A QUALITATIVE STUDY OF THE IMPLEMENTATION OF HEALTHY RELATIONSHIP AND MARRIAGE EDUCATION BY CHILD WELFARE PROFESSIONALS IN GEORGIA

by

ANDREA SCARROW

(Under the Direction of Nicholas Fuhrman)

ABSTRACT

The purpose of this study was to understand the extent to which child welfare professionals (CWP’s) who completed the Healthy Relationship and Marriage Education Training (HRMET) delivered by Georgia Cooperative Extension, during July and August of 2012, implemented the HRMET skills/tools with their clients. Using qualitative methods, three focus groups were conducted with four CWP’s in each group. Objectives included: to identify HRMET skills/tools that were or were not implemented by CWP’s; to identify perceived benefits and barriers to implementation; and to identify recommendations from CWP’s for implementing HRMET skills/tools. Twenty-three domains emerged including nine skills/tools which were implemented, the influence of the training experience, professional and personal benefits, beliefs and barriers which negatively impacted implementation, and three areas of recommendation. Knowles’ andragogy and Social Exchange Theory provided a basis for interpreting the findings.

INDEX WORDS: Relationship and marriage education, Child welfare, Cooperative Extension, Social Exchange Theory, Knowles’ andragogy
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by

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August 2013
DEDICATION

I dedicate this thesis to my Lord and Savior, Jesus Christ, who sustains my life and fulfills all His purposes for me; and to my husband, Steve, my very best friend and lifetime partner; and to our son, Stephen, and his bride, Laurie, who make our lives so much fun; and to our family who has always encouraged and supported our every endeavor. I love you all!
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To my thesis committee—Dr. Nicholas Fuhrman, Dr. Ted Futris, Dr. Jason Peake, and Dr. Jill Rucker—thank you for so much of your time and for keeping me focused on the question of “so what?” because research should go beyond academic rigor to making a difference. I sincerely appreciate each of you and your support both professionally and personally.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>ACKNOWLEDGEMENTS</th>
<th>LIST OF TABLES</th>
<th>LIST OF FIGURES</th>
<th>CHAPTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>.................................................................................................................................................. v</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>.............................................................................................................................................. viii</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>............................................................................................................................................... ix</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 INTRODUCTION TO THE STUDY ................................................................................................. 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purpose of the Study ................................................................................................................ 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem Statement ..................................................................................................................... 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub Questions ........................................................................................................................... 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assumptions ............................................................................................................................. 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Definitions of Key Terms ......................................................................................................... 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limitations/Delimitations ......................................................................................................... 7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 REVIEW OF THE LITERATURE ............................................................................................... 10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theoretical Framework ............................................................................................................. 10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conceptual Framework ............................................................................................................. 15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conceptual Model ..................................................................................................................... 22</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 RESEARCH DESIGN AND METHODS ....................................................................................... 24</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rationale for the Research Design ........................................................................................... 24</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Researcher Subjectivity ............................................................................................................. 25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Validity and Reliability in the Research Design ................................................................... 26</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research Context ....................................................................................................................... 28</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Research Procedures ........................................................................................................30

4 RESULTS .......................................................................................................................34

Research Objective One ...............................................................................................34
Research Objective Two ...............................................................................................46
Research Objective Three ............................................................................................50
Research Objective Four ...............................................................................................52
Research Objective Five ...............................................................................................58

5 SUMMARY, DISCUSSION, AND RECOMMENDATIONS ................................................62

Purpose and Objectives of the Study ...........................................................................62
Review of Methods ........................................................................................................63
Summary of Findings ....................................................................................................64
Key Findings and Implications ....................................................................................67
Recommendations for Research ..................................................................................76
Recommendations for Practice .....................................................................................77

REFERENCES ..................................................................................................................80

APPENDICES

A IRB APPROVAL ..........................................................................................................86
B FOCUS GROUP GUIDE ................................................................................................87
C FOCUS GROUP COMMUNICATIONS .........................................................................91
D NATIONAL EXTENSION RELATIONSHIP AND MARRIAGE EDUCATION
   MODEL .........................................................................................................................94
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1: Job Description and Experience in Years for Each Participant and Corresponding Group</td>
<td>30</td>
</tr>
<tr>
<td>Color</td>
<td></td>
</tr>
<tr>
<td>Table 2: HRMET Skills/Tools Implemented by Participant and According to Frequency</td>
<td>44</td>
</tr>
<tr>
<td>Reported</td>
<td></td>
</tr>
</tbody>
</table>
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 1: Flow of HRMET Delivery by Cooperative Extension and Implementation by CWP’s</td>
<td></td>
<td>22</td>
</tr>
</tbody>
</table>
CHAPTER 1
INTRODUCTION TO THE STUDY

In order to ensure the safety and well-being of children in Georgia, Cooperative Extension partnered with children’s welfare services to offer relationship and marriage education (RME) to families at risk. This study explored how child welfare professionals (CWP’s) trained in RME may implement newly acquired skills and tools with their clients. A case study approach was employed with CWP’s who attended Extension’s Healthy Relationship and Marriage Education Training (HRMET). This was a “purposeful sampling” with participants who met specific criteria based on their expertise and experience (Merriam, 2009, p. 77).

Healthy couple relationships promote stable families where children have greater opportunity to flourish and experience positive development (Schulz, Pruett, Kerig, & Parke, 2010). Research supports the use of RME to strengthen families and improve child outcomes (Ooms, 2005). Goddard and Olsen (2004) have documented Cooperative Extension’s efforts in response to this need since 1997 with the organization of the National Extension Marriage and Couples Education Working Group. Today, the National Extension Relationship and Marriage Education Network (NERMEN) exists “to provide research-based resources and promote partnerships to advance the knowledge and practice in relationship and marriage education” (National Healthy Marriage Resource Center, 2013, p. 3). Cooperative Extension specialists and county agents are strategically positioned to offer research-based RME to both urban and rural communities who are struggling with issues of family instability, poverty, and increased crime. However, connecting with low income, at risk audiences is often difficult (Ooms, 2007).
Therefore, Cooperative Extension has partnered with child welfare services to deliver RME. This partnership began in Georgia in 2012, so little is known about its effectiveness and the long term outcomes for improving child well-being.

The HRMET curriculum was developed by a multi-state team of Extension experts to provide training for CWP’s who work with “families who have few resources, single parents, immigrant families, and ethnically diverse families” (Schramm et al., 2011, p.1). Although CWP’s typically focus on parenting skills with their clients, healthy relationship skills are found to promote and support better parenting skills (Ludlam, 2005). Most importantly, relationship education for couples is shown to directly impact the stability and safety of children with positive outcomes. (Antle, Frey, Sar, Barbee, & van Zyl, 2010). Relationship and marriage education through CWP’s is likely to bring about positive impacts (Schramm, 2013), but we do not fully know to what extent HRMET tools and skills are being implemented by CWP’s in Georgia.

Child welfare professionals have the opportunity to model and teach healthy couple relationship skills to families at risk, but typically they are not trained to do so (Antle et al., 2010). Also, few marriage education curricula have been designed for use with diverse, high-risk, low income audiences such as the clientele of CWP’s (Ooms & Wilson, 2004). There are several barriers that CWP’s must overcome to teach relationship skills, including: “systemic, conceptual, and cultural factors and may extend to individual worker beliefs and attitudes” (Christensen, Antle, & Johnson, 2008, p. 308). However, we do not know which of these barriers or others may affect the implementation of RME tools by CWP’s who have participated in HRMET in Georgia.
Social Exchange Theory (Homans, 1958) was used to help guide data collection and interpretation of the findings of this research study. Attending HRMET, CWP’s were equipped to share healthy marriage and relationship knowledge and skills with their clients. What did they share subsequent to the training and why? Social Exchange Theory (SET) views the “interaction between persons” as “an exchange of goods, material and non-material” (Homans, 1958, p. 597). In regards to the implementation of HRMET, there may be rewards and costs (real or perceived) to the CWP in relationship to the client which would encourage or discourage the sharing of HRMET skills and tools. Therefore, the principles of SET were used to develop focus group questions to probe for the barriers and benefits to CWP’s who attempted to implement RME after attending HRMET.

A qualitative approach was deemed appropriate for this study because of its exploratory nature (Chesebro & Borisoff, 2007). In depth focus groups were planned to mine for richer insight concerning HRMET skills and tools which CWP’s were implementing most often in the six months following their training and why. Merriam (2009) describes qualitative case studies as “Heuristic” because they provide an opportunity to “bring about the discovery of new meaning, extend the reader’s experience, or confirm what is known” (p. 44). This study may expand what we know from secondary, quantitative data about the implementation of HRMET skills and tools by CWP’s. By offering CWP’s the opportunity to recount their experiences with a small group of colleagues, a description of the real-life situations which may inform improvements to HRMET could be captured.

**Purpose of the Study**

The purpose of this study was to evaluate how CWP’s in Georgia have implemented RME with their clients after participating in HRMET. Observed obstacles encountered by
CWP’s who attempted to implement HRMET principles may serve to inform improvements to the HRMET curriculum. The evaluation may also reveal best practices for implementation of HRMET in the field and in other, similar programs in other states. The overarching goal of this study was to contribute to the relationship health of couples and therefore the safety and well-being of children at risk in Georgia. Understanding the characteristics of HRMET that were most influential for CWP’s through focus group discussions was one method of achieving this broader goal.

**Problem Statement**

Problem Statement: To what extent do CWP’s who complete the Healthy Relationship and Marriage Education Training (HRMET) in Georgia implement the skills and tools to which they have been exposed? Based on the literature review which demonstrates various barriers to the implementation of RME by CWP’s, the researcher assumed that CWP’s in Georgia likely utilized the seven core skills from HRMET (see below); however, they may not have implemented most of the fact sheets and worksheets known as HRMET tools (defined below).

**Sub Questions**

The following sub questions were used to formulate research objectives:

1. What skills and tools from HRMET did the professionals implement, and why?
2. What were the perceived benefits that CWP’s experienced when implementing HRMET?
3. Were there skills and tools from HRMET that were not implemented, if so, why not?
4. What were the perceived barriers to implementing the HRMET skills and tools?
5. What recommendations do CWP’s offer for implementing RME in their field?
Assumptions

The following assumptions helped inform this study:

1. Participants in the focus groups will be honest about their experience at the Healthy Relationship and Marriage Education Training (HRMET) and their own implementation of the skills and tools they learned through HRMET.

2. Certain patterns will be observable in the qualitative data gathered in the focus groups, and these patterns will inform best practices by CWP’s who implement relationship and marriage education (RME).

3. The results of the data collection will also provide a rich understanding of both benefits and barriers to implementing the skills and tools learned in HRMET. These findings may serve to improve the HRMET curriculum and training experience.

Definitions of Key Terms

Relationship and Marriage Education (RME): RME (or MRE in some of the literature) includes a variety of research-based training programs for couples, whether married or not, to increase the health of their relationship in areas such as communication, conflict resolution, and also developing and maintaining respect for one another. RME takes a skills-based approach as opposed to marriage therapy which takes a clinical approach.

Healthy Relationship and Marriage Education Training (HRMET): trainings in Georgia offered by Cooperative Extension specialist and county agents. Trainings last one full day and consist of both lecture and activities. Targeted participants include CWP’s and other professionals working to improve family stability and specifically the well-being of children. Participants receive instruction in seven core RME skills and corresponding tools.
**HRMET Skills:** Seven core RME skills presented in the National Extension Relationship and Marriage Education Model (Appendix D; Futris & Adler-Baeder, 2013). These skills include:

- **Care for Self:** Teach the client to take care of personal health and well-being and to model that for his or her children.
- **Choose:** Talk with the client about healthy relationship choices so that the client makes informed, deliberate decisions about relationships.
- **Know:** Share the importance of taking time to know a potential partner before committing to a relationship.
- **Care:** Work with individuals to help them express care and respect toward their loved ones.
- **Share:** Talk with clients about how to share meaningful time and experiences together.
- **Manage:** Teach clients coping strategies such as low-level conflict management.
- **Connect:** Talk with clients about developing a support network, connecting with the larger community.

**HRMET Tools:** A set of fact sheets and worksheets for each specific HRMET skill for use with clients. Each participant in HRMET received a binder which included an explanation of the seven core skills, fact sheets for clients, and five or six reproducible client worksheets for each corresponding skill. HRMET fact sheets consist of a one page, double-sided, reproducible summary of the core skill with tips that relate this skill to the client’s life. HRMET worksheets include several interactive, written exercises to encourage integration or practice of a specific skill by the client. In addition to the binder, the *relationship wheel* is a two-sided, fully-colored disc with spinning parts which highlight a synopsis of each HRMET skill. The *relationship wheel* provides a quick reference tool for CWP’s to share concepts with their clients.
**Child Welfare Professionals (CWP's):** CWP’s in this study refer to professionals who work primarily with the Department of Family and Children’s Services (DFCS) as family case managers for at-risk children and families.

**Limitations/Delimitations**

It is estimated that 400 CWP’s in Georgia will have completed HRMET by December 2013. This study was limited to CWP’s from the July and August trainings conducted by the University of Georgia Cooperative Extension in 2012. There were 73 total participants in those trainings, including some Cooperative Extension agents and Family Connection coordinators; however, for the purposes of this research, only CWP’s were invited to participate in the focus groups. There were 37 CWP’s invited to focus groups and 12 who accepted to participate (32.4%).

The most common limiting factor for participation in the focus groups was a high rate of employment turnover among CWP’s working at DFCS. As of February 2013, nine of the 37 invited participants (24.3%) no longer worked for DFCS or were transferred to a different location. Thus, they were unable to participate in the study. The DFCS participants in one county, which will remain undisclosed, had the highest rate of turnover (50%). The focus group scheduled for that county was canceled because employees communicated they were too overburdened with the resulting extra workload.

In addition to the 37 CWP’s, five School Social Workers (SSW’s) from the August 2012 HRMET were invited to a focus group. On behalf of the five SSW’s, one responded as follows by email: “The SSW team is in a state of transition as we have two SSW’s out on maternity leave, which leaves the rest of us pretty swamped. I think meeting would be difficult at this point. In addition, after I spoke with the team, I think you might get more useful information
from those that are doing more of the in home services with the family. Because we are school-based, we really don’t utilize the techniques of the training as much as some of the others.”

Three focus groups were conducted in three different locations for the convenience of the participants. Each focus group consisted of four participants whose responsibilities consistently represented several aspects of family case management by CWP’s within DFCS: investigations, family preservation, and foster care. Commonalities related to experience among the focus groups helped to achieve “convergence (triangulation) of the data: many separate pieces of information must all point to the same conclusion” (Leedy & Ormrod, 2013, p.142). While broad generalizations are limited with qualitative studies, the synthesis present in the data collected from the focus groups likely reflects the overall experience of the 37 CWP’s who were invited to participate in this research.

In qualitative research, the researchers themselves are instruments “because the bulk of their data collection is dependent on their personal involvement in the setting” (Leedy & Ormrod, 2013, p. 97). For this reason, the researcher’s own experience and perspective introduces a certain amount of bias into this study which is important to admit for the sake of integrity and internal validity. Leedy and Ormrod (2013) further assert that “the researcher’s tone of voice or emphasis within a sentence may influence how a respondent replies” (p. 217). Although I have designed a written guide for conducting the focus groups, I realize that it is impossible to keep my own tone of voice and emphasis entirely consistent from one group experience to the next. Regardless of how I may have stressed one word over another, my goal was to create an environment where the participants felt comfortable sharing whatever opinion they had about the HRMET tools and skills. A researcher subjectivity statement detailing my own previous experiences with this subject matter can be found in Chapter 3.
Summary

The implementation of HRMET skills and tools by CWP’s in Georgia offers an opportunity to support distressed families and encourage healthy relationships for couples responsible for parenting children who will in turn benefit from more stable home environments. HRMET is currently in the piloting stage in Georgia; therefore, this research aims to provide relevant, qualitative feedback from participants which may serve to strengthen the training offered to CWP’s and increase the extent to which they implement the tools and skills learned in the training. Chapter two will provide a review of the literature and develop a theoretical framework as a basis from which this research was conducted.
CHAPTER 2

REVIEW OF THE LITERATURE

A review of the literature will promote an understanding of the context and contribution of this research study. This chapter will discuss the factors that may either encourage or hinder the implementation of Relationship and Marriage Education (RME) by child welfare professionals (CWP’s). Social Exchange Theory (SET) may offer an explanation for the extent to which the HRMET tools and skills were applied by CWP’s in this study. Factors which influence implementation may be perceived as benefits (rewards) or barriers (costs) to the relationship between CWP’s and their clients. The conceptual framework includes the following elements: recent developments in RME (since 2002), the impact of RME on the well-being of children, and the choice of CWP’s as potential RME educators. In addition, principles from adult learning and knowledge transfer theories will be examined for application to this study. This review of the literature will relate previous research to the main research question concerning the implementation of HRMET by CWP’s in Georgia.

