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Life Factors And Attendance Rates For Women Enrolled In A Parenting Program

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LIFE FACTORS AND ATTENDANCE RATES FOR WOMEN ENROLLED IN A PARENTING PROGRAM

by

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THESIS

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CHAPTER 1: INTRODUCTION

Overview

The goals of the study were a) qualitatively to describe reasons and expectations parents report for participating in a parenting group intervention; and b) quantitatively to examine the extent to which demographic factors (i.e., age, race/ethnicity, income, education, and marital status), negative affect (i.e., depression and PTSD symptoms), motivation (i.e., expectations about the intervention for self, child, parenting), perceived social support (i.e., for self and for parenting), and past intervention experience were associated uniquely and in combination with attendance at the parent intervention. To examine these aims, this study utilized archival data gathered by the University of Michigan’s Mom Power Group (Muzik, Rosenblum, Schuster, & Krause, 2011). Data for 99 participants were included in the analyses of the study. Parenting group success begins with attendance, therefore, the study sought to understand which life factors were associated with attendance.

Attending Parenting Intervention Matters

Parenting interventions consistently have been shown to improve positive parenting effectiveness, child adjustment, and family functioning (Gardner, Hutchings, Bywater, & Whitaker, 2010). However, attendance rates tend to be low and dropout rates tend to be high, which likely diminishes the positive impact of such programs (Dumas, Nissley-Tsiopinis, & Moreland, 2007). Although research has shown various parenting groups and programs are effective in improving parent functioning, and thereby, child behavior, few research programs have examined how pre-treatment life factors contribute to intervention adherence and outcome, and even fewer studies have looked at the reasons and motivation for parents to attend intervention (Finney & Moos, 1989; Ingoldsby, 2010). Presumably, parents seek training
programs or support groups to lessen the burden of parenting, to gain knowledge and insight into various parenting techniques and skills, and to improve their children’s development (Gross, Julion, & Fogg, 2001; Kilpatrick, Resnick, Saunders, & Best, 1989). For these reasons, this study focused on cataloguing and describing parents’ spontaneous statements about their reasons and hopes for attending a parent group. Moreover, the study also examined how these reasons and other factors combine to account for the variance in intervention attendance. As seen in Figure 1, Finney and Moos (1989) proposed that commitments, like work and family, and client specific factors, like SES or personality, may affect intervention participation. Since these factors are unique across individuals, assessing these circumstances before treatment can help provide some indication of the effects on intervention attendance rates.

**Sociodemographics and Parent Group Attendance**

Although there is some evidence that socioeconomic disadvantage, minority group status, high levels of stress, and difficult living circumstances (e.g., single-parent families) are associated with lower attendance, findings for these factors have not been consistent (Kazdin, Holland, & Crowley, 1997). Garland and others (Garland, Haine-Schlagel, Accurso, Baker-Ericzén, & Brookman-Frazee, 2012; Gaskin, Kouzis, & Richard, 2008; Miller, Southam-Gerow, & Allin, 2008) found that single parent status, higher parent education, White race/ethnicity, and public insurance coverage have been found to be associated with greater treatment attendance. Research has also found that families of lower socioeconomic status are less likely to participate in treatment (Heinrichs, Bertram, Kuschel, & Hahlweg, 2005). Dumas, Nissley-Tsiopinis, and Moreland (2007) reviewed articles and found that married or cohabiting caregivers have been reported to be more engaged than single caregivers in some, but not other studies, and that older caregivers are more likely to attend interventions in some studies, but not others. Given the mix
of findings on which demographic factors impact attendance for parents, it becomes important to keep all parents engaged and consider potential barriers that may stand in the way of intervention attendance. This study looked at sociodemographics like age, race/ethnicity, income, education, and marital status; how they are associated with intervention attendance rates, and whether they serve as barriers to attendance.

**Mental Health Factors and Parent Group Attendance**

Parents with mental health concerns are in a vulnerable place when it comes to seeking interventions for parenting (Ingoldsby, 2010). Exposure to trauma and diagnoses like depression and post-traumatic stress disorder may put parents in a position that makes it difficult to seek out parenting interventions (DeGarmo, Patterson, & Forgatch, 2004). Overall, there is mixed research suggesting that maternal psychopathology can have either a positive or a negative association with client engagement in services. In one study, researchers found that increased service completion was predicted by higher levels of caregiver depression (Girvin, DePanfilis, & Daining, 2007). However, other studies examining such factors have reported that family risk factors like depression are related to lower family engagement in services (Josten et al., 2002).

Amongst the life context factors that parent’s face, stressful conditions like burdensome responsibilities and difficult life circumstances often prove to be challenging and may affect any potential intervention benefits (Rueter, Rand, & Ramisetty-Mikler, 1999). Beyond daily life stressors, stress following a traumatic event may also affect parenting. Research has consistently shown that parental distress following a traumatic event often has a negative impact on child adjustment (Ostrowski, Christopher, & Delahanty, 2007). Additionally, Murphy et al. (2009) cited that individuals with PTSD may be less likely to recognize that they have a problem and therefore less likely to attend interventions. Their study found that the treatment group utilizing
motivational interviewing had greater attendance than a comparative psychoeducational group (Murphy et al., 2009). This study focuses on understanding whether factors like depression and PTSD may play a role in poor intervention attendance to begin with, further contributing to a parent’s inability to find support and a way to deal with stress. Although it is unclear exactly what effect risk factors may have on intervention attendance, this study looked at a composite variable called negative affect, which combines maternal scores for depression and PTSD, to determine if they play a negative role in intervention attendance rates.

**Motivation and Parent Group Attendance**

Research has shown that parent perceptions of the nature and severity of parenting problems, parent demographics, perceived social support, and intrapersonal and attitudinal factors are some of the most common variables that influence attendance of adult parent programs (McCarthy, Sundby, Merladet, & Luxenberg, 1997). One factor that is essential to intervention attendance is parental recognition of a problem or a need to seek help. When parents fail to see any problems or need for intervention, it becomes increasingly difficult for them to motivate themselves to change or even continue attending interventions (Chaffin et al., 2009). For many parents, recognition of increased severity of parenting problems may act as a factor for increased attendance. It is also possible that some parents will acknowledge a problem exists, but rather than engaging actively in the work required for psychological changes, they may focus their efforts on continuing to look for a clear-cut answer to their problems (MacNaughton & Rodrigue, 2001).

Oftentimes, individuals fail to attend interventions or adhere to treatment requirements because of low motivation or potential barriers to treatment (Nock & Kazdin, 2005). Motivational factors include readiness to change parenting behaviors, attitudes toward the
program, and problem recognition (Chaffin et al., 2009). Negative attitudes and beliefs about intervention and mental health treatment may play a role in parents’ interest in seeking out interventions. Problems such as dislike of the health provider or a belief that an intervention is unnecessary are factors that may lead to decreased attendance rates (MacNaughton & Rodrigue, 2001). An individuals’ internal motivation also plays a role in whether clients continue taking advantage of services or stop attending (Littell & Girvin, 2005). One study found that parenting motivation rooted in wanting to share experiences with other parents, to learn more about young children, to socialize children more effectively, and to have a better relationship with their child were top reasons parents enrolled in and continued to seek treatment (Gross et al., 2001).

