

Delivering Parent Training to Families At Risk to Abuse: Lessons From Three Meta-Analyses

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Introduction

The profound responsibilities of child welfare workers cannot be overstated because vulnerable children and adults are heavily influenced by the services these workers and other service providers deliver. Child welfare and other services can affect children's immediate and long-term physical welfare, emotional and social well-being, and opportunities for future success as well as parents' self-esteem, sense of competence, and satisfaction with childrearing. Although intervening with families who have multiple challenges provides an opportunity to support and strengthen these families, success is not guaranteed. In many communities, there are insufficient resources to meet the complex needs of these families. This reality underscores the importance of using empirically supported practice and intervention decisions to increase the likelihood of achieving desired outcomes (Gambrill, 2006).

Ideally, child welfare practitioners should provide a broad continuum of preventive and treatment services, such as child protective services, foster care, adoption, day care, emergency shelter services, intensive home-based services, respite services, and others. National standards and guidelines suggest that capable staff and multiple high-quality services are essential if we are to achieve desired outcomes for children and families. Thus, child welfare professionals who have appropriate education and training and have the necessary knowledge and skills to serve culturally and ethnically diverse client populations are needed at all levels of the child welfare system (APFSA, 1995).

Because of substantial problems affecting the ability of child welfare systems to meet the needs of children and families, these systems have been under considerable scrutiny in recent years. Studies suggest that child welfare systems are not able to provide effective services for a variety of reasons. Child welfare agencies have been faced with staffing issues, including inadequate educational requirements, lack of career ladders, salaries that are not commensurate with responsibilities, insufficient training opportunities, inadequate supervisor-caseworker ratios, and stressful work environments that lead to high staff turnover (GAO, 2003; Pecora, Whitaker, Maluccio, Barth, & Plotnick, 2000; Pecora, Briar, & Zlotnik, 1989; Graef & Hill, 2000). Even though many improvements have been made due to passage and implementation of laws and practice innovations, the child welfare system cannot and should not be solely responsible to address the needs of all vulnerable children and families and, therefore, must rely on the involvement of other stakeholders including children's parents.

The entry point into child welfare is generally through child protective services. Recent innovations, such as early intervention and multiple service tracks that offer flexibility in response to maltreatment reports, have increased the overall responsiveness of child protective services (U.S. Department of Health and Human Services, 2003). In addition, the use of multidisciplinary teams, implementation of family-centered approaches, improved data tracking systems, and other factors also have been helpful in achieving positive outcomes for families in child welfare systems. Further, CPS agen-

cies must conduct accurate assessments and provide timely services to families and children because many children are re-reported a number of times before decisions are made to substantiate the allegations, thereby bringing the families and children into the CPS systems. For many children who are re-reported, the effects of repeated exposures to maltreatment and harmful activities of the parents are cumulative. By the time CPS provides intervention, these families are often in crises and drastic measures may be needed to protect the children. Many CPS agencies are "incident driven," meaning the focus of investigations into family situations is based solely on the incident reported to officials rather than including other factors affecting children's safety. When needed services are delayed, children often experience developmental problems in physical, intellectual, emotional, and social domains.

In this article, we discuss factors associated with successful parent training. Our suggestions are based on two published and one unpublished meta-analytic reviews of parent training (Lundahl, Nimer, & Parsons, 2006; Lundahl, Lovejoy, & Risser, 2006; Lundahl, Risser, & Lovejoy, 2006). Prior to reviewing data that can guide intervention decisions, we provide a brief overview of parent training.

Parent Training

Two major findings support the use of parent training as a means of helping parents and children. First, volumes of research indicate parents play an important role in their children's psychosocial development through parenting practices and the environment they create for their children (Darling & Steinberg, 1993; Grusec & Goodnow, 1994). Second, research has shown that parent training can directly change the childrearing strategies parents use, as well as modify parents' attitudes and perceptions toward childrearing (Lundahl, Risser, & Lovejoy, 2006). Thus, parent training appears to be a valuable and needed intervention for both parents and their children.

