



## Primary prevention of parent-child conflict and abuse in Iranian mothers: A randomized-controlled trial<sup>☆</sup>

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### ABSTRACT

**Objective:** The aim of this study was to assess whether primary health care settings can be used to engage and provide a preventive intervention to mothers of young children.

**Methods:** Two hundred and twenty-four mothers who had come to the health centers were randomly assigned to either control group (CG:  $n = 116$ ) or intervention group (IG:  $n = 108$ ). Mothers in IG were taught about the role of parenting skills in families and common mistakes in parenting in 2-h-weekly sessions for 2 successive weeks. A parenting questionnaire was distributed to mothers at pre-test and after 8 weeks from the last training session.

**Results:** Compared to the CG, there were significant improvements from pre- to post-test in IG on measures of Parenting Scales (PS) total scores and Parent-Child Conflict Tactics Scale-modified (CTSPCm) total scores. This improvement was maintained at 8-week follow up.

**Conclusion:** The results support previous international studies that primary health care settings can be used successfully to engage and provide preventive interventions to mothers of young children.

**Practice implications:** Within health centers of Iran where parents routinely bring their children for monitoring of growth or vaccinating against some disease, mothers with a child aged between 2 and 6 years received a parent training. The program gave skills for managing misbehavior and preventing child behavior problems. Mothers reported that their behaviors improved from pre-treatment to post-treatment measured at 8-week follow up. The current work may lead decision-makers to organize this program for all of the health centers to train Iranian mothers.

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### Introduction

Child abuse and neglect (CAN) are worldwide problems. An estimated 872,000 children were victims of child abuse or neglect in 2004 (US Department of Health and Human Services, 2006). It is widely accepted, and there is much empirical evidence, that children's exposure to physical abuse is related to a host of negative outcomes. The impact of child abuse and neglect is often discussed in terms of physical, psychological, behavioral, and societal consequences. In reality, however, it is impossible to separate them completely (Child Welfare Information Gateway, 2006). Some of the problems associated with

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abuse include post-traumatic stress disorder, depression, and alcoholism (Carlin et al., 1994; Kolko, 1992), aggressive and violent behavior (Dodge, Bates, & Pettit, 1990), and academic and interpersonal difficulties (Kolko, 1992).

Attempts to apply behavioral theory and technology such as parent training to family problems including CAN began in the late 1960s and the field has grown steadily since then (Falloon, 1988). In young children (toddler and preschool-aged children), there is strong evidence that social-learning-based parenting programs are effective with a wide range of family problems from quite diverse socio-economic and ethnic backgrounds (Biglan, 1995). Quality of parenting is a modifiable risk factor contributing to early-onset conduct problems in children, and parenting practices have a major influence on many different domains of children's development (Biglan, 1995). In one of the most celebrated examples, families who participated in an early intervention program focusing on parental skills and support had a 50% lower abuse rate than a comparison group (Olds, 1992).

The targeting of prevention programs at different groups with varying degrees of risk for child maltreatment is referred to as a "composite approach" to prevention. In the public health model of child maltreatment prevention, preventative interventions are described as either: primary, secondary, or tertiary interventions (Holzer, Higgins, Bromfield, & Higgins, 2006). Secondary or early intervention programs target individuals at risk of developing a disorder or showing early or mild signs of the problem. Yet primary or "universal programs" in the purest sense do not require that an individual be either at risk or showing any signs of disorder. An advantage of universal programs is that no selection procedures are needed and thus stigmatization is unlikely to result (Dadds, 2002). Universal interventions are strategies that target whole communities in order to build public resources and attend to the factors that contribute to child maltreatment (Holzer et al., 2006). Thus, a key assumption of a public health or a population-based approach is that parenting interventions strategies should be widely accessible to the community (Sanders & Morawska, 2006). The Australian Childhood Foundation's "Every Child is Important" campaign is an example of a primary intervention (Australian Childhood Foundation, 2004). The other example of universal intervention is the Triple P-Positive Parenting Program (Australia). Clinical Outcome with participating families in the Triple P by measure of Parenting Scale was 4.3 with 1.1 (SD) in the pre-test and 2.6 with 1.2 (SD) in the post-test (Sanders, 2007). Although many parenting programs exist to prevent child abuse, few are supported by research evidence (Cowan, 2001).

In Iran, one way of accessing parents is at health centers where parents routinely bring their children for monitoring of growth or vaccinating against some disease at least once a year. In Iran, health services are free for all parents. Most of the personnel who work in these centers hold science degrees in the field of family health. Mothers are routinely educated at the health centers about nutrition problems, failure to thrive (FTT), upper respiratory tract infection, diarrhea diseases; however, nothing is taught about parenting skills.

