Family Wellness: Strengthening Familial Dynamics Among Underserved Populations

Evidence from a quasi-experimental research design employing an intervention and control group

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Prepared by
Marcel Montañez, Ph.D.

New Mexico State University
Email: **marcel@nmsu.edu**

Introduction

This report is a summary of findings from a quasi-experimental trial of the Family Wellness Curriculum using an experimental and a matched control group. The sample represents a community sample from a state in the southwestern United States with a significantly large population of Hispanic citizens. Results from this study indicate that 1.) Exposure to the Family Wellness program causes significant positive outcomes in behavioral and emotional health of families ($p<.05$) and 2.) The outcomes of the family intervention are significantly higher ($p<.05$) for participants, in all anticipated areas, than for a control group over a 12-week period.

Theoretical and Research Base for Program

The inception of the Family Wellness model in 1980 was based on meeting the needs of underserved individuals returning to their respective families/communities following the completion of a drug and alcohol rehabilitation program. The greatest need stemmed from the realization that while drug and alcohol use had diminished following treatment, family dysfunction continued and contributed to a high incidence of relapse. Today, Family Wellness has expanded worldwide serving families from a variety of cultures, including but not limited to U.S. Armed Forces, ethnic minorities, immigrants, refugees, and other underserved populations. The focus includes strengthening marital/couple satisfaction, parenting skills and family functioning.

The original funding for the development of this program was provided by the State of California Department of Alcohol and Drug Programs. Program expansion occurred in response to identified needs among families coping with the effects of poverty, immigration, language barriers, domestic violence, discrimination, gang violence, and deterioration of traditional family support systems.

After reviewing the current effective social science/psychological research and theory of that time i.e., family systems theory, structural family therapy, family life cycle theory, Adlerian theory, and behavioral theory (Creighton & Doub, 2000), three skills and patterns that are

consistently evident in healthy families were identified and became the core elements for the program. These three skills and patterns transcend time, culture, ethnicity, and family constellation. A major goal of program development was to translate these complex theoretical models into practical skills utilizing everyday language that can be readily learned and integrated by families regardless of their socio-economic, educational and cultural background. In addition, highly interactive teaching techniques (drama, role play, coaching, and group participation) were included and proved to be highly effective with most type of audiences. Groups of families, including children, are taught together to build family cohesion and a sense of community.

Having served over 1,000,000 participants worldwide since its inception, research of program efficacy was important from the beginning. Early efforts at research were conducted by asking participants to document what they learned and how the curriculum impacted their lives. Overwhelmingly, participants loved the Family Wellness program and provided encouragement regarding positive impact. The first study of the Family Wellness Program was conducted by the Drug and Alcohol Abuse Prevention Project in Santa Cruz, California, in 1987. This was a six-month follow-up telephone study that was conducted to understand the lasting nature of the knowledge and change resultant from participation in the Family Wellness program. This study demonstrated that 70% of participants improved their communication skills, 45% reduced or eliminated drug use, 80% considered their family to be "closer," and 25% believed their families were solving problems more effectively.

In 1990, a quantitative study was undertaken by Joseph L. Hernandez, Ph.D., with 72 participants and updated in 1991 with a sample size of 200. FACES III (Olson, Portner, and Lavee) was utilized to determine efficacy. Statistical significance was approached in the direction of connection and increased structure. During that approximate period other studies were conducted utilizing FACES focusing on stepfamilies (Creighton, 1987) as well as a dissertation (1994) by Gena G. Rhodes, Ph.D.

More recently, independent research has been conducted on the efficacy of the Family Wellness model. For example, the St. Louis Healthy Marriage Coalition Evaluation Report

(October 2006) conducted by Philliber Research Associates indicated that "Data suggest that the Family Wellness program is making progress toward the program objectives of improved relationships between parents and their children, increased parental involvement with their children, and decreased number of adversarial relationships between [custodial and non-custodial] parent partners."

The Center for Family and Demographic Research of Bowling Green University wrote "The Healthy Relationships and Healthy Marriages: Final Report" (2007). This report documents the impact of the Family Wellness model utilized by the Healthy Marriages Grand Rapids and Pine Rest Christian Mental Health Services. "Respondents were generally pleased with the program, and six months after the class there remained demand for additional classes and 'refresher' classes. Participants often reported recommending the classes to others. Participants were able to recall and implement class lessons with children, partners, friends, fellow employees, and extended family members."

