

THE RELATIONSHIP OF MATERNAL PERCEPTION
VARIABLES AND PARENTAL PERCEPTIONS
OF A HOME VISITATION
SERVICE PROVIDER

By

ANGELA MICHELLE STAUDT

Bachelor of Science

Oklahoma State University

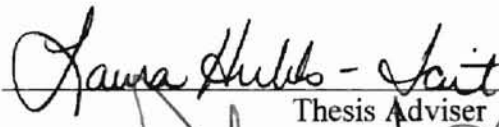
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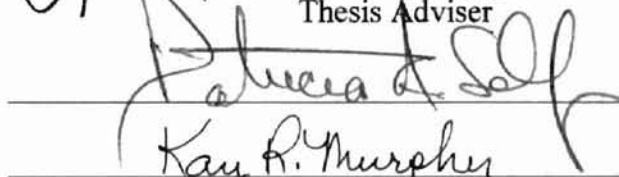
May, 1997

Submitted to the Faculty of the
Graduate College of the
Oklahoma State University
in partial fulfillment of
the requirements for
the Degree of
MASTER OF SCIENCE
May, 1999

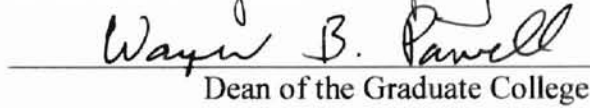
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Thesis Approved:


Thesis Adviser






Dean of the Graduate College

ACKNOWLEDGEMENTS

I wish to express my sincere appreciation to my major advisor, Dr. Laura Hubbs-Tait for her overwhelming commitment to the success of her students. Her guidance and unwavering support have been instrumental in influencing my educational endeavors. Special consideration also goes to the members of my advisory committee, Dr. Kay Murphy and Dr. Patricia Self, for their careful consideration, challenging demeanor, and lasting friendship, I will forever be grateful. I would also like to thank Drs. Anne and Rex Culp for providing me with this wonderful research opportunity, and John and Sue Taylor for their generous financial support. Thanks is also extended to the Oklahoma State Department of Health for their support to this research project.

Ultimately, I would like to express my undying appreciation and devotion to my husband, Joseph Staudt, for his constant support and adventurous heart. His technical and spiritual encouragement has formed the foundation of this research. Special appreciation also goes to my parents, William and Jennie Woodard, for their unending encouragement and financial support, as well as for instilling in me the value of higher education. I would also like to express thanks to all other family members, too numerous to mention by name but who continually supported my educational endeavors and personal goals-your support is invaluable.

Above all, I would like to express overwhelming gratitude to the Lord God for his wondrous plan for my life. I can do all things through You, who strengthen me.

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CHAPTER I

INTRODUCTION

In 1994, more than 3.1 million cases of suspected child abuse were reported by child protective agencies and more than three children a day died from child abuse and neglect (Wiese & Daro, 1995). In the state of Oklahoma, a child is a victim of confirmed abuse or neglect nearly every forty-five minutes (Oklahoma Kids Count, 1998). The causes of child maltreatment are complex and multi-faceted. Research often attempts to define these demographics and precursors as interrelated characteristics or determinants of child maltreatment (Belsky, 1993). The foundation of both abuse and neglect may well include the parents' understanding of children and their expectations of child development. This notion was upheld by Leventhal (1996), when he argued that an underlying cause of child maltreatment is negative parental attitudes and feelings reflected in how the parent both views and cares for the child.

Though this explanation implies a simplistic answer, it is to be noted that no simplicity exists in the study of child maltreatment. Rather, researchers must work to identify interventions that attempt to prevent child abuse and neglect with the greatest degree of success and longevity. In accepting this responsibility, all effort must be made to determine those programs that help parents to view their children in a more positive way, in an attempt to "keep the parent's hand from striking the child" (Leventhal, 1996, p. 647). It is only through such collaborative interventions that child maltreatment can be targeted and eventually prevented.

Prevention programs that work successfully to reduce child abuse and neglect

have been defined as intensive, comprehensive, long-term, flexible and culturally appropriate (Daro & McCurdy, 1994). One such intervention is the home visitation program. Home visiting has provided a promising strategy to assist families with a wide variety of problems. Evidence has been found that suggests that extended home visitation has had the greatest effect on the promotion of parenting skills, knowledge of child development, and the long-term prevention of physical child abuse and neglect when compared to the outcomes of other types of parent education programs (Benasich, Brooks-Gunn, & Clewell, 1992; MacMillan, MacMillan, Offard, & Griffith, 1994; Zahr, 1994; Wallach & Lister, 1995; Roberts, 1997). Program evaluations indicate that early childhood interventions implemented through home visitation often improve parenting skills, child behavior, and parent-child interaction (Morgan, Nu'Man-Sheppard, & Allin, 1990). A study done by Marcenko and Spence (1994) also found that parents who had participated in a home visitation program for over ten months reported significant increases in social support, greater access to community services, and decreased stress. As a result of the popularity and effectiveness of these interventions, the U. S. Advisory Board on Child Abuse and Neglect identified home visiting as the most promising method of preventing child maltreatment (Olds & Kitzman, 1993).

Statement of the Problem and Purpose

The measurement of parent satisfaction has been identified as an essential component of home visitation program evaluation (Bailey & Simeonsson, 1988; Strain, 1988). However, to date no research has examined one essential component of parental satisfaction: perceptions of the home visitor. The purpose of the present study is to determine the variables that are related to parents' perceptions of their home visitor and

to the home-visitor's self-assessment of their service. This study is aimed at providing some insight into defining the construct of parental perception as it relates to home visitation interventions. The present study will determine the relationship between maternal depression, perceived social support, and parenting attitudes and the parents' perceptions of their home-visitor.

While research on the effectiveness of home visiting is only beginning, a need exists for a greater understanding of the internal workings of programs including an understanding of the factors that relate to parental perceptions of the home visitor-parent relationship (MacMillan et al., 1993; Olds & Kitzman, 1993). The relationship between the home visitor and the parent can be seen as the vital link that determines the effectiveness of parent education strategies in preventing child maltreatment. The notion that parent educators should develop a collaborative relationship with parents is not new (Olds, 1989; Schaefer, 1991). Leventhal (1996) has compiled a list of nine "ingredients" that constitute a successful home visitation program. One component states that the central goal of the home visitor should be to develop a therapeutic relationship with the parents, within which the "parents will be able to feel better about themselves and in turn feel better about their children" (Leventhal, 1996, p. 649).

The recognition of the importance of the home visitor's relationship with parents can be seen as a call to further research and evaluation of this dyadic group and the variables to which it is linked. While many program intervention teams have sought to enhance the effectiveness of the provider/client relationship (Kitzman, Yoos, Cole, Korfmacher, & Hanks, 1997), this study argues that program effectiveness lies in a greater understanding of the parents' perceptions of their home-visitor. The present study

is unique in its attempt to look at maternal variables that may be related to parental perceptions of their service provider. This study is being conducted with the intent of defining a construct, parent perceptions of the home-visitor, that can be used to further evaluate and promote the effectiveness of home-visitation interventions.

Theoretical Framework

Human ecological, self-efficacy, and attachment theories have been used to define the manner in which home visitors interact with parents by providing support on interrelated health and developmental problems (Olds, Kitzman, Cole, & Robinson, 1997). Ecological theory has been used to focus on the social and contextual factors that influence the family's ability to protect and nurture its members, while self-efficacy has brought to light the psychological factors that influence an individual's motivation for change (Kitzman, Yoos et al., 1997). Although these contributions are significant, perhaps the most relevant theoretical application to this study lies within the conceptual framework provided by attachment theory. Attachment theory focuses on the development of a strong therapeutic relationship with the parents of the child in order to promote the sensitive and responsive care of their infant (Kitzman, Yoos et al., 1997).

Urie Bronfenbrenner's views on human ecology are concerned with the development of the human and the way in which external factors affect this phenomenon. This theoretical approach makes note of the resilience, versatility and promise of human beings as evidenced by their capacity to adapt to and to create ecologies in which to live and grow (Bronfenbrenner, 1979). Bronfenbrenner (1979) also states that what matters for behavior and development is the environment, as it is perceived rather than as it may actually exist in "objective" reality. This notion further suggests the importance of

understanding the variables that are related to parents' perceptions of their home-visitor. It can be argued that by determining the concepts that are linked to parental perceptions, one can then begin to target interventions that work to improve parental perceptions and ultimately improve parent education interventions.

According to Albert Bandura's self-efficacy theory (1977), individual differences in motivation and behavior are a function of individuals' beliefs about the connection between their efforts and their desired results. Cognitive processes are seen to play a central role in the acquisition and repetition of new behavior patterns. Self-efficacy theory has been used to form the foundation of a program of prenatal and early childhood home visitation conducted by David Olds and his colleagues (O'Brien & Baca, in press). The program was designed to promote client self-efficacy through the use of a solution-focused approach to dealing with family concerns and the promotion of positive health behaviors. The program was based upon Penders's Health Promotion Model that involves: (1) assisting a client to recognize that a behavior will lead to a desired health outcome; (2) teaching the client how to execute the behavior; (3) getting the client to believe that she can successfully carry out the behavior; and (4) motivating the individual to value the outcomes in order to maintain the behavior (O'Brien & Baca, in press). A premise of self-efficacy theory suggests that individual differences in motivation and behavior are a function of an individual's beliefs about the connection between their efforts and desired results. Therefore, it is assumed in using this theoretical model that an individual's sense of self-efficacy will be strengthened through repetitive experiences of achieving one's goals.

Bowlby's theory of attachment assumes the position that humans have evolved a

set of behaviors that promote interaction between caregivers and their infants and that these behaviors tend to keep specific caregivers in proximity to defenseless youngsters. Humans are thus biologically predisposed to seek proximity to caregivers under times of illness, fatigue or stress in order to survive (Bowlby, 1969). This theory has influenced the design of home visitation models in several ways (Olds, Kitzman et al, 1997). Attachment theory suggests that home visitors develop an empathetic relationship with the mother and other family members in order to form a therapeutic alliance. Secondly, this theory emphasizes that home visitation programs help mothers and other caregivers to review their own childrearing histories in order to help them develop more accurate conceptions about the infant's motivations and methods of communicating. Attachment theory also promotes the teaching of sensitive, responsive, and engaged caregiving in the early years of the child's life (Olds, Kitzman et al, 1997).

Research Questions and Relevance

Literature in the area of home visitation and parent education suggests the importance of the relationship between the home visitor and the parent. A consistent and emotionally sound relationship is likely to nurture a more effective educational environment and, thus contribute to more positive parenting attitudes. "The extent to which such interventions foster supportive social and emotional bonds between at-risk parents and others will likely increase the long-term effectiveness of any such efforts to promote more nurturant parenting" (Belsky, 1993, p. 428). The ultimate goal of this research is vested in finding ways to enhance the effectiveness of parent education and home-visitations programs. As a result, the present study will attempt to answer several questions surrounding the definition and composition of the construct of parental

perceptions.

Several questions will be considered. Primarily, the present study will determine: What, if any, maternal variables (including maternal depression, perceived social support, parenting attitudes, and parental identity/intimacy) load on the same factor or factors as parents' perceptions of their home-visitor? Secondly, this research will attempt to answer: Whether maternal parenting attitudes are related to parent's perceptions of their home-visitor or to their home-visitor's evaluations of their own service? Research questions are being used in this exploratory study because of the absence of research that focuses on parents' perceptions in the home visitation literature. The field is too young at the present time to make appropriate and justifiable hypotheses regarding parent perceptions.

Conceptualization

The use of home visitation in the present study has been modeled after studies carried out by David Olds and his colleagues (Olds, et al., 1997; Olds & Kitzman, 1993). These studies employ a scientific rigor that is unparalleled in the field of home visitation. While Olds' studies utilize public health nurses as home visitors, the present study differs in that the service provider is a parent educator rather than a registered nurse.

