Retrospective program evaluation of a domestic violence curriculum

Hasmik Chakaryan

The University of Toledo

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A Dissertation

entitled

A Retrospective Program Evaluation of a Domestic Violence Curriculum

by

Hasmik Chakaryan

Submitted to the Graduate Faculty as partial fulfillment of the requirements for the

Doctor of Philosophy Degree in Counselor Education

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The University of Toledo
December 2013
An Abstract of
A Retrospective Program Evaluation of a Domestic Violence Curriculum

by

Hasmik Chakaryan

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The University of Toledo
December 2013

Domestic Violence (DV) continues to be a worldwide public health problem. Research in the area indicates that domestic violence has damaging, long-term serious mental, emotional, as well as physiological consequences both for the partners of the perpetrators and for their children. Even though various programs focused on treatments of the damaging effects of domestic violence exist, research on domestic violence treatment, interventions, and program evaluations is extremely scarce. The practice of program evaluation is fairly new to the social and behavioral sciences, and thus it has many flaws requiring immediate attention by researchers. Program evaluation is particularly challenging in the counseling profession due to financial constraints for most community-based agencies. Program evaluation has historically been a time-consuming and complex procedure which has caused counselors to avoid it.

The program evaluated in this study directed its services to court-referred female domestic violence victims and delivered its self-designed curriculum. The primary goal of the program was to increase victims’ awareness about domestic violence in order for them to provide safety for their children. Thus, the curriculum taught the women basic knowledge on domestic violence, as well as how it affects children and how they can
maintain safety. The staff administered pre- and post-program questionnaires which were created by the staff. No evaluations studies had been employed prior to this research.

The researcher coded the historic data from the agency, which was collected by the staff over years 2010 to 2013, and examined the data using a paired-samples t-test. The results of this statistical analysis revealed that participants overall scores on their post-program questionnaires significantly improved upon completion of the program. The researcher also found that participants’ level of ability to define and identify types of domestic violence and ways they can keep themselves and their children also had statistically significant difference between their pre- and post-program questionnaire scores.

The researcher identified several limitations of the study as well as illustrated several areas in which the program can employ improvements. The study includes a list of recommendations for community-based agencies and counseling centers as to how they can best prepare for program evaluation and conduct their own outcome studies that are time- and cost-efficient. The last chapter of this study includes implications and suggestions for future research. Appendices are available at the end of this paper to guide researchers and practitioners in future outcome studies.
This dissertation is dedicated to my parents, Ashot Chakaryan and Silva Hovakimyan, my sisters, Lilit Chakaryan, Ani Chakaryan, Sona Chakaryan, and Mariam Chakaryan; my friends, especially, Rebekah Sinclair, Mariya Zaturenskaya, Michael Grinberg, Olya Zaporozhets, Kateryna Kuzubova, Robert Howell Rees, Sylvia Lindinger-Sternart, Keyla Fortuna and many others, as well as my extended family for all their support, love, encouragement and for helping me not lose my vision and perspective to accomplish all I was able to ever start. My gratitude is to all of you who believed in me and empowered me through a challenging path on which I continuously grow.
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List of Abbreviations

DV..........................Domestic Violence

PE..........................Program Evaluation
Chapter One

Introduction

The 2011 statistics published in the World Report on Violence and Health by the World Health Organization indicate that each year 2.5 million people die from acts of violence, and Domestic Violence is globally becoming one of the leading causes of death for women (Dura, Baier, & Dura, 2011). Domestic Violence against women is a serious public health concern; it has received much medical attention because of its crucial effects on women’s mental, emotional, and physical health (Sarkar, 2009). Data suggest that between 1.3 million (Centers for Disease Control and Prevention [CDCP], 2011) and 1.8 million U.S. women (Brown, 2008) annually are victims of domestic violence. An estimated 4,000 women die annually in the United States as a result of domestic violence (Brown). It is stated that 92 percent of Domestic Violence victims are female (Finigan, 2010).

Domestic Violence Definitions

When defining Domestic Violence, it is crucial to note that there are two terms “domestic violence” and “intimate partner violence” that are used interchangeably in the research literature. Both terms refer to violent acts perpetrated by one intimate partner against another. For consistency throughout this paper the term Domestic Violence will be used and it will include any violent act perpetrated against female victims by a current or a former intimate partner.

The Child Welfare Information Gateway (CWIG) gives two contextual definitions of Domestic Violence. The first is a clinical/behavioral definition where Domestic Violence is "a pattern of assaultive and/or coercive behaviors, including physical, sexual,
and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners" (para. 3). The second is a legal definition and describes domestic violence as “a specific conduct or acts that are subject to civil and criminal actions, and the jargon used may vary depending on whether the definition is found in the civil or criminal sections of the State's code” (CWIG, para. 4). The U.S. Department of Justice defines domestic violence as:

A pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. Domestic violence can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone. (2013, para. 4)

The domestic violence program staff who designed the curriculum evaluated in this study used a definition which combined all the different components of the term explained by various legal entities and associations. The program staff teaches this definition and its different sub-parts to the participants during various phases of the program and expects these women to define and identify the term on the program questionnaire. The program curriculum definition reads as followed:

Domestic Violence is a pattern of coercive control perpetrated by one person against another in an intimate relationship. It includes relationships that have ended; current and former partners who are not cohabitating; and is gender and sexual orientation neutral. Domestic Violence is not an isolated individual event but rather a pattern of multiple tactics and repeated events. It includes physical,
sexual, spiritual, and psychological attacks, as well as economic coercion and stalking. It tends to escalate. (Program Handout 1)

The Impact of Domestic Violence on Children

Domestic violence affects every unit within society and children are often the most vulnerable targets. Schewe, Riger, Howard, Staggs, and Mason (2006) found that childhood exposure to domestic violence is a “risk factor for both sexual assault and domestic violence victimization” (p. 473). Schewe et al. also discussed the increased risk factor for domestic violence victimization for women who had more than one child. They explain that women/mothers have a financial and economic dependence on their perpetrators, thus their decision to leave the violent relationship may be compromised due to concern for providing for children without a partner’s support. Such factors elevate the chances of women remaining in abusive relationships and of children being subjected to prolonged domestic violence (Schewe et al.).

The National Center for Children Exposed to Violence (NCCEV) estimated that up to ten million children in the United States are annually exposed to violence in their homes (NCCEV, 2013). Studies (Sullivan, Egan, & Gooch, 2004; Byrne & Taylor, 2007) have established a link between childhood exposure to domestic violence and psychiatric disorders in later adulthood. NCCEV concluded that children who are exposed to domestic violence, particularly repeated episodes of violence, are at risk for many psycho-social and psycho-somatic problems, not only during the exposure, but also in later adulthood. Such difficulties include many psychological, social, and somatic dysfunctions. Among these are sleeping and eating disorders, depression, aggressiveness, anxiety, problems regulating emotions, problems with family and peer relationships, and
problems with attention, concentration, as well as challenges with academic performance (NCCEV).

Because exposure to domestic violence is considered a form of child abuse and neglect, courts often get involved in such cases. Domestic violence victims can face separation from their children and are referred to programs that focus on psycho-education and domestic violence victim treatment. Programs which specifically work with domestic violence victims have among their goals the psychological improvement of these mothers who can then provide a safe environment for themselves and their children. In order for the women to regain custody of their children, they need to show improvement between the time they entered treatment and when they graduated from the program. This change will assist the court in determining their further actions in regards to the victims’ treatment and child custody.

**Safety**

As discussed above, domestic violence presents serious, long-term physical and psychological harm or threat of harm to both victims and their children who are physically and/or psychologically affected by exposure to violence. Many programs teach victims what safe relationships look like and how they can maintain their safety. Women in the study program were taught how to write their own safety plan based on their community resources and available support system. The program staff historically assessed program success using completion rates and did not assess whether participants have actually learned the curriculum that was taught.
The Program

Family Service of Northwest Ohio (Toledo, OH) houses a community-based domestic violence program comprised of two phases of psycho-education: Basic Education and Regular Support Group. The program staff developed a curriculum designed for groups of 15 women teaching them self-awareness, healthy relationships, confidence, and the effects of domestic violence on children. Two-hour long psycho-educational sessions were held on a weekly basis for four months. At the end of the program, after a series of multi-subject support group sessions, the women were expected to write how they were planning on continuing their work on self-esteem and were expected to write a safety plan which they could implement as soon as they and their children appeared in an abusive and life-threatening situation. The curriculum overall aimed to help these women get to a state where they can distinguish between abusive and non-abusive partners in order to create a safe place for their families.

The staff administered pre- and post-program questionnaires created by the program coordinator to establish whether or not there is any change in knowledge among the domestic violence victims who attend the program. The program works in collaboration with Legal Aid of Western Ohio; Violence Against Women Act (VAWA) Collaborative; and Lucas County Domestic Violence Task Force, and serves about 200 women each year. The program staff has assessed its success only by program completion rates prior to this study. The program’s success, thus, was based on the number of women who attended both phases of the program and turned in a safety plan. This and the completion of an exit interview served as a way for the staff to evaluate program effectiveness.
The program staff has never evaluated the program based on whether or not participants are learning the curriculum. The staff has collected their own pre- and post-program questionnaires reflecting the two phases of the curriculum taught. This has helped them determine whether or not the women are responding to the program, however, no evaluation has been carried out using the questionnaire data. Such research could potentially help establish if the program is effective in teaching women its curriculum and if any changes need to be made.

**Program Evaluation**

Programs for domestic violence victims constitute a widespread community outreach resource for violence prevention. Even though a large number of such programs is hosted within community mental health agencies and counseling centers, the practice of evaluating these programs and services is very new and limited (Bennett et al., 2004). As Lyon and Sullivan (2007) state, “unfortunately very few studies to date have examined the long-term impact of victim services on survivors over time” (p. 9).

One of the reasons proposed as to why program evaluation has been less implemented documented in the framework of domestic violence programs is limited time and financial resources. Therefore, in many social service programs “providing direct services takes priority over evaluating the efficacy of those services” (Bennett et al., 2004, p. 815). This prevents policy-makers and program planners from successfully determining future program design and implementation (Krishnan, Subbiah, Khanum, Chandra, & Padian, 2012). Financial constraints within the mental health professions make independent evaluations of their programs unfeasible and leave counselors to rely on limited resources and research skills to implement program evaluation practices of
their own services often with no training (Astramovich & Coker, 2007). Harrell and her colleagues (1996) did extensive research on various program evaluation models and activities in the field of human services concluding that:

In the continuing effort to improve human service programs, funders, policymakers, and service providers are increasingly recognizing the importance of rigorous program evaluations. They want to know what the programs accomplish, what they cost, and how they should be operated to achieve maximum cost-effectiveness. They want to know which programs work for which groups, and they want conclusions based on evidence, rather than testimonials and impassioned pleas. (p. 1)

Several models exist to assist in guiding professionals in program evaluation. Many of these models have been adapted from the business field and applied to the human services professions. Some of these models also come from the education field and appear to be more applicable to the counseling profession and programs. They emphasize ongoing program evaluation for continuous improvement (Astramovich & Coker). The Center for Disease Control and Prevention (CDC) has conducted several studies and has designed a framework for program evaluation that can be applied to various counseling services (see appendix 1.3). The main steps include engaging stakeholders; describing the program; focusing the evaluation design; gathering credible evidence; justifying conclusions; ensuring use and share; and identifying implications for future research and improvement (Milstein & Wetterhall, 2000).

Other fields, such as criminal justice, have a long-standing record of evaluating court-mandated programs, juvenile services, substance addiction treatment programs and
so on. The office of Juvenile Justice and Delinquency Prevention has introduced the Aftercare design which is a model for program evaluation for court-related services. The rating schema court-mandated programs designed by the department can be compared and adapted to counseling programs with similar clientele and services. According to this department, “the effectiveness dimensions as well as the overall scores are used to classify programs into three categories that are designed to provide the user with a summary knowledge base of the research supporting a particular program.” (See Appendix 1.5)

Riger (2002) states that among positive outcomes of continuous and regular program evaluation practices is the motivation for staff members to develop a mechanism of applying the evaluation results for the purpose of enhancing their practice quality, support those practitioners who systematically observe their own work and outcomes, as well as come up with solutions that are based on those methodical observations. Overall, regular program evaluation has the potential to create a climate of “critical and constructive thinking that results in improved services, which in turn result in stronger evaluations” (p. 46). When program evaluation activities become a regular practice it is reported that outcomes of services become stronger, and that there is increased efficiency of treatment delivery, service quality, and client and third-party satisfaction improves. According to Sullivan (2000), “evaluation is also important because it provides us with ‘hard evidence’ to present to funders, which encourages them to continue or increase our funding” (p. 9). He states that even though most practitioners would agree on the need for examining the work and services counselors and agency staffs provide, they are “still hesitant to evaluate” their programs for various reasons (Sullivan, p. 9). Constant
evaluation of practices enhances staff objectivity regarding their own service quality and need for improvement.