Over the past five years, independent research has been conducted at New Mexico State University on the Family Wellness model using a variety of validated nationally-known research instruments. The OFA (Office of Family Assistance) Healthy Marriage Demonstration Grant Final Evaluation Report (2011) documents statistically significant growth in all three areas targeted: 1) Increased couple or marital satisfaction, 2) Improved parenting skills, and 3) Improved family functioning. "By incorporating a multidimensional evaluation protocol, we were able to demonstrate that participants of the program made statistically significant growth and personally meaningful growth in couple skills, attitudes and knowledge. In addition, findings indicate that equally important growth was made in family functioning. Evaluation results are useful for a number of reasons. First, the evaluation results give definitive support that indicates that this social intervention has utility if applied to families in communities. Specifically, exposure to the Family Wellness curriculum, under the guidance of an expert facilitator causes participants to make significant and meaningful growth in couple relationship skills, attitudes, and beliefs. Secondly, this information yields support to indicate that family functioning improves as a result of exposure to the Family Wellness curriculum. Taken together, this

provides evidence to indicate that improvements to couple relationship, parenting and family functioning occur as a function of being exposed to the Family Wellness curriculum."

Recent research from across the U.S. document the positive and profound impact of Family Wellness programs. In a study of 354 Hispanic parents, Montañez, Devall, and Shields (2009) reported significant growth in couple relationship skills, parenting skills, and family functioning. In addition, Montañez et. al (2010) reported a theoretical model of program delivery that incorporated aspects of social capital with Hispanic samples. Researchers in Ohio reported that Family Wellness participants improved in: (a) how to communicate effectively with children, partners, family, and others; (b) how to establish family time, use new discipline techniques, and set routines for children; and (c) how to compromise with partners and take time together as a couple (Manning, Trella, Lyons, Gulbis, & du Toit, 2007).

Methods

Participants for the experimental group came from community referrals, advertising and self-registration. This group received the intervention and provided pre and post information. The intervention consisted of a 1-3 hour class delivered once per week over a 12 week period. The control group was solicited at a neighborhood grocery and general store. The control group provided information about themselves over the same 12-week period. It was anticipated that the dosage needed to make behavioral changes would be best if it came from combined sessions from 4 curricula. This created a 12-week program. Adults and their children ages 8 and older participated in sessions 1-7 and 12. During sessions 8-11, only adults engaged in discussions on the couple relationship. Because Hispanics tend to value the parent-child relationship more than the couple relationship, we have found it more effective to begin the classes with a focus on the family and parenting.

Family Wellness Matrix.

SESSION		TOPIC	CURRICULUM UNIT
Parenting	1	Couple and Family Wellness: Expectations Strong Parents: Parents as Leaders	Survival Skills, Session 1 The Strongest Link, Appendix B
	2	Strong Parents: Parents as Models	Wellness Way, Session 3 Domestic Violence, Session 6
	3	Strong Parents: Children in Healthy Families	Survival Skills, Session 2 Domestic Violence, Session 3
	4	Strong Parents: Dealing with Change	Survival Skills, Session 4 Domestic Violence, Session 9
Family Functioning	5	Strong Families: Passing on Your Values	Survival Skills, Session 6 Wellness Way, Session 8
	6	Strong Families: Communication	The Strongest Link, Session 4
	7	Strong Families: Stepfamily and Extended Family Issues	The Strongest Link, Appendix C Domestic Violence, Session 8
Couples and Relationships	8	Strong Couples: Signs of a Healthy Relationship	The Strongest Link, Session 1
	9	Strong Couples: Domestic Violence	Domestic Violence, Session 2 Appendix D Domestic Violence, Session 3 and 10
	10	Strong Couples: Commitment	The Strongest Link, Session 2 and 6
	11	Strong Couples: Conflict Resolution and Money Management	The Strongest Link, Session 4 and 5
	12	Acknowledging Your Success; Program Completion	Program Impression and Reflection Completion Certificates

The measurement instrument was the Family Wellness Evaluation Instrument. It is a 48-item questionnaire that asks about each of the major components of the Family Wellness curriculum. It was delivered in Spanish and English on the same pages so that participants can choose to use either one or two languages when reading items. Response ranges cover a scale from 0-10 with higher scores indicating more favorable responses. Subscale scores were calculated by taking the average of the items where no more than 1 item was missing. This scaled the total scores according to the response options. The questionnaire asked about current and retrospective situations and was delivered at the completion of the classes for the intervention group. The control group answered at a single time point also and covered the previous 12-week period.