Theoretical Framework

Social Exchange Theory – An Overview

Social Exchange Theory (SET), founded in part on the writings of Homans (1958) and Blau (1960), challenged sociologists to look at relationships as “an exchange of goods, material goods but also non-material ones, such as the symbols of approval or prestige” (Homans, 1958, p. 606). Foa and Foa (1980) elaborated on the types of goods which could be exchanged between people including resources such as information. SET may apply to the relationship transactions
of CWP’s offering information such as HRMET skills and tools to clients whom they serve. Potential benefits for CWP’s in this type of transaction could include increased rapport with clients and accomplishment of case management goals in a timely manner. Clients could benefit from the information they receive by learning new skills to strengthen their family relationships.

**Social Exchange Theory – Applications in Related Studies**

The premise of SET is that the interaction of two people creates a social exchange in which benefits and costs are shared. Molm (2003) explains that there are both “reciprocal” and “negotiated” exchanges:

In *reciprocal exchange*, actors’ contributions to the exchange are separately performed and nonnegotiated. Actors initiate exchanges individually, by performing a beneficial act for another (such as giving assistance or advice), without knowing whether, when, or to what extent the other will reciprocate. Exchange relations evolve gradually, as beneficial acts prompt reciprocal benefit. . . . Although *negotiation* is more typical of exchange in some settings (e.g., work) than in others (e.g., families), both forms of exchange are observed in a wide range of social contexts (p. 3).

These types of exchange may take place when CWP’s share HRMET skills and tools with their clients. Reciprocal benefits may be experienced by the professional and the client during the education process. For example, if the CWP communicates the *care* skill, then the client could respond with more respect toward others. In that case, the CWP’s work with that client could advance bringing mutual benefit.

CWP’s get to know their clients in a variety of settings, but they also establish formal case management plans in which the clients determine clear goals and objectives. Within these varied settings, there is opportunity for both reciprocal and negotiated exchanges between CWP’s and their clients. “The goal of engagement is to develop and maintain a mutually beneficial partnership with the family that will sustain the family’s interest in and commitment to change” (U. S. Department of Health & Human Services [HHS], 2000, p. 31). This objective
clearly reflects the “central ‘essence’ of SET: Social exchange comprises actions contingent on the rewarding reactions of others, which over time provide for mutually and rewarding transactions and relationships” (Cropanzano & Mitchell, 2005, p. 890).

Blau (1960) spoke about the importance of “approachability” and respect to win the cooperation of members in the group context (p. 549). In later studies, Molm, Takahashi, and Peterson (2000) affirmed the importance of trust: “All forms of social exchange involve uncertainty and risk, but the amount and kind of risk vary. In reciprocal exchanges, actors initiate exchange without knowing what they are getting in return, and with no guarantee of the other’s reciprocity” (p. 1400). These principles from SET may contribute insight to the challenge faced by CWP’s seeking to build trust and rapport with their clients who are under investigation for child abuse and neglect (Besharov, Lowry, Pelton, & Weber, 1998; Curran & Pfeiffer, 2008).

The relationship between a CWP and her client is an important component to the success of intervention and the establishment of family stability (Gockel, Russell, & Harris, 2008). Presently, little is known about how rapport and trust may increase between CWP’s and their clients when CWP’s implement RME to address client needs. This study hopes to contribute to the body of knowledge about possible increases in rapport and trust in this type of exchange.

**Perceived Benefits to Implementing HRMET**

SET proposes that social interactions are affected by the resulting rewards and costs to those who exchange goods or services (Emerson, 1976; Homans, 1958). CWP’s may be influenced to implement RME if they perceive certain benefits (rewards) for themselves and their clients. “By strengthening the couple relationships of child welfare clients, the deleterious effects of maltreatment on children may be minimized” (Antle et al., 2010, p. 224). In addition, DeMaria (2005) suggests that couples who face a lot of stress in their relationships would benefit
from marriage education. The clients of CWP’s are often distressed; if couple relationships are strengthened, the greatest reward may be increased stability for children at risk in those families. CWP’s and their clients would benefit by having families preserved and relationship goals achieved. Additional research is needed to understand how trainings designed to enhance the social interactions of CWP’s could better prepare CWP’s to increase client rewards and reduce costs with the information provided during trainings.

How RME Benefits Children

Research on the effectiveness of RME shows beneficial results not only for a couple, but indirectly for their children, as the quality of the parents’ relationship improves (Ooms, 2005; Schulz, Pruett, Kerig, & Parke, 2010). Policy makers, researchers, and educators have a growing interest in RME as studies continue to link the stability and well-being of children directly to the relationship health of parents (Amato, 2005; Cummings & Merrilees, 2010). Concerning the type of at-risk families serviced by CWP’s, Cowan, Cowan, and Knox (2010) state the following:

Although many fragile families demonstrate remarkable strengths, with some maintaining stability and promoting family members’ well-being while struggling against almost overwhelming odds, these families face disproportionate levels of financial impoverishment, poor health, psychological distress, relationship conflict and both residential and relationship instability, all of which are risk factors for the development and well-being of children and adolescents (p. 206).

Of special note to this research, a child’s well-being is directly affected by relationship conflict and relationship instability. It is the goal of HRMET to improve these risk factors so that children benefit alongside their parents. The HRMET curriculum explicitly states this goal and reinforces this objective with CWP’s who attend the training. Evaluating the use of HRMET skills and tools by CWP’s will help determine the fidelity and benefits of implementation thereby ensuring better outcomes for children.
Perceived Barriers to Implementing HRMET

The literature also reveals certain barriers to the implementation of RME by CWP’s which could be conceived as costs to their relationship with clients. Christensen et al. (2008) cite such barriers as “diverse family configurations and uncertain relationship commitments, the individual presentation of maltreatment, and worker discomfort with these issues” (p. 303). According to Ooms and Wilson (2004), RME “curricula have been largely designed for Caucasian middle-class committed couples” (p. 442); therefore, the availability of skills, tools, and training for implementation with diverse audiences has only come about with recent legislation and public funding support. It is a relatively new concept for CWP’s to implement RME with their clients, and the perceived costs may discourage them from trying.

The challenge of reaching diverse audiences is addressed in the HRMET curriculum. For example, when discussing the *share* skill, CWP’s are encouraged to note that Hispanic families may *share* differently than Caucasian families (Schramm et al., 2012). In general, Hispanic families view their children’s participation as very important to all sharing times. Couple time apart from the children is not sought after to the same degree by Hispanic couples as by Caucasian couples. HRMET also encourages sensitivity to a variety of family relationships: married couples, unmarried parents, biological parents, stepfamilies, foster and adoptive parents, to name a few. HRMET skills and tools are designed to be flexible and appropriate for use among diverse cultures, backgrounds, and situations. This study hopes to improve our understanding of how HRMET skills and tools are implemented with diverse audiences.

Child protective services encounter resource and personnel challenges which could present additional barriers to the implementation of HRMET by CWP’s. High turnover rates (20% and greater per year) are prevalent among CWP’s and more than double the rate occurring
in other government agencies (Faller et al., 2009). This high turnover among CWP’s is attributed in part to an insufficient workforce and burdensome caseloads (Scannapieco & Connell-Carrick, 2007). To ask professionals who are already taxed physically and oftentimes emotionally (Sprang, Craig, & Clark, 2011) to implement RME with their clients may seem unreasonable to some in light of job pressures which weigh heavily upon their time and responsibilities.

**Conceptual Framework**

**Recent Developments**

Current child welfare reform began in 1997 with the passing of the Adoption and Safe Families Act (ASFA) which “codifies many innovative state policies and practices that have emerged to respond to the multiple, often complex, needs of children and families” (HHS, 2000, p. 3). Since 2002, public funding has been available for marriage education through the Administration for Children and Families (ACF) and the Temporary Assistance for Needy Families (TANF) to serve a more diverse clientele (Ooms, 2007). Program evaluation has been a required component of these new RME programs, and there is a growing body of applied research related to curriculum development and implementation (Ooms & Wilson, 2004). By discovering to what extent some CWP’s in the field are implementing HRMET, this study hopes to contribute to the body of research and best practices for the implementation of RME by CWP’s or others working with high risk, diverse audiences.

This qualitative study is a complimentary component to a much larger quantitative evaluation of HRMET’s implementation, round two pilot, conducted during April to September of 2012 (Futris, Barton, Thurston, & Duncan, 2012). The results from the quantitative study informed the development of the focus group guide (Appendix B) used in this research. The preliminary report of “pre-, post, and follow-up evaluation data indicates that there were positive
changes in the knowledge, attitudes and practices of the participants over time” (Futris et al., 2012, p. 19). Further qualitative study with a few of these participants was deemed appropriate for revealing deeper insight about their implementation of HRMET skills and tools and may inform the development of future measures to examine impact.

**RME versus Parenting Education**

Parent-child interactions are impacted by the relationship health of the parents. Erel and Burman (1995) concluded that “efforts to improve parent-child interactions may be enhanced by addressing parents’ marital difficulties” (p. 129). Since that time, research continues to link “child victimization” with “marital discord” among other factors (Turner, Finkelhor, & Ormrod, 2007, p. 283). Child welfare professionals have often focused on parenting education to improve the outcomes for children. While parenting education is important, it may be equally important to address the health of parents’ relationships in order for a child to thrive (Ludlam, 2005; McLanahan & Beck, 2010; Schramm, Futris, Galovan, & Allen, 2013). RME is not meant as a substitute for parenting education, but the research recognizes that it supplies an additional and necessary component because the interaction between parents/co-parents affects the well-being of children.

**RME versus Marriage Therapy**

RME is grounded in the research contributions of psychology, neurology, biology, and linguistics; however, it is skill-based as opposed to the clinical approach of marriage and family therapists (MFT's) (Ooms, 2005). RME focuses on teaching communication skills, conflict resolution, problem solving, empathy, and other components of healthy relationships. The purpose is more preventive—teaching attitudes and behaviors that promote successful marriages and relationships. In contrast, marriage therapy is often concerned with remedial measures for
helping couples in crisis. Even so, the majority of couples facing a marriage crisis never seek out a marriage therapist; many people view therapy as intrusive and expensive (Larson, 2004). Marriage education is implemented in various contexts by clergy, educators, and counselors; it has gained in popularity with groups and couples. Halford, Markman, Kline, and Stanley (2003) suggest “that an important way MFT’s can broaden their reach to couples is by collaborating with clergy in offering relationship education” (p. 386).

Cooperative Extension has contributed to the expansion of RME. While Extension specialists and agents are not usually trained marriage therapists, they do have expertise as family life educators. Cooperative Extension across many states has developed RME program curricula, fact sheets, and newsletters based on unbiased research with evaluation of program impact (Goddard & Olsen, 2004). HRMET is one example of Cooperative Extension’s contribution to this field, and this study represents a small component of Georgia Cooperative Extension’s efforts for ongoing evaluation.

Traditionally, marriage therapy has been preferred over RME for high-risk couples in crisis. However, there is growing evidence that RME may be beneficial for distressed couples as well (Blanchard, Hawkins, Baldwin, & Fawcett, 2009). In addition, RME curricula are being developed specifically for low-income, diverse audiences (Dion, 2005). Halford et al. (2003) discovered “widespread interest in relationship education” among minority communities that faced economic hardship (p. 396). These descriptors fit the clients of CWP’s; therefore, the literature indicates a plausible opportunity for the implementation of RME by CWP’s with their clients. However, little is known about how CWP’s implement RME and what could be done to enhance their abilities to facilitate positive relationship change.
Child Welfare Professionals as Educators

Child welfare professionals may feel their opportunities to function as marriage educators are limited with clients for various reasons. For example, clients may not disclose relationship problems to a CWP for fear that it could be interpreted as domestic violence resulting in separation from a partner or children (Christensen et al., 2008). Nevertheless, Ooms and Wilson (2004) found that low-income, at-risk audiences feel very positively toward receiving RME. Since the Adoption and Safe Families Act of 1997, CWP’s have been expanding their role with clients beyond intervention to achieve well-being outcomes such as families having an “enhanced capacity to provide for their children’s needs” (HHS, 2000, p. 47).

The above indicators place an emphasis on prevention of abuse and neglect and suggest that CWP’s need skills for being proactive—sharing skills and concepts to promote family stability—rather than only responding to crisis needs with reactive intervention (Schramm et al., 2013). This implies that CWP’s need to be trained in effective teaching. There is potential for positive impact by implementing RME through child welfare:

Generally, the more an educational initiative attaches itself to an established setting that already serves individuals and couples, the greater its potential outreach. . . . These professionals already know and understand their clients and can adapt marriage education to meet their particular circumstances (Hawkins, Carroll, Doherty, & Willoughby, 2004, pp. 555-556).

In order to implement this new skill set effectively, CWP’s need teaching skills. In the following section we will examine literature which defines adult teaching and learning principles. These principles could apply to CWP’s in both roles—learner and teacher.

Effective Adult Teaching and Learning

Studies document that those who participate in professional training workshops often do not implement the knowledge and skills they were exposed to (Baer et al., 2009; Leake, Holt,
Potter, & Ortega, 2010). There are many factors which influence whether adults apply newly acquired knowledge. Burke and Hutchins (2007) cite learner characteristics such as “cognitive ability, self-efficacy, pre-training motivation, negative affectivity, perceived utility, and organization commitment variables” as important to the implementation of learning (p. 271). Research also stresses the importance of combining theory with practice when developing pedagogy for social work education (Larrison & Korr, 2013; Vayda & Bogo, 1991).

Since the Morrill Act of 1862, followed by Smith-Lever Act of 1914, land grant universities have provided continuing adult education through Cooperative Extension to meet public needs and to extend unbiased, research-based knowledge to citizens throughout the nation (Kellogg Commission on the Future of State and Land-Grant Universities, 2000; Dunifon, Duttweiler, Pillemer, Tobias, & Trochim, 2004; Franz, 2007). Extension educators have the opportunity to deliver specialized training designed for adult participants by integrating locally relevant information with research-based findings.

Malcolm Knowles, coined the term “andragogy” for his theory of adult learning needs which he felt should impact the teaching style of the adult educator (Knowles, 1972, p. 34). Ota, DiCarlo, Burts, Laird, and Gioe (2006) suggest that Extension programming should heed Knowles’ principles and “focus on experiential techniques that tap into the experience of learners, such as group discussion, problem-solving, case methods, simulation exercises, games, and role-play” (p. 2). Since Knowles (1972) had applied this theory specifically to continuing education for social workers, it seems appropriate to consider these principles for training CWP’s in RME. The ability of the educator to connect with their audience through creative and relevant teaching methods is critical to influencing positive learner outcomes.
Elements of Trainings that Influence Participant Behavior Change

In addition to adult learner characteristics, there are certain elements of trainings which promote behavior change and the transfer of knowledge to practice. MacRae and Skinner (2011) found seven elements of training which affect behavior change:

. . . that the intervention fulfills the expectations of participants;
that participants are given an opportunity to influence programme content;
that the intervention is related to the short- and long-term learning goals of the learner;
that the content is relevant;
that there is an opportunity to practice and give feedback;
that there is positive behavioral modeling;
and that the intervention includes error-based examples (p. 984)

Similarly, Leake et al. (2010) suggest the use of simulations for CWP’s who attend cultural responsiveness training in order to boost implementation of new knowledge with their clients. Investigating what makes continuing professional education meaningful for social workers, Daley (2001) states, “Professionals indicated that new information had to connect to other concepts before it was meaningful to them, and part of the process of making knowledge meaningful was to use it in practice in some way” (p. 50). Focus groups conducted during this study provided an opportunity for further reflection and experiential learning as CWP’s shared how they had used HRMET skills and tools. In conclusion, training for CWP’s may be more effective if it is interactive, experiential, and deemed practical or useful by the participants.

This study sought to understand the elements of the current HRMET which are most influential at helping CWP’s to become more effective change agents. As described in the conceptual model below (Figure 1), principles from Knowles’ Theory of Andragogy relate to the effectiveness of Cooperative Extension’s delivery of HRMET when training CWP’s who will in turn implement the tools and skills with their clients. According to Chan (2010), applying Knowles’ principles helps adult learners “to be involved actively in the learning process, to
construct their own knowledge, to make sense of the learning, and to apply what is learned” (p. 33). This is precisely the goal of HRMET: that CWP’s will be able to apply what is learned, sharing the skills and tools to promote healthy relationships and healthy marriages among their clients for the well-being of children.