Parental perception, as defined in the present study, is considered to be a measure of parental satisfaction. This distinction has been made because the measure of parent satisfaction in the early intervention literature closely resembles the undefined construct that this study is targeting. The measurement of parent satisfaction has been identified as an essential component of home visitation program evaluation (McNaughton, 1994) because parents are considered to have the major responsibility and control of a child's

development. However, parents' perceptions of the home visitor have not previously been investigated as one component of parent satisfaction. Parental perceptions include the parents' view of the helpfulness, patience, and friendliness of their home-visitor. This construct also includes the parents' perception of the knowledge and devotion that their home-visitor exhibits toward the parent education component of the program.

Maternal variables that are being considered in the present study include: maternal depression, perceived social support, parenting attitudes, and parent identity/intimacy. Maternal depression is determined through the use of an instrument entitled the Center for Epidemiologic Studies-Depression (CES-D; Radloff, 1977). This measure is a 20-item self-report depression scale designed for research in the general population. Perceived social support is being measured through the use of the Maternal Social Support Index (MSSI; Pascoe, 1981). This 21-item questionnaire is designed to assess the qualitative and quantitative aspects of the mother's perceived social support systems. The variable of parenting attitudes will be assessed through the use of Stephen Bavolek's (1984) Adult-Adolescent Parenting Inventory (AAPI). This instrument consists of four areas of parenting including inappropriate expectations, lack of empathy, parent/child role reversal, and belief in physical punishment. The AAPI is designed to measure parenting attitudes and child rearing practices in both adolescent and adult parents. The Erikson Psychosocial Stage Inventory (EPSI; Rosenthal, Gurney & Moore, 1981) will be used to measure the mothers' psychosocial development in the context of developing relationships. Twenty-four items from two subscales of this inventory, identity and intimacy, will be used to measure this type of emotional development.

CHAPTER II *Effective use of home visitation*

REVIEW OF THE LITERATURE

In an attempt to validate the purpose of the present study, the literature review in this chapter will be focused in several different areas. The review will begin with a brief overview of the past and current state of home visitation service provision in the United States. The remainder of the chapter will then review the literature in each of the following areas: (1) the work of David Olds and his colleagues in the implementation of randomized trials of nurse-provided home visitation; (2) the implementation and evaluation of the Healthy Families America program of home visitation; (3) various home visitation program models that are focused on a variety of maternal and child outcomes; and (4) the conceptualization of the measurement of parent satisfaction and parent perception in the field of early intervention.

Overview of History of Home Visitation

Home visitation for the purposes of preventing child maltreatment and promoting the health and well-being of pregnant women and parents of young children has been one of the primary strategies employed by the U.S. Public Health Service since the early 1900's (Chavingy & Korske, 1983). After nearly seventy years of home visitation conducted primarily by public health nurses, the government's funding for these programs was substantially cut in the early 1970's (Chavingy & Korske, 1983). The rationale behind the decrease in financial support was grounded in the limited research

and lack of empirical evidence that supported the effectiveness of home visitation services.

Many studies that had been carried out until the early 1980's utilized a scientific rigor that was less than optimal for supporting the utilization of home visitation services. Those programs that did utilize a good research design often evaluated programs that were not well designed either clinically or theoretically to address some of the most important characteristics associated with the outcomes of at-risk families (Olds & Korfmacher, in press). By the mid-1970's, those home visitation programs that continued to exist were designed to provide services primarily to women and children with identifiable health problems (Chavingy & Korske, 1983).

In an attempt to statistically validate the use of nurse-provided home visitation services, David Olds and his colleagues initiated a series of randomized trials beginning in Elmira, New York in 1977. With original funding from the Research Division of the Maternal and Child Health Bureau, the Elmira trial began to test a new method for visiting pregnant women and parents of young children in their homes (Olds & Korfmacher, in press). Olds' model consisted of home visitation by nurses during pregnancy and the first two years of the child's life. The program was focused on low-income women with no previous live births. Nurses were trained to follow well outlined program protocols that were designed to improve women's health-related behaviors, parent's care of their children, and parent's own personal development. In the mid-1980's, empirical evidence emerged from this randomized trial supporting the utilization of the program for mothers and young children (Olds & Korfmacher, in press).

The findings from the Elmira trial suggested that nurse-provided home visitation

services had a positive impact not only on maternal and child health, but also in reducing government expenditures. In 1987, Olds' and his colleagues then began a second randomized trial in Memphis, Tennessee to test program effectiveness with a minority population. The preliminary analyses of this replication study suggest that "the program is producing corresponding effects with respect to improving women's health-related behaviors and pregnancy outcomes, reducing the rates of dysfunctional caregiving, and improving maternal life course" (Olds & Korfmacher, in press).

The findings of the Elmira trial once again brought to light the question of the effectiveness of home visitation services in the United States. In 1991, the U. S. Advisory Board on Child Abuse and Neglect recommended the immediate phasing in of a national system of neonatal home visitation support for low-income, pregnant women and parents (Guterman, 1997). Only a year later, the National Committee to Prevent Child Abuse initiated a major campaign to promote the development of a system of early child abuse and neglect prevention programs based on the Hawaiian "Healthy Start" program (Guterman, 1997). The Hawaiian "Healthy Start" model called for home visitation services provided to low-income, pregnant women and parents of young children. One primary difference between this model and the Olds' program is that the "Healthy Start" model utilizes paraprofessional home visitors where the Olds' model suggests the use of nurse-provided visitation.

As early as 1996, the NCPA initiative to promote the utilization of the "Healthy Start" program has resulted in more than 150 programs across twenty-eight states (Guterman, 1997). These programs fall under the program title Healthy Families America and follow the model set forth by the original Hawaiian "Healthy Start"

program. Recently, David Olds and his colleagues have begun their third randomized trial of nurse-provided home visitation in Denver, Colorado. This trial was designed to examine the unique contributions that nurses and trained paraprofessionals can make when following the same program model (Olds & Korfmacher, in press).

Strong support has emerged for the expansion of home visitation services to new parents. Repeated randomized trials of home visitation intervention, as well as quasi-experimental evaluations of community-based home visitation programs suggest great potential for altering parent behavior in pregnant women and young parents (Daro & McCurdy, 1994). Interest has risen once again in the utilization of a variety of home visitation services. Many states, including those that provide funding to Healthy Families America programs, have contacted David Olds' Prevention Research Center for assistance in modeling his program in high-need communities (Hill, 1997). In the state of Oklahoma, an interagency team worked with the state legislature and local public health officials to begin the implementation of Olds' model in each of the state's seventy-seven counties (Hill, 1997). The Oklahoma Legislature appropriated over 4.5 million dollars to the statewide implementation of Olds' model which has been titled "Children First".

David Olds' Work

Elmira trial. David Olds and his colleagues began their first randomized trial of nurse-provided home visitation in Elmira, New York in 1977. The program began with a primarily Caucasian sample (N=400) in a semi-rural county of approximately 100,000 residents (Olds, Henderson, Tatelbaum & Chamberlain, 1986a). The program was designed to modify the risks for poor pregnancy outcomes, dysfunctional care giving, and compromised maternal life-course. Home visitation was provided by nurses who carried

out three basic activities: parent education, the enhancement of the women's informal support systems, and the linkage of the parent with community services (Olds et al, 1986a).

Pregnant women were recruited through a variety of public health and human services agencies if they had no previous live births and had any one of the following characteristics: (1) young age (<19 years), (2) single-parent status, (3) low socioeconomic status (Olds et al, 1986a). Participants were then assigned to one of four treatment conditions. *Treatment group 1* families served as a control group and received no services provided through the research project. These families were screened during the child's first and second years of life for sensory and developmental problems. *Treatment group 2* families were provided with free transportation for regular prenatal and well-child care at local health clinics and physicians' offices. These families were also screened when the children were one and two years of age. *Treatment group 3* families were provided with a nurse home-visitor during pregnancy as well as the screening and transportation services. Nurses visited these families biweekly for an average of nine visits during pregnancy. *Treatment group 4* families received the same pregnancy services as treatment group 3, but the nurses continued to visit these families until the children were two years of age. The nurses' home-visits were made on a schedule of diminishing frequency.

In the mid-1980's, the findings of the Elmira trial began appearing in the form of numerous scientific publications on the positive effects of the program. This review will consider only a representative portion of the empirical reports covering maternal and child outcomes related to the following areas: (1) prenatal care and the outcomes of

pregnancy; (2) maternal life course and the prevention of child maltreatment; (3) and parental care giving and child health.

In looking at the effects of prenatal care on overall maternal health, Olds et al. (1986a) reported that nurse-visited women had fewer kidney infections after enrollment ($P = .005$), and they made greater improvements in the quality of their diets from registration to the 32nd week of pregnancy. Olds et al (1986a) also found that nurse-visited smokers made greater reductions in the number of cigarettes smoked than comparison group smokers, leading to a four cigarette-per-day difference at the end of the pregnancy ($P = .0001$). The authors also reported that nurse-visited mothers attended child birth classes more frequently; used the WIC nutrition program more often; and talked more to support persons about pregnancy and problems.

When looking at the outcomes of pregnancy, Olds et al (1986a), found no overall treatment effects for birth weight or length of gestation, although it was reported that the nurse-visited young adolescents gave birth to babies who were an average of 395 g heavier than babies of young adolescents in the comparison group ($P = .02$). The authors also reported that for the nurse-visited smokers, there was a 2% incidence of preterm delivery in contrast to 10% for smokers in the comparison group ($P = .04$) (Olds et al, 1986a).

The Elmira trial also produced results that focused on the prevention of child abuse and neglect. Data analysis revealed that during the first two years of the children's lives, 19% of the comparison group at greatest risk (poor, unmarried teens) and 4% of their nurse-visited counterparts had abused or neglected their children ($P = .07$) (Olds et al, 1986b). Olds et al (1986b) also found that nurse-visited women were observed in

their homes to punish and restrict their children less frequently than their counterparts in the comparison group ($P = .007$ and $P = .04$, respectively). In addition, nurse-visited unmarried teenagers provided their children with a larger number of appropriate play materials than did the comparison group teens ($P = .01$ and $P = .002$, respectively) (Olds et al, 1986b).

Olds et al (1986b) found that nurse-visited women reported that their babies had more positive moods ($P = .04$) and that they cried less frequently ($P = .07$). When considering the impact between maternal sense of control and the incidence of child maltreatment, Olds et al (1986b) noted that for the comparison group, child maltreatment increased as maternal sense of control decreased ($P = .005$). In the nurse-visited population, a decline in maternal sense of control did not lead to an increase in abuse and neglect ($P = .75$). Ultimately, this pattern of initial results suggests that “nurse home-visitors are capable of preventing a number of care-giving dysfunctions, including child abuse and neglect” (Olds et al, 1986b, p. 76).

In a later publication by Olds, Henderson, Kitzman, and Cole (1995), the effects of prenatal and infancy nurse home visitation were considered for children in both the nurse-visited and comparison groups who had been identified as maltreated in the first four years of life. The study found that during the two-year period after the completion of the program, nurse-visited, maltreated children lived in homes with (1) fewer observed safety hazards for children ($P = .03$), and (2) more emotionally and intellectually stimulating games, toys, and reading materials ($P = .07$) (Olds et al, 1995; Olds et al, 1994). The children in nurse-visited families were found to have paid 87% fewer visits to the physician’s office for injuries or ingestions, and 38% fewer visits to the

emergency room or clinic (Olds et al, 1995; Olds et al, 1994). It was noted that no statistically significant differences in the types of maltreatment or the extent to which children were removed from the home were reported between the intervention and comparison groups. The authors concluded that the children who were identified as maltreated and were visited by nurses during the first two years of life had less serious expressions of “caregiving dysfunction” than their maltreated comparison group counterparts (Olds et al, 1995).