Both groups completed the questionnaire within three weeks of each other. Previous validation studies (Montañez et al., 2011) of this instrument indicate that a post and retrospective-pre administration is the optimal method of administration because prior to training, people are likely to overestimate their skills and knowledge.

The intervention consisted of several important relationship and family areas where growth is expected to improve the overall emotional and behavioral health of families. These constructs are listed below with brief explanations using the Family Wellness lingo:

1. **Communication** – speak, listen, and cooperate.

2. **Conflict resolution** – it's okay to disagree, avoid blaming, stay physically close, don't try to discuss issues if under the influence of drugs or alcohol, finish the discussion, staying connected is more important than being right.

3. **Stress and change** – Expect change, stress is a signal that change is needed, expect resistance, take one new step at a time, use outside help when you get stuck.

4. **Problem solving** – Know when you are having a hard time, ask for help, talk it over, get clear on the results you want, make a plan, carry out the plan.

5. **Discipline skills** – make rules, stay in charge, stick together, share your values, know alternatives to physical discipline.

6. **Cohesion skills** – plan time with children, encourage children, listen to children, talk to children.

7. **Family dynamics** – adults stay in charge, expect and accept change, allow room to be close and apart.

8. **Couple skills** – commit yourself, be cooperative.

9. **Domestic violence** – understand the difference between equality vs. power and control.

Demographic Makeup of Participants

Two groups are represented in this report. The first group includes participants in a Family Wellness intervention sponsored by Strengthening Families Initiative at New Mexico State University. This group is referred hereafter as the experimental group. The second group was formed for comparison purposes and includes members of the same community as the experimental group and had statistically identical characteristics on key demographic indicators. For example, the experimental and control group was not significantly different ($p>.05$) on age. The control group had more evenly matched percentage of males and females than the experimental group. Patterns of ethnicity were similar across both groups, with Hispanic and White groups making up the largest percentages. Family characteristics were similar between the two groups with equal representation from various relationship types (e.g. married, single). The length of current relationships was 2 years longer for the experimental groups than for the control group. However, given the nature of relationship development, the difference is not meaningful. Finally the average number of children was equal between groups with the experimental group having 2.6 children on average and the control reporting 2.5. Taking all of the demographic information as a whole, it indicates that both samples come from the same population are equally representative of that population. In other words, the experimental and control group only differ on whether or not they received the intervention.

Table 1. Age (in years) distribution by Cohort

	15-25	26-35	36-45	46-55	56-65	66+
Experimental (N=86)	15	31	23	11	4	2
Control (n=93)	11	40	27	10	4	1

Figure 1.

Figure 2.

