

2017

# Impact of Training on Kin Caregivers' Use of Discipline Practices

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*Walden University*

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# Walden University

College of Health Sciences

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Bertha Ansley

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Walden University  
2017

Abstract

Impact of Training on Kin Caregivers' Use of Discipline Practices

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MS, Washington Adventist University, 2011

MS, University of New York at Buffalo, 1999

BS, University of New York at Buffalo, 1978

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

August 2017

## Abstract

Research has shown that child abuse is a serious public health issue that may warrant child welfare agency intervention and removal of children from their homes. Placement with kin caregivers is considered the least restrictive placement option by social workers. It has been recognized that kin caregivers require some type of formal parental training to prepare them to care for relative children. A large city implemented the Caring for Our Own training program as prelicensing training to prepare relatives for roles as kin caregivers. Prior to this study, no research had assessed whether this training program adequately addressed caregivers' ability to adopt effective discipline practices in response to perceived child misbehavior. The purpose of the study was to examine how the Caring for Our Own prelicense training impacted kin caregivers' use of ineffective discipline practices, as measured by change in scores on the 3 subscales of the Parenting Scale. The theoretical framework for this study was based on Ajzen's theory of planned behavior. One-way repeated measures ANOVA revealed no statistically significant difference in kin caregivers' ( $n = 27$ ) use of ineffective discipline practices as measured by the 3 subscales of the Parenting Scale over time. In light of this finding, the child welfare agency may create an evidence-based curriculum to assist in the development of competent kin caregivers. Social change to improve training and thus foster more effective responses from kin caregivers may occur within educational departments of child welfare agencies, through assessing and developing prelicensing kin caregiver training that allows for effective child behavior discipline management.

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## Dedication

For Estelle, beloved mother, who by example encouraged me to love and to pursue lifelong learning. For Jethro, a man I knew as my father. For my three daughters, LaVon, Carla, and Yasmeen. For my grands, sister, brother, and friends. Thank you for your support, and for your words that encouraged, made me laugh, and kept me moving forward.

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## Chapter 1: Introduction to the Study

### **Introduction**

Child maltreatment is a serious public health issue (Dahlberg & Krug, 2002; Nguyen, 2014). According to the U.S. Centers for Disease Control and Prevention (CDC), in 2012, 686,000 cases of child maltreatment were reported. During that time, a total of 1,640 children died as a result of physical abuse and neglect (CDC Understanding Child Maltreatment Fact Sheet, 2014). In 2013, there were 24 child fatalities resulting from maltreatment in the study's large northeastern city (Child and Family Services Agency [CFSA], 2014). Furthermore, in 2013, there were 1,162 out-of-home placements due to child maltreatment in the study site eastern city (CFSA, 2014). These statistics reveal how significant the problem of child maltreatment continues to be.

After maltreated children enter the child welfare system because of primary caregiver abuse and neglect, formal kinship care begins when they are placed with their relatives (CFSA, 2014). Placement with kin caregivers is considered the least restrictive placement option, and kin are the first individuals to be contacted by social workers in such cases (Lin, 2014). In most cases, these individuals are not prepared for the emergency situation of receiving traumatized children into their homes. The placements of relative children into kin homes can create challenges and stress and call for a complete rearrangement of household routines (Lin, 2014). It has been recognized that kin caregivers require some type of formal parental and supportive training to prepare them to care for relative children (Richardson & Gleeson, 2012). The Caring for Our Own training program is prelicensing training provided to relatives in a large northeastern

city to help them prepare for their roles as kin caregivers (Child Alliance of Kansas, 2011).

The implications of this study for positive social change relate to the potential impact of the Caring for Our Own training program through the empowerment of kin caregivers with knowledge to help them avoid harsh discipline practices with the children in their care. Acquiring and practicing positive disciplinary practices may help caregivers change outdated intergenerational patterns of physical and verbal abuse that are entrenched in many families nationally and internationally (Wang & Xing, 2014). In this chapter, detailed background information that was pertinent to the study is provided. The problem statement and purpose of the study are provided, as well as the research questions and hypotheses. The chapter concludes with a discussion of the assumptions, limitations, and significance of the study.

### **Background**

A review of the literature indicates that individuals, families, and informed communities can create a culture of health and safety that prevents child maltreatment (Tucker & Rodriguez, 2014). Parental discipline practices to prevent child maltreatment include interventions that effectively impact beliefs, societal norms, and policy agendas (CDC, 2015; Haegerich et al., 2014; Nadan, Spilsbury, & Korbin, 2015). In the United States, children under the age of 21 years may be separated from their biological parents for various reasons, including separation after the death of parent(s), illness, and deployment into the military, and they may become victims of abuse or neglect and end up in foster care (Annie E. Casey Foundation, 2010). Nationally, there are an estimated 400,000 children in foster care, with 28% of these children living with extended family

members in what are called *formal kinship foster homes* (Gateway, 2012). The Fostering Connections to Success and Increasing Adoptions Act of 2008 states that relatives should be contacted first regarding children's placement after removal from their home (H.R. 6893). The act also states that these relatives should be offered financial subsidies, training, and agency support (H.R. 6893). Research shows that placing children with extended family members helps to facilitate reunification with the primary caregiver when appropriate, strengthen family ties, and sustain cultural and religious practices (Pelaez, Amoros, Pastor, Molina, & Mateo, 2015). However, relative caregivers require adequate training to help them transition into parenting roles in relation to traumatized underage relatives (Pelaez et al., 2015).

This study evaluated the impact of a training intervention called The Caring for Our Own program, which was designed for this purpose (Children's Alliance of Kansas, 2011). It entailed structured classroom training conducted over a 5-week period, with two classes per week (Children's Alliance of Kansas, 2011). The goal of the program was to provide information framed from a strength-based perspective to help prospective foster and adoptive families make decisions regarding their abilities, willingness, and readiness to provide a safe and supportive home for children coming into formal relative foster care (Children's Alliance of Kansas, 2011). The training offered knowledge in alternative ways to manage child behavior, which, if practiced, may decrease retraumatization in kin foster children (Children's Alliance of Kansas, 2011). The knowledge that kin caregivers obtain from the Caring for Our Own training program also has the potential to change kin caregivers' beliefs about the way in which they discipline their own biological children, thereby decreasing child maltreatment (Douglas, 2013).



To date, there has been no study that has examined the impact of the Caring for Our Own training program on kin caregivers' abilities to change their beliefs regarding the use of physical or harsh verbal discipline. In this study, I sought to address this research gap. Findings from this study may provide theoretical insights into the belief factors of the theory of planned behavior, which anchored the study, and the effects of the training program on kin caregivers' beliefs and behavior regarding the use of child discipline practices.

### **Problem Statement**

The research problem the study addressed was child maltreatment resulting from the use of discipline practices by kin foster parents. Parental beliefs endorsing physical and harsh verbal discipline of children must be changed to manifest behavior that does not perpetuate incidences of child maltreatment (Chavis et al., 2013). In some families, the use of harsh verbal and physical discipline is passed down through generations, reflecting both family norms and broader societal norms (Pelaez, Amoros, Pastor, Molina, & Mateo, 2015). A recent study revealed that the use of harsh verbal and physical discipline toward children and adolescents is still a common practice (Wang & Kenny, 2014). The impact of harsh verbal and physical discipline has been shown to cause conduct problems and depression in children and adolescents (Wang & Kenny, 2014). Conditions that cause stress in families are predictors of physical and harsh verbal discipline (Wang & Kenny, 2014). The origins of this parental stress may reside in mental health issues such as depression, unemployment, and/or illegal activity and substance abuse, including taking prescription drugs (Denby, Brinson, Cross, & Bowmer,

2015). Additional social determinants include single parenting, parenting of multiple children, living in unsafe neighborhoods, domestic violence, and feelings of isolation, which have been shown to increase the probability of unmanaged stress experienced by parents (Denby et al., 2015). Unmanaged stress is most often inflicted on children through harsh parenting practices (Barlie, Edwards, Dhingra, & Thompson, 2015).

In 2013, 144,000 children were removed from their homes and placed in foster care (Department of Health and Human Services [DHHS], 2013). The nation's economic burden resulting from child maltreatment was estimated at an average lifetime cost per victim of \$210,012 in 2010 (Fang, Brown, Florence, & Mercy, 2012). The long-term effects of child maltreatment have been linked to adult-onset conditions such as alcoholism, obesity, smoking, cancer, cardiovascular disease, and depression (Anda & Felitti, 2002; Widom, Bentley, & Johnson, 2012; Vander-Weg, 2011). Universal parenting program interventions to help caregivers manage child behaviors are being implemented in many communities in the United States (Sanders, Kirby, Tellegen, & Day, 2014). The continual need for kin caregivers in the United States is evidence of the need to develop training interventions, support, and services that decrease the incidence and prevalence of child maltreatment (Lin, 2014). While it is important to understand the needs of traumatized children, it is equally important to understand and meet the needs of the relatives who will formally care for them (Lin, 2014). This study contributes to the current research literature related to kin caregiver training in a large city in the northeastern United States.

### **Purpose of the Study**

The purpose of this quantitative study was to assess the impact of the Caring for Our Own training program on kin caregivers' use of discipline practices, as measured by the three subscales of the Parenting Scale. The independent variable in the study was the Caring for Our Own training program, and the dependent variable was the use of disciplinary practices. The study had the covariates of time and the number of other children living in the home. All variables were measured quantitatively. The study was intended to examine any change in the caregivers' use of discipline practices across three points in time. The study was conducted in an urban setting in a large city in the northeastern United States.

### **Research Questions and Hypotheses**

The study research question (RQ) and hypotheses were as follows:

RQ1: How does Caring for Our Own training impact kin caregivers' use of discipline practices as measured by the three subscales of the Parenting Scale?

H<sub>10</sub> = The Caring for Our Own training will have no statistically significant impact on the caregivers' use of laxness as a discipline practice as indicated by a change in scores on the Laxness subscale of the Parenting Scale after controlling for time, pretest scores, and number of children in the home.

H<sub>1A</sub> = The Caring for Our Own training will have a statistically significant impact on the caregivers' use of laxness as a discipline practice as indicated by a change in scores on the Laxness subscale of the Parenting Scale after controlling for time, pretest scores, and number of children in the home.

H<sub>20</sub> = The Caring for Our Own training will have no statistically significant impact on the caregivers' use of overreactivity as a discipline practice as indicated by a change in scores on the Overreactivity subscale of the Parenting Scale after controlling for time, pretest scores, and number of children in the home.

H<sub>2A</sub> = The Caring for Our Own training will have a statistically significant impact on the caregivers' use of overreactivity as a discipline practice as indicated by a change in scores on the Overreactivity subscale of the Parenting Scale after controlling for time, pretest scores, and number of children in the home.

H<sub>30</sub> = The Caring for Our Own training will have no statistically significant impact on the caregivers' use of verbosity as a discipline practice as indicated by a change in scores on the Verbosity subscale of the Parenting Scale after controlling for time, pretest scores, and number of children in the home.

H<sub>3A</sub> = The Caring for Our Own training will have a statistically significant impact on the caregivers' use of verbosity as a discipline practice as indicated by a change in scores on the Verbosity subscale of the Parenting Scale after controlling for time, pretest scores, and number of children in the home.

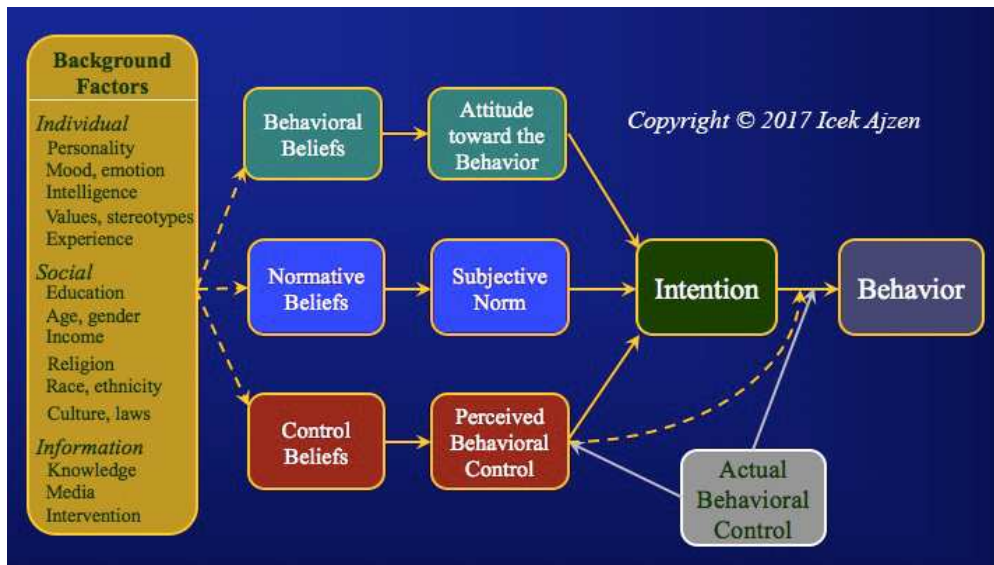
A one-way repeated measures analysis of variance (RM ANOVA) was used to test the null hypotheses for the research question (Field, 2013). A repeated measures design entails participation of the same individuals in all conditions of an intervention with provision of data at multiple points in time (Field, 2013). RM ANOVA analysis was used to compare means within all of the dependent variables in the same analysis, using a

combination of the three subscales of the Parenting Scale (Field, 2013). This method can be a powerful way to test theoretical models and to develop the most parsimonious answer to a research question (Field, 2013). Additional details regarding the data analysis procedures are provided in Chapter 3.

### Theoretical Framework for the Study

The theoretical framework for this study was based on Ajzen's (1991) theory of planned behavior (TPB). This intrapersonal theory posits that intentions to act on a behavior are influenced by three constructs: (a) beliefs in the behavior, (b) normative beliefs, and (c) behavior control beliefs (Ajzen, 1991). Figure 1 diagrammatically depicts the theory.

Figure 1. Theory of Planned Behavior



**Figure 1. Ajzen's theory of planned behavior. From *the Theory of Planned Behavior*, by I. Ajzen, 2000 (<http://people.umass.edu/aizen/tpb.background.html>) Copyright 2017 by Icek Ajzen. Reprinted with permission.**

According to the theory of planned behavior, behavioral beliefs influence a person's attitude toward a behavior, while normative beliefs make up subjective norms that are shaped by socially expected ways of behaving (Ajzen, 1991). Control beliefs, which are similar to self-efficacy, provide the basis for an individual's perception that he or she is in control of the performance of the behavior (Ajzen, 1991). Beliefs and attitudes influence an individual's intention to act. An example of intention is the level of motivation a person has to try something new. It is the level of effort the person exerts when performing a behavior (Ajzen, 1991). Beliefs are influenced by three factors: individual, social, and information. Individual factors influence personal preference, and the positive and negative feelings that an individual has about a behavior (Ajzen, 1991). Social factors influence the belief in the expectations of significant others regarding how one should behave (Ajzen, 1991). Lastly, information serves as a background factor that influences behavior change. The theory of planned behavior framework relates to this study approach because of the belief constructs in relationship to kin caregiver child discipline practices. Kin caregiver intentions to change ineffective discipline practices are influenced by the value they place on the behavior, the influences of others, as well as their thoughts about their ability to change, and the level of information they receive (Ajzen, 1991). The application of the theory of planned behavior and how it relates to this study are discussed in more detail in Chapter 2.

### **Nature of the Study**

This study was quantitative and quasi-experimental. The rationale for conducting a quantitative study was based on the postpositivist tenet that scientific truth exists and can be statistically analyzed (Creswell, 2014). A quantitative design, unlike qualitative

approaches, allows researchers to distance themselves from the study participants, which encourages objectivity (Quick & Hall, 2015). The quantitative design can be used to test hypotheses and differences within and between groups. Moreover, a quantitative design can be used to examine relationships between variables and to evaluate the impact of an intervention (Hagan, 2014). The primary independent variable in this study was the Caring for Our Own training intervention. The covariables were time and number of other children in the home. The dependent variables were kin caregiver use of discipline practices indicated by change in scores on the Parenting Scale.

A purposeful sample was recruited from kin caregivers who signed up for the prelicensing training with the DC CFSA. The questionnaire used for data collection was the Parenting Scale (PS; Arnold, O'Leary, Wolff, & Acker, 1993). The questionnaire was given to respondents prior to the start of the Caring for Our Own training, after completion of the training, and again 30 days after the training was completed. The data analysis consisted of descriptive statistics, and one-way RM ANOVA using Statistical Package for Social Sciences (SPSS) software (Field, 2013). Postpositivism involves the assumption that one cannot be positive about how knowledge was acquired when studying the behavior of humans (Creswell, 2014). The actions of humans are based on observation and the measurement of what is observed (Creswell, 2014). The quantitative approach uses numbers to measure data from a survey and is appropriate for studying attitudes that could impact the outcome of this study (Salkind, 2010).

### **Definitions**

The Caring for Our Own training program, which was the independent variable, was defined as training. The dependent variable in the study was kin caregiver use of

discipline practices as measured by the three subscales of the Parenting Scale. Definitions for other terms in the study are presented below; some were extracted from the U.S.

Department of Health and Human Service (DHHS) publication *Child Maltreatment 2013*:

*Caregiver*: “A person responsible for the care and supervision of a child” (DHHS, 2013, p. 103).

*Caregiver risk factor*: “A primary caregiver’s characteristic, disability, problem, or environment, which would tend to decrease the ability to provide adequate care for the child” (DHHS, 2013, p. 103).

*Child*: “A person who has not attained the lesser of (a) the age of 18 years (b) except in the case of sexual abuse, the age specified by the child protection law of the state in which the child resides” (DHHS, 2013, p. 103).

*Child maltreatment*: “Any act or series of acts of commission or omission by a parent or other caregiver that results in harm, potential for harm, or threat of harm to a child” (CDC, 2015; Leeb, Paulozzi, Melanson, Simon, & Arias, 2008, p. 11).

*Foster parent*: “Individual who provides a home for orphaned, abused, neglected, delinquent, disabled children under the placement, care, or supervision of the state. The person may be a relative or nonrelative and need not be licensed by the state agency to be considered a foster parent” (DHHS, 2013, p. 108).