Success of human service programs depends on ongoing evaluation directed to regular examination of what works and what needs to be altered to enhance effectiveness of services for stronger results. Exploring why program evaluation is limited for DV programs is very important. According to Lyon and Sullivan (2007), many practitioners have shared that program evaluators collect data on their programs and are never heard of again resulting in a disconnect between program evaluation specialists and agency staffs in follow-up procedures. If the results are not communicated for the purposes of improving the program quality and efficiency, the act of program evaluation becomes self-serving. Another important issue related to the limitation of program evaluation and is resistance of agency staffs against such practices is the inaccurate or one-sided interpretation of the results by researchers who do not have in-depth understanding of domestic violence issues and thus treat the results out of context. Lyon and Sullivan call this “drive-by data collection” (p. 5). This is when numbers of statistical tests are explained without clinical context and are illustrated. Numerical values are meaningful only if interpreted within the context in which they were retrieved. Otherwise, again, the purpose of program evaluation is defeated.

In addition to these problems related to program evaluation, practitioners also fear that the results of their program evaluation may result in funding cuts. Lyon and Sullivan state that “our own evaluations could be used against us because they might not 'prove' we are effective in protecting women from intimate violence” (p. 6). For example, if no statistically significant results are found in a program evaluation, third party payers may
decide to cut funds which will then hurt the domestic violence victims that these programs serve.

**Purpose of the Study**

The purpose of this study was to determine if existing agency data were sufficient to provide outcome data for a 16-week domestic violence program and to identify what components of the curriculum were effective. The researcher attempted to establish if there was any change in domestic violence victims’ responses to pre-program versus post-program questionnaires. This analysis demonstrated whether the participants acquired any knowledge of the curriculum taught by the program staff.

**Statement of the Problem**

Research on domestic violence program outcomes with court referred female victims is extremely scarce as opposed to batterer program evaluation studies. The author used a variety of search terms on Google Scholar; Academic Search Complete, and EBSCO Host webpages and was unable to find any results that were specific to court-referred female victims. There were, however, ample batterer or offender program evaluation studies. This study contributes to the body of knowledge on domestic violence program outcomes as it pertains to those programs that work with court-referred female victims of domestic violence. This study was also intended to demonstrate a method for conducting program evaluation in a naturalistic environment using a time- and cost-effective method and suggesting some practical steps for program staffs and administers who prepare for evaluation of their programs.
Significance of the Study

The researcher examined whether or not there was a difference in the domestic violence program’s participants’ scores from pretest to posttest. The effectiveness of the delivery of the curriculum was assessed by examining the pre- and post-program questionnaires completed by the participants. The outcome of this study enables the program staff to determine how effectively they communicated the program’s curriculum to their clientele and what changes need to be made. Astramovich and Coker (2007) contended that there is a general lack of program evaluation research in the field of social and behavioral sciences. The significance of this study is that it demonstrates that program evaluation can be successfully conducted in the field and in a manner that is cost-effective. As a result of this study, the program should be able to demonstrate its effectiveness to the courts and children’s services that work with domestic violence victims. Other programs can benefit by adopting similar evaluation procedures to demonstrate their effectiveness.

Research Questions

Reviewing the domestic violence program and its goals, as well as the needs of the program staff, the following are identified as the research questions of this study:

1. Is there a significant difference in participants’ total pre- and post-program questionnaire scores?
2. Is there a significant difference in participants’ pre- and post-program questionnaire scores based on ability to define and identify types of domestic violence?
3. Is there a significant difference in participants’ pre- and post-program questionnaire scores based on the ability to identify ways domestic violence impacts children?

4. Is there a significant difference in participants’ pre- and post-program questionnaire scores based on the ability to identify ways to protect personal and child safety?

**Definition and Operational Terms**

The program discussed in this study is defined as a two-phased basic psycho-educational and regular support group treatment designed to increase participants’ awareness and knowledge of domestic violence and help them identify types of abuse, effects of domestic violence on children, healthy and safe relationships, and eventually develop a safety plan to keep themselves and their children away from violence.

The definition of domestic violence based on the curriculum is “a pattern of coercive control perpetrated by one person against another in an intimate relationship, including relationships that have ended; current and former partners who are not cohabitating; and is gender and sexual orientation neutral” (program curriculum). It also identifies domestic violence as “a pattern of multiple tactics and repeated events, including physical, sexual, spiritual, and psychological attacks, as well as economic coercion and stalking” (program curriculum).

Program evaluation is defined as a systematic and methodical assessment and outcome evaluation of all phases and elements that make up the program for the purpose of assisting program staff to make necessary changes in order to facilitate desired change in participants (Astramovich & Coker, 2007; Dunsworth & Billings, 2012). Program
outcomes, in turn, are defined as the results that the program aims to produce (Wholey, Hatry, & Newcomer, 2010).

**Summary**

Domestic violence is a nationwide public health problem representing major health, social, and cultural concerns. This issue has been of essential focus in both the public and academic spheres for the past 40 years (Lee, Kolomer, & Thomsen, 2012). The literature emphasizes the damaging impact on children who are exposed to domestic violence in their homes who are at a high risk for lifelong psychological problems and later adulthood violence both as perpetrators and as victims (Sullivan et al., 2004; Byrne & Taylor, 2007). Courts are the primary referral source of domestic violence victims to community agencies which target this specific population in their treatment programs. Very limited research exists on the effectiveness of domestic violence program outcomes on change in a group of female victims specifically recording increase of awareness, knowledge and skills among them for recognizing, identifying and responding to domestic violence and types of abuse by creating a safe environment for themselves and their children. Thus, further research is necessary to help practitioners design best treatment models to respond to the unique needs of this population and assist the courts in their appropriate decision-making processes.

**Organization of Chapters**

This dissertation is organized into five chapters. Chapter One comprises the identification, description, and background of the problem reflected in the literature for the past years of relevant research. Chapter One also discusses program evaluation as a new, limited and a challenging activity within the counseling profession. It also includes
the description of the purpose and the significance of the study, by also defining specific terms used in the paper. Chapter One also describes the program under evaluation and identifies the variables and research questions of the study, as well as lays out the overall summary of the section. Chapter Two covers the literature review regarding the issue of domestic violence, its impact on children, legal services involvement, court referral to treatment programs, need for domestic violence program evaluation, the practice of program evaluation, and the documented lack of such outcome studies within the counseling field. Chapter Three explains the method which was used in this study to analyze the effectiveness of the domestic violence program. Chapter Four presents the findings of this study. Chapter Five discusses the findings of this study and suggests future research ideas.
Chapter 2

A Review of the Literature

This chapter illustrates the review of the literature on two main themes: program evaluation and domestic violence. The first section includes the overall review on the practice of program evaluation within the social and behavioral sciences as well as several comparisons with other fields, such as juvenile justice and courts. Discussion on need for program evaluation on the subject of domestic violence programs particularly with court-referred female adult victims concludes this section. The second portion includes discussion on domestic violence and sub-themes that reflect the research questions, such as impact of domestic violence on children and safety planning.

Program Evaluation

Astramovich and Coker (2007) consider program evaluation applied research and describe it as a “systematic process of collecting and analyzing information about the efficiency, the effectiveness, and the impact of programs and services” which can be “geared toward monitoring and improving a particular program or service” (p. 85). Their assumption is that because micro-evaluations are usually implemented on a smaller scale, they can be carried out by practitioners. Ongoing evaluation can be very useful as it allows professionals to make vital decisions in several areas regarding the program’s progress and implementation in order to successfully determine and facilitate the next steps as necessary (Dunsworth & Billings, 2012). Evaluation also aims to determine “the worth or merit” of the program that is evaluated (Fitzpatrick, Sanders, & Worthen, 2004, p.10). This definition emphasizes the goal that evaluation should be implemented for a purpose. Accordingly, “evaluations should be conducted for action-related reasons, and
the information provided should facilitate deciding a course of action” (Frechling Westat, 2002, p. 3). The various types of program evaluation designs and approaches include exploratory evaluation, performance measurement systems, comparison group designs, randomized control trials, case studies, and logic models (Wholey et al., 2010). Wholey and his colleagues describe program evaluation as a practice which can also be classified as formative or summative, ongoing or one-shot, observatory or participatory, goal-based or goal-free, quantitative or qualitative, and problem- or non-problem-oriented (Wholey et al.).

The aspects of an ongoing evaluation include the determination of the extent to which the program meets its goals; assessment of program delivery consistency; conclusion on continuation, modification, or termination of the program; and appropriate conflict resolution on deferring opinions regarding the current format, practice, and method of program implementation (p. 4). Dunsworth and Billings identify five major steps that any program evaluation within the behavioral sciences field can follow: (a) creating and completing a program evaluation blueprint to define the purpose and scope of the evaluation; (b) gathering data needed to assess a program’s effectiveness; (c) analyzing the data in order to identify a program’s strengths and weaknesses; (d) using the results of the program evaluation to plan next steps; and finally (e) communicating results to stakeholders in order to build community involvement and support (p. 6).

Wholey et al., in addition to the above stated components, emphasize that through these steps an evaluator can highlight different program aspects in conducting performance management evaluation: program outcomes (results that the program
produces), cost-effectiveness (the cost of the outcomes received), outputs (quantity of completed work, e.g., number of seminars taught), efficiency (ratio of the outputs to total program costs), service quality or quality of the outputs (e.g., timeliness, turnaround time, accuracy, thoroughness, accessibility, convenience, courtesy and safety), and customer satisfaction (e.g., clients’ perception of their service experience) (Zaporozhets, 2012).

According to Lyon and Sullivan (2007), evaluation is a “particular kind of research. It answers questions about programs or other kinds of efforts to provide services or create change in some way” (p. 8). They specify that the questions asked within program evaluation “can be simple, such as ‘what did the program do?’ or more complex, such as ‘how was the program helpful, and for which people?’, thus, evaluation research, as the term suggests, tries to answer questions about a program’s ‘value.’” (p. 8). They state that without extra resources program evaluation practices are often beyond the capacity of most local domestic violence programs to do on their own. However, quality evaluations can also be done by local programs with minimal financial investment (Lyon & Sullivan).

Recent research on program evaluation “stresses the inherent interrelationships between evaluation and program implementation, which means it is not separate from, or added to, a project, but rather is part of it from the beginning” (Frechtling Westat, 2002, p. 3). All three elements, which involve planning, evaluation, and implementation, are undivided parts of a whole process, and “they work best when they work together” (p. 3). (See attachment of interrelational program evaluation chart under Appendix 1.4.)

Researchers typically discuss two kinds or stages of evaluation: formative and summative. Formative evaluation serves the purpose of assessing initial and ongoing
program activities, whereas summative evaluation aims to assess the quality and impact of a fully implemented program (Frechtling Westat, 2002, p. 7). In addition, formative evaluation consists of two components: implementation and progress evaluation and the entire process lies on a timeline of early stages and later stages activities (p. 8). (See appendix 1.5)

**Formative Evaluation**

According to Frechtling Westat (2002), formative evaluation starts as program development begins and continues throughout the life of the project. Formative evaluation is concerned with systematic assessment of the program activities in process and it aims to provide information to monitor and improve the project on ongoing basis. It is implemented at several points in the developmental life of a program and its activities (Frechtling Westat, 2002, p. 8). The figure provided under *Appendix 1.5* demonstrates this cycle. In addition, formative and “process evaluation efforts shape and refine programs, the do not constitute summative or conclusive evaluation” (Royse, Thyer, and Padgett, 2006, p. 108). According to Lyon and Sullivan (2007), “process evaluation assesses the degree to which the program is operating as intended” and the examination as to “how a program is operating requires some creative strategies and methods, including interviews with staff, volunteers, and service recipients, focus groups, behavioral observations, and looking at program records” (p. 17).

**Summative Evaluation**

In contrast with formative evaluation, the purpose of summative evaluation (sometimes referred to as impact or outcome evaluation) is to assess a “mature program’s success in reaching its stated goals, and as such, it frequently addresses many of the same
questions as a progress evaluation, but it takes place after the project has been established and the timeframe posited for change has occurred” (Frechling Westat, 2002, p. 10).
Lyon and Sullivan (2007) state that summative evaluation assesses what occurred as a direct result of the program. They emphasize that outcomes must be measurable, realistic, and philosophically tied to program activities. (p. 19). Frechling Westat adds that summative evaluation gathers information about outcomes and related processes, strategies, and activities that have led to them and, overall, it is an “appraisal of worth, or merit (p. 11). This type of evaluation is usually required to help make decision regarding any future steps of the program.

In summary, the goal of program evaluation is to collect and use data to guide decisions about how well a specific program is working, inform the next steps, and do so in a way that is both time- and cost-effective (Dunsworth & Billings). Royse and his colleagues suggest following “Deming Cycle” or the PDCA which stands for Plan, Do, Check, and Act, that is, study the program by collecting data and deciding what activities would improve it, then put the plan in action, implement the program, after which and during the entire process assess how the different elements are working, afterwards, and finally, make the necessary changes on the basis of the results obtained through ongoing appraisal (2006, p. 137).