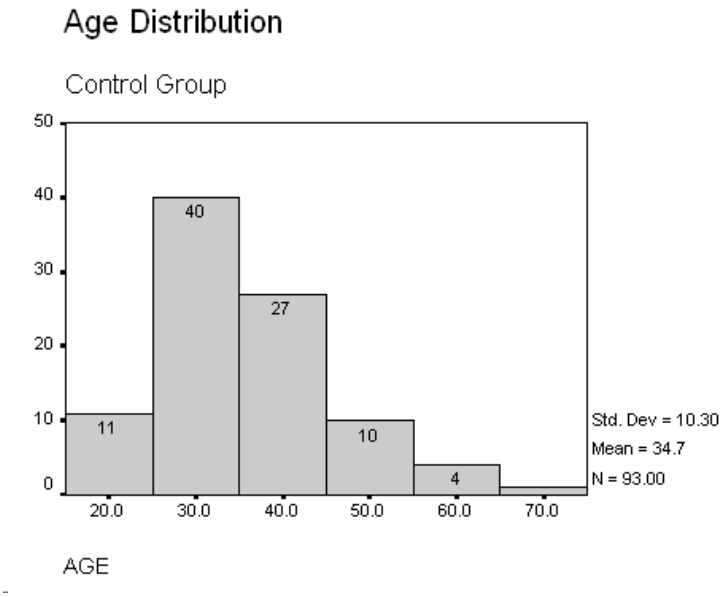


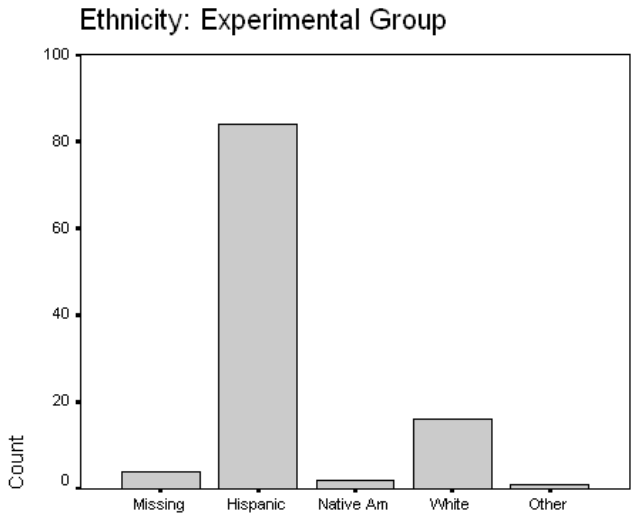
Table 2. Gender	**Male**	**Female**

Experimental (N=105)	21	84
Control (N=100)	36	64

Table 3. Ethnicity

	Native Am.	African Am.	Hispanic	Asian	White	Other
Experimental (N=103)	2	0	84	0	16	1
Control (n=102)	0	3	74	1	22	2

Figure 4.



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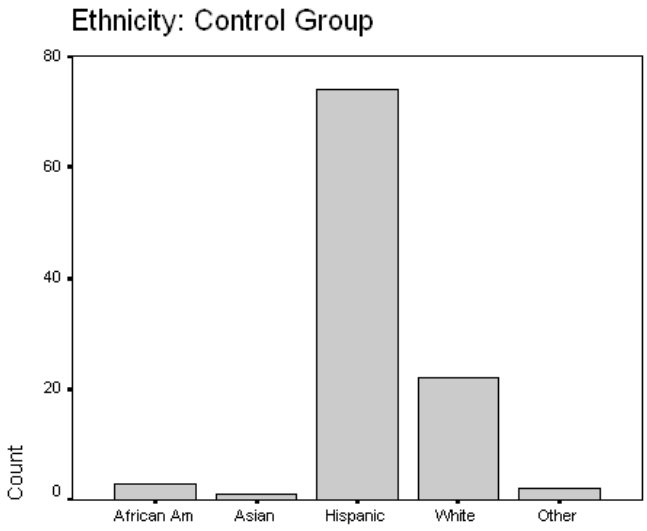


Table 4. Relationship Status by Cohort

	Married	Cohabitating	Dating	Single	Widowed
Experimental (N=103)	51	33	9	12	1
Control (n=102)	52	31	7	9	0

Table 5. Family Characteristics

	Experimental	Control
Years with Current Partner	11.5 (N=40)	9.5 (N=97)
Number of Children	2.6 (N=101)	2.5 (N=101)

Outcomes

The primary research question in this study was whether there was a measureable effect of the intervention on participants. It was hypothesized that the experimental group would demonstrate growth on all constructs because they relate directly to the curriculum. It was also anticipated that the control group would not make progress over a 12-week period because they received no intervention. Furthermore, if growth were made, for some reason, it would be significantly lower in the control group than in the experimental group.

Figure 6 shows the amount of growth that was made by the experimental and control group. Table 6 is a list of the mean growth scores for the experimental and control group. Higher scores indicate more growth. The experimental group scored higher on every construct indicating that they made more growth on every family and relationship outcome. Furthermore, the difference in growth scores is statistically significant ($p<.05$). These findings indicate that there is a positive and statistically significant effect of the intervention on participants across 10 dimensions of behavioral and emotional health related to family well-being, parenting and intimate relationships.

Figure 7 is a visual depiction of the scores that are listed on Table 7. These scores are the average pre and post scores on all constructs. Higher scores mean better overall health. The distance between pre and post lines for groups on Figure X represents the amount of growth made. The top (post) and bottom line (pre) represent the experimental group. The two middle lines represent the control group. It is strikingly clear that the experimental out performed the control group in terms of improving their family well-being and relationships as a result of being exposed to the intervention.

Figure 6.