In addition to Knowles’ Theory of Andragogy, the conceptual model (Figure 1) also pictures an effective implementation of HRMET skills and tools by CWP’s with their clients in which both enjoy reciprocal benefits. Social Exchange Theory (Blau, 1960; Emerson, 1976; Homans, 1958) helps us understand that such an exchange requires trust and could produce benefits for CWP’s and their clients such as increased rapport, accomplishment of client goals, and increased family stability.

Of course, the opposite outcome is possible if CWP’s encounter barriers when attempting to implement HRMET skills and tools (also pictured in Figure 1). Barriers present costs which CWP’s may not be willing to assume or overcome when attempting to teach the relationship skills and tools they have learned. Barriers such as cultural differences, lack of resources, and a high volume of caseloads may discourage implementation of HRMET by CWP’s. In that case, the social exchange is interrupted and there are no resulting benefits.
Figure 1. Flow chart showing the delivery of HRMET by Cooperative Extension to CWP’s who in turn educated their clients using healthy relationship skills and tools received in training. Knowles’ Theory of Andragogy (Knowles, 1972) provides insight for training CWP’s. Social Exchange Theory (Blau, 1960; Emerson, 1976; Homans, 1958) informs the extent to which CWP’s may or may not implement HRMET with their clients.
Summary

Previous research indicates support for the implementation of RME by CWP’s with their clients to achieve greater well-being and permanency for children. Legislation and public funding have also strengthened support of new RME endeavors in the last decade, especially for underserved audiences. The HRMET project is one such new endeavor specifically aimed at equipping CWP’s to deliver RME. This study relates to previous research as it examines elements of the HRMET experience which may encourage or hinder implementation by CWP’s. In SET terminology, what are the perceived benefits and/or costs related to implementation?

From an adult teaching and learning standpoint, this study sought to understand the mechanics of “how” the training was implemented and which teaching methods were modeled most effectively to benefit CWP’s clients. The following chapter provides details on the methods used to collect, analyze, and interpret the data in line with this study’s research questions.
CHAPTER 3

RESEARCH DESIGN AND METHODS

A qualitative research design was chosen to evaluate how child welfare professionals (CWP’s) have implemented the Healthy Relationship and Marriage Education Training (HRMET) tools and skills with their clients during the first six months following their training. Three focus groups were conducted with CWP’s in Georgia to understand to what extent they had used the tools and skills, barriers they may have encountered, and outcomes they had observed. This chapter presents a rationale for the research design and describes the researcher’s role in this qualitative study. Participant and site selection are discussed within the context of the study. Finally, methods for data collection, analysis, and interpretation are delineated.

Rationale for the Research Design

This study used the findings from a quantitative evaluation of HRMET to inform the development of a qualitative focus group guide. A quantitative evaluation was conducted with HRMET participants by an evaluation team at the University of Georgia using pre-test and post-test surveys as well as follow-up surveys two months and six months after the training (Futris et al., 2012). The researcher conducted focus groups with CWP’s who participated in the 1-day trainings conducted in Moultrie and Cumming, Georgia, during July and August of 2012, respectfully. This qualitative study has the potential to expand what we know from secondary, quantitative data concerning the implementation of HRMET skills and tools by CWP’s.

A qualitative approach was deemed appropriate for this study. In depth group discussions with participants provided richer insight into which skills and tools CWP’s chose to
implement most often and why. A review of the literature detailed in Chapter 2 described various barriers that CWP’s may encounter when implementing relationship and marriage education (Antle et al., 2010). By offering CWP’s the opportunity to recount their experiences with a small group of colleagues, a description of the real-life situations which may inform improvements to HRMET could be captured.

**Researcher Subjectivity**

Since my personal background and traits influence my perspective and interpretation of the data, I would like to share pertinent facts about myself. I grew up in Moultrie, Georgia, the very place I live and work now. From an early age, I felt a desire to help people. For that reason, I pursued and received my undergraduate degree in Bible and Theology with a Concentration in Counseling from Toccoa Falls College, in Toccoa, Georgia.

After graduation, I married Steve Scarrow, and we began a ministry career with the Christian and Missionary Alliance denomination. We worked in youth ministry in Raleigh, North Carolina, for four years, and our son was born there. We lived in Canada for two years where my husband completed his graduate degree in missiology. From there, we moved to Edinburg, Texas, where I completed a Spanish Language Diploma at the Rio Grande Language School. These studies prepared my husband and me to be missionaries in Guadalajara, Mexico. During twelve years in Guadalajara, we mentored Mexican church leaders and coordinated Marriage Encounter Ministries. We had the opportunity to help many couples repair broken relationships and reach greater family stability.

In 2005, my family and I returned to Moultrie, Georgia, where my husband pastors Friendship Alliance Church. In 2007, I began to work as a county extension agent with the University of Georgia, Colquitt County Cooperative Extension. I strive to develop and teach
programs that truly meet the educational needs of program participants. Since 2009, family stability has been identified through local needs assessment as one of the top five issues to address for a stronger community in Colquitt County.

The opportunity to be involved in HRMET fits closely with my life goal of helping others, especially couples and families. I do have a vested interest in seeing families in my community thrive and grow in healthy relationships. I want HRMET, or any other training that I implement, to be effective. Testing the effectiveness of HRMET in the real world is one of the reasons I embarked on this research. Regardless of the outcome, whatever the data may indicate, this research will be applied to my work and is well worth my time.

My experience has taught me that no one training holds the key to producing healthy relationships. It is a matter of being open-minded, changing what does not work, and refining what works well. I am rewarded by playing a role, however small, in addressing the needs of child welfare and family stability in Georgia. In order to reduce the influence of personal bias, I took certain measures to maintain an accurate report of the participants’ responses during the focus groups. These measures are discussed in the following sections addressing validity and reliability as well as the research context and procedures.

**Validity and Reliability in the Research Design**

Leedy and Ormrod (2013) suggest the use of several relevant techniques for insuring the validity of a qualitative study: “extensive time in the field,” “thick description,” “feedback from others,” and “respondent validation” (p. 104). Some of these strategies apply more than others to this study and will be discussed below. At the time of this study, the researcher had been involved with HRMET and had interacted closely with the Moultrie/Albany participants for more than one year and with the Cumming/Gainesville participants for at least six months. This
type of qualitative study must not be rushed and requires extensive time, travel, and resources for thorough data collection. To achieve the type of rich detail which Leedy and Ormond (2013) term “thick” (p.104), each focus group lasted at least one hour and was held in a location that was accessible to participants. In addition, the researcher conducted the focus groups in a comfortable environment by providing a meal to welcome participants who were seated together around a table in order to encourage open dialogue.

A variety of sources were used to test the validity of this research. The researcher’s thesis advisory committee provided close scrutiny of the focus group guide, email communication, and phone script in order to ensure balance and limit bias in the interactions with participants. The focus group guide and other communications can be found in Appendices B and C, respectively. Along with the focus group meetings being audio recorded, a third party observed the focus groups and took notes, helping to capture body language and other non-verbal communication. These notes were then compared to the transcriptions of conversation from the focus groups to provide additional checks for accuracy. Participants themselves were also asked to provide feedback. Once a summary of the transcriptions was finished, it was emailed to the respective participants to check for accuracy. This last element would be what Leedy and Ormrod call “respondent validation” (p. 104).

Internal validity is often termed “credibility” in qualitative research; in other words, “are the findings credible given the data presented” (Merriam, 2009, p. 213). This credibility is often influenced by a researcher’s own values and experience. Therefore, the researcher employed “reflexivity” throughout this study—remaining honest with how her own experience, values, and assumptions affected the research procedures and the conclusions made from the observable data (Leedy & Ormrod, 2013, p. 312). In addition, the researcher had a colleague conduct a domain
analysis of the raw data which was then compared with domains found by the researcher. Trustworthiness was established through this comparison as domains were found to be similar. Validity was ensured by rooting the focus group guide in the theoretical framework as well as developing probing questions based on the findings from quantitative secondary data (Futris et al., 2012).

Merriam (2009) makes the case that “achieving reliability in the traditional sense is not only fanciful but impossible” for qualitative studies because “what is being studied in the social world is assumed to be in flux, multifaceted, and highly contextual” (p. 222). However, qualitative researchers can use an “audit trail” providing a detailed account of research methods and procedures to ensure greater dependability (Merriam, 2009, p. 223). While a qualitative study is impossible to replicate in the purest sense, methods must be clear and conclusions authenticated by the audit trail (Merriam, 2009). In the subsequent sections of this chapter, the researcher provides an audit trail for the research.

**Research Context**

**Site Selection**

Proximity and familiarity were the two factors which determined site location so that it would be convenient for the participants to attend the focus groups. There were two sites chosen for the Moultrie/Albany group. For those living or working in Moultrie, the Colquitt County Cooperative Extension office was chosen. This is also where HRMET was held in July 2012, which made the location familiar. For those participants from Albany, a more convenient focus group was held at the Dougherty County Cooperative Extension office, only a few blocks from where the participants work at the Dougherty County DFCS office. There were two participants
from Worth County and Thomas County who were invited to attend either group according to their own convenience.

There were also two sites chosen for the HRMET group trained in Cumming, Georgia. This group partially consisted of 17 participants in or near Cumming, Forsyth County. They were invited to the Forsyth County Public Safety Complex where they had participated in HRMET in August 2012, a familiar location. The remainder of this HRMET group lived and worked in Hall County, so they were invited to the Hall County Cooperative Extension office in Gainesville, Georgia, more conveniently located for their participation.

**Participant Selection**

HRMET trainees invited to participate in the focus groups met the definition of child welfare professionals who are charged with the well-being and stability of children. These trainees came from two main organizations: the Department of Family and Children Services (DFCS) and local school social workers. Only five of the potential participants were school social workers. In actuality, only DFCS professionals accepted to participate in the focus groups. DFCS professionals included those who investigate child abuse, service families at risk, and place abused and neglected children in foster homes. Because these participants had attended HRMET with Cooperative Extension, the researcher had access to their contact information which they had submitted with their registration forms. Each focus group participant received a 15 dollar honorarium for any personal cost related to attending after normal work hours.

The names of focus group participants have been changed so that they remain anonymous. For the same reason, focus groups will be designated as “blue,” “red,” and “green” groups in order to avoid identifying participants through their places of work or residence. It is
important to provide a short job description of the participants as their comments often related to their particular responsibilities. The following table provides participant information.

Table 1

*Job Description and Experience in Years for Each Participant and Corresponding Group Color*

<table>
<thead>
<tr>
<th>Group</th>
<th>Name</th>
<th>Job Description</th>
<th>Experience-level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue</td>
<td>Rhonda</td>
<td>Facilitates family team meetings</td>
<td>5 years</td>
</tr>
<tr>
<td>Blue</td>
<td>Amber</td>
<td>Case manager family preservation</td>
<td>5 years</td>
</tr>
<tr>
<td>Blue</td>
<td>Lisa</td>
<td>Permanency unit</td>
<td>18 months</td>
</tr>
<tr>
<td>Blue</td>
<td>Sally</td>
<td>Supervises permanency unit</td>
<td>18 years</td>
</tr>
<tr>
<td>Red</td>
<td>Nancy</td>
<td>Previously family preservation</td>
<td>7 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Supervises social services</td>
<td>1 month</td>
</tr>
<tr>
<td>Red</td>
<td>Sarah</td>
<td>Previously family preservation</td>
<td>4 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Works in intake department</td>
<td>3 months</td>
</tr>
<tr>
<td>Red</td>
<td>Tabitha</td>
<td>Social services--various positions</td>
<td>2 years</td>
</tr>
<tr>
<td>Red</td>
<td>Andrew</td>
<td>Child protective services investigation</td>
<td>7 years</td>
</tr>
<tr>
<td>Green</td>
<td>Dina</td>
<td>Family preservation</td>
<td>7 years</td>
</tr>
<tr>
<td>Green</td>
<td>Darla</td>
<td>Family preservation</td>
<td>5 years</td>
</tr>
<tr>
<td>Green</td>
<td>Katrina</td>
<td>Child protective services investigation</td>
<td>Time not stated</td>
</tr>
<tr>
<td>Green</td>
<td>Gail</td>
<td>Family preservation</td>
<td>5 years</td>
</tr>
</tbody>
</table>

**Research Procedures**

**Instrument and Materials**

All communication documents and the focus group guide were approved by the University of Georgia Institutional Review Board (IRB). An amendment form was submitted for project #2011-10220-03, Healthy Relationship and Marriage Education Training (HRMET) -- Phase II, with Dr. Ted Futris as the Principal Investigator and Co-Principal Investigators.
including Dr. Nick Fuhrman, Andrea Scarrow, and Allen Barton. IRB approval documentation is included in Appendix A.

The focus group guide was written with the problem statement and the sub-questions in mind. In addition, quantitative evaluations of HRMET were consulted to develop follow-up questions based on data collected from the same population sample—CWP’s in Georgia (Futris et al., 2012). Questions were written to be open-ended with sub-questions for extracting rich data. The guide then passed through several revisions with input from the researcher’s thesis committee. The focus group guide is included as Appendix B.

An informational letter was developed and sent to prospective participants by email. This informational letter served as the initial invitation to the focus groups. It included the place, date, and time of the focus group along with the purpose of the study. The informational letter was followed up with a phone call and a confirmation email. After the focus groups were completed, participants received an email expressing sincere appreciation for their time and thoughtful contributions. These communication documents are included in Appendix C.

Materials also included copies of the HRMET curriculum notebooks and relationship wheels. These were identical to the binders and tools which participants received previously when they attended HRMET in July and August of 2012. Copies were provided as reference materials for participants to look through as they talked about these items during the focus groups.

Data Collection

Three focus groups were conducted. In order to capture each participant’s response in its entirety, each focus group was audio recorded and each lasted approximately one hour. The researcher transcribed the three recordings verbatim, including non-verbal feedback such as
pause words, laughter, and simultaneous agreement by one or more participants. The recordings were of high quality and easily understandable.

Non-verbal communication was also noted. The researcher invited a helper to each of the focus groups to support with the logistics of set up, take notes, and record observations. These helpers were invaluable to the flow of the focus groups as they helped prepare the room, set up the dinner, and welcome the participants. On one occasion, the digital recorder stopped working during the last ten minutes of the focus group. However, due to careful note taking by the helper, all of the main points expressed by the participants were safely written down. Dr. Ted Futris, the Principal Investigator, attended the Moultrie focus group and participated in the discussion, encouraging participants in their responses to the focus group questions.

**Domain Analysis**

Domain analysis, a form of content analysis, was used to summarize the raw data into categories. The researcher read through the transcripts, writing key words and phrases in the margins of the transcripts and color coding items which were repeated throughout. Merriam (2009) explains this process: “Because you are being open to anything possible at this point, this form of coding is often called open coding” (p. 178). Based on this initial process of interacting with the data, the researcher developed broad categories, or emerging themes, in which to group the different data elements.

Once the broad categories were developed through open coding, the researcher printed each transcript in a different color to identify it as belonging to the blue, red, or green focus group. In this way, it would be easy to trace each quotation back to a group and, as necessary, a participant. The researcher then cut and pasted quotations from the transcripts into different broad categories. Content analysis was conducted with attention given to “the frequency and
variety of messages, [and] the number of times a certain phrase” was used (Merriam, 2009, p. 205). Content analysis helped to tease out concepts that in turn refined the categories or emerging themes. These themes were then compared to the original problem statement. Finally, the researcher discussed the overarching themes with a colleague who also used domain analysis to examine the raw data and the two discussed consistencies they found in their interpretations.

**Summary**

This chapter presented a rationale for the qualitative design and methods employed by the researcher. The focus groups conducted may provide rich insight for improving HRMET and expanding its implementation by child welfare professionals. The researcher shared her background and bias which could influence the collection of data and the conclusions drawn from the data. In addition, applied techniques for insuring validity and reliability were delineated. Site selection, participant selection, and descriptions were discussed along with research procedures for analyzing and interpreting the data. The following chapter will share the results of this study based on the initial research questions.
CHAPTER 4

RESULTS

The purpose of this study was to understand the extent to which Child Welfare Professionals (CWP’s) who completed the Healthy Relationship and Marriage Education Training (HRMET) in Georgia implemented the skills and tools to which they were exposed. Three focus groups were conducted with 12 CWP’s who had attended HRMET which was delivered by Georgia Cooperative Extension. After transcribing and analyzing the transcripts from these focus groups using domain analysis, themes emerged about the implementation of HRMET skills and tools by CWP’s. These themes informed the research objectives of this study.

Chapter Four presents the domains that emerged from analyzing the raw data found in the focus group transcriptions. The domains, or themes, are presented in order of frequency under headings which correspond with the initial research objectives. There were five research objectives originally presented in Chapter One as sub-questions. Raw quotes from participants and their corresponding domains are presented under the most appropriate research objective in this Chapter.