Motivation for intervention and change may be important for parents to evolve and take advantage of any potential benefits that treatment can provide. Motivational interviewing (MI) was created in the 1980’s as a treatment for substance abusers with the intention of increasing a client’s intrinsic motivation to change (Miller, 1983). MI use has continued to grow over the years and it is consistently used in several domains, including parenting interventions. Evidence from one study suggests that even brief motivational interviewing protocols a few questions long may lead parents to attend at least one more session than parents who did not receive the MI condition (Sterrett, Jones, Zalot, & Shook, 2010). Research has shown that motivation often plays a role in attendance, so this study aims to understand motivation both qualitatively and quantitatively to see if increased levels are associated with greater attendance. One unique aspect of this study was the qualitative analysis of reason’s parents give for attending a parenting group. Two additional coders and I examined mothers’ expectations for group and recorded their responses in detail. This study aimed to analyze these expectations, and given that research
indicates that even brief MI techniques may influence adherence, I hypothesized that increased motivation would be related to increased attendance rates.

**Perceived Social Support and Past Intervention Experience**

Research suggests that perceived social support is another factor that may predict intervention utilization and attendance (Ingoldsby, 2010; McCarthy et al., 1997; McCurdy et al., 2006). McCurdy suggests that satisfaction with one’s social support may lead to a family’s service avoidance when they feel that they have adequate resources available to them (McCurdy et al., 2006). One study found that families who refused home visitation services did in fact have higher educational levels and healthier infants than parents who accepted services (Duggan et al., 2000). On the other hand, evidence suggests that a family’s service refusal may also reflect a tendency toward isolation, stigma, or a higher level of risk for parenting (McCurdy et al., 2006). These mixed findings suggest that perceived social support has the potential to affect intervention attendance just as much as isolation does. Another study suggests that perceived levels of social support may vary for different people (Veenstra et al., 2011). That is, perceived supportiveness is in the eye of the beholder. For example, some individuals may benefit from having a friend to talk to and ask for medical advice from, however, they might not be open to the same information from a medical professional or vice versa. This raises the question as to whether the relation between attendance and a parents’ perceived level of social support might be moderated by mental health factors like depression and PTSD (negative affect). That is, when a parent is both high on negative affect and lacking in social support, they may not be particularly open to professional help. However, if they are high in negative affect but feel supported, they may be more open to outside help.
Another study has indicated that past participation in interventions is also predictive of intervention attendance (Spoth, Redmond, & Shin, 2000). This study was interested in examining whether mothers received intervention services in the past and whether this previous experience was positive, negative or neutral.

This study attempted to evaluate parents’ responses to a brief intervention using MI techniques by using a coding system developed by the author to understand maternal expectations of group, perceived social support, and previous intervention experience. The goal was to uncover whether mothers responses to these questions revealed differences and predicted their attendance. These findings may help clinicians understand maternal support networks in a different way, which may aid in increasing attendance rates.

**Aims**

Mom Power Group is a manualized 13-week parenting and mental health intervention with 3 individual and 10 group-based sessions for high-risk mothers and their young children (ages birth to 6) (Muzik, M., Rosenblum, K., & Schuster, 2010). The intervention incorporates 5 key components: 1) Enhancing Social Support; 2) Parenting Skills Training; 3) Child Routines and Mother-Child Interaction Practice; 4) Mental-Health Care/Stress-Reduction; and 5) Connecting to Care through individual meetings with mothers to discuss targeted referrals for mother or child to quality, culturally-sensitive community resources. The intervention is manualized, brief, yet comprehensive—combining individual and group-settings, and provision of both tangible (transportation, childcare, food) and therapeutic modalities. Although Mom Power provides didactic information, the emphasis is on therapeutic, experiential, hands-on, and supported learning opportunities.
During the initial home–based session prior to the group participation, the clinicians ask mothers questions created in the spirit of motivational interviewing. Motivational Interviewing (MI) is an empirically supported treatment that has been proven to increase intrinsic motivation to change and is often used to address problems with participation and engagement in varying treatments (Miller, 1983). Questions in the interview included inquiries about reasons mothers wanted to make changes, supports available to help, and expectations for the coming weeks. The first goal of this study was to understand qualitatively the expectations mothers have and specify as reasons for enrolling in Mom Power Group.

Based upon Finney and Moos’ model and the current literature, the author proposed a multivariate model to predict parental attendance of Mom Power Group by looking at life factor variables. The proposed multivariate model, as seen in Figure 2, suggests that sociodemographic factors like age, race, income, education, and marital status have an impact on intervention attendance or can interact with the intervention or risk factors to lead to an outcome. Additionally, posttraumatic stress, depression, motivation, perceived social support, and previous intervention experience can independently have an impact on intervention attendance or can interact with the intervention or sociodemographic factors to contribute to an outcome. Based on the existing literature and the model presented above, the following aims were examined:

**Qualitative.** The first aim was to provide qualitative descriptive information about the reasons or expectations parents spontaneously give to open ended questions about what they expect from group. Based on analyses, I designed and developed four categories that captured all of the mothers’ responses.

**Quantitative.** The second aim was to analyze a quantitative predictive model of how variables combine to predict attendance. This multivariate model analyzed age, race/ethnicity,
income, education, marital status, negative affect, motivation, perceived social support, and previous intervention experience and their association with intervention attendance.
CHAPTER 2: METHOD

Participants

Data for this study were collected by the Mom Power Group developers (Muzik et. al, 2010) and provided to the author as an archival data set. Mothers were recruited for Mom Power Group from various community sites across Southeast Michigan including the Corner Health Center, the Ypsilanti Health Center (and Adams Elementary), the Guidance Center, and Taubmann Church in Ypsilanti (see Figure 3 for geographic breakdown). Mothers were recruited in multiple ways: Social workers referred mothers from the University of Michigan (UM) Hospital and the Corner Health Center in Ypsilanti, flyers were posted around the community (see Appendix A), and some were referred by mothers who already participated in the program. Twelve mothers in this sample were self-referred by flyers or word of mouth, and a professional (i.e., primary care, OB, or mental health) referred 86 mothers. As noted in the recruitment flyer, there were a number of incentives given for parental participation and attendance. Mothers interested in enrolling in Mom Power Group were screened to determine eligibility. Women considered at ‘high risk’ were excluded from the group format. High risk factors included serious mental health issues (e.g., reporting or showing hallucinations and delusions), criminal histories, and active substance abuse problems. Women reporting one or more of these characteristics were referred to licensed social workers at their nearest community site for individualized help. Additionally, women who did not wish to be video recorded and who were not fluent in English were excluded. Unfortunately, information was not gathered on how many mothers were excluded for one or more of these reasons.

In total, 114 mothers and their children were recruited (see Table 1 for demographics). Thirty-five mothers (31%) completed measures with no pre-intervention Motivational
Interviewing (MI) questions, and 64 (56%) of the participants completed pre intervention MI questions and measures and (see Figure 4 for an intervention flowchart). Motivational interview questions were not introduced until the 35th participant, and three participants thereafter do not have motivational interview data due to audio recorder error. A variable was created for MI questions with zero assigned to no MI participants and one assigned to MI participants. Both mothers with and without MI questions were included in analyses for a total of 99 (87%) participants. Table 1 provides information on participants with missing variables and Table 2 includes options mothers received for race/ethnicity and marital status.