The aim of this study was to assess whether primary health care settings can be used to engage and provide a preventive intervention to mothers of young children. It was hypothesized that parents would agree to participate in a parenting education program, and those participating would report reduction in negative parenting practices. In addition, this study explored whether parents who completed the SOS (helps for parents) Program (Clark, 2003) improved their parenting skills.

## Method

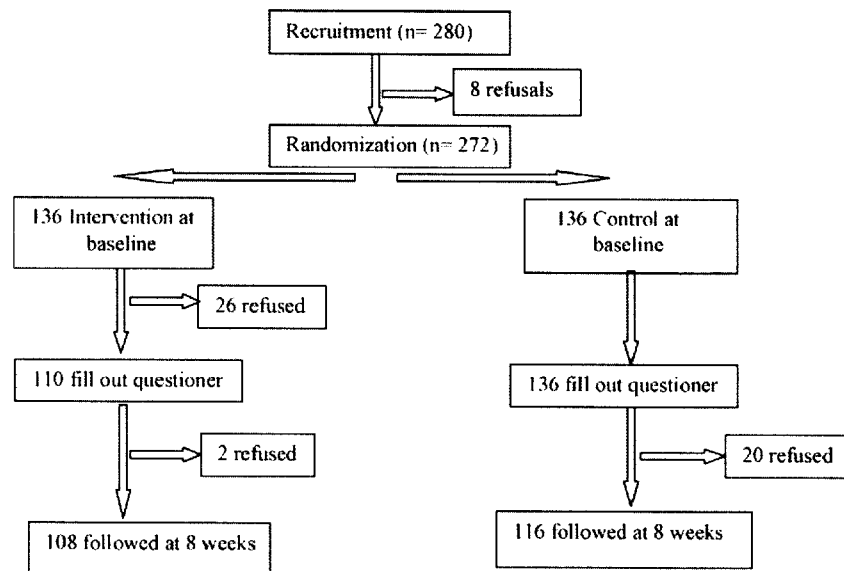
### Participants

The study was conducted in Qazvin, Iran, a city near Tehran with a population of about 500,000 at the time of study. We invited consecutive eligible mothers who had come to health centers to vaccinate their children between June 15 and 20, 2007. Participants in this study were 224 mothers with a child aged between 2 and 6 years ( $M$  age = 29.8 years,  $SD$  = 4.49 years) who attended any 1 of 5 centers of health service. Mothers were all biological parents of the child; all participants provided written informed consent before enrolment and responses were confidential. The ethics review board of the Tehran University of Medical Science approved the study. For inclusion in the study, parents needed to: (a) have children aged between 2 and 6 years and desire to participate in this survey; (b) come to health centers for receiving the health care. Families were excluded from the study if they had a plan to travel in the near future that precluded their attendance. The centers were chosen by simple randomization from 25 centers in this city. We randomly allocated mothers within each health center to control or intervention groups using 14 blocks A, B (AABB, ABAB, etc.) of Balanced Blocked Randomization method. Figure 1 shows the trial profile and the proportion of mothers who completed follow up. Mother non-completers were similar to completers for age, work status, education, spouse's work status and education (Table 1).

There were 110 (49%) female children and 114 (51%) male children in these families who came to the health centers for vaccinating or monitoring growth. They were between 2 and 6 years and the mean of children's age was 4.53 ( $SD$  = 1.36). The mean number of children per family was 1.6 ( $SD$  = 0.63). Education in mothers ranged from unlettered ( $n$  = 13, 5.8%), did not complete high school (<12 years education) ( $n$  = 82, 36.6%), high school graduate (12 years education) ( $n$  = 115, 51.3%), college/university graduate ( $n$  = 14, 6.3%).

### Measures

Measures were completed prior to commencing the group program and 2-months following completion of the program. Parents completed a basic sociodemographic questionnaire (Parent Information Form) on program entry to elicit age, gender,



**Figure 1.** The trial profile and the proportion of mothers who completed follow up.

**Table 1**

Compare of characteristics of non-participants and participants (*t*-test and  $\chi^2$  analyses for demographic characteristics).

