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Level Of Motivation, Treatment Modality, And Change In Parenting Skills Among Parents Involved In A Child Protective Service Agency

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LEVEL OF MOTIVATION, TREATMENT MODALITY, AND CHANGE IN PARENTING SKILLS AMONG PARENTS INVOLVED IN A CHILD PROTECTIVE SERVICE AGENCY

BY

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ABSTRACT

LEVEL OF MOTIVATION, TREATMENT MODALITY, AND CHANGE IN PARENTING SKILLS AMONG PARENTS INVOLVED IN A CHILD PROTECTIVE SERVICE AGENCY

The number of children involved with child protective service agencies due to child maltreatment has increased throughout the past few decades. The purpose of this study was to examine if intrinsic motivation, extrinsic motivation, and treatment modality related to treatment success of changes of parenting skills of parents involved in a protective service agency. It also examined if the level of motivation (intrinsic and extrinsic) changed over eight sessions depending on treatment modality (individual or group).

The participants were given pre and post treatment measures. Specifically, the pre treatment measures included a demographic questionnaire, the Client Motivation for Therapy Scale (CMOTS), and Adult-Adolescent Parenting Inventory-2, Form A (AAPI-2). The post treatment measures included the CMOTS and AAPI-2, Form B.

The results of the study were mixed in regard to finding any significance. The results demonstrated that the pre treatment level of intrinsic motivation, extrinsic motivation, and treatment modality related to changes on three of the five parenting constructs: developmental
expectation, punishment, and role reversal. There was a significant increase from pre to post treatment scores on the three above parenting constructs following eight sessions of individual therapy. There was also a significant increase from pre to post treatment scores regarding punishment and role reversal following eight sessions of group therapy. However, there was no significant difference from pre to post treatment regarding developmental expectations following eight sessions of group therapy.

Finally, there was no difference between treatment modalities in the amount of change in level of motivation for therapy. However, there was a significant change in pre and post treatment scores for both intrinsic and extrinsic motivation for participants involved in treatment. The intrinsic score for each participant increased in both therapy modalities and the extrinsic score decreased in both therapy modalities.

Although there were mixed results, it is obvious that continued research in this area is essential. Further research may provide additional insight into the parenting skills, treatment modality, and level of motivation of parents involved in child protective service agencies. This may assist in alleviating the amount of children
referred to child protective service agencies due to maltreatment.
ACKNOWLEDGMENT

This dissertation is dedicated to my husband, Stephen. It is through his love, support, and constant encouragement throughout these numerous years that I have learned to believe in myself. Thank you.
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CHAPTER I

Introduction

Background of the Study

Throughout the past few decades, there has been a documented increase in the number of children involved with child protective service agencies. Specifically, in 2000, three million referrals concerning the welfare of approximately five million children were made to child protective service agencies in the United States due to allegations of child maltreatment (U.S. Department of Health and Human Services, 2002). The rates of child victims per 1,000 children in the United States were reported in the U.S. Department of Health and Human Services (2002). Specifically, there has been a steady decrease from 15.3 victims per 1,000 children in 1993 to 11.8 victims per 1,000 children in 1999. In 2000, the rate has been stable with a rate of 12.2 per 1,000 children (U.S. Department of Health and Human Services, 2002). Child protective service agencies are increasingly overwhelmed by the number of children in need of both protection and treatment services (Waldfogel, 1998). Child maltreatment includes many types of child victimization such as child neglect and child abuse (Belsky, 1993; DePanfilis, 1996).
Child neglect is generally defined as the failure of the child's parents or caretakers to provide the child with the basic necessities of life, when financially able to do so or when offered reasonable means to do so (Cowen, 1999; Dubowitz, Black, Starr, & Zuravin, 1993). The basic necessities in caring for a child include minimally adequate care in the areas of shelter, nutrition, health care, clothing, education, affection, and nurturance (Dubowitz et al., 1993). According to the U.S. Department of Health and Human Services (2002), of the substantiated cases involved with a child protective service agency (992,617) over half involved childhood neglect (474,945 or 52%). Even though childhood neglect is the most common form of child maltreatment, it is the least studied (DePanfilis, 1996; Dubowitz, 1994). On the other hand, child abuse may consist of physical abuse, sexual abuse, and/or emotional abuse (Carlson, Furby, Armstrong, & Shlaes, 1997; Fennell & Fishel, 1998). In other words, neglect consists of acts of omissions regarding basic care whereas abuse consists of the acts of commission or inflicting injury (Cowen, 1999; DePanfilis, 1996).

The effect of abuse and/or neglect on children has been studied by Pilowsky (1995). He reported that children involved in a child protective service agency and are also in an out of home placement are susceptible to multiple and
extensive behavioral disorders. For example, using the Achenbach’s Child Behavior Checklist, Pilowsky (1995) estimated psychopathology prevalence rates among children in foster care to be between 29% and 48%. Widom (1999) also studied the effect of abuse or neglect on children. He researched the extent to which childhood abuse and neglect increases a person's risk for subsequent posttraumatic stress disorder (PTSD) in a sample of 1,196 participants who were victims of substantiated child abuse or neglect from 1967 to 1971. Widom concluded that the victims of child abuse (sexual and physical) and neglect are at increased risk for developing PTSD. Regarding limitations in this study, Widom stated that childhood victimization is not the only variable contributing to PTSD, but one must also look at the family, individual, and lifestyle variables.

The cycle of maltreatment that continues within generations of a family is known as intergenerational transmission of abuse and neglect. Through researching the intergenerational transmission of abuse, this concept can be better understood and may assist in explaining and possibly discontinuing this cycle. For instance, Simons, Whitbeck, Conger, and Chyi-In (1991) studied the intergenerational transmission of harsh parenting. Their results indicated that grandparents who engaged in aggressive parenting with their children produced present-day parents who were likely
to use similar parenting practices with their children. Therefore, supporting the concept of intergenerational transmission of abuse and neglect.

Families typically become involved with child protective service agencies after there is a concern that minimum protection or standards of care have not been met by the parents (Dubowitz, 1997). Parents involved in a child protective service agency may be court-ordered or recommended to attend therapy by the child protective service agencies or the courts in order to remediate abusive behaviors. Dinkmeyer (1999, p. 101) stated that people who are court-ordered may "attend with a different kind of 'willingness'." Agencies may recommend parents to attend therapy so "that parents can demonstrate their willingness to retain custody of their children" (Dinkmeyer, 1999, p. 101). In other words, the motivation of the parent to attend therapy is of interest to study.

Motivation for treatment is an area of psychology that is relevant to the issues of dropout, compliance, and maintenance of change (Pelletier, Tuson, & Haddad, 1997). Specifically, over the last decade, according to Pelletier, Tuson, and Haddad (1997), one perspective of human motivation that has received a great deal of attention from researchers is the theory of intrinsic motivation and self-determination proposed by Deci and Ryan (1985).
Specifically, the different types of motivation range through a continuum of self-determination in which the lowest type is amotivation, followed by external regulation, introjection, identification, integration, and intrinsic motivation (Pelletier et al., 1997). A study regarding motivation was conducted by Deci, Eghrari, Patrick, and Leone (1994). They hypothesized that the “combination of a meaningful rationale, an acknowledgment of conflicting feelings, and a style that minimizes pressure and conveys choice are the three critical, social-contextual facilitating factors that support self-determination” (Deci et al., 1994, p.125). They studied 192 introductory psychology students who were asked to watch a computer screen and when a dot of light appeared on the screen, the participants were to press the space bar to make the light disappear. Following a practice trial and prior to the actual trial, the experimental manipulations were done orally by the experimenter. The participants were either given or not given: a rationale for completing this task, an acknowledgment of the disinterest of the task, and any control. The results supported their hypothesis that the three facilitating factors “proving a meaningful rationale, acknowledging the behavior’s feelings, and conveying choice – promote internalization, as evidenced by the subsequent self-regulation of behavior” (Deci et al., 1994, p.119).
A possible means of intervention against childhood maltreatment and the discontinuation of abuse is the development of parent education and training to assist parents in modifying their parenting skills. Parent education assists parents in learning parenting skills that may prevent children from developing problematic behaviors. Parent education targets more generalized parenting skills and information concerning child development (Bond & Burns, 1998). Parenting training, on the other hand, is more focused on specific behaviors and ways to implement these learned behaviors to practice with the child (Bond & Burns, 1998). Parent training programs which focus on building parenting skills have become widely used since their advent in the 1960's and 1970's (Serketich & Dumas, 1996). However, the terms parenting education and parenting training have been used interchangeably "to denote a wide range of intervention models designed to enhance parents' capacities to foster optimal child development" (Dore & Lee, 1999, p. 314).

Parent training has been studied regarding research on child psychotherapy. Parent training focuses on a broad range of problems including conduct problems, attention deficit disorder, mental retardation, learning disorders, and enuresis and encopresis (Kazdin, 1997). It has been reported that abusive and neglectful parents have been
treated through parenting approaches, and parenting training has been used in early intervention programs (Barclay & Houts, 1995).

Once families are involved in a child protective service agency, they are usually recommended to participate in treatment (Donnelly, 1997). However, Bowdry (1990) states that parents who continue to deny their responsibility for the abuse often do poorly in psychotherapy, especially more traditional, insight-oriented individual therapy. Therefore, resistant parents involved in parenting training therapy may also do poorly if they continue to deny their responsibility for the maltreatment of their children.

Even though parenting skills are usually taught in group therapy, DePanfilis (1996) reported that initially, individual support might be more appropriate for neglectful families due to their lack of social skills, which are necessary to get along well in groups. However, DePanfilis (1996) reported that including a social support component in teaching parent skills in a group setting with parents who maltreat their children might reduce social isolation and therefore become more successful in treatment. Even though statements regarding how group and individual therapy may or may not be beneficial for parents involved in a social service agency to learn parenting skills, there has not been
much published research in the success of these different types of modalities.

While parent training has been shown to be an effective intervention for child behavior problems, there are certain parent characteristics which moderate outcome effectiveness. Among the variables related to less positive outcomes in parenting training are parent's high parenting stress, harsh parenting practices, low social support, marital discord, psychopathology in a parent, socioeconomic disadvantage, and single parenting (Kazdin, 1997). Also, Peterson and Hawkey (1998) reported that lack of social support within the family and neighborhood has also been associated with the presence of child abuse. However, motivation as a parent characteristic has not yet been addressed as a factor in the effectiveness of parent training.

Statement of the Problem

A possible means of intervention against childhood maltreatment is the development of parent training to assist parents in modifying their parenting skills. A factor that may affect treatment success, specifically parenting skills, is the motivation for the client to attend therapy. According to Pelletier, Tuson, and Haddad (1997), over the last decade one perspective of human motivation that has received a great deal of attention from researchers is the theory of intrinsic motivation and self-determination.
proposed by Deci and Ryan (1985). Specifically, the different types of motivation range through a continuum of self-determination in which the lowest type is amotivation, followed by external regulation, introjection, identification, integration, and intrinsic motivation (Pelletier et al., 1997).

There is a lack of research on the effectiveness of individual or group therapy for parents involved in a social service agency and a lack of information regarding interaction of the client type and level of motivation. Therefore, there was a need to study whether motivation should be a consideration for the type of treatment modality that the parent was assigned to (group or individual). In other words, there was a need to understand how motivation affects treatment success and if the success differs depending on the type of treatment modality, individual or group therapy.

Therefore, it was necessary to understand how the opposite sides of the same factor, extrinsic or intrinsic, motivation changed over time as a result of participating in either individual or group therapy. Specifically, did motivation change over time depending on whether the parent was involved in group therapy versus individual therapy.

According to Wasik and Roberts (1994), parents who maltreat their children rarely seek treatment for themselves.
because of lack of motivation and logistical problems such as transportation and child care, but also because of the "public stigma" of being abusive or a neglectful parent. Therefore, with the assistance of the child protective service agency recommending treatment for these parents, they may be required to attend treatment in order to remediate their abusive behaviors. However, despite the existing literature regarding parents who maltreat their children, there remains a lack of evidence for the most effective treatment for this population (Kolko, 1996).

Therefore, expanding the existing knowledge of treatment success regarding parenting skills for this population was essential. By understanding how motivation (intrinsic or extrinsic) affects treatment success in specific modalities (individual or group therapy), it may assist in clarifying who is assigned to either treatment modality.

Significance of the Study

Cases of child maltreatment continue to rise in the United States, leading to a tremendous demand in the need of services from the child protective service agencies which are already overburdened (Schneiderman, Connors, Fribourg, Gries & Gonzales, 1998). This increase in cases of child maltreatment may either be due to more accurate reporting procedures in the child protective service agency or an
actual increase in child maltreatment incidents. The children entering child protective service agencies are commonly displaying “complex social, medical, developmental, and psychiatric problems” (Schneiderman et al., 1998, p. 29).

Therefore, studies providing information regarding this population are necessary in order to gain understanding on what affects treatment success in parenting training. This study addressed the care and treatment of families that were at risk for childhood maltreatment and therefore assisted in understanding the type of treatment modality that was more successful.

The focus of this research was to gain information regarding effective treatment approaches and factors affecting the increase of parenting skills and motivation for treatment with parents involved in a child protective service agency. This information will assist in developing appropriate treatment for this population. This was achieved by researching a suburban area hospital in a northern area of New Jersey that works with parents involved in a child protective service agency. The child protective service agency involved with this study was a Northern New Jersey Division of Youth and Family Services (DYFS). These parents were either involved in individual therapy or group therapy.
Specifically, this was a quasi-experimental study that examined if the level of intrinsic motivation, level of extrinsic motivation, and the two types of therapy (individual and group therapy) related to treatment success of changes of parenting skills. This study also examined if the level of motivation (intrinsic and extrinsic) changed over eight sessions depending on the treatment modality, specifically group or individual therapy.

Due to the lack of research regarding treatment modality, level of motivation, and parenting skills, hypotheses were unable to be developed.

Research Questions

1. Do the pre-treatment variables intrinsic motivation, extrinsic motivation, and type of therapy (group or individual) predict changes in parenting skills (appropriate developmental expectations, empathy, alternative to corporal punishment, role reversal, and understanding children's power/independence)?

2. Is there a significant change in motivation for therapy (intrinsic and extrinsic) over eight sessions and is it related to participating in individual or group therapy for parents involved in a child protective service agency?
Definition of Terms

Child protective service agency.

In 1974, the United States Congress passed the Child Abuse Prevention and Treatment Act (CAPTA) (Hutchison, 1990), with the goal of protecting children from maltreatment through abuse (commission) and neglect (omission) by their parents and other care givers (Hutchison, 1990). This act, CAPTA, assisted in creating child protective service agencies, which are currently in every state in the United States. These agencies were developed mainly as “child welfare systems that receive and investigate reports of child abuse and neglect, offer services to families, provide foster homes for children who must be removed from their parents' care, and work to find permanent placements for children who cannot safely return home” (Matthews, 1999, p. 55). Specifically, the child protective service agency that was involved with this study was a Northern New Jersey Division of Youth and Family Services (DYFS).

Parenting skills.