In the sample of 64 MI mothers, the average maternal age was 28.84 years ($SD = 5.56$), the average age for the child was 20.49 months ($SD = 16.55$), and 31 (48%) of the participants were African American, 28 (44%) of the participants were Caucasian, one (2%) was Asian or other Pacific Islander, and four (6%) were Biracial. In total, 47 (73%) women had an income of less than $20,000 a year, and 16 (25%) had less than a high school education. Twenty (31%) women reported being single. Overall, 64 (100%) of mothers attended group for 10 weeks ($M = 71.41\%$ attendance, $SD = 33.42$).

In the sample of 35 no-MI mothers, the average maternal age was 21.46 years ($SD = 4.10$), the average age for the child was 23.19 months ($SD = 18.54$), and 10 (29%) of the participants were African American, 17 (49%) of the participants were Caucasian, and two (6%) was Biracial. Twenty (57%) women had an income of less than $20,000 a year, 4 (11%) had less than a high school education, and 13 (37%) women reported being single. Overall, 21 (60%) of the mothers attended the 8-week session, 5 (14%) attended the 9-week session, and nine (26%) attended the 10-week session with an average attendance of 77.92% ($SD = 31.43\%$).

Measures
**Attendance.** Based on changes over the evolution of the group, families interested in Mom Power Groups were enrolled into the eight (n=21), nine (n=5), or ten-week (n=74) parenting program geared for mothers and their children ages 0-6. The original program began as an eight-week group program and progressed into the current ten-week program. Given that the number of sessions varied for participants, an attendance percentage variable was created to control for differences in program length. Attendance was measured at each group session, and mothers who attended a full session were counted as attending.

**Postpartum Depression Screening Scale.** The Postpartum Depression Screening Scale (PDSS) was created to assess women for signs of postpartum depression (Beck & Gable, 2000). The PDSS is a 35-item likert scale with ratings from 1 (strongly disagree) to 5 (strongly agree) that asks women to answer how they have felt in the past two weeks, has summative scoring, and has scores ranging from 35 to 175 (Beck & Gable, 2005). The Total scores in the range of 35-59 are within normal limits, scores in the 60-79 range represent significant symptoms of postpartum depression, and scores in the range of 80-175 indicate major postpartum depression (Beck & Gable, 2005). This study focused on the Total score; however, the PDSS does tap seven dimensions: sleeping/eating disturbances, anxiety/insecurity, emotional lability, cognitive impairment, loss of self, guilt/shame, and contemplating harming oneself (Beck & Gable, 2000). The sleeping/eating dimension has items like “Had trouble sleeping even when my baby was asleep”, the anxiety/insecurity dimension has items like “Feel all alone”, the emotional lability dimension has items like “Cried a lot for no real reason”, the cognitive impairment dimension has items like “Had difficulty focusing on a task”, the loss of self dimension has items like “Did not feel real”, the guilt/shame dimension has items like “Feel like a failure as a mother”, and the contemplating harming oneself dimension has items like “Wanted to hurt myself” (Beck &
Gable, 2000). Alpha internal consistency reliability from the original validation study was high across all dimensions (Beck & Gable, 2000). Cronbach’s alpha for the current sample was .93.

**National Women’s Study Posttraumatic Stress Disorder.** The National Women’s Study Posttraumatic Stress Disorder (NWS-PTSD) is a questionnaire that assesses Criteria A-F for PTSD as defined in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV, American Psychiatric Association, 1994; Kilpatrick et al., 1989). This study used a modified instrument that is a version of the Diagnostic Interview Schedule (DIS) created for use in an epidemiological study of PTSD specific women conducted via the National Crime Victim Center (Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). The modified NWS-PTSD has 21 items with “yes”-“no” response options and asks mothers to rate items based on past-month presence of a symptom that has had a duration of 2 weeks or longer at some time in the respondent’s life (Ruggiero, Rheingold, Resnick, Kilpatrick, & Galea, 2006). Items include questions like, “You had repeated bad dreams or nightmares?” and “Little things bothered you a lot or could make you very angry?” There is also a question that asks mothers to rate how distressing the problems have been from “very distressing”, “a little distressing”, “not at all distressing”, “not sure”, or “not applicable”. Research on the NWS-PTSD has provided support for concurrent validity, reliability, and internal consistency (Cronbach’s alpha of 0.87) (Kilpatrick et al., 2003). Cronbach’s alpha for the current sample was .87. Research using nationally representative samples has yielded similar prevalence of traumatic events and PTSD as those of other national probability studies, which suggests good construct validity for the NWS-PTSD module (Kessler, Sonnega, Bromet, & Hughes, 1995).

**Procedures**
**MI Coding.** As part of the pre-intervention home visit interview with the mothers, research assistants asked 64 participants a series of MI questions in an effort to activate and increase participants’ motivation for the intervention. These questions were aimed to elicit parents’ reasons and goals for joining the Mom Power Group (see Appendix B). The questions also examined whether parents perceived themselves as having any support and whether parents had any past intervention experience.

For this study, the pre interview questions were coded using a system designed by the author to classify mothers’ reasons for group participation, perception of social support, and experience of previous interventions (see Appendix C). Interclass correlations were calculated to determine reliability among three raters on mothers’ expectations, perceived social support, previous group experience, and perception of previous group experience. Analyses demonstrated coefficient alphas ranging from good to excellent (see Table 3). A Fleiss’ Kappa was employed to determine the reliability for the four categories under the expectations code, and analyses demonstrated kappa coefficients ranging from poor to substantial (see Table 3). Coders met to discuss discrepancies, and consensus was reached on all differences. This final set of codes was used to run all analyses and qualitatively evaluate mothers’ responses.

**Expectations.** Expectations for Mom Power Group were coded into four categories: help for self, child, parenting, or other. Coders tallied total number of categories acknowledged by the mother and briefly summarized each response on the coding sheet (see Appendix D). Coefficient alpha for expectations was .874 and kappa percent agreement for the four categories ranged from 87.5-97.9 (see Table 3).

**Support.** For perceived social support, raters assessed the mothers’ reported level of support for herself and/or for her parenting. Support was rated on a four- point scale with zero
indicating no support and four indicating strong support for both self and parenting. A score of one was given for response sets that indicated some sense of support for self or parenting and a score of two was given for strong sense of support in one area, but not the other. Coders also briefly summarized the mothers’ reported perception of support. Coefficient alpha for support was .942.

**Previous experience and Perception.** Finally, raters coded previous experience with a score of zero indicating that the mother had no previous intervention experience and a score of one indicating that she had previous experience. Raters then assessed whether the experience had been positive (a score of 2), neutral (a score of 1), or negative (a score of 0). Coefficient alpha was .939 for previous experience and 1 for perception.

**Pre group.** Families interested in Mom Power Group were enrolled into the parenting program geared for mothers and their children ages 0-6 years. All mothers filled out demographics and were videotaped interacting with their child up to four weeks before group. The interaction was based on Crowell and Feldman’s research and was aimed to challenge the child to determine the child’s ability to use his or her resources (Crowell & Feldman, 1988). Mothers also were interviewed and responded to questions developed using a modified Working Model of the Child Interview (WMCI) and questions developed in the spirit of Motivational Interviewing (MI). The purpose of these interview questions was to develop an understanding of a mother’s perception of her children and to examine maternal reasons for participating. Finally, mothers filled out the Postpartum Depression Screening Scale (PDSS), the Postpartum Bonding Questionnaire (PBQ), the Caregiving Helplessness Questionnaire (CHQ), the National Women’s PTSD Scale (NW-PTSD), and the Parenting Stress Index (PSI). The purpose of these measures was to gather information on various maternal factors including parent stress, mental health, and
bonding. Mothers completed the same set of questionnaires at the pre-intervention home visit, post-intervention home visit, and at the follow up home visit. They were reimbursed $10 for the Crowell and interview and $10 for the questionnaire packet.