Parent training includes a variety of interventions designed to increase the likelihood that parents will provide a nurturing, structured environment for their children while concurrently strengthening the parent-child relationship. Parent training programs specifically aim to decrease parents' use of coercive childrearing practices. Examples of interventions used by parent training programs include reviewing child development literature, teaching and helping parents practice specific parenting skills (e.g., attending, rewarding desirable behaviors, time-out), identifying maladaptive parent-child interactions, and supporting parents' ability to manage their own emotions, including responding in constructive ways to stress.

A number of manualized parent training programs have been developed (e.g., Barkley, 1997; Forehand & Long, 2002; Webster-Stratton, 1994). While many of these programs share common aims and strategies, there are differences. Programs may vary on dimensions, such as mode of delivery (e.g., individual, group, self-directed), theoretical orientation (e.g., behavioral or nonbehavioral), recipient (e.g., one parent, both parents, involvement of the child), instructional aids (e.g., video, actual practice with child), amount of

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material covered, and the number of sessions offered. In addition to variability in parent training programs, differences exist in the targeted populations, such as children's age (e.g., younger, older), identification of clinical difficulties in children (e.g., acting out behavior, ADHD), or parental risk factors (e.g., low socioeconomic status, history, child abuse). Consistent with knowledge that "one size does not fit all," there is a need to understand factors associated with successful parent training. To help clarify such factors, we describe three meta-analytic reviews conducted by the primary author that address the conditions under which parent training can be expected to be most helpful.

Meta-analytic Reviews

Meta-analysis is a research strategy that provides a quantitative summary of outcomes from primary and secondary studies focusing on a particular question (Cooper & Hedges, 1994; Lipsey & Wilson, 2001). In our case, three separate meta-analyses were conducted. These involved exhaustive literature searches for articles that employed parent training programs, coding these studies, and calculating their effect sizes. An effect size, known as Cohen's d , is a measure of the impact of an intervention. Values in the 0.20 are considered small, while values in the 0.50 and 0.80 range are considered moderate and large, respectively (Cohen, 1988). Negative values would indicate the intervention was harmful or less beneficial than no intervention. Within a meta-analysis, d s are calculated for each study and entered into a master database, which allows for a descriptive summary of the overall effectiveness of parent training. In addition, if a sufficient number of studies exist, meta-analysis allows for hypothesis testing. In our case, this was done by using the variability in characteristics of parent training programs and target populations as predictors or independent variables. Thus, interaction or moderator effects were tested. For example, we investigated whether delivery mode or child age influenced outcomes and, if so, under what conditions.

These three meta-analytic reviews investigated parent training focused on (a) children with disruptive behaviors, (b) parents at risk of physical abuse or neglect of a child, and (c) the role played by fathers in parent training outcomes. The first meta-analysis investigated the results from 63 separate studies of parent training focused on children displaying behavioral problems. All studies in this meta-analysis compared control groups with experimental groups; this review will be referred to as the *general meta-analysis* (Lundahl, Risser, & Lovejoy, 2006). The second meta-analysis investigated the results from 23 separate studies of parent training programs targeting families identified as having physically abused or neglected a child, families at risk of doing so, or both. Some, but not all, of the studies in this sample employed a control group. This review will be referred to as the *parents at risk to abuse meta-analysis* (Lundahl, Nimer, & Parsons, 2006). The third meta-analysis, which is currently under review, investigated whether fathers and mothers experience similar outcomes from parent training and whether inclusion of fathers in parent training enhances outcomes. This review will be referred to as the *fathers in parent training meta-analysis* (Lundahl, Risser, & Lovejoy, 2006).

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The goal of this article is to provide guidance to child welfare practitioners about how best to use parent training; therefore, we provide relatively little information about the methodology of each study, and we present only selected findings. Interested readers are encouraged to request the actual meta-analyses in print form from the primary author.

The three meta-analyses are similar in that they all examine three broad classes of dependent variables: positive changes in children's behavior (e.g., increased compliance, decreased noncompliance), positive changes in parents' behavior (e.g., increased sensitivity, decreased coercion, lowered risk to abuse), and improved parental perceptions related to childrearing (e.g., decreased stress, fewer cognitions associated with abuse, and increased sense of childrearing efficacy).

Findings

As a reminder and guide, " d " is a measure of the impact of an intervention, referred to as the effect size. Values in the 0.20 range are considered small, while values in the 0.50 and 0.80 ranges are considered moderate and large, respectively. The symbol " k " represents the number of studies used in a particular comparison.