For this study, parenting skills was defined as the ability to have a) appropriate developmental expectations, b) an ability to be empathic and aware of children's needs, c) appropriate means of discipline, d) appropriate family roles, and e) understanding of children's power and
independence (Bavolek & Keene, 1999). These five parenting skills will be measured using the Adult-Adolescent Parenting Inventory - 2 (AAPI-2) (Bavolek & Keene, 1999) and are further explained in Chapter III.

The first parenting skill construct, appropriate developmental expectations, is defined as having an understanding of growth and development, being supportive of children, and allowing children to exhibit normal developmental behaviors (Bavolek & Keene, 1999). The second parenting skill construct, appropriate level of empathy, is defined as understanding and valuing children’s needs, nurturing children and encouraging positive growth, and recognizing children’s feelings (Bavolek & Keene, 1999).

The third parenting skill construct, appropriate means of discipline, is defined as understanding alternatives to physical force, utilizing alternatives to corporal punishment, and tends to have respect for children and their needs (Bavolek & Keene, 1999). The fourth parenting skill construct, appropriate family roles, is defined as having children’s needs met appropriately, children are allowed to express developmental needs, and the parent is able to find comfort, support, and companionship from their peers (Bavolek & Keene, 1999). Finally, the fifth parenting skill construct, understanding children’s power and independence, is defined as placing high value on children’s ability to
problem solve, empower children to make good choices, and encourages children to express their views, but expects cooperation (Bavolek & Keene, 1999).

Group therapy.

Group therapy was conducted on a weekly basis at a Northern New Jersey Division of Youth and Family Services (DYFS)-funded outpatient clinic based out of a Northern New Jersey Hospital. The focus of this eight-week cycle closed group was parenting training. Specifically, parenting training that focused on specific behaviors and ways to implement these learned behaviors to practice with the child (Bond & Burns, 1998) in a group setting.

The therapist conducted the group in a cognitive/behavioral theoretical orientation. The therapist who led this group was a New Jersey licensed social worker with approximately eight years of experience who was not told the specifics of this study. She was supervised by a New Jersey licensed social worker in New Jersey who was then supervised by a New Jersey licensed psychologist. This New Jersey licensed psychologist also supervised the two therapists that conducted the individual therapy. Also, the therapist that led the group and the therapists that conducted individual therapy were part of the treatment team at this agency. During the weekly treatment team meetings, specific cases were discussed.
There was no manualized treatment for this group. However, the main treatment goals included teaching appropriate discipline techniques throughout the childhood years and ways to implement these learned behaviors with the child. Specifically, the focus was on the benefits of positive reinforcement, incorporating limit setting while using praise, natural consequence for children's actions, empathy toward the children, and appropriate childhood development. This group used group discussion, role-play, and written information as means of learning appropriate discipline techniques for their children.

*Individual therapy.*

Individual therapy was conducted on a weekly basis at a Northern New Jersey Division of Youth and Family Services (DYFS)-funded outpatient clinic based out of a Northern New Jersey Hospital. The focus of the individual therapy was parenting training on specific behaviors and ways to implement these learned behaviors to practice with the child (Bond & Burns, 1998) in an individual setting. There were two female primary therapists that conducted the individual therapy. Neither of these therapists was told the specifics of this study. One therapist had five years of experience and received a Master of Arts degree in psychology. The other therapist had eight years of experience and received a Master of Arts degree in psychology. Individual therapy was
conducted in a cognitive/behavioral theoretical orientation. Both therapists were supervised by the same New Jersey licensed psychologist that supervised the therapist that conducted the group therapy. Also, both therapists and the therapist leading the group were part of the treatment team at this agency. During the weekly treatment team meetings, specific cases were discussed.

Along with group therapy, there was no manualized treatment for individual therapy. However the two main treatment goals included teaching appropriate discipline techniques throughout the childhood years and ways to implement these learned behaviors with the child. Specifically, the focus was on the benefits of positive reinforcement, incorporating limit setting while using praise, natural consequence for children’s actions, empathy toward the children, and appropriate childhood development.

Motivation for treatment.

Motivation for treatment was defined in this study to include Deci and Ryan’s (1985) three types of motivation (intrinsic, extrinsic, and amotivation). However, for the purpose of this study, only intrinsic and extrinsic motivation was studied because they are the two opposite ends of the same factor. Motivation was scored using the Client Motivation for Therapy Scale (CMOTS)(Pelletier, 1997). This instrument is further discussed in Chapter III.
According to Deci and Ryan (1985), intrinsic motivated behaviors are defined as the behaviors that are performed voluntarily by the person due to the pleasure derived by the performance (Deci & Ryan, 1985). Extrinsic motivated behaviors are defined as the behaviors that are performed to receive a reward or to avoid punishment. Finally, amotivation is when there is no perceived relationship between a person's actions and their outcome (Deci & Ryan, 1985).

For this study, intrinsic motivation occurs when participants were motivated to change due to their own wish to change on the other hand extrinsic motivation was stimulated from influences outside of themselves such as from DYFS or the courts.

Limitations of the Study

Any generalizations based on the findings of this study should be limited to the characteristics of the sample. These characteristics include only English speaking, single family households involved in a child protective service agency in the northern region of New Jersey. Specifically, the child protective service agency that was involved with this study was a Northern New Jersey Division of Youth and Family Services (DYFS). Also, for participants who demonstrate insufficient reading ability, the instruments were read to them by the intake clinician.
Participants in the study were placed in individual therapy or group therapy depending on the available openings in either group or individual therapy. Therefore, there was concern of selection bias due to the participants not being randomly assigned to either individual or group therapy.

This study also limited its population to parents involved in a child protective service agency who are being treated on an outpatient basis with no fee for group therapy or individual therapy. The fees are paid through a child protective service agency's grant fund.

This study did not account for how the child was maltreated, the severity of the abuse, or the age of the abuse for the child. It did not attempt to divide parents into groups between those parents that a child protective service agency had substantiated or unsubstantiated abuse against them specifically. If the abuse was substantiated for a specific person, this study did not account for how many counts of abuse were placed against them. Also, this study did not attempt to divide parents into separate groups due to whether or not they are currently involved in family court or criminal court due to the substantiation of the abuse.

The research was conducted through self-report measures. Therefore, due to the subjective nature of the instruments utilized, there was a potential threat of
validity of the research as a result of social desirability and acquiescence (Gall, Borg & Gall, 1996).

Also, this study was quasi-experimental in nature. Therefore, the lack of manipulation of variables reduced the robustness of causality between the variables.

Finally, since the participants volunteered to participate in this study, there were potential threats towards the validity of the research due to the factors of social desirability.
CHAPTER II
Review Of Related Literature

The review of this literature addresses seven constructs relating to this study. First, the studies related to child maltreatment will be examined. The second section will address the intergenerational transmission of child maltreatment in order to clarify the necessity of this study in regard to discontinuing this cycle of abuse. Third, relevant literature regarding parenting skills will be presented. Fourth, group and individual therapy will be discussed. Fifth, a review of literature pertaining to child protective services will be explored. Sixth, studies relating to court-ordered therapy will be examined. Finally, the seventh section will address motivation for treatment.

The current quasi-experimental study examined if the level of intrinsic motivation, level of extrinsic motivation, and the two types of therapy (individual and group therapy) related to treatment success of changes of parenting skills of parents involved in a protective service agency. It also examined if the level of motivation (intrinsic and extrinsic motivation) changed over eight sessions depending on the treatment modality (individual or group therapy).
Child Maltreatment

According to Belsky (1980), child maltreatment is a complex and multicausal problem resulting from interactions between individual characteristics of the caretaker and familial, environmental, and cultural factors. Childhood maltreatment includes many types of child victimizations, including child neglect and child abuse (Belsky, 1993; DePanfilis, 1996). According to Widom (1999), neglect cases reflect a judgment that the parents' deficiencies in child care were beyond those found acceptable by the community and professional standards at the time. The cases of neglect represent a failure to provide adequate shelter, nutrition, health care, clothing, education, affection, and nurturance (Dubowitz et al., 1993). On the other hand, child abuse may consist of physical abuse, sexual abuse, and/or emotional abuse (Carlson, Furby, Armstrong, & Shlaes, 1997; Fennell & Fishel, 1998). Physical abuse is defined to include injuries such as "bruises, welts, burns, abrasions, laceration, wounds, cuts, bone and skull fractures, and other evidence of physical injury" (Widom, 1999, p. 158).

Approximately 1,200 children died in the United States in 2000 as a result of child abuse and neglect at a rate of 1.71 children per 100,000 children in the United States (U.S. Department of Health and Human Services, 2002). In 2000, approximately three million referrals were made to
child protective service agencies concerning approximately five million children throughout the United States (U.S. Department of Health and Human Services, 2002).

Approximately 879,000 children were found to be victims of child maltreatment, which included 63% of the children were suffering from neglect (including medical neglect), 19% were physically abused, 10% of the children were sexually abused, and 8% were found to be psychologically maltreated (U.S. Department of Health and Human Services, 2002).

The response to being abused or neglected varies among children. For instance, Hall (2000) reported that abuse is a targeted violence on children that leads to a variety of distinct developmental related responses throughout life. For instance, Hall (2000) stated that older children tend to physically run away from the abuse or turn to using substances, whereas younger children tend to respond with more fear and anxiety. Hall (2000) also stated that some of the abused and neglected children do not display any immediate responses from the abuse. However, during adulthood, various responses may emerge.

The effects of physical abuse on children's social relationship were studied by Salzinger, Feldman, & Hammer, 1993. They compared 87 physically abused children, ages 8-12 years, in urban areas with 87 nonmaltreated classmates regarding social behavior and peer status. Using peers in
the classroom, they collected peer nominations and peer ratings on the children. They used child interviews to assess social networks. Finally, parents and teachers rated behavior problems. Salzinger et al., (1993) found that abused children had lower peer status and less positive reciprocity with peers chosen as friends. Abused children were rated by peers as more aggressive and less cooperative. The abused children were rated by parents and teachers as more disturbed. Finally, their social networks showed more insularity, atypicality, and negativity. However, it can not be generalized due to the researchers using only urban children that were physically abused in this study.

Fergusson and Lynskey (1997) researched the relationship between retrospective reports of physical punishment/maltreatment and rates of adjustment difficulties at the age of 18 years. The data was gathered over the course of an 18 year longitudinal study of 1,265 people in New Zealand. At the age of 18, retrospective reports were completed to assess exposure to physical punishment/maltreatment during childhood. At this time, the participants were also assessed regarding their psychosocial adjustment including juvenile offending, substance abuse behaviors, and psychiatric disorders. Fergusson and Lynskey (1997) concluded that the participants who reported exposure to abuse during childhood had elevated rates of juvenile
offending, substance abuse, and mental health problems. Fergusson and Lynskey (1997) also stated that elevated risks might arise from social context within the abusive period.

Widom (1999) studied the possible effect of childhood abuse and neglect on psychological disorders. Specifically, Widom (1999) studied the extent to which childhood abuse and neglect increase a person's risk for subsequent posttraumatic stress disorder (PTSD) and determined whether the relationship to PTSD persists despite controls for family, individual, and lifestyle characteristics associated with both childhood victimizations and PTSD. The researcher used 1,196 adult participants. One group consisted of adults that were substantiated victims of child abuse and neglect and the other group consisted of adults that were not abused and not neglected during childhood. The results indicated that childhood victimization was associated with increased risk for lifetime and current PTSD. Widom (1999) reported that 37.5% of childhood victims of sexual abuse, 32.7% of physical abuse, and 30.6% of victims of childhood neglect met the criteria for PTSD according to the DSM-III. However, this study did not separate among type of victimization, gender, or if there were any past or current psychological disorders.

The long-term effects of childhood abuse and neglect on adulthood has been studied by Taussig and Litrownik (1997).
They studied whether type of abuse experienced as a child was related to the type of destructive behavior displayed by children who had been placed in foster care. Taussig and Litrownik (1997) studied 731 children between the ages of four and seventeen that were placed into foster care. Child maltreatment classification was gathered through case record data for each participant. The researchers constructed a variation of the Child Behavior Checklist and Youth Self Report from the Achenbach and also had the caregiver complete a Demographic Questionnaire. A t-test for independent and paired samples was utilized. The results indicated that physically abused youth reported significantly more (p<.02) other-directed destructive behaviors than did sexually abused youth. The sexually abused youth reported significantly more (p<.005) self than other-directed destructive behaviors. Therefore, the results suggested that the type of disruptive behavior is differentially related to the type of abuse that the child has experienced. Taussig and Litrownik (1997) report that there are some limitations with this study. For instance, they state that there is a small sample size, all of the children were in foster care during the interview, there was no control group, and the classification of the abuse does not necessarily mean that there was no other type of abuse toward the child. This study did not separate between the
genders of the child and therefore it can not be
generalized.

Child maltreatment has also been correlated with
single-parent caretakers. According to Gelles (1989),
single-parent households are at high risk for aversive
family outcomes such as child maltreatment. Forehand,
Thomas, Wierson, Brody, & Fauber (1990), conducting a study
investigating youth’s reactions to stressful life events.
They compared adolescents from divorced and intact families.
The results indicated that there were significant
differences between the divorced and intact families with
respect to a number of characteristics, with divorced
mothers displaying more depression and poorer parenting and
the children of divorced parents displaying poorer cognitive
skills, poorer social skills, and more internalizing and
externalizing problems. The study, however, does not
account for any other stressors that may be occurring during
this period. This study also did not separate gender
between the female and male adolescents. Forehand et al.
(1990) states that this study should be used as a
preliminary and conservative test. Specifically, because
the constructs were “assessed by a different informant, thus
preventing a problem of common method variance” (Forehand et
al., 1990, p.282).
Overall, the effects of childhood maltreatment, which include child neglect and child abuse, varies depending on the age, type of abuse, and numerous other variables. Studies have been explored regarding the effects that age has on childhood abuse (Hall, 2000), effects of physical abuse on social relationships (Salzinger, Feldman, & Hammer, 1993), effects of abuse and neglect on psychological disorders (Widom, 1999), and numerous other studies. In other words, the results of these studies regarding childhood maltreatment continually indicate that there is a negative impact on children who have been abused and neglected. Therefore, studies which focus on possibilities to decrease child maltreatment, such as parenting techniques to eliminate abuse, are essential.

**Intergenerational Transmission**

In order to gain an understanding of intergenerational transmission of abuse, one may look towards Bowlby’s attachment theory. According to Bowlby’s theory (1973), there is a working model of the self, others, and self-other relationships that are derived from early child-caregiver relationships. These are carried forward and therefore, account for the continuing of abuse. The parent’s internalized working model of attachment may explain how they behave as an attachment figure towards their own child and therefore continue the transmission of the abuse.
According to Egeland, Jacobvitz, and Sroufe (1988), Bowlby's attachment theory may also assist in explaining the discontinuities of the cycle of abuse. Specifically, Egeland et al., (1988), stated that there are three kinds of relationship variables that are important in order to develop an alternative model of relationships and therefore forming a nurturing relationship with the child despite having one's own abusive childhood. The three relationship variables are 1) having both an abusive relationship during childhood and an emotionally supportive relationship available, 2) having an ongoing therapeutic relationship with a therapist during the parent's life, 3) and having a stable and satisfying relationship with a partner during adulthood (Egeland et al., 1988).