Some of the most monumental findings to come out of the Elmira trial resulted from a fifteen-year follow up of the families who had participated in the program. The authors noted differences between the nurse-visited intervention and comparison groups in a variety of outcomes. These included: the number of subsequent pregnancies, the use of welfare, the incidence of child abuse and neglect, and criminal behavior on the part of the low-income, unmarried mothers for up to fifteen years after the birth of the first child (Olds et al, 1997). Assessments were completed on 81% of the cases that had been originally randomized (Olds et al, 1997).

Olds et al (1997) reported that nurse-visited, unmarried women from lower SES households had fewer subsequent pregnancies ($P = .03$) and greater spacing between first and second births ($P = .001$). In addition, these mothers reported using AFDC (Aid to Families with Dependent Children) and food stamps fewer months than did their comparison group counterparts ($P = .005$ and $P = .001$, respectively). In contrast to the women in the comparison group, those mothers who were visited during their pregnancy and the first two years of their child’s life were identified as perpetrators of child abuse and neglect in fewer verified reports during the fifteen year interval ($P = .0006$) (Olds et

al, 1997). When examining the effects of nurse home visitation on later criminal behavior on the part of the mother, nurse-visited, low SES, unmarried women reported having been arrested and convicted fewer times and having spent fewer days in jail ($P = .0009$, $P = .008$, and $P < .0001$, respectively) since the birth of their first child (Olds et al, 1997).

Memphis trial. David Olds and his colleagues began the second trial of randomized nurse-provided home visitation in Memphis, Tennessee in 1987 with a primarily African-American sample ($N=1125$) (Kitzman, Olds et al, 1997). The repeated trial was conducted using an “updated and refined version of the same program model from (the) Elmira” study (Olds & Korfmacher, in press, p. 4). The results of this trial have only recently been analyzed and published, thereby providing a minimum of literature on which to report.

Kitzman, Olds et al (1997) have reported findings from the Memphis trial on pregnancy outcomes, incidence of childhood injuries, and repeated childbearing. The authors found that women who received home-visits from nurses had less pregnancy-induced hypertension (13% vs. 20%, $P = .009$) than their comparison group counterparts. The Memphis trial showed no program effects on preterm delivery, low birth weight, or children’s immunization rates (Kitzman, Olds, et al, 1997). During the first two years after the delivery, women, who received nurse home visitation, had fewer health care encounters for children in which injuries or ingestions were detected ($P = .05$) and fewer days that children were hospitalized with injuries or ingestions ($P < .001$) (Kitzman, Olds, et al, 1997). The Memphis trial has also shown that nurse-visited women reported having fewer second pregnancies and fewer subsequent births than did women in the comparison

group ($P = .006$ and $P = .01$, respectively) (Kitzman, Olds, et al, 1997).

While much program evaluation has been done on the program effectiveness of home visitation interventions, little research has been conducted about the program processes that are necessary to achieve success in implementation. This question prompted Kitman, Cole, Olds & Yoos (1997) to examine the common challenges that were faced by nurse home visitors in delivering a program of prenatal and early childhood home visitation in the large randomized trial that was conducted in Memphis, Tennessee (Kitzman, Cole, et al, 1997). Qualitative analyses were utilized to examine the common challenges identified by the nurses in their implementation of the program. As a result of this study, the authors identified and discussed nine challenges commonly faced by nurse home-visitors during the implementation of the program including: managing in the face of cultural complexities; waiting for the readiness of mothers to change; and overcoming the limitations posed by the environment (Kitzman, Cole, et al, 1997). The authors concluded that challenges are an inevitable and yet useful part of home-visitation implementation (Kitzman, Cole, et al, 1997).

Denver trial. A question concerning the effectiveness of paraprofessionals as home visitation service providers has long been debated. The methodology of the Olds' program suggests that programs with a greater chance of success begin in pregnancy; follow families who are at-risk for at least two years of the child's life; and are based on a comprehensive service model conducted by nurse home visitors (Olds & Korfmacher, in press). The question of the effectiveness of paraprofessionals prompted David Olds and his colleagues to begin a third trial of randomized home visitation in Denver, Colorado. The Denver trial utilizes the principle components of both the Elmira and Memphis trials,

although it is aimed at examining the unique contributions that both nurse and paraprofessional home visitors can make in serving low-income, at-risk families (Olds & Korfmacher, in press). No results have been published from this third trial.

Healthy Families America

Healthy Families America programs have been created following the model lead of Hawaii's Healthy Start program. The Hawaii Healthy Start program originated from a 1975 demonstration by the Hawaii Family Stress Center on the child abuse prevention ideas of Henry Kempe, M.D. (Wallach & Lister, 1995). Nearly a decade after this demonstration, a three-year project among high-risk parents in the Ewa district of the island of Oahu was implemented by the Hawaii Family Stress Center with funding from the Hawaii Department of Maternal and Child Health (Wallach & Lister, 1995). This pilot project led to an expansion of the Healthy Start program throughout the state of Hawaii, serving approximately 52% of the state's families with newborn children (Wallach & Lister, 1995). A program evaluation of Hawaii's Healthy Start program suggests a major reduction in child maltreatment rates to 1.8% in neighborhoods that were served by the Healthy Start project (Mansfield, 1997).

Hawaii's Healthy Start model of early intervention for the environmentally at-risk population has been replicated at over 244 sites in 36 states under the banner of Healthy Families America (Daro, 1997). "Healthy Families America (HFA) is based on the premise that child abuse can be prevented if parents have access to intensive, comprehensive, and flexible support services at the time their children are born" (Daro, 1997, p. 17). Unlike the Olds' model of nurse-provided home visitation, the HFA program is built upon a system of critical elements rather than a highly specified program

model. The NCPCA utilized this approach because family life, community resources, and parental practices in the United States are so diverse that they require a program model that is flexible enough to allow individual programs to better address and meet their community's specific needs (Daro, 1997).

The critical elements of the HFA program include a comprehensive assessment of the target population and an evaluation of the capacity of current services to address the needs of that population (Daro, 1997). HFA also allows for existing home visitation services and support programs to continue to serve new parents as much as is necessary. HFA requires that services are provided prenatally and that programs allow for the identification of new parents who are most in need of home visitation services (Daro, 1997). Lastly, the HFA program model suggests that all programs be intensive, comprehensive, and flexible.

Daro (1997) states that research has played a central role in the implementation and management of the HFA program. Empirical findings were used to define and establish the initial HFA model and continued program evaluation strategies have helped to refine and improve the home visitation project throughout its use in the United States. Although program evaluation has been a component of the HFA model, there has been a lack of collaboration and information exchange among those individuals who are conducting HFA research (Daro, 1997). Evaluators who were conducting both randomized trials and quasi-experimental designs had little opportunity to exchange information or to build upon each other's efforts. As a result, a Research Network was established to facilitate more systematic and effective program collaboration and evaluation (Daro, 1997). The goals of the Research Network are to improve the quality,

comparability, and relevance of HFA programs to ensure that they lead to a distinct improvement of the delivery of services. At the present time, nearly fifty evaluators representing projects in twenty-five states are Network members (Daro, 1997).

Despite the efforts of the Research Network, little empirical evidence has been published regarding the effectiveness of either the Healthy Start or Healthy Families America programs. As a result, there is little information available on the efficacy of these projects. This review will consider (1) a primary assessment of Hawaii's Healthy Start program and (2) two evaluations of HFA programs.

Hawaii's Healthy Start Program. In the early 1990's, the NCPCA's Center on Child Abuse Prevention Research was awarded a three-year grant to conduct an intensive evaluation of Hawaii's Healthy Start Program. With funding from the U.S. National Center on Child Abuse and Neglect, the evaluation study considered the initial and long-term efficacy of Healthy Start through three primary components: (1) a review of the risk assessment procedures used to determine service eligibility; (2) a two-year evaluation of the immediate impacts of home visitation; and (3) an assessment of the long-term effects of the Healthy Start home visitation program (National Committee to Prevent Child Abuse (NCPCA), 1996).

One of the primary goals of the Healthy Start evaluation was to consider two aspects of the risk assessment procedure. First, the study looked at the ability of the program to accurately screen out families who were at a limited or lower risk than the families for whom the services were created. Second, the evaluation examined the stability of a family's risk for maltreatment over time (NCPCA, 1996). The sample included 117 families whose initial profile, including a hospital record review and an in-

person assessment, did not suggest a risk for child abuse (NCPCA, 1996).

Three outcome variables were assessed through the use of multiple quantitative and qualitative measures. The first outcome variable, parental capacity and skills, was measured through the use of the Child Abuse Potential Inventory (CAP), the Michigan Screening Profile of Parenting (MSPP), and a parental interview assessing parent-child interactions (NCPCA, 1996). Parent-child interaction, the second outcome variable, was measured using the Nursing Child Assessment Satellite Training (NCAST II) and the Home Observation Measurement Environment scale (HOME) (NCPCA, 1996). The final outcome, utilization of social supports and community resources, was measured through the use of the Maternal Social Support Index (MSSI) (NCPCA, 1996). Families in the “no visible risk” and “low risk” groups were compared on all outcome measures at six and twelve months in order to test the effectiveness of the initial screening procedures.

NCPCA (1996) concluded that the adoption of a widely used hospital screening protocol of all new births, as employed by the Healthy Start program, provided a useful tool for narrowing the potential population of prevention families. Only 10% of the families, who were initially screened out of services, displayed significant parenting difficulties at the six or twelve month assessment points (NCPCA, 1996). When identifying families at risk for maltreatment, only the CAP showed substantial differences in parental attitudes, parent-child interaction patterns, and utilization of formal and informal supports between the low-risk and high-risk participants by the time the child was one year of age (NCPCA, 1996). In assessing parental capacity, the study found that participants in the no visible risk group tended to improve over time while participants in the low risk group declined or remained the same (NCPCA, 1996).

In an assessment of the impacts of home visitation, the study examined two Healthy Start sites run by the Hawaii Family Stress Center on Oahu at Ewa and Diamond Head. Those families with newborns, who were eligible to be served by these two centers, were assessed on the Family Stress Checklist (FSC). Those families that scored 25 or more on the FSC were recruited into the study if they had not been a previous client of Healthy Start and if they had no previous or current involvement with Child Protective Services (NCPCA, 1996). The recruitment process resulted in the participation of 372 families, 147 who were randomly assigned home visitation services and 157 who were designated as controls (NCPCA, 1996).

Multiple measures were utilized to examine the effectiveness of Healthy Start services for each of the following outcome variables: parental attitudes, parent-child interaction patterns, maternal social support, child cognitive development, health care utilization, and confirmed instances of child abuse or neglect (NCPCA, 1996). Instruments that were used to examine particular outcomes included the CAP, MSPP, MSSSI, NCAST II, and the HOME (NCPCA, 1996). The Mental Development Index and the Behavior Rating Scales of the Bayley Scales of Infant Development, II were used to assess the child's cognitive and social development (NCPCA, 1996).

The results of the study indicate that mothers who received home visitation by paraprofessionals reduced their potential for physical child abuse three times faster, as measured by changes in the CAP (NCPCA, 1996). Families who received home visits also exhibited more positive parent-child interaction patterns than their control counterparts at both the six and twelve month assessment points (NCPCA, 1996). Visited mothers were also more likely to display greater maternal involvement and

sensitivity to their child's clues at six months (NCPCA, 1996). When looking at the presence of child maltreatment, six confirmed instances of maltreatment occurred in the visited families as compared to thirteen in their control counterparts (NCPCA, 1996). This evaluation study also reported that home visitation services produced limited impacts when considering social support, child development, and child health outcomes.

