.64, t=-2.35, df=186, p=.020), life stress (CPS=0.62, non-CPS=0.49, t=-1.98, df=186, p=.049), parenting stress (CPS=2.22, non-CPS=2.01, adj. t=-3.66, df=120, p=.000) and a lower sense of their parenting competence (CPS=2.81, non-CPS=3.03, adj. t=3.98, df=186, p=.000), and lower family functioning (CPS=2.92, non-CPS=3.17, adj. t=3.13, df=186, p=.002).

Maltreatment outcomes. Change was experienced by both those parents with and without a CPS history. Parents reporting prior CPS contact indicated reduced parenting distress in the short term (1.30 vs. 1.26, t=2.13, df=133, p=.035) and reduced

use of psychological aggression in both the short (0.90 vs. 0.67, t=2.60, df=50, p=.012) and long term (0.89 vs. 0.58, t=3.86, df=48, p=.000).

Those reporting no prior CPS contact indicated short- and long-term reduction in parenting distress (short-term: 1.24 vs. 1.22, t=2.15, df=136, p=.033; long-term: 1.24 vs. 1.21, t=2.28, df=136, p=.024) and rigidity (short-term: 1.39 vs. 1.36, t=2.39, df=136, p=.018; long-term: 1.39 vs. 1.32, t=4.89, df=136, p=.000), but did not show any change in their aggressive tactics.

Risk factors. Parents with CPS histories showed a broader pattern of change on risk factors than those without CPS contact. Parents who reported prior contact with CPS indicated short-term decreases in life stresses (0.62 vs. 0.50, t=2.51, df=50, p=.015), emotional domestic violence (0.53 vs. 0.34, t=2.49, df=23, p=.021), and alcohol use (0.12 vs. 0.05, t=3.06, df=50, p=.004). Parents reporting prior CPS contact also indicated decreases in parental stress (2.22 vs. 2.13, t=2.12, df=50, p=.036) and alcohol use (0.12 vs. 0.05, t=2.61, df=50, p=.012) in the long term. It should be noted that parents reporting prior CPS contact showed short-term decrease approaching significance on physical domestic violence (p=.057).

Parents who reported no prior contact with CPS indicated decreased drug use in the long term (0.12 vs. 0.06, t=3.09, df=135, p=.002) and life stresses in the short (0.49 vs. 0.30, t=4.90, df=136, p=.000) and long term (0.49 vs. 0.39, t=3.59, df=136, p=.000).

Protective factors. Parents reporting prior contact with CPS indicated increase in their quality of life in the short term (3.59 vs. 3.70, t=2.06, df=50, p=.045), but showed no other change in protective factors.

Parents reporting no prior history with CPS indicated decreased use of nonviolent discipline tactics in the short term (2.24 vs. 2.02, t=2.54, df=135, p=.012) and increased general social support in the long term (1.51 vs. 1.59, t=-1.98, df=132, p=.049). Parents with no prior CPS history also indicated decreased sense of parenting competence in the short term (3.04 vs. 2.99, t=2.20, df=135, p=.030) and decreased family functioning in the long term (3.17 vs. 3.09, t=2.19, df=136, p=.031).

Mandated attendance

Baseline differences between parents mandated to attend Parents Anonymous® and those not mandated. Compared to parents attending Parents

Anonymous® of their own accord, parents required to attend Parents Anonymous® indicated more parenting rigidity (mandate=1.49, non-mandate=1.38, t=-2.00, df=181, p=.047), lower sense of competence in parenting (mandate=2.84, non-mandate=3.00, t=2.11, df=181, p=.036), and lower family functioning (mandate=2.87, non-mandate=3.13, t=2.65, df=181, p=.009).

Maltreatment outcomes. Both parents required to attend Parents Anonymous® and those not required to attend showed improvement in maltreatment outcomes. The 27 parents required to attend Parents Anonymous® reduced their use of psychological aggression in both time periods (short-term: 0.81 vs. 0.52, t=2.16, df=26, p=.040; long-term: 0.84 vs. 0.53, t=2.30, df=25, p=.030) but there was no evidence of change on parenting distress or rigidity. Parents not required to attend improved in the short and long term for psychological aggression (short-term: 0.69 vs. 0.58, t=2.29, df=1.54, p=.024; long-term: 0.69 vs. 0.56, t=2.84, df=153, p=.005), parenting distress (short-term: 1.27 vs. 1.24, t=2.86, df=155, p=.005; long-term: 1.27 vs. 1.24, t=2.22, df=155, p=.028) and parenting rigidity (short-term: 1.38 vs. 1.35, t=2.47, df=155, p=.015; long-term: 1.38 vs. 1.31, t=5.47, df=155, p=.000).

Risk factors. Parents required to attend Parents Anonymous® indicated a decrease in life stresses in the short term (0.56 vs. 0.42, t=2.14, df=26, p=.042). There was no evidence of long-term change in risk factors for parents required to attend. Parents not required to attend Parents Anonymous® indicated short- and long-term decreases in life stresses (short-term: 0.52 vs. 0.42, t=4.77, df=155, p=.042; long-term: 0.52 vs. 0.45, t=2.72, df=155, p=.007) and problems with alcohol (short-term: 0.09 vs. 0.06, t=2.25, df=154, p=.026; long-term: 0.09 vs. 0.05, t=2.30, df=154, p=.023). Parents not required to attend also showed decreases in emotional domestic violence (0.36 vs. 0.24, t=2.08, df=77, p=.040) and drug use (0.15 vs. 0.09, t=3.17, df=154, p=.002) in the long term.