Research Objective One

To identify which skills and tools from HRMET were implemented by CWP’s, and why.

Ten domains emerged from the raw data pertaining to research objective one. The participants used copies of the HRMET binder and relationship wheel to reference their comments during the focus group. They spoke of specific skills/tools which they had
implemented. At times, the CWP’s commented on their reasons for using these skills/tools as well as the situations in which they had implemented them. They shared anecdotes of what they observed from their clients during implementation. Those anecdotes are reported in this section as they relate to the “why” of implementation. Research participants talked about aspects of the training experience which encouraged them to implement the skills and tools; these remarks also provide insight as to why the CWP’s implemented skills/tools presented to them during HRMET.

The Care for Self Skill

Seven participants, representing all three focus groups, brought up *care for self* when talking about the tools they had implemented. Regarding *care for self*, “Nancy” who has worked in family preservation for seven years said:

> And most times our clients they don’t have anyone else but themselves; so therefore, you know, just introducing this and going over basically their physical well-being, um, just everything as a whole, they were able to, some of the clients were able to you know, let me know, “Ms. ‘N.’ you really are saying something.” (“Nancy”)

Two of “Nancy’s” co-workers agreed that *care for self* was a skill which they taught clients. “Sarah” used these tools specifically with a father:

> I think the dad had issues with, um, with drug usage and so just kind of trying to help him to see that hey, you know, you’ve got to get yourself together and care about yourself so that you can be able to care about mom and care about this child. (“Sarah”)

In another focus group, “Dina,” who has worked in family preservation for seven years, talked about how *care for self* compares to “caregiver capability” –a term found in her case plan template:

> It’ll say, um, “caregiver capability,” well I know what that means, but I’m the case planner. A parent looking at that and they might not know what it is. Then like, you could do like the “care for self,” you take care of yourself, you had better capability of taking care of yourself. . . . I like the little icon. (“Dina”)
“Dina’s” comment indicated that care for self was a concept her clients could relate to more easily than the case plan terminology that she used before attending HRMET. She liked the care for self icon for communicating this concept. Another participant in this group, “Gail,” also talked about implementing care for self:

OK, well the self-care section, I always teach my overwhelmed mothers the importance of taking care of the caregiver. So I did make copies of that, and I presented it to like two moms ‘cause I felt like they were getting overwhelmed. And I explained to them: “you know, I know you have to take care of your husband and your kids, but at the same time how are you taking care of you? You know, where do you stand on the list of priorities?” (“Gail”)

Two participants in the third focus group had similar comments to make about the care for self skill. “Rhonda,” who has worked for five years as a CWP and facilitates family team meetings, said:

I think one of the, some of the material that I’ve tried to use is that we have to make the parents realize that they have to take care of themselves. Um, you know, once you can take care of yourself, you can take care of the children, but you know you need to look after yourself and make sure that you’re OK. (“Rhonda”)

Her co-worker, “Amber,” spoke about a specific client situation when she implemented care for self:

. . . this couple were so, they have three children, and they were so busy trying to be with their children so much that they forgot about taking care of themselves, that they lacked self-care for themselves. Um, they didn’t do anything; they just let themselves fall apart, um, and then it affected their marriage, you know. They didn’t do anything together, so what I did was just gave suggestions as to how to start small. . . . Um, and so that couple, I think they really got a lot out of that. (“Amber”)

Care for self was the skill most often referenced and spoken of by CWP’s who participated in this qualitative study. They applied the tools from this module of the HRMET toolkit in a variety of situations and felt it was helpful to their clients.
The Relationship Wheel Tool

The relationship wheel was the next most often mentioned tool/skill from the HRMET curriculum. “Katrina,” a child protective services investigator, liked the wheel because it gave the client a visual, “almost like a slideshow.” She liked that the wheel is “interactive” and “they can focus on one part at a time.” From the same focus group, “Gail” shared the following testimonial about using the relationship wheel:

I was going over it with her and I felt like I was making a breakthrough because I was helping her to understand, you know, the kind of relationships that you have been in since you were 12 years old with abusive men, these aren't healthy relationships; and I tried to help her understand the trickle-down effect that it has on her children,. . . so that was the first way I was able to implement it was using the wheel to make someone just see what a healthy relationship actually looked like. (“Gail”)

Gail also spoke about the convenience of using the relationship wheel:

Well, when I was talking to the lady about taking care of herself I had the wheel so I could just spin it around and rattle off to her, you know, this is what you need to be doing, you know, so I, that made it easier for me just having the wheel. (“Gail”)

Another testimonial about a specific client situation with regards to the relationship wheel came from “Amber”:

I’ve used the relationship tool some . . . I think she’s eighteen years old on my case load and she um, she’s married . . . and I remembered when I looked at it, um, she was abused as a child and she did not understand how to be loving and affectionate to her husband, and so one thing that I did we focused on how to give, um, love and affection appropriate to your mate because she didn’t really know how to do that. I mean she’s young; she got married young. Um, I think that she wasn’t ready for it, um, just by speaking with her, but I was able to use that to actually help her to learn some things that could maybe better her relationship with her spouse. (“Amber”)

In total, the relationship wheel was mentioned by five different participants across all three focus groups. Those participants felt that it was practical for implementation, visually helpful, and applicable to their clients’ lives.
The Binder Tools

Five participants, representing all three groups, commented on their use of the HRMET binder: a set of fact sheets and worksheets which CWP’s could copy and share with clients as needed. “Tabitha” brought her own copy of the HRMET binder to the focus group and showed how she had added paper tabs to mark what she wanted to use. She and “Gail” had copied and shared some of the fact sheets and worksheets with clients. “Nancy” seemed to gain confidence when using the binder: “It’s not me just saying something, you know, I’m getting it from the book.” “Katrina” spoke of two specific worksheets that she liked from the binder: “Love Languages” and “Choosing a Partner.” Lastly, “Amber” said, “because it’s so nicely put together, I did keep it readily available. . . . It was easy reading, and it was easy, um, to, you know, give back to the client.”

The focus group participants appreciated having a binder with tools they considered useful and practical. All three groups affirmed that the binder had not just set on their shelves after attending HRMET. The “blue group” (see Table 1) spoke specifically of sharing the binder with their co-workers who had not attended HRMET. “Gail” requested a binder for her college age daughter who accompanied her to the focus group. All three groups were very positive about receiving some updated tools for their binders.

The Manage Skill

The manage skill, as taught in HRMET, focuses on helping clients manage stress, difficulties, and conflicts while demonstrating acceptance, forgiveness, and understanding to one another. Manage was spoken of by four participants, and again, it surfaced in all three focus groups. “Tabitha” felt the manage skill was especially needed by her clients. “Darla” explained the need for manage by her clients:
... they don’t know how to manage anything that confronts us, a lot of times, uh, people don't know how to manage anything different. ... because our families, like we stated earlier, our families are overwhelmed. When you’ve got five babies, you got boo boos, and then you got baby daddies and you got all that, I mean, baby mama drama ... so you got all these things that these folks have to manage. (“Darla”)

Her colleague “Gail” agreed with her:

... the managing techniques really come into play because then they are trying to manage the family and sometimes managing a job but they are having to go here and there to do their services in order to get their Case Plan completed. (“Gail”)

“Rhonda” talked about the importance of teaching clients to handle conflict which is part of the manage skill: “I guess another thing was, um, you know like the conflicts that the parents or the couples may have, realizing how that affects the children, and learning how to handle that.”

While some of the participants’ comments focused on managing circumstances which may lead to conflict for clients, “Rhonda’s” feedback reflected the true nature of this skill: helping clients manage interpersonal conflict with others.

**The Share Skill**

Four participants, representing all three focus groups, spoke of the share skill in their implementation of HRMET skills. In the red group, “Tabitha” shared a dramatic story about teaching the share skill to one of her clients and the results for that family:

So I began to talk to her, “Share what you feel, you know, talk to them, really express your emotions, you know, just be free. You can’t expect for them to just drop this wall when you helped build it up. ... And so let them know that my lifestyle is going to change. I’m not doing drugs anymore, being open and honest with the children.”

So I think the sharing part is just learning to, you know, create a safe environment to communicate with each other was very good. So they’re still working towards that; they’ve not accomplished all that because it took time for them to get here, and it’s going to take time for it to break down. ... She has come back and said, “Well you know Ms. ‘T,’ I did talk to ‘em, and we just spent some family time together and just us, no, not my cousin, not my niece, and they were happy you know.”
Because they had to live from house to house because mom was on drugs and not have her own. . . . So during that time I really saw a great change in her and the connection between her and her children. (“Tabitha”)

“Dina” from the green group told how she used share with her clients to build rapport and to build couple identity:

Well, sometimes I, like, couple identity under “share” . . . . Sometimes it doesn't have anything to do with their case, but I’ll ask them where they met just because I want to know. (Laughter) No, it just gets them to think, and that way I get to know them better, and they don't think like, I'm that person coming from DFACS. I'm actually asking about them. (“Dina”)

Similarly, “Rhonda” from the blue group told about a couple that she and her colleague,

“Amber,” met with; they used the share skill to teach this couple about the importance of spending time together:

Amber would get to talking to them in the family team meeting and talking about their relationship (Amber: um-hum) um—what did they do together? Um, they would both start crying, you know. And it’s ‘cause it would hit home to them. Um, so I think Amber did make them realize, um, “y’all need y’all's time together, you know, you need to focus on each other for a little while and not more on your children because your children are picking up on what you’re doing.” (“Rhonda”)

“Amber” confirmed what “Rhonda” was relating, and it was obvious that both participants felt positive about how their clients received the concept of “sharing” time together as a couple.

**The Choose Skill**

*Choose*—which focuses on wise relationship choices and intentionally growing healthy relationships—was mentioned as an important skill three times, once by each focus group.

“Sarah” shared how she implemented the skill and how the client responded:

I did like the one, um, the “choose,” and I made sure I turned to it, about prioritizing the relationship. . . . I had a family and one of the children was having problems in school and he was kind of acting out. . . . he said, “Well I really want to spend more time with my dad.” And so, you know, I got in touch with dad and kind of talked with him. And I was like, you know, I understand you pay child support but it’s more to it than that. And um, and I remember one of the things he came down, he was from Texas, and he came down and he got the children. He took them back with him for the summer. (“Sarah”)
“Sarah” was enthusiastic about this client’s choice to spend more time with his children. She expressed that “choose” was her “favorite” skill and the only one that she had gotten to implement before changing from her role in family preservation to the intake department at DFCS. In another group, “Darla” talked about why she felt choose was an important skill for her clients:

And we have a lot of clients that don't know how to choose. They think that because Mom got beat up and he loves me because he hit me, but no, that is not love you know. So sometimes we have to walk through with our clients on what’s love and what’s not love—what’s healthy and what is not healthy because a lot of them don't know that. (“Darla”)

In a third group, “Sally” pointed out that “choose” would be good for “prevention” when speaking to clients about “picking” a partner. The choose skill emerged as an important domain, appreciated by all three focus groups for its application to existing as well as potential client relationships.

The Know Skill

Know is another skill which applies to both new and existing relationships. This skill helps clients focus on what they need to know about someone before committing to a relationship with that person. It also helps a couple develop more intimate knowledge and support for each other. The know skill was spoken of by “Nancy” and “Andrew” in the red group as well as by “Rhonda” in the blue group. “Nancy” talked about cautioning her clients to “know” the person and look for good communication in a relationship:

And with the “know” um not generally just putting it in these terms here, but I will always talk with people, you know, “Do you know who this person is?” You know, “Are you able to tell this person how you feel without them getting ‘x, y, and z’? Are you able to just communicate, you know, express yourself?” If you’re not able to do all those things then something is wrong. (“Nancy”)
“Andrew” has worked for seven years as a child protective services investigator. He expressed that the “know” skill is especially applicable to his work with families:

A lot of times during the duration of the investigation there’s some type of uh general concept of your not being in a healthy relationship and how it’s affecting your kids, so this “know” section, it really kind of stuck out to me because a lot of these are questions we already ask assessing the safety of the children. (“Andrew”)

“Andrew” related a specific case that he had investigated where there had been four generations of children in foster care:

. . . it was all neglect. So it was serious but you know, it was just a matter of getting the family to a point to realize that this is your issue and this is what we have to address to kind of break the cycle, so “knowing” is very important. (“Andrew”)

“Rhonda” captured the essence of the “knowing” skill when she pointed out one of the tools (worksheets) from that section:

A lot of the material that y’all, that was presented and, you know, we enjoyed looking at was uh, “getting to know your partner;” and a lot of our people that we work with they rush into a relationship before they get to know the person; and then once, you know, when a child comes along that’s when, you know, they separate, you know, or can’t learn to handle it, but um I guess one of the things that I got out of the training was um the importance of communicating. (“Rhonda”)

Just like “Nancy” from the red group, “Rhonda” tied good communication to the skill of knowing. She believed this skill was essential to help her clients find good partners and healthy relationships.

**Care and Connect Skills**

*Care* and *connect* were also mentioned by participants. *Care* teaches that one can initiate affection, acceptance, and respect independently of the other person’s actions. “Nancy,” from the red group talked about using the *care* skill with a mother and her adult daughter:

. . . using this tool of care and letting the mom know you have to accept your child for who she is and daughter you have to accept your mom for who she is, you know, just like it says, “accept and value differences.” Let’s see what we can do to kind of work things
out and maybe, possibly, you all need counseling. Let’s look at different ways to appreciate each other. . . . I guess it was just amazing to see, you know, we’re talking about healthy relationships and marriages but just, that was a relationship, a mother and daughter relationship; so I was able to use you know that with them, the mother and daughter, and kind of bridge the gap with them. (“Nancy”)

The connect skill highlights the importance of building a support network with extended family and community organizations that will provide strength for a couple and their family. “Dina,” from the green group mentioned the connect skill and helping her clients “think about their support systems.” From the same group, “Katrina’s” understanding of the connect skill varied somewhat from the definition given in the National Extension Relationship and Marriage Education Model (Appendix D). She talked about connect as a way to encourage good co-parenting skills among parents who are divorced or separated:

I try to point out to them that. . . you still have to stay connected in some kind of ways. We still have to parent. You don’t have to like each other, but you have to show respect for each other to make the relationship work. It’s not fair to the child that every other month one of you guys is calling DFCS on the other just because you guys are angry, because he moved on or she moved on or whatever, you know, so it’s, it’s, you know you have to stay connected to, to the fact that you are both still parents and that you still have to nurture this relationship in order to be successful in, in um raising your children. (“Katrina”)

Although it was only mentioned specifically by two CWP’s, it was evident that the connect skill goes hand in hand with the goals of CWP’s to connect their clients with a network of people who will support the overall relationship health of their families.

The table below summarizes the data concerning HRMET skills and tools which were implemented to some degree by the CWP’s who participated in the focus groups.
Table 2

HRMET skills/tools implemented by participant and according to frequency reported.