**Purpose of Evaluation and the Role of Stakeholders**

Melvin (2003) argued that regardless of the specific area, a program or policy evaluation most frequently focuses on the question of impact or effect of the intervention. He further explains that evaluations may be conducted in order to present to funders whether or not the services were actually delivered to the target population or provide
program managers with ongoing feedback for possible improvements or changes. Depending on the purpose of the program evaluation and to whom these results are reported, such research may include either causal analysis or correlational methods (Melvin).

Usually, more than one group of individuals will be eager to find out the results of such evaluations. In the case of multiple stakeholders, each may have their own interests in the results of the program evaluation with various motives and agenda. Hence, it is vital that professionals conducting such evaluations make excellent decisions not only regarding the research methods best fitting the study, but also ask the most appropriate research questions effectively reflecting the purpose of program evaluation.

**Program Evaluation Format**

Many program evaluations utilize surveys, interviews, focus groups, observational data, and Likert scale inventories. Standardized and/or non-standardized tests may also be used based on program format, population, purpose of the evaluation, and to whom the results are reported. Pre- and post-tests are most often used in the behavioral sciences to establish effectiveness of a program. In addition, different data require different analytical approaches, for example, quantitative or quantifiable data can be organized numerically, while qualitative data can be organized into thematic groupings and trends can be displayed for descriptive analysis (pp. 46-47).

Program evaluation can utilize both causal and correlational analyses. In fact, causal methods are not always absolutely necessary to establish a program’s merit or worth (Melvin, 2003). In situations where specific characteristics or value-driven attributes are assessed, less intensive, simpler, and descriptive means can be employed.
Causal methods, however, are typically perceived as best for establishing the direct relationship between the program and the changes that occurred after implementing it. For example, one outcome question might be whether or not the program is solely responsible for the change observed and measured among the recipients. For this reason, causal analyses can be very challenging in that many factors can influence the outcome. Researchers cannot always control for these external factors to single out the program’s influence in pure isolation from the environment.

Research during the past several years, however, has allowed professionals to consider correlational methods as a more affordable, simpler, and still very useful approach to evaluation that can benefit the field of social and behavioral sciences. A quasi-experimental design is an example of a method which can be used when randomization is not feasible (Melvin, 2003). One of the most employed forms of quasi-experiment is the pretest-posttest single-group design. Using such correlational methods can help evaluators establish if there is a relationship between program attendance and outcome, regardless of whether the relationship is causal or not.

**Interdisciplinary Comparisons and Models**

Various professions within human services employ program evaluation procedures. Among these are the fields of criminal and juvenile justice. Courts struggle with decisions on what programs are most appropriate for their clients (Zaporozhets, 2012). Such dilemmas include determining whether incarceration or therapy is more effective for addressing various offenses, for example, drugs and juvenile delinquency. Because human lives and public safety depend on such decisions, it is crucial that best program evaluation practices are conducted to help make the most just verdicts. Such
decisions are especially crucial because on the basis of program evaluation results states make their decisions about legislating treatment standards (Buttell & Carney, 2006).

The National Institute of Justice (NIJ) has designed a logic model for adult drug court programs. Its purpose is to aid court administrators and their partners in examining the performance of their drug courts. The logic model “can help clarify the best way to use resources and what long- and short-term outcomes drug court teams should consider measuring” (NIJ, para. 1). The model includes six components: inputs; activities; outputs; short-term outcomes; long-term outcomes; and external factors. This model identifies program evaluation via four main components: process evaluation; outcome evaluation; impact evaluation; and cost-efficiency analysis (see Appendix 1.7). The model is very comprehensive and can be adapted to other spheres, such as counseling programs, especially since the main goal of this model is to aim treatment-based program evaluations with most cost-effective methods (NIJ, 2013).

Because this study is a retrospective, naturalistic study, the researcher found that the most appropriate method for this study was using a pretest-posttest, single group, quasi-experimental design. The data were drawn from questionnaires administered prior to entering the program and upon graduation from the program. The group served as its own control. The design is quasi-experimental as participants were not randomly assigned to groups.

Need for Evaluation Studies

In a careful examination of the Family Violence Prevention and Services Administration (FVPSA) programs within the U.S. Department of Health and Human Services (HHS), as well as other federal grant programs within the Administration for
Children and Families at HHS, the Office of Management of the Budget (OMB) discovered that “results were not adequately demonstrated” (Lyon & Sullivan, 2007). The team that was assigned the task to investigate all domestic violence programs and assess their success with accomplishing treatment goals, discovered that most successful programs were victim advocate run programs and shelter programs; it was observed that “a stay at a shelter dramatically reduced the likelihood the women would be abused again” (p. 9). Another study examined if the victims’ skills in safety planning improved after they completed a domestic violence program and discovered that even though the results were interpreted as statistically significant, the clinical significance was much less because the women had mainly indicated on their safety plan they would contact a domestic violence program as a safety plan (p. 11). However, research on agency or community-based domestic violence victim program evaluation is extremely scarce. In fact, Lyon and Sullivan write in their report that “evaluations of support groups have unfortunately been quite limited” (p. 11). In the 2004 report, Sullivan, Egan and Gooch stated that out of five evaluation studies of domestic violence child and mother victim intervention programs, only two were actually about the mothers’ program outcomes.

As demonstrated under Introduction section, various reasons have caused programs to shy away from evaluation procedures. These include fear of improper and out-of-context interpretation of results, using results against programs and thus causing cuts of budget for domestic violence victim services, as well as practitioners’ feelings of inadequacy and unpreparedness for conducting program evaluation of their services. More issues include limited budget, human and financial resources that community-based and non-profit agencies face. Lyon and Sullivan (2007) found that:
The only evaluation of a legal advocacy program to date is Bell and Goodman’s (2001) quasi-experimental study conducted in Washington, DC. Their research found that women who had worked with advocates reported decreased abuse six weeks later, as well as marginally higher emotional well-being compared to women who did not work with advocates. Their qualitative findings also supported the use of paraprofessional legal advocates. All of the women who had worked with advocates talked about them as being very supportive and knowledgeable, while the women who did not work with advocates mentioned wishing they had had that kind of support while they were going through this difficult process. These findings are promising but given the lack of a control group they should be interpreted with extreme caution. (p.10)

Even this one study does not reflect results of court-referred domestic violence victim program evaluation. Hence, as indicated above, outcome studies on domestic violence programs are very limited. This problem makes it extremely challenging for program staff to develop curricula based on best practices because very few studies have illustrated the successes and the shortcomings of such programs. Having good evaluation data would guide domestic violence programmers in their strategies and improvement because it grants leaders the ability to create the best possible programs, learn from previous mistakes, make modifications as needed, monitor ongoing progress toward program goals, and evaluate whether or not the program succeeded in achieving its short-term, intermediate, and long-term outcomes (CDCP, 2005).

Ongoing and regular program evaluation activities help shed light on the future activities of the program management and help stakeholders determine the status and
extent of their involvement. In addition, program evaluation helps to maintain the accountability to their third-party payers by demonstrating results based on statistical data obtained through appropriate analysis. According to Lyon and Sullivan (2007), programs are going to increasingly feel “external pressure from funding sources to conduct outcome evaluation” (p. 3). Thus, if practitioners were to be adequately trained on fairly simple and less time/fund consuming program evaluation methods, they could pre-plan their outcome assessment strategies and save much anxiety and more resources.

Thus, summarizing the answer as to why program staffs and researchers should conduct ongoing, regular evaluation studies is because, most importantly, evaluation provides information to help improve the program. It is essential to a continuous improvement process to determine if the goals are being met and if all elements of the program are working harmoniously to achieve those goals. In addition, and equally important, “evaluation frequently provides new insights or new information that was not anticipated, and thus, “unanticipated consequences” of a program are among the most useful outcomes of the assessment enterprise” (Frechtling Westat, 2002, p. 3).

**Domestic Violence**

The terms Domestic Violence (DV) and Intimate Partner Violence (IPV) are used interchangeably throughout the literature. The first one originally was used to only address those cases where victims cohabitated with their perpetrators, however, the term was later changed to include all individuals who were victims of abuse and violence in any type of intimate relationship. In this paper, the term Domestic Violence will be used to describe the entirety of the victim population in any situation of intimate partner abuse and violence. Moreover, the discussion on domestic violence will only focus on female victims of male-perpetrated domestic violence, not only because this is statistically the
overwhelming majority, but also because the program under evaluation, which is the center of this work, serves this particular clientele.

Cobia, Robinson, and Edwards (2008) defines domestic violence “the willful intimidation, assault, battery, sexual assault, and/or other abusive behavior perpetrated by one intimate partner against the other” (p. 249). In addition, the National Coalition Against Domestic Violence (NCADV, 2007) describes domestic violence as “an epidemic affecting individuals in every community, regardless of age, economic status, race, religion, nationality or educational background” (para. 1). The NCADV reports that violence against women is often accompanied by emotionally abusive and controlling behavior, and thus is part of a systematic pattern of dominance and control. Domestic violence results in physical injury, psychological trauma, and sometimes death. The consequences of domestic violence can cross generations and truly last a lifetime (NCADV, 2007). The World Health Organization (WHO, 2010) recognizes domestic violence as an international public health issue which affects all individuals regardless of race, ethnicity, religion, and socio-economic status.

Centers for Disease Control and Prevention (CDCP, 2010) data indicate that one in four women have been victims of severe physical violence by an intimate partner. An estimated 1.3 million U.S. women are victims of physical assault by an intimate partner each year. The NCADV (2007) reported that 85 percent of domestic violence victims are women who have been most often victimized by someone they knew. Women who are 20 to 24 years of age are at greatest risk of nonfatal domestic violence, and almost one-third of female homicide victims are killed by an intimate partner. Approximately 20 percent of the 1.5 million people who experience domestic violence annually obtain civil
protection orders. One-half of the orders obtained by women against intimate partners who physically assaulted them were violated. More than two-thirds of the restraining orders against intimate partners who raped or stalked their victims were violated. Most cases of domestic violence, however, are never reported to the police (NCADV, 2007).

The CDCP 2012 nationwide survey showed that 81 percent of women who experienced rape, stalking, or physical violence by an intimate partner reported significant short- or long-term effects related to the violence experienced in this relationship. Among those are mental health issues such as Post-Traumatic Stress Disorder (PTSD) and physical issues such as severe injury. The CDCP also found that women were disproportionately affected by sexual violence, domestic violence, and stalking.

During 2011, there were a total of 74,842 calls reporting domestic violence in the state of Ohio (Ohio Domestic Violence Network, 2012). The investigation of these calls resulted in 44,302 arrests; this left 30,540 calls that did not result in arrest. Westbrook (2013, para. 1) broadened the definition of domestic violence to include “child abuse, elder abuse, and intimate partner violence”, whereas domestic violence is legally recognized as any physical abuse of one partner by another. Westbrook defined domestic violence as including emotional, physical, or psychological abuse as well as economic control and social isolation. These definitions do not contradict one another, rather, with time, as more research on the issue was available and more awareness and understanding grew, the definition of the term expanded to include all components that are part of the problem. This helps with more comprehensive response within legal services and
domestic violence programs as providers have a wider understanding of all elements involved in the matter of domestic violence.

**Impact of Domestic Violence on Children**

Intimate partners are not the only victims in most cases of domestic violence. More often than not, children are involved in inter-partner conflicts and either directly or indirectly become the victims as well (Lee, Kolomer, & Thomsen, 2012). Children can be the direct victims of domestic violence perpetrated against them, but they can also be victimized by witnessing domestic violence perpetrated against others. The involvement of children in domestic violence often prevents mothers from reporting the abuse because they fear possible legal ramifications which may include losing their children (McCluskey, 2010). In situations where domestic violence is a frequent occurrence between partners, children are subject to neglect of their psychological and/or physical needs because of the emotional absence of a parent (Byrne & Taylor, 2007).

Children who are victims of domestic violence are negatively affected mentally, emotionally, spiritually and/or physically. Their growth and healthy development can be halted and damaged and their educational attainment can be impaired. These children are often bullies or victims of bullying in social environments, such as the school (Byrne & Taylor, 2007). Witnessing violence between one’s parents or caretakers is the strongest risk factor for transmitting violent behavior from one generation to the next (NCADV, 2007). In fact, boys who witness domestic violence are twice as likely to abuse their own partners and children when they become adults, and 30 percent to 60 percent of perpetrators of domestic violence also abuse children in the household (NCADV). By creating effective domestic violence victim treatment programs, it is possible to gradually
reduce the number of children who because of childhood domestic violence exposure become perpetrators abusing their partners and children.

According to Summers (2006), “each child’s response to domestic violence must be carefully evaluated for harmful consequences before the court and appropriate agencies intervene to determine the best possible intervention, because ignoring the issues of domestic violence can lead courts or child protective services to inappropriately removing the child from their battered mother, which only succeeds in increasing the negative impact of exposure to violence and effectively re-victimizing the mother” (p. 8). Therefore, child protective services and domestic violence programs should work in close collaboration to better understand the complex psycho-social impact of domestic violence on children and mothers. This will help them effectively choose the best options not only for the children’s safety but also for mother-child healthy ties and prevention of re-victimization for both. This way also, programs can keep track as to what strategies work and which need to be abandoned.