The third focus of this Healthy Start evaluation included an assessment of the long-term effects of the program involving thirty-four families who terminated home visitation services twelve to eighteen months prior to the onset of the study. Families, who discontinued participation in the program, were contacted for a follow-up evaluation. Those families, who agreed to participate in the follow-up evaluation, were then assessed through the use of the HOME, CAP, MSPP, and the MSSSI. The cognitive development of the child was measure through the use of the Peabody Picture Vocabulary Test (PPVT-R), and the parents' perceptions of the Healthy Start program were assessed using a semi-structured Parent Interview.

The results of the study indicated that these families displayed average to above-average scores on multiple measures of parental functioning and parent-child interaction, and that 75% of the participants reported average or higher levels of social support (NCPCA, 1996). Two-thirds of the sample scored in the "low risk" range on the measure of physical abuse (NCPCA, 1996). Fifty-seven percent of the children in these families scored at or below the 25th percentile in receptive vocabulary as measured by the PPVT-R (NCPCA, 1996). One qualitative finding of the study indicated that the majority of parents possessed a good working knowledge of positive, non-physical methods of child discipline and fifty percent of the parents reported no use of physical punishment

(NCPCA, 1996).

Aside from NCPCA's controlled program evaluation, little structured analysis has been conducted on the effectiveness of the Healthy Start program. Nonetheless, several authors have published impressive statistics that are related to the impact of the program. Oskow (1985) reported that 241 families were served with no cases of abuse and four cases of neglect found among families assessed at high-risk on the Family Stress Checklist. In another publication, ninety percent of two-year old children in the Healthy Start program were fully immunized as compared with only 60% of two-year-olds throughout the United States (Elmer-Dewitt, 1994). Elmer-Dewitt (1994) also reported that eighty-five percent of the children served by the program were tested to be developmentally age appropriate, and that ninety percent of Healthy Start mothers had received timely family planning information.

Healthy Families America. While the program evaluation component of many Healthy Families America sites has been overlooked both financially and theoretically, several intervention sites have provided valuable evidence to suggest the effectiveness of this model. This review will consider two different programs, one that is being carried out in Hampton County, Virginia and the other in the state of Oklahoma.

The Hampton Family Resource Project provides both home visitation and comprehensive community-based services to families through a program they have titled Healthy Start. Healthy Start is a home-based, early intervention program for at-risk families who have been identified during the mother's first or second trimester of pregnancy (Galano & Huntington, 1996). In a universal screening of all pregnant women who received services at the Hampton Department of Health, 467 women were assessed

at-risk and invited to participate in the program. This study examined the effect of the Healthy Start program on maternal and child outcomes including: immunizations, parent-child interaction, child development, and subsequent pregnancy (Galano & Huntington, 1996).

The authors report that ninety percent of the children born to women enrolled in Healthy Start were appropriately immunized, as compared to the seventy-four percent immunization rate for clients not enrolled in the program (Galano & Huntington, 1996). Mother-infant interaction improved for all Healthy Start families from birth to six months and for first-time mothers, it continued to improve when their child grew from six to twelve months of age (Galano & Huntington, 1996). No statistical differences were found between children enrolled in Healthy Families and those that were not receiving home visits, on measures of child development as assessed by the Battelle Developmental Inventory. When examining subsequent pregnancies among teen mothers, the rate of repeat teen births (29.7%) for the City of Hampton was nearly 300% higher than the rate for Healthy Start participants (10%) (Galano & Huntington, 1996).

The Parent Education/Home Visitation Program was conducted in several counties in the state of Oklahoma. First-time, adolescent and non-adolescent mothers were recruited in their third trimester through rural county health departments to participate in a voluntary home visitation intervention program (Culp, Culp, Blankemeyer & Passmark, 1998). Parent educators provided weekly home visits to the families utilizing an individualized curriculum centered around parenting skills, child development, home safety, and community services (Culp et al, 1998). The evaluation component of the program assessed four areas of maternal development: (1) parent's

knowledge of appropriate developmental expectations; (2) parent's knowledge of appropriate parenting skills; (3) safety of the home; and (4) use of community resources.

The data from this study were evaluated using repeated measure multivariate analysis of variance (MANOVA) to determine group differences over time. After six months of intervention, mothers were found to have significantly improved their knowledge of empathetic responsiveness, infant development, and child and parent roles in the family (Culp et al, 1998). The safety of the mothers' homes and their involvement with agencies in the community were also found to have increased significantly. After six months of intervention, no significant differences were found between adolescent and non-adolescent mothers although differences were detected in earlier assessments. The authors conclude that the results of this model of home visitation suggest an effective intervention for addressing the needs of both adolescent and non-adolescent mothers regardless of prior knowledge of child development and parenting (Culp et al, 1998).

Other Home Visitation Programs.

Although the work of both David Olds and the Healthy Families America Program provide a comprehensive overview of the home visitation services that have been implemented in the United States, there are many other programs that have conducted research on various models of visitation. This review will consider a number of studies that have considered the impact of home visitation services on a variety of developmental outcomes. The review will cover: (1) programs aimed at improving child developmental outcomes; (2) programs that provide social support and improve parent-child interaction; and (3) programs aimed at preventing child abuse and neglect.

Child development outcomes. The Parent Education Project began in 1966 as a

series of three intervention programs designed to enhance the development of infants through weekly visits by parent educators who taught mothers activities to stimulate their children (Jester & Guinagh, 1983). The purpose of the program was to raise the chance that infants who received home visits would reach higher levels of intellectual functioning. The authors considered a variety of child and maternal outcome measures including: intelligence, placement in special education classes, mother interaction, and mother's self-concept (Jester & Guinagh, 1983).

The general aims of the investigation were to determine if a parent education approach to intervention, for economically disadvantaged infants and mothers, would produce positive, long-term effects (Jester & Guinagh, 1983). Differences in intelligence were found between treatment and control children, but only in those individuals who had been in the program for three years ($P < .05$). These differences in intelligence, as measured by the WISC-R, were maintained until the children reached ten years of age. When examining placement into special education classes, the authors note that fewer children from the treatment group were placed into such classes, although these differences diminished over time (Jester & Guinagh, 1983). Mothers of project children were found to report more books and educational materials in the home, use more positive rewards, were more aware of their children's development, and had higher expectations for their children than did control mothers (Jester & Guinagh, 1983). In addition, mothers, who had participated in the project, also became more positive in their self-perceptions over time when compared to mothers in the control group.

Another home visitation program entitled the Mother-Child Home Program (MCHP) was initiated to enable low-income mothers to prevent later educational

disadvantage in their two to four-year-old children by maintaining cognitively stimulating home interaction (Madden, O'Hara & Levenstein, 1984). The intervention consisted of a series of biweekly home visits by a "Toy Demonstrator", who would model verbal interaction with the child, centered on toys and books that were permanently assigned to the family (Madden et al, 1984). The MCHP program was conducted for over four years during which four cohorts of children were served for a period of two years each. The study concentrated its examination on outcomes including: maternal interaction style, child IQ, and achievement scores (Madden et al, 1984).

The authors reported that in terms of maternal interaction, significant correlations ($P = .05$) were found between the child's educational success and mother's educational aspirations for her child ($r = .26$), father presence vs. absence ($r = .23$), and father's age ($r = .39$) (Madden et al, 1984). Differences between treatment and control children's developmental quotients, as measured by the Stanford-Binet, were found only to be significant among one of the four cohorts. In achievement test scores, one cohort produced significant results of ($r = .33$) at a significance level of $p < .05$. The overall results of the MCHP program suggest only short-term program effects in maternal behavior, although no meaningful differences emerged between groups for either nonverbal demonstrations of affection or verbal praise (Madden et al, 1984). The authors also note that there was no evidence that the MCHP program was effective in preventing educational disadvantage for first-grade children.

Social support and parent-child interaction. In a home visitation study conducted by Barnard, Magyary, Sumner, Booth, Mitchell, and Speiker (1988), the authors noted that less depressed women are more likely to seek support and have a stronger base from

which to nurture their children. This intervention program was based on the premise that the best way to insure a healthy environment for a child is to foster and nurture competence in the parents. Participants for this study were recruited during their third trimester of pregnancy from public health clinics in King County, Washington, if they met the general criteria of "lacking support" (Barnard et al, 1988). After the initial assessment, mothers were randomly assigned to either the Mental Health Model (MHM), conducted by project nurses, or the Information and Resource Utilization Model (IRUM), conducted by nurses from the public health department. Home visitors in this study were used to form a therapeutic relationship with the pregnant mother in an attempt to increase the mother's social competence (Barnard et al., 1988). All participants were visited in their own home throughout her pregnancy and the first year of the infant's life.

A variety of outcomes were assessed using a number of different measures. The measures utilized by this study included the Beck Depression Inventory, the Personal Resources Questionnaire, the Community Life Skills Scale, and the Social Skills Scale (Barnard et al, 1988). Parenting competency was also measured using the Nursing Child Assessment Teaching Scale and the Nursing Child Assessment Feeding Scale in addition to the Home Observation for Measurement of the Environment. Child competency was evaluated on standardized tests including the Bayley Developmental Scales and the Achenbach Child Behavior Checklist. The Ainsworth Strange Situation was used to measure child attachment to the mother at thirteen and twenty months (Barnard et al, 1988).

The authors found that the MHM group attained more of the treatment goals ($t[105] = 2.71, p < .01$) than the mothers in the IRUM group (Barnard et al, 1988).

Mothers in the MHM group demonstrated less depression, perceived more support, and had a more positive view of their world than their IRUM counterparts. The MHM group was also evaluated more positively on parental competencies including the HOME scale. No differences were noted in the security of attachment classifications at thirteen months or on the Bayley Developmental Scales at two years. Differences between groups were found to be linked to maternal IQ (Barnard et al, 1988). Children of lower IQ mothers demonstrated more success in the MHM group while mothers of higher IQ's tended to fare better in the IRUM group. Overall, this study suggests that support reinforced the importance of maternal social competence as defined by the mother's mood, perception of social support, and common life and social skills (Barnard et al, 1988).

Evidence has also been found that suggests that supporting low income parents of infants can lead to better mother-child interaction (Dawson, Robinson, Butterfield, van Doorninck, Gaensbauer, & Harmon, 1990). This home visitation program, provided by paraprofessionals, enabled well-functioning mothers to maintain good interactions with their infants. Women were recruited during their second trimester of pregnancy to participate in a health department program entitled the Parent-Infant Project (Dawson et al, 1990). Women were randomly assigned to one of three experimental groups. The control group (n = 53) received routine maternity and pediatric care, while the first treatment group (n = 42) received these routine services in addition to weekly home visits. The second treatment group (n = 50) received routine services, weekly home visits, and an invitation to parent groups that met every two weeks. A second control group (n = 27) was selected from mothers attending the clinics in the few months that followed the randomized enrollment. The main focus of the home visitors was to be a

social support for the mothers and to work toward developing other, more permanent support networks for them (Dawson et al, 1990).

Data analyses found differences between home-visited mothers over controls in teaching and feeding situations and in encouragement of their infant's learning attempts (Dawson et al, 1990). Infants of home-visited teen mothers showed greater task persistence and more optimal alertness for learning than did infants of control teen moms. At one year, the authors note two nonsignificant trends. Multiple regression, controlling for parental demographics, showed that home-visited mothers displayed less authoritarian attitudes than control mothers, $F(1,83) = 3.12, p < .10$ (Dawson et al, 1990). In addition, home-visited mothers, who were classified at one month as positive, were more likely to have securely attached infants than control positive mothers ($p = .09$). In conclusion, the authors note that these findings may suggest that it is important to continue home visitation services over time and that more parental support may be necessary (Dawson et al, 1990).