*Harsh discipline*: Discipline that involves parental use of coercive and verbally aggressive commands, as well as physical punishment (Sturge-Apple, Suor, & Skibo, 2014).

*Ineffective*: Inadequate to accomplish a purpose; not producing the intended or expected result (Dictionary.com).



*Physical abuse:* “Type of maltreatment that refers to physical acts that caused or could have caused physical injury to a child” (DHHS, 2013, p. 112).

*Psychological emotional maltreatment:* Acts or omissions—other than physical abuse or sexual abuse—that could have caused conduct, cognitive, affective, or other behavioral or mental disorders. Frequently occurs as verbal abuse with excessive demands on a child’s performance (DHHS, 2013).

### **Assumptions**

Assumptions made in this study included the following: (a) the theory of planned behavior would be the most appropriate theoretical framework for this study, (b) the selected questionnaires and scales were suitable for obtaining quantitative data from respondents, (c) study participants would be truthful in answering closed-ended questions, (d) study participants would agree to be tested 30 days after the completion of training, (e) validity and reliability standards would be maintained throughout the research study, (f) the development of methods and conclusions would be conducted without bias, and (g) all participants would comprehend the English language used in the questionnaire. These assumptions were necessary in the context of the study.

Assumptions are necessary because they need to be met or addressed for a study to remain viable (Simon, 2011).

### **Scope and Delimitations**

The boundaries of this study were defined by the following delimitation: Within child protective services in the large northeastern city, kinship care is the priority placement choice for children who have been abused or neglected and can no longer reside in their original homes (Lin, 2014). I decided to focus on kin caregivers who were

responsible for the care of these children and the study site, Child and Family Service, because of the importance of identifying and meeting training program needs of kin caregivers. This sample population of kin caregivers consisted of individuals who had not yet participated in the mandatory Caring for Our Own training program. Relatives who could be contacted to care for these children might have resided in the northeastern city that served as the study site. This sample population may not be similar in nature to the population of kin caregivers in various other child welfare agencies (Lin, 2014). Therefore, results will be generalizable to kin caregivers who reside in the study's northeastern city.

### **Limitations of the Study**

The limitations of this study were related to the sample and the measures used (Creswell, 2011) and became apparent during data collection and analysis. First, the sample was drawn from volunteer kin caregivers residing in a large northeastern city. Therefore, generalizability can only be suggested; it cannot be extended to the general population of kin caregivers (Simon, 2011). Moreover, the study was limited by the number of respondents who participated fully (Creswell, 2014). Limitations of survey research may include how participants respond. For example, because of inaccurate self-perceptions or biased memory, participants may not answer questions in a valid way (Salkind, 2010). Participants may not fully understand the questions and the response options. The inclusion only of English-speaking kin caregivers could have biased the study and influenced study outcomes (Salkind, 2010). Therefore, study results cannot be generalized to non-English-speaking kin caregivers. Additionally, participants may have adopted a "response set" whereby they did not answer the items truthfully regardless of

what was being asked (Salkind, 2010). Reasonable measures were taken to address all of the limitations in the study, such as listing them in the study discussion, varying the direction of the response options, using a survey that has proven validity, and using sound sampling practices (Salkind, 2010).

### **Significance of Study**

The significance of this study resides in its findings concerning whether or not universal training interventions such as Caring for Our Own impact kin caregivers' use of discipline practices as measured by the three subscales of the Parenting Scale (Children's Alliance of Kansas, 2011). Yelling is a nonphysical yet aggressive management technique that is frequently used to quell child misbehavior, especially in some African American families (Bradley-Adkison, Lin, 2014, Terpstra, & Domitorio, 2014). Yelling can serve as a caregiver risk factor for disciplining children in kin foster care (Richardson & Gleeson, 2012). Findings from this study may contribute to advancing knowledge in relation to public health and community health education. The study may contribute to efforts to advance community health education to empower kin caregivers as they become kinship foster parents (Richardson & Gleeson, 2012). The potential positive social change implications of this study include the possibility that the training intervention that kin caregivers receive will provide them with the knowledge they need to implement child discipline practices that are effective and that do not include physical or harsh verbal discipline practices. These changes could ultimately contribute to eliminating incidences of child maltreatment.

## Summary

The long-term effects of trauma on children placed in kin foster care demand an evaluation of interventions that were implemented to support their recovery and subsequent healthy growth. Interventions that could impact kin caregivers' use of effective discipline practices have not been evaluated. To conduct this evaluation, a theoretical foundation that helps to explain beliefs, influences on intentions, and actual behavior changes was applied. In this quantitative study, I sought to answer the question of whether the training intervention kinship caregivers received impacted their selection of discipline practices over time. In this chapter, the background, the problem statement, the purpose, and the significance of the study have been discussed. The theoretical framework and literature relevant to this study, as well as the study's research questions and hypotheses, definitions, assumptions, scope, and limitations/delimitations, have also been presented. Chapter 2 presents an in-depth discussion of the literature relevant to the study and an examination of the study's theoretical framework.

## Chapter 2: Literature Review

### **Introduction**

The research problem that this study addressed is child maltreatment resulting from the use of discipline practices by kin foster parents. The purpose of the study was to examine whether the training that kin foster parents receive prior to obtaining their permanent kin foster home licenses could impact their ability to administer effective discipline practices. The Caring for Our Own training program is a universal training intervention (Children's Alliance of Kansas, 2011). This means that all kin caregivers must complete the same training curriculum before they are officially licensed to function as kin foster homes (Prinz, 2015). A consideration of sociodemographic differences within the kin caregiver population raises the question of whether a universal training intervention can, to a significant extent, meet the needs of all kin caregivers. Parental training is frequently a component of child welfare programs (Estefan, Coulter, Weerd, Armstrong, & Gorski, 2013). Raising participant awareness regarding research findings on the ill effects of harsh discipline is a component of parenting programs (Chen & Chan, 2015). Evidence-informed parental training interventions to support the needs of kin caregivers were considered the most efficacious and sustainable approach (Gray, Joy, Plath, & Webb, 2012).

This chapter presents a critical review of the peer-reviewed literature to provide a background on the theoretical foundation of the study based on Ajzen's (1985) postpositivist theory of planned behavior, the literature on parenting interventions, and an in-depth review of the current literature regarding key variables as they relate to child maltreatment, kin foster care, and parenting interventions.

## Literature Search Practice

The primary research practice encompassed peer-reviewed articles published in 2011 through 2015. Seminal work dating back to 1979, 1985, and 2000 through 2003 was also drawn upon. The following digital library databases were used for this study: Academic Search Complete, CINAHL & MEDLINE, Google Scholar, ProQuest Central, PsycARTICLES, PsychINFO, SocINDEX, Thoreau, Dissertations & Theses at Walden University, and the Cochrane Database of Systems Reviews. Most database searches were accomplished using Google Scholar and resources available at Walden University's library. Key research terms included *parenting interventions, attitudes, parenting styles, discipline beliefs, child abuse, child discipline, child maltreatment, child maltreatment prevention, corporal punishment, emotional abuse, foster care, kinship foster care, parental attitudes, attributes, psychological abuse, shame, yelling, theory of planned behavior, and harsh discipline*. Articles that were included in the search contained specified names and addressed at least one of the three constructs of the theory of planned behavior.

## Theoretical Foundation

### Theory of Planned Behavior

The study used the theory of planned behavior as a theoretical framework to examine the ability of kin caregivers to administer appropriate forms of child discipline after receiving the Caring for Our Own training. The theory of planned behavior is an intrapersonal theory and posits that information and reason contribute to intentions to act on a behavior (Hayden, 2014). This theory had particular explanatory power in this context because kin caregivers are provided with education on parenting for traumatized

relatives and may need to develop parenting practices that differ from those they are accustomed to (Children's Alliance of Kansas, 2011). The theory of planned behavior is a value-expectancy theory. It holds that people will change their behavior if they feel that the benefits of changing that behavior will outweigh the costs (DiClemente, Salazar, & Crosby, 2013). The theory of planned behavior was developed by Ajzen based on previous health behavior models, and it considers various determinants of change in human health behavior (Ajzen, 1985). It extends Fishbein's theory of rational action, which assumes the existence of a relationship between beliefs, intentions, and health behavior (Sarver, 1983). The theory of rational action also suggests that social expectations influence an individual's beliefs when considering whether or not a behavior is beneficial (DiClemente et al., 2013). Fishbein (1975) assumed that a well-intentioned individual would implement appropriate behavioral changes. However, the intention to implement a certain kind of behavior may be influenced by multiple environmental and social situations (Ajzen, 1985). Financial, environmental, or political factors can affect individuals' perceived ability to act on their intentions to change. Consequently, Ajzen (1985) added the construct of behavioral control belief that explains whether or not individuals believe that they have the ability to act on their intentions and can make the requisite behavioral change in the face of constraints (Ajzen, 1985).

### **Previous Application of the Theory of Planned Behavior**

Behavioral change is influenced by three constructs: (a) *behavior beliefs*, or beliefs relating to the importance of the behavior that shape attitudes toward the behavior; (b) *normative beliefs*, or the subjective beliefs of important others; and (c) *behavior control beliefs*, or the beliefs of individuals that they can perform the behavior (Hayden,

2014). The above constructs, identified within the theory of planned behavior, appropriately lend themselves to explaining whether and how an individual is likely to make a behavior change (Hayden, 2014). By understanding how people are affected by these constructs, one may more effectively encourage them to make a positive behavioral change, assuming that such a change is warranted.

Beliefs concerning the physical discipline of children are influenced by many factors. Zolotor, Chang, Berkoff, and Runyan (2008) conducted an anonymous telephone survey on parents' attitudes toward physical discipline, and the study results revealed that based on their attitudes toward spanking, parents did indeed spank their children (Zolotor et al., 2008). The data further revealed that spanking using an object such as a belt led to an increase in self-reporting of child abuse (Zolotor et al., 2008).

Researchers have used the above constructs from the theory of planned behavior to investigate parental attitudes and behavior in relation to child discipline and childcare. For example, a study conducted by Taylor, Hamvas, Rice, Newman, and DeJong (2011) examined attitudes, perceived social norms, and expectations regarding corporal punishment held by urban parents as predictors of the use of corporal punishment. The authors conducted a stratified random digital-dial telephone survey of male and female participants ( $n = 500$ ). The study's independent variable was perceived social norms, and the dependent variable was positive attitudes toward corporal punishment (Taylor et al., 2011). The results of the study revealed that the most significant predictors of a positive attitude toward corporal punishment were approval of corporal punishment by family and friends and advice received from physicians and religious leaders that endorsed physical punishment (Taylor et al., 2011). Specifically, the study revealed that social norms



regarding physical discipline were strong predictors of parental attitudes in support of or against physical discipline of children.

Likewise, a similar study found that the theory of planned behavior predicted the opinions of others regarding child discipline. Taylor, Moeller, Hamvas, and Rice (2012) conducted a study on a sample of parents ( $n = 500$ ) comprising African Americans 60% and European Americans (40%) to investigate from whom parents would seek advice about child rearing and the use of corporal punishment (Taylor et al., 2012). The authors performed a stratified random digit-dialing survey to test the subjective social norm construct of the theory of planned behavior (Taylor et al., 2012). European American parents who were married and had some college education reported that they would seek child discipline advice from pediatricians. Those who stated that they would seek professional advice from religious leaders were more frequently African Americans, with education below the college level and with lower incomes (Taylor et al., 2012). Mental health professionals were the second option for parents seeking advice on child discipline. This study revealed that the endorsement of physical discipline by physicians, family members and friends, and clergy had a significant influence on parents' use of physical discipline (Taylor et al., 2012).

Beliefs regarding the use of corporal punishment can be examined in relation to professionals as well as parents. A study conducted by Ben-Natan, Faour, Naamhah, Grinberg, and Klein-Kremer (2012) tested whether the theory of planned behavior could predict the reporting of child abuse by Israeli and Arab physicians and nurses. Behavioral beliefs, subjective norms, and behavior control along with mandated reporting responsibilities were examined. A Child Abuse Report Intention Scale measured the

following research variables: (a) intended reporting behaviors, (b) knowledge, (c) subjective norms, (d) perceived behavioral control, and (e) attitude toward reporting (Ben-Natan et al., 2012). The study sample ( $n = 185$ ), which was composed of hospital and community medical staff, consisted of 42 senior doctors and interns and 143 nurses, including nurse practitioners, critical care nurses, clinical nurse specialists, and community health nurses (Ben-Natan et al., 2012). The results of the study revealed that 60% of the respondents had not reported child abuse incidents over the past year (Ben-Natan et al., 2012). Significant differences were found between Arab and Jewish doctors and nurses, with Jewish staff reporting child abuse more frequently than Arab staff (Ben-Natan et al., 2012).

Correlations revealed that subjective beliefs of staff opposing child abuse resulted in higher intentions to report child abuse (Ben-Nathan et al., 2012). Doctors reported cases of child abuse more often than nurses, and Jewish doctors reported cases more often than Arab doctors. Nurses reported cases according to the type of child abuse they had witnessed. If the medical staff had children of their own, they were found to have a higher tendency to report suspected child abuse (Ben-Nathan et al., 2012). Most medical staff reported possible litigation issues and errors in assessing child abuse as reasons for their reluctance to report child abuse (Ben-Nathan et al., 2012). The authors concluded that the theory of planned behavior did predict some but not all of the associated factors for reporting child abuse by the medical staff (Ben-Natan et al., 2012). This study emphasized the need for professional and mandated reporters to become more confident in reporting child abuse. It further indicated that behavior control issues could be

addressed through training and role-playing by enacting incidents of child abuse reporting to make the reporting procedure more familiar and comfortable.

The theory of planned behavior was also foundational for a study that examined nonresidential fathers and their intentions to interact with their children. Perry and Langley (2013) extracted secondary data from a national-level survey, the Fragile Families and Child Well-Being Study. The data for the study were collected between 1998 and 2000 from low-income, unmarried parents (both women and men) who lived separately (i.e., the father did not reside with the mother and/or child). Data from the initial interviews with fathers held in 1998, and from 1-year follow up interviews ( $n = 3,830$ ) were analyzed (Perry & Langley, 2013). Three constructs from the theory of planned behavior were analyzed using a scale developed by Mathematica Policy Research, a survey design, data collection, and statistical services agency (Mathematica, n.d.), along with measures for paternal engagement, coparenting relationships, and paternal engagement intention (Perry & Langley, 2013). Two multiple regression analyses were performed. The first was for fathers who reported the intention to engage with their children, and the second was for those who reported actual engagement (Perry & Langley, 2013). Belief in the behavior and subjective norms were both found to be significant predictors of fathers' intentions to engage more with their children, whereas perceived behavior control was not found to be a significant predictor (Perry & Langley, 2013). Fathers' belief that it was important to engage with their children predicted their actual engagement with their children.

The theory of planned behavior was applied in another study to predict the childcare behavior of mothers toward their adolescent daughters. Hertweck et al. (2013)

applied this theory within a prospective cross-sectional study to predict whether or not a mother would decide to inoculate her adolescent daughter with the human papillomavirus vaccine. The sample consisted of mother-daughter pairs ( $n = 68$ ), with European American 74%, and African American 22% mothers who had a high school or higher education. The researchers used a questionnaire and performed path analysis to test their hypothesis using the three constructs of the theory of planned behavior: attitude toward the behavior, subjective norms, and behavior control. Attitude toward the behavior would be influenced by health information obtained primarily from a physician (Hertweck et al., 2013). Similar to the findings of Taylor et al. (2011), the study revealed that subjective norms or opinions of others facilitated the mothers' decision to have their daughters vaccinated. Control beliefs relating to the ease with which the vaccination could be initially obtained and given, and subsequently repeated in the scheduled sequence, were also a significant factor for vaccination (Hardwick et al., 2013). This study demonstrated that advice from friends, family members, and professionals influences behavior change.

### **Rationale for the Choice of the Theory of Planned Behavior**

The theory of planned behavior was appropriate for this study because its three constructs are capable of predicting whether kin caregivers are able to dispense effective discipline to relatives after receiving parental training. Application of this theory also provided valuable information on how to develop research-informed interventions that would be effective in enhancing parental protective factors and outcomes. These include positive parenting attitudes, parent-child interactions, and parenting behavior, as well as increased parental confidence and satisfaction (Chen & Chan, 2015). Specifically, the theory of planned behavior's framework relates to and builds upon existing theory for the

following reasons: Parental discipline style is related to attitudes around the use of specific practices and is influenced by social norms. Effective discipline and ineffective discipline are related to parenting style. Moreover, certain demographic and cultural factors contribute to a parent's discipline style in general, and specifically to his or her willingness to resort to verbal and physical aggression. The research question relates to the theory of planned behavior in the following manner: There is mixed and somewhat limited evidence about (a) how well kin foster parents do in general, and (b) how training can affect parents generally and kin foster parents specifically. The current state of knowledge suggests that there is a gap that needs to be addressed. The present study helps to fill the research gap.

### **Literature Review Related to Parenting Interventions**

A review of the literature did not yield any studies on evidence-informed interventions for kin caregivers. This may be because most training programs are intended for parents in general and are not specifically designed for kin caregivers (Pelaez et al., 2015). A meta-analysis of parenting interventions in low-, middle-, and high-income countries conducted by Chen and Chan (2015) yielded 37 evidence-informed studies out of 3,578 initial results. Chen and Chan reviewed parenting program interventions analyzed using randomized designs to examine the magnitude of effects and conducted quantitative analysis to confirm their effectiveness. Chen and Chan found that parents were more likely to oppose inappropriate parenting attitudes and that their confidence in their parenting roles increased after participating in a parenting program intervention. The analysis found that parenting programs were effective as primary, secondary, and tertiary interventions in preventing child maltreatment (Chen & Chan,

2015). The types of universal training programs included home visits by nurses to families considered to be at risk, interventions initiated by schools, and parent education-support programs provided by community agencies (CDC, 2015).

Festinger and Baker (2013) reviewed the efficacy of foster parent training programs under the following categories: preservice, in-service single session, and in-service multisession. Findings revealed that few of the preservice training programs performed well, and that those that were completed were not robust (Festinger & Baker, 2013). According to Festinger and Baker the most widely used programs were the Model Approach to Partnership Parenting (MAPP) and Parent Resource Information Development Education (PRIDE). However, they noted in their study that more specific information on various aspects of fostering, especially the management of behaviors, was needed. They also observed a lack of training content on discipline techniques to meet the needs of troubled youth. Festinger and Baker recommended further studies focusing on foster parents' attitudes and knowledge, use of stronger methodologies, and mixed method studies.