<table>
<thead>
<tr>
<th>Participant Name</th>
<th>Care for self</th>
<th>Relationship Wheel</th>
<th>Binder Fact Sheets &amp; Worksheets</th>
<th>Manage</th>
<th>Share</th>
<th>Choose</th>
<th>Know</th>
<th>Connect</th>
<th>Care</th>
</tr>
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<tr>
<td>Rhonda</td>
<td>x</td>
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<td>x</td>
<td>x</td>
<td>x</td>
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<td>Amber</td>
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<td>Lisa</td>
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<tr>
<td>Nancy</td>
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<td>Katrina</td>
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<td>Gail</td>
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The Training Experience

Comments made by the CWP’s concerning the training experience may serve to understand “why” they chose to implement HRMET skills and tools. Specifically, the CWP’s commented on thoughts they had during the training about the practicality and usefulness of the content. “Sarah” stated:

I remember sitting in the training and thinking, “Wow, I could use that with ‘miss so and so’ or I can use that with this family, and I don’t know if it will work with those people because they’re a little more dysfunctional than that,(laughs), you know, but just kind of thinking about my caseload at that time. (“Sarah”) “Tabitha” agreed, “I think that the whole training was just practical every, it’s just so right now, not a training that is so specific that it fits only this group.” Participants from the green group also agreed; for example, “Dina” said: “They also gave us some basic tools to use when we were in the home of our clients, with the families. It was practical.” Her coworker “Darla” echoed, “Exactly, oh I can do this!” From the same group, “Katrina” said:
I just want to piggy back on both of what they were saying. It was useful, useful information. It was stuff that we could really apply to our families and kind of put it to each situation, and kind of, you know, instead of kind of putting a Band-Aid on the problem, kind of really seeing the problem and working towards the root of the problem. ("Katrina")

“Gail,” also from the green group, shared:

And it’s something we could implement in the families that we work with. . . . And we kind of left the training with a sense of empowerment. We felt like that we could make these people see that that there is a better way of life you know, use the wheel you know to help them see that that they’re not in a healthy relationship. ("Gail")

In addition, some CWP’s remarked that they appreciated the interactive aspects of the training which were helpful for internalizing and remembering the content. “Rhonda” expressed her point of view:

I’m a people person, you know. And it sinks in when someone’s talking to me, demonstrating, using uh, examples, that’s what sticks, doing uh being in activity. I remember the balloons we were popping all over the place, you know, the little strings. Being active, I guess, being, participating in something, you know, is what sticks. ("Rhonda")

Similarly, “Amber” recounted how the training activities motivated her to implement the skills/tools:

And I used that. I mean, of course, I didn’t play the game, but the game prompted me to ask questions and then the responses I got, I was like “wow” no wonder this is going on. And so it gave me, you know, it helped me realize things that I wouldn’t have normally realized if the game hadn’t of prompted me to ask the question. ("Amber")

“Lisa” agreed, “We remember the activities”, and her colleague “Sally” added:

It helps to remember, ‘cause if we’re going to be honest, we go to a lot of trainings sometimes, and just going to the training itself can be overwhelming because what all we have waiting for us when we get back . . . I think anything that’s more the activities to help kind of keep that in your mind or the um or even scenarios. ("Sally")

A third factor from the trainings which could have influenced implementation of HRMET by CWP’s who attended the focus groups was the rapport which they felt with the training instructors. For example, from the red group, “Tabitha” made the observation:
And I liked the fact that the instructors were very energetic. They knew the information. They were very interactive, and to me that’s always good because when you go to trainings and they are dead and they’re dry, and you sleep in it, and you try to stay awake, but this was a good interactive training. I mean, I know you probably weren’t looking for that, but that was a plus. (“Tabitha”) (Everyone agrees in the background.)

From the green group, “Dina” commented concerning the HRMET instructors, “I thought they were knowledgeable about the topic.” Her colleague “Gail” said:

I thought the trainers did a really great job presenting, because they made it fun and they made it interesting for me, and it wasn’t a training that I would just sit there and fall asleep the whole time. We were active, we were up, we did activities that required walking around, moving about the room, so I felt like the way that the material was presented – that was one thing I liked about it. . . . I found, the training to be interesting and helpful. (“Gail”)

Research Objective Two

To identify perceived benefits that CWP’s experienced when implementing HRMET skills and tools.

The domains that emerged pertaining to research objective two could be classified under two types of benefits: personal and professional. Nine participants, three from each group, mentioned at least one way the HRMET skills and tools had been of benefit to them in personal relationships outside of their work at DFCS. The data related to personal benefits will be reported under “specific relationships” and “specific tools” that were discussed. Concerning professional benefits, two sub domains emerged: self-efficacy and client outcomes.

Personal Benefits

Specific Relationships

Eight participants shared that they had used the skills learned during HRMET in the context of their own personal relationships. They mentioned specific relationships such as spouse, family, friends, church, and coworkers. “Nancy” shared:
I was able to try and take away things for my personal life. Um, you know just ensuring that, you know, family as a whole is being taken care of and that the mental and physical capacity of family. Um, I think this training, you know, really enlightened and shared a lot. (“Nancy”)

“Sarah,” “Darla,” and “Amber” mentioned that the HRMET resources had been utilized at their churches by their pastors and adult ministries. “Rhonda” told of how her relationship with her husband had benefitted:

But, um, this has been helpful, and I’m like “Sally”—it’s been helpful for my relationship with my husband. You know I like the little things about, you know, giving them a kiss good-night, or send them a little text during the day, so it’s (the little things, yeah) right. (“Rhonda”)

Previously, “Sally” had shared:

I think that um, I think we all kind of, it may have not been the purpose, but personally in your own relationships and then the stress that this job brings and how that impacts relationships at home . . . . I was going to say this would be great even for, I mean this would be something like you know I would want to attend with, you know, with my husband. Even, even people that are not in the child welfare, you know, it would be good marriage stuff ‘cause there’s really not a lot out for marriages period, for any kind of marriage (various voices agreeing) I mean there’s not a lot out there for us. (“Sally”)

Specific Tools

In addition to talking about specific relationship benefits, the participants spoke about how they implemented specific skills or tools in their personal lives. “Andrew” stated:

For me, uh, the communication piece was uh, very important because in just your everyday life you, that’s something that you, you, have to do on a daily basis whether it’s communicating with coworkers and friends, family, but I guess the important piece would be effective communication, kind of, uh, get your part over in a, uh, I’d say a positive manner. (“Andrew”)

“Katrina” shared that she had used the “language of love” worksheet at home:

Like the language of love, you know it, it's kind of like an exercise to understand how people express love the different ways . . . And I used it at home . . . You know just to try it out and see, you know, if we were still on the same page, you know, and I wanted to make sure that we were communicating the way that it's more effective for him as well as for myself. (“Katrina”)
“Rhonda” spoke of implementing the *know* skill with her husband:

> And one thing that I liked, and I had to learn, was you know you talk about getting to know each other and sacrificing. You know, so my husband likes to ride a motorcycle, so I sacrifice riding the motorcycle a day with him so that I can go shopping another day . . . and by sacrificing you get involved with their interest. (“Rhonda”)

“Sarah” reported that her pastor used the relationship wheel in his ministry with couples, and “Darla” shared that she uses “manage” at her church to navigate conflict and change. By revealing these specific ways in which HRMET had been of personal benefit to them, these participants demonstrated integration of the training they had received. In addition to helping their clients, these CWP’s experienced encouragement in their own relationship health through their personal implementation of HRMET skills and tools.

**Professional Benefits**

**Self-efficacy**

Ten of the 12 CWP’s who participated in this research emphasized that they felt more knowledgeable, more confident, and/or more aware about implementing marriage education after attending HRMET. “Nancy” stated that it “let me know some things to do and not to do as far as it related with domestic violence families.” “Andrew” said, “for me it was kind of encouraging to approach the family in a more of a positive way.” Similarly, “Tabitha” expressed her feelings:

> You know, in here it talked about being positive and communicating like “Andrew” said in a positive manner, so it was just good to look at. Because sometimes you feel like, oh, these are just our rules and, you know, but to see it from somebody else’s perspective and to put it into the family setting on another level was good to me. (“Tabitha”)

“Katrina” and “Gail” shared how confident they felt after attending HRMET:

> You don’t have to be clever or think of a way, because somebody already did it for you, you could just pretty much read it off and elaborate where you need to elaborate at. (“Katrina”) And it makes you sound really intelligent. (“Gail”)

48
Participants also expressed an increased awareness about when to implement marriage education with their clients. “Rhonda” stated that “instead of tunnel vision on, you know, trying to help the family, you know, look at the whole big picture.” “Lisa” said:

. . . You’re more observant as to things that’s going on in the home that could, you know, cause stress. So you pick up on like little antennas like well I’m gonna mention it and kind of see how that’s going . . . . Before then, I wasn’t as focused, you know, we’re there to see the kids, but, you know, we’re looking for impending dangers. (“Lisa”)

“Sally” agreed, “since this training we try to put more focus on the relationship.” These comments by CWP’s demonstrated growth in self-efficacy: an increased confidence about their knowledge of healthy relationships and their awareness of situations in which to implement HRMET skill/tools.

Client Outcomes

CWP’s in all three focus groups shared positive outcomes which they observed or experienced with clients. “Tabitha” spoke about increased rapport with clients when using positive tools found in HRMET: “they’ll open up a little bit more to you.” “Dina” shared about a client’s response after using the “choose” skill: “We went over there last week to talk to her, and she seemed a lot more positive and like motivated. . . . It’s like she’s starting to spot like what’s good about a man when you date him.” “Darla” confirmed that client’s progress: “. . . but now she realizes what’s good and what’s healthy, and she’s taken more ownership of her life and her children’s life and it’s all positive, so far so good.” Concerning client outcomes, “Katrina” said:

I feel like you kind of made a breakthrough, like they understood what you are saying like they, they appreciate the information. . . . It seemed like I made a difference, absolutely, it seemed like I made a breakthrough, like they were really, um, engaged in what I was saying. Um, they were really receiving what I was saying and you know they, they were happy with the information like they were going to really use it. (“Katrina”)

“Sally” also observed positive client outcomes with the implementation of HRMET skills and tools. She related a specific example:
But then we’ve had, you know, a couple of other situations where even though they were not the father of the child, where we tried to get them to feel important, because they, well they are, because they’re the person that’s being the father figure in the home. And they’re in the relationship with the mother. To get them to um jointly do things, and I think it’s been positive with most of the situations. (“Sally”)

Professional benefits could be summarized as those which help CWP’s experience success on the job. As seen through their comments, the majority of participants in the focus groups felt better prepared to speak with their clients about healthy relationships. Some expressed taking a more positive approach in communication with their clients. In addition to feeling positive and more prepared, CWP’s witnessed positive outcomes with their clients when interacting with them through implementing HRMET skills and tools. This positive feedback may increase the likelihood that CWP’s will implement the skills and tools they learned through HRMET long after their training.

**Research Objective Three**

**To identify which HRMET skills and tools were not used, and why not.**

Four specific skills/tools were identified as “not used” by three different CWP’s who participated in this research. These participants also gave their reasons for not using these tools. Each tool is reported under a domain that relates the reason for which it was not implemented:

**CWP’s beliefs about themselves or audience appropriateness.**

**CWP’s Beliefs about Themselves**

“Well I wouldn’t personally use “manage” that much because of my degree. I feel like this would be like if we referred them to a therapist they might use this. Like um, when I first started working here, we were told we were not supposed to counsel people because we weren’t licensed. (“Dina”)

“Dina’s” comment may reflect a belief that managing relationship conflict is better addressed by marriage therapists than CWP’s like herself. Concerning the relationship wheel, “Darla” stated:
“It’s a good tool, but with me, um, I carry a lot of stuff already.” Her statement communicated a belief that it would be impractical for her to carry the relationship wheel or to keep up with it.

**CWP’s Beliefs about Audience Appropriateness**

Two participants mentioned specific tools which they would not use in some situations because they believed them to be inappropriate for certain audiences. “Darla,” commented that she would not give copies of the HRMET fact sheets or worksheets to her clients:

> . . . because the case load that I'm dealing with a lot of them is not, you know, don’t really know how to read, don’t really know how to understand, so I'm not giving them a packet like this. They wouldn’t read it; it would just be set aside. So I would just talk through some of the information with them. (“Darla”)

“Darla’s” statement reflects her belief that low-literacy audiences would not benefit from the HRMET written fact sheets and worksheets. In addition, the worksheet “Being Angry without Hurting” from the manage skill was identified by “Sally” (supervisor of the permanency unit / blue group) as a tool which she would not use. “Sally” explains:

> It would kind of be difficult with that form to do with foster care because they’re, you know they’re a little combative at that point, . . . I think they feel endorsing it is like “evidence” or it’s a negative thing (others agreeing) that they endorse this thing, so I think that they would probably be a little “put off” by that particular tool. Some of the families we work with, they might be more receptive if it was coming from say the parent aide who’s working with them on, as part of the module or something. They might not be as threatened by it. But I think if we pulled out that type of thing they’re like thinking we’re going to take it to court or something. Nothing we say will convince them otherwise. (“Sally”)

“Sally’s” explanation communicates her belief that the tool “Being Angry without Hurting” would be inappropriate to use with some clients whose children have been placed in foster care. According to “Sally,” some of these clients experience greater distrust and defensiveness toward the CWP’s.

Each focus group had a very open conversation about the implementation of HRMET tools and skills. The researcher did not observe hesitancy on the part of participants to relay
negative feedback. As seen in the above comments, the beliefs that CWP’s hold about their audiences and themselves may affect the implementation of HRMET skills and tools to some extent.

**Research Objective Four**

**To identify perceived barriers to implementing the HRMET skills and tools.**

There were six domains which emerged concerning perceived barriers by CWP’s when attempting to implement the skills/tools which they had been exposed to through HRMET. These domains will be reported in order of frequency of appearance in the raw data from focus group transcripts:

**Client Attitudes**

Every participant in the green group and the blue group talked about different client attitudes which they perceived as barriers to implementation. These CWP’s saw the main issues as lack of trust, dislike of DFCS, and lack of receptivity on the part of their clients. “Dina” expressed the following:

…a lot of clients they just hate DFCS, like . . . Not us personally, but before you even, like before you even knock on their door, “Oh, DFCS is coming over,” and they already hate me, (several agree) so they’re not, automatically they are not going to take my advice. (“Dina”)

“Darla,” also from the green group, added:

A lot of times it’s not the tools; it’s the individual that you are dealing with at that moment because you know . . . . But again these folks have to be willing to, to take part I guess in their own, I guess in their own case plan and their own cases. You know, we only can do so much, and we try not to enable them, and sometimes it can become to a point where OK either I'm enabling them or you want to do it because you have these children that you want to keep out of DFCS custody. But we tried every, every tool, every, I mean we managed everything with them. We did everything, self-care, every possible tool that we could use and it just didn't work. . . . And that's where you see the tools is not really working then, because again they, they are in denial. (“Darla”)
As an investigator with DFCS, “Katrina” had also experienced this attitudinal barrier from clients:

And um, they look, look at you like, “You can't tell me nothing.” I mean, like, you know, “not only are you not welcome in my home, but, and once you get in here you're going to try to tell me what to do,” that’s not really, you know. And you get that, and you, and you, and when you feel the resistance, you are not going to pull out a book or a wheel and, and try to discuss; you want to get your, you know, your information and try to, you know, to leave out. You know, get out of there because we are just armed with a pen, (laughter) that’s all we have, you know. (“Katrina”)

“Gail” offered her insight as well:

Now some of the material, even though it's good material, getting people to want to buy into it, because you have so many clients that are in denial. Number one, they don't feel like they have a problem even though it's obvious to everybody else, but if they're in denial no amount of education or material in the world is going to help. You know, and sometimes it's hard to break through the denial barrier because some people are just so adamant that they [don't] have a problem. (“Gail”)

As with the green group, all four members of the blue group discussed their clients’ attitudes as barriers. Lack of trust was an issue cited by each of these CWP’s, for example:

It’s um, on our end we have to build that trust with the uh, with the person because you know they know their children or, you know, it’s at stake if they don’t get their act together. So it’s hard sometimes to build their trust within a client to get to know them, to know where, you know, exactly what the real main issue is. (“Rhonda”)

In addition, “Sally” brought up lack of receptivity:

And you have to be careful with that because they’re sometimes not real receptive because they think, they don’t have any kind of, you know, that they don’t have any kind of a problem, or you’re saying they have a problem but you’re just, you know, trying to offer that support. (“Sally”)

The barrier most often cited by CWP’s for not implementing HRMET was negative client attitudes. They did affirm, however, that this barrier affected any type of education with clients, not just the implementation of relationship education.
Client Crises

The next most often cited barrier by CWP’s was that of client crises which limit the implementation of relationship and marriage education from their viewpoint. Seven CWP’s shared similar thoughts, and all three groups were represented among these comments. “Nancy” stated that the “need is crisis need—too far below healthy.” From the same group, “Tabitha” said, “As well put together as this material is, the people we deal with is in such a deep hole that it is hard for them to get to this. . . . the focus has to be on the immediate issue.” “Katrina” shared a crisis situation where the mother felt trapped with a man who was abusive to her daughter:

…she wasn't into hearing any kind of tools, about choices, or about, you know, caring about self first, or, or becoming independent so that she won't have to be in this financial situation. It was, her immediate thought was, “What am I, I’m 38 years old, I don't have a job, you know, if I leave this man, he, you know, what am I supposed to do?” (“Katrina”)

Financial crises were also mentioned by “Rhonda,” from the blue group: “When the children do come into foster care, um, the family that had Medicaid, uh, the parents lose the Medicaid. The children keep it, so actually the parents are having a lot more barriers.” Rhonda’s colleague, “Lisa,” shared that removing a child from a dangerous situation is the first concern in many crises: “our role is to make sure the best interest of the kids is taken seriously so by that, you know of course we want to help you with this by all means, but we’ve got to get this child placed in a timely manner.” Finally, “Sally” described the type of crisis CWP’s are often confronted with:

A little more difficult for us to implement with the families that’s already to the point that they are . . . . sometimes by the time they come into foster care, I mean, we’re just trying to keep everybody from, where’re they gonna sleep the night, from killing each other (crisis mode—“Amber”) It’s just so crisis mode that you can’t even go anywhere with it. (“Sally”)
The general consensus among CWP’s in the focus groups was that crisis situations often limit the opportunity to implement interventions beyond the most basic needs of physical safety and shelter for children at risk.