Safety

Because domestic violence is a crime, courts often get involved to determine punishment for perpetrators, and to provide protection and compensation for victims. Courts may designate special programs for both parties, such as anger management, assertiveness, self-esteem classes, and/or mental health services. Courts are concerned with both appropriate punishment and rehabilitation programs. Therefore, judges often refer victims of domestic violence to specialized treatment programs which are usually run by non-profit organizations and/or community based agencies. Courts need valid and reliable outcome data on these programs to determine their efficacy and effectiveness.
They are ultimately interested in whether or not programs can teach victims how to maintain their own and their children’s safety.

Because safety is a major concern within the problem of domestic violence, educating victims how to develop a safety plan for escaping a violent situation is an essential portion of any curriculum. Programs assist victims to compose their own safety plans based on their circumstances, the resources available to them, and their support system. Safety education is a crucial component of domestic violence program curriculum because “it relates not just to individual level change (the survivor’s safety and well-being), but it also provides evidence, important to more and more funders, of stronger and safer communities” (Lyon & Sullivan, 2007, p.2). According to Lyon and Sullivan, “research has demonstrated that increasing survivors’ knowledge of safety planning and of community resources leads to increased safety and well-being over time” (p. 2).

Conclusion

Domestic violence is an epidemic which affects all societies regardless of race, ethnicity, color, religion, age, educational level, and employment status (WHO, 2011). Each year, 1.3 million U.S. women are raped, stalked, or assaulted by an intimate partner (Brown, 2008). Domestic violence influences children exposed to the violence in damaging ways the consequences of which can persist in their life all through later adulthood. These effects include psychological, mental and physical trauma which often requires a prolonged therapy. These children often have difficulties with social interactions and frequently use violence and abuse with their partners and children. Various domestic violence programs work with women/mothers who are domestic
violence victims. These programs are usually community based non-for profit agencies and centers who target this vulnerable population and utilize psycho-education, diverse methods and types of counseling, regular support group and/or more intense psychiatric treatment.

Children’s services who are concerned with the safety of children exposed to domestic violence, are regularly involved in domestic violence cases where the victim mothers become the client of court. In such instances, courts are interested in appropriate treatment programs which can help these women achieve their therapeutic goals and become knowledgeable about domestic violence, abuse and safety for themselves and their children. Courts use outcomes collected from such domestic violence programs to help them determine further actions in child custody matters. Therefore, it is vital that domestic violence treatment programs conduct outcome studies to examine the effectiveness of the programs in creating change among the beneficiaries of these agencies.

Program evaluation has historically been classified as a larger-scale organizational practice and has thus been described in the past years’ literature as an extensive, complex and time/money consuming activity which is designed and implemented by program evaluation professionals. Such attitudes toward the practice of program evaluation have alienated many counselors simply because the methods and models identified in literature are not practical for the setting of counseling agencies who are working with such target populations and survive on government funds and private grants. This phenomenon has created a gap between outcome research and counseling practice. Thus, several researchers have offered ways to create new paradigms in order to
overarch this gap and create novice models. Such models would allow practitioners to conduct program evaluations which are fairly simple, require less monetary and time consumption, and, in the same time, are reliable in providing program managers and stakeholders with necessary data for future strategies and decision-making processes.

The program under examination is a domestic violence victim treatment model. It consists of two phases: Basic Education and Regular Support Group. The curriculum guides a group of six to eight women on weekly basis for four months teaching them self-awareness, healthy relationships, confidence, the effects of domestic violence and its influence on children among other subjects. The staff conducts pre- and post-tests to establish whether or not there is any change among the domestic violence victims who attend the program. The program collaborates with several state and private agencies, including the legal services of Lucas County.

No prior research has been conducted thus far to determine whether the program is responsible for the change in domestic violence victim’s responses from pre- to post-tests. This chapter discussed domestic violence as a nationwide problem, illustrated program evaluation procedures in various fields, and identified appropriate methods on implementing an outcome study to determine whether or not there was any statistically significant change in responders’ pre- and post-program questionnaires and whether the change was due to the program.
Chapter Three

Method

The first chapter of this study was an introduction to the treatment of domestic violence (DV) victims in community-based programs and the need for evaluating such programs’ effectiveness, especially with court-mandated populations. The introduction included the problem statement of this study, the study’s significance, the research questions identified for this study, as well as definitions of terms. The second chapter described the extent of the domestic violence problem and the type of psychosocial and somatic issues associated with it as life-long difficulties both domestic violence victims and their children endure. It also examined the current literature regarding program evaluation in the field of social-behavioral sciences as well as human services. It specifically reviewed domestic violence treatment programs and any available outcome studies reflecting such programs. The issues of lack of research on domestic violence program effectiveness, concerns about cost-efficiency, and relevance or practicality to the counseling field were also discussed. In this chapter, the author focuses on the method employed in the present study, to examine the effectiveness of the domestic violence program.

Variables

The primary predictor variable of this study was the pre-treatment questionnaire score, which was used to establish baseline knowledge of domestic violence upon entry into the program. The criterion variable for this study was the post-treatment questionnaire score, which was used to establish improvement over baseline upon completion of the program curriculum. Both the predictor and the criterion variables were
continuous variables. The three secondary variables were the ability to define and identify types of domestic violence; the ability to identify ways domestic violence affects children; and the ability to identify ways participants can keep themselves and their children safe. All of the secondary variables were continuous and were measured on three levels: 0 (no response); 1 (partial response), 2 (complete and accurate response).

Questions that were left blank or had a wrong response, are coded as 0. Questions that were answered partially, which means some elements of the question were addressed but others were not, are coded as 1. And finally, questions that fully reflect the curriculum the participants were taught, addressing all the elements, are coded as 2.

Sample

This study included all the participants who completed all 16 sessions and both phases of the domestic violence program between January 1, 2010 and January 1, 2013. According to the program staff, the program has served about 200 women each year. Hatry (2010) recommended including only those data which had been completed and exclude non-matching or incomplete questionnaire in order to establish accurate results (Wholey, Hatry, & Newcomer, 2010). Consequently, program drop outs and any other participants who had not completed the post-program questionnaire were not included in the study.

Instrumentation

An interview with the program staff (September 25, 2012) revealed that the staff had used a pre-treatment questionnaire to determine a baseline for domestic violence victims’ knowledge of domestic violence and related themes. After the completion of the first phase, the staff administered a post-program questionnaire to examine if domestic
violence victims were able to identify main concepts before they were transitioned into second phase. At the end of the program, the questions were summed up in a post-treatment questionnaire to match the pre-treatment questions for both phases. The staff created the curriculum by reviewing the literature on domestic violence and identifying common needs of domestic violence victims (A. Abbott, personal communication, September 25, 2012). They incorporated three main topics which are found in the literature on domestic violence as recurring themes (Lyon & Sullivan, 2007; Sullivan & Coats, 2000, Sullivan, Egan, & Gooch, 2004; & Saltzman, L., Fingerhut, L.A., Rand, M.R., & Visher, C., 2000). Those include awareness about partner violence and abuse; impact of domestic violence, and safety plans that victims can write.

The coordinator of the program also created the pre- and post-program questionnaire matching the questions to the curriculum topics taught. For example, to assess if participants have retained the information from domestic violence definitions, types and various instances in which these types can play out taught by the curriculum, the questionnaire reflects the following statement: “Identify types of domestic violence”. Regarding damages domestic violence can cause children exposed to it, the questionnaire reflects: “Identify ways DV impacts children”. Finally, to assess if participants have learned ways to keep themselves safe and can write a safety plan, the questionnaire states: “Identify ways you can keep yourself and your children safe” (see Appendix 2.2). However, the questionnaire had not been standardized and no validity and reliability studies had been conducted for the created instrument. This was not surprising as researchers have stated that evaluators will encounter various problems when using
agency data such as non-standardized instruments and incomplete data (Wholey, Hatry, & Newcomer, 2010).

**Procedures**

This was a nonexperimental, retrospective, naturalistic study by design. The study was nonexperimental because (a) the primary predictor variable--score on the pre-treatment questionnaire of the program--was not manipulated by the researcher (Johnson, 2001, as cited by Zaporozhets, 2012) and (b) participants were not randomly assigned to the program. Therefore, the researcher used a comprehensive sample of convenience. The study was also a retrospective or *ex post facto* design, because the researcher incorporated data that had already been collected by program staff (Zaporozhets, 2012). Finally, the study was naturalistic in that the researcher used naturally occurring data collected by the program staff with no *a priori* input from the researcher regarding data collection instruments or procedures. According to Hatry (2010), “traditional sources of data used by evaluators are records kept by the agency delivering the service” under evaluation as a common method (cited in Wholey, Hatry, & Newcomer, 2010, p. 243).

The intervention in this study was a local domestic violence program. The purpose of the program was to educate court-referred domestic violence victims on basic domestic violence concepts and definitions. The curriculum was delivered by the program staff in order to assist participants in improving their awareness of domestic violence, ways it effects children, and ways they can plan safety for themselves and their children. This domestic violence program was a community-based psycho-educational and support group program which had offered its services to a group of fifteen women once a week for 16 weeks. The program consisted of two phases: phase one was an eight-
week basic education, and phase two was a regular support group. The participants of the program were court-referred women/mothers who were domestic violence victims and whose children had been found to be exposed to domestic violence.

**Research Questions**

The following were the research questions identified for this study:

1. Is there a significant difference in participants’ total pre- and post-program questionnaire scores?
2. Is there a significant difference in participants’ pre- and post-program questionnaire scores based on the ability to define and identify types of domestic violence?
3. Is there a significant difference in participants’ pre- and post-program questionnaire scores based on the ability to identify ways domestic violence impacts children?
4. Is there a significant difference in participants’ pre- and post-program questionnaire scores based on the ability to identify ways to protect personal & child safety?

**Hypotheses**

The following were suggested hypotheses for the study under examination:

1. There is no significant difference in participants’ total pre- and post-program questionnaire scores.
2. There is no significant difference in participants’ pre- and post-program questionnaire scores based on the ability to define and identify types of domestic violence.

3. There is no significant difference in participants’ pre- and post-program questionnaire scores based on the ability to identify ways domestic violence impacts children.

4. There is no significant difference in participants’ pre- and post-program questionnaire scores based on the ability to identify ways to protect personal and child safety.

Statistical Analyses

The researcher used the pre- and post-program questionnaires and assessed the answers each participant gave to the questions based on the curriculum taught. Answers that were left blank or were answered incorrectly were coded as 0. Partially correct answers were coded as 1. Answers that fully reflected the curriculum and were accurate were coded as 2. There were a total of 8 items on the pre-/post-program questionnaire, with two items measuring each of the four research questions. There is a total possible score range of 0 to 16. After completing the coding of both pre-and post-program questionnaires, the researcher summed the results of the questionnaires to obtain the participants’ scores. Any incomplete data or non-matching pre- and post-treatment questionnaires were left out of the study. Within the pre- and post-program questionnaires were subscales that measured participants’ ability to (a) define and identify types of domestic violence, (b) identify ways domestic violence impacts children, (c) identify ways to protect personal and child safety. Scores for these subscales
were computer in a manner similar to that used for the entire questionnaire. Each subscale consisted of 2 items with a cumulative score range from 0 to 4. For example, to question 1 (Identify types of DV), the accurate answer taught by the curriculum includes:

Domestic Violence is a pattern of coercive control perpetrated by one person against another in an intimate relationship. It includes relationships that have ended; current and former partners who are not cohabitating; and is gender and sexual orientation neutral. Domestic Violence is not an isolated individual event but rather a pattern of multiple tactics and repeated events. It includes physical, sexual, spiritual, and psychological attacks, as well as economic coercion and stalking. It tends to escalate.”

After which the curriculum specifies the instances in which these various types of abuse occur, expecting participants to recognize these situations on the questionnaire and be able to describe them, as “physical abuse includes …”; “verbal abuse includes …”; “sexual abuse includes …”, and so on (see Appendix 2.2). Therefore, 2 would be scored an answer that fully reflected all the elements of the curriculum; 1 could be scored an answer that only mentioned a brief definition, however missed identifying the types of abuse with their description; and finally, 0 would be given to an answer which inaccurately identified the definition or its types, or fully missed the question, leaving it blank.

The primary predictor variable of this study was the total score on the pre-treatment questionnaire, which was used to establish baseline knowledge of domestic violence upon entry into the program. Secondary predictor variables used in hypotheses two through four consisted of the total score on the subscales measuring these variables.
Because all the variables in this study were continuous variables, all four questions were answered using the paired-samples t-test. The paired-samples or dependent t-test is used when comparing “one group of people on two measures,” such as a pretest and posttest (LaFountain & Bartos, 2002, p. 186).