Preventing child abuse and neglect. Hardy and Street (1989) evaluated a program that was designed to assess the cost and effect of providing parenting and child care education in the homes of inner-city mothers of poor infants, who were receiving health care in a large federal Children and Youth Program. Infants weighing more than 2000gm, who were born to black women aged eighteen and older, were randomly selected for the program. A treatment group ($n = 131$) was visited by a paraprofessional home visitor for a minimum of ten months of the child's life. The role of the home visitor was to provide parent education and social support to the mothers in this population. The control group ($n = 132$) received only routine health care and well-child

check-ups.

The results of this study suggest that children in the treatment group made fewer clinic visits than control subjects and that fewer intervention than control children lacked compliance with well-child care (Hardy & Street, 1989). One of the major goals of the home visiting program was the prevention of child maltreatment. Two instances of child abuse and neglect were suspected among intervention infants (1.5%), compared with thirteen cases (9.8%) among control infants. When assessing differences in hospital admission between the two groups, the results indicate that inpatient care was required by eight (6.1%) of the children in the intervention group and twenty (15.2%) of the control children (Hardy & Street, 1989). The authors conclude that funds for home visits to improve parenting skills, child care, and compliance with preventative services among disadvantaged families should be considered as a way of reducing the overall cost of health care for the poor (Hardy & Street, 1989).

MacMillan, MacMillan, Offord, Griffith and MacMillan (1994) conducted a review of intervention programs aimed at the prevention of child maltreatment. This evaluation examined thirty-three studies that met the following criteria: (1) a target population of children, up to and including age eighteen; (2) an intervention based on preventative measures; (3) outcome measures including the evaluation of maltreatment (MacMillan et al, 1994). The most frequently studied intervention was home visitation including programs which have been discussed in this review including David Olds' Elmira trial and Hardy and Street (1989). In summary, the authors concluded that long-term home visitation has been shown effective in the prevention of child physical abuse and neglect among families with one or more of single parenthood, poverty, and teenage-

parent status (MacMillan et al, 1994).

It can be seen that several home visitation interventions have focused their efforts on looking at the importance of parenting attitudes and beliefs with respect to the care and health of their children. As a result of the number of studies that utilize program outcomes centered around parenting attitudes and beliefs, maternal social support, and depression, the present study will consider these maternal variables and their linkage to parents' perceptions of their home-visitor.

The Measurement of Parent Perception and Satisfaction

Daro and McCurdy (1994) state that the experiences of individuals in any prevention program will be shaped by a variety of factors including: how each person enters the program; the quality of the interaction between an individual and the program staff; and the willingness of each to participate in all service components or activities offered. The multifaceted construct of parent perception is easier to comprehend as the different components of the construct are more clearly defined. While little work has been done in the field of home visitation to examine the measurement of parent satisfaction, other early intervention programs, primarily those aimed at children with developmental delays, have considered this outcome variable.

The measurement of parent satisfaction has been identified as an essential part of early intervention program evaluation for a number of reasons. McNaughton (1994) suggests several primary considerations for collecting parent satisfaction information: (1) parents have the major responsibility and control of a child's development, and their decisions concerning success and failure should be of primary concern; (2) information about parent satisfaction can be used to improve services and prevent program rejection;

and (3) parent participation in evaluative decision making may increase overall program participation. While the importance of these data is firmly supported, there has still been little work done in defining the construct of parent satisfaction and developing a reliable and valid measurement tool for examining its impact.

Recent attempts at identifying significant variables in the conceptualization of satisfaction with social services have identified two key factors. The first factor involves an individual's aspiration or expectations of the program, and the second is an individual's perception of the outcome of the service (Michalos, 1983). The construct of parent satisfaction is thus considered to be a highly individualized and volatile construct because it is founded in an individual's perception of a particular experience (McNaughton, 1994). The challenges of defining this construct may have limited the number of studies that look at parent satisfaction in the early intervention literature.

In a review of fourteen early intervention programs that included a measure of parent satisfaction in their program evaluation, McNaughton (1994) stated that all studies reported high levels of parent satisfaction. Results of the findings were incomplete due in part to limited descriptions of the measurement tools and little information on the reliability and validity of the instruments (McNaughton, 1994). McNaughton (1994) suggests that a good measure of parent satisfaction should assess the degree to which an intervention gratifies the wants, wishes, and desires of the parent for a variety of services. The use of parent satisfaction measures should not be considered as a sole indicator of program success, but as one component within the comprehensive framework of outcomes.

The measurement of parent satisfaction is in its infancy, therefore it would be

premature to suggest that one particular tool or approach is optimal for examining the impact of parent's perceptions in program evaluation. The examination of parent satisfaction has had little empirical support and direction, thus the field of research is in need of study in a variety of areas. McNaughton (1994) suggests that work be focused on the development of sound measures of satisfaction, the impact of parent satisfaction on the provision of services, and the study of the relationship between parent satisfaction and parent behavior.

A small amount of research has been conducted on the relationship between satisfaction measures and other measures of program success. Marfo, Browne, Gallant, Smyth, & Corbett (1991) reported a moderate correlation of $r = .20$ ($p < .05$) between parent satisfaction and child progress as measured by rate of development during intervention. In another study by Upshur (1991), a correlation was observed for father's satisfaction and the child's development of cognitive skills ($r = .22$, $p = .016$). Despite these findings, it should be noted that the presence of statistical relationships between satisfaction measures and measures of progress on standardized instruments may be influenced by the high levels of program satisfaction that are usually reported (McNaughton, 1994).

The importance of the measurement of parent satisfaction to the field of early intervention can be seen in the research and discussion that have considered the value of this program outcome. The link between home visitation services and early intervention programs is evident in that both fields provide parent education and support during critical periods in the development of children. Thus, it is vital that the program evaluation of home visitation services begins to include measures of parent satisfaction in

the standard regime of outcome measures.

The present study will begin to define the construct of parent satisfaction by considering the importance of parent perception. McNaughton (1994) and Michalos (1983) suggest that the construct of parent satisfaction is comprised of an understanding of the parents' perceptions of the program implementation. As a result of the invaluable link between the parent and the individual service provider (i.e. the home visitor), the present study will focus on the parent's perceptions of this relationship with regard to other program measurement outcomes. The results of the present study will lend insight into the maternal variables that may be related to a parent's perception of their home visitor, thereby providing a more concrete definition of the construct of parent satisfaction as it is related to the field of home visitation. The measurement of parent satisfaction must be more clearly defined within the field before further program evaluation can be conducted.

CHAPTER III

METHODOLOGY

Research Design

The research approach for the present study was correlational in design as the study gathered information about the relationship of two or more variables. This design has an advantage in that it allows for the measurement of both the magnitude and the direction of the relationship. A correlational design was chosen to determine the strength of the association between parent's perceptions of their home visitor and other maternal perception variables. Any association between the parental perception variable and other maternal variables would lend insight into the composition of the construct of parental perceptions, which would prove helpful in the future study of parent satisfaction. A limitation of this design lies in the fact that it does not provide evidence to suggest that cause-and-effect linkages exist among the variables under investigation.

Procedure

The purpose of this research was exploratory as it considered the variables that were related to parents' perceptions of their home visitor. The unit of analysis in the present study was the mother, who was considered as an individual. The time dimension was longitudinal because the same mothers were followed over a specified period of time. The methodology was survey research. Data were collected through face-to-face interviews conducted by trained study staff members or by home-visitors.

Participants were recruited from selected counties in the state of Oklahoma. Five

counties were determined as the intervention group, while eight counties were utilized as the control/nonintervention group. Since only the intervention group received home visitation services, then only those participants in the intervention group served as participants in the current project. The participants were recruited from the county health department clientele prior to their twenty-eighth week of pregnancy. Only women who were pregnant with their first child were eligible to participate. Participants in both the intervention and nonintervention groups were assessed as they began the program (baseline), when their child was six months old, and when their child was twelve months old. Only the participants in the intervention group received weekly home visits provided by a parent educator. The parent educators, who provided home visits to the participants of the study, were assessed through a mail survey at the completion of the program which occurred after the twelve-month interview.

Several measures were included in each of the three assessment visits. The only measures that were utilized by the present study were the CES-D (Radloff, 1977), the MSSSI (Pascoe, 1981), the AAPI (Bavolek, 1984), the EPSI (Rosenthal, Gurney & Moore, 1981), Describing Our Home-Visitor, and Mother and Father Demographics. The CES-D, the MSSSI, the EPSI, and the AAPI were completed at baseline, at six months, and at twelve months. Describing Our Home-Visitor was completed by the parents in the intervention group at the twelve-month interview. Mother and Father Demographics were completed at baseline, when the child was six months old, and when the child was twelve months old. The parent educators were assessed through the use of a Home-Visitor demographics instrument and a self-evaluation measure entitled, Describing Myself as a Home-Visitor.

Baseline data were collected within the first few home visits by the parent educator. The six and twelve month interviews were conducted in the participant's home. Home-visits that were implemented in the intervention group also took place in the mother's home. Participants were given \$25.00 after the completion of each of the three data collection sessions. Therefore, if a participant remained in the program through the twelve-month interview, she would have received a total of \$75.00 for completing the program.

The home-visitors in the present study were provided with a mail questionnaire that they completed and returned to the researcher. Don Dillman's Total Design Method for mailed surveys was utilized for the distribution of these measures. The home visitor received \$5.00 for the completion and return of the packet.

The Total Design Method for mailed surveys consists of a series of up to four mailings in order to assure the most accurate and sufficient participant response rates. The first mailing included a cover letter explaining the program, the surveys to be completed, and a business reply envelope. The second mailing, a post card follow-up reminder, was sent out one week after the original mailing to all participants. Three weeks after the original mailing, a second packet containing a cover letter and questionnaire were sent out to all participants who had not returned the surveys. The fourth mailing was used seven weeks after the original mailing. It contained a third cover letter and questionnaire packet that were sent via certified mail to all participants who had not sent in a completed survey.

Sample

The target population for the present study was all women who were pregnant

(prior to twenty-eight weeks gestation) with their first child. In order for a woman to have participated, she could not have ever carried a child to term. The sampling frame was the list of all eligible mothers who choose to participate in the study and continued through the twelve-month interview. The data from participants who did not complete the twelve- month interview were not used for this study. The individual mothers who participated in this study were the sampling unit.

This research study utilized a convenience sample because the mothers were recruited from local, county health departments within the state. The sample was also considered to be purposive because the mothers were chosen because they were first-time parents who used the services provided by the county health departments. No sampling procedures were applied because the entire sampling frame was included. The data from all intervention participants, who completed the twelve-month interview, were analyzed for this study.

The sample was intended to provide a representative analysis of the population under study. Despite this intent, it should be noted that the attrition rates associated with parent education programs have been recorded at over fifty percent (Danoff, Kemper, & Sherry, 1994). Taking this into consideration, it should also be noted that the participants who did not continue to the twelve-month interview may differ from those continuing participants in ways other than simple non-continuance. One should also consider that the mothers who choose not to participate in the study may differ from those mothers who did participate. There may be characteristics that distinguish these different groups and therefore, the final analysis may not provide an accurate representation of the entire population.

Instrumentation and Measurement

Center for Epidemiological Studies-Depression: The Center for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977, 1991) was used to measure maternal depression in the present study. This standardized instrument is a 20-item self-report depression scale for research in the general population. The CES-D measures the degree to which subjects have been troubled by depressive symptoms that they experience in the past week. The CES-D utilizes such questions as: "I was bothered by things that don't usually bother me;" "I did not feel like eating; my appetite was poor;" and "I felt that people dislike me." Participants were asked to answer questions on a scale from "rarely or none of the time" to "most or all of the time."

Radloff (1991) reported internal consistency of the CES-D ranging from .82 to .89 for samples of adolescent and young adult females. Test-retest reliabilities for the CES-D have been reported at moderate levels due to the fact that the instrument is designed to measure state of being. These reliabilities range from .32 to .54 for intervals from 3 to 12 months (Radloff, 1977). In a study of children of adolescent mothers, test-retest reliabilities on the CES-D have also been reported at .41 for intervals of 10 months (Hubbs-Tait et al., 1996).