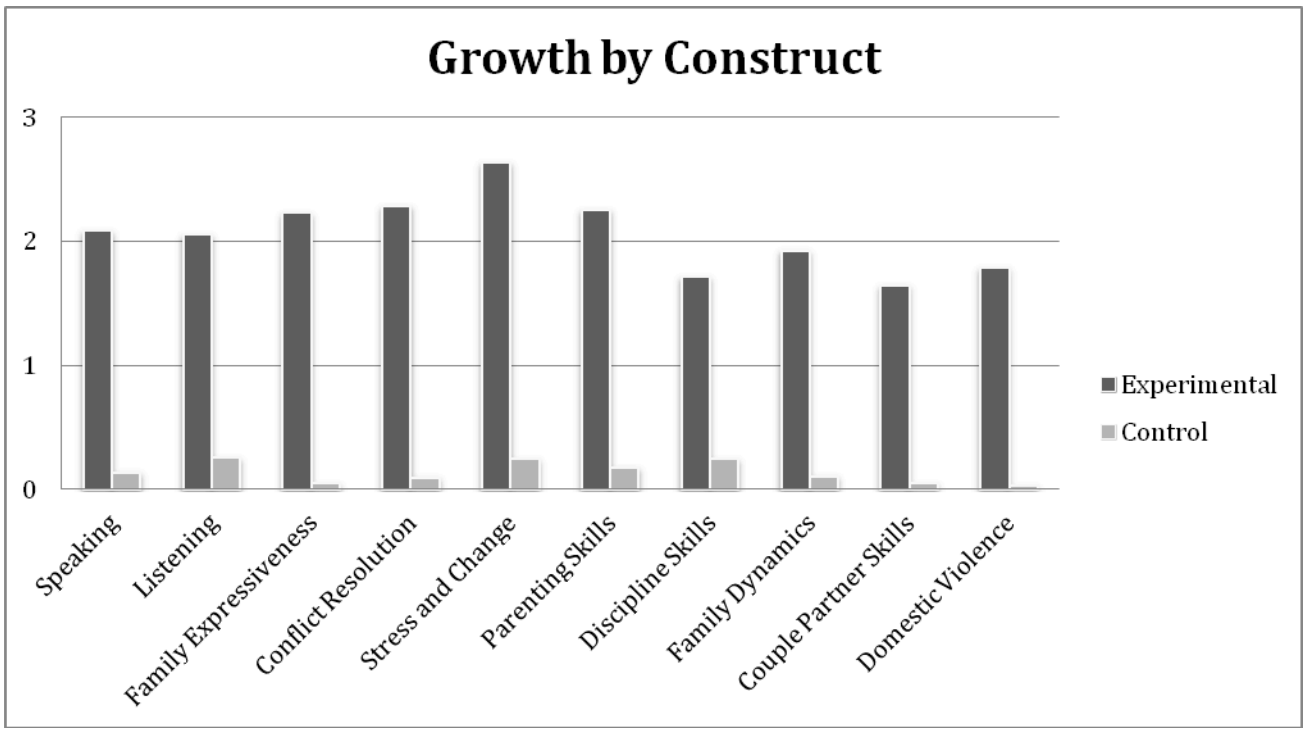


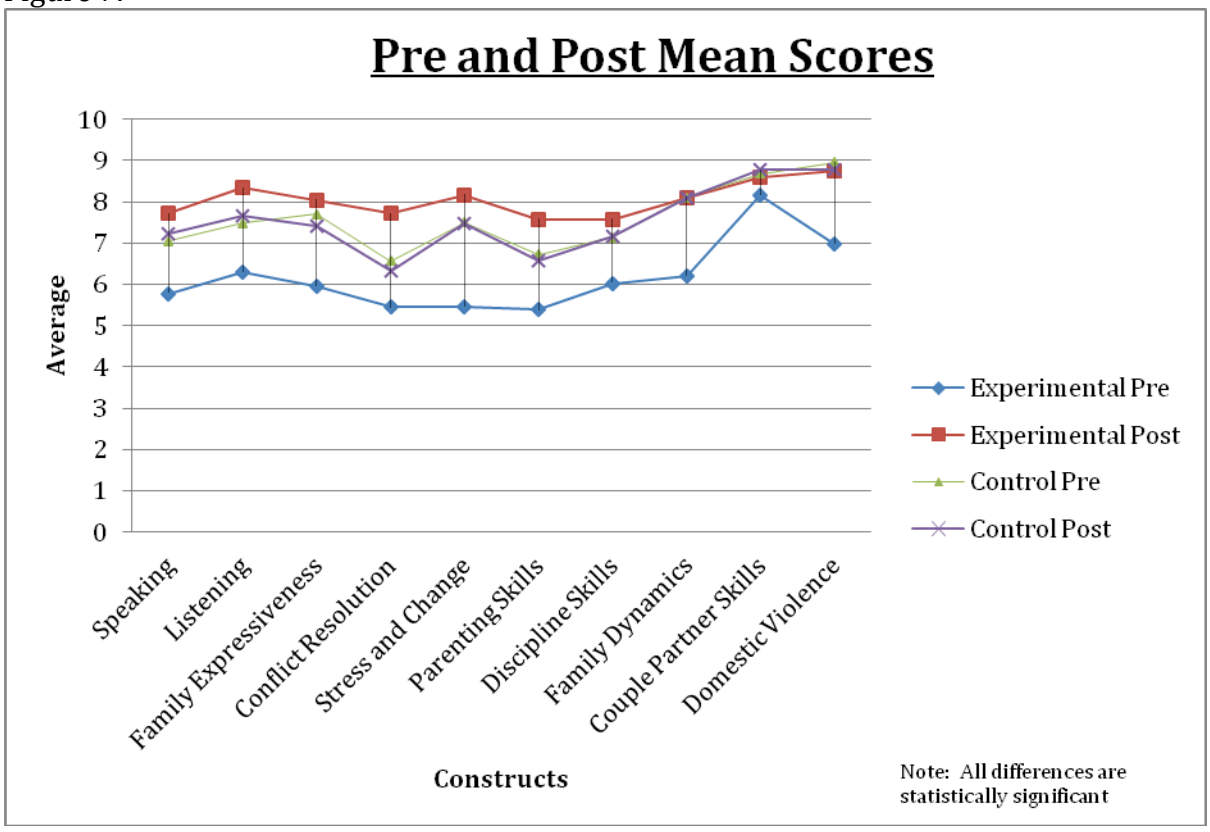
Table 6. Amount of Growth by Construct and Cohort from Pre to Post