Universal parenting programs endorsed by the CDC such as the Triple P Positive Parenting Program (Sanders, 2008), and the Nurturing Parents Program (Bavolek, 2000) have been established. The Triple P Positive Parenting Program is described by Sanders (2008) as a multi-level parenting training program based on the social cognitive learning model. Its tenets support a self-regulation philosophy where parents were trained to control their behaviors, to facilitate changed behaviors in their children. The system viewed as a public health approach is described as follows:

The system aims to prevent severe behavioral, emotional, and developmental problems in children and adolescents, by enhancing the knowledge, skills, and confidence of parents. It incorporates five levels of intervention on a tiered continuum of increasing strength for parents of children from birth to age 16. The suite of multilevel programs in Triple P is designed to create a “family friendly” environment that supports parents in the task of raising their children. It specifically targets the social contexts that influence parents on a day-to-day basis. (Sanders, 2008, p. 507)

Bavolek (2000, p. 6) has described the Nurturing Parenting Program as a parenting training program that teaches parents the value of family strength and cohesiveness. The program’s main goal is to prevent child abuse and neglect, and its ultimate objectives were to teach parents alternatives to hitting, and yelling, increase communication within the family, and help parents substitute nurturing behaviors for abusive ones, thereby improving the parent child relationship.

Whether these programs were adaptable to parents belonging to different cultures is matter of ongoing debate. The Triple P program has been disseminated worldwide and implemented primarily in European countries, and in Japan. However, critics question the efficacy of the Triple P program because of poor quality trials, bias, and underpowered studies (Coyne & Kwakkenbos, 2013). Another significant factor in program intervention is the location of its implementation. Parental interventions can be implemented at various sites. For example, Chavis et al. (2013) conducted a randomized controlled study of parents ( $n = 258$ ) at a pediatric primary care clinic, to explore ways of teaching parents

not to spank their children. The sample consisted of 63 White, 121 Black, and 55 Hispanic parents who had infants and toddlers, aged between six and twenty-four months.

Chavis et al., (2013) wanted to measure whether Play Nicely, a short video intervention that was viewed only once by parents during a well-baby clinic visit, could change parental attitudes towards physical discipline. The control and intervention groups were presented with a hypothetical situation of a child being aggressive with another child. The intervention group was told to view four options for disciplining a child (Chavis et al., 2013). Options for responding to the hypothetical situation consisted of spanking, time-out, removal from the situation, setting a limit, explaining, redirecting, stopping the child from hitting the other child, and getting the child to apologize. The control group saw their doctor without taking part in the intervention, and both groups completed an Attitudes Toward Spanking questionnaire. Frequency distributions were performed on the data, and the results of the study revealed that parents in the intervention group had lower scores for Attitudes Toward Spanking score, and were more likely to explain to, and redirect the child, compared with parents in the control group (Chavis et al., 2013). The parents in the control group reported a significantly stronger intention to spank their children compared with those in the intervention group (Chavis et al., 2013). This study highlights the importance of developing alternative conceptual and practical parenting interventions with information that can be disseminated at accessible, and regularly visited locations such as primary care clinics.

Similarly, Holden, Brown, Baldwin, and Caderao (2014) conducted two random design studies to investigate the impact of active reading of empirical findings, versus passively receiving instructions on adverse effects, and child behavior problems



associated with corporal punishment. In the first study, non-parents ( $n = 118$ ) were given brief articles to read. The second study included parents and a control group ( $n = 520$ ), and used the following scales as measures: The Attitudes Toward Spanking scale, and an Intention to Spank scale, which were completed online by participants (Holden et al., 2014). ANOVA results revealed a significant reduction in attitudes towards spanking and the intention to spank. Parents in both intervention and non-parent groups reported a drop in their intention to use corporal punishment with children they planned to have in the future (Holden et al., 2014).

Preventing child maltreatment is a major goal of parenting interventions. Lanier, Kohl, and Benz (2014) assessed the Parent-Child Interaction Therapy to test its impact on the prevention of child maltreatment. The study targeted families who were referred from child welfare services ( $n = 120$ ) because of a history of child maltreatment. The program was adapted from a social learning model, using coaches to train parents to interact with their children, and to apply appropriate behavior management techniques during play sessions with their children (Lanier et al., 2014). Participants' demographics were as follows: European Americans 51%, African Americans 42%, and other ethnicities 7% including American Indians, Asians, Indians, and other multiracial individuals. To assess new cases of reported child maltreatment post training, clinical intervention participation records were linked with child protection records (Lanier et al., 2014).

The results of the study revealed that during a follow-up postsession 28 months after undergoing the therapy, 15% of the participating families reported the repeated incidence of child maltreatment, with two of these families having had substantiated records of child maltreatment (Lanier et al., 2014). The study also found that self-

reporting was higher at the baseline level for those who later repeated acts of child maltreatment (Lanier et al., 2014). Moreover, maltreatment during childhood, and poverty were strong predictors of repeated acts of child maltreatment perpetrated by participants after the intervention (Lanier et al., 2014). Therefore, the authors posited that while the Parent Child Interaction Therapy may have been effective in imparting new parenting skills, it was not effective in preventing the future occurrence of child maltreatment in this population. These studies indicate that there is a need to assess the impacts of interventions within specific populations that care for children such as kin caregivers.

This proposed study seeks to examine whether the training provided to kinship foster parents prior to their receiving their permanent kinship foster care licenses could impact their use of discipline practices as measured by the three subscales of the Parenting Scale. The study will evaluate the Caring for Our Own training program, which is a mandatory 5-week classroom-based training program for participants aged 18 years or older, desiring to license their homes as kin foster homes. The goals of the program were to provide information to help prospective foster and adoptive families make decisions regarding their ability, willingness, and readiness to provide a safe and supportive home for children coming into foster care in their homes (Children's Alliance of Kansas, 2011). Instruction was given via power point presentations, and through interactive adult learning activities. Participants received information about child development, kin caregiver, child, and the birth parents' transitional reactions to change, and the importance of collaborative interventions with the school, and child welfare personnel. Instruction was also given on effects of trauma to the child, impacts of

substance abuse and mental health on the family as a system, child behavior management practices, as well as practices for managing and resolving conflicts with birth parents (Children's Alliance of Kansas, 2011).

### **Literature Review Related to Key Variables and Concepts**

#### **Social Determinants and Discipline Practices**

The study used a quantitative, quasi-experimental, pretest, posttest, within group one-way repeated measures ANOVA approach. This design will assess the main independent variable of the Caring for Our Own training on kin caregivers' use of discipline practices as measured by the three subscales of the Parenting Scale.

Appropriate disciplining of children and adolescents in the process of kin caregiving occurs in specific contexts. Parenting interventions must take into consideration the fact that in some families, the transmission of beliefs regarding parenting occurs inter-generationally (LeCuyer, Christensen, Kreher, Kearney, & Kitzman, 2014). Research has uncovered characteristics that may predict whether individuals will be appropriate kin caregivers. Characteristics such as the relative's intentions were motivation, and clear roles and expectations help determine what tools can be offered to kin caregivers that can facilitate them in responding to crisis situations (Pelazis, Amoros, Pastor, Molina, & Mateo, 2015). Parents may choose the same methods to discipline their children that were used to discipline them when they were children. Baumrind (1971) describes three parenting styles: authoritative, authoritarian, and permissive. An authoritative parenting style entails the willingness of an individual to parent in a warm and emotionally supportive manner that is favorable to the child's needs. The child participates in policy

decisions of the home, enabling a positive parent-child relationship to develop (Baumrind, 1971).

A parent with an authoritarian parenting style confronts the child regarding his or her misbehavior, refusing to compromise and generally using an aggressive, non-conciliatory approach that promotes the parent's way of doing things (Baumrind, 1971). A passive parenting style entails a parental-child relationship in which the parent does not assign responsibility to the child for doing chores or meeting other standards relating to the allocation of household responsibility. The child is treated in a non-confrontational manner, and there is no guidance given to the child by the parent on the importance of following rules outside of the home (Baumrind, 1971). These descriptions of parenting styles have been applied in various research studies over the years.

The choice of appropriate discipline practices helps children internalize family values, and develop healthy concepts of self, authority, and peers in socializations, while promoting good parent-child relationships (Westbrook, Harden, Holmes, Meisch, & Whittaker, 2013). The use of yelling, cursing, and verbal threats by parents has not been as extensively researched as the use of physical discipline or corporal punishment. However, verbal threats that have been shown to result in adverse outcomes for children, both in the short term and in the long term, were more pervasive because of their use in conjunction with physical discipline (Wager, Bates, Dodge, & Pettit, 2012). Lansford et al. (2012) examined secondary data from a multi-state longitudinal study of parents recruited in 1987 and 1988, assessing whether the use of various child discipline techniques such as spanking, yelling, reasoning, and denying privileges differed between African American and European American mothers.

Data were obtained from the Child Development Project in which parents self-reported the discipline techniques they used for their children in grades one to three, and teachers completed forms reporting on child-externalizing behavior exhibited from kindergarten up to the fourth grade (Lansford et al., 2012). The results of the study revealed that both African American and European American mothers used denial of privileges, reasoning, and yelling more frequently than physical punishment. They further revealed that mothers who did not support physical punishment used yelling to compensate for physical punishment. Moreover, yelling was found to be associated with verbal aggression (Lansford et al., 2013). These findings suggest the importance of raising awareness, and disseminating information on the detrimental effects of emotional and physical child discipline so as to change social norms regarding its use.

Parents' use of yelling at children as a form of verbal discipline is as damaging to children as physical discipline. Furthermore, yelling has been linked to corporal punishment, described as the first step that leads to child abuse (Bartkowski, & Wilcox, 2000). Thus, the use of yelling as a child discipline technique by parents is a disciplinary technic that needs to be addressed. Evans, Gordon, and Simmons (2012) found that verbal and physical aggression of adolescents was associated with verbal hostility used by their fathers towards them. Yelling is often the verbal expression of anger, and when used as a discipline practice it can invoke feelings of guilt and shame (Grille & Macgregor, 2013). This can lead to the internalization of negative feelings of rejection, low self-esteem, and isolation in children (Grille & Macgregor, 2013). While yelling is used in some families, it is frowned upon in others.

### **Cultural and Social Determinants**

Culture and religion were contributing factors that shape the discipline practices used by parents. A seminal study conducted by Bartkowski and Wilcox examined the practice of using physical discipline, over the use of yelling among conservative Protestant parents. The target population of parents in the study was found to be significantly less likely to yell at their pre-school and school-aged children, and more likely to spank them. These parents' beliefs in biblical tenants, namely, refraining from the use of harsh language and yelling protects the spirit of the child and the child's self-esteem, were found to be the reasons for their decreased use of parental yelling (Bartkowski & Wilcox, 2000).

Other studies have revealed parental discipline styles in different contexts. Westbrook et al. (2013) used Baumrind's (1971) model of parenting styles, and Lazarus' (1963) family stress theory to examine whether physical disciplining of toddlers predicted their aggression, one year later. The sample consisted of African American mothers ( $n = 69$ ) described as being low income and high-risk individuals (Westbrook et al., 2013). Stress theory (Lazarus, 1963) was also applied in this study to examine whether parental stress, and depression influenced respondents' ability to cope. Relationships between the variables, maternal depression, warmth, parenting stress, and a child's aggressive behavior, were measured one year later. The results revealed that the study variables had no significant relationships with the aggressive behavior of the children (Westbrook et al., 2013).

Child discipline is not only a concern of parents in the United States. Passini, Pihet, and Favez (2014) used a mixed-method research design to explore parenting

beliefs and values within a community of French mothers living in Switzerland, to gain an understanding of the mother-toddler relationship. Data were collected using three methods: (a) Q-methodology that measured parental beliefs and values, (b) a questionnaire based on the Dimensions of Discipline Inventory, and (c) information on daily lives compiled from papers, journals, and smart phones or other handheld devices used for ecological momentary assessments, to measure actual use of discipline practices. Passini et al. tested respondents' acceptance of various discipline practices using cognitive behavior and behavior management constructs. The parent-child relationship was explored in relation to Baumrind parental styles. Recommended parental discipline responses such as timeout, ignoring, explaining rules, giving praise, and removal of privileges were measured along with the use of yelling and spanking. The authors found that yelling was used as often as time out, and that all of the techniques were acceptable to respondents except spanking and timeout (Passini et al., 2014). Although the acceptance rating for spanking was low, mothers reported spanking their children at least once every ten days based on ecological momentary assessment monitoring (Wang, Deater-Deckard, & Bell, 2013). These results raise the question of whether harsh parenting, and physical discipline is a reflexive response to a child's misbehavior.

An equally significant aspect of parenting concerns whether parents interpret the misbehavior of their children as being intentional or accidental. A study by Sturge-Apple, Suor, and Skibo (2014) examined whether working memory capacity in mothers moderated their harsh discipline behavior responses towards their children. Working memory capacity is purported to help self-regulation by giving an individual time to respond to challenging situations in a rational manner versus an autonomic reactionary

manner (Hofmann, Schmeichel, & Baddeley, 2012). Working memory can be advantageous when perceiving a child's misbehavior as stemming from a planned intention. This kind of thinking is defined as dysfunctional child centered attributions of a parent towards a child (Sturge-Apple et al., 2014). The main variables of the study were the socioeconomic status, working memory capacity, maternal child-oriented attributions, and harsh discipline behavior of the participating mothers. Harsh discipline consisted of physical punishment, verbal coercion, or a combination of the two (Sturge-Apple et al., 2014). The socioeconomic status of participants was measured based on a demographic survey in which participants reported the number of persons living in the household, and their education and annual household incomes.

The measure of maternal working memory capacity was based on an auditory digit span task extracted from the Wechsler Adult Intelligence Scale that was administered to the participants. This scale measures whether parents attribute a purposeful intention to a child for his or her misbehavior, for example, a three-year's old purposeful manipulation or disrespecting of an adult (Sturge-Apple et al., 2014). Harsh discipline behavior of the mothers in the study was measured using a parenting questionnaire, and observational ratings behavior towards their children after completing a cleanup activity. Discipline was determined to be harsh if a parent made comments that were hostile in tone, to obtain a child's cooperation in cleaning up (Sturge-Apple et al., 2014). The researchers found that greater working memory capacity was a factor that influenced the ability of a mother to reason, and was of value when assessing how to respond to a child's misbehavior in a less reactive way (Sturge-Apple et al., 2014). By contrast, mothers with low working memory capacities were not able to effectively assess



environmental cues, and would react in a more automatic way, using discipline techniques that were either physical or entailed verbal abuse (Sturge-Apple et al., 2014).

In another study, Wang et al. (2013) gathered data from self-report questionnaires, as well as from observations for a sample of mother-child pairs ( $n = 160$ ). They examined how parents interpreted their children's behavior in the context of a chaotic family environment. The sample consisted of 76 European Americans, 13 African Americans, 1 Asian American, 6 mixed-race individuals, and 4 others. Two-thirds of the mothers were married or cohabiting (Wang et al., 2013). Data were obtained from self-reporting questionnaires relating to respondents' perceptions regarding: (a) household chaos, (b) maternal attributions, and (c) maternal negativity and positivity, and from observations of mother-child interactions (Wang et al., 2013). Examples of household chaos items included questions relating to the atmosphere in the home such as whether a TV was always on. Maternal attributions were measured after mothers had rated child behavior, and described in vignettes what they were asked to read, as intentional, situational, or accidental (Wang et al., 2013).

Maternal negativity was assessed and measured through mothers' self-reported feelings of frustration, disappointment, or anger directed towards their children. Positivity was assessed through items that measured feelings of happiness and pleasure directed towards their children. Interactions between mothers and their children were observed after mothers were instructed to help their children perform three tasks: putting together a puzzle, drawing and completing an "etch-a-sketch," and building a model from blocks (Wang et al., 2013). The parents and children each had their own control button, and were instructed not to touch other buttons. They were videotaped and allowed to help out

in some other activities. In the last exercise, mothers were told to impart only verbal instructions to their children (Wang et al., 2013). The researchers performed a multiple regression analysis to test the hypothesis that household chaos would moderate the association between attribution bias and parenting behavior. The strongest link was found in high chaos households, and the weakest link was found in calm and ordered households (Wang et al., 2013, p. 235).

Constructs of internal/intentional and external/situational bias were further hypothesized. Wang et al. (2013) defined internal/intention bias as the mother's attribution of intentional misbehavior to her child. External/situational bias was defined as the mother's attribution of her child's misbehavior to the situation at hand (Wang et al., 2013). The researchers hypothesized that negative parenting behavior would be associated with a stronger internal /intentional bias and weaker external/situational bias in more chaotic family environments. They further noted that yelling was associated with negative verbal aggression and had worse outcomes for children than physical aggression (Wang et al., 2013).

### **Ethnicity and Gender Determinants**

Previous research has also documented variances in child discipline practices among different ethnic groups. The parenting styles of African Americans have been repeatedly documented to be harsher than those of European Americans and Latinos (Simons, Simons, & Su, 2012). Co-occurring stressors of adolescent pregnancy, family income, the child's age, mental wellness issues, substance abuse, family culture, and religious beliefs have been documented as factors that can contribute to child maltreatment (Estefan et al., 2013). Common determinants of child maltreatment were

mental illness and substance abuse. Estefan et al. (2013) conducted a mixed-methods study to explore how substance abuse, mental illness, and family violence, identified as family stressors, impacted parenting attitudes and discipline styles. The study included mothers as well as fathers who were referred by a division of a child protection/child welfare service, and who were participants in a 15-week intensive parenting program for parents who had maltreated their children (Estefan et al., 2013). The study's findings revealed that allegations of physical abuse were higher for fathers than for mothers. However, mothers had more substance abuse, violence, and mental illness allegations made against them than fathers (Estefan et al., 2013).