Protective factors. There was no evidence of short- or long-term change in protective factors for parents required to attend Parents Anonymous®. Parents not required to attend Parents Anonymous® indicated less use of nonviolent discipline tactics in the short term (2.29 vs. 2.09, t=2.42, df=154, p=.017) and *lower* family functioning in the long term (3.13 vs. 3.07, t=1.99, df=155, p=.048). It should be noted that parents not

required to attend Parents Anonymous® showed an increase approaching significance in quality of life in the short term (p=.051).

GROUP IMPLEMENTATION

Finding 4. Parents in groups which had a higher level of implementation of the Parents Anonymous® model showed consistent pattern of change on child maltreatment outcomes.

Parents in groups at the high level of model implementation indicated a reduction in parenting rigidity in the short term (T1 m=1.35 vs. T2 m=1.26, t=2.97, df=16, p=.009) and long term (1.35 vs. 1.22, t=2.99, df=16, p=.009) and a long-term reduction in their use of both psychological aggression (0.85 vs. 0.50, t=3.45, df=16, p=.003) and physical aggression (0.34 vs. 0.19, t=2.16, df=16, p=.046). (See Table 3.4.)

Parents from groups in the middle level of model implementation indicated both short- and long-term reduction in parenting distress (short-term: 1.27 vs. 1.24, t=2.56, df=121, p=.012; long-term: 1.36 vs. 1.31, t=3.47, df=121, p=.001) and parenting rigidity (short-term: 1.36 vs. 1.33, t=2.06, df=121, p=.041; long-term: 1.36 vs. 1.31, t=3.47, df=121, p=.001).

Parents in groups with the lowest level of implementation improved on only one measure; they indicated a reduction in parenting distress in the short term (1.27 vs. 1.22, t=2.41, df=42, p=.020).

Finding 5. Parents in each of the three levels of group implementation of the Parents Anonymous® model showed at least some change on risk factors. There was no clear differentiation between the levels.

Parents from groups in the high implementation category indicated a reduction in alcohol use in the short term (0.12 vs. .00, t=3.11, df=16, p=.007) and in life stress in the long term (0.73 vs. 0.49, t=2.26, df=16, p=.039). (See Table 3.4.)

Parents from middle implementation groups indicated a reduction of drug problems in the long term (T1 m=0.15 vs. T3 m=0.10, t=2.53, df=120, p=.013), a reduction of intimate partner emotional violence in the short term (0.41 vs. 0.31, t=2.27,

df=63, p=.027), and a reduction in life stresses in both the short term (0.52 vs. 0.42, t=3.91, df=121, p=.000) and long term (0.52 vs. 0.44, t=2.23, df=121, p=.026).

Parents attending groups in the low implementation category indicated a reduction in life stresses in the short term (0.48 vs. 0.37, t=2.74, df=42, p=.009) and a reduction of drug abuse problems in the long term (0.09 vs. 0.03, t=2.46, df=42, p=.018).

Finding 6. Parents in groups which had the lowest level of implementation of the Parents Anonymous® model showed improvement on protective factors, while those in the middle and high implementation groups showed no change.

There was no evidence of change in protective factors among parents from groups in the middle or high implementation category. (See Table 3.4.) (The long-term increase in quality of life for parents in middle implementation groups was approaching significance, p=.053.)

Parents from groups in the low implementation category indicated change on a number of protective factors. The low implementation group showed evidence of short-term increase in quality of life (3.89 vs. 4.03, t=2.33, df=42, p=.024) and a short-term (1.39 vs. 1.60, t=3.16, df=41, p=.003) and long-term (1.41 vs. 1.59, t=2.27, df=40, p=.029) increase in general social support. They also showed a short term *decrease* in nonviolent discipline tactics in the short term (2.44 vs. 2.06, t=2.25, df=42, p=.030).

CONTINUING PARENTS VS. PARENTS WHO DROPPED OUT

Of the total sample (N=206), 18 parents did not attend any meetings after the first interview (see Table 3.1 above). (These 18 parents were not included in the analysis except in this section.) This group of 18 parents had attended from 1 to 5 meetings prior to the first interview (mean=2.2, sd=1.34), a similar number of pre-study meetings as the rest of the sample. This group and the continuing group were analyzed in a number of ways in order to answer the questions: *What characteristics distinguish parents who continue in Parents Anonymous® and those who do not.*

Finding 7. Parents who continued to attend meetings and those who stopped attending were not different on background characteristics or on any study measures at the start of the study.

Chi-squares showed no evidence of any differences on background characteristics between parents who continued to attend Parents Anonymous® meetings and those who did not attend any meetings between the first and last interview.

Also, t-tests showed no evidence of differences between parents who continued attending and those who did not on first interview scores on any of the sixteen study measures (four child maltreatment outcomes and twelve risk and protective factors).

Finding 8. Parents who continued to attend showed improvement on a far greater number of measures than those who stopped attending.

Of the total of sixteen measures, parents who did not attend meetings after the first interview indicated significant change on just one measure in the short term (a reduction in life stresses; T1 m=0.54 vs. T2 m=0.33 , t=3.95, df=17, p=.001) and on no measures in the long term. In contrast, the group who continued indicated significant improvement on a total of eight measures: six measures in the short term and seven measures in the long term.

(End appendix text. Tables A-2, A-3 and A-4 follow.)