Simons, Whitbeck, Conger, and Chyi-In (1991) studied the intergenerational transmission of harsh parenting. Harsh parenting was defined as "yelling,spanking,slapping,shoving,or hitting the child with an object" (Simons et al., 1991, p. 161). They studied 451 2-parent families, which included a seventh grader. Simons et al., (1991) utilized a parent self-report and an adolescent-report to measure the harsh parenting construct. The results indicated that grandparents who engaged in aggressive parenting with their children produced present-day parents who were likely to use similar parenting practices with
their children. Specifically, the effect was stronger for mothers than fathers. In addition, Simons et al., (1991) reported that there were also similarities noted across generations regarding the harsh discipline of male children being partly a function of socioeconomic characteristics transmitted across generations. Since this study used self-report measures, the results should be read with caution because the participants may be portraying themselves in a favorable light.

Hall, Sachs, and Rayens (1998) also studied intergenerational transmission of abuse. They investigated the relationship of low-income single mother's history of childhood abuse and the social resources with their potential for physical child abuse. The Child Abuse Potential Inventory (CAPI) (Milner, 1986 as cited in Hall et al., 1998) was used to assess the mother's potential for physical child abuse. The Violence Scale on the Conflict Tactics Scale (CTS) (Straus, 1974 as cited in Hall et al., 1998) was used to measure the mother's history of physical abuse before the age of 18 years. The Duke-UNC Functional Social Support Questionnaire (FSSQ) (Broadhead, Gehlbach, de Gruy, & Kaplan, 1988, 1989, as cited in Hall et al., 1998) measured perceived emotional support. The Interpersonal Support Evaluation List (ISEL) (Cohen & Hoberman, 1983 as cited in Hall et al., 1998) was used to measure tangible
social support. The Family Function Questionnaire (FFQ) (Reeb, Graham, Zyzanski, & Kitson, 1987 as cited in Hall et al., 1998) measured social resources in family relationships. Finally, the Autonomy and Relatedness Inventory (ARI) (Shaefer & Edgerton, 1982 as cited in Hall et al., 1998) was used to assess the quality of the primary intimate relationship. The results indicated that the levels of physical and sexual abuse in childhood were positively associated with the mother's child abuse potential with the strongest association being sexual abuse (Hall et al., 1998). They also reported that mothers that reported violent sexual abuse as children were almost six times more likely to have high potential for physically abusing their children when compared with mothers who did not report being sexually abused during childhood. However, there were some limitations with this study. Specifically, there was no descriptive data regarding the perpetrator, the mother's age during the abuse was not collected, the length of the abuse was not collected, and the specific type of abuse was also not collected. In addition, there was no assessment of the actual occurrence of the abuse.

Along with studies that support the concept of intergenerational transmission of abuse, Williams and Vines (1998) conducted a study that does not support this concept. They researched mothers who were abused or neglected during
their childhood. They studied the mother's view of their childhood struggles, their transition into motherhood, and their relationships after becoming a parent. Williams and Vines (1999) interviewed seven first-time mothers, ages 13 to 20, who were involved in a community-based parenting program that reported being abused or neglected as children. The results of this study indicated that the mothers reported that the process of pregnancy and parenting was a mechanism for growth where they viewed the experience as an opportunity to receive support from family members and to build more positive relationships. A limitation to this study is that they only interviewed first-time mothers who were currently involved in a parenting program.

Through understanding the research of intergenerational transmission of abuse, this assists in explaining and possible discontinuing this cycle. Simons et al., (1991) and Hall et al., (1998) studied intergenerational transmission of abuse. Overall, the results from their studies indicated that parents use parenting skills learned by their parents with their children. These parenting skills included "harsh discipline" (Simons et al., 1991) and physical abuse (Hall et al., 1998). However, in Williams and Vines (1999) study, mothers who were abused or neglected as children, viewed pregnancy and parenting as an
opportunity to receive support from family members and gain positive relationships.

Parenting Skills

An intervention against childhood maltreatment is the development of parent education and parent training to assist parents in modifying their parenting skills. Parent education targets more generalized parenting skills and teaches information concerning child development (Bond & Burns, 1998), while parenting training attempts to resolve existing childhood behavior problems by teaching parents ways of changing and controlling the child’s environment (Briesmeister & Schaefer, 1998). However, in research the terms parenting education and parenting training have been used interchangeably “to denote a wide range of intervention models designed to enhance parents capacities to foster optimal child development” (Dore & Lee, 1999, p.314).

There are various parent training programs which are focused toward a specific approach. For instance, some parent trainings are grounded in behavioral principles or Adlerian psychology (Whipple & Wilson, 1996). One type of parent training that is focused on behavioral principles is known as Behavioral Parent Training (BPT) which began in the late 1960’s. The main focus of this type of training emphasis the role of the parent in regard to the development and maintenance of the child’s antisocial behavior.
(Serketich & Dumas, 1996). Specifically, this program uses didactic instructions, modeling, and role playing in order to teach parents how to increase their child’s compliance by modifying their own behaviors (Serketich & Dumas, 1996). An example of an Adlerian psychology parent training program is the Systematic Training for Effective Parenting (STEP). The STEP program was developed by Dinkmeyer and McKay in 1976 and was not designed for children who have psychological problems, instead it is designed for “typical” challenges in parenting (Fennell & Fishel, 1998).

Another parenting training program that relies on child management skills, behavior modification, and focuses on helping parents to modify the undesirable behaviors exhibited by their children is known as the Parent Management Training program (PMT) (Barclay & Houts, 1995). This type of program is based on social learning principles that specify decreasing deviant behaviors, while developing positive prosocial behaviors (Kazdin, 1997).

Parent training programs have been shown to generate positive changes which may be maintained for long periods of time following treatment, generalize to other children, and generalize to behaviors other than those initially targeted as most problematic (Briesmeister & Schaefer, 1998). Abusive and neglectful parents have also been treated through parenting approaches (Barclay & Houts, 1995).
However, while parent training has been shown to be an effective intervention, there are certain parent characteristics which moderate outcome effectiveness. Examples include harsh parenting practices, marital discord, low social support, and single parenting (Kazdin, 1997). Parent training programs began in the 1960’s, specifically for low-income families (Weinman, Schreiber, & Robinson, 1992) and are now being created to assist families at different socioeconomic levels.

Miller, Fox, and Garcia-Beckwith (1999) examined the child protection process in cases of severe physical abuse and compared the characteristics of the families with risk factors. These researchers examined 30 case records of severely abused children under the age of five that were involved in child protective services. The results indicated that the parents displayed a range of psychological characteristics, such as depression, anxiety, and personality disorders. The parents also displayed life problems, such as domestic violence, substance abuse, and abuse during their childhood. A majority of the parents denied any abuse against their child. Miller et al. (1999) also reported that the most common form of treatment for these parents were individual therapy and parent training classes. Of these families, more than half of the children were reunified with at least one parent within one year.
However, Miller et al., (1999), stated that the data should be interpreted with caution due to the study’s retrospective nature, there was no control or random sampling, and it was limited to a single community with a relatively sophisticated child protective service agency.

Whipple (1999) studied the effectiveness of a community-based group parent education and support program in improving risk factors associated with physical child abuse. Whipple (1999) conducted a pre-test and post-test on 116 families with preschool children that included parents from violent households, single and/or young parents, and community mental health center clients. The research specifically studied parental stress, impaired parent-child interactions, verbal and physical aggression, and poor quality of the home environment. Parental stress was measured by using the Parental stress Index/Short Form (PSI/SF) (Abidin, 1990 as cited in Whipple, 1999), the Conflict Tactics Scales (CTS) (Straus, 1999 as cited in Whipple, 1999) measured the physical and verbal aggression, and the Early Childhood Home Inventory (ECD) (Caldwell & Bradley, 1984 as cited in Whipple, 1999) measured the quality of the home environment. Overall, the results indicated that parents who completed the 30 week group parenting education and support program were better able to provide a developmentally stable home environment for their
four year old children, parental stress decreased, and the parents were able to negotiate conflicts with their children in a less violent manner. However, this study did not have a comparison group to differentiate their results.

Weinman, Schreiber, and Robinson (1992) evaluated a 24-group session program that primarily focused on preventing childhood abuse among adolescent mothers. They studied 73 participants from this program using the Adult-Adolescent Parenting Inventory (AAPI) (Bavolek, 1984), Offer Self-Image Questionnaire (Offer, Ostrow, & Howard, 1982 as cited in Weinman et al., 1992), Nowicki-Strickland Locus of Control (Nowicki & Strickland, 1973 as cited in Weinman et al., 1992), and the Stein Future Events Test (Stein, Sarbin, & Kulik, 1986 as cited in Weinman et al., 1992). The results revealed that the participants that completed the program showed positive changes on the Adult-Adolescent Parenting Inventory constructs (role reversal, empathy, developmental expectations, and corporal punishment). This indicated that the adolescent parent was retaining the information that was taught in the program. The results also revealed significant changes on the Offer Self-Image Questionnaire, which indicated that their self-image increased following the parenting skills program. However, the Nowicki-Strickland Locus of Control and the Stein Future Events Tests did not show any changes. This lack of changes might
be because these tests are too abstract for this specific age group (Weinman, Schreiber, & Robinson, 1992). However, this study did not look at the non-completers of this program, therefore it is difficult to state whether the positive changes on the Adult-Adolescent Parenting Inventory and the Offer Self-Image Questionnaire were due to completing the program.

Hurlbut, Culp, Jambunathan, and Butler (1997) also studied adolescent mothers and parenting skills. They investigated the relationship between the adolescent mother’s self-esteem and her knowledge of parenting skills using the Adult-Adolescent Parenting Inventory (AAPI) (Bavolek, 1984) and the Index of Self-Esteem (ISE; Hudson, 1982 as cited in Hurlbut et al., 1997). They studied 24 first-time mothers who were 21 years old or younger at the time of their baby’s birth. The participants were from an ongoing parenting group program in the county health department. A demographic questionnaire and the ISE were conducted prior to the birth of the baby. Three months following the birth of the baby, the ISE was again completed along with the AAPI. When the baby was six months old, the AAPI was again completed. The results revealed that self-esteem is a good indicator of the adolescent mother’s parenting skills. Hurlbut et al. (1997) revealed significant correlations between the mother’s baseline self-
esteem and her knowledge about role reversal, empathy, developmental expectations, and corporal punishment. However, this study did not account for any social support that the participant may have had throughout the research.

Even though parent skills group training has been shown to be a positive form of treatment with parents involved in a child protection service agency, some researchers do not support the same outcome. For instance, Whipple and Wilson (1996) researched the effectiveness of a community-based group parent education and support program in ameliorating risk factors associated with physical abuse. They collected data from 34 physically abusive families at three different points of a parent education program over a nine month period. Data was collected by means of questionnaires, face-to-face interviews, and telephone contacts. The questionnaires included an intake questionnaire, Life Experiences Survey (LES) (Sarason, Johnson, & Siegel, 1978 as cited in Whipple & Wilson, 1996), the Beck Depression Inventory (BDI) (Beck, Steer, & Garbin, 1988 as cited in Whipple & Wilson, 1996), and the Maternal Social Support Index (MSSI) (Pascoe, Ialongo, Horn, Reinhart, & Perradatoo, 1988 as cited in Whipple & Wilson, 1996). Whipple and Wilson (1996) concluded that parental depression and stress were significantly reduced following the parent education. However, social support and child misbehaviors were not
significantly reduced following the parent education. Whipple and Wilson (1996) state that these findings should be interpreted with caution because the parents were already involved with this parent program prior to becoming involved in this study. Also, the sample size is relatively small and there is no control group to compare the results to.

Overall, parent education and/or parent training have been studied as a means of intervention against childhood maltreatment. Programs have been developed and studied that focus toward specific approaches such as behavioral principles (Whipple & Wilson, 1996) and social learning principles (Kazdin, 1997).

*Group / Individual Therapy*

Group therapy is a treatment modality where members in group discuss "common issues and share feelings in an atmosphere of trust" (Cameron, 1998, p.5). Group interventions assist in diminishing the sense of isolation while alleviating the effect of silence and shame (Marotta & Asner, 1999). Groups also replicate familial dynamics, which means the group member must explore their role in their family of origin and how it is influencing their current functioning (Yalom, 1985). Moreover, a major factor in group therapy is the mutual assistance in making experiences feel normalized by group members, on the other hand the most important goal is the enhancement of coping
skills the member gain through this mutual sharing and assistance (Yalom, 1995). Group members learn to communicate and express their feelings to others and have a sense of belongingness.

However, there are some limitations to group therapy. Specifically, the most frequent exclusion of a member in group is when they are in an acute crisis (Rutan & Stone, 1993). The acute crisis can be "a developmental crisis (such as marriage, divorce, retirement), a situational crisis (death of a loved one, physical illness), or a crisis of pathology (eruption of a psychotic process or extraordinary anxiety)" (Rutan & Stone, 1993, p.84). These patients would benefit more from individual therapy where they may gain the vast attention they need and they do not have to be concerned about having the time and interest to meet and develop relationships with group members (Rutan & Stone, 1993). Furthermore, the group members would be able to spend the time needed on their issues, instead of devoting a majority of the time to the member that is going through a crisis.

Another population set that would also not benefit from group therapy, are those with "insufficient impulse control (so that the physical safety of other members cannot be guaranteed), chronically psychotic patients, patients with
organic brain syndromes, and sociopathic patients" (Rutan & Stone, 1993, p.85).

Individual therapy focuses on a one on one relationship and requires a level of collaboration between only the patient and therapist (Durham, Swan, & Fisher, 2000).

Although individual and group therapy for other populations have been compared, a search of the literature did not reveal any previous studies comparing these treatment modalities in adults regarding levels of motivation or parenting skills. However, there was one study found which examined the differences between subjects in only individual therapy and subjects in both individual and group therapy in regards to parenting skills.

Iwaniec (1997) studied two groups of 20 emotionally abusive and neglectful parents. One group was offered individual parent training of ten sessions and the second group was also offered the individual parent training along with a ten session group work. Checklists completed by an observer were utilized for obtaining parental emotionally abusive behavior and child’s reactive behaviors. The State-Trait Anxiety Inventory (STAI) (Spielberger, Gorsuch, & Lushene as cited in Iwaniec, 1997) was administered to the parents to obtain their anxiety levels. The parents rated themselves on a 0 through 10 scale regarding their prenatal stress with ten signifying extreme stress and tension.
Finally, a post treatment questionnaire was completed by the participants following treatment to obtain their perception on their new parenting skills. The results revealed that the group that had both individual and group therapy improved significantly regarding lower levels of anxiety, more confidence, and less stress when compared to their baseline scores. Regarding reductions in emotionally abusive behaviors, both groups achieved significant reductions. However, in this study, the participants were assigned to both group and individual therapy sequentially and not randomly. Therefore, this study is limited in regard to truly being able to compare the outcomes of the two conditions.