A survey was conducted by Bradley-Adkison, Terpstra, and Domitorio (2014) to determine whether African American parents changed the way they disciplined their children between the first time the children misbehaved, and after the same misbehavior was repeated a second time. They also measured whether the age of the child and the circumstances under which misbehavior occurred influenced the discipline techniques used (Adkison-Bradley et al., 2014). The age groups of the children were 3–5 years, 6–11 years, 12–14 years, and 15–17 years (Bradley-Adkison et al., 2014). In this study, the severity of the behavior was categorized as mild, moderate, or severe. The results of the study revealed a significant difference in the parents' first and second responses according to age group. The researchers found that the discipline methods used by African American mothers increased in severity when the misbehavior was repeated a second time for all incidents of severe behavior (Bradley-Adkison et al., 2014). However, physical discipline in the form of spanking was chosen as the first response for the 12–14-year-old age group. Further, more severe discipline techniques were used for children

in the 3–5-year-old age group in situations involving moderate misbehavior that could harm a child, or in response to incidents such as a child throwing juice on the floor after being told not to do this again (Bradley-Adkison et al., 2014). For the 15–17-year-old age group, physical discipline was utilized less often and methods of verbal coercion, for example yelling or telling the adolescent to get out of the home, were used as alternatives (Bradley-Adkison et al., 2014). This study supported the assertion that sub-abusive child discipline could escalate into more severe forms of child maltreatment.

Demographic variables do not always turn out to be significant determinants of child maltreatment. A study by Taillieua, Afifib, Motac, Keyes, and Sareen (2014) examined secondary data to assess differences in demographic variables of sex, age, and racial characteristics, in relation to the prevalence of harsh physical punishment experienced during childhood. Data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) compiled in 2004 and 2005 ( $n = 34,653$ ) were used. Logistic regression analyses were conducted to examine the variables. Taillieua et al. hypothesized that positive attitudes towards physical punishment and its prevalence were decreasing in the United States. The results of their study revealed that the prevalence of harsh physical punishment has indeed been decreasing over time among younger age groups that were racially diverse (Taillieua et al., 2014). The greatest difference in relation to a decrease in physical punishment was observed among males rather than females. Regarding race, little change in the use of physical punishment was observed for African Americans, compared to European Americans who reported the greatest decrease in the use of physical punishment (Taillieua et al., 2014). However, the study revealed an increase over time in harsh physical punishment among Hispanics in the United States

(Taillieua et al., 2014). Conversely, other studies have shown that Hispanics in the United States use less physical and harsh verbal discipline than African Americans and European Americans (Lee & Altshul, 2015, Bartkowski, & Wilcox, 2000).

Parenting styles have been studied not only in relation to different ethnicities, but also within specific ethnic groups. Lee and Altshul (2015) analyzed survey data to test their hypothesis that foreign-born Hispanic parents spanked their young children, aged three to five years, less often than American-born Hispanic parents (Lee & Altshul, 2015). The authors examined whether religion and the role of the father as the traditional head of the family had an effect on spanking of children by parents. Secondary data from the Fragile Families and Child Wellbeing Study were used for this study, as well as data from a birth cohort study namely, the In-Home Longitudinal Study of Pre-School Aged-Children (Lee & Altshul, 2015). The inclusion criteria for study participants ( $n= 1739$ ), with 650 fathers and 1,089 mothers, were parents who self-reported as Hispanic, provided information on where they were born, and stated that their children had, since birth, been raised by them. The study's independent variables were (a) religious attendance (b) traditional gender norms, and (c) foreign-born versus native-born Hispanic origin (Lee & Altshul, 2015). The dependent variable was spanking. Variables that the authors controlled for included parental use of alcohol, family stress, the level of children's aggressive behavior, and parents' reports of psychological stressors such as depression, and violence inflicted by intimate partners (Lee & Altshul, 2015). The study's findings revealed that while foreign-born Hispanics may not have been financially on par with native-born Hispanics, and may have faced other social and environmental hardships, foreign-born Hispanics spanked their young children less often

(Lee & Altshul, 2015). Stronger endorsement of traditional gender norms was negatively associated with spanking by mothers, and the influence of religion was not found to be significant (Lee & Altshul, 2015). Among mothers and fathers both foreign and native born, heavy alcohol use, violence inflicted by intimate partners, and ages were significant predictors for spanking (Lee & Altshul, 2015).

### **Psychological Effects of Verbal Abuse**

Children often express their feelings through their behavior. Evans, Simons, and Simons (2012) examined secondary data from the first and second waves of the Family and Community Health Study, using available information for the states of Georgia and Iowa. Their study specifically investigated determinants of child development within different community settings to examine the effects of repeated verbal abuse and corporal punishment on the incidence of delinquency behavior (Evans et al., 2012). The first wave of data was collected in 1998 from a sample ( $n = 867$ ) of 400 African American boys, and 467 African American girls. The second wave consisted of data for the year 2000 obtained from a sample ( $n = 779$ ) of 361 African American boys and 418 African American girls (Evans et al., 2012). The researchers also measured interactions of verbal abuse and corporal punishment, to predict both delinquency and whether verbal abuse or corporal punishment was mediated by the level of self-control, a hostile view of the relationship, or anger and frustration on the part of the parent (Evans et al., 2012).

The same research procedures were used for the sample populations in Iowa and Georgia. These samples consisted of pre-teens aged 10–12 years for the first wave, and teens aged 13–14 years for the second wave. The researchers reported that harsh verbal discipline had a greater effect on the increased incidence of delinquency than physical

discipline did for both males and female children (Evans et al., 2012). They also found that verbal abuse was a strong predictor of delinquency. The data further revealed that anger and frustration were mediators of increased delinquency in females. Low self-control was a mediator of increased delinquency of males over the two-year period of this longitudinal study.

Child discipline practices can have a dramatic and long-lasting impact on the emotional development of children, adolescents, and adults. Coates, Dinger, Donovan, and Phares (2013) examined the long-term effects of verbal abuse on a sample of Southeastern college students ( $n = 173$ ), mostly European Americans 68%, who reported experiences of verbal abuse from either of their parents. Some of the students had received psychological therapy, while others had not (Coates et al., 2013). The authors applied a definition of verbal abuse, referenced from a previous study as, someone who insulted you or swore at you, sulked or refused to talk to you, stomped out of the room, said something to spite you, threatened to hit you, and smashed or kicked something in anger (Greenfield & Marks, 2010 cited in Coates et al, 2012, p. 396). Global self-worth and psychological distress were measured against the gender of the child, and whether the mother or father had initiated the verbal abuse. Psychological distress was defined as “a repeated pattern of caregiver behavior was extreme incident(s) that convey to children that they were worthless, flawed, unloved, unwanted, endangered, were only of value in meeting another’s needs” (APSAC, 1995, cited in Coates, et al., 2013, p. 397). The researchers formulated two hypotheses: The first was that both male and female students who were subjected to verbal abuse by their mothers would experience greater psychological distress and feelings of lower global self-worth compared with those who

were subjected to verbal abuse by their fathers (Coates et al., 2013). The second hypothesis was that females who experienced verbal abuse from their fathers would suffer greater psychological distress and lower global self-worth than males who were verbally abused by their fathers (Coates et al., 2013). The researchers found that verbal abuse received from the mother was a significant predictor for psychological distress for females, but not for males (Coates et al., 2013).

However, in terms of global self-worth, verbal abuse from mothers was a significant predictor of low self-esteem and depression in both females and males. Verbal abuse received from fathers was not a significant predictor of greater psychological distress for either adult females or males (Coates et al., 2013). Questioning why their findings did not correspond to those of other studies, namely, that verbal abuse from fathers negatively affected both females and males, the researchers attributed this difference to sample variation (Coates et al., 2013). It is likely that verbal abuse is as devastating for males as it is for females. These results may be used as key components in the development of parenting programs to prevent further trauma suffered by children under the care of relatives.

### **Kin Caregivers' Characteristics**

While many studies have examined differences between kin and traditional foster caregivers, few have focused on the specific characteristics of kin caregivers. The passage of the United States Adoption and Safe Family Act (1997) encouraged states to adopt caregiving by relatives as a primary placement mode for children entering the child welfare system (Lin, 2014). A small number of studies have discussed certain characteristics of kin caregivers (Hong, Algood, Chiu, & Lee, 2011). However, kin



caregiver characteristics may vary in relation to different geographic areas of the United States. One reason for this variation is that states may choose whether to provide services and financial subsidies to relative foster caregivers (H.R. 6893, 2008). The Fostering Connections to Succeed and Increasing Adoptions Act (2008) provides states with the option to continue to provide financial subsidies to kin caregivers who progress from foster care to guardianship (PL 110-351). These provisions may enhance the demographic diversity of kin caregivers.

Studies in the foster care field have frequently reported on demographics. Sakai, Lin, and Flores (2011) conducted a three-year prospective cohort study of kinship caregivers and traditional foster caregivers, to compare services, and well-being outcomes between the two groups. For this study, data were obtained from the National Survey of Child and Adolescent Well-Being survey conducted by the Department of Health and Human Services. The survey measured the health outcomes for children within the child welfare system in the United States. Social workers completed a questionnaire that asked about the abuse of children, and their placement details at the baseline level, as well as after three years (Sakai et al., 2011). The study consisted of 572 kin caregivers, and 736 traditional foster caregivers ( $n = 1,308$ ).

Demographic results showed no significant age-related differences. More female children were found to reside in kin foster care than in traditional foster care (Sakai et al., 2011). The study further found that kin caregivers were older, had less money and education, and were single parent households compared with traditional foster parents. Moreover, the study revealed a lower degree of peer support and training for kin caregivers than for traditional foster parents (Sakai et al., 2011). Similarly, Tucker and

Rodrigues (2014) found that kin caregivers who were single mothers with low incomes and education were at high risk in relation to their use of harsh parenting and engagement in child maltreatment.

However, few studies have looked at differences within kin caregiver samples. Kin caregivers were not a homogeneous group, and there were differences within this population. Zinn (2010) examined secondary survey data from the Illinois Department of Children and Family Services. Specific kin caregiver household characteristics such as the presence of other children in the household, parental age, and partner status were examined. Two categories of kin caregiver relatedness to kin foster children were developed as follows: 1 Grandparents, including great-grandparents, with foster children, and 2. Non-grandparents, including other relatives such as aunts, uncles, siblings, cousins and stepparents, with foster children. From these two categories, four types of kinship families were described: (a) empty-nest grandparent families, (b) parenting grandparents (partnered grandparents with other adults or non-foster children living in the home), (c) collateral kin with some children (non-grandparent relatives with other non-foster children in the home), and (d) parenting collateral kin (partnered non-grandparent relatives with children in home), (Zinn, 2010).

This study found that parenting grandparents were least capable of parenting their grandchildren. This group included kin caregivers who were parents to the foster child's parents. They lived closer in proximity to the birth parents, and were more closely allied with the birth parents. A significant finding of the study was that this group was less likely to provide a safe environment for relative children in their care (Zinn, 2010). The study results also revealed that the empty-nest grandparent structure was the largest group

of kin foster caregivers, usually 60 years or older, and were more likely to suffer from health problems (Zinn, 2010).

Kin caregiver's homes may comprise parents who were heterosexual, homosexual, married, cohabitating, or single. In relation to adopting or becoming foster parents for special needs children, there were no differences between gay, bi-sexual, and transgender populations, and those that were heterosexual (Weber, Hill, Ren, & Beatty, 2011). Differences in kin caregivers' characteristics can be associated with geographical areas, family structure, and family household compositions that were important variables in a study of interventions for this targeted population. Major themes in the literature include reports that kin caregivers were the ideal placement for children who were under the authority of the child welfare agency, because of the decreased stigma of foster care and the closeness to family, among other benefits (Liao & White, 2014).

Reportedly, kin caregiver homes were headed by females, usually older, with limited formal education, and lower income status (Zinn, 2010). The research on kin caregiver-ability to administer effective disciplinary techniques that prevent the re-traumatization of the children in kin foster care homes is limited. An assessment of the Caring for Our Own training program has never been formally documented (Children Alliance of Kansas, 2011). This study provides additional knowledge regarding whether previous covariables are still relevant, and provides data on the kin caregivers who participate in the Caring for Our Own training program.

### **Summary**

The research questions and hypotheses of this study have guided and shaped the literature review presented in this chapter. Parental factors related to parental discipline

that contributes to the prevalence and incidence of child maltreatment were discussed. The rationale for selecting the theory of planned behavior, described in many of the reviewed articles, was provided as an anchor and focus for the study. The interventions aimed at preventing child maltreatment were also discussed. Based on previous studies, certain contextual and environmental predictors impact parental behaviors in ways that may in turn lead to child maltreatment. However, it is not known whether or not universal interventions meet the specific needs of target populations. This study extended the knowledge through its investigation of the Caring for Our Own training program, and addressed whether or not it meets the needs of kin caregivers in administering effective child discipline. In Chapter 3, the methodology used for the study, including the sample population, instrumentation, data collection and analysis, and ethical considerations that informed the study will be discussed.

## Chapter 3: Research Method

### **Introduction**

The purpose of this study was to assess the impact of the Caring for Our Own training program on kin caregivers' use of discipline practices as indicated by scores on the three subscales of the Parenting Scale. In this chapter, the target population, sample size, sampling methods, and procedures used for recruiting respondents are addressed. The discussion includes details of procedures, including the criteria for study participation and data collection, the instrumentation and operationalization of constructs, data analysis, validity issues, and ethical considerations.

### **Research Design and Rationale**

The primary independent variable for this study was the Caring for Our Own training program. The dependent variable was kin caregiver use of discipline practices as indicated by scores on the three levels of the Parenting Scale. The covariables were time and the number of other children living in the home. This study used a quantitative, quasi-experimental, within-factor repeated measures ANOVA with covariates design to answer the following research question: How does Caring for Our Own training impact kin caregivers' use of discipline practices as measured by the three subscales of the Parenting Scale? Due to time and resource constraints, a prospective cohort study was used to collect data for the study.

A quantitative research design is used to test a hypothesis or theory that proposes the existence of a relationship between variables (Creswell, 2009). The quantitative approach was relevant to this study, compared to a qualitative approach, because of the philosophical assumptions and the data collection methods (Creswell, 2009). The

quantitative approach was grounded in a positivist position. The positivism worldview is based on the scientific method of research. The scientific method of research involves the use of a theoretical foundation and numerical methods to gather objective evidence that supports or refutes a theory (Creswell, 2009). A qualitative approach would not have been suited for this study because a qualitative approach entails an inductive style, which focuses on individual meaning, where data are collected in the individual's setting (Creswell, 2009; Ngumezi, 2014). Data for this study was collected quantitatively on an instrument, rather than qualitatively through observing a setting (Barlie, et al., 2015).

Quasi-experimental designs are appropriate when random assignment of subjects to groups is not possible (Creswell, 2009). Lack of random assignment can cause internal and external validity issues in a study. Pretests were recommended to control for lack of randomization, where similar scores on a pretest administered to the same groups indicated that the groups were matched adequately (Salkind, 2010). The Caring for Our Own training program is an intervention that offers kin caregivers information that can be used to help them transition into roles of parenting relative to foster children who have been or will be placed in their care. The Caring for Our Own intervention had not been examined for its impact, if any, on kin caregivers' ability to administer effective disciplinary techniques (Children's Alliance of Kansas, 2011). Therefore, a treatment was implemented and a measure was made on the outcome (Thompson & Kegler, 2006).

The quasi-experimental approach was also appropriate because such studies have been used to advance health promotion and health prevention. For example, Rowe, Sperlich, Cameron, and Seng (2012) used a quasi-experimental design in a study to test the effectiveness of a trauma-specific psychoeducational intervention. The target

population was pregnant women with a history of childhood maltreatment. Rowe et al., (2012) specifically noted that “the quasi-experimental method symmetrically collected data to provide a matched comparison sample to assess effect sizes on standardized assessment of six outcomes of interest” (p. 289).

Another quasi-experimental study was performed by Donofrio, Quetzal, Lahey, and Henrik (2014), who tested the developmental origin of health and disease hypothesis framework that emphasized how early risk factors in children such as low gestational age causally influenced later child and adult psychopathology. The three measures of psychopathology were (a) psychiatric or bipolar illness, (b) autism, and (c) suicide ideation or attempt (p. 154). Donofrio et al. used within-group family-based quasi-experimental studies to rule out the possibility of environmental and genetic confounding factors in within-group sibling comparisons (Donofrio et al., 2014).

The choice of a survey research design was appropriate for this study because this design enabled the collection of data on individuals that could be used in multivariate analysis to explain, compare, or describe human behaviors (Frankfort-Nachmias & Nachmias, 2009; Salkind, 2010). Specifically, the survey research design can be applied in situations that involve an assessment of beliefs, values, and knowledge of a particular population of interest (Frankfort-Nachmias & Nachmias, 2009). Additional benefits of survey instruments are that they are economical and allow data to be collected quickly with close-ended questions (Frankfort-Nachmias & Nachmias, 2009).

The choice of a repeated-measures design for this study was appropriate for several reasons. For instance, the purpose of the study was to determine whether caregiver training impacted the caregivers’ use of discipline practices across time.

Further, there was one group. Verma (2016) noted three advantages of a within-factors, repeated-measures design. First, participants serve as their own control group since the same subjects are tested in all treatments, thereby reducing experimental error. Second, fewer subjects are required for the study, allowing the researcher to have more control in the experiment. Finally, the repeated-measures design is practical for use with performance trends over time (Verma, 2016).

## **Methodology**

### **Population**

The targeted population of interest in this study consisted of potential kin caregivers in the United States. The sample of participants recruited for the study consisted of kin caregivers of foster children who resided in the large northeastern city that served as the study location. Participants were recruited through the Child and Family Services Agency (CFSA) in the study location.

### **Sampling Procedures**

A power analysis using the G\*Power 3.1.9.2 program, (Buchner, Faul, & Erdfelder, 2010) was performed to determine the minimum sample size required to obtain adequate power for assessing the impact of the Caring for Our Own training program on caregivers' ability to administer effective disciplinary techniques. The results of the G\* power analysis for the repeated-measures within-factors design, using a low effect size of 0.25, an alpha value of 0.02, and a power value of 0.95, calculated a sample size of ( $n = 27$ ). A minimum sample size of 27, measured on three levels yields 81 cases (Field, 2013).