The researcher compared the sums of the results on both pre- and post-treatment questionnaires and for the subscales on all the research questions using the Statistical Package for the Social Sciences (SPSS) software. Such statistical analysis allowed examining the difference in means (Newcomer & Cogner). Descriptive statistics tables were also run on each of the secondary variables using SPSS and are illustrated under Results section.

According to Wholey and colleagues (2010), Evaluation studies are often performed with smaller sample sizes and their results might be applicable and worth discussing at confidence levels of 80-90 percent. In order to increase statistical power of this study and counter for smaller sample size, this study set the confidence level at 95 percent.

**Limitations of the study**

Internal validity is concerned with whether there is a” relationship between the dependent and independent variables” (LaFountain & Bartos, 2002, p. 67). The biggest threat to internal validity in this study was the fact that data were collected using non-standardized instruments and techniques, and no validity or reliability studies were conducted on the instruments prior to their implementation. As noted above, however, this is not an unusual circumstance when conducting naturalistic studies based (Wholey, Hatry, & Newcomer, 2010).
External validity refers to the generalizability of results (LaFountain & Bartos, 2002). External validity was not a major concern in this study, as the purpose of the study was to evaluate the effectiveness of how well this one program communicated its curriculum to its participants. The results of this study do not generalize to other domestic violence programs because this program was unique in its curriculum design, very specific population of court-referred female victims, and in its self-designed assessment instruments. Applicability to other programs may be found in the method used to evaluate the program.

This study used a sample of convenience. Participants were not randomly referred to the program, but were court referred. Consequently, there was no way to insure that participants were representative of victims of domestic violence in general. The results of this study are intended for use to evaluate this specific program and thus, inferences to generalization of results to other programs or groups should be avoided.
Chapter Four

Results

The findings in this chapter were the result of analyzing a local program for victims of Domestic Violence (DV) that consisted of a database on 677 women who enrolled in the domestic violence curriculum from January, 2010 through January, 2013. All the program participants were referred to the court by the local child protective service agency. Participants were subsequently referred to the domestic violence program by the court for the purposes of improving their ability to keep themselves and their children safe. The ultimate outcome of the program from the court’s point of view was reunification for these women with their children. The purpose of the domestic violence program was to teach the basic concepts of domestic violence, its impact on children, healthy self-esteem, and ways to protect themselves and their children. The purpose of this study was to analyze the program database to determine if participants who completed the program had learned the curriculum they were taught.

Demographics

After screening all 677 cases, 609 were eliminated because the data were incomplete, missing, or the individual did not complete the program. The sample consisted of 68 participants who had completed the questionnaire. Incomplete data sets and attrition are not an uncommon circumstance for community-based agency programs. An important practice would be to investigate and determine the reason why participants drop out. Staff could call the women after they have missed a session or two, explain the importance of the attendance and ask about the reasons they stopped attending. It is also helpful to include some type of incentives to motivate participants and increase
attendance and completion rates (Schlomer, Bauman, & Card, 2010). In fact, as Schlomer, Bauman, and Card indicate, missing data are reported in most studies in the behavioral sciences. Because no demographic data were accessible to the researcher for this study, explanation for incomplete data is very limited. According to the domestic violence program staff, many of the women who started the program, did not complete the program for various reasons, including mental health problems, addictions, relocation, limitation for transportation, and resistance to change (A. Abbott, personal communication, June 24, 2013).

In order to compare pre-program and post-program data, only completed cases were included in this study. Therefore, only 68 (10.04%) female participants had completed both the pre- and post-program questionnaires and were included in the analysis. No socio-demographic information about the sample is presented in this study because the agency where the program took place made the database available on condition that these data about participants not be disclosed.

**Data Screening**

**Group sizes and assumptions testing**

The study research questions were answered with the help of paired-samples t-tests. The total number of cases of pre-program and post-program were even numbered, which is an essential component of the paired-samples t-test analysis (Cone & Sharon, 2006). All predictor and criterion variables of the study were continuous variables. Other criteria for choosing paired-samples t-tests include independence of observations or sampling assumptions (the study included all participants who had completed both pre- and post-program questionnaires), and finally normal distribution of the dependent
variables (primary dependent variable is the overall post-program score and the secondary dependent variables are: [a] level of ability to identify types of domestic violence; [b] level of ability to define and identify ways domestic violence affects children; and [c] level of ability to identify ways to protect themselves and their children). Normal distribution of dependent variables is a function that represents “a distribution of values, that when graphed, produces a smooth, symmetrical bell-shaped distribution” (George & Mallery, 2006, p. 374).

Table 1

*Descriptive Statistics*

<table>
<thead>
<tr>
<th></th>
<th>Pre1 Types of DV</th>
<th>Pre2 Impact on Children</th>
<th>Pre3 Safety</th>
<th>Pre 4 Total Score</th>
<th>Post 1 Types of DV</th>
<th>Post 2 Impact on Children</th>
<th>Post 3 Safety</th>
<th>Post 4 Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N</strong></td>
<td>68</td>
<td>68</td>
<td>68</td>
<td>68</td>
<td>68</td>
<td>68</td>
<td>68</td>
<td>68</td>
</tr>
<tr>
<td><strong>Mean</strong></td>
<td>1.88</td>
<td>1.59</td>
<td>1.44</td>
<td>4.93</td>
<td>1.99</td>
<td>1.65</td>
<td>1.96</td>
<td>5.59</td>
</tr>
<tr>
<td><strong>Median</strong></td>
<td>2.00</td>
<td>2.00</td>
<td>2.00</td>
<td>5.00</td>
<td>2.00</td>
<td>2.00</td>
<td>2.00</td>
<td>6.00</td>
</tr>
<tr>
<td><strong>Mode</strong></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td><strong>Std. Deviation</strong></td>
<td>.368</td>
<td>.604</td>
<td>.699</td>
<td>1.213</td>
<td>.121</td>
<td>.540</td>
<td>.207</td>
<td>.652</td>
</tr>
<tr>
<td><strong>Range</strong></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>Minimum</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>Maximum</strong></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>6</td>
</tr>
</tbody>
</table>

As demonstrated in table 1.1, for variable “Identify types of DV,” on pre-questionnaire, the minimum value was 0 and maximum value was 2 with a range of 2. The mode was 2 and the median was 2. On post-questionnaire, the minimum value was 1 and the maximum value was 2 with a range of 1. The mode was 2 and median was 2.

For variable “Identify ways DV impacts children,” on pre-questionnaire, the minimum value was 0 and maximum value was 2 with a range of 2. The mode was 2 and
the median was 2. On post-questionnaire, the minimum value was 0 and maximum value was 2, with a range of 2. The mode was 2 and the median was 2.

For variable “Identify ways to keep yourself and your kids safe,” the minimum value was 0 and the maximum value was 2 with a range of 2. The mode was 2 and the median was 2. On post-questionnaire, the minimum value was 1 and maximum value was 2, with a range of 1. The mode was 2 and the median was 2.

On the total score, for pre-questionnaire, the minimum value was 1 and the maximum value was 6 with a range of 5. The mode and median were 6 and 5 respectively. For the post-questionnaire, the minimum value was 3 and the maximum value was 6 with a range of 3. The mode and median were both 6.

**Research Question 1**

A series of paired-samples t-tests were conducted to answer the research questions of this study. The first research question of this study was: Is there is a significant difference in participants’ total pre- and post-program questionnaire scores? The first paired-samples t-test was run to compare the total on pre- and post-program questionnaires. The level of significance was set at \( p \leq .05 \). There was a statistically significant difference in pre-program scores (\( M = 4.9, SD = 1.21 \)) and post-program questionnaire scores (\( M = 5.5, SD = .65 \)). The result of the paired samples t-test was significant, \( t(67) = -5.758, p = .000 \). As a result of the statistical analysis, the Null hypothesis was rejected. These results suggest that Domestic Violence Program participants’ post-program questionnaire scores significantly improved (increased) after they completed the curriculum. The results are illustrated in Table 2.
Table 2

*The Dependent t-test Result for the Difference in Pre- and Post-Program Questionnaire*

**Total Scores**

*Paired Samples Statistics*

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair 1 PreTotal</td>
<td>4.9118</td>
<td>68</td>
<td>1.21846</td>
<td>.14776</td>
</tr>
<tr>
<td>PostTotal</td>
<td>5.5882</td>
<td>68</td>
<td>.65187</td>
<td>.07905</td>
</tr>
</tbody>
</table>

*Paired Samples Test*

<table>
<thead>
<tr>
<th>Paired Differences</th>
<th>95% Confidence Interval of the Difference</th>
<th>Std.</th>
<th>Std. Error</th>
<th>Mean</th>
<th>Lower</th>
<th>Upper</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair 1 Pre Total</td>
<td></td>
<td>-.67647</td>
<td>.96878</td>
<td>.11748</td>
<td>-.91097</td>
<td>-.44197</td>
<td>-5.758</td>
<td>67</td>
<td>.000</td>
</tr>
</tbody>
</table>

**Research Question 2**

The second research question of this study was: Is there a significant difference in participants’ pre- and post-program questionnaire scores based on ability to define and identify types of domestic violence? The level of significance was set at $p < .05$. There was a statistically significant difference in the level of ability to identify types of domestic violence from pre-test ($M=1.88$, $SD=.37$) to post-test ($M = 1.99$, $SD = .12$) at $t(67) = -2.42$, $p = .018$. The results indicate that participants’ level of ability to define and identify types of domestic violence improved after they completed the program.
curriculum. Therefore, the researcher rejected the Null hypothesis. The results are illustrated in Table 3 below.

Because the range on the pretest and posttest was restricted (i.e., 0 to 2), descriptive data were used to determine if the improvements were clinically significant. Therefore, the researched examined each participant’s pretest score in comparison to posttest score to determine if the individual had moved to an improved category (e.g., from no credit/understanding to partial or partial to full understanding). On variable one, defining and identifying abuse, nine percent of the participants improved their score (i.e., moved from a 0 or 1 to a 1 or 2, moved from a 1 to a 2). It should be noted that on this variable, 91 percent of the participants were rated a 2 on the pretest. In descriptive statistics, the table demonstrates that 1 person had scored 0 and 6 participants had scored 1 on their pre-questionnaire, however on post they all moved to category 2 with exception of 1 person, who scored 1. It seems, even though most people were able to define and identify abuse and its types, those who did not score high on their pre-questionnaire, moved to score 2 on their post-questionnaire. This means, even if the magnitude of the change was not significant, change was still observed among those who had initially scored lower.

Table 3

*The Dependent t-test Result for the Difference in Pre- and Post-Program Questionnaire Scores Based on the Ability to Define and Identify Types of Domestic Violence*

*Paired Samples Statistics*

<table>
<thead>
<tr>
<th>Pair 2</th>
<th>Identify types of DV</th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post</td>
<td>Identify types of DV</td>
<td>1.99</td>
<td>68</td>
<td>.121</td>
<td>.015</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pair 2</th>
<th>Identify types of DV</th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post</td>
<td>Identify types of DV</td>
<td>1.88</td>
<td>68</td>
<td>.368</td>
<td>.045</td>
</tr>
</tbody>
</table>
**Paired Samples Test**

<table>
<thead>
<tr>
<th>Paired Differences</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Std.</td>
<td>Std. Error</td>
</tr>
<tr>
<td>Mean</td>
<td>Deviation</td>
</tr>
<tr>
<td>Pair 2</td>
<td>Pre- types of DV</td>
</tr>
<tr>
<td>Post- types of DV</td>
<td></td>
</tr>
</tbody>
</table>

**Descriptive Statistics**

<table>
<thead>
<tr>
<th>Identify Types of DV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale</td>
</tr>
<tr>
<td>Pretest</td>
</tr>
<tr>
<td>Posttest</td>
</tr>
</tbody>
</table>

**Research Question 3**

The third research question of this study was: Is there is a significant difference in participants’ total pre- and post-program questionnaire scores based on ability to identify ways Domestic Violence impacts children? The level of significance was set at $p < .05$. There was no statistically significant difference found in the pre-program ($M = 1.5$, $SD = .60$) and post-program questionnaire scores ($M = 1.6$, $SD = .54$) at $t(67) = -1.42$, $p = .159$. These data failed to reject the Null hypothesis. These results suggest that Domestic Violence Program participants’ post-program questionnaire scores on the level of ability to identify ways domestic violence impacts children did not change after they completed the curriculum. The results are illustrated in Table 4.
### Table 4

**The Dependent t-test Result for the Difference in Pre- and Post-Program Questionnaire Scores Based on the Ability to Identify Ways Domestic Violence Impacts Children**

**Paired Samples Statistics**

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Ways DV impacts children</td>
<td>1.59</td>
<td>68</td>
<td>.604</td>
<td>.073</td>
</tr>
<tr>
<td>Post-Ways DV impacts children</td>
<td>1.65</td>
<td>68</td>
<td>.540</td>
<td>.065</td>
</tr>
</tbody>
</table>

**Paired Samples Test**

<table>
<thead>
<tr>
<th></th>
<th>Paired Differences</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Std. Deviation</td>
</tr>
<tr>
<td>Pre- Ways DV impacts children</td>
<td>-.059</td>
<td>.340</td>
</tr>
<tr>
<td>Post- Ways DV impacts children</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Descriptive Statistics**

<table>
<thead>
<tr>
<th>Identify Ways DV Impacts Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>Pretest</td>
</tr>
<tr>
<td>Posttest</td>
</tr>
</tbody>
</table>
Research Question 4

The fourth research question of this study was: Is there a significant difference in participants’ pre- and post-program questionnaire scores based on the ability to identify ways to protect personal and child safety? The level of significance was set at $p \leq .05$. There was a statistically significant difference in the level of ability to identify types of domestic violence from pre-test ($M=1.44$, $SD=.69$) to post-test ($M = 1.96$, $SD =.20$) at $t(67) = -6.05$, $p = .000$. The results indicate that participants’ level of ability to identify ways to protect personal and child safety increased after they were administered the program curriculum. The results are illustrated in Table 5 below. Under this category, participants showed the most clinical difference in the increase of their scores from pre- to post-questionnaire. Eight people had scored 0 and 22 people had scored 1 on the pre-questionnaire scores, totaling in 38 responses that were scored 2. However, on post-questionnaire scores, no one scored 0 and only 3 people scored 1, totaling in 65 full and completely accurate responses. This means that 27 (40 percent) participants moved from a lower score to a higher score from pre- to post-treatment on their understanding and ability to identify ways to maintain self and children’s safety to prevent future exposure to violence.