In general, parent training was shown to have effect sizes in the moderate, significant range (i.e., d s ranged from .40 to .60) for all dependent variable categories across the general and at risk to abuse meta-analyses. Similarly, fathers and mothers showed no significant differences in the degree to which they were influenced by parent training. Thus, there is generic support for parent training programs in helping parents improve how they interact with their children and how they perceive themselves in the parenting

role. Similarly, children whose parents were in training tended to show increases in positive behaviors, which can increase the likelihood of further positive parent-child interactions (Bell & Chapman, 1986).

While it is comforting to know that parent training tends to result in positive and meaningful outcomes, the generic findings do not tell the whole story of parent training. Rather, several factors related to parent training participants and how parent training was delivered significantly influenced outcomes. Understanding the optimal conditions under which parent training is presented provides critical information that can be used to make informed intervention choices. Next, we pose and answer questions that service providers often consider when making decisions about recommending or designing parent training programs.

Do characteristics of participants matter?

It depends. Not surprisingly, socioeconomic challenges are associated with significantly poorer outcomes from parent training. Data from the general meta-analysis showed that positive changes in child behavior in studies targeting disadvantaged families ($d = .24$, $k = 18$) were significantly lower compared with nondisadvantaged families ($d = .54$, $k = 17$), $p < .01$. This pattern held for positive changes in parental behavior ($d = .34$, $k = 16$ versus $d = .75$, $k = 12$) and parental perceptions linked to childrearing ($d = .38$, $k = 7$ versus $d = .72$, $k = 14$), $ps < .01$ and $.05$, respectively. In a related manner,

outcomes for children in studies that included a high percentage of single parents ($d = .24$, $k = 16$) were significantly lower compared with studies with fewer single parents ($d = .45$, $k = 29$), $p < .05$, though this was not true for changes in parental behavior or perceptions. The results from the parents at risk to abuse meta-analysis were similar. Thus, special attention needs to be given to families facing socioeconomic challenge. As an example, individually delivered parent training is superior to group delivered parent training for families facing economic challenges (see section entitled “Does delivery mode matter?”).

Contrary to predications that younger children would benefit more than older children from parent training because they are more malleable, no statistical differences were found, although the patterns did follow predictions. Similarly, children evidencing a broad range of acting out symptoms benefited from parent training; in fact, children who displayed greater degrees of difficulty prior to their parents’ involvement in parent training changed their behavior more after the intervention.

Do the characteristics of parent training programs matter?

Yes. Children’s service workers cannot directly influence the characteristics of the families they serve. Increasing a family’s socioeconomic status, for example, usually goes beyond the scope of intervention options. Child welfare workers, however, can influence intervention characteristics to best meet the needs of individual families.

The goal of this article is to provide guidance to child welfare practitioners about how best to use parent training; therefore, we provide relatively little information about the methodology of each study, and we present only selected findings.

Should fathers/partners be included in parent training?

Yes. Results from the meta-analysis on fathers’ role in parent training indicate that fathers or partners should be included. Specifically, desirable outcomes for children from mother-only studies ($d = .23$, $k = 13$) were significantly lower than studies involving both mothers and fathers ($d = .49$, $k = 18$), $p < .01$. Similarly, increases in desirable parenting behaviors were significantly higher in mother and father groups ($d = .59$, $k = 16$) compared with mother-only groups ($d = .21$, $k = 7$), $p < .01$. No significant differences were found for parental perceptions. It is important to note that this pattern held when the socioeconomic status of families and the percentage of single parents were statistically controlled. While these findings may seem intuitive, and some parent training programs openly advocate the involvement of both parents (Barkley, 1997), controversy about this issue does exist. Two early studies (Firestone, Kelly, & Fike, 1980; Martin, 1977) tested the hypothesis that including fathers in parent training did not enhance outcomes. The explanation for these findings was that the recipient of formal training would communicate the results to the untrained partner. Current estimates suggest that fewer than 20% of families participating in parent training include fathers (Budd & O’Brien, 1982; Coplin & Houts, 1991) and many programs do not actively recruit fathers or partners. Based on the findings from this study, we strongly encourage recruitment and involvement of fathers or partners in parent training efforts.