APPENDIX Table A-2. CHILD MALTREATMENT OUTCOMES: Mean and Standard Deviation for All Scales at Each Interview by Parent Characteristics

		Parenting Distress (Possible Range 1-2)						Parenting Rigidity (Poss. Range 1-2)						Psychological Aggression (Poss. Range 0-5)						Physical Aggression (Poss. Range 0-5)					
		Time 1		Time 2		Time 3		Time 1		Time 2		Time 3		Time 1		Time 2		Time 3		Time 1		Time 2		Time 3	
	n	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*
ALL PARENTS	**188**	**1.28**	***0.26***	**1.25**	***0.25***	**1.24**	***0.25***	**1.394**	***0.26***	**1.364**	***0.28***	**1.338**	***0.27***	**0.708**	***0.67***	**0.584**	***0.71***	**0.563**	***0.66***	**0.205**	***0.39***	**0.187**	***0.39***	**0.166**	***0.33***
Gender																									
Female	169	1.29	*0.26*	1.25	*0.25*	1.24	*0.25*	1.39	*0.26*	1.36	*0.28*	1.32	*0.26*	0.71	*0.68*	0.61	*0.73*	0.58	*0.67*	0.21	*0.36*	0.20	*0.41*	0.17	*0.34*
Male	19	1.20	*0.23*	1.19	*0.24*	1.23	*0.26*	1.44	*0.26*	1.44	*0.27*	1.47	*0.30*	0.66	*0.60*	0.38	*0.41*	0.41	*0.55*	0.20	*0.64*	0.04	*0.09*	0.09	*0.24*
Race																									
African American	92	1.23	*0.23*	1.20	*0.23*	1.20	*0.25*	1.50	*0.25*	1.47	*0.28*	1.43	*0.27*	0.70	*0.68*	0.64	*0.82*	0.62	*0.75*	0.26	*0.50*	0.21	*0.48*	0.18	*0.38*
White	79	1.34	*0.27*	1.31	*0.27*	1.29	*0.26*	1.27	*0.21*	1.25	*0.23*	1.24	*0.22*	0.70	*0.64*	0.51	*0.55*	0.51	*0.54*	0.15	*0.25*	0.18	*0.30*	0.13	*0.24*
Other race	17	1.28	*0.27*	1.23	*0.23*	1.24	*0.20*	1.43	*0.26*	1.34	*0.26*	1.29	*0.28*	0.80	*0.82*	0.61	*0.72*	0.51	*0.71*	0.15	*0.23*	0.13	*0.27*	0.24	*0.38*
Education																									
Less than high school	43	1.31	*0.28*	1.31	*0.29*	1.33	*0.29*	1.51	*0.27*	1.50	*0.31*	1.45	*0.31*	0.77	*0.79*	0.65	*0.94*	0.65	*0.83*	0.33	*0.54*	0.31	*0.55*	0.16	*0.25*
Graduated HS	142	1.27	*0.24*	1.23	*0.24*	1.21	*0.24*	1.36	*0.25*	1.33	*0.26*	1.31	*0.25*	0.68	*0.63*	0.55	*0.62*	0.54	*0.61*	0.17	*0.33*	0.15	*0.32*	0.17	*0.35*
Income																									
$13,000 or less	88	1.28	*0.25*	1.25	*0.25*	1.24	*0.25*	1.45	*0.26*	1.44	*0.28*	1.41	*0.26*	0.64	*0.62*	0.51	*0.67*	0.53	*0.61*	0.19	*0.32*	0.18	*0.40*	0.19	*0.39*
More than $13,000	92	1.29	*0.26*	1.25	*0.26*	1.24	*0.26*	1.35	*0.25*	1.30	*0.27*	1.29	*0.27*	0.81	*0.72*	0.67	*0.74*	0.63	*0.72*	0.23	*0.46*	0.20	*0.40*	0.15	*0.28*
Child with special needs																									
Special needs child	96	1.37	*0.27*	1.33	*0.26*	1.32	*0.26*	1.43	*0.26*	1.40	*0.28*	1.37	*0.29*	0.80	*0.71*	0.68	*0.79*	0.63	*0.73*	0.19	*0.43*	0.21	*0.45*	0.16	*0.31*