Even though parenting skills are usually taught in group therapy, DePanfilis (1996) reported that initially, individual support might be more appropriate for neglectful families due to their lack of social skills, which are necessary to get along well in groups. However, DePanfilis (1996) reported that including a social support component in teaching parent skills in a group setting with parents who maltreat their children, might reduce social isolation and therefore become more successful in treatment.

Child Protective Services

In 1974, the United States Congress passed the Child Abuse Prevention and Treatment Act (CAPTA), (Hutchison,
1990), with the goal of protecting children from maltreatment through abuse (commission) and neglect (omission) by parents and other caregivers. To implement this act, child protective service agencies were developed to operate within a framework created by federal law and funding, however these agencies are primarily the responsibility of state and local governments (Findlater & Kelly, 1999).

Child protective service agencies become involved with specific families when there are concerns that minimum standards of care and protection have not been met by the caretaker (Dubowitz, 1997). According to Findlater and Kelly (1999), the primary function of child protective service agencies is to screen and investigate reports of child maltreatment and determine whether child abuse or neglect has occurred. If it has occurred, there is a need to assess risk of harm to the child and to assess the needs that the family may have in order to determine what intervention or services are necessary. If the investigation as to whether child abuse or neglect has occurred, the case is considered founded or substantiated. However, if the investigation yielded that child abuse or neglect has not occurred, the case is classified as indicated, inconclusive, or unfounded (English, Marshall, Brummel, & Irme, 1999).
If the risk for child abuse or neglect is substantiated, the case will be opened at the child protective service agency. According to Drake and Jonson-Reid (2000), most states have substantiation rates in the 20% to 50% range. The child protective service worker will then develop a service plan, arrange for necessary services, and evaluate the family's progress under the plan (Findlater & Kelly, 1999). If the family is able to follow the plan and reduce the risk of harm to the child, the worker may allow the child to remain in the home. However, if the risk remains in the home, the worker may seek family court approval to place the child out-of-home (Findlater & Kelly, 1999). According to Findlater and Kelly (1999), the federal law requires that placement must be made as close to the home as possible and in the least restrictive environment for the child. When the child is removed and placed out-of-home, another case plan is required by the federal government, to be developed with the family so that the child may be reunified with the parent (Findlater & Kelly, 1999).

Dubowitz (1997) reported that once a child protective service agency becomes involved with the family and abuse or neglect has occurred, child protective services intervenes in the family by providing parental guidance and support or punishment.
Donnelly (1997), reported that since self-reporting is on the rise, child protective services workers are too often overwhelmed. Therefore, Donnelly (1997) stated that it is becoming difficult for child protective service workers to provide what was once normal to families involved in their services. For instance, workers used to provide treatment, support, and help for families having difficulty in taking care of their children.

Marshall and English (1999) studied the importance of risk factors for chronic recidivism in child abuse and neglect. The data set used for this research consisted of approximately 120,000 referrals to a child protective service agency in the Northwest United States between July 1, 1994 and December 31, 1997. The results revealed that "families with multiple referrals are distinguished by caregivers with a history of abuse and neglect as children, a history of abuse or neglect that begins at an early age, children with developmental delays, and multiple victims in the family" (Marshall & English, 1999, p. 294). They also reported that the time to rerefer decreased when there was an increase in the number of prior referrals. This study is limited because it did not distinguish between different types of abuse and if there was a rereferral. It also did not differentiate between the types of abuse. Finally, this
study is limited because it did not report the statistics and the specific results of the study.

The study of recidivism in child abuse and neglect was also noted in English, Marshall, Brummel, and Irme's (1999) research. They studied 12,329 cases of referrals to the child protective service agency in Washington State within an 18-month period. They reported that the 18-month rereferral rates were 29%. They stated that the "largest single factor associated with rereferral and recurrence is the number of prior CPS referrals" (English et al., 1999, p.304). Also, English et al., (1999) reported that the principal risk factors associated with rereferrals are "history of child abuse and neglect as a child, history of domestic violence, substance abuse, and caregiver impairments" (English et al., 1999, p. 305). Finally, families that have one or more children placed in foster care and then are reunited, have a higher rate of rereferral (39% within 18 months) when compared to families that did not have their children placed in foster care (27% within 18 months). This study, however, did not take into account the type of abuse and the age of the child that was abused.

Child protective services were created nationwide to protect children from maltreatment from their parent or caregiver. Understanding what the parent lacks in regard to
motivation and parenting skills to prevent further referrals to protective services are necessary.

Court-ordered Therapy

Some clients attend therapy because they are court-ordered due to legal matters. In cases that are adjudicated in cases of child maltreatment, a common response by the court is a referral of the parent to a parent training program (Dore & Lee, 1999). For instance, parents may be court-ordered to attend therapy to remediate abusive behaviors so that parents may demonstrate their willingness to retain custody of their children (Dinkmeyer, 1999).

Dinkmeyer (1999, p. 101) stated that those that are court-ordered might attend with a different kind of "willingness". A decade ago, Hutchison (1990), stated that it was still unclear whether mandated therapy (court-ordered therapy) prevents subsequent maltreatment of children from occurring again.

A difficulty that might be present in working with court-ordered clients is that they did not seek therapy voluntarily (Dore & Lee, 1999; Lehmer, 1986; Watkins, 1984). Instead, those that are court-ordered for treatment may show little interest in the therapeutic process (Haley, 1987, 1992 as cited in Waldman, 1999, p. 507). According to Waldman (1999), court-ordered people usually blame the system or others because they need to attend therapy. Also,
these feelings may "prevent them from recognizing their responsibility and their contribution to the situation that led to their detention" (Waldman, 1999, p. 509).

There were no research studies found which addressed court ordered clients in regard to parenting skills. However, the effects of court-ordered substance abuse treatment of parents involved with a child protective service agency were studied by Rittner and Dozier, (2000). They examined the effects of court orders in preventing recurrence of substance abuse in the cases of 447 children involved in kinship care while involved in a child protective service agency. The results of this study indicated that the level of compliance with the parents in the study, those mandated for substance abuse and mental health treatment, did not appear to influence the rates of re-abuse or duration of services ($\chi^2(2, N=202)=5.279$, $p>.5$). This study was limited to only children involved in kinship care. This study also did not differentiate among the type of abuse or amount of times the parents may have been referred to a child protective service agency.

Parents who attend therapy due to a court order have not been extensively studied. However, this population does exist and understanding their willingness to attend therapy is essential.
Motivation for Treatment

Some clients that are in therapy drop out prematurely against their therapist's recommendation. A lower level of motivation for treatment is an area of psychology that is relevant to the issues of dropout, compliance, and maintenance of change (Pelletier, Tuson, & Haddad, 1997). According to Pelletier, Tuson, and Haddad (1997), over the last decade, one perspective of human motivation that has received a great deal of attention from researchers is the theory of intrinsic motivation and self-determination proposed by Deci and Ryan (1985).

According to Deci and Ryan (1985) there are three basic types of motivation that regulate a person's behavior: intrinsic, extrinsic, and amotivation. Specifically, intrinsic motivated behaviors are performed voluntarily due to the pleasure derived by the performance. Deci and Ryan (1985), stated that intrinsic motivation is thought to stem from the needs to feel competent and self-determined and are internally regulated and therefore are more likely to occur on a consistent basis.

Extrinsic motivated behaviors are performed to receive a reward or to avoid punishment. Deci and Ryan (1985) stated that there are four types of extrinsic motivation classified along a continuum of increasing self-determination: external regulation, introjection,
identification, and integration. External regulated behaviors are controlled by external sources, such as material rewards or constraints imposed by another person (Deci & Ryan, 1985). Introjected regulated behaviors are reinforced by internal pressures that were formerly motivated from an external source and have now been internalized (Deci & Ryan, 1985). Identified regulated behaviors are those that a person chooses to perform because it is congruent with their values and goals. They are also performed due to extrinsic reasons, but it is internally regulated and self-determined (Deci & Ryan, 1985). Finally, integrated regulation is the most fully self-determined among the group of extrinsic motivational types (Pelletier et al., 1997). The integrated regulations are behaviors that are not only performed because an individual values its significance, but also because it is consistent with the individual’s self-identity and with the other self-schema’s that they possess (Deci & Ryan, 1985).

Finally, amotivation is when an individual does not perceive a relationship between their actions and their outcome. Deci and Ryan (1985) stated that there is an experience of feelings of incompetence and lack of control. For instance, this is when someone begins an activity without having a clear understanding of why they are doing
it. In other words, there is no real sense of purpose (Pelletier et al., 1997).

On the basis of Deci and Ryan’s three forms of motivation, a formal statement of Cognitive Evaluation Theory (CET) was developed. Cognitive evaluation theory states that intrinsic motivation can be effected by an event that affects a person’s perceived self-determination and perceived competence (Deci, Ryan, & Koestner, 1999).

According to Deci and Ryan (1985), motivation type can change throughout therapy depending on the situation. For instance, a client may move from intrinsic motivation towards extrinsic motivation due to the therapist’s interpersonal style.

Gordon (1976) compared treatment effectiveness for voluntary college students versus college students that were encouraged to participate. They were either given a choice between two relaxation techniques or were not given a choice. The results reported that the participants who were given a choice between the two relaxation treatments reported that it was significantly more effective than those who were not given a choice. However, Gordon (1976) stated that there were no significant differences between the choices of relaxation techniques among those participants who were encouraged to participate. The lack of a significant difference among the participants who were
encouraged to participate may be due to them not seeing the choice between the two relaxation techniques as truly having a choice, less important, because they were encouraged to participate in this study.

Deci, Eghrari, Patrick, and Leone (1994) hypothesized that the "combination of a meaningful rationale, an acknowledgment of conflicting feelings, and a style that minimizes pressure and conveys choice are the three critical, social-contextual facilitating factors that support self-determination" (Deci et al., 1994, p.125). They studied 192 introductory psychology students that participated in this study in order to fulfill a course requirement. There were three hypothesized factors: rationale/no rationale, acknowledge/no acknowledge, and low verses high controllingness was studied. Specifically, the participants were asked to watch a computer screen and when a dot of light appeared on the screen, the participants were to press the space bar to make the light disappear.

Following a practice trial and prior to the actual trial, the experimental manipulations were done orally by the experimenter. The participants were either given or not given: a rationale for completing this task, an acknowledgment of the disinterest of the task, and any control. The results supported their hypothesis that the three facilitating factors "proving a meaningful rationale,
acknowledging the behavior's feelings, and conveying choice - promote internalization, as evidenced by the subsequent self-regulation of behavior" (Deci et al., 1994, p.119). Their results also stated that "when the social context supports self-determination, integration tends to occur, whereas when the context does not support self-determination, introjection tends to occur" (Deci et al., 1994, p.199). Overall, these results indicated that providing a rationale, acknowledging a person's feelings, and conveying choice are relevant in order to promote internalization. This study used introductory psychology students as the participants in order for the students to fulfill a course requirement. Therefore, applying these results to people in therapy cannot be made. However, understanding what promotes internalization as a means of motivation, is necessary.

Summary

Overall, seven constructs were addressed that relate to factors affecting change in parenting skills, treatment modality, and level of motivation for treatment among parents that are involved in a child protective service agency. These seven constructs were child maltreatment, intergenerational abuse of child maltreatment, parenting skills, group and individual therapy, child protective services, court-ordered therapy, and motivation for
treatment. Reviewing the literature that focused on these areas, encouraged the necessity of addressing and therefore understanding the care and treatment of families that are at risk for child maltreatment.

Child maltreatment has increased more than fourfold over the number reported just 20 years earlier (Waldfogel, 1998). Through parent training and education, a parent is assisted in learning how to modify their parenting skills in order to effectively parent a child. Although individual and group therapy for other populations have been compared, a search of the literature did not reveal any previous studies comparing these treatment modalities in adults regarding levels of motivation or parenting skills.

However, regarding treatment modality and parenting skills, DePanfilis (1996) reported that even though parenting skills are usually taught in group therapy, initially, individual support might be more appropriate for neglectful families. Specifically due to their lack of social skills, which are necessary to get along well in groups. However, DePanfilis (1996) reported that including a social support component in teaching parent skills in a group setting with parents who maltreat their children, might reduce social isolation and therefore the parents may become more successful in treatment.
Intergenerational transmission of child maltreatment needed to be reviewed in order to understand the necessity of this study in regard to discontinuing this cycle of abuse. It is through researching the cycle of abuse that it can be understood and therefore assist in explaining and possibly discontinuing this cycle. For instance, Simons, Whitbeck, Conger, and Chyi-In (1991) studied the intergenerational transmission of harsh parenting. Their results indicated that grandparents who engaged in aggressive parenting with their children produced present-day parents who were likely to use similar parenting practices with their children. Therefore, supporting the concept of intergenerational transmission of abuse.

Since the parents that were asked to participate in this study were currently involved in a child protective service agency, an understanding of child protective services was necessary. Even though this study did not differentiate between participants that were court ordered for therapy, having an understanding of this population is necessary because some of the participants are court ordered. Specifically, child protective services become involved with families when there are concerns that minimum standards of care and protection have not been met by the caretaker (Dubowitz, 1997). Once child protective services becomes involved with the family and abuse or neglect has
occurred, child protective services intervenes in the family by providing parental guidance and support or punishment (Dubowitz, 1997). Some parents may be court-ordered to attend therapy to remediate abusive behaviors so that parents may demonstrate their willingness to retain custody of their children (Dinkmeyer, 1999). However, in 1990, Hutchison stated that it was still unclear whether mandated therapy (court-ordered therapy) prevents subsequent maltreatment of children from occurring again.

Overall, the level of motivation for treatment becomes an important area to review with this population. A level of motivation for treatment is an area of psychology that is relevant to the issues of dropout, compliance, and maintenance of change (Pelletier, Tuson, and Haddad, 1997). According to Pelletier, Tuson, and Haddad (1997), over the last decade, one perspective of human motivation that has received a great deal of attention from researchers is the theory of intrinsic motivation and self-determination proposed by Deci and Ryan (1985).

Therefore, after reviewing the literature relating to these constructs, the current investigation was essential in order to gain more information to assist in understanding what affected treatment success in parenting training. Specifically, this study examined if the level of intrinsic motivation, level of extrinsic motivation, and the two types
of therapy (individual and group therapy) related to treatment success of changes of parenting skills with parents involved in a child protective service agency. This study also examined if the level of motivation changed over eight sessions depending on the treatment modality, specifically group or individual therapy.
CHAPTER III

Methodology

Participants

Participants for this study were single parents involved in a child protective service agency in a suburban area in a northern area of New Jersey. Specifically, the child protective service agency that was involved with this study was a Northern New Jersey Division of Youth and Family Service (DYFS) agency. Forty-six English speaking parents participated in this study. These participants were single parents, 22 males, and 24 females, over the age of 18 from a variety of ethnic backgrounds. The participants were mostly from the middle socioeconomic status and educational backgrounds. The participants were either attending individual therapy on an outpatient basis with no fee for services or attending group therapy on an outpatient basis with no fee for service. The individual and group therapy were both conducted at a DYFS-funded outpatient clinic based out of a Northern New Jersey Hospital. The data was collected over approximately a 14 month period.