**Group.** A few weeks after the initial home visits were completed, participants were able to begin weekly attendance of Mom Power Group. Mom Power Group met every week for 2.5-2.75 hours. Mothers received $5 for weekly participation and reimbursement for travel in an attempt to eliminate potential attendance barriers. Mom Power Group started at noon with a half an hour lunch and playtime before an observed separation time between mother and her children. After separation, mothers attended session where weekly topics and personal experiences in parenting and self-care skills were discussed. After an hour and fifteen minutes, mothers were reunited with their children and families departed. After ten weeks, mothers still enrolled in the program were visited at home up to four weeks after the completion of group to participate in another questionnaire packet and Crowell observation. A third home visit occurred between 10-14 weeks after the second home visit and consisted of a questionnaire packet and Crowell observation.

The aim of Mom Power Group was multifaceted and was largely based on the principles of the tree model depicted in Figure 5. The tree emphasizes the importance of a secure base for parents to explore and help, and a secure haven for parents to connect and restore. The program aims to increase accessible social support, improve stress management and coping skills, decrease maternal anxiety and depression symptoms, decrease relationship problems between mother and child, and help parents and children develop peer relationships.
CHAPTER 3: RESULTS

Preliminary Results

Data screening procedures were conducted at the outset of analyses to ensure normality, homoscedasticity, and linearity of the variables. One univariate outlier was identified for mother’s age (i.e., 42 years) and was replaced with the next largest value for mother’s age (i.e., 39 years). Data screening revealed positive skew for age, income, and experience (see Table 4). To correct for skew, age and income were Winsorized at the 20th and 80th percentile, while experience was not changed given the inherent dichotomized nature of the data. Missing value analyses revealed that 0% of data for age, 6.1% of data for race, 12.1% of data for income, 18.2% of data for education and 5.1% of data for marital status were absent. These data were not altered and analyses were conducted with missing variables.

T-tests were used to compare the two condition groups in terms of baseline characteristics including demographic variables and independent and dependent variables. With two exceptions, the MI and no-MI groups were not significantly different from each other. Mothers age was an exception with older moms in the MI group, $t(97) = -4.99$, $p < .001$, ($M = 23.56$ years, $SD = 2.89$ vs. $M = 21.11$ years, $SD = 1.97$) and a chi square was significant for education ($\chi^2 = 13.06$). Consequently, age and education were controlled for in analyses examining differences between the two conditions. Given the high correlation between depression and PTSD scores ($r = .70$), a dichotomized variable was created measuring clinically significant negative affect. Mothers who had one diagnosis or both were categorized separately from mothers who did not meet for a diagnosis.

Aim One
**Expectations.** The motivational interview spirited questions at the end of the Working Model Child Interview were qualitatively reviewed in order to understand the types of expectations mothers have for Mom Power before or at the start of group. Sixty-four mothers provided responses about their expectations for group. Overall, 44 mothers cited an expectation related to their child (68.8%), 58 cited an expectation related to parenting (90.6%), and 61 cited an expectation for group related to themselves (95.3%). Four mothers (6.3%) cited one type of expectation, 21 (32.8%) cited two types, and 39 (60.9%) listed all three types.

**Self.** Sixty-one mothers responded with expectations falling into the self-category and talked about wanting Mom Power to help them learn to cope (4 mothers, 6.5%), provide them with a chance to make friends (10 mothers, 15.6%) and have fun (10 mothers, 15.6%). Mothers were interested in learning (23 mothers, 38%), improving their communication (6 mothers, 10%) and socialization skills (6 mothers, 10%) and having something to do (2 mothers, 4%). Nearly every mother included an expectation for group to help her personally (61 mothers, 95.3%). One mother responded to interview questions shortly after starting group1 and said,

> I really like the aspect of self-care being involved. And it was nice to actually practice you know, we practiced deep breathing last time and, and it’s nice that it’s focused on mom as opposed to you know, how do we help ourselves as opposed to, you know with the other studies, it’s more about the child. You know, like the circle is meeting the child where he is. Okay, what about me? Who’s going to meet me where I am, you know, so I like that a lot.

**Parenting.** Fifty-eight mothers responded with expectations falling into the parenting-category and talked about wanting Mom Power to help them learn new and fresh ideas (43 mothers, 74%) and about how to understand their child’s behaviors (12 mothers, 21%). Mothers were interested in learning more about discipline techniques (6 mothers, 10%) and consistent parenting skills when working with their child’s father (3 mothers, 3%). Overall, most mother’s

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1 It is unknown how many mothers completed the interview after beginning group.
included an expectation for group to help her parenting (58 mothers, 90.6%). One mother responded to interview questions and said,

Um, I don’t know, I like to take any opportunity I can to learn how to be a better parent. If that’s what this is, then I’m all for it. I don’t know. Um, it seems like it might be like, um, different, different moms with different types of parenting styles that, you know, maybe they’re going to try to add and different techniques to make it more effective, you know? So, yeah. I don’t know. I guess just getting even different, you know, different outlooks on, you know, what it is or how it is.

**Child.** Forty-four mothers responded with expectations falling into the child-category and talked about wanting Mom Power to help their child learn more about coping (7 mothers, 16%) and separation (4 mothers, 9%), and how to bring out their child’s personality (5 mothers, 11%). Mothers were interested in the group providing a place for their children to play and interact with other children (17 mothers, 38.6%) in a fun and social environment (10 mothers, 23%). Overall, over half of the mother’s included an expectation for group to help her child (44 mothers, 68.8%). One mother responded to interview questions and said,

It’s wonderful. I like it because my son gets to react with other children around his age. That’s why I like it, he’s never really around other kids. I don’t know. I just know that he’ll learn to be nice with other children and not be mean. He’s just learning to be around other kids and you know how kids are when they first react to other children. They start like hitting them or try to touch them and I just don’t want him to do that.

**Support.** The motivational interview spirited questions at the end of the working model child interview were qualitatively reviewed in order to understand the perceived social support mothers have before Mom Power group. Sixty-three mothers provided responses about their expectations for group. Overall, 3 mothers cited no perceived support (4.8%), 32 cited some support for self and/or parenting (50.8%), 16 cited strong support for either self or parenting (25.4%), and 12 cited perceived support for both self and parenting (19%).
None. Examples of responses indicative of no support included, “I am a very unique, different person from most people. And, nobody understands me, nobody supports me in my decisions, um, I am, I feel like an outsider, and I’ve always been that way” and “I help myself.”

Some. Mothers who cited some support for self and/or parenting answered support questions indicating limited social support such as, “His godmothers, my cousin, and she’s very involved in his life. If I need diapers or anything I can call her” and

I mean I have a lot of supportive people in my life though. I definitely have people I’m really close with so. It’s not that I don’t think they won’t support me, I just you know, I don’t know. I guess, things will just be different between me and those people. Just cuz it’s, it’s just not me anymore. I’m just not, It’s not, I’m not just like, oh it’s X, you know it’s X and her baby.