No special needs children	92	1.19	*0.20*	1.16	*0.20*	1.16	*0.22*	1.36	*0.25*	1.33	*0.28*	1.30	*0.24*	0.62	*0.62*	0.48	*0.60*	0.50	*0.58*	0.22	*0.36*	0.17	*0.33*	0.17	*0.35*
Caretakers in the household																									
Single parent	95	1.29	*0.25*	1.25	*0.23*	1.27	*0.28*	1.41	*0.24*	1.40	*0.27*	1.38	*0.26*	0.70	*0.65*	0.57	*0.64*	0.60	*0.67*	0.19	*0.40*	0.14	*0.26*	0.17	*0.37*
Other caretaker(s)	93	1.27	*0.26*	1.25	*0.27*	1.21	*0.22*	1.38	*0.28*	1.33	*0.29*	1.30	*0.27*	0.72	*0.70*	0.60	*0.78*	0.52	*0.65*	0.22	*0.39*	0.24	*0.49*	0.16	*0.29*
Physical or mental illness history																									
Health history	92	1.39	*0.28*	1.34	*0.27*	1.33	*0.28*	1.38	*0.25*	1.35	*0.25*	1.32	*0.25*	0.86	*0.73*	0.72	*0.69*	0.66	*0.68*	0.22	*0.42*	0.21	*0.34*	0.22	*0.39*
No health history	96	1.18	*0.18*	1.16	*0.19*	1.16	*0.20*	1.41	*0.27*	1.38	*0.30*	1.35	*0.29*	0.56	*0.59*	0.46	*0.70*	0.47	*0.63*	0.19	*0.36*	0.17	*0.43*	0.12	*0.25*
Alcohol or drug abuse history																									
Substance abuse history	36	1.31	*0.29*	1.30	*0.28*	1.28	*0.29*	1.49	*0.26*	1.50	*0.28*	1.46	*0.27*	0.84	*0.74*	0.71	*0.83*	0.72	*0.73*	0.14	*0.29*	0.14	*0.39*	0.11	*0.24*
No substance abuse history	152	1.27	*0.25*	1.23	*0.24*	1.23	*0.24*	1.37	*0.25*	1.33	*0.27*	1.31	*0.26*	0.68	*0.66*	0.55	*0.68*	0.53	*0.64*	0.22	*0.41*	0.20	*0.39*	0.18	*0.35*
Help-seeking behavior for parenting																									
Help-seeking history	134	1.30	*0.26*	1.27	*0.25*	1.26	*0.26*	1.41	*0.25*	1.39	*0.27*	1.37	*0.26*	0.76	*0.68*	0.64	*0.68*	0.59	*0.62*	0.18	*0.31*	0.17	*0.32*	0.17	*0.33*
No help-seeking history	54	1.24	*0.24*	1.20	*0.25*	1.19	*0.23*	1.35	*0.28*	1.31	*0.29*	1.27	*0.27*	0.58	*0.65*	0.45	*0.76*	0.50	*0.76*	0.27	*0.54*	0.24	*0.53*	0.15	*0.32*
History of CPS Allegations																									
CPS history	51	1.38	*0.29*	1.32	*0.26*	1.33	*0.27*	1.39	*0.26*	1.38	*0.26*	1.39	*0.28*	0.90	*0.68*	0.67	*0.65*	0.58	*0.59*	0.20	*0.34*	0.19	*0.29*	0.17	*0.30*
No CPS history	137	1.24	*0.23*	1.22	*0.24*	1.21	*0.24*	1.39	*0.26*	1.36	*0.29*	1.32	*0.26*	0.64	*0.66*	0.55	*0.73*	0.56	*0.69*	0.21	*0.41*	0.19	*0.43*	0.16	*0.34*
Mandated attendance																									
Mandated attendance	27	1.33	*0.31*	1.27	*0.26*	1.27	*0.28*	1.49	*0.26*	1.45	*0.26*	1.49	*0.34*	0.81	*0.62*	0.52	*0.64*	0.53	*0.64*	0.26	*0.57*	0.22	*0.30*	0.17	*0.27*
Not mandated	156	1.27	*0.24*	1.24	*0.25*	1.24	*0.25*	1.38	*0.26*	1.35	*0.28*	1.31	*0.25*	0.69	*0.68*	0.58	*0.71*	0.56	*0.66*	0.20	*0.36*	0.18	*0.41*	0.16	*0.34*