Variables	N	M	SD	<i>t</i>	<i>P</i>
Mother's age					
Completes	224	29.53	5.62	0.84	0.33
Non-completes	22	28.73	4.11		
Father's age					
Completes	224	34.37	6.25	1.28	0.34
Non-completes	22	33.14	4.09		
Total person who live together					
Completes	224	3.60	1.62	0.89	0.49
Non-completes	22	3.36	1.14		
Number of children in family					
Completes	224	1.62	0.72	0.55	0.56
Non-completes	22	1.55	0.60		
Child's age					
Completes	224	4.48	1.54	0.44	0.96
Non-completes	22	4.32	1.62		
Variables	N (completes)	N (non-completes)	$\chi^2$	<i>P</i>	
Child's gender			4.52	0.21	
Male	114	8			
Female	110	14			
Mother's education			1.7	0.79	
Unlettered	13	0			
Did not complete high school (<12 years education)	82	8			
High school graduate (12 years education)	107	11			
College/University graduate	22	3			
Father's education			3.23	0.52	
Unlettered	12	1			
Did not complete high school (<12 years education)	106	7			
High school graduate (12 years education)	72	8			
College/University graduate	34	6			
Mother's job			3.04	0.22	
Unemployment	165	19			
Employment	59	3			
Father's job			1	0.8	
Unemployment	9	0			
Employment	215	22			

and grade level of their children; and age, education, marital status, occupation, employment, and family income. There were two questionnaires about Parenting Scales and Child Abuse:

1. In the present article, the term of child abuse is used to refer to any of the 2 types of physical and emotional abuse. Child Abuse was assessed by using a standardized questionnaire that developed with Tehran University School of Public Health, Tehran, Iran. The questions used to measure child abuse were based on the Parent-Child Conflict Tactics scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998) which was used as a framework to guide the areas of investigation. In addition, specific questions were adapted to suit the local environment. Each item is answered on a 7-point scale ranging from 1 to 7 to compare control and intervention group in 2 times, pre- and post-test. Mothers who trained their children in the best way without any abusive behavior received 1 and who used to doing physical or emotional abuse received 7. The questionnaire was tested in a pilot study among 20 mothers. Alpha reliability for CTSPCm total scores with 18 items was 0.72. Mothers also completed the questionnaire again after 10 days. The Intra-Class Correlation for test-retest of this measure was CTSPCm total = 0.87.
2. Parenting Scales (PS): The Parenting Scale is a brief instrument designed to measure dysfunctional parenting practices for parents of young children. The PS total scores with 30 items in 1 to 7 grades which consists of 3 subscales; Laxness, Overreactivity, and Verbosity; has adequate internal consistency ( $\alpha=0.84$ ) and test-retest correlations ( $r=0.84$ ), and reliably discriminates between parents of clinical and non-clinical children where scores in excess of 3.1 denote "clinical" levels of dysfunctional parenting (Arnold, O'Leary, Wolff, & Acker, 1993). Scores on the PS are not correlated significantly with measures of social desirability, maternal education level, or parent report of internalizing behavior problems (Ritman & Currier, 2001). The questionnaire was tested in a pilot study among 20 mothers. Alpha reliability for PS total scores with 30 items was 0.8. Mothers also completed the questionnaire again after 10 days. The Intra-Class Correlation for test-retest of this measure was PS total = 0.85.

#### *Procedure*

After random allocation, one of the personnel explained how to fill out questionnaire and the questionnaires were self-completed. If any mother was unlettered; one of the personnel asked the questions and completed her questionnaire. For the intervention group there was 2-h weekly session for 2 successive weeks. At the first session, the physician who had been trained and certified in the [SOS! Helps for parents](#) model taught about the role of parenting skills in families and common mistakes in parenting. At the second session, the mothers did role-playing and video-clips ([www.sosprograms.com](http://www.sosprograms.com)) were shown and discussed. After 8 weeks from the last training session the questionnaire was completed again by 2 groups. This package is contained behavior management. Focuses on ways to increase positive behaviors and decrease negative behaviors. It is notable that in one of the studies in Iceland, level of data in baseline was 18% and after intervention was 80%. The dependent measure was defined as a percentage of correct parent response to the childrens behavior as it was taught in the SOS! Help for parents course (Gylfason et al., 2008).

#### *Statistical analysis*

Analyses involving these measures consisted of ANCOVA using the pre-intervention score as a covariate. Analyses were performed separately for mothers for each of the two dependent variables.

### **Results**

#### *Sample equivalence*

We first compared to demographic characteristics and pre-scores on two domains (PS, CTSPCm) of the two groups. Using  $\chi^2$  and *t*-tests, there was no significant difference between them (see Tables 2 and 3) on any of the demographic variables and all pre-scores.

#### *Intervention effects*

First we conducted ANCOVA using the Last Observation Carried Forward (LOCF) procedure (Lane, 2007) to manage missing data. There were main effects for treatment (see Table 4). The results were similar to those with missing data, so we continued with standard ANCOVA to compare the effects of Treatment on the two measures. There were main effects for treatment too (see Table 5). Means and standard deviations for all measures at pre- and post-intervention compared to the control group are shown in Figure 2.