**Time Constraints**

CWP’s also spoke about time constraints as a barrier to implementation of the HRMET tools and skills. This barrier also surfaced in all three groups from five different participants.

“Nancy” said, “I could not find anything wrong with the concepts or tools. It is just a matter of the time we have with our clients.” Her colleague, “Tabitha” explained in more detail:

We’re only touching these families twice a month, so it’s very hard for us to get in there and reiterate. You know, we might give them a good point, but I may not bring that point back up every time I go because they’ve got so much other stuff going on, or they’re pulled in so many different directions. So I think the information that provided is very is awesome, great information, but to get it to our clients on the level that we work with them on, it would have to be in a different, it would have to be in a sit down, let’s have some weekly, monthly meetings to really bring this stuff home . . . (“Tabitha”)

“Katrina” shared a similar comment: “You know, I find that 30 to 45 days goes around so fast. Before you know it, it's time to work towards closing out this case, so I really don't feel like I get a chance to really work with the families the way I want to work with the families.” From the blue group, “Amber” elaborated on the barrier of time constraints:

The only barrier is because we don’t have a lot of time to keep, you know, to keep implementing the information. Sometimes if I notice that I don’t talk about it in a session, when they come back they may have reverted back just a little bit. If I had more time to actually, to be more consistent on a regular basis with it I think that I would see a better outcome. (“Amber”)

“Lisa” echoed “Amber’s” sentiment about the restrictions of being on “a time line.” Time as a barrier to implementation could be considered a systemic barrier—inherent in the system of DFCS. For example, CWP’s reported seeing clients twice a month with only 30 to 45 days for
closing out a case. Such a systemic barrier could hinder the implementation of HRMET skills and tools.

**Low Literacy/Mental Capacity**

CWP’s participating in the red and green groups mentioned the low literacy/mental capacity levels of their clients as a difficulty in the implementation of HRMET skills and tools. “Dina” said, “I think this would be good for certain types of people, but like if you are not educated, I don’t know if it would be meaningful to somebody. Yeah, like if you're a high school dropout or low-level learner it wouldn't meet the mark.” This was also a concern of “Darla”:

> They do not read or they do not have time to read the material, you know they're always in a hurry. They got five or six little “Johnnies” or little “Becky’s” running around. Uh, it’s just poverty, they just really don't have the time to sit down and read the information so we have a dialogue. (“Darla”)

Participants in the red group attributed this barrier to mental handicaps. “Tabitha” mentioned “the ability of the client to understand.” Her colleague “Sarah” further explained, “A lot of our clients are MR [mentally retarded] or have a mental illness, and it is hard to get the concepts across and for them to remember it.”

**Cultural Differences**

Three CWP’s from the green group talked about cultural differences as a hindrance to implementing RME such as HRMET tools and skills. Katrina said:

> It’s not only about, you know, where a person was, um, born but just sometimes you know different races of people, you know, are not so acceptable of getting information from someone who is not of their culture, their race, you know. And um, they look, look at you like, “You can't tell me nothing.” (“Katrina”)

“Darla” and “Gail” spoke about cultural differences as well. “Gail” explained in detail:

> . . . has a really high Hispanic population, and in their culture there are some behaviors that are more accepted than in our culture. So sometimes we run into those barriers, uh, sometimes, and not just the Hispanic population, the Asian population, or any other culture you know outside of the culture in the United States; but we do run into some
cultural barriers because it's their culture. It's their belief system, and they may not see it to be a problem, especially a child welfare problem. So sometimes it can be hard to get through to these families that, you know, that is not accepted in this culture. I mean, you still have to, you know, approach the family being culturally sensitive and culturally diverse, but that can definitely be a barrier because people are not always willing to change, you know, their culture or go against their culture. (“Gail”)

“Gail” added the caveat: “It’s not just this material, any material, when it comes to a cultural thing, no amount of material, I don’t feel like, is going to change . . . .” In addition to these comments, “Rhonda” from the blue group mentioned “a high Hispanic population,” but she did not elaborate on how she saw this as a barrier.

**Lack of Resources/Personnel at DFCS**

Four different times the lack of resources and personnel at DFCS was mentioned as a barrier to implementation. From the red group, “Tabitha” said that implementation would be more feasible with “finances—agency having the staffing—training the people on the inside, dedicated to this in our system.” “Nancy” also mentioned “shortage of staff” as a barrier. This issue surfaced twice in the blue group. “Sally” commented, “We just lost a worker, she moved to another county, so of course we had to split all her cases amongst the people who are already drowning.” Her colleague “Rhonda” agreed that it was a matter of “state budgets, lack of resources, funding, you know to help these families.”

Each of the six domains discussed under research objective four pointed out barriers to implementation which the CWP’s felt were outside of their control. These barriers were also generalized to other aspects of their work with clients, not just the implementation of HRMET skills/tools. Therefore, a certain amount of frustration was present when they spoke of these issues. Some of the recommendations following under research objective five were generated while talking about the barriers.
Research Objective Five

To identify recommendations from CWP’s for implementing RME, such as HRMET skills and tools, in their field of work.

There were three domains from the analysis of raw data which related to research objective five. These domains included recommendations for curriculum content/format, field implementation, and training. All three focus groups had ideas to contribute as recommendations.

Curriculum Content/Format

From the red group, “Nancy” felt it would be helpful to have more content “to deal with family violence.” Her colleague, “Tabitha,” felt that “a lot of things deal with poverty” and that it would be good to know “how this affects relationships;” therefore, include “things concerning finances.” The majority of comments concerning content came from the green group. “Dina,” “Gail,” and “Katrina” felt that content specifically related to teens and teen parents would be helpful. “Katrina” explained, “The way that things are changing now, um, parents are not always adults . . . they are younger and younger, and you have to have material that’s going to reach those kids at their level.” Several in this group also commented on including material specific to grand-parents who are raising children. “Darla” and “Katrina” suggested cultural sensitivity as a topic: “how to be sensitive and relate to whatever their needs are” (“Katrina”). “Darla” also suggested a focus on fathers, “a fatherhood initiative.” There were two recommendations related to the format of content: “Break it down to a pamphlet, just for our clients—a pamphlet for each issue” (“Tabitha”). “Andrew” said, “Put the material online.”
Field Implementation

The CWP’s also had recommendations to share for field implementation. “Darla” said that family team meetings would be a great time to implement the skills/tools: “Connect, share, manage, resources—all of those could be shared in the family team meetings.” “Gail,” from the same group, suggested including the service providers in implementation. Members of the blue group had the same idea concerning implementation by service providers. “Rhonda” said:

I think this would be a very good training, I guess looking at the private providers for DFCS agencies. And also, don’t forget about the Independent Living Program, that is a part of DFCS. What do you think about group homes? Like the Methodist group home? People like that. I think it would gear towards more having a healthy relationship with responsible adults, and I think this would be a good way to, you know, start it off as like “Sally” said, you know, let’s start it off early. Um, and I think that’s a good idea with the parent aides. Um, getting you know parent aides, um, included on, uh, you talked about ILP’s, uh, –Independent Living Program. (“Rhonda”)

“Lisa” agreed that it would “be a good module for the parent aids . . . to put it in parenting.” Her colleague, “Sally” elaborated on this idea:

This could really be good with some of the parent aids too that have more time to sit and stay on one subject is, um, when they’re doing parenting to make that a module of parenting classes, is that relationship part of it. And a lot of the, you know, the handouts and things where they go through and do, because they do that type of thing with them with the parenting, but um I don’t think that they really go into a whole section about that relationship. . . I still think that they’re more receptive, um, when we put parent aides in the home because they don’t see the parent aides as DFCS. And I think they’re more receptive with sharing things and doing those type things, tool type things, and um, with them than they are with us. (“Sally”)

“Sally” had another recommendation for field implementation:

There’re some things we could do just looking back through where we could go through and take out some of the things you can do—the hands on, some of the tools and make little packets; so that, say if you did have a situation where this is “this is the family we could probably do some of this with,” um, you would have it right there readily stapled together and not have to remember to go try to find it in here, just have it all ready. (“Sally”)
As a supervisor, “Sally” had even more suggestions during our conversation about recommendations for field implementation:

We could do a better job of, you know we have team meeting every Tuesday, of taking out some of, taking out some of these and stapling them together where maybe they’d be more likely to use it, put it in a folder, OK, when you’re going out, you’ve got a situation, you know, you don’t have to do all this planning, just come grab it. . . . If you have something you think that would work with a particular family, but you think maybe they’re not receptive from you, then copy it, talk to the parent aide. (“Sally”)

Training

The last domain which emerged under objective five included recommendations for training. “Dina” suggested that future trainings be set up “more like this [the focus group], like a roundtable instead of in rows.” “Rhonda” felt that “it’s better when you have more” coworkers from the same agency, as with her own agency: “we took different departments.” Also, “Sally” thought the use of scenarios would be good to incorporate in trainings:

Some scenarios of like realistic families we have, and OK how you might not could do “this and this” with them, but “this and this” would be good. You know, just some hands on because sometimes if you don’t take that extra step where you can visualize, “How is this gonna look?” This is all good stuff. But how’s it gonna look when I go back to work tomorrow? What am I going to actually do with it? Put it into play. I think if you had some more time to follow up with more of that. . . . more hands on type stuff. (“Sally”)

The blue group thought it would be good to have more than one training day: “more sessions closer together” (“Rhonda”). “Lisa” also commented, “to see how everybody else is putting it into place, get some ideas, yeah, from everybody . . . . So we can measure progress, too.” Their colleague, “Sally,” agreed: “You may even hear, like, you hear ideas from others, you know, if you had a bigger group where you could hear things they’re doing with it. . . . I would say not to let a lot of time pass because we forget.” Quite a lot of enthusiasm was generated during the discussion of recommendations, and participants left the focus groups with new ideas from each other for implementing HRMET tools and skills.
Summary

The domains reported in this chapter present a rich, detailed picture of the implementation of HRMET skills and tools by 12 CWP’s who work daily with DFCS clients toward the goals of safety, permanency, and well-being of children at risk. These CWP’s shared which tools and skills from HRMET they had implemented and why. Care for self and the relationship wheel were some of the tools most often mentioned. CWP’s related both professional and personal benefits they had received as a result of participating in HRMET. Perhaps the most rewarding benefits were the client outcomes which they had observed.

The participants were also straightforward about skills and tools they had not implemented. Their beliefs about themselves and their audience shaped their decisions not to use certain tools at specific times. In addition, they shared certain barriers such as client attitudes, client crises, and time constraints which deterred their implementation of RME. Every focus group contributed recommendations for greater implementation of HRMET including changes to the curriculum content/format as well as ideas for field implementation and future trainings. Chapter Five will discuss conclusions based on the domain analysis in light of the literature review. Finally, recommendations for further research and best practices concerning the implementation of HRMET skills and tools by CWP’s will be presented in Chapter Five.
CHAPTER FIVE
SUMMARY, DISCUSSION, AND RECOMMENDATIONS

Purpose and Objectives of the Study

The purpose of this qualitative study was to determine to what degree CWP’s trained by Georgia Cooperative Extension in Healthy Relationship and Marriage Education (HRMET) implemented the skills and tools they were exposed to with their clients. Previous research has identified both barriers (Christensen et al., 2008) and benefits that affect the implementation of RME by CWP’s with their clients (Ooms, 2005; Schulz et al., 2010). The researcher wanted to investigate which HRMET skills and tools were most often used, or not, by CWP’s as well as the factors which influenced implementation. Targeted objectives for this research included:

**Objective One:** To identify which skills and tools from HRMET were implemented by CWP’s, and why.

**Objective Two:** To identify perceived benefits that CWP’s experienced when implementing HRMET skills and tools.

**Objective Three:** To identify which HRMET skills and tools were not used, and why not.

**Objective Four:** To identify perceived barriers to implementing the HRMET skills and tools.

**Objective Five:** To identify recommendations from CWP’s for implementing RME, such as HRMET skills and tools, in their field of work.
This Chapter will respond to these objectives by summarizing key findings and recommendations for Cooperative Extension and CWP’s who implement HRMET skills and tools. In addition, implications for future research and practice will be discussed.

**Review of Methods**

This study used a qualitative research design which conducted focus groups in order to generate in depth conversations with CWP’s about their personal experience with HRMET and their use of the skills and tools received during training. CWP’s, who attended HRMET delivered by Georgia Cooperative Extension in July and August of 2012, were invited to participate in this study. The participants represented a purposeful sample in that they were individuals who would likely yield targeted information about the topic under investigation (Leedy & Ormrod, 2013).

Three focus groups were conducted in separate locations, convenient to where participants worked. Four participants attended each focus group representing various responsibilities and jobs within the child welfare system such as investigations, family preservation, foster care, and supervision of services. Having these various perspectives within each focus group resulted in a richer understanding of the situations in which CWP’s might implement HRMET skills and tools. Each focus group lasted from 50 to 60 minutes. A light supper was provided 30 minutes before the focus group so that the researcher could meet and establish rapport with the participants.

Focus group questions were written based on the research objectives and informed by the secondary data from pre- and post-surveys and two-month follow up surveys of HRMET participants (Futris et al., 2012). Recent literature which discusses barriers and benefits to implementing HRMET with CWP’s and their clients also informed the choice of focus group
questions (Antle et al., 2010; Christensen et al., 2012; Ludlam, 2005). The focus group conversations were audio recorded with the participants’ consent, and the researcher transcribed those recordings verbatim. Each transcription was analyzed using content analysis procedures, and domains emerged which represented recurring themes within the data. Members of the focus groups were asked to verify this initial analysis in order to increase credibility (Merriam, 2009). The data analysis was also reviewed by graduate professors to ensure trustworthiness. The researcher then merged the domains from all three transcriptions and reported these findings under the research objectives. Domains were reported by research objective and in order of their occurrence in the raw data.

**Summary of Findings**

Chapter 4 presented a narrative of the research results with raw quotes from the participants providing depth and context for the findings. This summary of findings gives an overview of the research results. Each domain is listed under the research objective with which it corresponds.

There were ten domains related to objective one: skills and tools from HRMET which were implemented by CWP’s, and why. Nine of these domains described specific tools and skills that were implemented, and these are listed in order of frequency of occurrence during the focus groups:

1. The Care for Self Skill
2. The Relationship Wheel Tool
3. The Binder Tools
4. The Manage Skill
5. The Share Skill
6. The Choose Skill
7. The Know Skill
8. The Connect Skill
9. The Care Skill

One other domain emerged, *the training experience*, which also related to the first objective. This domain was unique in that it spoke more to the aspect of “why” HRMET skills and tools were implemented by CWP’s. The study participants shared elements of the training experience such as the practical concepts, the activities, and instructor qualities which encouraged them to implement the tools and skills they received with their clients. This tenth domain emerged across all focus groups and was spoken of by all 12 participants.

There were two types of benefits spoken of by the CWP’s in this research study: *professional* and *personal*. These domains related to objective two: to identify perceived benefits that CWP’s experienced when implementing HRMET skills and tools. There were two sub-domains under *professional benefits*: *self-efficacy* (feeling more knowledgeable, confident, and aware) which was spoken of by ten participants and *client outcomes* which was mentioned in all three groups by five different participants. Under *personal benefits*, there were also two sub-domains: *specific relationships* and *specific tools*. Eight participants named specific personal relationships in which they had used the HRMET tools and skills. Six of these participants named the specific skills/tools which they had implemented personally.

The responses were fewer to research objective three: to identify which HRMET skills and tools were not used, and why not. Two domains emerged here: *CWP’s beliefs about themselves* and *CWP’s beliefs about audience appropriateness*. There were two comments from CWP’s concerning *beliefs about themselves* and two comments under *beliefs about audience*
appropriateness. There were four skills/tools which were linked to these comments: the manage skill, the relationship wheel, binder fact sheets/worksheets in general, and the “Being Angry without Hurting” worksheet. In general, implementation did not take place when CWP’s felt the tool or skill was impractical, unrelated to the role of a CWP, or was not appropriate given the client’s situation.

There were six domains observed from the raw data which corresponded with research objective four: to identify perceived barriers to implementing the HRMET skills and tools. These domains are listed below in order of greatest frequency of occurrence:

1. Client Attitudes
2. Client Crises
3. Time Constraints
4. Low Literacy/Mental Capacity
5. Cultural Differences
6. Lack of Resources/Personnel at DFCS

Eight participants, representing two different groups, talked about client attitudes as a hindrance to implementation. Seven CWP’s, from three different groups, expressed that client crises limited the use of HRMET skills and tools. Five participants, across all three groups, spoke of time constraints as a barrier. The remaining barriers were each spoken of by four different participants from at least two different focus groups.