Participant recruitment began after approval of the project was received from the Institutional Review Board at Seton Hall University and at this site. Even though approval to collect participants from this site was
dependent on final approval of the project through the Institutional Review Boards of both the university and this agency, the therapists had indicated preliminary agreement to allow the study to be conducted at the site.

Participants were informed that the purpose of the study was to demonstrate if the level of motivation and type of treatment predict changes in parenting skills over a number of sessions. They were also told that the study would examine whether the level of motivation affects treatment success in different types of treatment.

Instruments

The Client Motivation for Therapy Scale (CMOTS).

The Client Motivation for Therapy Scale (CMOTS) is a 24-item instrument designed to measure client motivation for therapy. The CMOTS is an instrument that is designed to measure client’s Intrinsic Motivation, four forms of regulation for Extrinsic Motivation (integrated, identified, introjected, and external regulation), and Amotivation for therapy. This instrument is based on Deci and Ryan’s theoretical perspective of human motivation and self-determination. According to Deci and Ryan (1985), there exist six different types of motivation that fall along a self-determination continuum. The six subscales on the CMOTS correspond to Deci and Ryan’s six different types of motivation.
The questions are answered on a 7-point Likert-type scale, ranging from (1) does not correspond at all through (7) corresponds exactly. Four items from the instrument are associated with each of the six subscales. For instance, one item that is associated with intrinsic motivation states "For the pleasure I experience when I feel completely absorbed in a therapy session." One item that is associated with external regulation states "Because other people think that it is a good idea for me to be in therapy." The four items from each of the subscales are totaled to develop a number for each of the levels of motivation (see Appendix D and Appendix E for the CMOTS form).

There were two versions of the CMOTS used for this study which included a pre and post treatment measure. The questions on the instruments are exactly alike, however, the instructions differ between the two versions. Permission from the creator of CMOTS was given to alter the instructions for the instrument.

The norms for the CMOTS were obtained using clients in three outpatient hospital clinics and two university-based clinics in Ottawa (Pelletier, Tuson & Haddad, 1997). Clients that came from inpatient hospital clinics or clients who were taking medications for their psychological conditions were removed from the sample. Of the remaining 138 participants, 83 were women with the average age of 24.8
and 55 were men with the average age of 28.3. Ninety percent of the participants had more than a 12 year education, 83% had an annual income higher than $20,000, 87% were employed, and 68% were married or living with a significant other (Pelletier et al., 1997). Regarding reasons for being in therapy, the participants reported the following reasons: low self-esteem (15), depression (16), physical abuse (5), sexual abuse (11), substance abuse (10), vocational problems (6), eating disorders (15), anxiety (7), phobias (11), adjustment to physical disabilities (5), interpersonal problems (22), obsessive-compulsive behaviors (6), personal growth and self-awareness (5), and sexual offense (4) (Pelletier et al., 1997).

Pelletier et al. (1997), found internal consistency with alpha values from .70 for external regulation to .92 for intrinsic motivation.

The CMOTS has also demonstrated good construct validity, with significant correlations between its subscales and perceptions of therapists' interpersonal behaviors (Pelletier et al., 1997). Specifically, the 138 participants also completed several scales assessing various motivational consequences (distraction, tension, and positive emotions during therapy, importance ascribed to therapy, client satisfaction, and future intentions to persist in therapy) (Pelletier et al., 1997). The
participants also completed scales associated with psychological functioning (self-esteem, locus of control, depression, and life satisfaction) (Pelletier et al., 1997). This was done because the various forms of motivation lie on a continuum from low to high self-determination and a higher level of self-determination is associated with enhanced forms of psychological functioning (Deci & Ryan, 1985). Therefore, Pelletier et al. (1997) expected to find a correlation between the CMOTS subscales and various consequences associated with therapy. The results displayed support for the construct validity of the CMOTS as well as the self-determination continuum because positive consequences associated with therapy sessions and constructs associated with positive psychological functioning were positively correlated with more self-determined forms of motivation and negatively with the less self-determined forms of motivation.

Adult-Adolescent Parenting Inventory-2.

The Adult-Adolescent Parenting Inventory-2 (AAPI-2) was renormed in 1999 and replaced the original AAPI, which was first developed in 1979 and published since 1984 (Bavolek & Kenne, 1999).

The AAPI-2 is a 40-item self-report assessment designed to assess the parenting and child-rearing attitudes for both adolescent and adult parents. The inventory items are
written at the fifth grade reading level and can be administered orally to non-readers (Bavolek & Keene, 1999). It was developed and has been used with adults or adolescent with either nonabusive or abusive backgrounds (AAPI-2) (Bavolek & Keene, 1999). The questions are answered on a 5-point Likert-type scale, ranging from (1) strongly agree through (5) strongly disagree. These responses provide an index of risk for abuse and neglecting parenting and child rearing behaviors. The AAPI-2 provides a standard instrument for assessment of risk on five parenting constructs that contribute to the maltreatment of children: a) inappropriate growth and developmental expectations, b) parents inability to be empathic and aware of children’s needs, c) strong belief in corporal punishment as a means of discipline, d) reversal in child and parent family roles, and e) children’s power and independence is oppressed through strict and rigid adherence to obedience (Bavolek & Keene, 1999; Bavolek, Kline, & McLaughlin, 1979). Therefore, this instrument yields scores on five parenting constructs: a) inappropriate developmental expectations, b) empathy, c) corporal punishment, d) role reversal, and e) power independence.

Using either the AAPI-2 Profile Worksheet, Form A or the Form B, the items 1 through 40 on the instrument are associated with one of the five constructs. The total raw
scores are then summed for each of the constructs. Using the Norm Table for AAPI-2, Form A and the Form B, the raw scores are changed to standard scores ranging from one through ten. Scores one through three are considered low scores and indicate poor parenting skills knowledge. Scores four through seven are considered average scores and indicate average parenting skill knowledge. Finally, scores eight through ten are considered a high score and indicates appropriate parenting skill knowledge.

An AAPI-2, Form A and an AAPI-2, Form B are provided in order to measure treatment effectiveness through a pretest and a posttest. Form B provides an alternate test form to reduce the practice effect in completing the inventory in a short period of time.

Data for the factor analysis consisted of 1,427 cases from diverse populations. Adult parents, both abusive and non-abusive; adolescents, both abusive and non-abusive; and teen parents from 53 different agencies in 23 different states contributed to the normative data (Bavolek & Keene, 1999). Specifically, the norms for this instrument utilized 713 adult parents who have not participated in a formal parenting program, 198 adolescent non-parents who have not participated in a formal parenting program to represent the "normal teenager", and 87 adolescent mothers.
Correlations between Form A and Form B range from .80 to .92, which provides evidence of the comparability of the two forms (Bavolek & Keene, 1999). The internal reliability for the combined Form A and Form B range from .86 to .96. Alpha reliability coefficients range in magnitude from .75 for empathy to .82 for role reversal. The total score test-retest reliability was measured at .76 with internal consistency at .86 (Bavolek & Keene, 1999).

The subscale structure of the AAPI-2 has been factor-analytically validated with items loading on all five constructs from .70 to .82 (Bavolek & Kenne, 1999).

Procedure

The initial contact between the potential participant and the outpatient treatment facility occurred once the participant was referred for treatment by the county child protective service agency. Once the referral was made, contact was made via telephone to schedule the initial appointment. Potential participants were asked to participate in the study by the intake clinician. (see Appendix A for Letter of Solicitation). It was emphasized that participation was not mandatory and that there were no consequences for refusing to participate. The participants were also informed that their decision to participate was not shared with their DYFS caseworker. They were also made aware that their choice to participate did not assist or
impede their attempt to have their case closed in DYFS. Participants were free to discontinue participation in the study at any time, without consequences (see Appendix B - Informed Consent Form). Throughout this study, none of the participants chose to discontinue. However, there was a low participation rate.

If the participant agreed to participate in this study, they were told to drop their signed Consent Form (see Appendix B for Informed Consent Form) in the box located at the end of the hallway labeled 'Consent Form'.

The participants were told not to place their names on any measure, instead, they were asked to create a three-digit number for themselves and place the same three digits on each measure and to recall these three digits on the post-treatment measures. This was done so as to compare their baseline scores on the measures to their post-treatment scores. Also, the master key with the three-digit number and the research data was secured in a locked draw, which was not located in the same room. The master key was destroyed after the post-data collection, preventing any identification of participants.

Following the participants signing of the consent form, initial data collection occurred. Specifically, the demographic questionnaire, the Adult-Adolescent Parenting Inventory - 2- Form A (AAPI-2), and the Client Motivation
for Therapy Scale (CMOTS) were completed during the initial session. This took approximately 30 minutes to complete.

Participants in the study were placed in either individual therapy or group therapy depending on the available openings at that time in. The participants were not randomly selected to be in either individual or group therapy.

Individual and group therapy were conducted on a weekly basis for eight sessions at a Northern New Jersey Division of Youth and Family Services (DYFS)- funded outpatient clinic based out of a Northern New Jersey Hospital. Both the individual and group therapy was conducted in a cognitive/behavioral theoretical orientation. The therapist who led the group therapy was a New Jersey licensed social worker with approximately eight years of experience who was not told the specifics of this study. She was supervised by a New Jersey licensed social worker in New Jersey who was then supervised by a New Jersey licensed psychologist. There were two primary female therapists that conducted the individual therapy. Neither of these therapists was told the specifics of this study. One therapist had five years of experience and received a Master of Arts degree in psychology. The other therapist had eight years of experience and received a Master of Arts degree in psychology. All of the therapists were supervised by a New
Jersey licensed psychologist. Also, all of the therapists were part of the treatment team at this agency. During the weekly treatment team meetings, specific cases were discussed.

There was no manualized treatment for either the group or individual therapy, however the main treatment goals included teaching appropriate discipline techniques throughout the childhood years and ways to implement these learned behaviors with the child. Specifically, the focus of the therapy was on the benefits of positive reinforcement, incorporating limit setting while using praise, natural consequence for children’s actions, empathy toward the children, and appropriate childhood development. Appropriate childhood development is defined as having an understanding of growth and development, being supportive of children, and allowing children to exhibit normal developmental behaviors (Bavolek & Keene, 1999). Throughout treatment (individual and group), role-play and written information as means of learning appropriate discipline techniques was utilized. Group therapy also utilized group discussion regarding specific parenting issues.

Once the participants had agreed to participate in this study, knowing that it involved pre and post treatment measures, those in group therapy were contacted immediately following the final group of an eight week cycle and asked
to complete the post treatment measures. On the other hand, the participants in individual therapy were asked to complete the post treatment measures following their eighth session. These participants were included for the final analysis and completed the post treatment measures. These measures included completing the AAPI-2, Form B and the CMOTS, which took approximately 30 minutes to complete.

Once the eight sessions were completed, the participants were contacted by their initial intake counselor in order to complete the post-treatment measures. The participants were again asked to place the three digit number they created for themselves on the pre-treatment measures on each post-treatment measure. This was done so as to compare their baseline scores on the measures to their post-treatment scores. This took approximately 30 minutes to complete.

Participants who withdraw from therapy before it was therapeutically recommended, were not included in this study. Also, participants who were not single and did not read English were not included in this study. For participants who demonstrated insufficient reading ability, the instruments could have been read to them by the intake clinician. However, this was not necessary. All of the participants had a sufficient reading ability.
Analysis of Data

This study was quasi-experimental in nature. All statistical analyses were performed using SPSS 11.5 for Windows.

The first research question was in regard to the pre-treatment variables intrinsic motivation, extrinsic motivation, and type of therapy (group or individual) and if these variables predict changes in parenting skills (appropriate developmental expectations, empathy, alternative to corporal punishment, role reversal, and understanding children's power/independence).

The analysis used for the first research question was a canonical correlation. A canonical correlation is used as a method that identifies group separation provided by a set of quantitative attributes (Grimm & Yarnold, 1997). In other words, a canonical correlation is the correlation of two canonical (latent) variables, one representing a set of independent variables and the other a set of dependent variables. The predictor variables were the level of intrinsic motivation, level of extrinsic motivation, and the two types of therapy (individual and group therapy). The criterion variable was the change of parenting skills (appropriate developmental expectations, empathy, alternative to corporal punishment, role reversal, and
understanding children's power/independence) over the eight sessions.

The second research question asked if there was a significant change in motivation for therapy (intrinsic and extrinsic) over eight sessions and did it change in reaction to participating in individual or group therapy for parents involved in a child protective service agency.

For the second research question, a multivariate analysis of variance (MANOVA) procedure was conducted. A one-way MANOVA is conducted when a research question involves testing group differences on more than one dependent variable (Stevens, 1992). The predictor variable in this study was the treatment modality with the two levels being individual therapy and group therapy. The criterion variables were the client motivation for treatment (intrinsic and extrinsic motivation). The post-treatment numbers on each of these variables were subtracted from the pre-treatment number in order to obtain a numerical difference. This numerical difference was utilized in the MANOVA for the intrinsic and extrinsic scores.

Since there was no significant difference found once the MANOVA was completed, it was unnecessary to perform a discriminate function analysis.

A one-way MANOVA was conducted to test the research question. This was conducted because when using a MANOVA,
the criterion variables were treated as a group. Therefore, if a significant difference were found, a series of individual analyses of variance (ANOVA's) would have been conducted on each of the criterion variables in order to see what produced the significance.

**Power Analysis**

Power is defined as the probability of detecting a significant effect when the effect truly exists in nature (Grimm & Yarnold, 1997, p.274). The power of a statistical test is determined by power \( (\text{reject a false } H_0) = 1 - \beta, \) Beta is defined as failing to reject a false null hypothesis, the probability of committing a Type II error (Stevens, 1992). In order to obtain a statistical power analysis for each of the research questions a computer program was utilized, Gpower-version 2.0 (Faul & Erdfelder, 1992).

For the first research question, a canonical correlation was conducted to examine if the pre treatment variables intrinsic motivation, extrinsic motivation, and type of treatment (group or individual therapy) predict changes in parenting skills. The predictor variables were the pre treatment level of intrinsic motivation, pre treatment level of extrinsic motivation, and the two types of treatment (individual and group therapy). The criterion variables regarding change in parenting skills were the
appropriate developmental expectations, empathy, alternative to corporal punishment, role reversal, and understanding children's power/independence. The computer program, Gpower-version 2.0, was utilized to obtain the statistical power analysis. However, this program was unable to conduct a specific power analysis on the canonical correlation. Therefore, a power analysis using a MANOVA, which mathematically is a specialized case of canonical correlation, was conducted. Regarding a multivariate analysis of variance (MANOVA), Borenstein and Cohen (1988) reported that an effect size at .02 is a small effect, .15 is a medium effect, and .35 is a large effect. With the medium effect size set at .15, the alpha level set at .05, and with the total sample size of 46, the power level was at .77.