Does it help to involve children in their own therapy in addition to parent training?

Not necessarily; in fact, it might diminish outcomes when a child therapy component is added to a parent training program. Data

from the general meta-analysis suggest that involving children in their own therapy in conjunction with parent training did not result in enhanced outcomes. For example, positive changes in parental behavior were lower from programs that included a child therapy component in addition to parent training ($d = .18$, $k = 5$) when compared with parent training only ($d = .54$, $k = 37$), $p < .05$. This same pattern held for changes in parents’ perceptions of child rearing where parents who participated in a parent training program that also had a child therapy component experienced fewer positive changes about their parenting ($d = .33$, $k = 6$) compared with parents of programs without a child therapy component ($d = .59$, $k = 31$), $p < .05$. While including a child therapy component lowered desirable changes in parents’ behavior and perceptions, there was no statistically significant benefit (or liability) on children’s behavior.

The reasons the few studies that included a separate child therapy component evidenced poorer outcomes are not known. We speculate that inclusion of a therapy program for children may inadvertently communicate to parents that children have primary responsibility for parent-child interaction problems, which may reduce parents’ engagement or motivation to change. Also, it could be that such programs are more complicated to conduct, which dilutes the effect of parent training. It should be noted that this finding was based on studies of programs targeting child non-compliance, not those that provided therapies directed at helping children who have suffered abuse, neglect, deprivation, or multiple attachment insults. Thus, this finding should not be used to dissuade referrals for child-specific therapy that is distinct from parent training.

Does including a home visitor or home visits help?

Yes. In the parents at risk to abuse meta-analysis we found that interventions that included a home visitor showed significantly higher improvements in attitudes linked to abuse ($d = .76$, $k = 5$) and in using desirable parenting practices ($d = .64$, $k = 9$) compared with interventions that did not ($ds = .46$ and $.40$ and $ks = 6$ and 4 , respectively), $p < .05$. Similarly, interventions that provided a mixture of services in the family’s home and an office setting produced significantly higher results for both attitudes linked to abuse ($ds = .82$ and $.46$, $ks = 6$ and 4 , respectively), $p < .05$, and childrearing behaviors ($d = .85$ and $.41$, $ks = 5$ and 7 , respectively), $p < .05$. There are many reasons why including a home visitor could potentially promote positive outcomes. Parent trainers may obtain a better assessment of what really happens at home, which could enhance their ability to design effective and individualized interventions. Involvement in home visits may also communicate the seriousness of problems to families, heightening their engagement. It may be that home visits increase the likelihood that parent training occurs, as it is more difficult for families to drop out prematurely. Or, it may be that home visits are an effective “transfer of learning” intervention that supports the integration of learned parenting skills into family life.

Does theoretical orientation matter?

It depends. In the at risk to abuse meta-analysis, programs that involved only a behavioral component ($d = .24, k = 3$) were less likely to positively change parents' attitudes linked to abuse, when compared with those programs that involved nonbehavioral parent training only ($d = .69, k = 4$) or a mixture of nonbehavioral and behavioral components ($d = .80, k = 3$), $ps < .05$. By contrast, childrearing skills changed more when a behavioral component ($d = .61, k = 6$) was present compared with nonbehavioral only programs ($d = .32, k = 2$), $p < .10$. In the general meta-analysis, which involved many more studies, theoretical orientation did not influence outcomes, although there was suggestion that programs involving both behavioral and nonbehavioral components may provide parents with the best opportunities to change both their childrearing behaviors and their attitudes toward parenting. We hypothesize that behavioral programs are ideal for helping parents learn discrete parenting skills and that nonbehavioral programs may be better suited for changing parents' attitudes, consistent with the training program's stated objectives and methods. Thus, the question does not seem to be whether one orientation is better than the other, but how can both orientations be used best to support parents and their children.

Does length of parent training matter?

It depends. In the parents at risk to abuse meta-analysis, studies that included a larger number of sessions ($d = .70, k = 7$) showed significantly greater changes in attitudes linked to abuse when compared with those with a lesser number of sessions ($d = .33, k = 3$). Length of time in parent training did not matter, however, for childrearing behaviors. Although not reported in the general meta-analysis, time in treatment was not significantly related to outcomes. It makes sense to the author that extra time in the training helped to change parents' attitudes linked to abuse, because such attitudes are often not conscious and it may require more time to examine and challenge long-held beliefs.