(Field, 2013). Determining the minimum a priori sample size assures adequate power to assess the impact of a treatment and is aimed at preventing Type I and Type II errors. A Type I error occurs when a researcher believes that the independent variable exerts an effect on the dependent variable, when in fact this is not the case (Field, 2013).

Conversely, a Type II error occurs when the researcher believes that the independent variable does not exert an effect on the dependent variable, when in fact there is an effect (Field, 2013). The beta level is the statistical power relating to a Type II error (Field, 2013). The probability that a given test conducted for a study will identify an effect if one exists is generally held to be 0.8 (Field, 2013).

### **Sampling Procedures**

A purposive sampling method was used to recruit kin caregivers who signed up for the prelicensing Caring for Our Own training program offered by the CFSA in a large northeastern city. With this sampling method, researchers specify preestablished criteria for targeting and recruiting a sample (Trochim, 2006). For this study, the preestablished criteria for recruiting participants were: (a) status as kin caregivers and (b) residence in the northeastern city that served as the study location. Therefore, the use of purposeful sampling was appropriate for the study.

My sampling frame consisted of kin caregivers who signed up to attend the Caring for Our Own training program during March–May 2016 (Creswell, 2014). The following inclusion criteria were applied:

1. Participants must be 18 years of age or older and be relatives or close family acquaintances of the children requiring foster care.

2. Participants must have agreed to care for these children while undergoing self-assessment and assessment by the study site's CSFA to determine their ability to provide permanent care in the event of nonreunification with the parent.
3. Participants must be able to read, write, and understand English.
4. Participants must have agreed to participate in the Caring for Our Own training program.

### **Recruitment Procedures**

An important part of conducting research studies is the ability of the researcher to recruit and retain research participants (Salkind, 2010). Recruitment practices for this study included having the study site CFSA administration endorse the study (Salkind, 2010). Invitations to participate in the study were assigned to a CFSA staff member to mail. I was on location on the first day of class to explain the letter of consent and to answer any questions (see Appendix C for the recruitment flyer). Research participants were monetarily compensated for their valued time and for their willingness to participate in the study (Groth, 2010). Respondents were compensated with two gift cards that were disbursed as follows: A \$10.00 gift card for pretest and posttest participation, and a \$15.00 gift card for follow-up posttest participation, 30 days after training completion, for an incentive total of \$25.00 (Groth, 2010).

### **Informed Consent**

The following information was provided to each volunteer: (a) identification of the researcher and sponsoring institution, (b) a description of the study's objectives, (c) an explanation of the voluntary nature of the study, (d) identification of procedures, (e) identification of benefits that may accrue from research participation, and (f)

specification of possible risks to the participants (Creswell, 2014). A statement describing the extent of confidentiality of participants and their responses was clearly presented in the consent form. Participants were provided with my name and contact information in case they had additional questions; also provided were the name of my dissertation chair as well as information for the Walden University IRB and the study site CFSA IRB (Sample Informed Consent, Walden University, 2015; see Appendix D for informed consent form).

### **Data Collection**

The self-reporting Parenting Scale (Arnold et al., 1993) was used to collect data at the following three time points: (a) before commencement of the training, (b) immediately after the training, and (c) 30 days after participants completed the training. The repeated measures one-way ANOVA method of data collection allowed for assessment of the immediate impact of the training program, as well as its enduring impact, if any, on the participants' behavior 30 days after completion of the training (Creswell, 2009). Responses to questions were measured on a 7-point Likert scale (Arnold et al., 1993). Participants were provided with the questionnaire and asked to complete it when they attended class on the first day, before commencing their training. Immediately after the 5-week training, participants were again asked to complete the posttest. The telephone interview was used to collect data from the 30-day follow-up questionnaire. Prior research had documented kin caregivers as older and having limited formal education (Taylor et al., 2012). Therefore, it was anticipated that respondents might require extra training to complete web-based surveys because of their age, as well as limited access to and use of computers, resulting in their lack of familiarity with

software applications (Ahern, 2005). Therefore, Internet-based research methods did not seem to be appropriate for the kin caregivers sample. Each questionnaire was assigned a unique identification code used for organization and data analysis (Virginia Tech, n.d.).

### **Follow-Up Procedures**

Study participants were asked to complete a 30-day follow-up survey to complete participant involvement in the research study. The participants were informed that the survey would be conducted 30 days from the date of their completion of the posttest at the end of the training. As further recommended by Rudestam and Newton (2007), clear and explicit explanations were written in the consent form, related to the requirement to complete the final 30-day follow-up posttest via a telephone data collection method conducted by the principal investigator.

### **Debriefing Research Participants**

When participants exited the study, they were offered a summary of the results if they wished to receive it (Rudestam & Newton, 2007). Research participants were instructed to write their name and address on a summary request form. Following these instructions yielded the anonymity of the research participants; however, confidentiality was still preserved (Rudestam & Newton, 2007).

### **Intervention Information**

The Caring for Our Own training intervention is a mandatory 5-week, two-classes-per-week structured classroom-based training program for individuals aged 18 years or older who wish to be licensed to provide kin foster homes. The Model Approach to Partnership Parenting (MAPP) developed the training curriculum. The goals of the program are to provide information to help prospective foster and adoptive families make

decisions regarding their ability, willingness, and readiness to provide safe and supportive homes for relative children coming into their homes for foster care (Children's Alliance of Kansas, 2011). Teaching and instruction were conveyed via PowerPoint presentations and through interactive adult learning activities. A CFSA social worker and licensed kin foster parent served as facilitator and cofacilitator, respectively. The kin caregiver cofacilitator had successfully completed the Caring for Our Own facilitator's training and had a cotrainer certificate (Children's Alliance of Kansas, 2011).

During the course of the training program, participants received information on a number of relevant topics. These topics included child development and transitional reactions of kin caregivers, children, and birth parents (Children's Alliance of Kansas, 2011). The program also included discussions of the definitions of abuse and neglect, as well as other reasons that children come into child welfare protection. Other topics included child development and practices for managing child behavior (Children's Alliance of Kansas, 2011). Transitional reactions were described as natural reactions that kin caregivers, children, and birth parents experience as a result of changes in their living arrangements, lifestyles, and family roles (Children's Alliance of Kansas, 2011). The program also addressed the impacts of substance abuse and mental health on the family as a system. Moreover, the Caring for Our Own training imparted practices for managing and resolving conflict with birth parents (Children's Alliance of Kansas, 2011). The Caring for Our Own training program was structured as 10 meetings held over a period of 5 weeks. There were two meetings per week, each lasting 3 hours. Caregiver descriptions were provided orally and in caregiver workbooks.

The first three meetings focus on the kin caregiver. Meetings four through six focuses on the kin child being cared for, and meetings seven through nine focuses on the birth parents. The tenth meeting was devoted to evaluations, speeches by noted community speakers, and the official graduation ceremony during which kin caregivers who have completed all of the program requirements receive their certificates (Children's Alliance of Kansas, 2011). A brief outline of the theme and component activities of each meeting extracted from Children's Alliance of Kansas (2011) are presented below:

**Meeting 1: Introduction to Caring for Our Own.** This meeting provided an opportunity for the participant kin caregivers and the facilitators to get acquainted with each other. It also enabled them to feel at ease with sharing personal information within a supportive group environment (Children's Alliance of Kansas, 2011). During this meeting, kin caregivers defined the meanings of kin, kinship caregiver, and kinship care. Facilitators and caregivers defined family strengths and needs, and they also described and discussed the strengths, approach, and meaning of self-disclosure. Half the class participants shared their family circumstances related to how the children came into their care; an activity called family sharing (Children's Alliance of Kansas, 2011).

**Meeting 2: Assessing the impact of the children living in my home.** This meeting began with a continuation of family sharing experiences recounted by the remaining class participants (those who did not share in meeting one). Facilitators reminded kin caregivers that the procedures for group meetings include listening, offering advice or suggestions, and sharing (Children's Alliance of Kansas, 2011). The next activity comprised a presentation on the family assessment process by the facilitator. This instructed kin caregivers on how to perform a self-assessment of their individual

strengths and needs, and those of their families. The assessment will help them in planning short and long-term care goals (Children's Alliance of Kansas, 2011). Kin caregiver family assessments were documented in a "personal keepsake journal" that was handed out to each class participant during this meeting (Children's Alliance of Kansas, 2011).

**Meeting 3: Looking at my role in achieving permanency.** During this meeting kin caregivers first identified sources of stress outside of their immediate family structures. During the subsequent activity, the facilitators discussed how kin caregivers support permanency, and they also defined and discussed reunification, adoption, and legal permanency (Children's Alliance of Kansas, 2011). Kin caregivers identified ways in which they can support the principle of permanency, namely that "all children deserve safe, nurturing, permanent families who can provide an unconditional lasting commitment to them." Facilitators describe and discuss permanency-planning options for example adoption, guardianship, custody, and foster care (Children's Alliance of Kansas, 2011).

The concepts of reasonable efforts, concurrent planning for permanency, and adoption subsidies were explained and discussed. The Adoption and Safe Family Act of 1997, and the family court process were also introduced and discussed (Children's Alliance of Kansas, 2011). Facilitators explained the roles and responsibilities of the caseworker in the context of case planning, concurrent planning for permanency, and accessing financial assistance. For the third activity, kin caregivers defined and drew elements of their eco-maps (Children's Alliance of Kansas, 2011). The last activity conducted during this meeting focused on identifying transition reactions for kin

caregivers. The facilitators encouraged kin caregivers to discuss their reactions to the changes that have taken place in their lives subsequent to the placement of the children in their homes (Children's Alliance of Kansas, 2011).

**Meeting 4: Assessing the strengths and needs of children in my care.** This meeting began with kin caregivers listing the reasons why the children come into their care (Children's Alliance of Kansas, 2011). The next activity focused on the impact of abuse and neglect on children, enabling the kin caregivers to better understand how children were affected by their experiences of abuse and neglect. Kin caregivers also explored how children's experiences of maltreatment affect their emotions and behaviors (Children's Alliance of Kansas, 2011). During the third activity, which focused on ensuring children's safety, facilitators described and discussed the agency's requirements on safety. Kin caregivers were asked to identify their roles and responsibilities in ensuring children's safety (Children's Alliance of Kansas, 2011). This discussion entailed a review of the CFSA Agency Policy on Discipline, and Corporal (Physical) Punishment that states "foster parents may not use corporal punishment as a disciplinary method" (CFSA, n.d.). The policy also states that "foster parents may not use emotional neglect or verbal abuse as a disciplinary method" (CFSA, n.d.)

During the fourth activity, kin caregivers identified the weaknesses, needs, and strengths of a particular child presented in a scenario, and discussed the benefits of the strengths approach. Stages of child development were identified and discussed for age groups ranging from birth to young adulthood. The fifth activity focused on identifying practices for managing the behavior of a child. Each kin caregiver described a type of behavior displayed by the child in his or her care, that was of the most concern



(Children's Alliance of Kansas, 2011). The caregiver identified the feelings underlying the child's behavior, and the strengths of the child. Kin caregivers also identified practices for responding to the child's behavior.

This was accomplished by reviewing and discussing 15 recommended approaches for helping kin caregivers and children manage their behaviors that do not involve physical or harsh verbal techniques; taking away privileges, and putting a child in time out (Children's Alliance of Kansas, 2011). Many of the kin caregivers often struggled with the presentation and discussion of alternative discipline practices. Within these discussions training facilitators were instructed to remind kin caregivers of the fact that they may not use physical, verbal, or psychological punishment techniques on the foster children in their care. This was accomplished by providing the kin caregivers with information that reviews what constitutes safety for the child (CFSA, n.d.). For parents that have biological children in the home, a decision was made by the kin caregiver to use the same discipline practices (no hitting, no yelling, cursing, or berating verbiage) with their biological children as they do with their foster child.

**Meeting 5: Building on the strengths and meeting the needs of the children in my care.** Meeting 5 continued the discussion on discipline practices and ways in which the kin caregivers could help the foster child manage their behaviors. The first activity of this meeting focused on identifying trauma and children's transitional reactions.

Facilitators and caregivers began by defining trauma. They described how trauma affects children's behaviors and life experiences. The class discussed how children's behaviors that result from their life experiences may become most challenging for kin caregivers to manage (Children's Alliance of Kansas, 2011). The kin caregivers also shared the

trauma-related experiences of the children under their care, and identified the children's transitional reactions to those trauma experiences. The next activity focused on applying behavior management practices. Facilitators and class participants identified and reviewed the 15 practices for managing children's behaviors, and applied them to the child's transitional reactions (Children's Alliance of Kansas, 2011). Kin caregivers identified ways to help the children better understand their current living situation. Kin caregivers were assisted in identifying ways of building on the children's strengths to manage their behaviors and/or their transitional reactions. Kin caregivers were encouraged to think about, and identify their own family member's mental health needs, as appropriate (Children's Alliance of Kansas, 2011). Community mental health resources and services were shared with the kin caregivers.

**Meeting 6: Preparing children and youth for the future.** The first activity of this meeting focused thematically on kin caregivers as advocates. A discussion was conducted around the importance of education, and kin caregiver responsibilities to work in collaboration with the school system (Children's Alliance of Kansas, 2011). Caseworker responsibilities in relation to support for the foster child's education were also discussed. The next activity provided kin caregivers with information on emancipation planning for adolescents approaching the age of 21 (Children's Alliance of Kansas, 2011). Next, kin caregivers constructed eco-maps of the birth parents. An eco-map is a diagram of the entities in an individual's life that give energy or those that take energy from the individual (Children's Alliance of Kansas, 2011). The exercise was aimed at helping caregivers identify the stress and systems of support for the birth

parents, thereby creating a deeper understanding, and possibly empathetic view of the birth parents' challenges (Children's Alliance of Kansas, 2011).

**Meeting 7: Understanding the issues of birth parents.** The first activity of this meeting was aimed at helping kin caregivers identify the transitional reactions of birth parents, and to understand the interplay between the birth parents' issues and their transitional reactions (Children's Alliance of Kansas, 2011). The second activity of this meeting focused on chemical dependence that was introduced and discussed in terms of a disease concept. The roles assumed by family members of a chemically dependent parent were played out in a pantomime "sculpting play," by six kin caregiver volunteers (Children's Alliance of Kansas, 2011). Kin caregivers also defined and discussed the components of recovery and relapse as a part of the chemical dependence disease process (Children's Alliance of Kansas, 2011). The last activity in meeting seven focused the kin caregiver's attention on developing management practices for interacting with birth parents. This segment helped the kin caregivers identify transitional reactions and chemical dependence issues experienced by the birth parents of the children in their care. Kin caregivers identified and discussed management practices to deal with birth parents' transitional reactions, and birth parents chemical dependence (Children's Alliance of Kansas, 2011).

**Meeting 8: Working with birth parents to achieve permanency for their children.** The agenda of this meeting was to examine how kin caregivers can redefine their relationships with birth parents, to ensure children's physical safety and emotional well-being, and to support the birth parents' efforts to achieve permanency for their children (Children's Alliance of Kansas, 2011). During an activity that focused on the

family as a system, definitions of the family, the characteristics of a family structure, and the parenting roles that parents assume with their children were discussed. Facilitators described the potential conflict that can arise when birth parents and kin caregivers assume the same parenting roles for the same children (Children's Alliance of Kansas, 2011). The subsequent activity on resolving conflict centered on defining and discussing conflict and conflict resolution. The activity also introduced kin caregivers to a technique they could use for resolving conflicts that were associated with shared parenting roles (Children's Alliance of Kansas, 2011). This conflict resolution exercise was demonstrated first by facilitators in a role model exercise that kin caregivers also demonstrated (Children's Alliance of Kansas, 2011). The final activity of this meeting focused on the importance of visits and contacts between the birth parents and children. Discussions centered around how kin caregivers can prepare the children for meetings with their birth parents. Kin caregivers were encouraged to express their feelings towards having the birth parents visit, and maintaining contact with their children (Children's Alliance of Kansas, 2011).

**Meeting 9: Final instructional meeting of the group.** During the first activity, kin caregivers learned how to develop a family plan from entries they made in their journals during the previous meetings (Children's Alliance of Kansas, 2011). A family plan is a documented assessment of the kin caregiver's strengths, needs, or family concerns. The information kin caregivers documented in their family plan serves as a reference for future conversations with their caseworkers (Children's Alliance of Kansas, 2011). Entries were intended to help kin caregivers prepared for conversations they

would have with their caseworkers regarding their ability to provide a permanent home for the foster child, as long as needed (Children's Alliance of Kansas, 2011).

**Meeting 10: Kin caregiver graduation ceremony.** This final meeting included speeches by community agency guests, presentation of certificates of program completion, and celebratory refreshments. A formal graduation ceremony was performed whereby, kin caregivers present and receive their certifications. For example, kin caregivers said something they learned from a classmate that helped them in some manner in the class. This process was continued until each class member had received his or her certificates. This activity was intended to provide positive support and affirmation of the members of the kin caregiver class.

### **Instrumentation and Operationalization of Constructs**

#### **The Parenting Scale: An Overview**

The primary data collection tool in this study was the Parenting Scale developed by Arnold et al. (1993). This instrument is a 30-item, self-reporting survey scale designed to measure parental discipline practices used on young children (Arnold et al., 1993). The Parenting Scale was appropriate for this study because of the relationship between the dependent variable, the research question, and the items of the survey (Creswell, 2009). Additionally, the survey measured parental discipline styles towards various types of child misbehavior. The Parenting Scale was easy to use, took approximately 30 minutes to complete, and was economical (Creswell, 2009). The two main theories used in the item construction were Patterson's coercive theory (Patterson et al. 1992), and Baumrind's (1968) theory of parenting styles (Salari, Terreros, & Sarkadi, 2012). The scale is divided into the following three subscales: laxness, over reactivity, and verbosity

(Arnold et al., 1993). There were 11 items on the laxness subscale, 10 items on the overreactivity subscale, and 7 items on the verbosity subscale. The Parenting Scale data was analyzed using a mixture of descriptive and inferential statistics. Permission was obtained from the authors to utilize this scale in the study, (See Appendix D for a copy of the permission email).