APPENDIX Table A-3. RISK FACTORS: Mean and Standard Deviation for All Scales at Each Interview by Parent Characteristics

		Parenting Stress (Possible Range 1-4)						Life Stress (Poss. Range 0-3)						Emotional Domestic Violence (Poss. Range 0-3)					
		Time 1		Time 2		Time 3		Time 1		Time 2		Time 3		Time 1		Time 2		Time 3	
	n	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*
ALL PARENTS	**188**	**2.067**	***0.4***	**2.061**	***0.39***	**2.033**	***0.4***	**0.528**	***0.4***	**0.415**	***0.36***	**0.445**	***0.39***	**0.375**	***0.61***	**0.33**	***0.6***	**0.253**	***0.44***
Gender																			
Female	169	2.06	*0.40*	2.06	*0.39*	2.03	*0.40*	0.53	*0.41*	0.42	*0.36*	0.44	*0.39*	0.35	*0.61*	0.30	*0.61*	0.20	*0.37*
Male	19	2.13	*0.31*	2.05	*0.40*	2.03	*0.40*	0.47	*0.37*	0.33	*0.30*	0.49	*0.44*	0.54	*0.58*	0.55	*0.48*	0.59	*0.70*
Race																			
African American	92	2.00	*0.41*	2.00	*0.36*	1.99	*0.41*	0.46	*0.35*	0.37	*0.29*	0.38	*0.35*	0.14	*0.22*	0.18	*0.34*	0.20	*0.39*
White	79	2.15	*0.37*	2.14	*0.40*	2.09	*0.36*	0.58	*0.45*	0.45	*0.41*	0.50	*0.42*	0.52	*0.72*	0.45	*0.73*	0.28	*0.46*
Other race	17	2.08	*0.39*	2.01	*0.48*	2.02	*0.45*	0.62	*0.45*	0.49	*0.40*	0.51	*0.43*	0.58	*0.81*	0.33	*0.59*	0.37	*0.55*
Education																			
Less than high school	43	2.11	*0.41*	2.09	*0.40*	2.05	*0.36*	0.51	*0.33*	0.45	*0.35*	0.45	*0.35*	0.28	*0.48*	0.30	*0.59*	0.31	*0.55*
Graduated HS	142	2.05	*0.39*	2.05	*0.39*	2.03	*0.41*	0.53	*0.41*	0.40	*0.36*	0.45	*0.40*	0.38	*0.60*	0.32	*0.59*	0.24	*0.41*
Income																			
$13,000 or less	88	2.05	*0.37*	2.01	*0.34*	2.00	*0.35*	0.54	*0.38*	0.44	*0.37*	0.45	*0.38*	0.30	*0.49*	0.26	*0.53*	0.28	*0.47*
More than $13,000	92	2.09	*0.43*	2.12	*0.42*	2.08	*0.42*	0.52	*0.43*	0.38	*0.33*	0.44	*0.40*	0.43	*0.69*	0.39	*0.65*	0.23	*0.44*
Child with special needs																			
Special needs child	96	2.21	*0.38*	2.18	*0.39*	2.17	*0.39*	0.66	*0.43*	0.49	*0.37*	0.55	*0.40*	0.49	*0.71*	0.44	*0.71*	0.33	*0.47*
No special needs children	92	1.92	*0.36*	1.93	*0.35*	1.89	*0.35*	0.39	*0.33*	0.34	*0.33*	0.34	*0.35*	0.25	*0.45*	0.21	*0.43*	0.18	*0.41*
Caretakers in the household																			
Single parent	95	2.10	*0.40*	2.09	*0.35*	2.10	*0.37*	0.56	*0.42*	0.43	*0.37*	0.46	*0.40*	0.38	*0.63*	0.34	*0.68*	0.13	*0.26*
Other caretaker(s)	93	2.03	*0.39*	2.03	*0.43*	1.96	*0.42*	0.50	*0.39*	0.40	*0.34*	0.43	*0.38*	0.38	*0.61*	0.33	*0.55*	0.32	*0.50*
Physical or mental illness history																			
Health history	92	2.19	*0.39*	2.15	*0.40*	2.16	*0.37*	0.67	*0.44*	0.53	*0.39*	0.59	*0.41*	0.55	*0.75*	0.52	*0.71*	0.38	*0.50*
No health history	96	1.95	*0.37*	1.98	*0.37*	1.91	*0.38*	0.39	*0.32*	0.31	*0.28*	0.31	*0.32*	0.19	*0.35*	0.15	*0.38*	0.14	*0.35*
Alcohol or drug abuse history																			
Substance abuse history	36	2.17	*0.39*	2.16	*0.35*	2.13	*0.37*	0.60	*0.43*	0.49	*0.43*	0.48	*0.45*	0.47	*0.83*	0.50	*0.75*	0.48	*0.57*
No substance abuse history	152	2.04	*0.40*	2.04	*0.40*	2.01	*0.40*	0.51	*0.40*	0.40	*0.33*	0.44	*0.38*	0.35	*0.54*	0.29	*0.55*	0.20	*0.39*
Help-seeking behavior for parenting																			
Help-seeking history	134	2.10	*0.40*	2.09	*0.39*	2.07	*0.40*	0.55	*0.40*	0.44	*0.37*	0.50	*0.40*	0.35	*0.58*	0.35	*0.62*	0.26	*0.46*
No help-seeking history	54	1.99	*0.38*	2.00	*0.40*	1.95	*0.37*	0.46	*0.40*	0.34	*0.32*	0.32	*0.33*	0.43	*0.69*	0.28	*0.54*	0.23	*0.40*
History of CPS Allegations																			
CPS history	51	2.22	*0.31*	2.17	*0.33*	2.14	*0.34*	0.62	*0.46*	0.50	*0.39*	0.61	*0.44*	0.49	*0.67*	0.44	*0.74*	0.29	*0.44*
No CPS history	137	2.01	*0.41*	2.02	*0.41*	1.99	*0.41*	0.49	*0.38*	0.38	*0.34*	0.39	*0.35*	0.34	*0.59*	0.29	*0.54*	0.24	*0.45*
Mandated attendance																			
Mandated attendance	27	2.18	*0.40*	2.20	*0.39*	2.12	*0.45*	0.56	*0.45*	0.42	*0.28*	0.45	*0.39*	0.48	*0.58*	0.33	*0.41*	0.40	*0.57*
Not mandated	156	2.05	*0.38*	2.03	*0.39*	2.01	*0.39*	0.52	*0.40*	0.42	*0.37*	0.44	*0.39*	0.36	*0.63*	0.34	*0.63*	0.23	*0.42*