A multivariate analysis of variance (MANOVA) procedure was conducted for the second research question. This was conducted to test if the change in level of motivation for therapy (intrinsic and extrinsic) over eight sessions of therapy was different for the two treatment modalities (individual and group therapy). The predictor variable in this study was the treatment modality with the two levels being individual and group therapy. The criterion variables were the pre and post treatment level of motivation for treatment (intrinsic and extrinsic motivation). Regarding a
multivariate analysis of variance (MANOVA), Borenstein and Cohen (1988) reported that effect size at .02 is a small effect, .15 is a medium effect, and .35 is a large effect. With the medium effect size set at .15, the alpha level set at .05, and with the total sample size of 46, the power level was at .90.
CHAPTER IV

Results

The purpose of this chapter is to describe the descriptive statistics used in this study, report the results of the research questions, and finally to summarize the results of the study.

Description of Groups

Included in this study were two groups of single English speaking parents involved in a Northern New Jersey Division of Youth and Family Service (DYFS) agency in a suburban area hospital in a northern area of New Jersey. Twenty four participants attended individual therapy on an outpatient basis with no fee for services and 22 participants attended group therapy on an outpatient basis with no fee for services. The total study population was 46 participants. Two participants withdrew from the study because they were terminated in therapy prior to the eight weeks necessary to collect the post treatment data. There were no participants that requested to be withdrawn from this study.

Descriptive statistics.

Following are descriptive statistics regarding the participants answers on the demographic questionnaire (see Appendix C for Demographic Questionnaire), which they
completed during the pre-treatment measures. Table 1 consists of the complete detailed demographic statistics results.

The age of participants ranged from 22 years old through 56 years old with a mean age of 34.0, standard deviation of 7.1. There were 22 males and 24 females. Fifty nine percent of the participants were never married, 22% were separated from their spouse, 13% were divorced, and 7% were widowed. Sixty one percent of the participants were employed full-time, on the other hand 26% were employed part-time. Regarding income levels of the participants, 41% had income levels between $30,000 to $50,000, while 30% were between $50,000 to $70,000, and 15% earned above $70,000. Finally, the levels of education regarding the subjects were gathered. Twenty six percent had a high school diploma, 30% had a four year college education, and 24% had a two year college education.
Table 1

*Descriptive Statistics on the Demographic Questionnaire*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Treatment</strong></td>
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<td></td>
</tr>
<tr>
<td>Group</td>
<td>22</td>
<td>47.8</td>
</tr>
<tr>
<td>Individual</td>
<td>24</td>
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</tr>
<tr>
<td><strong>Gender</strong></td>
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<td></td>
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<tr>
<td>Male</td>
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<td>Female</td>
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</tr>
<tr>
<td><strong>Marital Status</strong></td>
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<tr>
<td>Single</td>
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</tr>
<tr>
<td>Divorced</td>
<td>6</td>
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</tr>
<tr>
<td>Widowed</td>
<td>3</td>
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<tr>
<td>Separated</td>
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<td>21.7</td>
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<tr>
<td><strong>Therapy</strong></td>
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</tr>
<tr>
<td>Less than 1 month</td>
<td>42</td>
<td>91.3</td>
</tr>
<tr>
<td>More than 1 month</td>
<td>4</td>
<td>8.7</td>
</tr>
<tr>
<td><strong>Therapy outside of agency</strong></td>
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<td></td>
</tr>
<tr>
<td>Yes</td>
<td>0</td>
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</tr>
<tr>
<td>No</td>
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<tr>
<td><strong>Employment</strong></td>
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<td>Part-time</td>
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<tr>
<td>Full-time</td>
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<td>60.9</td>
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<tr>
<td>Unemployed</td>
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<tr>
<td>Homemaker</td>
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<tr>
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<td>6.5</td>
</tr>
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</tr>
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<td>$50,000 - $70,000</td>
<td>14</td>
<td>30.4</td>
</tr>
<tr>
<td>above $70,000</td>
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</tr>
<tr>
<td><strong>Education</strong></td>
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<td>Prior to high school</td>
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<tr>
<td>High school</td>
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</tr>
<tr>
<td>2-year college</td>
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<td>4-year college</td>
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<td>graduate degree</td>
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<tr>
<td>post graduate degree</td>
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</table>
Table 2 consists of the pre and post treatment descriptive statistics regarding level of motivation (intrinsic and extrinsic) and parenting skills (appropriate developmental expectations, empathy, alternative to corporal punishment, role reversal, and understanding children's power/independence).
Table 2
Descriptive Statistics: Pre and Post Treatment Level of Motivation and Parenting Skills

<table>
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</tr>
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<tbody>
<tr>
<td><strong>Pre Treatment:</strong></td>
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<td></td>
</tr>
<tr>
<td>Intrinsic Motivation</td>
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</tr>
<tr>
<td>Extrinsic Motivation</td>
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<td>7.74</td>
</tr>
<tr>
<td>Expectations</td>
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<td>2.13</td>
</tr>
<tr>
<td>Empathy</td>
<td>4.72</td>
<td>2.60</td>
</tr>
<tr>
<td>Punishment</td>
<td>4.87</td>
<td>2.00</td>
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<tr>
<td>Role reversal</td>
<td>5.30</td>
<td>2.49</td>
</tr>
<tr>
<td>Power/Independence</td>
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<td>2.62</td>
</tr>
<tr>
<td><strong>Post Treatment:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intrinsic Motivation</td>
<td>19.59</td>
<td>7.16</td>
</tr>
<tr>
<td>Extrinsic Motivation</td>
<td>8.48</td>
<td>5.30</td>
</tr>
<tr>
<td>Expectations</td>
<td>7.33</td>
<td>1.79</td>
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<tr>
<td>Empathy</td>
<td>5.50</td>
<td>2.57</td>
</tr>
<tr>
<td>Punishment</td>
<td>5.89</td>
<td>1.45</td>
</tr>
<tr>
<td>Role Reversal</td>
<td>7.37</td>
<td>1.96</td>
</tr>
<tr>
<td>Power/Independence</td>
<td>5.48</td>
<td>2.41</td>
</tr>
</tbody>
</table>
Table 3 consists of the correlation matrix regarding changes in level of motivation (intrinsic and extrinsic) and changes on the parenting skill constructs (appropriate developmental expectations, empathy, alternative to corporal punishment, role reversal, and understanding children's power/independence) following eight sessions of treatment.

Table 3

**Correlation Matrix: Changes of Level of Motivation and Changes of Parenting Skill Constructs Following Eight Sessions of Therapy (Group and Individual Therapy)**

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Intrinsic Motivation</td>
<td>-</td>
<td>-.87**</td>
<td>.21</td>
<td>-.05</td>
<td>.23</td>
<td>.02</td>
<td>.17</td>
</tr>
<tr>
<td>2. Extrinsic Motivation</td>
<td>-.07**</td>
<td>-</td>
<td>-.14</td>
<td>.12</td>
<td>-.13</td>
<td>.10</td>
<td>.08</td>
</tr>
<tr>
<td>3. Expectations</td>
<td>.21</td>
<td>-.14</td>
<td>-</td>
<td>.04</td>
<td>.34*</td>
<td>.44**</td>
<td>.01</td>
</tr>
<tr>
<td>4. Empathy</td>
<td>-.05</td>
<td>.12</td>
<td>.04</td>
<td>-</td>
<td>.50**</td>
<td>.36*</td>
<td>.24</td>
</tr>
<tr>
<td>5. Punishment</td>
<td>.23</td>
<td>-.13</td>
<td>.34*</td>
<td>.50**</td>
<td>-</td>
<td>.41**</td>
<td>.30*</td>
</tr>
<tr>
<td>6. Role Reversal</td>
<td>.02</td>
<td>.10</td>
<td>.44**</td>
<td>.36*</td>
<td>.41**</td>
<td>-</td>
<td>.25</td>
</tr>
<tr>
<td>7. Power/Independence</td>
<td>.12</td>
<td>.08</td>
<td>.01</td>
<td>.24</td>
<td>.30*</td>
<td>.25</td>
<td>-</td>
</tr>
</tbody>
</table>

**Note.** * p<.01  
** p<.05

**Test of Research Questions**

Research question #1.

The first research question was to examine if the pre-treatment variables intrinsic motivation, extrinsic
motivation, and type of therapy (group or individual) predict changes in parenting skills (appropriate developmental expectations, empathy, alternative to corporal punishment, role reversal, and understanding children's power/independence). Therefore, a canonical correlation was performed because this study examined a correlation of two canonical (latent) variables, one representing a set of independent variables and the other a set of dependent variables. Specifically, the predictor variables were the pre-treatment level of intrinsic motivation, pre-treatment level of extrinsic motivation, and the two modalities of treatment (individual and group therapy). The criterion variable was the change of parenting skills (appropriate developmental expectations, empathy, alternative to corporal punishment, role reversal, and understanding children's power/independence) over the eight sessions.

The first canonical correlation was .63, which was significant beyond the .05 level ($\chi^2(15) = 27.31$, $p = .03$) and accounted for 40% of the variance. The second and third canonical correlation was .39 and .09 respectively and they were not significant beyond the .05 level ($\chi^2(8) = 7.12$, $p = .52$ and $\chi^2(3) = .34$, $p = .95$).

Data on the only significant pair of canonical variates are in Table 4. Specifically, the correlations between the variables are shown. With a .3 cutoff correlation, all
three predictor variables (pre treatment intrinsic motivation, pre treatment extrinsic motivation, and treatment modality) were correlated with the first canonical variate. Of the criterion variables, changes in three of the five parenting skill constructs (developmental expectation, punishment, and role reversal) were correlated with the first canonical variate. In other words, the first canonical variate had a medium negative loading on the pre treatment level of intrinsic motivation ($r = -0.46$), a medium positive loading on the pre treatment level of extrinsic motivation ($r = 0.37$), and a high positive loading on the treatment modality ($r = 0.97$) which related to high positive loading on appropriate developmental expectations ($r = 0.80$), and higher positive loading on understanding alternatives to corporal punishment ($r = 0.60$) and role reversal ($r = 0.77$).

Specifically, treatment modality included all participants in the study (group and individual therapy). Therefore, attending therapy correlated highly with changes in three parenting skill constructs.
Table 4

Correlations, Standardized Canonical Coefficients, Canonical Correlations, and Percents of Variance

<table>
<thead>
<tr>
<th>Variables</th>
<th>First canonical variate</th>
<th>Canonical coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrinsic motivation</td>
<td>-.46</td>
<td>.08</td>
</tr>
<tr>
<td>Extrinsic motivation</td>
<td>.37</td>
<td>.31</td>
</tr>
<tr>
<td>Treatment</td>
<td>.97</td>
<td>.95</td>
</tr>
</tbody>
</table>

Predictor Variables

Criterion Variables

Changes in parenting skills

| Expectations      | .88 | .61 |
| Empathy           | .25 | -.05|
| Punishment        | .60 | .25 |
| Role reversal     | .77 | .42 |
| Power/Independence| .17 | -.01|

Canonical correlation  .63

Squared Canonical Correlation  .39

Table 5 summarizes the descriptive statistics for the mean scores and standard deviations for group and individual treatment and changes in developmental expectation, punishment, and role reversal.
Table 5

Descriptive Statistics: Treatment Modality and Changes From Pre to Post Treatment Parenting Skills (Expectation, Punishment, and Role Reversal)

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expectation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>2.4</td>
<td>1.8</td>
</tr>
<tr>
<td>Group</td>
<td>.5</td>
<td>1.2</td>
</tr>
<tr>
<td><strong>Punishment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>1.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Group</td>
<td>.5</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Role Reversal</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>3.0</td>
<td>2.2</td>
</tr>
<tr>
<td>Group</td>
<td>1.0</td>
<td>1.3</td>
</tr>
</tbody>
</table>

A paired sample t-test was then conducted for participants in individual therapy to test the pre treatment and post treatment scores regarding developmental expectation, punishment, and role reversal. This was done to determine if there was a significant change in pre treatment and post treatment for the above three parenting constructs for participants involved in individual therapy.
There was a significant difference from pre to post treatment scores for developmental expectations, increasing from a mean of 5.29 to a mean of 7.67 \( (t(24)=-6.60, p<.05) \). There was also a significant difference from pre to post treatment scores for punishment, increasing from a mean of 4.58 to a mean of 6.04 \( (t(24)=-4.85, p<.05) \). Finally, there was also a significant difference from pre to post treatment scores regarding role reversal, increasing from a mean of 4.42 to a mean of 7.46 \( (t(24)=-6.67, p<.05) \). All of the above three parenting skill constructs increased from pre to post treatment following eight sessions of individual therapy.

Finally, a paired sample t-test was conducted for participants in group therapy to test the pre treatment and post treatment scores regarding developmental expectation, punishment, and role reversal. This was done to determine if there was a significant change in pre treatment and post treatment for the above three parenting skill constructs for participants involved in group therapy. There was a not a significant difference from pre to post treatment scores for developmental expectations, a mean of 6.45 to a mean of 6.95 \( (t(22)=-1.92, p>.05) \). There was a significant difference from pre to post treatment scores for punishment, increasing from a mean of 5.18 to a mean of 5.73 \( (t(22)=-2.66, p<.05) \). Finally, there was also a significant difference from pre to
post treatment scores regarding role reversal, increasing from a mean of 6.27 to a mean of 7.27 ($t(22)=-3.69$, $p<.05$).

Research question #2.

A one-way multivariate analysis of variance (MANOVA) procedure was conducted for the second research question, which examined if the change in level of motivation for therapy (intrinsic and extrinsic) over eight sessions of therapy was different for the two treatment modalities (individual or group therapy). The predictor variable in this study was the treatment modality with the two levels being individual therapy and group therapy. The criterion variables were the client motivation for treatment (intrinsic and extrinsic). The post-treatment numbers on each of these variables were subtracted from the pre-treatment number in order to obtain a numerical difference. This numerical difference was utilized in the MANOVA for the intrinsic and extrinsic scores.

Table 6 summarizes the descriptive statistics regarding the mean scores and standard deviations for treatment modalities (individual and group) and changes in level of motivation (intrinsic and extrinsic).
Table 6

Descriptive Statistics: Mean Scores and Standard Deviations

for Changes in Level of Motivation and Treatment Modality

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intrinsic Motivation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>4.5</td>
<td>6.6</td>
</tr>
<tr>
<td>Group</td>
<td>3.3</td>
<td>7.0</td>
</tr>
<tr>
<td><strong>Extrinsic Motivation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>-3.9</td>
<td>7.1</td>
</tr>
<tr>
<td>Group</td>
<td>-4.0</td>
<td>6.9</td>
</tr>
</tbody>
</table>

Wilks criterion was used regarding the multivariate test of significance. Specifically, the changes in the pre and post treatment intrinsic and extrinsic motivation scores did not differ based on treatment modality, Wilks' $\Lambda = .97$, $F(2,43) = .71$, $p > .05$.

Regarding the univariate F-tests, again there was no significant difference in the amount of change in either intrinsic [$F(1,44) = .324$, $p > .05$] or extrinsic [$F(1,44) = .000$, $p > .05$] motivation for therapy over eight sessions based on treatment modality.