### **Validity and Reliability of the Parenting Scale**

Validity refers to the degree to which a survey instrument measures what it is intended to measure (Field, 2013). Reliability is the “ability of a measure to produce consistent results when the same entities were measured over different conditions” (Field, 2013, p. 882). There are three traditional forms of validity. The first is content validity, which provides evidence that the instrument covers the attributes of the construct to be measured (Frankfort-Nachmias & Nachmias, 2008). The second is predictive or concurrent validity, which addresses whether scores predict a criterion, and the degree to which constructs measured by an instrument correlate with results from other instruments that measure the same or similar constructs (Field, 2013). The third form of validity is construct validity, which is related to whether items measure hypothetical constructs were concepts (Field, 2013). Establishing the validity of the scores obtained in a survey helps to ascertain whether the use of a particular instrument may be appropriate in survey research (Creswell, 2014). To validate a particular instrument, a researcher must look for information that relates to one of the following: content validity, construct validity, or predictive validity (Frankfort-Nachmias & Nachmias, 2008).

In the process of developing the Parenting Scale, Arnold et al. (1993) conducted a review of the literature to find studies that identified parental discipline “mistakes” that

induced externalizing behaviors in young children. The authors used a complete sample of mothers ( $n = 168$ ) to estimate the internal consistency of the Parenting Scale. Mothers of clinical children reported more parenting than did mothers of non-clinical children (Arnold et al., 1993). The Parenting Scale was used to obtain scores for maternal ratings of children's behavior and marital discord. The scores correlated significantly with observational measures of ineffective discipline and children's misbehavior (Arnold et al., 1993). Scores obtained for alpha coefficients for the factors and total scores were: 0.83 for laxness, 0.82 for over reactivity, 0.63 for verbosity, and a total score of 0.84 (Arnold et al., 1993, p. 139). The test-retest correlations over a two-week interval with a subgroup of mothers ( $n = 22$ ) were, ( $r = 0.83$ ) for laxness, ( $r = 0.82$ ) for over reactivity, and ( $r = 0.79$ ), for verbosity, with a total score of 0.84 (Arnold et al., 1993).

The Parenting Scale is an intact survey instrument that has been used in the past to measure parental discipline practices (Arnold et al., 1993). For example, Whittingham, Sofronoff, Sheffield, and Sanders (2009) applied the Parenting Scale in their study of 59 families, each with a child who had a diagnosis of Autism Spectrum Disorders (ASD). They found the Parenting Scale to be an appropriate instrument for measuring parenting styles. Specifically, they reported that the Parenting Scale had good test-retest reliability and internal consistency for the total score of (0.81) and for the following subscales in their study; laxness (0.78), over reactivity (0.78), and verbosity (0.65). The authors concluded that the Parenting Scale was appropriate for measuring parenting styles applied to children with an ASD developmental disability (Whittingham et al., 2009).

In additional research, Reitman et al. (2001) conducted a study to examine the psychometric characteristics of the Parenting Scale with a sample of African American

mothers ( $n = 184$ ), with children enrolled in the Head Start program. One goal of the study was to determine if the reliability, and factor structure of the Parenting Scale could be replicated in a lower socioeconomic sample (Reitman et al., 2001). In their study, nearly two thirds of the mothers indicated that they were single and had never been married, and only 56% had earned a high school diploma or equivalent certificate (Reitman et al., 2001). Cronbach's alpha for the original full scale, and the laxness and overreactivity subscales were reported as adequate: full scale (.71), laxness (.77), and overreactivity (.72). The authors reported that the estimates for the revised scales were also acceptable, despite their brevity: laxness (.70), overreactivity (.74), and full scale (.71). Strong correlations between the original and modified measures were reported as laxness (.91), overreactivity (.89), and full scale (.87). One-month test-retest correlations for a small sample of parents ( $n = 18$ ) were acceptable for laxness (.73), overreactivity (.71), and full scale (.75). There were two major types of reliability information computed on the questionnaires: test-retest and internal consistency (Frankfort-Nachmias & Nachmias, 2008). Kin caregivers were expected to self-report a decrease in their use of ineffective discipline practices in the follow-up post-test conducted 30 days after program completion.

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Instructions: At one time or another, all children misbehave or do things that could be harmful, that are "wrong," or that parents don't like. Examples include:

hitting someone	whining	not picking up toys
forgetting homework	throwing food	refusing to go to bed
having a tantrum	lying	wanting a cookie before dinner
running into the street	arguing back	coming home late

Parents have many different ways or styles of dealing with these types of problems. Below are items that describe some styles of parenting.



For each item, fill in the circle that best describes your style of parenting during the past two months with the child indicated above.

1. When my child misbehaves...

I do something right away.	1	2	3	4	5	6	7	I do something later.
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*Figure 2.* Parenting scale sample item. From “The Parenting Scale: A Measure of Dysfunctional Parenting in Discipline Situations,” by D. S. Arnold, S. G. O’Leary, L. S. Wolff, and M. M. Acker, 1993, *Psychological Assessment*, 5, p. 140. Copyright 1993 by the American Psychological Association, Inc. Reprinted with permission.

### **Materials, Programs Applied as Treatment**

The Caring for Our Own training curriculum was developed by the Children’s Alliance of Kansas, and was published in 2011. The training curriculum has been given to prospective kin caregivers nationally (Children’s Alliance of Kansas, 2014). The study site Child and Family Services Agency (CFSA) contracted with the Children’s Alliance of Kansas to administer the Caring for Our Own training program to their kin caregivers, prior to licensing their homes as kin foster homes (CFSA, 2013).

### **Operationalization of Variables**

A one-way repeated measure within factors ANOVA measured the independent variable, which is the Caring for Our Own training. The dependent variables were the use of discipline practices as measured by the change in scores in the three subscales of the Parenting Scale. The dependent variable was operationalized, and indicated by the scores on the Parenting Scales for laxness, overreactivity, and verbosity (Arnold et al., 1991). The co-variables of the study were time, and the number of children living in the foster home.

### **Scoring Instructions for the Parenting Scale**

The Parenting Scale (PS) is scored on a 7-point Likert-type scale, where 1 indicates effective discipline practice, and 7 indicates ineffective discipline practice. Some of the items were reversed coded (Lorber, Xu, Smith-Slep, Bulling, & O’Leary, 2014). Below is a sample of the three subscales of the PS. Each item receives a 1-7 score, where 7 is the "ineffective" end of the item. Thus, the following items were coded in reverse, where the number 7 is on the left side (the others item numbers were on the right): 2, 3, 6, 9, 10, 13, 14, 17, 19, 20, 23, 26, 27, and 30 (Arnold et al., 1993).

- To compute the total score, average the responses on all items.
- To compute a factor score, average the responses on the items on that factor.
- Laxness:                               7, 8, 12, 15, 16, 19, 20, 21, 24, 26, 30 (11 items).
- Overreactivity:                       3, 6, 9, 10, 14, 17, 18, 22, 25, 28 (10 items).
- Verbosity:                             2, 4, 7, 9, 11, 23, 29 (7 items).
- Items not on a factor:               1, 5, 13, 27 (4 items).

### **Data Analysis**

The Statistical Package for Social Science (SPSS) was used to perform data analysis. Data cleaning procedures prepare the data set for analysis (Field, 2013) as missing values and reverse coding can create errors in data analysis. Running frequencies of descriptive statistics is a procedure that can be used to detect missing values. Content analysis in SPSS is a procedure that can be used to screen reverse coding errors in SPSS (Field, 2013). The data analysis was accomplished using a mixture of descriptive and inferential statistics.

## Research Questions and Hypotheses

RQ1: How does the *Caring for Our Own* training impact kin caregivers' use of discipline practices as measured by the three subscales of the Parenting Scale?

H<sub>10</sub> = The *Caring for Our Own* training will have no statistically significant impact on the caregivers use of laxness as a discipline practice as indicated by a change in scores on the Laxness subscale of the Parenting Scale after controlling for time, the pretest scores, and the number of children in the home.

H<sub>1A</sub> = The *Caring for Our Own* training will have a statistically significant impact on the caregivers use of laxness as a discipline practice as indicated by a change in scores on the Laxness subscale of the Parenting Scale after controlling for time, the pretest scores, and the number of children in the home.

H<sub>20</sub> = The *Caring for Our Own* training will have no statistically significant impact on the caregivers use of overreactivity as a discipline practice as indicated by a change in scores on the Overreactivity subscale of the Parenting Scale after controlling for time, the pretest scores, and the number of children in the home.

H<sub>2A</sub> = The *Caring for Our Own* training will have a statistically significant impact on the caregivers use of overreactivity as a discipline practice as indicated by a change in scores on the OverReactivity subscale of

the Parenting Scale after controlling for time, the pretest scores, and the number of children in the home.

H<sub>30</sub> = The *Caring for Our Own* training will have no statistically significant impact on the caregivers use of verbosity as a discipline practice as indicated by a change scores on the Verbosity subscale of the Parenting Scale after controlling for time, the pretest scores, and the number of children in the home.

H<sub>3A</sub> = The *Caring for Our Own* training will have a statistically significant impact on the caregivers use of verbosity as a discipline practice as indicated by a change in scores on the Verbosity subscale of the Parenting Scale after controlling for time, the pretest scores, and the number of children in the home.

The repeated measures one-way ANOVA within factors statistical test was used to test the null hypothesis for the research question (Field, 2013). A repeated measures design entails participation of the same individuals in all conditions of an intervention or provision of data at multiple points in time (Field, 2013). This method can be a way to test theoretical models, and to develop the most parsimonious answer to a research question (Cohen et al., 2003). The target sample size was 28. The independent variable was the impact of the Caring for Our Own training. The dependent variables for this study were the following three subscale scores from the Parenting Scale: Laxness subscale, Verbosity subscale, and the Overreactivity subscale (Arnold et al., 1993). The covariates for the study were time and number of other children living in the home. Time is often used in repeated measures studies to test time by treatment effects (Guo, Logan,

Gluec, & Muller 2013). The purpose of this study was to determine whether the kin caregiver training impacts the caregivers' use of discipline practices over time. Therefore, the repeated measures one-way ANOVA procedure was appropriate to assess the change in discipline practices over a period of time. The inclusion of the number of other children in the home as a covariate is also supported by existing research. A study by Zinn (2010) revealed that the number of other children in the home was related to the quality of kinship caregiving (Zinn, 2010). In addition, the number of other children in the home may vary because siblings who have been removed from their primary homes may not be placed together in the same kin foster home.

Past research indicates that discipline practices are influenced by a number of other variables such as the age of caregivers (Estefan, Coulter, Vande-Weerd, Armstrong, & Gorski, 2013; Taillieu, Afifi, Mota, Keyes, & Sareen, 2014), the gender of caregivers (Sturge-Apple et al., 2014; Wang et al., 2013), and the ethnicity of caregivers (Lansford et al., 2013). However, findings regarding the significance of those variables have been contradictory. Moreover, the focus of this study is on the within factors results in changes in participant scores (Field, 2013) on the three subscales of the Parenting Scale, over time. Consequently, age, gender, and ethnicity of caregivers were not used as covariates in this study. However, demographic frequencies of the kin caregivers will be presented in Chapter 4.

### **Threats to Internal Validity**

According to Salkind (2010), "validity refers to the relation between the conclusion of an inference and it's supporting evidence" (p. 1171). Creswell (2014) describes internal threats to validity as "procedures, treatments, or experiences of the

participants that threatens the researchers' ability to draw correct inferences from the data about the population in the study" (pg.174). Some internal threats to validity that threatened the validity of this study were selection bias, instrumentation, statistical regression, and attrition (Creswell, 2014). According to Creswell (2009), selection bias occurs when participants are selected who have certain characteristics that predispose them to have a certain outcome. For example, kin caregivers were volunteers, and may be more amenable to training. (Creswell, 2014). Also, the participants in this study were kin caregivers, and have the characteristic of caring for a relative child. Selecting participants of a different gender may minimize the impact of this threat (Creswell, 2014). Threats to internal validity from instrumentation stem from changing the instrument between a pretest and a posttest administration (Creswell, 2009). To minimize the impact of this threat, the same instrument was used for the pretest and posttest measures.

Threats to internal validity from statistical regression refer to selecting participants with extreme scores for the study (Creswell, 2009). To minimize the impact of this threat, participants who do not have extreme scores were selected for the research study. Threats to internal validity from attrition occur when participants drop out of the study before it is completed. To minimize this threat, a large sample was recruited. Another practice is to compare participants who drop out with those who continue, in terms of the outcome (Creswell, 2014, p.163). Results of any threats to internal validity revealed in this study were reported in Chapter 4, the results section of this study.

### **Threats to External Validity**

External validity pertains to the ability to generalize findings across populations, time frames, and settings (Salkind, 2010). Threats to external validity that pertain to this

study include the following: (a) validity, (b) reactivity to testing, (c) participant selection and treatment interactions, and experimental variables, (d) limitations of generalizability, and (e) variable specificity. Approaches to minimize the threats of external validity specific to this study are discussed next.

Statistical conclusion validity is the degree to which conclusions regarding variable relationships obtained from data are reasonable (Trochim, 2006). Threats to conclusion validity occur when the intervention was not administered with fidelity. The threats can cause a Type I or Type II error in the interpretation of the results (Trochim, 2008). Improvements to threats of statistical conclusion validity can occur by implementing a training curriculum that is standardized (Salkind, 2010). Protocols for administering the training were standardized, and followed by all trainers of the Caring for Our Own training (Children Alliance of Kansas, 2011). Verbal abuse such as yelling, cursing, and all physical discipline is considered abuse and is prohibited by the CFSA (Agency Policy on Discipline & Corporal Punishment, 2013). Program trainers emphasize the policy when presenting management practices that describe physical and harsh verbal practices as abuse (Appendix C).

Reactivity to testing could occur if the participants' responses to the experimental stimulus outcomes of the second test were affected by their prior participation in the pretest, thereby modifying what was being measured (Campbell & Stanley, 1963, p. 9). Responses to reactivity include participant selection, and treatment interactions. Threats occur when participants are selected in a way that causes bias from their unique characteristics (Salkind, 2010). The volunteers recruited for this study had the unique characteristic of being a relative of the children (CFSA). To be able to generalize the

research findings across populations of interest, it was necessary to recruit participants in an unbiased manner. This was addressed by recruiting participants from a variety of locations such as those found in the study site geographic area, and making participation as convenient as possible (Salkind, 2010).

Experimental variables can interact and influence the responses of participants with shared characteristics (Creswell, 2009). Each of the participants was a pre-licensed kin caregiver. Consequently, the results were not generalizable to individuals who do not have the same characteristics. To address this issue, the results of this study were restricted to groups other than kin caregivers (Creswell, 2009). Variable specificity refers to the number of sources of variance for a measured variable (Western Oregon, n.d.). Ineffective operationalization of variables has been identified as a factor that can hinder the identification of the required settings and procedures for their generalization. This issue was addressed by ensuring that an appropriate instrument for measuring the variables was applied (Western Oregon, n.d.).

### **Ethical Considerations**

The basic ethical principles for research on human subjects are respect for persons, beneficence, and justice (The Belmont Report, 1979). In the present study, all information that could be used to identify respondents was concealed, thereby avoiding issues relating to breaches of privacy or confidentiality (Creswell, 2009). The IRBs of Walden University, and the study site agency reviewed the research proposal, and application, respectively. IRB approval number for this study is 03-31-16-0320424. An informed decision was made that the research was ethical, that informed consent was



sufficient for the study, and that appropriate safeguards to protect the privacy and confidentiality of participants had been put into place (Creswell, 2009). Ethical procedures were followed during and after data collection. The protocol included obtaining an agreement to gain access to the participants of the Caring for Our Own training program at the study site CFSA.

Obtaining the agreement was managed by successfully completing the IRB Review Application at the study site. That process included writing a letter that identified the extent of time, the potential impact, and the anticipated outcomes of the planned research (Creswell, 2009). When approved by study site, this application was submitted with the Walden University IRB application to the Walden IRB. The research in this study falls within the CFSA category of “minimal risk” research (As stated in the IRB Policy of the CFSA, 2010) of human participants, which is defined as follows:

Minimal risk refers to research that involves an intervention with the human subject when the probability and magnitude of harm or discomfort that the researchers anticipate will be experienced by the human subjects are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests. (Study Site Northeastern City CFSA, IRB Policy, 2010, p. 8)

Informed consent included a statement that participation was voluntary, refusal to participate would involve no penalty or loss of benefits to which the participant is otherwise entitled, and that the respondent could discontinue participation at any time (Creswell, 2014). In addition, an explanation of the purpose of the study, and the benefits of participating in the study were explained to the respondents. Respect for the

respondents' cultures and norms was maintained, and they were informed that they have the right to ask questions, obtain a summary of the results, terminate their involvement at any point in the study, and have their confidentiality maintained (Creswell, 2014).

The use of study codes is an effective method for protecting the confidentiality of research participants (Virginia Tech, n.d.). Therefore, study codes were used in this study to link the data with the participant. A study code was assigned to each participant before data collection. The participants were instructed to indicate their unique study code on their questionnaire (Virginia Tech, n.d.). Participants were instructed to use the same unique study code for all survey instruments they completed so as to match survey results to individual participants (Virginia Tech, n.d.). Data was stored in a password protected external drive, and will be deleted after 5 years. Only the researcher has access to the password. The data was analyzed and reported in aggregate form.

### **Summary**

In this chapter, a discussion was presented of the rationale for the study design and the one-way repeated measures ANOVA methodology. A rationale for the selection of the Parenting Scale was provided (Arnold et al., 1993) as the method of inquiry employed for the study. Chapter 4 describes the results of the study.

## Chapter 4: Results

### Introduction

The purpose of this quantitative study was to assess the impact of Caring for Our Own training on kin caregivers' use of a discipline practices as measured by the three subscales of the Parenting Scale. The research question was the following:

RQ1: How does Caring for Our Own training impact kin caregivers' use of discipline practices as measured by the three subscales of the Parenting Scale?

The three hypotheses were as follows:

H<sub>10</sub> = Caring for Our Own training will have no statistically significant impact on caregivers' use of laxness as a discipline practice as indicated by a change in scores on the Laxness subscale of the Parenting Scale after controlling for time, pretest scores, and number of children in the home.

H<sub>1A</sub> = Caring for Our Own training will have a statistically significant impact on caregivers' use of laxness as a discipline practice as indicated by a change in scores on the Laxness subscale of the Parenting Scale after controlling for time, pretest scores, and number of children in the home.