Analyzing the transcriptions, three domains emerged pertaining to objective five: to identify recommendations from CWP’s for implementing RME, such as HRMET skills and tools, in their field of work. The most frequently talked about theme was curriculum content/format; seven participants recommended changes or additions to the curriculum content.
or format. In addition, five CWP’s suggested recommendations for field implementation—ways that they themselves could better implement the HRMET skills and tools. Finally, four participants had suggestions for different aspects of training for professionals.

**Key Findings and Implications**

**Skills and Tools from HRMET Which Were Implemented by CWP’s, and Why**

Previous research has suggested that CWP’s would find RME useful with their clients (Antle et al., 2010; Christensen et al., 2008; Schramm et al., 2013). This qualitative study sought to expand our understanding of RME’s usefulness, specifically the usefulness of HRMET skills and tools, by listening to the experience and viewpoint of CWP’s who attended HRMET in Georgia during July and August of 2012. Research participants identified nine skills and tools which they had implemented with their clients. These professionals often spoke of how and why they had used certain elements from HRMET. Their anecdotal examples of field implementation provided additional insight.

*Care for self* was the skill spoken of most often by CWP’s in this study. They applied the concept in various situations. *Care for self* was seen as easy to communicate by CWP’s and helpful for reaching case management goals with their clients (i.e. taking care of self in order to take care of their children). These factors of utility and applicability increased the likelihood of transfer from learning by CWP’s to implementation with their clients (Burke & Hutchins, 2007; MacRae & Skinner, 2011). Skills like *care for self* that aid in reaching case management goals could be considered a mutual benefit for CWP’s and their clients (Figure 1). According to Social Exchange Theory (SET), behavior is influenced when “actors are dependent on each other for valued outcomes” (Molm et al., 2000, p. 1398).
The *relationship wheel* was used often by CWP’s with their clients. They liked this tool as a visual aid—appealing, colorful, and interactive. CWP’s felt the *relationship wheel* effectively demonstrated to their clients the various factors included in a healthy relationship. It also served as a reminder of different skills and tools for CWP’s, giving them confidence to talk about healthy relationships with their clients. Visual aids often increase the transfer of knowledge, and the *relationship wheel* provides adults with an interactive tool which fosters participatory learning for CWP’s and their clients (Chan, 2010; Ghosh, Satyawadi, Joshi, Ranjan, & Singh, 2012; Knowles, 1972; Mealor & Frost, 2012). As shown in Figure 1, interactive learning encourages transfer of knowledge from CWP’s to their clients which may result in positive social exchange.

CWP’s from all three focus groups in this study cited various examples of implementing fact sheets and worksheets from the HRMET binder. The binder fact sheets gave CWP’s something concrete to discuss with their clients. The worksheets provided problem-solving exercises to encourage interactive learning and application of healthy relationship principles. Extension educators and helping professionals alike value these types of learning activities for their effectiveness in promoting experiential learning (Franz, 2007; Ota et al., 2006; Leake et al., 2010).

The *manage skill* was used by four CWP’s and was most often applied in the context of helping clients manage stress and circumstances. “Rhonda” was the only one who talked about the importance of helping clients to manage conflict. In contrast, “Dina” mentioned *manage* specifically as a skill she would not use, feeling that it was more appropriate for a marriage therapist to address conflict with the clients. It appeared to the researcher that this skill evoked mixed responses from the participants. Role play and simulations could promote more thorough
understanding and implementation of the manage skill (Leake et al., 2010). MacRae and Skinner (2011) also suggest that the transfer of knowledge to practice increases when social workers understand the link between the new skill and their role.

The share skill was also used by four CWP’s. Some of the most impactful client outcomes were related through the anecdotal testimonies of CWP’s who had implemented the share skill. The CWP’s themselves were moved emotionally as they told of these interactions with their clients. Daley (2001) suggests that knowledge becomes meaningful for social workers when it provides an emotional connection with clients. Establishing greater rapport and understanding between CWP’s and their clients would be a mutual benefit and reward to the social exchange (Blau, 1960; Emerson, 1976; Homans, 1958).

CWP’s thought that the choose skill was appropriate for both existing and potential relationship choices. Three professionals shared that it gave them a way to talk with their clients about prioritizing family relationships as well as being cautious in the choice of relationship partners. Similarly, three CWP’s implemented the know skill with their clients to talk about healthy relationships now and in the future. They felt this skill promoted good communication within family relationships as well as wise choices for developing relationships. It was notable that CWP’s were connecting these skills with preventive education even though they are often called upon to react with crisis intervention. This practice aligns with the benefits and goals of RME to promote stronger family relationships, reducing risk in fragile families and preventing child maltreatment (Schramm et al., 2011).

One CWP used connect to talk with a client about building a support network. Addressing best practices for offering RME to low income families, Ooms and Wilson (2004) assert that “for some of these couples, an educational program will suffice. However, others will
need comprehensive and intensive economic and support services. . .” (p. 446). The connect skill is designed for addressing this need. Another CWP implemented this skill to encourage parents who were living apart to connect as co-parents for the well-being of their children. With co-parenting adults, a healthy relationship supports positive outcomes for their children (Cummings & Merrilees, 2010; Schramm et al., 2013). The care skill was spoken of once by a CWP who used the skill to encourage mutual acceptance and appreciation between a mother and her adult daughter. As with other HRMET skills and tools, connect and care were found to be applicable to relationships outside of marriage as well as within marriage.

Insights offered by CWP’s concerning the training experience were very informative for understanding “why” they implemented HRMET skills and tools with their clients. Participants in this study said they thought about the needs of their clients during the HRMET experience. In the same way, Daley (2001) states: “When social workers attended CPE programs, they clearly had their clients’ needs in mind” (p. 44). It is also valuable when CWP’s consider the knowledge, skills, and tools as useful and practical for implementation (Burke & Hutchins, 2007; MacRae & Skinner, 2011). Not only did the participants in this study feel HRMET was practical, but the training also gave them a sense of empowerment for implementing the skills and tools. This type of training is responsive to adult learning needs such as the desire to increase capacity, effectiveness, awareness, and action (Franz, 2007; Knowles, 1972; Ota et al., 2006).

CWP’s also voiced their appreciation for the training activities and the trainers. They found the interactive aspects of HRMET helpful for retaining the information. In addition, they were motivated by the activities to implement the skills and tools. These findings coincide with the conceptual model for this study (Figure 1) which highlights interactive/experiential learning. Trainers who allow participants to engage and even direct the learning find increased outcomes
with adult learners (Mealor & Frost, 2012). CWP’s reported a feeling of rapport with the HRMET trainers as well as appreciating their energy and thorough knowledge of the subject matter. Their comments agree with research which correlates trainer attributes such as those mentioned by CWP’s with productive training experiences (Ghosh et al., 2012).

**Perceived Benefits that CWP’s Experienced When Implementing HRMET Skills and Tools**

Social Exchange Theory proposes that social exchanges include rewards (benefits) and costs (barriers) which affect the character and durability of relationships (Cropanzano & Mitchell, 2005). In addition, trust in a relationship is often affected by the exchange of rewards and the minimizing or sharing of costs (Molm et al., 2000). CWP’s in this study identified various benefits and barriers to their implementation of HRMET skills and tools. Personal and professional benefits emerged as domains from the raw data.

The personal benefits domain included two sub-domains: specific relationships and specific tools. Among those personal relationships reported to having benefited from the use of HRMET skills and tools were those with spouse, family, friends, church, and coworkers. The specific tools applied in the context of personal relationships included: communication, “the language of love” worksheet, the know skill, the relationship wheel, and the manage skill. It is significant that the focus group participants would share enthusiastically about their personal use of these skills and tools. Research shows that “being” is essential to “doing” in social work professions and a strong indicator of learning transfer (Larrison & Knorr, 2013, p. 200). In addition, such “positive behavioral modeling” in one’s personal life could produce greater effectiveness when CWP’s communicate these skills and tools to their clients (MacRae & Skinner, 2011, p. 984).
The professional benefits domain included the sub-domains of self-efficacy and client outcomes. Ten of the 12 CWP’s in this study said they felt more prepared in knowledge, confidence, and/or awareness for implementing RME. The ability to reflect on a situation and relate newly acquired skills to that situation is the result of effective training which aims to connect the learning experience to field implementation (Daley, 2001; Vayda & Bogo, 1991). Improved self-efficacy also demonstrates “development of the professional self,” a crucial element to successful practice as a social worker (Larrison & Korr, 2013, p. 200).

All three focus groups shared observations of client outcomes related to the implementation of HRMET skills and tools. Among the direct benefits reported with clients were increased rapport, positive outlooks and motivation, healthy relationship choices, and receptivity to the information. Positive outcomes such as these bring mutual benefit to the CWP and the client: case management goals are reached. Most importantly, if the relationship health of parents—whether married, separated, or co-habitating—increases, then the environment in which children live may be improved for their well-being and safety (Christensen et al., 2008; Erel & Burman, 1995; Turner et al., 2007).

HRMET Skills and Tools Which Were Not Used, and Why Not

There were four tools reported once by different CWP’s as ones they had not used. Two of these tools were categorized under the domain of CWP’s beliefs about themselves. “Dina” did not use the manage skill because she believed that teaching conflict management was the role of marriage therapists, not child welfare professionals like herself. Schramm et al. (2013) also found that CWP’s beliefs about their role could be a barrier to RME training implementation. “Darla” did not use the relationship wheel because she believed she had enough to carry and keep up with already. Research shows that for knowledge transfer to occur, the trainee must
perceive the concept as relevant and useful to her role and responsibilities (Burke & Hutchins, 2007; MacRae & Skinner, 2011).

The second domain which emerged under this objective was CWP’s beliefs about audience appropriateness. There were two tools which were not implemented under this category. “Darla” believed that the HRMET fact sheets and worksheets were not appropriate for low-literacy audiences, so she did not use them with her clients. “Sally” would not use the worksheet, “Being Angry without Hurting,” with clients in foster care because they could feel the information might be used against them. The perceived appropriateness or utility of these tools in certain client situations influenced whether CWP’s chose to implement them or not; other research reveals similar findings (Leake et al., 2010).

**Perceived Barriers to Implementing the HRMET Skills and Tools**

There were six domains which emerged as barriers to implementing the HRMET skills and tools: client attitudes, client crises, time constraints, low-literacy/mental capacity, cultural differences, and lack of resources/personnel at DFCS. These barriers could be perceived as costs to the social exchange between CWP’s and their clients (Blau, 1960; Emerson, 1976; Homans, 1958). The presence of these barriers could limit the implementation of RME and any potentially positive outcomes (Figure 1).

*Client attitudes*, the most prevalent barrier, included mistrust and dislike of DFCS as well as denial of the problem and lack of openness. Such barriers inhibit trust and increase risks for the implementation of HRMET skills and tools. Trust is necessary for a mutually beneficial social exchange (Molm et al., 2000). Additionally, seven CWP’s talked openly in the focus groups about the barrier of *client crises*. CWP’s are often so concerned about removing a child from imminent danger or finding food and shelter for clients that there is no time for introducing
RME. In situations of documented child abuse, RME would be inappropriate and could be seen as an effort “to minimize the responsibility of the abuser by inferring some sort of shared responsibility” (Christensen et al., 2012, p. 310). The third barrier reported by all three focus groups was *time constraints*. With limited time, other priorities in the case management plan easily crowd out opportunities to implement the HRMET skills and tools.

It is documented that high risk, diverse populations such as those served by child welfare experience lower literacy levels and a higher rate of mental health needs (Christensen et al., 2012; Ooms, 2007). CWP’s in this study expressed those same concerns, citing *low literacy/mental capacity* as a perceived barrier to using RME with some clients. CWP’s living in areas with a higher Hispanic/Latino population (green group—26.1% and blue group—17.1%) reported *cultural differences* as a barrier (Boatright, 2012). Ooms (2007) establishes the need to adapt RME programs and curricula for Hispanic/Latino audiences. This is more than a language barrier and includes the need to understand unique cultural expressions and value differences related to marriage and family.

Finally, *lack of resources/personnel at DFCS* was spoken of by four CWP’s as a barrier to the implementation of HRMET skills/tools. Lack of resources and increasing demands on an oftentimes reduced staff has been cited in the literature as a reason for high turnover among CWP’s (Weaver, Chang, Clark, & Rhee, 2007). Attempting to plan a fourth focus group for this study, the researcher communicated with a DFCS office where the staff had been reduced from 10 CWP’s to 5 CWP’s within 5 months; all of the casework had to be assumed and continued by the remaining staff. Needless to say, that fourth focus group had to be cancelled due to the stress and time constraints faced by those CWP’s.
Recommendations from CWP’s for Implementing RME, Such as HRMET Skills and Tools, in Their Field of Work

The first domain which emerged under recommendations was *curriculum/content format*. MacRae and Skinner (2011) suggest that when “participants are given an opportunity to influence programme content” there is greater learning transfer for child welfare professionals (p. 984). CWP’s thought the curriculum should include more content about family violence, poverty and finances, teens who are parents, grandparents raising children, cultural sensitivity, and fatherhood. Concerning the curriculum format there were suggestions to put the material on line and provide pamphlets for use with the clients. Research shows that training materials which are ready to use and promote active engagement are most effective in family education programs (Collins & Fetsch, 2012; Hughes & Fetsch, 2007; Small, Cooney, & O’Connor, 2009).

The next domain concerned ideas for *field implementation* by CWP’s. Family team meetings were suggested as an ideal time for using HRMET skills and tools with clients. It was also recommended that service providers contracted by DFCS and parent aides could be equipped to deliver RME. One noted advantage for delivering RME through these providers and parent aides is that they often enjoy higher levels of rapport with clients. One of the supervisors suggested preparing packets of information from the HRMET fact sheets and worksheets ahead of time for use with clients. She suggested that during team meetings the CWP’s could prepare these “grab and go” packets.

*Training* was the last domain under objective five. Recommendations included: the use of roundtable discussion groups, attending training as a team or department, the use of realistic scenarios that are hands on, more sessions closer together, and time to hear feedback from colleagues on how they implement HRMET skills and tools. Many of these recommendations
align with Knowles’ principles of andragogy (Knowles, 1972), including self-directed, experiential, and problem-centered learning (Figure 1). These principles have been applied successfully to Cooperative Extension programs (Ota et al., 2006; Mealor & Frost, 2012).

**Recommendations for Research**

Current literature calls for evaluation of “how RME services are best delivered to those in the child welfare system and how effective those services actually are for the families and children” (Schramm et al., 2013, p.437). This research was based on a case study with participants from two different trainings in Healthy Relationship and Marriage Education delivered by Georgia Cooperative Extension in 2012. This study added a qualitative dimension to existing quantitative studies concerning the effectiveness of HRMET with CWP’s. In addition, this study sought to understand the extent of implementation of HRMET skills and tools by CWP’s in light of Social Exchange Theory. Principles of Knowles’ Theory of Andragogy were also discussed as they relate to the training of adult learners in professions such as social workers in child welfare (Figure 1).

The following recommendations are possible topics for future study:

1. A quantitative evaluation with CWP’s trained in HRMET, using the domains found in this study as constructs in a questionnaire, to understand the extent to which they have implemented the HRMET skills and tools.

2. A qualitative evaluation with HRMET participants outside of DFCS, possibly private providers or family service workers in other agencies, to see if the same benefits and barriers exist when they implement HRMET skills and tools.

3. A longitudinal study with clients of CWP’s who have implemented HRMET skills and tools to determine the impact of RME on the health of client relationships/marriages.
4. A longitudinal study on the personal benefits of the HRMET skills and tools experienced by CWP’s in their own relationships and how modeling healthy relationship behaviors has been used with their clients.

5. A longitudinal study with clients of CWP’s who have implemented HRMET skills and tools to determine the impact of RME on the well-being of the children of those clients.

6. An evaluation of similar Cooperative Extension train the trainer programs to determine whether elements of Knowles’ andragogy and Social Exchange Theory affect learning and implementation of new skills.

**Recommendations for Practice**

The purpose of this study was to determine to what extent CWP’s who attended HRMET implemented the skills and tools they were exposed to during training. As a qualitative study, the results cannot be generalized to other professionals trained in RME; however, the findings can be transferred and used by Extension educators delivering HRMET to CWP’s. The following recommendations are presented for Extension educators who would like to offer HRMET for CWP’s who work with at risk audiences:

1. Allow as much time as possible during HRMET to include activities such as those suggested by CWP’s in this study: small group discussion, hands on practice, and scenarios.

2. Encourage CWP’s to follow-up their training experience with periodic sharing to enhance morale and communication about what is working and what is not.

3. Consider offering HRMET in a series of workshops as opposed to a one-day training event. This would allow for more experiential learning as well as the opportunity to problem-solve and reflect on implementation ideas (Figure 1).
4. Include scenarios in the training which reflect those situations encountered by CWP’s in this study: family violence, poverty, teen parents, grandparents raising children, and culturally diverse scenarios.