Finally, since there was no significance noted regarding the treatment modality, a paired sample t-test was conducted which combined all of the participants to test the
pre treatment and post treatment level of intrinsic motivation and the pre treatment and post treatment level of extrinsic motivation. This was done to determine if there was a significant change in pre treatment and post treatment for both intrinsic and extrinsic motivation for participants involved in treatment. There was a significant difference from pre treatment level of intrinsic motivation and post treatment level of intrinsic motivation, increased from a mean of 15.67 to a mean of 19.59 (t(45)=-3.94, p<.05).

There was also a significant difference from pre treatment level of extrinsic motivation and post treatment level of extrinsic motivation, decreasing from a mean of 12.41 to a mean of 8.48 (t(45)=3.85, p<.05).

Summary

The purpose of this quasi-experimental study was to examine if the pre treatment level of intrinsic motivation, pre treatment level of extrinsic motivation, and the two modalities of therapy (individual and group therapy) related to treatment success of changes of parenting skills of parents involved in a protective service agency. The parenting skill constructs included: appropriate developmental expectations, empathy toward children, alternative to corporal punishment, role reversal, and understanding children's power/independence. This study also examined if the level of motivation (intrinsic and
extrinsic motivation) changed over eight sessions depending on the treatment modality (individual or group therapy).

The results of the study were mixed in regard to finding any significance. Specifically, a canonical correlation was conducted to examine if the pre treatment level of intrinsic motivation, extrinsic motivation, and treatment modality (group and individual therapy) related to changes in parenting skills. The results of the first and only significant canonical variate had a medium negative loading on the pre treatment level of intrinsic motivation, a medium positive loading on the pre treatment level of extrinsic motivation, and a high positive loading on the treatment modality, which related to high positive loading on appropriate developmental expectations, and higher positive loading on understanding alternatives to corporal punishment and role reversal. In addition, a paired t-test revealed that there was a significant change in pre treatment to post treatment for the above three parenting constructs for participants involved in individual treatment. All of the above three parenting skill constructs increased from pre to post treatment following eight sessions of individual therapy. A paired t-test also revealed that there was a significant increase in pre treatment to post treatment scores regarding punishment and role reversal following eight sessions of group therapy.
However, there was no significant difference from pre to post treatment regarding developmental expectations following eight sessions of group therapy.

Moreover, a multivariate analysis of variance (MANOVA) was also conducted to examine if the change in level of intrinsic and extrinsic motivation was different over eight session of treatment based on treatment modality (individual and group therapy). There was no difference between treatment modality in the amount of change in level of motivation for therapy over eight sessions. A paired t-test revealed that there was a significant change in pre treatment and post treatment scores for both intrinsic and extrinsic level of motivation for participants involved in treatment. The intrinsic score for each participant increased in both individual and group therapy. On the other hand, the extrinsic score for each participant decreased in both individual and group therapy.
CHAPTER V

Discussion

There has been a growing concern regarding the increase of children that are maltreated by their parent or caregiver in the United States and referred to a child protective service agency. Specifically, in 2000, three million referrals concerning the welfare of approximately five million children were made to child protective service agencies in the United States due to allegations of child maltreatment (U.S. Department of Health and Human Services, 2002). Child maltreatment includes both child neglect and child abuse. Child neglect is commonly defined as the failure for the caregiver to provide a child with basic necessity of life. By comparison, child abuse may consist of physical abuse, sexual abuse, and/or emotional abuse (Carlson, Furby, Armstrong, & Shlaes, 1997; Fennell & Fishel, 1990).

In response to a parent being involved in a child protective service agency due to child maltreatment, they are typically court-ordered or recommended by the agency to attend therapy in order to remediate abusive behaviors. Therefore, it was of interest to study the level of motivation for therapy when a person is motivated to change due to their own wish to change (intrinsic motivation) or if
they are stimulated from influences outside of themselves (extrinsic motivation).

Furthermore, the type of treatment modality that provides changes in parenting skills was of interest. The two treatment modalities studied were individual and group therapy. The main treatment goals for both the individual and group therapy included teaching appropriate discipline techniques throughout the childhood years and ways to implement these learned behaviors with the child. Specifically, the focus was on the benefits of positive reinforcement, incorporating limit setting while using praise, natural consequence for children's actions, empathy toward the children, and appropriate childhood development. Throughout treatment (individual and group), role-play and written information as means of learning appropriate discipline techniques was utilized. Group therapy also utilized group discussion regarding specific parenting issues.

The present study was conducted to examine if the pre-treatment variables level of intrinsic and extrinsic motivation and modality of treatment (group and individual therapy) predict changes in parenting skills (appropriate developmental expectations, empathy, alternative to corporal punishment, role reversal, and understanding children's power/independence). This study also examined if the change
in level of motivation for therapy (intrinsic and extrinsic) over eight sessions of therapy is related to participating in the two treatment modalities (individual or group therapy).

Throughout the literature review, various research studies have separately addressed level of motivation, treatment modalities, and parenting skills. However, no study was found that addressed any of the variables in this study in conjunction with each other.

Summary of Results

A canonical correlation was conducted to examine the first research question regarding if the pre treatment variables level of intrinsic motivation, level of extrinsic motivation, and the two types of treatment modalities (individual and group therapy) related to treatment success of changes of parenting skills (appropriate developmental expectations, empathy, alternative to corporal punishment, role reversal, and understanding children's power/independence) of parents involved in a child protective service agency. A multivariate analysis of variance (MANOVA) was then used to examine the second research question regarding if the level of motivation (intrinsic and extrinsic motivation) changes over eight sessions depending on the treatment modality (individual or
group therapy) of parents involved in a child protective service agency.

Research question #1.

The results for the first research question revealed that the pre treatment level of intrinsic motivation, pre treatment level of extrinsic motivation, and treatment modality (individual and group therapy) related to changes on three of the five parenting skill constructs. Specifically, the three constructs were developmental expectation, punishment, and role reversal. On the other hand, the pre treatment level of intrinsic motivation, level of extrinsic motivation, and treatment modality did not relate to changes on the other two parenting skill construct, empathy and understanding children's power/independence.

These results may be due to the time limitation of the study being only eight weeks. Specifically, changes regarding empathy and understanding children’s power/independence may take more than eight weeks to reveal a relation to motivation and treatment. Also, these results may be due to the inability for these participants to recognize children’s feelings or be able to encourage children to make good choices.

Overall, a low score on the pre treatment level of intrinsic motivation, high score on the pre treatment level
of extrinsic motivation, and the treatment modality related to changes in parenting skills on three constructs, which relate to the maltreatment of children. Specifically, changes occurred regarding having an understanding of appropriate growth and developmental expectations, utilizing alternatives to corporal punishment as a means of discipline, and not having a reversal in child and parent family roles. Therefore, it appears that the intervention of therapy along with the participant's pre treatment level of motivation related to changes on three parenting skill constructs.

Of interest, was the pre treatment level of motivation being correlated with three parenting skill constructs. Participants with low pre treatment intrinsic scores and those with high pre treatment extrinsic scores were related to three changes in parenting skill constructs. Intrinsic motivation occurs when participants are motivated to change due to their own wishes; on the other hand extrinsic motivation is stimulated from influences outside of themselves. The positive changes on three parenting constructs are related to pre treatment scores higher in extrinsic and lower in intrinsic, which appears to be opposite of what would be believed. However, this may be due to the participants being referred to treatment from the child protective service agency or the court system.
Therefore, when they entered therapy, their pre treatment scores reflected their motivation for change was greater from external sources (child protective service agency and court) rather than internal sources.

For instance, Gordon (1976) compared treatment effectiveness for voluntary college students versus college students that were encouraged to participate. These participants were either given a choice between two relaxation techniques or were not given a choice. The results indicated that the participants that were given a choice between the two relaxation techniques reported that it was significantly more effective than those that were not given a choice. Also, there were no significant differences between the choices of relaxation techniques among those participants who were encouraged to participate. The lack of a significant difference among the participants who were encouraged to participate may be due to them not seeing the choice between the two relaxation techniques as truly having a choice and because they were encouraged to participate in the study. The participants that were intrinsically motivated displayed a significant difference, on the other hand those that were extrinsically motivated did not.

These results from Gordon (1976) were not noted in the results of this current study. However, this may be due to the population of this study, which were participants
referred for therapy by either the child protective service agency or the court system.

Changes in parenting skills were also noted in various studies similar to the research conducted by Miller et al. (1999). They studied cases of severe physical abuse and compared the characteristics of these families with risk factors. They concluded that the parents displayed a range of psychological characteristics, such as depression and anxiety, and the parents also displayed life problems such as domestic violence. However, what was of specific interest for this study was Miller et al. (1999) report that the most common form of treatment for these parents was individual therapy and parent training classes. Of these families, more than half of the children were reunited with at least one parent within one year following the parent training. However, this study did not differentiate between subjects that were in either individual therapy or group therapy.

In addition, there was a significant increase in the three parenting skill constructs, which were related according to the results of the canonical correlation (developmental expectation, punishment, and role reversal) in pre to post treatment following eight sessions of individual therapy. There was also a significant increase in pre treatment to post treatment scores regarding
punishment and role reversal following eight sessions of group therapy. However, there was no significant difference from pre to post treatment regarding developmental expectations following eight sessions of group therapy.

In other words, there was a significant relationship noted for all of the predictor variables and three specific parenting skill constructs (developmental expectation, punishment, and role reversal) which is based on the results of the canonical correlation. A significant difference was then noted regarding changes on the three parenting skill constructs based on individual therapy. All of the above three parenting skill constructs increased from pre to post treatment following eight sessions of individual therapy. A significant difference was then noted regarding changes on two of the three parenting skill constructs based on group therapy. There was an increase from pre to post treatment regarding punishment and role reversal following eight sessions of group therapy. However, there was no significant difference from pre to post treatment regarding developmental expectations following eight sessions of group therapy.

The intervention of individual therapy related to a significant increase on changes in three parenting skill constructs. Therefore, the process of individual therapy impacted the participants' changes regarding developmental
expectation, punishment, and role reversal. However, the intervention of group therapy related to a significant increase on changes for only punishment and role reversal and no significant difference regarding changes in developmental expectations. A significant increase regarding changes in developmental expectations was noted in participants in individual therapy and not in participants in group therapy. This may be due to the lack of manualized treatment for either the group or individual therapy. However, the focus for both individual and group therapy included the benefits of positive reinforcement, incorporating limit setting while using praise, natural consequence for children's actions, empathy toward the children, and appropriate childhood development. In other words, even though both group and individual therapy have the same goals and focus in treatment, since there is no manualized form of treatment, it is unclear if indeed both treatment modalities identically inform and educate the parent.

Overall, participants in individual and group therapy had significant increases from pre to post treatment on the two parenting skill constructs, punishment and role reversal. Therefore, attending eight sessions of therapy increased their understanding of alternatives to physical force, encouraged them to utilizing alternatives to corporal
punishment, understood how to appropriately meet children’s needs, and the parent was able to find comfort, support, and companionship from their peers instead of their children. Participants in individual therapy also had a significant increase from pre to post treatment on the parenting skill construct, developmental expectations. In other words, participants in individual therapy developed an understanding of growth and development of children, were supportive of their children, and allowed children to exhibit normal developmental behaviors.

Through the review of past literature, only one study was found that examined parenting skills and treatment modalities. However, the treatment modalities consisted of participants in only individual therapy compared to participants in both individual and group therapy. Specifically, Iwaniec (1997) conducted an example of a research study regarding treatment modalities. He studied two groups of emotionally abusive and neglectful parents. The results indicated that the parents with both group and individual therapy improved significantly regarding lower levels of anxiety, more confidence, and less stress when compared to their baseline scores. However, this study did not differentiate between individual and group therapy.
Research question #2.

The results for the second research question revealed that there was no difference between treatment modalities in the amount of change in level of motivation (intrinsic and extrinsic) for therapy over eight sessions. In other words, the type of treatment modality that the participants were involved in (group or individual therapy) did not make a difference regarding changes in their level of motivation. These results may be due to all of the participants being referred for treatment through the child protective service agency or the court system.

However, there was a significant difference from pre-treatment and post-treatment scores for both intrinsic and extrinsic level of motivation for participants involved in treatment. The intrinsic score for each participant increased in both individual and group therapy. On the other hand, the extrinsic score for each participant decreased in both individual and group therapy.

Overall, in both individual and group therapy the participants' level of motivation decreased in regard to being stimulated from influences outside of themselves and their level of motivation increased in regard to making changes due to their own wishes. This may be due to their initial feelings regarding being referred to treatment through the child protective service agency or the court.
system, which would reflect a high extrinsic and low intrinsic level of motivation score for their pre treatment measure. However, during the eight weeks of therapy, they became more motivated to change due to their own wishes to change and not due to the external influences. Therefore increasing their level of intrinsic motivation and decreasing their level of extrinsic motivation score on the post treatment measure.

There was no study found that examined level of motivation in regarding to treatment modality. Therefore, the combination of these two variables was a new area of research.

Limitations

There were several limitations noted throughout the process of this study. For instance, at the site where the data was collected, the group therapy was conducted on an eight week cycle. Therefore, the data was collected following the eighth week of group and the eighth week of individual therapy. However, in regard to some participants involved in individual therapy, the therapy was not terminated at the eighth session, instead therapy continued. Therefore, the time restraints necessary in group therapy may have caused the group to be more short term time directed, on the other hand the individual therapy could focus on a patient crisis if there was one knowing that
there is no time restraint on the individual therapy. Therefore, the eight week period between the collection of the pre and post treatment measures for participants involved in individual therapy are of concern.

There is also concern regarding the threat of history effect on the internal validity of this research. Specifically, during the eight weeks from pre to post treatment measures, participants were not isolated from their environment. In other words, this study did not have the ability to control all potential external events. Some of the participants may have had a child removed from their care, a child reunited with them, a rereferral to DYFS, or numerous other possibilities. These external influences may have had an impact on the results of the post treatment measures.

As stated in Chapter I, subjects were not randomly placed in either group or individual therapy. They were placed depending on the available openings at that time in either group or individual therapy. Therefore, there is concern of selection bias due to the participants not being randomly assigned to either therapy.

Also, as stated in Chapter I, there is concern regarding the research being conducted through self-report measures. This opens up the potential threat of validity of
the research as a result of social desirability and acquiescence (Gall, Borg & Gall, 1996).

Another limitation for this study was that the Client Motivation for Therapy Scale (CMOTS) and the Adult-Adolescent Parenting Inventory (AAPI-2), both Form A and Form B, does not have a validity scale. Therefore, the researcher was unable to clarify if the participants were attempting to portray themselves in a favorable light, in a negative light, or if indeed the participant was answering the questions in an open manner. Since the population of the participants in this study was either court ordered to attend therapy or recommended to do so by the child protective service agency, they may have attempted to portray themselves differently even though they were informed that participating would not help or impede their attempt to have their case closed in DYFS (see Appendix B - Informed Consent Form). Therefore, a measure specifically regarding social desirability would be useful in future research. Also, the CMOTS was used as a pre and post treatment measure, however there were no prior test/retest reliability study conducted.