H<sub>20</sub> = Caring for Our Own training will have no statistically significant impact on caregivers' use of overreactivity as a discipline practice as indicated by a change in scores on the Overreactivity subscale of the Parenting Scale after controlling for time, pretest scores, and number of children in the home.

H<sub>2A</sub> = Caring for Our Own training will have a statistically significant impact on caregivers' use of overreactivity as a discipline practice as indicated by a change in scores on the Overreactivity subscale of the Parenting Scale after controlling for time, pretest scores, and number of children in the home.

H<sub>30</sub> = Caring for Our Own training will have no statistically significant impact on caregivers' use of verbosity as a discipline practice as indicated by a change in scores on the Verbosity subscale of the Parenting Scale after controlling for time, pretest scores, and number of children in the home.

H<sub>3A</sub> = Caring for Our Own training will have a statistically significant impact on caregivers' use of verbosity as a discipline practice as indicated by a change in scores on the Verbosity subscale of the Parenting Scale after controlling for time, pretest scores, and number of children in the home.

In this chapter, the following are discussed: the data collection time frames and the data collection discrepancies; the data analyses, including the descriptive statistics of the study participants, the Parenting Scale scores, and additional statistical tests of reliability; an evaluation of the statistical assumptions; the study findings, organized by hypotheses; and a summary of the study conclusions.

## **Data Collection**

### **Time Frame of Data Collection and Discrepancies**

The data for the dissertation study were collected from March 5, 2016 through November 30, 2016. The CFSA set a mandatory completion date for data collection of November 30, 2016. There were 81 participants total in the Caring for Our Own training

program during the nine-month training period, and 27 (33%) of the total number participated in the present study. A small deviation from the original data collection plan outlined in the proposal occurred when the study researcher was not permitted to place invitations to participate in the study in common areas of the northeastern city CFSA. As an alternative plan, the CFSA staff person assigned to send out the scheduled training notices to kin caregivers was given the additional assignment of mailing invitations to participate in the study to class participants separately. I provided the stamps and envelopes for mailing the invitations. In July 2016, the study agency staff person assigned to mail the invitations to participate in the study passed away. The staff person was not replaced, and consequently no invitations were sent out in advance of the training classes. However, after July 2016, I was provided the opportunity to announce the study and to invite volunteers for the study on the first day of training, before the class began. All 10 training classes were conducted as scheduled.

## **Results**

### **Descriptive Statistics**

Table 1 presents a summary of the demographic data for the study participants.

Table 1

*Demographic Frequency Table*

Variable	Frequency	Valid percent	Cumulative percent
<b>Age of participants</b>			
Age 21 to 46	13	48.1	48.1
Age 47 to 72	14	51.9	100.0
Total	27	100.0	
<b>Gender of participants</b>			
Male	4	14.8	14.8
Female	23	85.2	100.0
Total	27	100.0	
<b>Educational level</b>			
GED equivalency	3	11.1	11.1
High school graduate	8	29.6	40.7
Some college	10	37.0	77.8
College graduate	6	22.2	100.0
Total	27	100.0	
<b>Number of children in home</b>			
0	3	11.1	11.1
1	9	33.3	44.4
2	10	37.0	81.5
3	2	7.4	88.9
4	2	7.4	96.3
5	1	3.7	100.0
Total	27	100.0	

The total sample of volunteers was ( $n = 27$ ). Males composed 14.8% of the participants, while 85.2% of the participants were female. Over 48% of the participants were between the ages of 21 and 46 years, while the majority of participants 52% were between 47 and 72 years of age. Results regarding education showed that 37% of participants had some college education and 22% were college graduates. Cumulatively, results showed that all participants had at least a GED. The majority of participants 37% had two children in the home, 33% of participants had one child in the home, and 11% had no children living in the home. The other 7.4% of participants had three or four children in the home.

### **Reliability Analysis of Parenting Scale**

A prime requirement for survey research is presenting evidence regarding the accuracy or reliability of the data obtained with a given instrument. Reliability is a function of scores obtained by an instrument, and therefore estimates can change from sample to sample. Reliability is a measure of whether the scale items were consistently measuring the same construct across different times. Cronbach's alpha is used to examine reliability (Field, 2013). A statistical value of 0.70 to 0.80 is considered an acceptable value for reliability. The closer the value of Cronbach's alpha is to 1, the more reliable the obtained data are (Field, 2013).

A reliability test was conducted on the three subscales of the Parenting Scale: Laxness, Overreactivity, and Verbosity (see Table 2 for a summary of the results). The initial estimate for the Laxness subscale was low. The obtained Cronbach's alpha was 0.57 for the 10 items assigned to the scale. An item analysis showed the following three poor-performing items: (a) Q21 had a negative item-total correlation ( $r = -.18$ ) with other

items in the scale, and (b) Q7 had a low item-total correlation ( $r = .02$ ) with other items on the scale. Therefore, the low-performing items on this subscale were excluded to raise the value of the alpha. A subsequent reliability analysis showed that Cronbach's alpha increased to .69 for the remaining items. The poor-performing items (Q21 and Q7) were excluded from subsequent statistical analyses.

The initial reliability estimate for the Overreactivity scale was also low. The obtained Cronbach's alpha was .37 for all items assigned to the scale. Data from the item analysis showed that Q18 had a negative item-total correlation ( $r = -.07$ ) with other items in the scale. Q18 was excluded from the scale reliability analysis, which increased Cronbach's alpha to .73 for the remaining nine items. Item Q18 was subsequently excluded from data analysis.

Additionally, the initial reliability estimate for the Verbosity Scale was low. The obtained Cronbach's alpha was .17 for all seven items. Data from the item analysis showed the following three poor-performing items: (a) Q7 and Q23 had negative item-total correlations of ( $r = -.14$ ) and ( $r = -.1$ ), respectively, with other items in the scale, and (b) Q29 had a low item-total correlation ( $r = .17$ ) with other items. Further review of the item-total statistics showed that deleting the three items would improve the reliability of the scale. Excluding Q7, Q23, and Q29 increased the reliability of the Verbosity scale to 0.5. The items were excluded from subsequent statistical analysis.



Table 2

*Reliability Analysis Summary Results*

Scale	Intraclass correlation	95% Confidence interval		<i>F</i> test with true value .7			
		Lower bound	Upper bound	Value	<i>df</i> 1	<i>df</i> 2	Sig
Laxness	.69	.48	.84	.98	26	182	.50
Overreactivity	.76	.59	.87	1.24	26	208	.20
Verbosity	.49	.07	.75	.59	25	75	.93

**Descriptive Statistics for Parenting Scales**

A summary of the descriptive statistics for each of the three scales across the three data collection periods is presented in Table 3. Kin caregiver mean scores decreased from preintervention to postintervention and then rose for the 30-day postintervention. The Kin caregiver mean scores for the Verbosity subscale decreased from preintervention to postintervention, as well as from postintervention to the 30-day postintervention. For the Laxness and the Overreactivity subscales, the means between the levels of the within-subjects factor were not significantly different. The mean scores for the Verbosity subscale were significantly different as determined by test for sphericity.

Table 3

*Descriptive Statistics for Parenting Scale Scores*

	<i>N</i>	Minimum	Maximum	Mean	Std. deviation
LaxnessT1	27	8.00	36.00	20.00	7.02
LaxnessT2	27	7.00	32.00	17.93	6.50
LaxnessT3	24	9.00	31.00	19.12	5.76
OverreactivityT1	27	9.00	39.00	21.56	8.63
OverreactivityT2	27	9.00	39.00	19.74	7.48
OverreactivityT3	24	10.00	45.00	20.37	7.99
VerbosityT1	27	7.00	28.00	17.22	4.60
VerbosityT2	27	7.00	27.00	16.30	5.20
VerbosityT3	24	9.00	24.00	16.21	3.67

**Evaluation of Statistical Assumptions for RM ANOVA**

Statistical assumptions help researchers to interpret statistical results accurately. Violations of a model's assumptions must be corrected so that the conclusions drawn from the analysis do not result in Type I or Type II errors. The five assumptions associated with RM ANOVA were (a) measurement for the dependent variable, (b) number of matched pairs, (c) absence of outliers, (d) normally distributed data, and (e) homogeneity of variance or sphericity. The following is a description of the statistical analysis of the RM ANOVA assumptions and how they were or were not met in the study.

**Level of measurement for the dependent variable assumption.** The level of measurement for the dependent variable was interval as the data were analyzed from the change in scores of each subscale. Therefore, this assumption was met.

**The number of matched pairs assumption.** There were three data points or three sets of matched pairs in this study. The number of groups for the independent variable was carried out on the same entities. The within-group variances came from the effects of the experimental manipulation. Therefore, this assumption was met.

**Absence of outlier assumption.** An outlier is an observation that is very different from others. Outliers bias statistics such as the mean. The absence or presence of outliers was tested with the extreme values tables generated by the Shapiro-Wilk test. There were no outliers in this study; therefore, this assumption was met.

**Normally distributed data assumption.** The Kolmogorov-Smirnov and Shapiro-Wilk tests were used to determine whether the distribution of scores was significantly different from a normal distribution. A significant value indicates a deviation from normality. Results from the Kolmogorov-Smirnov and Shapiro Wilk tests were not significant for the three subscales of the Parenting Scale, thus indicating that there was no deviation from normal distribution. Therefore, the assumption of normality was met. Table 4 presents a summary of the results from the Kolmogorov-Smirnov test of normality for the three subscales.

Table 4

*Test of Normality for the Three Subscales of the Parenting Scale*

	Kolmogorov-Smirnov <sup>a</sup>			Shapiro-Wilk		
	Statistic	<i>df</i>	Sig	Statistic	<i>df</i>	Sig
Over T1	.098	24	.200*	.949	24	.255
Over T2	.154	24	.099	.951	24	.280
Over T3	.163	24	.099	.879	24	.008
Lax T1	.091	24	.200*	.977	24	.843
Lax T2	.143	24	.200*	.945	24	.208
Lax T3	.144	24	.200*	.960	24	.439
Verbosity T1	.192	24	.022	.953	24	.313
Verbosity T2	.117	24	.200*	.971	24	.685
Verbosity T3	.148	24	.190	.955	24	.342

**Sphericity assumption.** Sphericity is used in RM ANOVA to assess whether the variances across conditions are equal. Mauchly's test is the test of the null hypothesis to determine whether there is a difference in the variance between conditions. Therefore, if Mauchly's test is significant, the assumption of sphericity is not met. In this study, Mauchly's test was not significant for the Laxness and the OverReactivity Scales,  $p = 0.374$  and  $p = 0.722$ , respectively, so the assumption of sphericity was met. Because Mauchly's test was not significant, the data were interpreted from the assumptions-met table in the RM ANOVA output. This means that the variances of the sets of scores across the three time periods were mostly equal. Data from the RM ANOVA table were interpreted from the sphericity assumed line entry for the Laxness and the OverReactivity scales.

However, the assumption of sphericity was not met for the Verbosity subscale,  $p = 0.001$ . Therefore, there were significant differences between the variances of the sets of scores across the three time periods for the Verbosity subscale. The Greenhouse-Geisser was used to correct the one-way RM ANOVA. Consequently, data for the Verbosity subscale were interpreted from the Greenhouse-Geisser values for the RM ANOVA ( $p = .661$ ). Table 5 presents a summary of these data.

Table 5  
*Results From Mauchly's Test of Sphericity*

Within-subjects effect	Mauchly's W	Approx. chi-square	df	Sig.	Epsilon		
					Greenhouse-Geisser	Huynh-Feldt	Lower-bound
Laxness	.906	1.969	2	.374	.914	1.000	.500
Over-reactivity	.968	.652	2	.722	.969	1.000	.500
Verbosity	.488	13.626	2	.001	.661	.761	.500

<sup>a</sup> Design: Intercept + of children + Gender ; Within Subjects Design: factor1<sub>a</sub>

<sup>b</sup> May be used to adjust the degrees of freedom for the averaged tests of significance. Corrected tests are displayed in the Tests of Within-Subjects Effects table.

### Statistical Data Analysis Organized by Hypothesis

A one way repeated measures ANOVA was conducted to determine whether there was a statistically significant difference in the three subscales of the Parenting Scale over the course of a 10-class training intervention.

**Hypothesis 1.** Hypothesis 1 addressed whether there were statistically significant differences in the Laxness subscale scores across the three data collection points. The results presented in Table 6 reveal that there was no statistically significant difference

between the mean scores on the Laxness subscale at the different time points ( $p > .05$ ).

Therefore, we cannot reject the null hypothesis and cannot accept the alternative hypothesis.

H<sub>10</sub> = The *Caring for Our Own* training will have no statistically significant impact on the caregivers use of laxness as a discipline practice, as indicated by a change in scores on the Laxness subscale of the Parenting Scale after controlling for time, the pretest scores, and the number of children in the home.

H<sub>1A</sub> = The *Caring for Our Own* training will have a statistically significant impact on the caregivers use of laxness as a discipline practice as indicated by a change in scores on the Laxness subscale of the Parenting Scale after controlling for time, the pretest scores, and the number of children in the home.

**Hypothesis 2.** Hypothesis 2 addressed whether there were statistically significant differences in the Overreactivity subscale scores across the three data collection points. The results presented in Table 6 reveal that there was a statistically significant difference between the mean scores on the Overreactivity scale at the different time points ( $p > .05$ ). Therefore, we cannot reject the null hypothesis and cannot accept the alternative hypothesis.

H<sub>20</sub> = The *Caring for Our Own* training will have no statistically significant impact on the caregivers use of overreactivity as a discipline practice as indicated by a change in scores on the OverReactivity subscale of the

Parenting Scale after controlling for time, the pretest scores, and the number of children in the home.

H<sub>2A</sub> = The *Caring for Our Own* training will have a statistically significant impact on the caregivers use of overreactivity as a discipline practice as indicated by a change in scores on the OverReactivity subscale of the Parenting Scale after controlling for time, the pretest scores, and the number of children in the home.

Table 6

*Results From RM ANOVA Including Number of Children in Home as a Covariate*

Source	Type III sum of squares	<i>df</i>	Mean square	<i>F</i>	Sig.	Partial eta squared	Observed power <sup>a</sup>
Laxness	108.878	2	54.439	2.484	.095	.101	.473
Laxness X number of children	52.325	2	26.162	1.194	.313	.051	.248
Error(factor1)	964.314	44	21.916				
Overreactivity	274.754	2	137.377	2.649	.082	.107	.499
Overreactivity X number of children	446.003	2	223.002	4.300	.020	.164	.719
Error(factor1)	2281.635	44	51.855				
Verbosity	47.900	2	23.950	1.771	.182	.075	.351
Verbosity X number of children	30.811	2	15.405	1.139	.329	.049	.238
Error(factor1)	594.884	44	13.520				

<sup>a</sup>Computed using alpha + .05

**Hypothesis 3.** Hypothesis 3 addressed whether there were statistically significant differences in the Verbosity subscale scores across the three data collection points. The results presented in Table 6 reveal that there was no statistically significant difference

between the mean scores on the Verbosity subscale at the different time points ( $p > .05$ ).

Therefore, we cannot reject the null hypothesis and cannot accept the alternative hypothesis.

H<sub>30</sub>= The *Caring for Our Own* training will have no statistically significant impact on the caregivers use of verbosity as a discipline practice as indicated by a change in scores on the verbosity subscale of the Parenting Scale after controlling for time, the pretest scores, and the number of children in the home.

H<sub>3A</sub>= The *Caring for Our Own* training will have a statistically significant impact on the caregivers use of verbosity as a discipline practice as indicated by a change in scores on the Verbosity subscale of the Parenting Scale after controlling for time, the pretest scores, and the number of children in the home.

Results from the repeated measures ANOVA that includes the number of children in the home as a covariate is revealed in Table 6. The analysis revealed that there was an interactive effect for the mean number of children in the home for the Overreactivity subscale. The Overreactivity mean for the number of children interaction was statistically significant at ( $p = .020$ ). Table 7 shows the means for Overreactivity X number of children. However, it was difficult to draw data conclusions due to the unbalanced cell sizes attributed to the 3 incomplete data cases.

Table 7

*Means for Overreactivity X Number of Children*



Number of children		Overreactivity	Overreactivity	Overreactivity
		T1	T2	T3
.0	Mean	20.3333	19.6667	30.3333
	<i>N</i>	3	3	3
	Std. deviation	14.74223	10.06645	15.01111
1.0	Mean	18.4444	16.5556	19.0000
	<i>N</i>	9	9	7
	Std. deviation	5.76869	5.68135	4.72582
2.0	Mean	21.4000	21.1000	18.4444
	<i>N</i>	10	10	9
	Std. deviation	7.16783	6.02679	5.29413
3.0	Mean	27.0000	14.0000	25.0000
	<i>N</i>	2	2	2
	Std. deviation	16.97056	2.82843	12.72792
4.0	Mean	33.0000	28.0000	19.0000
	<i>N</i>	2	2	2
	Std. deviation	8.48528	15.55635	4.24264
5.0	Mean	21.0000	30.0000	11.0000
	<i>N</i>	1	1	1
	Std. deviation	.	.	.
Total	Mean	21.5556	19.7407	20.3750
	<i>N</i>	27	27	24
	Std. deviation	8.63060	7.48122	7.98810

### **Summary**

A repeated measures one-way ANOVA was conducted to assess the research question: How does the Caring for Our Own training impact kin caregivers' use of discipline practices as measured by the three subscales of the Parenting Scale? The Caring for Our Own training intervention did not elicit significant changes in kin caregivers' use of discipline practices as measured, over time, by the three subscales of the Parenting Scale. These results may not mean that the training intervention did not have an effect however. Therefore, further study on training interventions for kin caregivers in the are needed to elicit responses that change disciplinary choices. In Chapter 5, the interpretation of study findings, the limitations of the study, and recommendations and interpretations for positive social change are discussed.

## Chapter 5: Summary, Conclusions, and Recommendations

### **Introduction**

The purpose of this quantitative study was to assess the effect of the Caring for Our Own training program on kin caregivers' use of discipline practices as measured by change in scores on the three subscales of the Parenting Scale. A self-report survey was given to study participants before training, immediately after training, and 30 days posttraining. A repeated-measures one way ANOVA was conducted to analyze data collected from 27 kin caregiver volunteers. I used IBM SPSS version 21.0 to analyze the data and to generate the results. Key findings of the study revealed that there were no statistically significant differences between the means for the self-reported use of discipline practices at the three different time points.