Does delivery mode matter?

Absolutely. One of the most salient findings across the general and parents at risk to abuse meta-analyses was that individually-delivered parent training outperforms group delivery. Furthermore, there is some evidence that the best mode might be a combination of individually-delivered and group-delivered parent training. In the general meta-analysis, individually-delivered parent training ($d = .69, k = 13$) was more successful in modifying children's behaviors when compared with group-only parent training ($d = .34, k = 33$). While significant differences were not found in the parent behavior and parental perception outcomes, the data pattern indicates that at least some form of individually-delivered parent training is superior to group-only parent training.

This finding was particularly salient for studies in the general meta-analysis involving low-income families, families who do most poorly as a result of parent training but who may need it the most. In the studies involving low-income families, it was found that children whose parents received individual parent training ($d = .76, k = 8$) benefited more than children whose parents received group parent training ($d = .12, k = 10$), $p < .01$. Similarly, parents evidenced more

desirable behavioral changes from individual parent training ($d = .70, k = 6$) when compared with group parent training ($d = .22, k = 8$), $p < .01$. For parental perceptions, the difference between individual- ($d = .59, k = 4$) and group-delivered ($d = .25, k = 3$) training did not reach statistical significance, though the difference appears to be meaningful (Lundahl, Nimmer, & Parsons, 2006, p. 97).

Individually-delivered parent training may be superior because interventions can be tailored to the unique needs of each family; or, families may develop a close relationship with the person delivering parent training, which may encourage their adoption of newly learned skills. Proponents of group-delivered parent training suggest it is more efficient and also promotes social support, although our data provide compelling evidence that socioeconomically challenged families do best when at least some individually-delivered parent training is provided.

What are long-term outcomes?

The preceding results were based on outcomes immediately following completion of parent training. Although such results are promising, the durability of outcomes is critical especially when considering families served by the child welfare system. Results from the three meta-analyses suggest that the effects of parent training are durable, although considerably diminished across times periods ranging from 6 to 12 months. Clearly, families with multiple needs will not be sufficiently served solely by parent training programs, and a broad-based system of care is needed to promote the likelihood of success for these families and their children. However, parent training is a valuable intervention and, when applied concurrently with other service programs, certainly can be expected to improve outcomes for vulnerable families and their children.

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Discussion

Child welfare practitioners play critical roles in providing assessments and appropriate service interventions for at-risk families. Of the many available intervention options, parent training is widely relied upon to benefit children by helping their parents use more effective parenting skills. Considerable evidence supports the use of parent training to address a wide variety of difficulties with various target populations (Ramey & Ramey, 2000; El-Mohandes, Katz, El-Khorazaty, McNeely-Johnson, & Shops, 2003; Huhn & Zimpfer, 1989; Huebner, 2002; Cheng, 2004). The pattern of findings from these three meta-analyses supports parent training as an effective intervention. However, many factors need to be considered when designing parent training interventions and when making referrals to such programs.

Families facing economic challenge and single mothers tend to benefit less from parent training compared with parents without economic challenges. More important, such single mothers and socioeconomically disadvantaged families do much better when parent training is delivered individually compared with group delivery. This finding provides a measure of hope because the mode of delivery, individual or group, is a factor that can be controlled by child welfare professionals. Moreover, our findings suggest that parent training providers should actively recruit fathers, partners, or both to

participate in parent training rather than assuming that having only a child's mother present is sufficient. Also, families considered to be at risk to abuse are more likely to show meaningful improvement when more sessions of parent training are offered. The attitudes and perceptions that contribute to parents being at risk to abuse are likely deeply engrained and, thereby, cannot be expected to change immediately. To decrease risk of future abuse, service providers should strongly consider using home visitors, as parent training programs that used such services tended to report improved outcomes for families. Our findings also suggest that programs that provide both behavioral and nonbehavioral instruction are likely to have broader effects for children and parents when compared with programs that rely on only one of these orientations.

It is our hope that the information provided in this review of three meta-analyses can help guide practice decisions. The primary articles provide more detailed information and should be consulted directly, since space limitations preclude inclusion of complete data.

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