Maternal Social Support Index: The concept of perceived social support was assessed through the use of the Maternal Social Support Index (MSSI; Pascoe, 1981). This instrument was designed to measure the quantitative and qualitative aspects of social support that are provided to the mother by her social network as well as her satisfaction with this support (Pascoe, Ialongo, Horn, Reinhart & Perradatto, 1988). The MSSI has been found to correlate significantly with child maltreatment (Pascoe, Walsh-Clifford, &

Earp, 1982), depression (Pascoe & French, 1990), and stress (Adamakos, Ryan, Ullman, Diaz, & Chessare, 1986) when used with samples of older mothers. This instrument has also been utilized by the National Committee for the Prevention of Child Abuse "Healthy Families America" campaign (Daro, 1988).

The MSSSI is a 21 item self-report questionnaire in which the mother answers questions about her current social support and her satisfaction with the support that she receives. The measure is constructed of seven social support subscales including: (1) Help with Daily Tasks, (2) Satisfaction from Visits with Kin, (3) Help with Crises, (4) Emergency Child Care, (5) Satisfaction from Communication with a Male Partner, (6) Satisfaction from Communication with Another Support Person, and (7) Community Involvement. The MSSSI is scored through the use of a ratio scale.

The construct validity of the MSSSI was assessed and the results revealed that "the construct of the MSSSI does reflect parameters of mothers' social support" (Pascoe, et al., 1982, p. 122). Test-retest correlations have been measured in another study by Pascoe, et al. (1988) and revealed high concurrence ($r = .72, p = <.001$). The generalizability of the MSSSI is considered limited, due to its use with primarily older mothers with low income status and low education level and at-risk mothers (Adamakos et al., 1986).

Adult-Adolescent Parenting Inventory: The present study measured parenting attitudes by the Adult-Adolescent Parenting Inventory (AAPI: Bavolek, 1984). This instrument was used to measure parenting attitudes in four areas: belief in corporal punishment, lack of empathetic understanding, inappropriate developmental expectations, and parent child role reversal. This thirty-two question, Likert-type instrument was created out of the suspicion that inadequate and destructive parenting attitudes constitute

one of the major causes of child abuse. The data that were collected from this measure indicated degrees of agreement and disagreement with various types of parenting attitudes.

Construct validity of the AAPI has been established through the use of inter item correlations and item-construct correlations (Hanson, 1990). Bavolek (1984) has reported item-construct correlations ranging from .53 to .75 and inter-item correlations within each construct from .17 to .55. The internal reliability of the constructs within the AAPI, as measured by a coefficient alpha, has been reported from .75 to .86 (Hanson, 1990). Hanson (1990) has also reported that test-retest reliability for the total test is .76.

Form A of the AAPI was administered in this study. During the interview sessions, participants were given a card that lists the five responses from which they could choose. The present study utilized face-to-face interviews in which an interviewer read the questions to the participant and then recorded her answers. This methodology was employed in an attempt to overcome any difficulties that may arise due to illiteracy on the part of the participant.

Erikson Psychosocial Stage Inventory. The Erikson Psychosocial Stage Inventory (EPSI; Rosenthal, Gurney & Moore, 1981) is a seventy-two question, self-report instrument measuring an individual's psychosocial development in Eriksonian stages. Items are rated on a five point scale ranging from hardly ever true to almost always true. The six subscales, trust, autonomy, initiative, industry, identity, and intimacy, yield a profile of an individual's psychosocial maturity. The present study included only two of these subscales, identity and intimacy. Identity items on the EPSI include such questions as "I can't decide what I want to do with my life" and "I like myself and am proud of

what I stand for.” Intimacy items on the EPSI are defined through questions such as “I have a close physical and emotional relationship with another person” and “I care deeply for others.” The EPSI has been found to exhibit an internal consistency of .63 to .78 and a construct validity of .48 and .56 (Arehart & Smith, 1990; Rosenthal et al, 1981).

Describing Our Home-Visitor/Describing Myself as a Home-Visitor: Parental perception, as defined in the present study, was considered to be a measure of parent satisfaction regarding their relationship with a home-visitor. The instrument, Describing Our Home Visitor, was used to assess parental perceptions of this relationship.

Describing Our Home-Visitor is a measure of home visitor ability, behavior, and attitudes, as perceived by the parent. This measure was adapted from an instrument which was used by the Mid-Iowa Community Action Institute for Family Support and Development in Marshalltown, Iowa. This program used the measure, Describing Our Family Development Specialist (Mid-Iowa Community Action, Inc: 1992), to assess parents’ perceptions of their family development specialist.

Describing Our Home-Visitor is a likert scale measure asking respondents to rank questions on a scale from “always” to “never”. The measure attempts to target the parents’ perception of the home-visitors’ interpersonal skills, teaching ability, and devotion to teaching. This instrument has face validity as the questions that are asked relate directly to the conceptual definition of parent perception. Internal consistency was assessed using Cronbach’s alpha. This measure was given during the twelve-month interview utilizing the same methodology as stated above. A member of the study staff read the questions to the participant. Participants received a card that listed the possible responses they could choose to answer each question on the instrument.

The parent educators that were involved in the present study were asked to complete a self-assessment on the service that they provided to each client with whom they were involved. This self-assessment, Describing Myself as a Home-Visitor, is an adaptation of the instrument used to assess parental perception. This instrument was used to assess the home visitors' perception of his/her own ability, behavior, and attitudes. Describing Myself as a Home-Visitor is also a semantic differential measure in which the parent educators will assess their abilities on a scale from "always" to "never". Internal consistency was also determined through the use of Cronbach's alpha.

Mother/Father Demographics Questionnaire: The third instrument that was utilized by the present study is the Mother/Father Demographics questionnaire. This measure was used to determine the parents' marital status, educational level, income, and ethnicity. The parent educators who participated in the present study also provided some basic demographic information that was obtained through the use of a Home-Visitor Demographics measure. These instruments have face validity due to the direct nature of the questions posed.

Data Analysis

The data analytic strategy for the present study began with computing Cronbach's alpha on each subscale of the maternal variable instruments (AAPI, CESD, MSSSI, EPSI). A principal components analysis of the instrument Describing My Home Visitor determined the subscales for this measure. Cronbach's alphas were then determined for the instruments Describing My Home Visitor and Describing Myself as a Home Visitor. Once Cronbach's alphas were calculated for all subscales, a principal components analysis of the subscales of the maternal variables and the Describing My Home Visitor

instrument was conducted. Provided that the subscales of the parental perception measure (Describing My Home Visitor) did not load with the subscales of the parenting attitudes instrument (AAPI), the analysis then considered the relationship between changes in AAPI scores over time and parents' perceptions of their home-visitor as well as the home-visitors' evaluation of their own service. The rationale behind this procedure was that if the parental perception measure subscales had loaded with the subscales of other maternal variable instruments, then the parent perception tool was measuring characteristics that were similar to those measured by the other instruments (i.e. depression, parenting attitudes, social support, etc.). If it was found that the subscales of the parent perception measure loaded separately from the other instruments, it could be inferred that this instrument was measuring a construct that was different from the constructs measured by the other maternal variables. After the independence of maternal perceptions of the home visitor and maternal attitudes toward parenting (as measured by the AAPI) was established, the relationship between these two constructs could be examined.

CHAPTER IV

ANALYSIS AND EVALUATION

Descriptive Statistics

The data from 59 participants were analyzed for the present study. These 59 first-time mothers, who participated in the study, had completed three intensive interview sessions including the prenatal interview, the six-month interview, and the twelve-month interview. During the twelve-month interview, each mother had provided information on her relationship with her current home-visitor. Those mothers who did not complete all three interviews were not considered during this analysis.

At baseline, the years of education completed by the mothers ranged between 7 years (7th grade) and 18 years (Master's level college); $M = 12.00$ years ($SD = 2.49$ years). These descriptive statistics remained largely unchanged at the twelve-month interview, $M = 12.28$ years ($SD = 2.26$ years). At baseline, 16 participants (27 %) were enrolled in some sort of educational program, while 43 participants (73 %) were not attending any educational programs. After receiving home visitation services through their child's first year of life, the percentage of mothers who were attending educational programs increased to 42.4 %. The income level of the home in which the participant and her child resided was also considered. Table 1 describes the participants in detail.

Seventeen home-visitors were evaluated for the present study. The home visitors provided demographic information on themselves, in addition to a self-evaluation of their service to each of their clients using the Describing Myself as a Home-Visitor measure.

The same home-visitor may have served more than one of the study participants, so she was asked to complete a separate evaluation on her service to each individual client. These evaluations were completed near the time of the mother's twelve-month interview. The home visitors ranged in age from 24 to 54; $M = 37.19$ ($SD = 11.34$). The years of education completed by the home visitors were between 12 years (high school degree) and 20 years (Doctoral level); $M = 16.50$ years ($SD = 1.90$ years). Table 2 provides information that describes the home-visitors in detail.

Research Question 1

The first research question considered the maternal perception variables (including maternal depression, perceived social support, parenting attitudes, and the psychosocial subscales of identity and intimacy) that may load on the same factor or factors as the parent's perceptions of their home visitor. The strategy for targeting this question began with a principal components analysis of the measure, Describing My Home Visitor, to determine any factors that might exist within the instrument. This analysis suggested that two distinct subscales did exist, (1) the home visitor's approach to her job and (2) the home visitor's approach to her client. Table 3 outlines the factors, items, and loadings for this instrument. The two factors found for the measure Describing My Home Visitor accounted for 80% of the variance within the instrument. The Kaiser-Meyer-Olin statistic, which considers the adequacy of the correlation matrix, was .84, suggesting that the correlation matrix was better than adequate for the analysis. Alphas were determined for this measure and are also reported in Table 3.

Alphas were then determined for each of the components in the AAPI, CESD, EPSI, MSSSI, and Describing Myself as a Home Visitor. The items on the measure

Describing Myself as a Home Visitor were identical to the items on the Describing My Home Visitor instrument. Therefore, the two factors from the Describing My Home Visitor measure were used for both instruments. The alphas for each component of these instruments are presented in Table 4.

The final step in addressing this research question was to run a principal components analysis on all maternal perception instruments (AAPI, CESD, EPSI, MSSSI) and the Describing My Home Visitor instrument to determine the higher-order factors across all of these measures. The analysis produced four separate factors that explained 70% of the variance. Table 5 outlines the factors, items, and loadings for this analysis. Through this analysis, it was determined that the parent perception measure, Describing My Home Visitor, loaded separately from all of the other maternal variable instruments. Thus, the second research question was considered.

Descriptive statistics were calculated for the measure Describing Myself as a Home Visitor for each of the 17 home-visitors in the sample. In the event that one home-visitor completed a self-evaluation on more than one client, the range, mean, and standard deviation of her scores is reported in Table 6.

Research Question 2

The second research question asked whether maternal parenting attitudes were predicted by parents' perceptions of their home visitor or by the home visitors' evaluations of their own service. A regression analysis was conducted for this question which considered the measures Describing My Home Visitor and Describing Myself as a Home Visitor as predictors in determining AAPI scores at the twelve-month interview. First, the control variable, income, was entered into the regression. Household income

was held constant in the regression to reduce any effects that might have been related to socioeconomic status as determined by the parent's income. The AAPI subscale scores from the baseline interview were then entered into the regression. The AAPI subscales were also held constant in the regression in order to determine any change that might exist between the baseline and the twelve-month interviews. Finally, each of the components, home visitor approach to job and home visitor approach to client, from the parent perception measure and the home visitor self-evaluation were entered as predictors. One set of regressions was run for each of the four subscales of the AAPI: (1) belief in physical punishment, (2) inappropriate expectations, (3) lack of empathy, and (4) parent/child role reversal. Each subscale was scored so that higher scores reflected better parenting (e.g. lower beliefs in physical punishment, higher empathy).