Self or Parenting. Mothers who cited strong support for self or parenting answered support questions indicating strong social support in one area such as:

I have Al-Anon, which is a support group that I go to which is free, and the therapist, and some friends, my best friend’s moving back from Mexico, so that’s great yeah, yeah I really, like this mom’s group is a good thing I’m doing, I’m starting a different mom’s group on Thursday, La Leche League is another group that’s supportive.

Another mother stated, I have a lot of support. Um, my mom, my grandma, the father of course, his mom, which is you know X’s grandmother, uhh, friends, all my friends had babies way before me (laughs) so I’m like the last person and you know they’re telling me bits and pieces of what their child did and what-not so I have a lot of support.

Both. Mothers who cited strong support for self and parenting answered support questions indicating strong social support across both areas such as,

Like my husband and my parents. And his parents, not so much, but definitely my parents. And I’ve got a strong group of like girlfriends that I met through Lamaze, so we have children the same age and that really helps um. Because you know it seems that they really understand more than anybody else. Yeah, so both for myself and for myself as a parent, would be the same kind of core group of people, um, yeah. Because for myself and myself as a parent, I mean, definitely one and the same, you know, so it’s so intertwined that I don’t know that you could separate it, you know because I think I need the support because I’m a parent.
Another mother noted, We (my baby and I) have each other. I mean, we are our strongest supports because we’re the ones that are with each other most. Um, outside of that, my husband’s parents are, our largest family support, because they are the closest family, like, geologically to us. And, um, you know they do take X four or five days out of the week, in the morning for a couple hours and, X is really close with my husband’s mom. But my grandma is like the closest thing to a mom. I mean, she really stepped up to the plate, and she’s done a lot for me, I mean she has helped us move every time we’ve moved, and I mean, she’s had to help us with bills if we were a little bit short because, you know we missed work because X was sick or whatever, for whatever reason. She is my main support, she’s my main support for me. I have my best friend, we’ve been best friends since fourth grade, so a long time...Um, I also have my friend, and we haven’t been friends quite as long, but she understands what it’s like too because she’s lived a pretty similar life to what I have, with parent problems and just problems in general. So it’s really nice to be able to go and talk to her, and you know, she’s not single, she is with her father, or with her children’s father. Um, so it’s nice to get that kind of perspective because she can give me the relationship angle along with the parenting angle, so yeah. I have those two for major supports too.

Previous Experience and Perception of Previous Experience. The motivational interview spirited questions at the end of the working model child interview were qualitatively reviewed in order to measure mothers’ previous experience with parenting groups and their perception of the experience. Thirteen mothers provided responses about previous group experience. Of these 13, 11 mothers cited positive previous experience (84.6%), 2 cited neutral previous experience (15.4%), and 0 cited negative previous experience (0%). Mothers identified previous parenting classes and described them positively, “It was good, it was a learning experience, you know. It’s always positive, you know, just, but they don’t give you a handbook and let you know how to raise a child, so when you do those classes, you know when you’re a new parent, I think an- any kind of information helps” and more neutrally, “Yes I have (previous experience) at Stone. It was okay.”

Aim Two

The next step required examination of quantitative variables for statistical prediction of attendance. Bivariate correlations were conducted between all the variables (see Table 5). There
was a positive correlation between age and four other variables (MI vs no-MI group, \( r(97) = .41, p < .001 \), Expectations, \( r(62) = .30, p = .02 \), Experience, \( r(61) = .34, p < .001 \), and Education, \( r(79) = .25, p = .02 \)). Positive correlations were also found between income and two other variables (Perceive Social Support, \( r(59)= .37, p = .003 \) and Education, \( r(74) = .24, p = .04 \)).

A multiple regression analysis was conducted with age, race/ethnicity, income, education, marital status, negative affect, and motivation as measured by mothers’ expectations, perceived social support, and past intervention experience as the predictors to examine the association with attendance percentage. Perception of previous experience was excluded due to lack of participant responses (n=13). The predictors in the model explained 5.5% of the variance, \( R^2 = .06, F (9, 51) = .330, p < .961 \). None of the variables significantly predicted attendance percentage (see Table 6).

Two multiple regression analyses were conducted to examine whether differences exist between the MI and no-MI groups. Age, race/ethnicity, income, education, marital status, and negative affect were entered as predictors to examine the association with attendance percentage. For the no-MI group, only 13 cases were valid and analyses were not conducted. For the MI group, predictors in the model explained 5% of the variance, \( R^2 = .05, F (6, 55) = .480, p = .82 \) (see Table 7). None of the variables significantly predicted attendance percentage.
CHAPTER 4: DISCUSSION

This study aimed to understand both qualitative and quantitative aspects of the mothers attending a parent group intervention program, Mom Power, and whether certain factors could be used to predict and understand parenting group attendance percentage. In addition to assessing the influence of factors like sociodemographics and negative affect, this study also aimed to understand how answers to motivational interview spirited questions might differentiate mothers who continue to attend parenting group sessions versus those who do not. One of the unique factors of this sample was that mothers in the group had high levels of motivation and relatively strong attendance rates.

Aim One

**Expectations.** In the first aim, qualitative examination of the expectations parents spontaneously gave to open ended questions about what they expect from group revealed a range of reasons falling into categories related to themselves, their children, or their parenting. These responses parallel parent’s reasons seen in the literature for seeking parenting interventions such as to lessen the burden of parenting, to improve their children’s development, and to learn parenting techniques and skills (Gross et al., 2001; Kilpatrick et al., 1989). A high percentage of responses from the sixty-four mothers fell into not only the parenting category (90.6%) but also the self category (95.3%), showing that parents reported concerns about what the group has to offer for them beyond the typical parenting skills training. Reasons like having fun, making friends, and learning to cope reveal that mothers are looking for something that is healthy and helpful for them as women.

Additionally, most of the expectations mothers reported for Mom Power Group were positive, suggesting that mothers are expecting group to provide them with a warm, safe
environment for them and their children to interact. Correlational analyses revealed that older mothers reported significantly more expectations for group, which indicates that time and experience may influence what and how much older mothers anticipate from parenting group interventions.

**Social Support.** When asked to indicate the level of support mothers believed they had for themselves as parents and personally, most mothers responded with at least some degree of perceived social support. Social support often includes emotional, financial, housing, or child care assistance, and mothers cited a combination of these supports (Byrnes & Miller, 2012). While perceived social support was not correlated with attendance percentage, income and perceived social support were significantly correlated in this sample. These results suggest that parents who are struggling financially also find themselves lacking in social support, further exacerbating their risk factors. These findings are consistent with previous research that has shown that social support has more health-promoting benefits for individuals with lower income (Dean & Lin, 1977; Schöllgen, Huxhold, Schüz, & Tesch-Römer, 2011).

**Previous Experience and Perception.** A qualitative review of mothers’ previous experiences with parenting groups and their perception of the experiences was completed. Previous experience was significantly correlated with mothers’ age, which suggests older mothers may have had more time or opportunities to seek out parenting group interventions. While previous experience was low in the sample, parents who acknowledged attending other groups perceived their experience as positive. The positively perceived previous experience was not significantly correlated with attendance percentage.

Mothers responded positively across the motivational interview spirited questions, but it is unknown how motivated or confident the mothers were to complete Mom Power Group before
sessions began. Tapping these motivations using motivational interview techniques like 10 point rating scales, eliciting change talk, and confronting barriers can provide group leaders with a baseline indication of mothers’ stage of change and level of motivation. Using this information combined with the mothers’ expectations, parenting interventions can aim to meet the needs of each of the mothers directly.