		Physical Domestic Violence (Poss. Range 0-3)						Alcohol Abuse Screen (Poss. Range 0-1)						Drug Abuse Screen (Poss. Range 0-1)					
		Time 1		Time 2		Time 3		Time 1		Time 2		Time 3		Time 1		Time 2		Time 3	
	n	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*
ALL PARENTS	**188**	**0.054**	***0.21***	**0.017**	***0.08***	**0.031**	***0.15***	**0.086**	***0.19***	**0.059**	***0.17***	**0.048**	***0.15***	**0.131**	***0.28***	**0.105**	***0.26***	**0.077**	***0.23***
Gender																			
Female	169	0.06	*0.22*	0.02	*0.08*	0.03	*0.16*	0.08	*0.18*	0.06	*0.16*	0.04	*0.15*	0.12	*0.26*	0.11	*0.26*	0.07	*0.22*
Male	19	0.03	*0.07*	0.00	*0.00*	0.01	*0.05*	0.11	*0.24*	0.08	*0.24*	0.08	*0.21*	0.25	*0.37*	0.11	*0.25*	0.11	*0.27*
Race																			
African American	92	0.02	*0.07*	0.00	*0.03*	0.02	*0.12*	0.09	*0.17*	0.07	*0.15*	0.03	*0.11*	0.19	*0.33*	0.12	*0.28*	0.11	*0.27*
White	79	0.07	*0.27*	0.03	*0.10*	0.04	*0.18*	0.08	*0.21*	0.05	*0.19*	0.07	*0.20*	0.09	*0.22*	0.10	*0.25*	0.06	*0.20*
Other race	17	0.10	*0.23*	0.02	*0.06*	0.02	*0.06*	0.09	*0.15*	0.04	*0.13*	0.04	*0.10*	0.04	*0.10*	0.03	*0.08*	0.00	*0.00*
Education																			
Less than high school	43	0.04	*0.08*	0.03	*0.09*	0.03	*0.11*	0.08	*0.17*	0.06	*0.15*	0.03	*0.08*	0.17	*0.33*	0.11	*0.26*	0.10	*0.28*
Graduated HS	142	0.05	*0.22*	0.01	*0.07*	0.03	*0.16*	0.09	*0.19*	0.06	*0.17*	0.05	*0.17*	0.12	*0.26*	0.10	*0.25*	0.07	*0.21*
Income																			
$13,000 or less	88	0.06	*0.15*	0.03	*0.10*	0.02	*0.13*	0.11	*0.21*	0.08	*0.18*	0.07	*0.20*	0.18	*0.34*	0.16	*0.33*	0.15	*0.31*
More than $13,000	92	0.05	*0.25*	0.01	*0.06*	0.03	*0.17*	0.07	*0.17*	0.05	*0.16*	0.03	*0.10*	0.09	*0.19*	0.05	*0.15*	0.01	*0.05*
Child with special needs																			
Special needs child	96	0.07	*0.27*	0.02	*0.10*	0.03	*0.17*	0.10	*0.20*	0.07	*0.19*	0.07	*0.19*	0.12	*0.28*	0.12	*0.27*	0.09	*0.24*
No special needs children	92	0.04	*0.10*	0.01	*0.05*	0.03	*0.12*	0.07	*0.16*	0.05	*0.14*	0.03	*0.11*	0.14	*0.27*	0.09	*0.24*	0.06	*0.22*
Caretakers in the household																			
Single parent	95	0.04	*0.12*	0.02	*0.10*	0.03	*0.14*	0.11	*0.22*	0.08	*0.20*	0.07	*0.19*	0.14	*0.30*	0.12	*0.28*	0.09	*0.25*
Other caretaker(s)	93	0.06	*0.24*	0.01	*0.06*	0.03	*0.16*	0.06	*0.15*	0.04	*0.12*	0.03	*0.10*	0.12	*0.26*	0.09	*0.22*	0.06	*0.20*
Physical or mental illness history																			
Health history	92	0.09	*0.28*	0.03	*0.11*	0.06	*0.21*	0.08	*0.18*	0.06	*0.17*	0.06	*0.18*	0.15	*0.30*	0.14	*0.29*	0.10	*0.26*
No health history	96	0.02	*0.07*	0.00	*0.00*	0.00	*0.03*	0.09	*0.19*	0.06	*0.17*	0.03	*0.12*	0.12	*0.25*	0.07	*0.22*	0.05	*0.19*
Alcohol or drug abuse history																			
Substance abuse history	36	0.11	*0.39*	0.04	*0.14*	0.10	*0.31*	0.26	*0.30*	0.23	*0.30*	0.13	*0.25*	0.52	*0.40*	0.38	*0.41*	0.30	*0.39*
No substance abuse history	152	0.04	*0.12*	0.01	*0.06*	0.01	*0.07*	0.04	*0.11*	0.02	*0.07*	0.03	*0.11*	0.04	*0.11*	0.04	*0.14*	0.02	*0.12*
Help-seeking behavior for parenting																			
Help-seeking history	134	0.04	*0.13*	0.02	*0.08*	0.02	*0.10*	0.10	*0.20*	0.08	*0.19*	0.06	*0.17*	0.16	*0.31*	0.12	*0.28*	0.10	*0.25*
No help-seeking history	54	0.08	*0.33*	0.02	*0.08*	0.06	*0.23*	0.05	*0.13*	0.01	*0.05*	0.02	*0.08*	0.05	*0.16*	0.06	*0.17*	0.02	*0.14*
History of CPS Allegations																			
CPS history	51	0.07	*0.17*	0.04	*0.13*	0.00	*0.00*	0.12	*0.23*	0.05	*0.17*	0.05	*0.13*	0.15	*0.31*	0.11	*0.28*	0.11	*0.27*
No CPS history	137	0.05	*0.22*	0.01	*0.05*	0.04	*0.17*	0.07	*0.16*	0.06	*0.17*	0.05	*0.16*	0.12	*0.27*	0.10	*0.25*	0.06	*0.21*
Mandated attendance																			
Mandated attendance	27	0.04	*0.12*	0.00	*0.00*	0.00	*0.00*	0.06	*0.11*	0.06	*0.13*	0.04	*0.11*	0.06	*0.20*	0.03	*0.11*	0.02	*0.10*
Not mandated	156	0.06	*0.22*	0.02	*0.08*	0.04	*0.16*	0.09	*0.20*	0.06	*0.18*	0.05	*0.16*	0.15	*0.29*	0.12	*0.27*	0.09	*0.25*

APPENDIX Table A-4. PROTECTIVE FACTORS: Mean and Standard Deviation for All Scales at Each Interview by Parent Characteristics