5. Expand the invitation to attend HRMET beyond CWP’s in DFCS to include private service providers and parent aides who work as auxiliary providers for DFCS. This could build understanding and collaboration between CWP’s and other providers.

6. Suggest to DFCS supervisors that it may be especially helpful for working teams to attend HRMET. Provide time during HRMET for these teams to discuss implementation of the skills and tools they are receiving as well as benefits and barriers to implementation.

In addition to recommendations for Extension educators, the findings from this study may inform the best practices for CWP’s who attend HRMET. CWP’s in all three focus groups enjoyed discussing their experiences and generated new ideas and enthusiasm for implementing HRMET. The following recommendations may be helpful for CWP’s from DFCS who attend HRMET in the future:

1. If possible, attend HRMET as a team: supervisor, investigator, family preservation, foster care, parent aides, and private providers. This could encourage a team approach to implementation with clients providing motivation and accountability.

2. Decide during HRMET the most practical method for using the binder fact sheets and worksheets, i.e. making grab and go packets or some other method. For example, the care for self skill was very popular for CWP’s in this study to discuss with their clients. There are 5 worksheets (tools) which can be used with care for self. Discuss how to use those worksheets with the clients to reinforce the skill.
3. Follow up HRMET with a team discussion about how to implement the skills and tools with current clients. Discuss how HRMET skills and tools could be used to build rapport, reach client goals, and increase family stability (Figure 1). Discuss the value of modeling healthy relationship behavior to clients, sharing personal relationship benefits as a result of attending HRMET.

The above recommendations for Extension educators and CWP’s who work with DFCS reflect adult learning principles and learning transfer theories such as Social Exchange Theory. These recommendations also assume that, based on the literature reviewed, there will be benefits for CWP’s and their clients when HRMET skills and tools are implemented. Implementation will not be possible in every circumstance for various barriers as noted in this study. However, the use of HRMET skills and tools by CWP’s may serve to achieve case management goals with DFCS clients and increase the well-being and safety of the children in those homes.
REFERENCES


# APPENDICES

## APPENDIX A

## IRB APPROVAL

<table>
<thead>
<tr>
<th>Name</th>
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**Title of Study:** Healthy Relationship and marriage Education training (HREM) – Phase II

**45 CFR 46 Category:** Continuing Review

**Parameters:**
- APPROVAL OF ABOVE NOTED CHANGES.

**Change(s):** Added Andrea Scarrow and Dr. Nicholas Fuhrman as co-investigators; revised procedures to include focus groups; added instruments and consent documents accordingly.

**Approved:** 2012-12-13

**Begin date:** 2012-12-13

**Expiration date:** 2015-09-30

**NOTE:** Any research conducted before the approval date or after the end date collection date shown above is not covered by IRB approval, and cannot be retrospectively approved.

**Number Assigned by Sponsored Programs:** 03/7978-02

**Funding Agency:** University of Missouri

**Your request for approval of renewal and/or changes has been approved.**

You must report any adverse events or unanticipated risk to the IRB within 24 to 72 hours. Refer to the IRB Guidelines for additional information.

Use the attached Researcher Request Form for requesting renewals, changes, or closures. Keep this original approval form for your records.

Chairperson or Designee, Institutional Review Board
APPENDIX B

Healthy Relationship and Marriage Education Training (HRMET) -- Phase II
Focus Group Guide

Introduction: Thank you for attending our focus group tonight about the Healthy Relationship and Marriage Education Training (HRMET). We appreciate your input as we continue to develop the HRMET curriculum and work toward improving the safety and well-being of children at risk in Georgia.

Research shows that healthy relationship skills are found to promote and support better parenting skills (Ludlam, 2005). Also, relationship education for couples is shown to “impact child outcomes of safety, permanency, and well-being” (Antle, Frey, Sar, Barbee, & van Zyl, 2010). As child welfare professionals, you have the opportunity to model and teach healthy couple relationship skills to families at risk. The Healthy Relationship and Marriage Education Training (HRMET) was developed to give you practical tools and skills to use with your clients. It’s been about six months since you attended HRMET, and we’re interested in the extent to which you have implemented the tools shared during this training.

I have prepared a series of questions I’d like to ask you concerning the information and tools you received during the HRMET. There are no right or wrong answers to these questions, and you can choose not to answer any question at any time. I’m interested in having a relaxed conversation with you in an environment where it’s okay to say anything you like. I’ll be audio-recording our conversation today, but please know that your name will not be associated with your responses.

Thanks very much for being here! Let’s begin…
1. Thinking back, what about the **training** itself did you enjoy?
   a. How did the training meet your professional needs?
   b. Was there anything about the training that encouraged you to use the materials?

2. Now, let’s move beyond the training and consider the HRMET tools you received. How have you used these tools with the clients you serve? *(Provide a copy of the participant binder with the tools and relationship wheel to stimulate recall)*
   a. Which tools have you used?
   b. How did you use those tools? (e.g., make copies and provide them to clients, sit down with clients and talk with them about it)
   c. Have you used the relationship wheel? How have you used it?
   d. When did you find yourself using these tools? What situations prompted you to use them?

3. What is it about the concepts and principles that you taught (using the tools) that made them relevant to your clients’ life and relationships?
   a. What motivated you to use those tools and teach those principles and skills?
   b. Which concepts were your favorites to use with clients and why?

4. Thinking about the tools you did use, I would like for you to think about how they helped you and your clients.
   a. How did the HRMET tools and resources help you in your work as child welfare professionals?
   b. Did using the HRMET materials generate positive outcomes with your client(s)? What specific benefits to your clients did you observe?
c. What about the HRMET tools, or your teaching of the tools, do you think contributed to the positive outcomes?

d. Were there HRMET tools that did not work as you had anticipated? If so, please explain.

5. Next, let’s talk about those tools that you have not used or used less often. What materials or concepts from the HRMET toolkit did you use less frequently and why?

6. Child welfare professionals whom we surveyed expressed some reservations about implementing Relationship and Marriage Education, such as being “overburdened with their caseloads” and “time with clients is too limited” (Futris, Barton, Thurston, & Duncan, 2012).

   a. What barriers have you encountered to implementing the HRMET tools and teaching these relationship and marriage education principles and skills?

   b. Any cultural barriers, work related, or content related barriers?

7. To help the authors of the HRMET curriculum and tools refine the tools in a way that would better meet your and your clients’ needs, I would like your suggestions on what could be updated or added.

   a. Are there any HRMET tools that you found difficult to implement? If so, let’s chat about what could be done to make them easier to implement.

   b. Would you recommend changes to the HRMET curriculum? If so, what changes would you recommend?

   c. If you had the opportunity to attend a second HRMET training, what would you like to experience or learn more about that you did not learn in the first training?

Wrap-up:
Thanks for your honest responses today. Your input is extremely valuable to us as we go forward with Healthy Relationship and Marriage Education. Is there anything else you would like to add? Does anyone have any questions for me?

Thanks again!
APPENDIX C

Healthy Relationship and Marriage Education Training (HRMET) -- Phase II
Focus Group Communications

Informational Letter

January 3, 2012

Dear <<Name>>:

Thank you for participating in the Healthy Relationship and Marriage Education Training (HRMET) in <<City>> on <<date>>. As a graduate student in the Department of Agricultural Leadership, Education, and Communication at the University of Georgia, I am conducting research entitled “A Qualitative Study of the Implementation of Healthy Relationship and Marriage Education by Child Welfare Professionals in Georgia.” The purpose of this study is to understand how participants have used the tools/information from the training and factors that facilitated their usage of those tools.

I would like to invite you to participate in a 1-hour focus group with other training participants. I am reaching out to all child welfare professionals who participated in the trainings in Georgia. Your contact information was provided by the HRMET research team.

Your experience in providing services to strengthen families will contribute key insight for the implementation of HRMET tools and skills. The focus group will be audio-recorded and transcribed; the tape will be destroyed (within approximately 60 days). Any information you provide that is individually identifiable will remain confidential, and your name will not be associated with any of your responses. The results of the research study may be published, but your name will not be used. In fact, the published results will be presented in summary form only. Your identity will not be associated with your responses in any published format.

A focus group is currently scheduled in <<City>> on <<date>> from <<time>>. Thirty minutes before our focus group begins, we will offer participants the opportunity to join us for dinner in order to facilitate attendance at the end of the work day. In addition, each participant will receive a $15 honorarium for any personal costs he or she may incur in order to attend the focus group after normal work hours.

Within the next week, I will be calling you at <<participant’s phone number>> to follow up with you about your participation. If there is another number where I should call you, please email me at ascarrow@uga.edu. Please feel free to call me at 229-873-1790.

The findings from this project may provide improvements associated with the Healthy Relationship and Marriage Education Training curriculum and resources. There are no known
risks or discomforts associated with this research. By participating in the focus group, you are agreeing to participate in the above described research project.

If you have any questions about this research project, please feel free to contact my advisor, Dr. Nick Fuhrman, (706-542-8828; fuhrman@uga.edu) or the principal investigator, Dr. Ted Futris, (706-542-7566; tfutris@uga.edu). Thank you for your consideration, please keep this letter for your records.

Sincerely,

Andrea Scarrow, Master’s Degree Candidate

Questions or concerns about your rights as a research participant should be directed to The Chairperson, University of Georgia Institutional Review Board, 612 Boyd GSRC, Athens, Georgia 30602-7411; telephone (706) 542-3199; email address irb@uga.edu.

**Phone Protocol**

**Follow up to Email Invitation for Focus Groups:**

**Greeting:** “Hello, this is Andrea Scarrow. May I speak with <<NAME>>?”

**Purpose of Call:** “Hi <<NAME>>. I’m calling today to follow-up an email I sent inviting you to participate in the focus group that I will be conducting concerning the Healthy Relationship and Marriage Education Training. Is this a good time to chat with you about your participation?”

If the response is “No”: “Is there another time that I can call to chat with you about this opportunity?

Thank you for your time, and I look forward to speaking with you on <<Date>> at <<time>>.”

**OR**

“Thank you for your time.”

If the response is “Yes”: “Great! I appreciate your time and this will be brief. As stated in the email, I am conducting research to understand how participants have used the tools/information from the training and factors that facilitated your usage of those tools. Your input would be very beneficial, and I hope that you can join us at the focus group which is most convenient for you. Do you have any questions about the details concerning the date, time, and place for the focus groups?”

(Respond to any questions.)

“May I confirm your attendance today at the focus group to be held at <<PLACE>>, on <<DATE>>, at <<TIME>>? “

If the response is “No”: “Well, thank you for your time today. Please contact me if I can be of assistance in any way.”
If the response is “Yes”: “I look forward to seeing you on <<DATE>>. You will receive an email reminder from me a few days before the focus group. Please call me if you have any questions beforehand, and thank you for your participation.

Email Reminder for Focus Group Participants

Date

Dear <<Name>>,

Thank you for confirming your participation in the focus group concerning the Healthy Relationship and Marriage Education Training. I look forward to seeing you at <<PLACE>>, on <<DATE>>. Thirty minutes before our focus group, we will serve dinner at <<TIME>> for all participants, and we hope you can join us. We have planned an enjoyable time which will be finished by <<TIME>>. Thank you again for your participation. We value your input! Please call me at 229-616-7455 or email me at ascarrow@uga.edu if you should have any questions or concerns.

Sincerely,

Andrea Scarrow

Email “Thank you” for Focus Group Participants
(To be sent within one week after focus group)

Date

Dear <<NAME>>,

Thank you for your participation in the focus group for Healthy Relationship and Marriage Education Training in <<PLACE>> on <<DATE>>. Your feedback was very valuable to my research as well as to the future development and implementation of the training tools and materials. I greatly appreciate the time you gave to join our conversation with others like yourself who are serving children and families to make a positive difference.

Sincerely,

Andrea Scarrow
APPENDIX D

National Extension Relationship and Marriage Education Model

The National Extension Relationship and Marriage Education Model: Core Teaching Concepts for Relationship and Marriage Enrichment Programming

The National Extension Relationship and Marriage Education Network has developed a model that reflects key principles and qualities of a healthy couple and marital relationship. This research-based, theoretically grounded and best-practice informed model presents key patterns of thinking and behaviors associated with healthy, stable couple relationships and marriages that can be taught in an educational setting. Each chapter in this publication will include a brief summary of the research literature showing the connection between each principle and healthy relationship development as well as promising practices for educators to apply when teaching these principles and skills. Below is a brief overview of the model.

This model serves as the core content of the Healthy Relationship and Marriage Education Training Curriculum developed in cooperation with the Children’s Bureau with funding provided by United States Department of Health and Human Services, Administration for Children and Families (Grant: 90CT0151). Also, this model serves as the core content featured in Strong Relationships, Strong Families: Integrating Healthy Relationship Education Skills into Social Services, developed in partnership with the National Resource Center for Healthy Marriage and Families and the Office of Family Assistance with funding provided by the United States Department of Health and Human Services, Administration for Children and Families (Grant: 90FH0002).

CARE FOR SELF—Individual health impacts the health of couple relationships. Taking care of yourself first can help improve the wellness of your relationship. Below are some ways that you can Care for Self and help your relationship:

- Eat healthy and exercise regularly.
- Set regular sleep and wake times for yourself.
- Noticing and appreciating the small, good things in your life can help find greater happiness and satisfaction.
- Find ways to use your strengths to serve your community.
- Look for the positive meaning in your life.
- Learn to manage stress in more healthy, effective ways.

CHOOSE—Are you making deliberate and conscious decisions about your relationships? It is important to be intentional when establishing and nurturing healthy relationships. Here are some ways to show how you Choose to strengthen your relationship:

- Make the decision to enter into a relationship rather than sliding into one.
- Commit and provide effort in the relationship.
- Focus on each other’s strengths, and what each of you bring to the relationship.
Avoid thoughts and behaviors that could potentially be hurtful to one another.
Find positive and effective ways to grow your relationship.
Envision and set goals for a healthy future together.

**KNOW**—How well do you know your partner? Sharing and developing an understanding with your partner creates stability and increases awareness of your partner and the relationship. Here are some ways you can get to Know your partner better:

- Ask about your partner’s life, thoughts, and feelings to get to know them better.
- Be sensitive to your partner’s worries and needs.
- Think back on positive experiences you have had together.
- Express sincere interest in what is happening in your partner’s life.
- See situations through your partner’s eyes to gain a better understanding of how they look at things.
- Discuss what you expect in a relationship with one another.

**CARE**—Keeping a relationship healthy is the responsibility of each person in that relationship. What do you do to show support, affection and respect for your partner? Here are some ways to show that you Care for your partner:

- Show respect by expressing caring actions towards your partner instead of crabby reactions when they’ve had a stressful day.
- When communicating, be open and listen to your partner.
- Focus on the good in your partner.
- Accept and value the differences that you and your partner share.
- Give love in the way your partner likes to be loved.
- Show appreciation as a way to make a deposit in your relationships love bank.
- To maintain a strong relationship, make time for togetherness and moments of connection.

**SHARE**—Developing and maintaining your friendship with your partner helps build couple identity. Learning and growing together as a couple further establishes this friendship. Use these tips to Share together when developing couple friendship:

- Schedule meaningful time together as a couple doing something you both like.
- Figure out common interest and activities you share as a couple.
- Create couple traditions and rituals that promote togetherness.
- Set and work towards common goals with one another.
- Nurture positive interactions with your partner.
- Send clear and positive messages when communicating.
- Embrace and turn toward your partner’s bids for connection instead of against.
- Envision yourselves as a “team”!
**MANAGE**—Dealing with differences in healthy ways can minimize friction among couples. Problems in healthy couple relationships may never be resolved, but they can be managed in effective ways. Here are a few tips on how to effectively Manage differences in your relationship:

- Understand and accept that there cannot always be an agreement between partners when in conflict.
- Share concerns with one another in a calm, respectful tone to avoid tension.
- Avoid criticism and defensiveness that could be insulting to your partner.
- Learn to stop conflict before it escalates out of control.
- When need be, take “time outs” during conflict, but making sure that you come back to talk.
- Soothe and support one another.
- Be open to forgiveness.
- Maintain emotional and physical safety with your partner.

**CONNECT**—Engaging in a supportive, positive social network can be beneficial to any couple. Maintaining these relationships can act as safety nets that provide security to couples during good and challenging times. Here are some ways that couples can Connect their relationship to others:

- Grow and maintain extended family relationships.
- Develop and be a part of a supportive network of friends that can set and be examples to you as a healthy couple.
- Jointly engage in community organizations and services that can bring you and your partner together.
- Seek out resources to strengthen your relationship.