**Aim Two**

The second aim was to analyze a quantitative analytical model of how variables combine to predict attendance. This multivariate model examined age, race/ethnicity, income, education, marital status, negative affect, motivation, perceived social support, and previous intervention experience and analyses revealed that attendance could not be predicted by the combination of these factors or by any of them individually.

Overall, 61.6% of mothers missed only one session or less while 38.4% missed between two to ten sessions ($M = 2.54, SD = 3.17$). These results are consistent with research findings suggesting that parenting programs have moderate attendance rates (Dumas et al., 2007). Given the mothers’ high rates of positive expectations and moderate attendance rates, this particular sample proved to be relatively motivated to continue attending parenting group sessions. A variety of factors such as the voluntary nature of the groups, cash incentives, weekly lunch, and provided transportation and childcare may contribute to Mom Power Group’s moderately high attendance rates. Additionally, the intervention’s goal to provide a combination of nurturance and enjoyment may be fulfilling the needs and expectations that the mothers’ have. Understanding whether mothers’ expectations were met throughout group and at the end of group can provide insight into how well the parenting group is matched to their needs and whether any concerns or barriers need to be addressed.
Limitations

Though the multivariate model was not significant, it is important to recognize that the study also had several limitations that may have affected the results. Due to the nature of the study as a convenience sample, it is necessary to proceed with caution when interpreting the results. Constructs such as expectations and perceived social support were assessed using methods and measures that have limited research on validity and reliability. The sample also includes missing data, which may affect the results.

Examination of the sample size of mothers that received the motivational interview spirited questions without missing data revealed a lower number than preferred (n=60). A larger sample size may provide additional information about mothers that attended group and help increase power for future analyses.

Another limitation was the lack of randomization. The lack of randomization resulted in no MI questions for the first set of mothers enrolled in the parenting groups. Due to the change in Mom Power Group from eight to nine to ten sessions, the later groups may have received a slight difference in material from earlier groups. Additionally, the experience and comfort levels of the interventionists may have increased. This limits generalizability and confounds the two conditions given that mothers who did receive MI questions were also in later groups with more sessions.

Additionally, because the data used for this study were pre-collected, there are a number of potential measures that were not included that may have provided more information on maternal motivation and perceived social support. The motivational interview spirited questions tapped some fundamental aspects of MI, but validated questions may provide researchers with an improved way to tap motivation and elicit change talk. Previous interventions have been found
to be successful, particularly with low to moderately motivated parents. Chaffin and colleagues found that low to moderately motivated parents who received motivational interviewing pretreatment combined with Parent-Child Interaction Therapy (PCIT) had significantly higher attendance rates (Chaffin et al., 2009). Evidence from one study suggests that even brief motivational interviewing protocols a few questions long may lead parents to attend at least one more session than parents who did not receive the MI condition (Sterrett et al., 2010).

The questions aimed to tap social support provided good information on mothers’ perceived levels of support, but an additional measure like the Multidimensional Scale of Perceived Social Support can provide valuable information on the types of support mothers may have or lack (Zimet, Dahlem, Zimet, & Farley, 1988). It is noteworthy, however, that the researchers of Mom Power Group have already introduced this measure to new mothers enrolling in the study. Additionally, a lack of quantification of social support in the coding system means that the qualitative results must be interpreted with caution.

**Implications and Future Directions**

Results from this study indicate that when asked, most mothers attending group had positive expectations and relatively consistent attendance rates. Implications suggest that tapping these positive expectations at the start of group may provide mothers with some incentive and motivation to continue attending the intervention. Given the high rates of attendance in the condition that did not report on expectations before group and other limitations of this study, implications are guarded. Nevertheless, evidence from one study suggests that even brief motivational interviewing protocols a few questions long may lead parents to attend at least one more session than parents who did not receive the MI condition (Sterrett et al., 2010).
Interventionists should consider the use of MI techniques to gauge motivation, elicit change talk, and work with parents to assess steps to success in order to increase parent’s motivations to continue attending the intervention. Parents who display readiness to change parenting behaviors, positive attitudes toward the program, and recognition of problems have been found to be more motivated and may attend more parenting group sessions as a result (Chaffin et al., 2009). Incorporating a brief MI intervention before the start of group, especially for low to moderately motivated parents, can provide interventionists with a baseline level of expectations, motivations, and perceived social support. Additionally, incorporating a MI-check-up with group members half way through the intervention may help parents reassess their expectations and potentially increase levels of motivation and in turn attendance.
Figure 1. An expanded framework for treatment evaluation (Finney & Moos, 1989)

LIFE CONTEXT FACTORS PRIOR TO TREATMENT (e.g., Family and Work Settings, Life Stressors)

INTERVENTION FACTORS (Program Components, Program Quality)

CLIENT PRETREATMENT FACTORS (Sociodemographic, Personality, and Intake Functioning Variables)

LIFE CONTEXT FACTORS FOLLOWING TREATMENT (e.g., Family and Work Settings, Life Stressors)

CLIENT POSTTREATMENT FACTORS (Status on Outcome Criteria)
Figure 2. Proposed model demonstrating the relationship between life factors, the intervention, and attendance outcome.
Figure 3. Mom Power Group locations: a geographic distribution

<table>
<thead>
<tr>
<th>Map Mark</th>
<th>Location</th>
<th>City</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Guidance Center</td>
<td>Southgate</td>
<td>13</td>
</tr>
<tr>
<td>B &amp; C</td>
<td>Ypsilanti Health Center</td>
<td>Ypsilanti</td>
<td>12</td>
</tr>
<tr>
<td>D</td>
<td>Taubmann Church</td>
<td>Ypsilanti</td>
<td>14</td>
</tr>
<tr>
<td>E</td>
<td>Corner Health Clinic</td>
<td>Ypsilanti</td>
<td>60</td>
</tr>
</tbody>
</table>
Mothers approached for Mom Power Group

Eligible
Did not participate
n = Unknown

Eligible
Participated
n = 114

Not eligible
Did not participate
n = Unknown

MI
PTSD + Depression + MI
n = 64

No MI
PTSD + Depression
n = 55

Missing Variables
n = 15

Figure 4. Intervention flow chart
Figure 5. *Mom Power Group* tree used as a basis for group meetings
Table 1.
Demographics for motivational and non-motivational interview groups

<table>
<thead>
<tr>
<th></th>
<th>MI (n=64)</th>
<th>N</th>
<th>No MI (n=35)</th>
<th>N</th>
<th>$\chi^2$</th>
<th>T-Test</th>
<th>Skew</th>
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<tr>
<td><strong>Average Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother (Years)</td>
<td>28.8 (5.6)</td>
<td>64</td>
<td>21.5 (4.1)</td>
<td>35</td>
<td>-3.5**</td>
<td>5.84</td>
<td></td>
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<tr>
<td>Child (Months)</td>
<td>20.5 (16.5)</td>
<td>61</td>
<td>23.2 (18.5)</td>
<td>34</td>
<td>.73</td>
<td>3.84</td>
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<tr>
<td><strong>Winsorized Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother (Years)</td>
<td>23.6 (2.9)</td>
<td>64</td>
<td>21.1 (2.0)</td>
<td>35</td>
<td>-4.9**</td>
<td>2.38</td>
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<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>African American</td>
<td>48%</td>
<td>34%</td>
<td></td>
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<tr>
<td>Caucasian</td>
<td>44%</td>
<td>59%</td>
<td></td>
<td></td>
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<tr>
<td>Bi-racial</td>
<td>6%</td>
<td>7%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>2%</td>
<td>0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Income: &lt; 20,000</strong></td>
<td>73%</td>
<td>62</td>
<td>57%</td>
<td>25</td>
<td>6.34</td>
<td>8.84</td>
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</tr>
<tr>
<td>Winsorized Income</td>
<td>76%</td>
<td>62</td>
<td>80%</td>
<td>25</td>
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<td>Education: &lt; 12</td>
<td>25%</td>
<td>64</td>
<td>11%</td>
<td>17</td>
<td>13.06*</td>
<td>2.84</td>
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<tr>
<td>Married</td>
<td>31%</td>
<td>64</td>
<td>37%</td>
<td>30</td>
<td>1.31</td>
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<tr>
<td>Negative Affect</td>
<td>64.1%</td>
<td>64</td>
<td>62.9%</td>
<td>35</td>
<td>.01</td>
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* * p < .05, ** p < .001
Table 2. *Mothers’ options for race/ethnicity and marital status*