The results of the regressions are presented in Table 7. The predictor variable of the home visitor's self evaluation explained marginally significant variance in parenting attitudes toward physical punishment. The beta weights suggest that the more positive the home visitor reports her approach to the client, the lower the client's progress toward changing her parenting attitudes on physical punishment. The beta weights indicate that the higher the home visitor rates her approach toward her job, the higher the client's progress toward changing parenting attitudes on physical punishment. The predictors did not explain significant variance in any of the other parenting attitude outcomes. As noted in the table, the control variable, household income, explained marginally significant variance in parenting attitudes toward role reversal. This finding suggests that as household income increased, the mother was more likely to report appropriate understanding of parent and child roles within the family.

CHAPTER V

DISCUSSION

Summary

This research study has provided information that helps to define the constructs of parental perception and satisfaction as they relate to the service delivery of a home visitation program. The findings of this study suggest that parents' perceptions of their home visitor are constructs that are independent of other maternal perception variables, such as depression, parenting attitudes, perceived social support, intimacy, and identity, as they are defined in this research. This study has also initiated the use of a measure of parent perception that can now be refined and tested to better measure parents' perceptions of the service they receive and the relationship that they maintain with a long-term service provider. The present study has only begun to consider the ways in which parents' perceptions of their home visitor affect program success. Additional research is necessary to determine the actual impact of this construct on the effectiveness of home visitation interventions.

Discussion of Research Questions

The first research question in this study considered whether parental perceptions of a home visitor were related to other maternal perception variables. The importance of this question lies in better defining the construct of parent perceptions in order that all facets of the characteristic may be measured accurately and completely. The results of this study suggest that parental perceptions of a home visitation service provider are not

related to other maternal variables including: (1) parenting attitudes, as measured by the AAPI, (2) depression, as measured by the CESD, (3) intimacy and identity, as measured by the EPSI, and (4) social support, as determined by the MSSSI. This finding allows parental perceptions to be defined separately from these other maternal variables, thus suggesting that it is a construct that can be measured separately from these maternal characteristics. Further research using the parent perception measure, Describing My Home Visitor, and other such measures will be necessary in order to determine if the construct is linked to additional facets of parenting and maternal mental health.

The second research question considered the ability of parental perceptions and home visitor perceptions to predict change in parenting attitudes over time. The rationale behind this question was to determine the impact that these perceptions may have on the effectiveness of the educational component of a home visitation program. Study results suggest that home visitors' self-evaluation of their own service does have an impact on the parents' belief in physical punishment, as measured by the AAPI. The instrument used to consider home visitor perceptions was an adaptation of the measure, Describing My Home Visitor. A principal components analysis on the parent perception measure was conducted, and the components that emerged were used for the home visitor evaluation as well. Additional studies using the measure, Describing Myself as a Home Visitor, should consider running a separate principal components analysis on the instrument to determine if differences exist between the ways in which parents and home visitors answer the items. In order for such an analysis to be conducted, a large sample of home visitors would be needed so that the assumption of independence of observations that underlies principal components analysis would not be violated. In the current study,

there were only 17 home visitors and, thus, only 17 independent observations, ruling out a principal components analysis of Describing Myself as a Home Visitor.

Recommendations

When additional studies on the measurement of parent perceptions of a home visitation provider are conducted, it is suggested that the construct be measured at different time intervals within the program. The present study measured parent perceptions at one point in time, after the participants had been receiving intervention for over fifteen months. The information received was initially biased in that the mothers, who continued in the study through their child's first year of life, may differ from those mothers who discontinued the program after only receiving intervention for six months. It is suggested that parent perception measures be administered earlier in the program. Perhaps, parent perceptions of the service provider may lend insight into the reasons why some participants choose to discontinue parent education intervention.

Extension and Implications for Practice

The results, presented in this study, can be used by program evaluation teams to identify additional variables that may improve the overall effectiveness of home visitation interventions. The relationship between a parent and the service provider may prove to be an essential link in providing comprehensive and effective parent education to families who are at risk for child maltreatment. The component of parent satisfaction has yet to be considered in home visitation program evaluations. The findings of the present study suggest that there may be reason to include this measure in future evaluations. Information, given by parents, on how they perceive their home visitor may provide insight into the educational content and training that may be necessary for service

providers of parent education. The measure of parent satisfaction could prove to be an essential component in determining the changes that may need to take place in order for home visitation programs to be as successful as possible.

Directions for Future Research

Future research on the study of parent perceptions of a home visitor should continue to explore the construct and its relationship to other parent perceptions and maternal mental health variables. A clearly defined construct will in turn lead to the construction of comprehensive and appropriate instruments with which to measure parent perceptions. Additional research on the measures utilized by this study may reveal their adequacy or inadequacy for considering this characteristic of intervention programs. Nonetheless, additional research using these measures, refined or otherwise, should be conducted. Perhaps as we begin to better understand the construct of parent perceptions, proper scientific questioning can occur that considers the impact of this construct on other intervention outcomes.

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Appendix A

Tables

Table 1: Demographic Frequencies of First-time Mothers

<u>MARITAL STATUS</u>	<u>BASELINE</u> %	<u>BASELINE</u> n	<u>12-MONTH</u> %	<u>12-MONTH</u> n
Married	33.9%	20	40.7%	24
Single, never married	64.4%	38	52.5%	31
Divorced	1.7%	1	1.7%	1
Separated	0.0%	0	5.1%	3

<u>YEARS OF EDUCATION COMPLETED</u>	<u>BASELINE</u> %	<u>BASELINE</u> n	<u>12-MONTH</u> %	<u>12-MONTH</u> n
Seventh grade	5.1%	3	1.7%	1
Eighth grade	1.7%	1	5.1%	3
Ninth grade	10.2%	6	3.4%	2
Tenth grade	10.2%	6	8.5%	5
Eleventh grade	10.2%	6	11.9%	7
High school degree	25.4%	15	30.5%	18
Freshman year of college	11.9%	7	11.9%	7
Sophomore year of college	11.9%	7	11.9%	7
Junior year of college	1.7%	1	5.1%	3
Bachelor's degree	8.5%	5	5.1%	3
First year graduate school	1.7%	1	5.1%	3
Master's degree*	1.7%	1	0.0%	0

*The baseline and 12-month data on one participant provided inconsistent reports.

<u>ENROLLED IN EDUCATIONAL PROGRAM</u>	<u>BASELINE</u> %	<u>BASELINE</u> n	<u>12-MONTH</u> %	<u>12-MONTH</u> n
Yes	27.1%	16	42.4%	25
No	72.9%	43	57.6%	34

<u>HOUSEHOLD INCOME</u>	<u>BASELINE</u> %	<u>BASELINE</u> n	<u>12-MONTH</u> %	<u>12-MONTH</u> n
Less or equal to \$3000	27.1%	16	18.6%	11
\$3001 to \$6000	10.2%	6	5.1%	3
\$6001 to \$9000	15.3%	9	3.4%	2
\$9001 to \$12,000	6.8%	4	11.9%	7
\$12,001 to \$15,000	11.9%	7	16.9%	10
\$15,001 to \$20,000	8.5%	5	8.5%	5
\$20,001 to \$30,000	8.5%	5	16.9%	10
\$30,001 to \$40,000	1.7%	1	6.8%	4
Over \$40,000	10.2%	6	11.9%	7

Table 2: Demographic Frequencies for Home Visitors

RACE	%	n
Caucasian	64.7%	11
African-American	17.6%	3
Native American/Alaskan	11.8%	2
Other	5.9%	1

YEARS OF EDUCATION COMPLETED	%	n
High school degree	5.9%	1
Junior year of college	17.6%	3
Bachelor's degree	29.4%	5
First year graduate school	11.8%	2
Master's degree	17.6%	3
Doctoral studies	11.8%	2
Missing data	5.9%	1

AGE	YEARS
Mean	37.19
Standard Deviation	11.34
Minimum	24
Maximum	54

TOTAL YEARS WORKED AS A HOME-VISITOR	YEARS
Mean	2.049
Standard Deviation	1.9617
Minimum	.33
Maximum	8.0

Table 3: Factors, Items, and Loadings from Rotated Component Matrix for Describing My Home Visitor

Factors and Items	Alpha	Factor Loadings
<u>Factor 1: Home visitor approach to client</u>	(.95)	
My home visitor is friendly.....		.85
My home visitor is rude.....		-.81
My home visitor is unprepared.....		-.59
My home visitor is uncaring.....		-.80
My home visitor is concerned.....		.83
My home visitor is interested.....		.80
My home visitor is well-prepared.....		.76
My home visitor is rushed.....		-.79
My home visitor is able to explain material well.....		.88
<u>Factor 2: Home visitor approach to job</u>	(.94)	
My home visitor is helpful.....		.72
My home visitor is patient.....		.51
My home visitor is skilled.....		.86
My home visitor is unskilled.....		-.82
My home visitor is familiar with services I'm interested in.....		.78
My home visitor is useful.....		.85
My home visitor is knowledgeable about child development.....		.80

Table 4: Alpha levels for Maternal Variable Instruments and Home Visitor Self-Evaluation Measure

Instrument and Factors	Alpha
<u>AAPI</u>	
Belief in physical punishment.....	.88
Inappropriate expectations.....	.68
Parent/Child Role Reversal.....	.92
Lack of Empathy.....	.84
<u>CESD</u>	
Depressed.....	.86
Happy73
Somatic.....	.70
Interpersonal.....	.60
<u>EPSI</u>	
Identity.....	.76
Intimacy.....	.72
<u>MSSI</u>	
Total Score.....	.58
<u>Describing Myself as a Home Visitor</u>	
Home visitor approach to client.....	.69
Home visitor approach to job.....	.86

Table 5: Factors, Items, and Loadings from Rotated Component Matrix for AAPI, CESD, EPSI, MSSI, and Describing My Home Visitor

Factors and Items	Factor Loadings
<u>Factor 1: Parenting Attitudes</u>	
AAPI; Belief in physical punishment81
AAPI; Inappropriate expectations.....	.80
AAPI; Parent/Child Role Reversal.....	.82
AAPI; Lack of Empathy.....	.77
<u>Factor 2: Social and Positive Adjustment</u>	
MSSI; Total Score.....	.72
EPSI; Identity.....	.86
EPSI; Intimacy.....	.65
CESD; Happy.....	.70
<u>Factor 3: Parent Perceptions of Home Visitor</u>	
Describing My Home Visitor; Home visitor approach to client.....	.94
Describing My Home Visitor; Home visitor approach to job.....	.93
<u>Factor 4: Depression</u>	
CESD; Depressed.....	.72
CESD; Somatic.....	.77
CESD; Interpersonal.....	.75

Table 6: Subscale Frequencies for Describing Myself as a Home Visitor

HOME VISITOR ID	N MOMS	RANGE CLIENT	RANGE JOB	MEAN CLIENT	MEAN JOB	S* CLIENT	S* JOB
1	8	37-40	25-30	38.29	27.86	.9512	1.5736
2	4	39-41	32-34	39.75	33.00	.9574	.8165
3	1	41	31	41.00	31.00	**	**
4	1	41	33	41.00	33.00	**	**
5	6	41-45	29-34	42.67	31.00	1.5055	2.4495
6	10	41-45	31-35	44.10	33.40	1.2867	1.3375
7	2	42-43	31-32	42.50	31.50	.7071	.7071
8	7	40-42	28-30	40.86	28.71	.6901	.7559
9	4	43-45	34-35	44.25	34.50	.9574	.5774
10	4	38-43	32-34	41.00	33.25	2.1602	.9574
11	2	45	34-35	45.00	34.50	.0000	.7071
12	1	38	33	38.00	33.00	**	**
13	4	45	35	45.00	35.00	.0000	.0000
14	1	41	29	41.00	29.00	**	**
15	1	44	32	44.00	32.00	**	**
16	1	38	27	38.00	27.00	**	**
17	2	44-45	33-35	44.50	34.00	.7071	1.4142