Table 5

The Dependent t-test Result for the Difference in Pre- and Post-Program Questionnaire Scores Based on the Ability to Identify Ways to Protect Personal and Child Safety

<table>
<thead>
<tr>
<th>Paired Samples Statistics</th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair 4</td>
<td>1.44</td>
<td>68</td>
<td>.699</td>
<td>.085</td>
</tr>
</tbody>
</table>
**Paired Samples Test**

<table>
<thead>
<tr>
<th>Paired Differences</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Std. Deviation</td>
<td>95% Confidence Interval of the Difference</td>
</tr>
<tr>
<td>Mean</td>
<td>n</td>
</tr>
<tr>
<td>Pre- Ways for safety</td>
<td>-.515</td>
</tr>
<tr>
<td>Post- Ways for safety</td>
<td>1.96</td>
</tr>
</tbody>
</table>

**Descriptive Statistics**

<table>
<thead>
<tr>
<th>Identify Ways to Keep Yourself &amp; Kids Safe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Pretest</td>
</tr>
<tr>
<td>Posttest</td>
</tr>
</tbody>
</table>

Observation of descriptive data table shows that the clinical significance is not as high in this study as the statistical significance. On two variables, participants showed increased scores and a move from one category (score 0 or 1) to the next (score 1 or 2). Participants demonstrated very minimal difference in their responses to one variable (identify ways DV impacts children) between the time they started the program and when they graduated. However, on the last variable (identify ways to keep self and children safe), participants went from 38 responses scored 2 to 65 that scored 2. Eight responses that were 0 had moved to 2, and 22 responses that were previously 1 had reduced to only
3. It is suggested that the wording of the questions, the construction of the questionnaire and other test quality issues may be responsible for smaller results. For example, on pre-questionnaire the first question reads as: “Name three types of abuse” and on post-questionnaire it reads as: “What is the definition of domestic violence? What are some examples of these common domestic violence tactics? Name at least 2-3” and lists the types. This difference between wording of questions could have been responsible for very minimal changes in participants responses. It looks like they were required to respond to less on the pre- than on the post-questionnaire. Thus, most participants scored quite high on their pre-questionnaire and did not show much clinical difference when exiting the treatment.

**Summary**

The results of this study revealed that the domestic violence program’s participants’ total scores on the post-program questionnaire were significantly higher after they completed both phases of the program. The levels of ability to define and identify types of domestic violence, as well as the level of the ability to identify ways to protect personal and child safety also increased significantly between pre- and post-program questionnaire scores. However, the level of ability to identify ways domestic violence impacts children did not differ significantly between pre- and post-program questionnaire scores. Thus, the researcher failed to reject the null hypothesis on Research Question 3. The rest of the null hypotheses were rejected in this study.

Regarding the clinical significance of the study, participants showed increased change on two variables out of three (excluding the total scores). Participants’ knowledge and ability to identify ways they can keep themselves and their children safe had moved
from 0 to 2 for eight participants and from 1 to 2 for 19 participants. This shows that even though the wording of the questionnaires administered during the pre- and post-phases might have differed slightly causing change in some responses not to be as expressed, participants overall finished the program knowing more and capable of more (skills on keeping themselves and their children safe).
Chapter Five

Discussion

The purpose of this study was to demonstrate that it was possible to evaluate whether a 16-week domestic violence (DV) program was effective in teaching its curriculum to domestic violence victims. Mainly, whether the program effectively taught the women how to identify abuse, impact of domestic violence on children, and safety planning/maintenance. The researcher attempted to establish if there was any change in domestic violence victims’ response to pre-program versus post-program questionnaires. This approach was used to demonstrate if the program was effective, in that whether or not participants had learned the curriculum being taught by the program staff. The researcher also hoped to determine whether there was a change in participants’ identification of abilities between pre- and post-program questionnaire scores, such as, whether or not participants were able to expand on their description of domestic violence types and in what ways these different types play out in life. Finally, the researcher hoped to demonstrate that it was possible to conduct an effective program evaluation using only data collected by an agency that had not anticipated conducting a program evaluation.

The researcher analyzed the domestic violence program database that included a total of 677 cases collected between January, 2010, and January, 2013. The database consisted of participant responses to pre- and post-program questionnaires which were designed by the staff. No validity and reliability studies had been conducted on these questionnaires. The domestic violence program staff administered these questionnaires as a part of program participants’ assessment process. The participants, all female, were referred to the domestic violence program by the court due to children’s services.
determination of child exposure to domestic violence. These women were required to participate in a 16-week, two-phased domestic violence program to increase their knowledge and understanding of domestic violence, ways domestic violence impacts children, and how they can keep themselves and their children safe. Courts typically allowed women to receive their children back upon successful completion of the domestic violence program.

**Summary of Results**

Four research questions and four null hypotheses were analyzed in this study. The research questions were answered with the help of paired-samples t-tests. The researcher found that the domestic violence program’s participants’ post-program scores on basic knowledge and awareness of domestic violence significantly increased after they completed both phases of the domestic violence program curriculum. Only post-program scores on the level of ability to identify ways domestic violence impacts children did not change significantly from the time they entered the program and the time they completed the curriculum.

Significance levels for all hypotheses were set at $p < .05$. Data analysis yielded the following results:

1. Is there a significant difference in participants’ total pre- and post-program questionnaire scores?

   Null Hypothesis: There is no statistically significant difference in participants’ total pre- and post-program questionnaire scores.
The researcher rejected the null hypothesis because the result of the dependent t-test was statistically significant ($p = .000$).

2. Is there a significant difference in participants’ pre- and post-program questionnaire scores based on the ability to define and identify types of domestic violence?
Null hypothesis: There is no statistically significant difference in participants’ pre- and post-program questionnaire scores based on the ability to define and identify types of domestic violence.

The researcher rejected the null hypothesis because the result of the dependent t-test was statistically significant ($p = .018$).

3. Is there a significant difference in participants’ pre- and post-program questionnaire scores based on the ability to identify ways domestic violence impacts children?
Null hypothesis: There is no statistically significant difference in participants’ pre- and post-program questionnaire scores based on the ability to identify ways domestic violence impacts children.

The researcher failed to reject the null hypothesis because the result of the dependent t-test was not statistically significant ($p = .159$).

4. Is there a significant difference in participants’ pre- and post-program questionnaire scores based on the ability to identify ways to protect personal & child safety?
Null hypothesis: There is no statistically significant difference in participants’ pre- and post-program questionnaire scores based on the ability to identify ways to protect personal & child safety.
The researcher rejected the null hypothesis because the result of the dependent t-test was statistically significant \( p = .000 \).

**Clinical Significance**

The analysis of descriptive data table indicates that even though the statistical significance of this study is much higher, the clinical significance is also noted. On two out of three variables (excluding the variable on total of overall scores), participants showed increased scores and a move from one category (score 0 or 1) to the next (score 1 or 2). Participants demonstrated very minimal difference in their responses to one variable (identify ways DV impacts children) between the time they started the program and when they graduated. However, on the last variable (identify ways to keep self and children safe), participants went from 38 (56 percent) responses scored 2 to 65 (95.5 percent) that scored 2. Eight responses that were 0 had moved to 2, and 22 responses that were previously 1 had reduced to 3.

The researcher suggests that the wording of the questions, the construction of the questionnaire and other test quality issues may be responsible for smaller results for the questions that did not show significant differences between pre- and post- scores. For example, on pre-questionnaire the first question reads as: “Name three types of abuse” and on post-questionnaire it reads as: “What is the definition of domestic violence? What are some examples of these common domestic violence tactics? Name at least 2-3” and lists the types. This difference between wording of questions could have been responsible for very minimal changes in participants responses. It looks like they were required to respond to less on the pre- than on the post-questionnaire. Thus, most participants scored
quite high on their pre-questionnaire and did not show much clinical difference when exiting the treatment.

**Implications of the Study**

In this study, the researcher found that the domestic violence program’s participants’ post-program scores on basic knowledge and awareness of domestic violence significantly increased after they completed both phases of the domestic violence program curriculum. Only post-program scores on the level of ability to identify ways domestic violence impacts children did not change significantly from the time they entered the program and the time they completed the curriculum.

This research demonstrates that the overall domestic violence program curriculum did help increase female victims’ understanding and awareness of ways they can protect themselves and their children from abusive relationships as measured by the pre- and post-program questionnaires. The results also show that the curriculum was not as effective at increasing understanding and awareness of domestic violence and no statistically significant result in increasing understanding and awareness of the impact of domestic violence on children.

Analyzing the results on the tables illustrated in sections above, the most beneficial area in which participants grew significantly in their knowledge and abilities was identifying ways they can keep themselves and their children safe, maintaining that safety to prevent potential exposure to violence in future. The next area in which the women also showed some change, even though not as significant as in the previous one, was defining domestic violence and identifying types of abuse. One person moved from not having any response to having an accurate response, and five people moved from
having a partial understanding to a full understanding. And finally, the last area, identifying ways domestic violence affects children by exposure to violence, most women already had at least a partial answer that might have not been a full answer, but included the answer to some extent. And out of four women who did not know about the damages of domestic violence on their children, two moved a category up, which means, their knowledge and understanding improved from pre- to post-test. This area seems to have the least effect on women, perhaps because they already had some understanding about the damage of violence exposure on their children, but they couldn’t really express what and how much they knew because the questions did not solicit such details on pre- and post-questionnaires consistently. Perhaps, it could be explained by the fact that they were referred by the children’s protective services and thus they were careful how much they actually reveal about their awareness and understanding as to what damaging effect exposure to violence has on children. Even then, the overwhelming majority of these women had some awareness about the matter (20 of them, which is 30 percent of the target population, had a partial, accurate answer and 44 (65 percent) had a full, accurate answer).

The study results did not indicate a statistically significant difference between participants’ scores on pre- and post-program questionnaires on the ability to identify ways domestic violence impacts children. The clinical significance of the results on this variable was also low. This means that women’s understanding on how domestic violence can affect their children who are exposed to violence in their households were not reflected in participants’ responses on the questionnaire. A possible explanation for this could be these women were referred by child protective services and therefore
already had some understanding or realization that domestic violence adversely affects children in numerous psychological and physiological ways. Another explanation might be that the questionnaires were ineffective at assessing improvement. A final explanation may be that the curriculum is not as effective at teaching this information. It is possible that the questions asked or the wording of the questions do not allow these women to express accurately how much they have actually learned from the curriculum. Perhaps, it would be better to ask them to illustrate examples of each of the types with scenarios where women could express their understanding of each of the types rather than simply repeating a word or two from the definition they have learned. This could accurately reflect whether or not there is a difference in their knowledge and understanding of the problem between the time they enter the program and when they graduate.

The overall results of this study were consistent with those found by Bennett et al. (2004) which revealed that even when considering all limitations of such a study, the results still indicate that:

(a) domestic violence victims gain important information about violence and increase their support during their participation in domestic violence counseling, advocacy, and hotline services… (c) domestic violence victims increase their self-efficacy and coping skills while participating in domestic violence counseling programs… and (e) the effects of domestic violence counseling programs are small but significant. (p. 826)

The results of this study are not generalizable to other domestic violence programs because the curriculum is unique to the study domestic violence program. In addition, the program did not permit access to demographic information due to
confidentiality concerns. Without these data, it is not possible to determine how this sample of domestic violence victims may compare to others.

**Limitations of the Study**

This study included all the female domestic violence victims who completed the program between January, 2010, and January, 2013. Due to a large number of incomplete cases, however, it is impossible to establish whether or not the sample is representative of the local domestic violence victim population since no information is available about those who did not complete the program to draw comparison analysis between completer and non-completer groups.