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<th>Mothers’ race or ethnicity:</th>
<th>What is your current marital status?</th>
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<td>__ (1) Caucasian</td>
<td>__ (a) Married</td>
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<tr>
<td>__ (2) African-American</td>
<td>__ (b) Living with birth father</td>
</tr>
<tr>
<td>__ (3) Latino</td>
<td>__ (c) Living with partner (not biological father)</td>
</tr>
<tr>
<td>__ (4) Native American</td>
<td>__ (d) Divorced</td>
</tr>
<tr>
<td>__ (5) Asian-Pacific</td>
<td>__ (e) Separated</td>
</tr>
<tr>
<td>__ (6) Bi-racial:</td>
<td>__ (f) Widowed</td>
</tr>
<tr>
<td>__ (7) Other:</td>
<td>__ (g) Never Married</td>
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<tr>
<td></td>
<td>__ (h) Other</td>
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Table 3.  
*Reliability Statistics*

<table>
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<tr>
<th>Expectation Type</th>
<th>Coefficient Alpha</th>
<th>Agreement</th>
<th>% Agreement Author/Coder 1</th>
<th>% Agreement Author/Coder 2</th>
<th>% Agreement Coder 1/Coder 2</th>
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</thead>
<tbody>
<tr>
<td>Expectations</td>
<td>0.874</td>
<td>Good</td>
<td>69%</td>
<td>75%</td>
<td>67%</td>
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<tr>
<td>Support</td>
<td>0.942</td>
<td>Excellent</td>
<td>79%</td>
<td>90%</td>
<td>85%</td>
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<tr>
<td>Experience</td>
<td>0.939</td>
<td>Excellent</td>
<td>83%</td>
<td>88%</td>
<td>80%</td>
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<tr>
<td>Perception</td>
<td>1</td>
<td>Excellent</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Expectation Type</th>
<th>Fleiss Kappa</th>
<th>Agreement</th>
<th>% Agreement (All 3 Coders)</th>
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<tr>
<td>Self</td>
<td>0.422</td>
<td>Moderate</td>
<td>92.70%</td>
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<td>Child</td>
<td>0.733</td>
<td>Substantial</td>
<td>87.50%</td>
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<tr>
<td>Parent</td>
<td>0.565</td>
<td>Moderate</td>
<td>88.50%</td>
</tr>
<tr>
<td>Other</td>
<td>-0.011</td>
<td>Poor</td>
<td>97.90%</td>
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Table 4.

*Descriptive Statistics*

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<tr>
<th>Measure</th>
<th>N</th>
<th>Min.</th>
<th>Max.</th>
<th>Mean</th>
<th>SD</th>
<th>Skewness</th>
<th>Std. Error</th>
<th>Kurtosis</th>
<th>Std. Error</th>
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<td>0.00</td>
<td>100.00</td>
<td>73.7093</td>
<td>32.71972</td>
<td>-1.154</td>
<td>.243</td>
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<td>.481</td>
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<td>Negative Affect</td>
<td>99</td>
<td>0.00</td>
<td>1.00</td>
<td>.6364</td>
<td>.48349</td>
<td>-.576</td>
<td>.243</td>
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<td>.481</td>
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<td>3.00</td>
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<td>.299</td>
<td>.068</td>
<td>.590</td>
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<td>Support</td>
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<td>0.00</td>
<td>3.00</td>
<td>1.5873</td>
<td>.85449</td>
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<td>1.00</td>
<td>.2063</td>
<td>.40793</td>
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<td>.595</td>
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<td>2.00</td>
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<td>-2.179</td>
<td>.616</td>
<td>3.223</td>
<td>1.191</td>
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<tr>
<td>Age (Years)</td>
<td>99</td>
<td>20</td>
<td>27</td>
<td>22.70</td>
<td>2.844</td>
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<td>.243</td>
<td>-1.387</td>
<td>.481</td>
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<tr>
<td>Measure</td>
<td></td>
<td>Attendance %</td>
<td>Mi vs NO</td>
<td>Negative Affect</td>
<td>Expectations</td>
<td>Support</td>
<td>Experience</td>
<td>Perception</td>
<td>Age (Years)</td>
</tr>
<tr>
<td>----------------------</td>
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Note. *p<.01, **p<.001, a. cannot be computed because at least one of the variables is constant.
Table 6.
*Hierarchical regression controlling for age and education: both the MI and no MI groups*

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<th>β</th>
<th>t</th>
<th>F</th>
<th>R²</th>
<th>ΔR²</th>
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Note: *p < .05, **p < .001
N = 60
Table 7.
Hierarchical regression controlling for age and education: MI group

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<tr>
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<td>8.93</td>
<td>.21</td>
<td>1.55</td>
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</table>

Note: *p < .05, **p < .001
N = 61
Mom Power!

A 10-week program for you and your kids

We Need You!

A Program for Moms

You Will Get:

**What:** A 10-week parenting program

**Who:** For moms and their kids 0–6 year old

**Where:** At home or in Ypsilanti, MI

**When:** Beginning October 2011

(pre- and post-program questionnaires and home visits will be asked as part of a project through the University of Michigan to evaluate the program)

- Cash incentives for attendance, home visits and questionnaires
- Toys for the children each week
- Potential opportunity to be invited to parenting group at local site facilitated by social workers

**To sign-up call Emily @: 734-998-8145**

IRBHUM18944 PI Dr. Maria Muzik
Appendix B
Motivational Interviewing Questions (Pre)

Add to end of WMCI:

1.) We just spent some time talking about your thoughts and feelings about your child – I appreciate your willingness to share your thoughts. Now I’d like to shift gears a bit and talk with you about the Mom Power program if that’s okay with you.
   - Possible probes:
     - From what you know about the Mom Power Program, what do you make of it?
     - What do you expect the program to be like?
     - What you hope the program to be like?
     - How does the program sound to you?
   - Connect MP program experience with what participant shared about relationship with child

   Probe:

   You told me a lot of your thoughts about Joe, his personality, and your relationship with Joe. What would you like to learn/talk about in Mom Power when you think about your relationship with Joe?

2.) Switching gears a little bit: I’d like to learn a bit more about your current supports being a parent of Joe.