Finally, the study did not account for any of the participants being placed on medication (i.e. psychotropic medication) while participating in this study. In other words, some of the participants may have seen a psychiatrist
or a primary doctor and been placed on medication while in therapy and this was not noted during this study. Being placed on medication might have influenced any changes in how the participant answered post treatment measures when compared to their pre treatment measures. For instance, if a participant was diagnosed with an impulse disorder or a mood disorder, medication may affect their ability to focus and comprehend the questions asked on the post treatment measures, which they were unable to do while completing their pre treatment measures.

Recommendations for Future Research

A number of questions remain regarding level of motivation, treatment modality, and change in parenting skills. For instance, it would be useful to have the therapist rate the participant's level of motivation and parenting skills throughout the therapy session in order to gain the therapist's viewpoint regarding the participant's motivation and parenting skills. Of interest would be to compare the therapist's perspective of level of motivation and parenting skills to the participant self-report.

It would be beneficial for future research to be longitudinal in study in order to follow the participant further than the eight weeks in this study. This should be done in order to note if the participants level of motivation changes and to note if they continue using the
parenting skills that they were taught. The longitudinal study could follow the participants over time to determine the long-term effect of therapy and note if there are any referrals to child protective service agencies.

Regarding future research, this study did not account for how the child was maltreated, the severity of the abuse, or the age of the abuse for the child. It would be of interest to divide parents into groups between those parents that a child protective service agency had substantiated or unsubstantiated abuse against them specifically. This would be of interest regarding if their level of motivation and parenting skills would be affected by the substantiation of the abuse. Also, it would be of interest to include the parental history of childhood maltreatment. Comparing the parents who were abused as children with those that were not abused.

Finally, this study did not attempt to divide parents into separate groups due to whether or not they are currently involved in family court and/or criminal court due to the substantiation of the abuse. Again, since this study investigated level of motivation, a participant’s motivation may have been affected if they were known to be involved in family or criminal court. It would also be of interest to see if there is a significant difference in level of
motivation between parents involved in family court compared to those involved in criminal court.

**Summary and Conclusions**

This study was conducted to assist in understanding how the pre-treatment level of motivation and modality of treatment predict changes in parenting skills and if the level of motivation changes over eight sessions of individual or group therapy.

The results of this study demonstrated that a low pre-treatment level of intrinsic motivation, high pre-treatment level of extrinsic motivation, and treatment modality (both group and individual therapy) related to positive changes on three parenting skill constructs, which relate to the maltreatment of children. Specifically, changes occurred regarding having an understanding of appropriate growth and developmental expectations, utilizing alternatives to corporal punishment as a means of discipline, and not having a reversal in child and parent family roles. In addition, there was a significant increase in changes from pre to post-treatment on all of the above three parenting skill constructs following eight sessions of individual therapy. There was also an increase from pre to post treatment regarding changes in punishment and role reversal following eight sessions of group therapy. However, there was no significant difference from pre to post treatment regarding
changes in developmental expectations following eight sessions of group therapy.

Finally, there was no significant change in level of motivation for therapy over eight sessions in reaction to participating in individual or group therapy for parents involved in a child protective service agency. However, there was a significant change in pre-treatment and post treatment scores for both intrinsic and extrinsic level of motivation for participants involved in treatment. The intrinsic score for each participant increased in both individual and group therapy. On the other hand, the extrinsic score for each participant decreased in both individual and group therapy.

In conclusion, there has been a great deal of research on parenting skills, treatment modalities, and limited research on level of motivation for treatment. However, there was no study found that looked at all of these variables together until this research was conducted. Even though there were mixed results, it is obvious that continued research in this area is essential. Further research may provide additional insight into the parenting skills, treatment modality, and level of motivation of parents involved in child protective services. In turn, this may assist in informing effective parenting treatment and reduce the rate of recidivism of child maltreatment.


Appendices
Appendix A

Letter of Solicitation
Letter of Solicitation

I am also here on behalf of a student from Seton Hall University's College of Education and Human Services, Department of Professional Psychology and Family Therapy, Clinical Psychology program.

The purpose of this study will be to demonstrate if the level of motivation and type of treatment predict changes in parenting skills. It will also examine if the level of motivation affects treatment success in different types of treatment. Participating in this study is expected to take approximately 30 minutes to complete.

Specifically, you will be asked to complete a demographic questionnaire, a parenting skills inventory called the Adult-Adolescent Parenting Inventory, and an inventory relating to how you believe you will experience treatment once you begin treatment called the Client Motivation for Therapy Scale. Finally, following eight sessions of treatment, you will be asked to complete the parenting skills inventory and the inventory regarding how you experience treatment again.

Participation is confidential and not mandatory and there are no consequences for refusing to participate. Your decision to participate will not be shared with your DYFS caseworker. Your choice to participate will not help or hurt your attempt to have your case closed in DYFS. You will be free to stop participating in the study at any time, without consequences.

Please do not place your name on any of the forms. Instead, you will be asked to create a three-digit number for yourself. You will need to place the same three digits on each form and be able to recall these three digits on the post treatment forms. This will be
done so as to compare your pre treatment scores on the forms to your post treatment scores.

Also, the master key with the three-digit number and the research data will be secured in a locked drawer, which will not be located in the same room. The master key will be destroyed after the post-data collection, preventing any identification of participants.

This project has been reviewed and approved by the Seton Hall University Institutional Review Board for Human Subjects Research. The IRB believes that the research procedures adequately safeguard the subject’s privacy, welfare, civil liberties, and rights. The Chairperson of the IRB may be reached at (973) 275-2974.
Appendix B

Informed Consent Form
CONSENT TO PARTICIPATE IN RESEARCH

TITLE OF RESEARCH STUDY: Level of motivation, treatment modality, and change in parenting skills among parents involved in a child protective service agency.

PRINCIPAL INVESTIGATOR (S): Marisela Gavlick, MA

DEPARTMENT: Atlantic Behavioral Health

AFFILIATION: Seton Hall University's College of Education and Human Services

Department of Professional Psychology and Family Therapy, Clinical Psychology program

This document describes a research study, which includes only participants who voluntarily choose to participate. Please take your time to make your decision. This form is designed to provide you with information about this study, which you should know prior to your consent to participate.

THE PURPOSE OF THE RESEARCH: The purpose of this study will be to demonstrate if the type of motivation and type of treatment predict changes in parenting skills. It will also examine if the type of motivation affects treatment success in different types of treatment. Your participation will involve approximately 30 minutes to complete. Approximately 100 single parents will be participating in this study.

REASON FOR PARTICIPATION: You are being asked to participate in this study because you are currently involved in either group or individual therapy at Atlantic Behavioral Health. There is no cost for participation in the study, and no compensation is offered to participate.

THE FOLLOWING PROCEDURES WILL BE INVOLVED: Once treatment begins, you will be asked to complete a demographic questionnaire, the Adult-Adolescent Parenting Inventory, and the Client Motivation for Treatment Scale relating to how you believe you will experience treatment. Following eight sessions of treatment, you will again be asked to complete the Adult-Adolescent Parenting Inventory and the Client Motivation for Treatment Scale.

THE POTENTIAL RISKS OR DISCOMFORTS: No potential risks or discomforts are predicted. If anything appears uncertain, please feel free to ask questions. If you feel that any of this material will be upsetting to you, please choose not to participate.

THE POTENTIAL BENEFIT TO ME OR OTHERS: Participation in this research will allow clinicians to develop and implement higher quality treatment services.

CONFIDENTIALITY: Should you consent to participate in this research, your identity will be kept confidential. Your decision to participate will not be shared with your DYFS caseworker. Your choice to participate will not help or hurt your attempt to have your case closed in DYFS. You will be asked to create a three-digit number. You will need to place the same three digits on each measure and be able to recall these three digits on the post treatment measures. This will be done so as to compare your pre-treatment scores to your post-treatment scores. The master key with the three-digit number and the research data will be secured in a locked drawer, which will not be located in the same room. The master key will be destroyed after the post-data collection, preventing any identification of participants. You understand that the results of the study may be published in the medical literature and that any publication will not contain information that will identify you.

WITHDRAW FROM THE STUDY: You understand that participating in this research is voluntary. Should you agree to participate in this research, you may change your mind at any time. Refusal to participate or withdrawal from the study will not harm your relationship with the attending staff, nor will it prejudice any further treatment at this institution. The Principal Investigator may terminate your participation in this study at any time if he/she feels it is in your best interest.

If you wish further information regarding your rights as a research subject, you may contact the Institutional Review Board through the Office of Grants and Research at 973-275-2974.
REQUEST FOR INFORMATION:
You have talked to ______________________ (name of clinician) about this study and he/she has answered your questions. ______________________ can be reached at ( ) and will be available to answer any questions or concerns that you may have. You understand that you will be informed of any significant findings discovered during the course of the study, which might influence your participation.

CLINICIAN STATEMENT
To the best of my ability, I have explained the purpose of the research required, and the risks and benefits of this study to the patient.

______________________________
Clinician's Signature

______________________________
Participant Initials:

______________________________
Date

______________________________
Name of Principal

______________________________
Phone

Morristown Memorial Hospital
Investigator: Maricel Gavlick
Morristown, New Jersey
Number: 973-971-4633

AGREEMENT TO PARTICIPATE

NAME OF PARTICIPANT: ______________________

I have read the above description of the research study and general conditions (or it was read to me by ______________________).

Everything I did not understand was explained to me by ______________________, and any questions I had were answered by ______________________. 

I have discussed this study with the clinician to my satisfaction. I understand the purpose of the research, the study procedure that I will undergo, the possible risks, discomforts and benefits that I may experience during the study. I understand that my participation is voluntary and that I can withdraw from the study at any time.

In consideration of this understanding, I voluntarily agree to participate in this research at Morristown Memorial Hospital.

I have read and been given a copy of this patient informed consent form for my records.

This project has been reviewed and approved by the Seton Hall University Institutional Review Board for Human Subjects Research. The IRB believes that the research procedures adequately safeguard the subject's privacy, welfare, civil liberties, and rights. The Chairperson of the IRB may be reached at (973) 275-2974.

I have read the material above, and any questions I asked have been answered to my satisfaction. I agree to participate in this activity, realizing that I may withdraw without prejudice at any time.

______________________________
Signature of Participant

______________________________
Date

______________________________
Signature of Witness

______________________________
Participant Initials:

Page 2 of 2
Appendix C

Demographic Questionnaire
Demographic Questionnaire

1) When is your birthday?
   _______/_____/____ (month, day, year)

2) What is your current marital status?
   Single          Divorced
   Widowed         Separated

3) How long have you been in therapy with this clinician?
   ____________ months

4) Are you currently involved in therapy outside of this agency?
   __ yes  __ no

5) What is your current employment status?
   Self-employed  Retired
   Part-time       Full-time
   Unemployed      Homemaker
   Other

6) What is your annual income?
   Less than $10,000
   $10,000 - $30,000
   $30,000 - $50,000
   $50,000 - $70,000
   Above $70,000

7) What is your highest grade completed in school?
   Prior to High school  High School
   2-year college        4-year college
   Graduate degree       Post graduate degree
   Other


Appendix D

Client Motivation for Therapy Scale (CMOTS) - Pre Treatment
CMOTS

Why are you presently involved in Therapy?

Using the scale below, please indicate to what extent each of the following items corresponds to the reasons why you are beginning therapy (individual or group counseling) by circling the appropriate number below each item.

<table>
<thead>
<tr>
<th></th>
<th>Does not correspond at all</th>
<th>Corresponds moderately</th>
<th>Corresponds exactly</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>1 2 3 4 5 6 7</td>
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<td>2.</td>
<td>1 2 3 4 5 6 7</td>
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<td>3.</td>
<td>1 2 3 4 5 6 7</td>
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<td>4.</td>
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<td>5.</td>
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<td>6.</td>
<td>1 2 3 4 5 6 7</td>
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<td>7.</td>
<td>1 2 3 4 5 6 7</td>
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<tr>
<td>8.</td>
<td>1 2 3 4 5 6 7</td>
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</tbody>
</table>

1. Because other people think that it is a good idea for me to be in therapy.
2. Honestly, I really don’t understand what I can get from therapy.
3. For the pleasure I experience when I feel completely absorbed in a therapy session.
4. For the satisfaction I have when I try to achieve my personal goals in the course of therapy.
5. Because I would feel guilty if I was not doing anything about my problem.
6. Because I would like to make changes to my current situation.
7. Because I believe that eventually it will allow me to feel better.
8. I once had good reasons for going to therapy; however, now I wonder whether I should quit.
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<tr>
<td>9.</td>
<td>Because I would feel bad about myself if I didn’t continue my therapy.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
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<tr>
<td>10.</td>
<td>Because I should have a better understanding of myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>6</td>
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<tr>
<td>11.</td>
<td>Because my friends think I should be in therapy.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>12.</td>
<td>Because I experience pleasure and satisfaction when I learn new things about myself that I didn’t know before.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>13.</td>
<td>I wonder what I’m doing in therapy; actually I find it boring.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
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<tr>
<td>14.</td>
<td>I don’t know; I never really thought about it before.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
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<tr>
<td>15.</td>
<td>Because I believe that therapy will allow me to deal with things better.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
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<td>16.</td>
<td>For the interest I have in understanding more about myself</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
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<tr>
<td>17.</td>
<td>Because through therapy I’ve come to see a way that I can continue to approach different aspects of my life.</td>
<td>1</td>
<td>2</td>
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<td>4</td>
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<tr>
<td>18.</td>
<td>Because through therapy I feel that I can now take responsibility for making changes in my life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>19.</td>
<td>Because it is important for clients to remain in therapy until it’s finished.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>6</td>
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<td>20.</td>
<td>Because I believe it’s a good thing to do to find solutions to my problem.</td>
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<td>3</td>
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<td>21</td>
<td>To satisfy people close to me who want me to get help for my current situation.</td>
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<td>22</td>
<td>Because I don’t want to upset people close to me who want me to be in therapy.</td>
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<td>23</td>
<td>Because I feel that changes that are taking place through therapy are becoming a part of me.</td>
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<td>24</td>
<td>Because I value the way therapy allows me to make changes in my life.</td>
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Appendix E

Client Motivation for Therapy Scale (CMOTS) - Post Treatment
CMOTS

Why are you presently involved in Therapy?

Using the scale below, please indicate to what extent each of the following items corresponds to the reasons why you are presently involved in therapy (individual or group counseling) by circling the appropriate number below each item. We realize that the reasons why you are in therapy at this moment may differ from the reasons that you initially began therapy. However, we are interested to know why you are in therapy at the present moment.

<table>
<thead>
<tr>
<th>Item</th>
<th>Does not correspond at all</th>
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<td>2. Honestly, I really don't understand what I can get from therapy.</td>
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<td>5. Because I would feel guilty if I was not doing anything about my problem.</td>
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22. Because I don't want to upset people close to me who want me to be in therapy.

23. Because I feel that changes that are taking place through therapy are becoming a part of me.

24. Because I value the way therapy allows me to make changes in my life.