Limitations of this study include the following: (a) instruments were created by the staff of the domestic violence program and no reliability and validity studies had been employed to establish this instrument’s psychometric capacities, however the staff had created questions on the questionnaire that linked directly to the curriculum they taught (for example, in the first section of their curriculum they teach extensively about what domestic violence is, what types of abuse there are, and how these types may be expressed in real life situations); (b) data were self-reported (because these women were referred by the court and had been there due to the children’s protective services, it is possible that their responses were influenced by certain degree of anxiety and fear as to how anything they say will be used against them in judge’s decision regarding their child’s custody); (c) all participants were court-referred, which means their responses could have been affected by the fact that they knew the chance to receive their children back depended on the successful completion of the program, also their motivation to learn and improve could have been affected by the desire to please the staff and the court
in order to obtain their child’s custody, rather than being self-motivated, and desiring to understand what and why they need to change for their own sake and for their children; and (d) substantial portions of data were missing, this could have been due to attrition and/or poor data collection procedures. It is important, however, to note that these limitations are practically identical two another research studies’ limitations which were identified by Bennett et al. (2004) and Sullivan, Egan, and Gooch (2004) and are actually, significantly less as compared to the aforementioned studies. Unfortunately, there is no right way of dealing with the problem of attrition, other than recognizing the fact and including it in the explanation of results and limitations. Many agencies that run court-mandated programs face high drop-out rates (Bennett et al., 2004) and this could be because of the fact that they are forced to enroll rather than admitting themselves.

This research only represents changes in scores on pre- and post-program questionnaires and did not examine whether this resulted in actual behavior change. In addition, the research did not involve studying whether these changes were stable over time or if there was loss of learning. This research was conducted in a naturalistic environment where the researcher had no control over the group sizes and selection was not random. In addition, the data were already collected and the researcher only had access to the content of the questionnaire and no identifying data. This limits the chance to describe the participants who did not complete the program and how they can be compared to the sample of this study who completed the program.

A final purpose of this study was to demonstrate if and how program evaluation in naturalistic environments with already collected data can be performed. Such a study could help staffs to demonstrate the effectiveness of their programs, find areas that need
to be changed, improved or omitted, and at the same time would help them provide strong data for third-party-payers who are all the interested stake-holders investing money into the program.

The results of this study showed that, though with many challenges, it is indeed possible to walk into an agency which has conducted its own programs with its own instruments and data collection, and implement program evaluation that is both time and cost-efficient. Ways to minimize challenges that were described under *Limitations* will be illustrated below.

**Future Recommendations**

With growing need to involve third-party providers to fund mental health agency programs, professionals are increasingly pressured to perform evaluations to show outcomes that indicate whether or not the program is effective in meeting its goal(s) to its target population. This also includes the essential need for keeping organized, detailed records about each intervention provided and the outcomes produced by these interventions (Astramovich & Coker, 2007). Agency mental health providers report receiving pressure from third-party payers and being overwhelmed by the demands of managed care to continuously demonstrate technical proficiency and services that are time and cost-efficient when they are already understaffed in providing best care for their clients (Astramovich & Coker). Such demands are especially challenging for mental health professionals due to the fact that they rarely receive any training in program evaluation (Granello & Hill, 2003). In order for mental health counselors to be “accepted as legitimate mental health providers” the ability to document outcomes and identify
effective treatment is critical so that they can “further the professional identity of mental health counselors within the mental health professions” (Astramovich & Coker, p. 165).

Nationwide studies have confirmed that evaluation practices are “becoming an inseparable part of public health” (Centers for Disease Control and Prevention [CDC], 2013). Oetting (1982) developed a framework which lays out step-by-step decision matrix for program evaluation process for health-care services professionals (see appendix 1.4). More recently, the CDC has created a framework for program evaluation for all public health services and professionals (see appendices 1.2 & 1.3). Astramovich and Coker (2007) also have designed a diagram of the continuous process of program evaluation as an accountability bridge, emphasizing collaboration between various units of the services and agencies (see appendix 1.1).

These models can be very helpful to professionals who provide counseling services and are required to demonstrate program evaluation with limited skills and training. For the program examined in this study, the researcher recommends the following steps in order to help guide the staff in further actions for improving the program, their services to their clients, as well as their method of demonstrating outcome data to third-party payers.

**Short-Term & Ongoing Recommendations**

1. Collaborate with other agencies and institutions: invite interns from counseling and related departments to assist in your services delivery, documentation, archiving, electronic database maintenance, and ongoing monitoring. Specifically, invite interns to work with your staff and regularly develop knowledge and methodology exchange seminars to go over various
practices and receive feedback for improvement. Enroll interns and delegate the work so that collaboration between the program staff and the interns (and their university/program) helps improve the agency’s work, preparing for ongoing evaluation and takes some of the load off of the main staff’s plate.

2. Review assessment instrument: consult with other similar agencies and programs about what standardized tools they are using for similar services and population; find appropriate standardized tools that fit the specific needs of the program clientele; if none is found – collaborate/consult with professionals to standardize existing questionnaires. Specifically, the program staff can consult with other programs in other locations that are also doing program evaluation and collaborate on adapting a questionnaire or a survey. Or consult with research interns from local universities who can collaborate with the agency by doing their required internships at the site and in return help the agency with developing surveys or questionnaires that fit the specific needs of the clientele and program goals. In addition, surveys do not need to be standardized and are a better choice for similar programs for the specific clientele and treatment goals. The agency staff can develop their own survey or can consult with interns from research classes to help them develop surveys that accurately reflect the curriculum taught and have accurate, simple and clear wording (Salant & Dillman, 1994). (Please, see Best Practices Manual samples included in the Reference list.)

3. Administer the same questionnaire or survey as a pre- and post-assessment for consistency and accuracy of results. Distribute the questionnaires to each
group before they start the program and the day they finish the program. It is helpful for more accurate results to use the same tool for all groups. For example, the program discussed in this study had various questionnaires for each phase and it created some confusion when trying to match the pre- and post-questionnaires on their questions. Also, the program modified the questionnaire several times in between groups and thus ended up having different questions for different groups. It is more efficient to administer one questionnaire as a pre- and post-assessment tool, even if you use other assessment tools in between sections of your curriculum as additional assignments, but for the final evaluation procedure use the one questionnaire that includes all the questions that reflect the entire curriculum as pre- and post-treatment assessment. The one questionnaire needs to have the same exact questions with the same exact wording so that the calculation of scores will be accurate and the results will truly reflect the program’s effectiveness (Salant & Dillman, 1994).

4. Develop better follow-up procedures to ensure higher completion rates. For example, have the staff check on participants while they are filling out the questionnaire and ask if they need any help with understanding the questions, or anything else they may need, provide a safe environment where they can have some privacy if needed to ensure high completion rate. For example, ask that each participant fills out the questionnaire and check the sheet before the person leaves to ensure the questionnaires were fully completed. This will
help insure that future databases contain complete data on every participant in
the program.

**Long-Term and Ongoing Recommendations**

1. Create an electronic database of all client files and update continuously. Most
researchers agree that proper documentation and database maintenance is vital
to quality program development and evaluation (Royse, Thyer, & Padgett,
2006; Sullivan & Coats, 2000, & Lyon & Sullivan, 2007). In the case of this
very study, it would help greatly to run an excel sheet and enter every
participants data, such as name, any demographic data available, date the
person entered the program, status – active, missing sessions, follow-up letter
or call sent or not sent, not attending, terminated without completion,
graduated with full completion; and status of assignments that were required,
as well as pre- and post-questionnaire completion status. The database would
need to be backed up and continuously updated and saved to run up-to-date
information that is safe. This way, when a report is needed on the program
progress, or each participant’s progress, the staff doesn’t need to locate a file
and look for pieces of papers to sum up a report, but it will all be in one place,
regularly updated. This will also help with regular and ongoing program
evaluation activities. Another running database can have an entry of their pre-
and post-questionnaire scores on each variable and a total.

2. Redesign the system for paper-file archiving: divide files into separate
sections by year and within each year category organize files alphabetically.
For example, instead of having all files in several different file-cabinets or
drawers with no organization, divide files into sections by year first and assign a cabinet/drawer for that one year, within which organize the files alphabetically. On the label of each file have the name, the year, as well as the status of the client, such as “active”, “terminated without completion”, “completed”, “returning”, and so on. Organizing data and client/participant files helps with more effective case management and makes follow-up procedures easier (Lyon & Sullivan, 2007).

3. Conduct ongoing audit of documentation and service quality: invite outside para-professionals for objectivity purposes or include interns in these procedures. For example, develop a checklist and have an intern or staff of another program within the same agency help you check all your database (paper-based and electronic) to ensure all information is up-to-date and in place. For services satisfaction assessment, ask participants to give the staff anonymous feedback on what needs to be improved.

4. Conduct ongoing needs assessment: every 6 months or annually for timely actions. For example, ask participants what they would like to learn and obtain in order to become more confident, knowledgeable about domestic violence tactics and red-flags as well as about ways they can maintain safety for themselves and their children. Ask how they would like to learn all these elements, via what specific methods. Perhaps, they can ask you to include methods of which you have not thought of yet, and the inclusion of which can enhance participants’ learning. Update the curriculum based on feedback received from participants. Formative feedback from clients can help the staff
continuously improve the program and be aware of any element needing attention in timely manner.

5. Conduct ongoing program evaluation based on needs assessment outcomes. For example, once the needs assessment is completed, incorporate that into program evaluation after those elements are integrated into the updated program. Include a feedback from participants as to how satisfied they were with the staff on including them into program development procedures and improvement of services and whether or not they were satisfied with the results of those changes (see Appendix 2.3 for a sample).

Future research study should focus on evaluations discovering whether or not the participants retained information taught over time and if they were able to put the information learned in real-life practice. Future research should also focus on finding whether or not these women returned to abusive relationships or were able to obtain healthy and safe relationships.

**Brief Report Summary to the Program Staff**

In addition to the entire report on the results and their statistical as well as clinical significance, and in addition to the list of recommendations, this section can help guide the program staff as to what exactly needs to be changed and improved.

Even though the researcher was able to use the existing questionnaire, match three main questions on pre- and post-program completion, and code the responses, it would be more practical and easier to measure, if the program adapts an already existing questionnaire from a program that has already been found effective (see Arizona Coalition Against Domestic Violence (2000) manual, Center for Disease Control and
Prevention manual, and the appendices provided in this study). Another option could serve including interns from a local university to help with program development and evaluation procedures. In collaboration with specialists, the staff can develop a survey, a Likert scale which can be of more practical use and will be easier to measure. The staff needs to use the same exact survey as a pre- and post-assessment tool, while incorporating all data into the regularly maintained database.

The curriculum seems to match the research on domestic violence and what themes appear to reoccur among victims. However, questions on questionnaires do not accurately reflect the curriculum. For example, the question on defining and identifying domestic violence and types of abuse has a different wording on pre- and post-questionnaire. Consistency is vital for accurate results. Also, since this question has the least significant results, it can be helpful to change it to asking them illustrate scenarios in which the types they identified may play out, and take out the list of types of abuse so the participants identify those on their own.

The staff may also benefit from choosing a few more themes, like identifying red-flags of abusive relationships, and add a question on this theme on the pre- and post-questionnaire. This can assess whether or not they are learning the curriculum and retaining the information.

For question, identify ways domestic violence affects children, ask specifically to describe how that type of damage can be demonstrated. For example, the women identify one or two ways, physically and psychologically, but do not describe what that looks like. This way you can assess if they are only repeating words they are hearing, or are truly understanding the impact and extend to which domestic violence can damage children.
For question on safety, ask in what ways they can maintain the safety of their own and that of their children. If asking “do you know ways?” the response can only include “yes” or “no”. Very few participants went into details as to how they can maintain their safety and prevent future exposure to violence. Other questions may include self-esteem and self-image.
Conclusion

In this study, the researcher found that the domestic violence (DV) program participants attained the information delivered by the curriculum which is designed by the staff. The results revealed statistically significant increases in participants’ scores on their post-program questionnaire after completing the program. With an exclusion of the level of ability to identify the impact of domestic violence on children, all the rest of the variables showed statistically significant difference between pre- and post-program questionnaires.

Clinical significance of the study lies within two main variables. The most beneficial area in which participants grew significantly in their knowledge and abilities was identifying ways they can keep themselves and their children safe, maintaining that safety to prevent potential exposure to violence in future. The second area in which women approved was identifying ways domestic violence affects children by exposure to violence. Most women already had at least a partial answer that might have not been a full answer, but included the answer to some extent. And out of four women who did not know about the damages of domestic violence on their children, two moved a category up. This area seems to have the least effect on women. The overwhelming majority of these women had some awareness about the matter (20 of them had a partial, accurate answer and 44 had a full, accurate answer). The last area was very similar to the previous one in that small change existed, however the improvement was significant for the one person who did not know anything about the definition and types of abuse/violence and after completion of the program, moved two categories up. In addition, five women
moved from knowing something about the definition and types of domestic violence to knowing it fully.