   - What kind of support do you have?
     - Being a parent? (elicit parenting support)
       - Trying to get at: How does the support or lack of support interfere or help with what’s important to you and your relationship with your child? (do not ask this)
     - For yourself? (elicit self-care needs)
     - What do you do to relax when things are hard or stressful? What other ways do you cope with stress? (elicit coping strategies)
     - Elicit information about previous group treatment/intervention experiences:
       - Have you ever done any other parent/child programs?
       - What was that like?
Elicit hopes and fears about the program:

- How do you think that the Mom Power program fits with your own needs and your child’s needs?
- What do you think the Mom Power program will be like?
- Probes: What are your hopes?
  - What are your fears?

Unstructured ending/goal:

- Elicit permission to give a summary/reiteration of pros and cons of the program in empathic style. Communicate to participate that she’s been heard.

- Highlight discrepancies between behavior, problems, and concerns regarding MP and goals and values (e.g., it seems that you don’t like or are having a hard time with your child’s behavior and would like to have more tools to handle different situations but you’re not sure that you’d feel comfortable sharing your stories with a group of strangers).

- Wrap-up: Prepare the participant for possible reactions to the program or more specifically the group (e.g., feeling initially unsure whether they like or can trust the group members and facilitators, thus having thought of not returning following week). Normalize these experiences
  - Normalize mixed feelings, setbacks, and second thoughts about group
  - Affirm participation
  - Instill hope
  - Express optimism
Appendix C
Coding Motivational Interviewing Questions (Pre)

Coding Expectations
1. Read through the set of answers that mothers provided in response to expectations of Mom Power Group. (This includes question probes like “What do you make of it?”, “What do you expect?”, “What do you hope?”, “How does the program sound?”, or “What would you like to learn?”) These questions are at the start and the end of the MI interview.
   a. Responses can fall into as many categories as is appropriate from the ones below:
      i. Help for self
      ii. Help for child
      iii. Help for parenting
      iv. Other (specify)

2. Scale
   a. Record the category type(s) under the appropriate column on the coding sheet and write a summary of the expectation under the appropriate category
   b. Under Category Total, tally the total amount of categories included in a mother's response set

Coding Perceived Support
1. Read through mothers’ responses to the various support type questions. (This includes support for being a parent, for self, and for coping)
   a. Provide an overall rating of perceived social support across these domains and write in a summary of the support provided by the mother

2. Scale
   a. 0 = No sense of social support for self or parenting
   b. 1 = Some sense of support self and/or parenting
   c. 2 = Strong sense of support in one area, but not the other
   d. 3 = Strong sense of support for both self and parenting

Coding Previous Experience
1. Read the response to the question, “Have you ever done any other parent/child programs?”
   a. First, code either 0 = No for no acknowledgment of previous intervention experience or 1 = Yes for acknowledgment of previous intervention experience
   b. Second, code whether the previous experience was positive, negative, or neutral. A neutral experience would be one where the mother does not have any complaints but also failed to see any benefits or positive outcomes.

2. Scale
   a. Experience
      i. 0 = No previous experience
      ii. 1 = Previous experience
   b. Perception of Experience
      i. 0 = Negative
      ii. 1 = Neutral
      iii. 2 = Positive
Appendix D
Coding Sheet For Expectations, Perceived Support, and Previous Experience

Expectation Type:

Category Total: _____

1. Help for Self
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

2. Help for Child
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

3. Help for Parenting
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

4. Other (Specify)
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

Perceived Support

Rating: _____

________________________________________________________
________________________________________________________
________________________________________________________

Previous Experience

Experience: _____
Perception of Experience: _____

1. Experience Type
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________

2. Perception of Experience
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
References


ABSTRACT

LIFE FACTORS AND ATTENDANCE RATES FOR WOMEN ENROLLED IN A PARENTING PROGRAM

by

LILIA ELIZABETH MUCKA

December 2013

Advisor: Dr. Douglas Barnett
Major: Psychology (Clinical)
Degree: Master of Arts

Parenting interventions consistently have been shown to improve positive parenting effectiveness, child adjustment, and family functioning (Gardner et al., 2010). However, attendance rates reported in the literature tend to be low and dropout rates tend to be high, which likely diminishes the positive impact of such programs (Dumas et al., 2007). Parenting group success begins with attendance, therefore, the study aimed to understand which life factors were associated with attendance. Specifically, the study both qualitatively and quantitatively evaluated parents’ responses to a brief intervention using MI techniques by using a coding system developed by the author to understand maternal expectations of group, perceived social support, and previous intervention experience. It was expected that mothers’ age, race/ethnicity, income, education, marital status, negative affect, motivation, perceived social support, and previous intervention experience would combine to predict their intervention attendance.

Data for this thesis were collected by the Mom Power Group developers (Muzik et al., 2011) and provided to the author as an archival data set. In total, 114 mothers and their children were recruited and 99 participated (or completed measures of depression and PTSD). Of the 99, 35 mothers (35%) completed measures with no pre-intervention Motivational Interviewing (MI)
questions, and 64 (65%) of the participants completed pre-intervention MI questions and measures. The pre-interview questions were coded using a system designed by the author to classify mothers’ expectations for group participation, perception of social support, and experience of previous interventions. Expectations were coded into four categories: help for self, child, parenting, or other. Perceived social support was rated on a four-point scale with zero indicating no support and four indicating strong support for both self and parenting, and coders also briefly summarized the mothers’ previous experience and perception of previous experience. Hierarchical linear regressions revealed that race/ethnicity, income, education, marital status, negative affect, motivation, and perceived social support were not significant predictors of attendance, either individually or together after controlling for mothers age and education. Qualitative analyses revealed high levels of positive expectations amongst mothers and that the program offered incentives and removed barriers for maternal participation. This study demonstrated that positive expectations and attendance rates were high for Mom Power Group, and future research is needed to understand the influence of motivational interviewing techniques and incentives on attendance when expectations are low.
AUTOBIOGRAPHICAL STATEMENT

Lilia Mucka was born and raised in Metro Detroit, Michigan, where she began attending Wayne State University in the fall of 2007. While she entered college as a pre-med major, it took just under a year to realize that Psychology was her passion. After visiting the undergraduate psychology advisor, she was referred to apply to work with Dr. Douglas Barnett. It was here that she began to gain research experience. Her initial project led her to evaluate recommendations given to parents after assessment and the barriers that stood in the way. After working with this data, she had the chance to help run participants for a health change study using a short motivational interview intervention. Additionally, she was given the opportunity to learn the principles of Multisystemic Treatment under the guidance of Dr. Sylvie Naar-King and coded nearly 40 asthma therapy sessions for reliability. She graduated Summa Cum Laude from Wayne State in December of 2010, with a Bachelor of Science in Honors Psychology.

Lilia enrolled at Wayne State University in August 2011, as a clinical psychology graduate student with an emphasis on child development. She works in the Children and Families Lab Group under the supervision of her mentor, Dr. Douglas Barnett, and Dr. Jeffrey Kuentzel. Additionally, she works in the Michigan Families Lab under the supervision of Dr. Valerie Simon. In each of these labs, she has had the opportunity to expand her research with active data collection. She has gained added experience as a student intern at the Third Circuit Court’s Clinic for Child Study in Detroit, under the supervision of Dr. Tangenilla Fry-Riggins. At the Clinic for Child Study, Lilia is responsible for seeing children and adolescents for person-centered therapy and helping to co-facilitate a therapy group for young sex offenders. She plans to graduate with her Master of Arts in Clinical Psychology from Wayne State University in December of 2013.