		Quality of Life (Possible Range 1-5)						Emotional & Instrumental Social Suppor (Poss. Range 0-3)						General Social Support (Poss. Range 0-2)						Parenting Sense of Competence (Poss. Range 1-4)						Nonviolent Tactics (Poss. Range 0-5)						Family Functioning (Poss. Range 1-4)					
		Time 1		Time 2		Time 3		Time 1		Time 2		Time 3		Time 1		Time 2		Time 3		Time 1		Time 2		Time 3		Time 1		Time 2		Time 3		Time 1		Time 2		Time 3	
	n	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*	m	*sd*
ALL PARENTS	**188**	**3.81**	***0.64***	**3.878**	***0.6***	**3.875**	***0.61***	**2.75**	***0.39***	**2.783**	***0.38***	**2.781**	***0.37***	**1.469**	***0.47***	**1.521**	***0.44***	**1.542**	***0.46***	**2.973**	***0.36***	**2.949**	***0.33***	**2.968**	***0.32***	**2.307**	***1.14***	**2.114**	***1.13***	**2.182**	***1.11***	**3.101**	***0.48***	**3.081**	***0.49***	**3.046**	***0.48***
Gender																																					
Female	169	3.79	*0.64*	3.87	*0.60*	3.86	*0.61*	2.74	*0.40*	2.79	*0.39*	2.78	*0.38*	1.45	*0.48*	1.52	*0.44*	1.54	*0.46*	2.98	*0.35*	2.95	*0.31*	2.96	*0.29*	2.31	*1.16*	2.15	*1.13*	2.19	*1.14*	3.11	*0.49*	3.09	*0.49*	3.05	*0.48*
Male	19	4.02	*0.54*	3.97	*0.56*	3.98	*0.59*	2.83	*0.26*	2.72	*0.29*	2.80	*0.28*	1.65	*0.37*	1.53	*0.51*	1.56	*0.48*	2.96	*0.41*	2.90	*0.48*	3.02	*0.49*	2.25	*0.87*	1.82	*1.11*	2.07	*0.82*	3.01	*0.47*	2.98	*0.47*	2.98	*0.47*
Race																																					
African American	92	3.96	*0.60*	4.02	*0.58*	3.98	*0.57*	2.83	*0.34*	2.86	*0.29*	2.89	*0.23*	1.48	*0.43*	1.58	*0.42*	1.61	*0.37*	3.03	*0.35*	2.97	*0.27*	3.00	*0.30*	2.20	*1.18*	1.99	*1.14*	2.06	*1.06*	3.18	*0.43*	3.13	*0.42*	3.12	*0.44*
White	79	3.64	*0.63*	3.71	*0.59*	3.76	*0.64*	2.71	*0.41*	2.74	*0.38*	2.68	*0.43*	1.47	*0.50*	1.47	*0.44*	1.46	*0.54*	2.91	*0.34*	2.91	*0.37*	2.93	*0.30*	2.41	*1.10*	2.25	*1.15*	2.27	*1.15*	3.01	*0.50*	3.02	*0.52*	2.95	*0.48*
Other race	17	3.77	*0.68*	3.90	*0.59*	3.81	*0.56*	2.49	*0.49*	2.59	*0.63*	2.69	*0.54*	1.42	*0.60*	1.44	*0.57*	1.58	*0.48*	2.97	*0.47*	3.03	*0.44*	3.01	*0.45*	2.38	*1.09*	2.13	*0.93*	2.41	*1.19*	3.07	*0.60*	3.11	*0.68*	3.06	*0.63*
Education																																					
Less than high school	43	3.93	*0.66*	3.96	*0.66*	3.94	*0.60*	2.78	*0.33*	2.80	*0.38*	2.77	*0.45*	1.41	*0.46*	1.53	*0.42*	1.43	*0.42*	2.94	*0.30*	2.89	*0.37*	2.95	*0.29*	2.13	*1.25*	2.03	*1.14*	1.86	*1.01*	3.04	*0.46*	2.99	*0.61*	2.96	*0.54*
Graduated HS	142	3.79	*0.63*	3.86	*0.57*	3.87	*0.60*	2.75	*0.40*	2.78	*0.38*	2.78	*0.35*	1.49	*0.48*	1.52	*0.45*	1.58	*0.47*	2.99	*0.38*	2.97	*0.32*	2.98	*0.33*	2.35	*1.09*	2.14	*1.14*	2.28	*1.13*	3.12	*0.49*	3.11	*0.45*	3.07	*0.46*
Income																																					
$13,000 or less	88	3.87	*0.64*	3.94	*0.59*	3.94	*0.56*	2.74	*0.45*	2.76	*0.43*	2.76	*0.42*	1.44	*0.46*	1.49	*0.46*	1.51	*0.44*	3.02	*0.36*	2.98	*0.34*	2.99	*0.34*	2.28	*1.06*	1.96	*1.06*	2.08	*1.13*	3.12	*0.50*	3.08	*0.43*	3.06	*0.46*
More than $13,000	92	3.75	*0.63*	3.80	*0.58*	3.81	*0.65*	2.76	*0.34*	2.81	*0.31*	2.79	*0.34*	1.50	*0.49*	1.55	*0.42*	1.57	*0.49*	2.93	*0.37*	2.93	*0.33*	2.94	*0.31*	2.43	*1.17*	2.29	*1.18*	2.31	*1.09*	3.09	*0.47*	3.09	*0.51*	3.04	*0.47*
Child with special needs																																					
Special needs child	96	3.62	*0.66*	3.70	*0.61*	3.68	*0.64*	2.70	*0.44*	2.74	*0.43*	2.69	*0.44*	1.34	*0.49*	1.39	*0.46*	1.40	*0.48*	2.92	*0.37*	2.91	*0.34*	2.90	*0.32*	2.41	*1.02*	2.23	*1.03*	2.29	*1.06*	3.02	*0.51*	3.01	*0.53*	2.97	*0.48*