This study did not assess whether or not the participants retained the information over time and whether they were able to maintain their safety after they completed the program. Future program evaluation can examine how many women return to the program within years because of re-exposure to violence.

The results of this study revealed that it is feasible to evaluate a program in its natural environment with already collected data which were obtained through assessment instruments that were not standardized. Based on the results of this study, the domestic violence program staff discussed above can demonstrate measurable and statistically significant outcomes of their services to their third-party payers. They can also use this information and the suggestions presented in this chapter to improve their pre-planning activities for further program evaluation activities in order to improve their services. The agency can use the appendices provided in this study to help them plan, develop, evaluate and deliver results of their program more efficiently. For example, they can follow practical steps recommended by researchers, illustrated in the appendices attached to this manuscript. Program staff can also benefit from the forms that Arizona Coalition Against Domestic Violence has provided in their *Best Practices Manual* (2000). A few samples of evaluation questionnaires are provided under appendices 2.3 and 2.4.
References


doi:10.1080/13575270701353465


http://www.cdc.gov/ViolencePrevention/NISVS/index.html


doi:10.1177/1066480708317670


Appendix A

The Accountability Bridge Model for Counselors by Astramovich and Coker (2007)
Appendix B

Framework for Program Evaluation by CDC
Appendix C

Steps in Evaluation Practice and Standards for Effective Evaluation by CDC

• Engage stakeholders

Those persons involved in or affected by program and primary users of the evaluation.

• Describe the program

Need, expected effects, activities, resources, stage, context, logic model.

• Focus the evaluation design

Purpose, users, uses, questions, methods, agreements.

• Gather credible evidence

Indicators, sources, quality, quantity, logistics.

• Justify conclusions

Standards, analysis/synthesis, interpretation, judgment, recommendations.

• Ensure use and share lessons learned

Design, preparation, feedback, follow-up, dissemination.

Standards for Effective Evaluation

• Utility

Serve the information needs of intended users.

• Feasibility

Be realistic, prudent, diplomatic, and frugal.

• Propriety

Behave legally, ethically, & with regard for the welfare of those involved and affected.

• Accuracy

Reveal and convey technically accurate information.
Appendix D

A Decision Matrix for Selecting a Research Design for PE

**TABLE 1**

A Decision Matrix for Selecting a Research Design for Program Evaluation

AFTER THE FIRST QUESTION, EVERY RESPONSE OF “YES” LEADS TO A BETTER DESIGN.

Note: If possible, *always* add a follow-up to the selected design.

1. Are you testing a clearly defined program *and* are you concerned with either whether it works or how well it works?
   - If NO, seek a consultant; this table is not appropriate.
   - If YES, go on.

2. Is the program to be tested still in the future?
   - If NO, go to Question 7.
   - If YES, go on.

3. Can a comparison group be found?
   - If NO, go to Question 10.
   - If YES, choose the type of comparison group by deciding which of the following questions you want answered:
     a. Does the program work?
        Use a wait-list or a no-treatment comparison group.
     b. Does it work better than the usual system (or better than another program)?
        Use your usual program or the other program as a comparison. (WARNING: It is hard to show a difference between two fairly effective programs.)
     c. Does the program work because of its content or just because a program was given?
        Use a placebo program, one that has everything but what you feel are the effective program elements.
   After choosing a comparison group, go on.
4. Can you use random assignment?

   If NO, go to Question 7.
   If YES, go on.

5. Before assignment, can you sort people on characteristics that might relate to program impacts (e.g., sex, age, socioeconomic status, ability, personality)?

   If NO, blocking is not possible, go on.
   If YES, use blocking; match people on important characteristics, randomly assign one of each pair to your program and the other to the comparison group. Go on.

6. Do you have really good outcome measures, both reliable and valid?

   If YES . . .
   and blocking is possible, the design is:
   Two groups, blocking-program-posttest only

   and blocking is not possible, the design is:
   Two groups, random assignment-program-posttest only

   If NO . . .
   and blocking is possible, the design is:
   Two groups, blocking-pretest-program-posttest
   (If a pretest is not possible, use a posttest only.)

   and blocking is not possible, the design is:
   Two groups, random assignment-pretest-program-posttest
   (If a pretest is not possible, use a posttest only.)

   NOTE: Any of the above designs are very good. They can lead to results with few important alternative explanations.

7. Can you locate two similar groups, one of which will have (or already had) the program?
   If NO, go to Question 10.
   If YES, go on.
8. Can you give a pretest?

Decide and go on.

9. Can you match samples, that is, match people in the two groups who have similar important characteristics?

If YES . . .
and pretest is possible, the design is:
Two groups (matched sample), pretest-program-posttest
and a pretest is not possible, the design is:
Two groups (matched sample), program-posttest

If NO . . .
and a pretest is possible, the design is:
Two groups (preformed), pretest-program-posttest
(Note: The above three designs are good. The results may be useful.)
and a pretest is not possible, the design is:
Two groups (preformed), program-posttest
Treat results with caution: the groups may have been different before the program started.

10. Below this line, you have only one group. Reconsider!
Can you find a comparison group?

If YES, return to Question 2.
If NO, go on.

11. Can you establish a base line by giving more than one pretest?

Decide and go on.

12. Can you check on differential effects (whether the program was more effective in one or more subgroups?)

If YES, the design is:
(Identify predetermined subgroups) pretest-time lapse-second pretest-program-posttest, or;
(Identify predetermined subgroups) pretest-program-posttest
If NO, the design is:
One group, pretest-time lapse-second pretest program-posttest, or;
One group, pretest-program-posttest
(Treat results with caution for any of these designs)

13. You have only one group and only a posttest.

Ask useful questions.
Ask “Now-then” questions.
Use naturalistic observation.
Do program monitoring.

Created by E. R. Oetting (1982).
Appendix E

The Program Development/Evaluation Cycle

- Project planning/modification
- Needs assessment and collection of baseline data
- Project implementation
- Project evaluation
Appendix F

Types of Program Evaluations

Evaluation

Formative
Implementation

Summative
Progress

Early stages
Later stages

Time
## Appendix G

The NIJ Drug Court Performance Measures and Program Evaluation

### Adult Drug Court Program Logic Model

A logic model can help drug court teams clarify how, in the context of their target population and environment, resources should support program activities and intended outcomes.

<table>
<thead>
<tr>
<th>INPUTS</th>
<th>ACTIVITIES</th>
<th>OUTPUTS</th>
<th>SHORT-TERM OUTCOMES</th>
<th>LONG-TERM OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probation</td>
<td>Risk/needs assessment</td>
<td>Program intake screen</td>
<td>Recidivism in-program</td>
<td>Recidivism post-program</td>
</tr>
<tr>
<td>Community</td>
<td>Judicial interaction</td>
<td>Court appearances</td>
<td>Alcohol and other drug use in-program</td>
<td>Alcohol and other drug relapse post-program</td>
</tr>
<tr>
<td>Public resources</td>
<td>Alcohol and other drug monitoring (including testing)</td>
<td>Treatment admission</td>
<td>Supervision violation</td>
<td>Program graduation/termination</td>
</tr>
<tr>
<td>Courthouse</td>
<td>Community supervision</td>
<td>Alcohol and other drug tests</td>
<td>Program violation</td>
<td>Probation revocation/successful termination</td>
</tr>
<tr>
<td>Treatment</td>
<td>Graduated sanctions/incentives (including jail)</td>
<td>Probation contacts</td>
<td>Treatment retention</td>
<td>Jail/prison imposed</td>
</tr>
<tr>
<td>Jail</td>
<td>Alcohol and other drug treatment services</td>
<td>Classes attended</td>
<td>Skills development</td>
<td>Employment/education/housing/health</td>
</tr>
<tr>
<td>Grant funds</td>
<td>Ancillary services</td>
<td>Services accessed</td>
<td>Service needs met</td>
<td></td>
</tr>
<tr>
<td>Technical assistance</td>
<td></td>
<td>Jail stays</td>
<td>Criminal thinking</td>
<td></td>
</tr>
</tbody>
</table>

### EXTERNAL FACTORS

- Community (including Tribal Council)
- Legal/penal code
- Courthouse
- Defendant/offender
Appendix H

Aftercare: Ratings

The MPG evidence ratings are based on the evaluation literature of specific prevention and intervention programs. The overall rating is derived from four summary dimensions of program effectiveness:

- The conceptual framework of the program
- The program fidelity
- The evaluation design
- The empirical evidence demonstrating the prevention or reduction of problem behavior; the reduction of risk factors related to problem behavior; or the enhancement of protective factors related to problem behavior

The effectiveness dimensions as well as the overall scores are used to classify programs into three categories that are designed to provide the user with a summary knowledge base of the research supporting a particular program. A brief description of the rating criteria is provided below.

**Exemplary**
In general, when implemented with a high degree of fidelity these programs demonstrate robust empirical findings using a reputable conceptual framework and an evaluation design of the highest quality (experimental).

**Effective**
In general, when implemented with sufficient fidelity these programs demonstrate adequate empirical findings using a sound conceptual framework and an evaluation design of the high quality (quasi-experimental).

**Promising**
In general, when implemented with minimal fidelity these programs demonstrate promising (perhaps inconsistent) empirical findings using a reasonable conceptual framework and a limited evaluation design that requires causal confirmation using more appropriate experimental techniques.
Appendix I
Curriculum One

Empowering Families to Manage Life’s Challenges

Curriculum for Project Genesis Support Group
Eight Week Basic Education- Phase 1

Week One: Definition of Domestic Violence
Types of Abuse, and Red Flags.
Week Two: Biderman’s Chart.
Week Three: Grief, Tears and How to Cope After an Abusive Relationship.
Week Four: Movie: “It’s Not Like I Hit Her”
Homework Assignment: How does this video relate to you?
Week Five: Safety Planning with You and Your Children.
Complete Safety Plan.
Week Seven: Why We Stay in Abusive Relationships.
Week Eight: Self Assessment, What Have You Learned?
Economic Empowerment Group.

Curriculum is subject to change ☺
Appendix J

Curriculum two

Empowering Families to Manage Life's Challenges

Curriculum for
Project Genesis Support Group
Phase 2 Regular Support Groups

Week 9: Healthy relationships/ equality wheel
Week 10: Healthy relationships can’t, setting personal boundaries, Homework Assignment: Cost and Benefit Analysis.
Week 11: Positive Self Talk, Homework Assignment: Self-Esteem Prepare for Speaker
Week 12: Why Does He Do That/ Belief System/ Speaker
Week 13: Domestic Violence Video’s
Week 14: Video can’t/ process video
Week 15: Being Assertive versus Aggressive
Week 16: What Do You Want Out of a Relationship/ Building Trust.

Curriculum is subject to change 😊

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Appendix K

Questionnaire: Items that Reflect the Research Questions of this Study

Research Question 1

The means of totals on Pre and Post

Research Question 2

1. What is the definition of domestic violence?

2. What are some examples of these common domestic violence tactics? Name at least 2-3 for each. Describe:

Physical

________________________________________________________________________

Verbal

________________________________________________________________________

Emotional

________________________________________________________________________

Sexual

________________________________________________________________________

Financial

________________________________________________________________________

Research Question 3

1. List ways children are affected by domestic violence.

2. What are some ways that infants are affected by domestic violence?

3. What are some ways that teenagers are affected by domestic violence?
Research Question 4

1. Do you know ways to keep yourself and your kids safe?

   Safety Plan

   ________________________________________________________________

2. Do you feel confident that you can identify domestic violence red flags in a new or current relationship?
Appendix L

Sample Feedback Questionnaire

By Arizona Coalition Against Domestic Violence (2000), p. 86

Evaluation by Clients

Staff may want to consider using an evaluation process to allow participants to provide feedback. Evaluation can be done on a regular basis (i.e., weekly, monthly, etc.) or when the group’s work is completed (either when the group has finished or an individual is leaving the group). A program may want to include the following questions on an evaluation tool:

- Was this group helpful for you, and if yes, how?
- What aspect of the group was most helpful?
- What aspect was not helpful? How could it be improved?
- Would you suggest this group to other women who have experienced domestic violence? Why or why not?
Appendix M

Sample Questionnaire for DV Program Evaluation

Arizona Coalition Against Domestic Violence (2000)

Training Evaluation

Name of Agency
________________________________________________________________________

Title of Training
________________________________________________________________________

Location: Date:
________________________________________________________________________

What information from today’s training was the most useful to you?
________________________

What information from today’s training was the least useful to you?
_______________________

Rate the following from: 1(poor) to 5(excellent)

Name of Topic 1 __________________________________________________________ 1 2 3 4 5
Name of Topic 2 __________________________________________________________ 1 2 3 4 5
Name of Topic 3 __________________________________________________________ 1 2 3 4 5

Overall Information
1 2 3 4 5

Other comments and/or suggestions for future training’s (Use back if necessary):

THANK YOU!
Appendix N

Descriptive Statistics

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