	Experimental	Control	t-value	Significance
Speaking	2.09	0.14	7.90	.000
Listening	2.06	0.26	6.43	.000
Family Expressiveness	2.23	0.05	7.78	.000
Conflict Resolution	2.29	0.10	7.60	.000
Stress and Change	2.64	0.25	8.64	.000
Parenting Skills	2.26	0.18	7.76	.000
Discipline Skills	1.72	0.25	6.81	.000
Family Dynamics	1.93	0.11	7.96	.000
Couple Partner Skills	1.65	0.05	8.06	.000
Domestic Violence	1.79	0.03	7.98	.000

Table 7. Pre and Post Scores by Cohort and Construct

	Experimental		Control	
	Pre	Post	Pre	Post
Speaking	5.78	7.71	7.05	7.21
Listening	6.29	8.33	7.48	7.66
Family Expressiveness	5.94	8.04	7.7	7.41
Conflict Resolution	5.45	7.72	6.57	6.33
Stress and Change	5.46	8.17	7.5	7.47
Parenting Skills	5.38	7.58	6.72	6.57
Discipline Skills	6.03	7.58	7.14	7.17
Family Dynamics	6.2	8.09	8.1	8.08
Couple Partner Skills	8.15	8.59	8.68	8.77
Domestic Violence	6.98	8.76	8.96	8.79

Figure 7.



Discussion

This study attempted to answer a series of questions relating to the efficacy of an intervention to improve the emotional and behavioral health of individuals and families. In this discussion, these questions are revisited with respect to their implications to the field of family science and family interventions.

1. Does the Family Wellness Intervention lead to significant and measurable outcomes in individuals? Yes, this study showed that participants in a Family Wellness intervention made significant growth in every anticipated growth area. In addition, the growth that was achieved was higher than a demographically matched control sample.

2. How do we know that the reported growth was not simply a chance occurrence? If the demonstrated growth was a naturally existing developmental phenomenon, then we could reasonable expect to see equal results from the control group. However, the control group did not make any meaningful growth on constructs. Because the control and experimental were statistically identical on demographic indicators, one can assume that they represent the same population. Because the experimental group made more growth than the control, and because both groups come from the same population, we have sufficient evidence to conclude that growth was attributable to the intervention.

3. How does this impact the science of family interventions? This evaluation provides evidence to support the idea that if the Family Wellness intervention is administered, one can assume growth will be made in participants. This report included a predominately Hispanic sample. Although it is assumed that the findings of this study are generalizable to most racial and ethnic groups in the United States, it cannot necessarily be concluded from the findings of this study.

In summary, it is clear that families who attend the Family Wellness program will improve their marital/couple relationship, their parenting skills and their family functioning as a result of the

skills learned from the program. Given that the implementation of this program is highly cost effective (groups of families learning together), and it contributes to breaking down isolation and building a sense of community, the use of this program is highly encouraging not only for the benefit of the participant families but also for the general well-being of our society.

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