No special needs children	92	4.01	*0.54*	4.06	*0.53*	4.08	*0.49*	2.80	*0.32*	2.83	*0.31*	2.88	*0.24*	1.60	*0.42*	1.67	*0.38*	1.69	*0.39*	3.03	*0.34*	2.99	*0.32*	3.04	*0.31*	2.20	*1.24*	1.99	*1.22*	2.07	*1.15*	3.19	*0.44*	3.15	*0.44*	3.13	*0.47*
Caretakers in the household																																					
Single parent	95	3.74	*0.66*	3.83	*0.59*	3.77	*0.61*	2.73	*0.42*	2.79	*0.35*	2.75	*0.42*	1.42	*0.47*	1.49	*0.44*	1.47	*0.49*	2.97	*0.35*	2.94	*0.29*	2.93	*0.31*	2.22	*1.04*	1.94	*1.07*	2.17	*1.08*	3.02	*0.51*	3.01	*0.49*	3.00	*0.47*
Other caretaker(s)	93	3.88	*0.61*	3.92	*0.60*	3.99	*0.58*	2.77	*0.36*	2.78	*0.40*	2.81	*0.31*	1.51	*0.48*	1.55	*0.45*	1.61	*0.43*	2.98	*0.37*	2.96	*0.37*	3.01	*0.33*	2.40	*1.23*	2.30	*1.17*	2.20	*1.15*	3.19	*0.44*	3.15	*0.48*	3.09	*0.49*
Physical or mental illness history																																					
Health history	92	3.60	*0.64*	3.67	*0.62*	3.66	*0.60*	2.71	*0.43*	2.73	*0.46*	2.71	*0.45*	1.40	*0.50*	1.42	*0.45*	1.45	*0.48*	2.86	*0.33*	2.87	*0.33*	2.88	*0.28*	2.47	*1.03*	2.30	*1.08*	2.34	*1.09*	2.99	*0.48*	3.00	*0.54*	2.98	*0.49*
No health history	96	4.01	*0.56*	4.08	*0.50*	4.08	*0.54*	2.79	*0.34*	2.83	*0.27*	2.85	*0.27*	1.54	*0.44*	1.62	*0.42*	1.63	*0.42*	3.08	*0.35*	3.02	*0.32*	3.05	*0.34*	2.15	*1.21*	1.93	*1.15*	2.03	*1.11*	3.21	*0.47*	3.16	*0.43*	3.11	*0.46*
Alcohol or drug abuse history																																					
Substance abuse history	36	3.85	*0.65*	3.87	*0.68*	3.91	*0.69*	2.72	*0.43*	2.79	*0.32*	2.81	*0.29*	1.40	*0.43*	1.36	*0.49*	1.46	*0.45*	2.87	*0.32*	2.87	*0.33*	2.94	*0.31*	2.18	*1.01*	2.07	*1.12*	2.21	*1.04*	3.03	*0.45*	2.94	*0.37*	3.01	*0.38*
No substance abuse history	152	3.80	*0.63*	3.88	*0.58*	3.87	*0.59*	2.76	*0.38*	2.78	*0.39*	2.77	*0.39*	1.48	*0.48*	1.56	*0.42*	1.56	*0.46*	3.00	*0.36*	2.97	*0.33*	2.98	*0.32*	2.34	*1.16*	2.12	*1.14*	2.17	*1.13*	3.12	*0.49*	3.11	*0.51*	3.05	*0.50*
Help-seeking behavior for parenting																																					
Help-seeking history	134	3.76	*0.65*	3.82	*0.60*	3.82	*0.61*	2.73	*0.41*	2.76	*0.41*	2.76	*0.40*	1.43	*0.49*	1.49	*0.46*	1.51	*0.48*	2.94	*0.36*	2.94	*0.31*	2.96	*0.31*	2.35	*1.12*	2.14	*1.15*	2.27	*1.14*	3.08	*0.49*	3.06	*0.49*	3.05	*0.49*
No help-seeking history	54	3.92	*0.59*	4.02	*0.56*	4.02	*0.57*	2.79	*0.35*	2.86	*0.25*	2.84	*0.28*	1.57	*0.43*	1.60	*0.39*	1.62	*0.40*	3.05	*0.36*	2.98	*0.39*	3.00	*0.33*	2.21	*1.17*	2.04	*1.08*	1.96	*1.01*	3.16	*0.48*	3.13	*0.50*	3.04	*0.45*
History of CPS Allegations																																					
CPS history	51	3.59	*0.57*	3.70	*0.50*	3.71	*0.61*	2.78	*0.33*	2.81	*0.36*	2.73	*0.43*	1.39	*0.49*	1.42	*0.42*	1.41	*0.53*	2.81	*0.30*	2.85	*0.27*	2.86	*0.25*	2.49	*1.16*	2.37	*1.00*	2.36	*1.07*	2.92	*0.50*	2.97	*0.53*	2.92	*0.50*
No CPS history	137	3.89	*0.64*	3.94	*0.62*	3.94	*0.59*	2.74	*0.41*	2.77	*0.38*	2.80	*0.34*	1.50	*0.47*	1.56	*0.45*	1.59	*0.43*	3.03	*0.36*	2.99	*0.35*	3.01	*0.33*	2.24	*1.12*	2.02	*1.17*	2.12	*1.12*	3.17	*0.46*	3.12	*0.47*	3.09	*0.47*
Mandated attendance																																					
Mandated attendance	27	3.72	*0.62*	3.80	*0.54*	3.89	*0.56*	2.86	*0.24*	2.89	*0.19*	2.83	*0.37*	1.41	*0.48*	1.53	*0.42*	1.47	*0.50*	2.84	*0.34*	2.85	*0.28*	2.88	*0.30*	2.50	*1.17*	2.38	*1.03*	2.25	*1.03*	2.87	*0.54*	2.93	*0.64*	2.86	*0.58*
Not mandated	156	3.83	*0.63*	3.90	*0.60*	3.87	*0.62*	2.73	*0.41*	2.76	*0.40*	2.78	*0.37*	1.48	*0.47*	1.52	*0.45*	1.56	*0.46*	3.00	*0.35*	2.97	*0.34*	2.98	*0.32*	2.29	*1.12*	2.09	*1.14*	2.17	*1.12*	3.13	*0.47*	3.10	*0.46*	3.07	*0.46*