### **Interpretation of the Findings**

The primary research question that guided this study was the following: How does Caring for Our Own training impact kin caregivers' use of discipline practices as measured by changes in scores on the three subscales of the Parenting Scale? Results from RM ANOVA revealed there were no statistically significant differences in the scores across the three data collection periods. In this section, I present interpretations and discuss findings from the study relative to previous literature.

Analysis of demographic data revealed that the majority of participants were female (85.2%), which was consistent with previous literature that indicated that most caregivers are female (Cross, Brinson, & Dendy, 2015; Sakai et al., 2011; Zinn, 2010). Regarding the educational level of participants, results from this study were not consistent with previous findings, which showed that most kin caregivers had less than a

high school education (Denby et al., 2015; Sakai et al., 2011). The high educational level of participants reflected the educational background that is typical of residents of the geographical area where the study was conducted. Recent statistics revealed that 50.2% of men and 48.5% of women in the geographic area of the study have a college education (U.S. Census Bureau, 2014; Strauss, 2016). Data from my results showed that 37% of participants had completed some college and 22% of the participants were college graduates.

Two additional variables are considered in the discussion of this study results. First, the age of the participants was a variable that possibly affected the outcome of this study. The majority of participants in this study were between the ages of 47 and 72 years. This age group indicates a cohort of those closely approaching advanced age (50-54 years), and those of advanced age (55 years and older), and those closely approaching retirement age (60 years and older; Social Security Administration, n.d.). In a study comparing kin caregivers to traditional foster care givers, Sakai et al. (2011) found no significant age-related differences in relation to the choice of child discipline practices. Conversely, another researcher found that grandparents were the least capable of parenting due to ailing conditions, particularly for those over 60 years of age (Zinn, 2010).

Researchers have studied the prevalence of harsh physical punishment across different age cohorts (Afifi et al., 2014). Afifi et al. (2014) found that in the 60- to 69-year-old age group, 17.8% had a prevalence of harsh physical discipline. The researchers also found that harsh discipline appeared to have been decreasing over time, from a high of 20.0% among 50- to 59-year-olds to a low of 13.7% among 20- to 29-year-olds (Afifi

et al, 2014). The results of my study may have been affected by the older participants (52%), who may have experienced harsh discipline practices and who continued to prefer those practices of child discipline.

The second variable that may have affected this study's outcome is gender. In one study, researchers examined secondary data to determine how demographic variables of gender, age, and racial characteristics related to the prevalence of harsh physical punishment of children (Afifi et al., 2014). The researchers found that the greatest difference in relation to a change in behavior resulting in a decreased use of physical discipline toward children was observed among males rather than females (Afifi et al., 2014). Their results indicated that the men in their study used less physical discipline over time than the females in their study. In my study, males comprised 14.8 % of the study participants, while 85.2% were female. It is reasonable to think that an increased number of male study participants might have lowered the study mean score results over time. Another factor that may have affected findings from this study was the participants' use of discipline practices prior to the training that were reflected in the pretest scores prior to training.

The authors of the Parenting Scale presented cutoff scores that indicated the point at which a given discipline technique would be considered problematic. The clinical cutoff scores for the parenting subscales were as follows: Laxness, 3.6; Overreactivity, 4.0; Verbosity, 2.4; and total score, 3.2. The higher the score value, the more ineffective the discipline practice (Acker et al., 1993; O'Leary et al., 2007). The participants for my study scored above the cutoff scores for the three subscales, at the three data points, thus indicating that when participants began the training, they were using high levels of

ineffective discipline practices. In addition, study participants ended the survey with a high level of ineffective discipline practices as evidenced by posttest scores.

The results from the data analysis revealed that the training did not make a statistically significant difference in lowering scores on the scales. It may be that the period of time for the training was too short to affect the participants' use of discipline practices. Based on the results of this study, it can be said that the high preintervention scores gave an indication of kin caregiver attitudes toward child discipline. Researchers have found that preexisting attitudes were evidenced for as long as 3 months after a parenting intervention had ended (Lansford et al., 2016). In addition, DiClemente and Prochaska's (1992) transtheoretical model of change posits that individuals pass through various stages before change occurs. If a change is practiced for 6 months, maintenance has occurred, and the change becomes part of an individual's lifestyle (DiClemente & Prochaska, 1992). This study's postintervention scores can reasonably be indicative of the variation in the time that it may take to change an attitude, belief, or behavior toward child discipline practices (Chavis, 2011; Taylor et al., 2012).

Researchers have examined the correlation between the number of children living in kin caregiver homes and the perception of child wellbeing by kin caregivers. In a study was conducted in a southeastern city in the United States, results revealed that "child count" was a significant covariate (Denby et al., 2015). The researchers found that as the number of children being cared for in the home increased, the perception of child wellbeing decreased (Denby et al., 2015). Researchers also found that the caregivers with the highest scores for child well-being had only one child living in the home (Denby et al., 2015, p. 474). In the current study, the analysis of the interaction of the mean number of

children in the home and the Overreactivity scale resulted in a statistically significant result (see Table 7). The analysis is difficult to interpret as a result of the unequal cell sizes as shown in Table 8.

Researchers have reviewed the efficacy of foster parent training programs that are not research-based, notably the Model Approach to Partnership Parenting (MAPP) and Parent Resource Information Development Education (PRIDE). The authors' findings revealed that few of the preservice trainings were effective in meeting specific caregiver needs (Festinger & Baker, 2013). The Caring for Our Own Training Program is a product of MAPP. By contrast, several researchers have examined the efficacy of research-based foster parent training interventions including the Triple P program, which has been supported by the CDC (Sanders, 2008). Evidence-based interventions have been shown to produce benefits that outweigh costs (Baker & Festinger, 2013; Bavelok, 2000; Sanders, 2008). Therefore, it is reasonable to expect that kin caregiver training interventions will be research based.

The findings of this study may further be explained in the context of the theory of planned behavior. The theory of planned behavior posits that information and reason contribute to intentions to act on a behavior (Ajzen, 1991; Hayden, 2014; Taylor et al, 2011; Taylor et al., 2012). Using the lens of the theory of planned behavior and the research question, I found an absence of a significant impact from training on kin caregiver use of discipline practices. I examined whether kin caregiver beliefs toward child discipline practices changed from those held before training (pre-existing beliefs). Further exploration of preservice training for kin caregivers using the theory of planned behavior is recommended. This would provide an opportunity to identify theoretical

constructs that may enable kin caregivers to realize the influence of personal experiences, social norms, and advice from influential individuals on their choice of child discipline practices. Equipping kin caregivers with information may help them reason that the benefits of using alternative child discipline practices outweigh the cost of not using them. That information would be beneficial to them as kin caregivers and to the children they care for.

The reliability of data collected with the Parenting Scale may have also been a factor that affected the results of this study. Details regarding the reliability estimates of the Parenting Scale are presented in Chapter 3. The results of this study did not confirm previous findings of the authors and other researchers. Results from the reliability analysis for the data collected for my study were not as robust compared to previous findings reported by the authors of the scale (Arnold et al., 1993, p. 139). The psychometric estimates of the three subscales for my study had reliability estimates under 0.70, which is the lower level of acceptable reliability. Moreover, items on all three scales had to be dropped to improve the reliability estimates before the data were subjected to statistical analysis. Further, the results of internal consistency did not compare with previous studies by other researchers who used the scale for various measures of autism and in low-income mother comparison. Previous researchers reported obtaining reliability scores above 0.70 (Reitman et al., 2001; Sanders et al., 2009).

Finally, the Caring for Our Own training itself may not have been adequate for addressing and teaching appropriate discipline practices. During the course of training, program participants received information on topics such as normal child development; kin, child, and birth parent transitional reactions; practices for managing child behavior;



impact of substance abuse, and mental health on the family as a system; as well as practices for managing and resolving conflict with birth parents (Children's Alliance of Kansas, 2011). Therefore, it is possible that the session of practices for managing child behavior were too broad. Perhaps there needed to be more specific material related to using appropriate discipline practices, as well as more time in which to present it.

### **Limitations of the Study**

Several limitations of this study should be noted. First, the study was based on only one umbrella agency and subsequently was limited by a lack of geographic variability, as well as in the ability to generalize findings to a broader population. A second limitation may have been the sample size. An a priori power analysis revealed that the minimum sample size needed for a RM ANOVA was 27 cases with three repeated measures totaling  $n = 81$ . The initial case size for this study was 27; however, due to attrition, I was not able to obtain data from three participants for the T3 posttraining follow-up. Consequently, there were 24 complete data cases, for a sample size of  $n = 72$ . The sample size was adequate based on the a priori analysis. However, it is reasonable to speculate that a larger sample size might have revealed different results. The third limitation was the low reliability estimates obtained for the three subscales of the Parenting Scale as discussed in Chapter 4, resulting in several items being dropped from analysis from each subscale to improve the reliability for the data analysis (Creswell, 2011)

### **Recommendations for Future Research**

Training interventions that align with the specific needs of kin caregivers are ones that will best equip kin caregivers for meeting the needs of the children they care for

(U.S. Department of Health and Human Services [DHHS], Office of Minority Health, 2002). Recommendations for future research on effective interventions specific to preparing an individual to be a kin caregiver include longitudinal mixed-method studies incorporating quantitative and qualitative data. Qualitative data could provide information on which elements of a training intervention create challenges for implementation, along with the problem-solving skills for meeting those challenges. Results assessed in future training evaluations should represent meaningful real-life outcomes from a variety of perspectives, including those of staff, foster parents, children, and teachers (Festinger & Baker, 2013; Thompson & Kegler, 2006). The information gleaned from the assessments could be used as the basis for creating a measurement tool that specifically targets the child discipline management techniques that the kin caregivers experience.

## **Implications**

### **Positive Social Change**

This study has positive social change implications on two levels: the family or microsystem level (Bronfenbrenner, 1979) and the organizational or mesosystem level (Bronfenbrenner, 1979). Theory indicates that self-efficacy or belief in one's ability to change coupled with motivation to change bolsters the transfer of learning into action (Ajzen, 1991). Due to the lack of a statistically significant impact on change in discipline practices, that were revealed in this study, the study site agency may want to update training curricula to those that are research-based and inclusive of kin caregiver families themselves (Daro, 2016). Obtaining data using qualitative methods will give specific

insights into what kin caregivers identify as their issues regarding child discipline management.

On an organizational level, knowledge from the results of this study may be useful for program developers at the study site agency who are searching for ways to effectively meet the specific needs of kin caregivers on a short-term and long-term basis. Social change at the organizational level could involve development of collaborative relations with communities where negative social determinants often create the need for kin caregiver intervention. Collaboration involving support organizations as well as kin caregivers might include ongoing training, dissemination of current research, and best practice information, as well as learning from community caregivers (Daro, 2016; Lavizzo-Mourey, 2017).

Methodological implications of using a one-way RM ANOVA center around the strengths and weaknesses of the design. Two strengths of RM one way ANOVA are as follows: (a) fewer subjects are required for the study, allowing the researcher more control, and (b) because all treatments are given to same participants, the participants serve as their own control group, reducing study error (Verma, 2016). On the other hand, a weakness of using a one way RM ANOVA is the carryover effect on the participants' performance. The participants may be affected by fatigue from the intervention and testing. Participants may lose interest in the study, which may, in turn, affect the way that they answer questions and thus affect the outcomes of the study (Creswell, 2011)

### **Recommendations for Practice**

Based on the results, strengths, and limitations of this study, I would suggest that future studies that evaluate the impact of training programs use a larger population to

obtain a wider and more diverse sample of participants. Additionally, it would be advantageous to use a mixed method approach to obtain data for further research. This would provide personal experiences of participants through interviews. Personal experiences of kin caregivers may serve to inform stakeholders and others who might experience a similar circumstance (Harris, 2013).

### **Conclusion**

The purpose of this quantitative study was to assess the impact of the Caring for Our Own training program on kin caregivers' use of discipline practices as measured by change in scores on the three subscales of the Parenting Scale. Key findings of the study revealed that there were no statistically significant differences between the means of the training intervention at the different time points. It is cost effective for organizations to assess the efficacy of training interventions they provide to their target populations (Festinger & Baker, 2013; U.S. Department of Health and Human Services, Office of Minority Health, 2002). The use of research-based interventions has been shown to decrease cost and increase efficacy. Training initiatives that increase knowledge, enhance ownership, and strengthen resolve for kin caregivers may ultimately empower them to successfully sustain their roles as entrusted child guardians for as long as they are needed.

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## Appendix A: Request and Permission to Use Parenting Scale

Bertha Ansley <bertha.ansley@waldenu.edu>

Jul  
14

to susan. oleary

Hello Dr. O'Leary,

I would like to examine the Overreactivity sub scale from the Parenting Scale to see if it is appropriate for my Theory of Planned Behavior constructs. My dissertation examines parental ability to refrain from yelling as a child disciplinary technique.

Would you give me permission to use it and would you send me a copy along with the fee? Thank you

---

Susan O'Leary <susan.oleary@stonybrook.edu>

Jul 14

to me

Of course, you may use it - it is free. say that the Overreactivity scale has no psychometrics to support it if it is administered alone, so I'd recommend using the whole scale or looking carefully at the Overreactivity psychometrics if you have a large enough sample. Attached is relevant information. Good luck!

Susan

## Appendix B: Flier

# An Opportunity to Participate in Research

- **An Opportunity to Participate in Research About Discipline Techniques.**

- Dear Kin Caregivers,
- You are invited to take part in a research study conducted by Bertha Ansley, a Walden University doctoral student. The purpose of the study is to obtain information about attitudes you have toward different discipline techniques in different situations. If you would like to participate in the study you will be asked to complete a questionnaire at 3 different times. The questionnaire has 30 questions and should take no longer than 20 minutes to complete each time.
- The 3 times in which you would be asked to complete the questionnaire are (a) once before the Caring for Our Own pre-license training begins, (b) once on the last day of the 5-week training, and (c) once again 30 days after training (the 30 day post training questionnaire will be completed via telephone contact by the researcher.
- An incentive is offered to you for your valued time in completing the surveys. A \$10.00 gift card for the pre and post-test, and \$15.00 for the second post-test given 30 days after training for a total of \$25.00.
- If you would like to be a part of this research project, or have any questions please contact Bertha Ansley at 202-554-0365 or [bertha.ansley@waldenu.edu](mailto:bertha.ansley@waldenu.edu)



8. I am the kind of parent that...  
 sets limit on what child is allowed to do. 1 2 3 4 5 6 7 lets my child do whatever he were she wants. my
9. When my child misbehaves...  
 I give my child long lecture. 1 2 3 4 5 6 7 I keep my talks and to the point.
10. When my child misbehaves...  
 I raise my voice were yell. 1 2 3 4 5 6 7 I speak to my calmly.
11. If saying no doesn't work right away...  
 I take some other action. 1 2 3 4 5 6 7 I keep talking and trying kind of to get through to my child.
12. When I want my child to stop doing something...  
 I firmly tell my child to stop. 2 3 4 5 6 7 I coax were beg my to stop.
13. When my child is out of my sight...  
 I often don't know child is doing. 1 2 3 4 5 6 7 I always have a good what my idea of what my child is doing.
14. After there's been a problem with my child...  
 I often hold a grudge. 1 2 3 4 5 6 7 things get back normal quickly.
15. When we're not at home...  
 I handle my child do at home. 1 2 3 4 5 6 7 I let my child get away the way I with a lot more.
16. When my child does something I don't like...  
 I do something time it happens. 1 2 3 4 5 6 7 I often let it go. about it every
17. When there's a problem with my child...  
 things build up and I don't mean to do. 1 2 3 4 5 6 7 things don't get out of I do things hand.
18. When my child misbehaves, I spank, slap, grab, were hit my child...  
 never were rarely. 1 2 3 4 5 6 7 most of the time.
19. When my child doesn't do what I ask...





*Note.* From “The Parenting Scale: A Measure of Dysfunctional Parenting in Discipline Situations,” by D. S. Arnold, S. G. O’Leary, L. S. Wolff, and M. M. Acker, 1993, *Psychological Assessment*, 5, p. 140. Copyright 1993 by the American Psychological Association, Inc. Adapted with permission.

### Appendix D: Scoring Instructions for the Parenting Scale

Each item receives a 1-7 score, where 7 is the "ineffective" end of the item.

Thus, the following items have 7 on the left side (the others on the right): 2, 3, 6, 9, 10, 13, 14, 17, 19, 20, 23, 26, 27, 30

To compute the total score, average the responses on all items.

To compute a factor score, average the responses on the items on that factor.

Laxness: 7, 8, 12, 15, 16, 19, 20, 21, 24, 26, 30 (11 items)

Overreactivity: 3, 6, 9, 10, 14, 17, 18, 22, 25, 28 (10 items)

Verbosity: 2, 4, 7, 9, 11, 23, 29 (7 items)

items not on  
a factor: 1, 5, 13, 27 (4 items)

Scale Developed by Susan G. O'Leary, David S. Arnold, Lisa S. Wolff, & Maureen M. Acker.

## Appendix E: Request and Permission to Use Theory of Planned Behavior Figure

**Bertha Ansley**

<ansleybertha78@gmail.com>

Hello Dr. Ajzen,

This note is to request permission to use your figure of the Theory of Planned Behavior in my Dissertation. (see attached) If you allow me to use it, would you please provide the copyright year

Thank you.  
Bertha Ansley

*Bertha Ansley*  
MSN, BSN, RN-BC, CHES

Dear Ms. Ansley,

The theory of planned behavior is in the public domain. No permission is needed to use the theory in research, to construct a TPB questionnaire, or to include an ORIGINAL drawing of the model in a thesis, dissertation, presentation, poster, article, or book. If you would like to reproduce a published drawing of the model, you need to get permission from the publisher who holds the copyright. You may use the drawings on my website ("<http://people.umass.edu/aizen/tpb.diag.html>" or "<http://people.umass.edu/aizen/tpb.background.html>") for non-commercial purposes, including publication in a journal article, so long as you retain the copyright notice.

Best regards,

Icek Ajzen  
Professor Emeritus  
University of Massachusetts - Amherst  
<http://www.people.umass.edu/aizen>