S* = Standard Deviation

** Not applicable

Table 7: Regressions Predicting Maternal Parenting Attitudes, Based on Parental Perceptions of the Home Visitor and the Home Visitor's Self-Evaluation

PARENTING ATTITUDES 12-MONTHS	MODEL	PREDICTORS	ΔR^2	F	df	beta
Physical Punishment	1.	Income	.014	.776	1, 56	.117
	2.		.328**	27.425**	1, 55	
		Baseline Physical Punishment				.587**
	3.		.092+	2.082+	4, 51	
		Client (Parent)				.136
		Job (Parent)				.074
		Client (H.V.)				-.188+
		Job (H.V.)				.228*
	Inappropriate Expect.	1.	Income	.018	1.034	1, 56
2.			.182**	12.531**	1, 55	
		Baseline Inappropriate Expect.				.433**
3.			.033	.543	4, 51	
		Client (Parent)				.069
		Job (Parent)				.122
		Client (H.V.)				-.021
		Job (H.V.)				-.003
Lack of Empathy		1.	Income	.045	2.627	1, 56
	2.		.425**	44.099**	1, 55	
		Baseline Lack of Empathy				.698**
	3.		.010	.241	4, 51	
		Client (Parent)				-.085
		Job (Parent)				.025
		Client (H.V.)				-.002
		Job (H.V.)				.071
	Role Reversal	1.	Income	.058+	3.479+	1, 56
2.			.364**	34.630**	1, 55	
		Baseline Role Reversal				.625**
3.			.012	.278	4, 51	
		Client (Parent)				-.137
		Job (Parent)				.069
		Client (H.V.)				-.050
		Job (H.V.)				.032

Note. ΔR^2 refers to the change in R^2 explained by each predictor when it is entered last.
 + $p < .10$. * $p < .05$. ** $p < .01$.

Client and Job (Parent) subscales from Describing My Home Visitor.

Client and Job (H.V.) subscales from Describing Myself as a Home Visitor

Appendix B

Instruments

Participant ID #
 Home Visitor ID #
 Date

Describing Our Home-Visitor

When the home-visitor works with my family, he/she is:

	NEVER	RARELY	SOMETIMES	USUALLY	ALWAYS
1. friendly.	1	2	3	4	5
2. rude.	1	2	3	4	5
3. helpful.	1	2	3	4	5
4. patient.	1	2	3	4	5
5. unprepared.	1	2	3	4	5
6. skilled.	1	2	3	4	5
7. uncaring.	1	2	3	4	5
8. unskilled.	1	2	3	4	5
9. concerned.	1	2	3	4	5
10. interested.	1	2	3	4	5
11. familiar with services I'm interested in.	1	2	3	4	5
12. well-prepared.	1	2	3	4	5
13. rushed.	1	2	3	4	5
14. useful.	1	2	3	4	5

15. knowledgeable about child development. 1 2 3 4 5

16. able to explain material in a way that is easy for me to understand. 1 2 3 4 5

17. other: (Please list any other descriptors that describe your home-visitor)

Participant ID #
Home Visitor ID #
Date

Describing Myself as a Home-Visitor

When I work with
this family as a home-
visitor, I am:

	NEVER	RARELY	SOMETIMES	USUALLY	ALWAYS
1. friendly.	1	2	3	4	5
2. rude.	1	2	3	4	5
3. helpful.	1	2	3	4	5
4. patient.	1	2	3	4	5
5. unprepared.	1	2	3	4	5
6. skilled.	1	2	3	4	5
7. uncaring.	1	2	3	4	5
8. unskilled.	1	2	3	4	5
9. concerned.	1	2	3	4	5
10. interested.	1	2	3	4	5
11. familiar with services my client is interested in.	1	2	3	4	5
12. well-prepared.	1	2	3	4	5
13. rushed.	1	2	3	4	5
14. useful.	1	2	3	4	5

15. knowledgeable about child development. 1 2 3 4 5

16. able to explain material in a way that is easy for my clients to understand. 1 2 3 4 5

17. other: (Please list any other descriptors that describe yourself as a home-visitor)

18. How long have you worked with this participant and her family? Years Months

19. How many parent educators has this participant had since she started the program? Parent Educators

HOME VISITOR DEMOGRAPHICS

ID#

DATE

AGE

HVD1. Racial Status

- Caucasian
- African-American
- Native American/Alaskan Native
- Asian/Pacific Islander
- Other

HVD2. Hispanic

- Yes
- No

HVD3. Marital Status

- Married
- Single, never married
- Widowed
- Divorced
- Separated

HVD4. Do you have any children?

- Yes
- No

HVD5. How many years of education have you completed?

HVD6. For how many months/years have you worked as a parent educator?

Years

Months

Appendix C

Documentation

Agreement to Participate In
An Evaluation of Home Visitation

Because you have worked as a parent educator providing home visits to participants of the CBFRRP program, you are being asked to be a part of this mail/evaluation study. Your participation will consist of the completion and return of two assessment measures. The assessments will ask you questions about your experience working as a parent educator and about your perception of the relationship between you and your clients.

Cost to You. There will be no cost to you. This study is funded by a John and Sue Taylor Graduate Research Grant through the College of Human Environmental Sciences at Oklahoma State University.

Benefits. You will receive \$5.00 for completing and returning the two assessment questionnaires. You will also gain the satisfaction of providing information that will allow home visitation programs to be modified to better meet the needs of all families.

Confidentiality. Information that is obtained in this study will be maintained in a confidential file which will be coded by number, not by name. All study staff have been carefully trained in matters of confidentiality. All study records will be kept in a locked file cabinet on the Oklahoma State University campus. The results of the study will be presented in aggregate so the identity of individual participants will remain unknown.

Risks. The only known risk might result from accidental disclosure of information. However, as noted above under **Confidentiality**, this risk has been greatly reduced by careful training of all study staff, by maintaining records coded by number, not by name; and by storing study records in locking cabinets. *It should also be known that the study staff will in no way discuss your response with the other participants in the program.

Voluntary Participation. Your participation is completely voluntary. You may choose not to participate, and you are free to withdraw your consent and participation at any time during the course of the study without penalty, after notifying the project director or a member of the study staff.

For Further Information. If you have any questions, you may contact the study staff director, Dr. Scott Plunkett (405-744-7043) or the head of the project, Angela Woodard (405-744-7051) at the Department of Family Relations and Child Development, 333 HES Building, Oklahoma State University, Stillwater, OK 74078. Or you may contact Gay Clarkson (405-744-5700) at University Research Services, 305 Whitehurst Hall, Oklahoma State University, Stillwater, OK 74078.

I _____ agree to participate in the enclosed mail/evaluation survey. I understand that I am being asked to complete the enclosed assessments and to return them to the research staff in the provided envelope. I know that I will receive \$5.00 for the completion of these measures. I understand participation is voluntary, and there is no penalty for declining to participate, and I am free to withdraw my consent and participation in this project at any time. I have read and fully understand this consent form. I sign it freely and voluntarily. I have received a copy.

Signed:

Signature of Participant

Date

I certify that all elements of this form are correct and valid.

Signed:

Signature of Principal Investigator

Date

November 25, 1998

Dear *Parent Educator*,

I am contacting you in regard to your participation as a parent educator in the CBFRP program. I am a graduate student at Oklahoma State University working on my Master's degree in Child Development. I have been working on the CBFRP project under Drs. Anne and Rex Culp, Dr. Linda Robinson, and Ms. Tammi Hechtner for over a year. During this time, I have become very interested in the relationship that develops between parent educators and the participants to whom they provide services. As a result of my interest in parent education, I have chosen this area of study as the topic for my Master's thesis.

I am interested in how you, as a parent educator, perceive your relationship to client number **XXXX**. In order to better understand your perspective, I am asking that you complete the enclosed questionnaires. The first form is an informed consent that I ask you read, sign, and return. Two copies of this form have been included so that you may keep one for your personal records and send the other one back to me. The second questionnaire is a basic demographic form about you. The third questionnaire is a form entitled "Describing Myself as a Home-Visitor." This form will allow you to assess your relationship with client number **XXXX**.

This packet is being sent to you two weeks prior to your client's twelve-month visit. This time has been chosen because it is assumed that you have been involved with this participant for several months. The information that I am requesting will allow home-visitation programs to be better suited to the needs of both parents and parent educators.

Once I have received your packet, you will be sent a \$5.00 stipend for completing the information on client number XXXX. In order for you to receive this money, you must complete and sign the enclosed Bill for Services Rendered. A check will be sent to you at the address that you request in 2-3 weeks. I would appreciate your quick response to this mailing. Once you have completed the questionnaires, place them in the self-addressed envelope and drop them in the mail. The postage has already been paid. If you have any questions regarding this project or its relationship to the CBFRP program, please feel free to contact Tammi Hechtner or myself at (405) 744-7051.

Thank you for your time and participation. You have played a tremendous role in the life of a first time parent and her child. Your work is truly appreciated!

Sincerely,

Angela (Woodard) Staudt

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
HUMAN SUBJECTS REVIEW

Date: 05-12-98

IRB #: HE-98-098

Proposal Title: PARENTAL PERCEPTIONS AND RELATED OUTCOME VARIABLES IN HOME VISITATION

Principal Investigator(s): Laura Hubbs-Tait, Angela Woodard

Reviewed and Processed as: Expedited

Approval Status Recommended by Reviewer(s): Approved

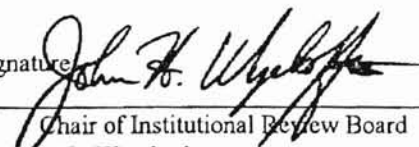
ALL APPROVALS MAY BE SUBJECT TO REVIEW BY FULL INSTITUTIONAL REVIEW BOARD AT NEXT MEETING, AS WELL AS ARE SUBJECT TO MONITORING AT ANY TIME DURING THE APPROVAL PERIOD.

APPROVAL STATUS PERIOD VALID FOR DATA COLLECTION FOR A ONE CALENDAR YEAR PERIOD AFTER WHICH A CONTINUATION OR RENEWAL REQUEST IS REQUIRED TO BE SUBMITTED FOR BOARD APPROVAL.

ANY MODIFICATIONS TO APPROVED PROJECT MUST ALSO BE SUBMITTED FOR APPROVAL.

=====
Comments, Modifications/Conditions for Approval or Disapproval are as follows:

Signature


Chair of Institutional Review Board
cc: Angela Woodard

Date: May 15, 1998

VITA ²

Angela M. Staudt

Candidate for the Degree of

Master of Science

Thesis: THE RELATIONSHIP OF MATERNAL PERCEPTION VARIABLES AND PARENTAL PERCEPTIONS OF A HOME VISITATION SERVICE PROVIDER

Major Field: Family Relations and Child Development

Biographical:

Personal Data: Born in Oklahoma City, Oklahoma, on March 13, 1975, the daughter of William H. and Jennie G. Woodard.

Education: Graduated from Guthrie High School, Guthrie, Oklahoma in June 1993; received Bachelor of Science degree in Early Childhood Education from Oklahoma State University in May 1997. Completed requirements for the Master of Science degree with a major in Family Relations and Child Development at Oklahoma State University, Stillwater, Oklahoma in May, 1999.

Experience: Employed as a preschool teacher and swim lesson instructor from 1995 to 1998. Employed as a graduate research assistant by Oklahoma State University Family Relations and Child Development Department, 1997 to present. Completed 20 week internship with Oklahoma State Department of Health.

Professional Memberships: National Association for the Education of Young Children, Oklahoma Association of Infant Mental Health, Phi Kappa Phi