Effect sizes were moderate to large:  $d=0.5$  on CTSPC total scores and 1.2 on PS total scores. We were also interested in clinical significance and we used a 25% improvement from baseline to post-assessment score as clinical significant (Macmillan et al., 2005; Webster-Stratton, 1998). Of the 108 mothers who completed the parenting training program, 33.3% on PS total and 37% on CTSPCm total showed at least 25% improvement. Of the 116 mothers who were in control, 0% on PS total and 12% on CTSPCm total showed at least 25% improvement. We also compared percentage in the non-clinical and clinical ranges on

**Table 2**  
Characteristics of participants and  $\chi^2$  analyses for demographic characteristics in Control Group (CG) and Intervention Group (IG).

Variables	CG (n = 116) N (%)	IG (n = 108) N (%)	$\chi^2$	P
Child's gender			0.3	0.59
Male	57(49)	57(53)		
Female	59(51)	51(47)		
Mother's education			4.4	0.22
Unlettered	4(3.4)	9(8.3)		
Did not complete high school (<12 years education)	48(41.4)	34(31.5)		
High school graduate (12 years education)	56(48.3)	59(55)		
College/University graduate	8(10)	6(5.6)		
Father's education			5.9	0.2
Unlettered	6(5)	6(5)		
Did not complete high school (<12 years education)	48(41.4)	53(49)		
High school graduate (12 years education)	36(31)	36(33)		
College/University graduate	24(20)	10(9)		
Mother's job			3.4	0.14
Unemployment	89(76.7)	80(74.1)		
Employment	27(23.3)	28(25.9)		
Father's job			0.2	0.9
Unemployment	9(7.8)	9(8.3)		
Employment	107(92.2)	99(91.7)		

**Table 3**  
Compare of demographic characteristics and pre-scores of samples (t-tests) in control group (CG) and intervention group (IG).

Group statistics	CG			IG			t	P
	N	M	SD	N	M	SD		
Mother's age	116	29.92	4.78	108	29.77	4.17	0.26	0.14
Father's age	116	34.79	4.99	108	34.75	4.68	-0.30	0.23
Number of children in family	116	1.69	0.66	108	1.53	0.57	1.96	0.37
Child's age	116	4.39	1.38	108	4.68	1.32	-1.63	0.8
PS total	116	3.89	0.46	108	3.81	0.55	1.16	0.07
CTSPCm total	116	2.73	1.02	108	2.68	0.86	0.36	0.2

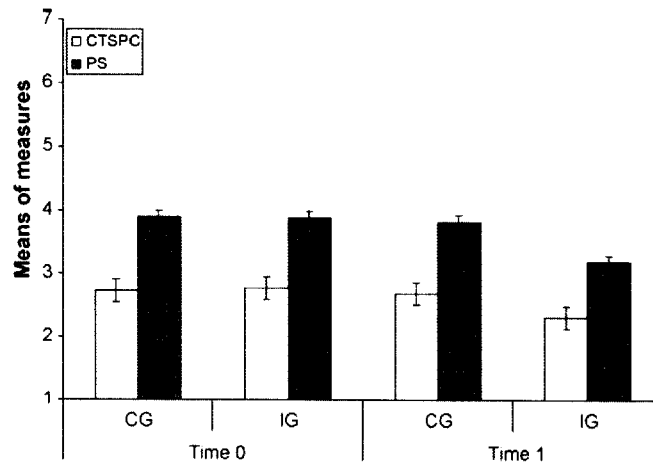
ns = non-significant.

**Table 4**  
ANCOVA using the pre-intervention score as a covariate by LOCF for missing data in control group (CG) and intervention group (IG).

Measure	CG (n = 136)		IG (n = 110)		F	P
	M	SD	M	SD		
PS						
Pre	3.88	0.71	3.70	0.56	76.02	0.001
Post	3.87	0.67	3.19	0.70		
CTSPCm						
Pre	2.87	0.95	2.67	0.85	10.02	0.002
Post	2.91	1.11	2.31	0.93		

**Table 5**  
ANCOVA using the pre-intervention score as a covariate in control group (CG) and intervention group (IG).

Measure	CG (n = 116)		IG (n = 108)		F	P
	M	SD	M	SD		
PS						
Pre	3.89	0.46	3.81	0.55	81.12	0.001
Post	3.87	0.39	3.19	0.70		
CTSPCm						
Pre	2.73	1.02	2.68	0.86	15.99	0.001
Post	2.77	0.92	2.31	0.94		



**Figure 2.** Graph on the measures in control group (CG) and intervention group (IG) in pre-test (time = 0) and post-test (time = 1) with 95% confidence interval.

**Table 6**

Compare of non-clinical and clinical percent of PS and CTSPC at pre- and post-intervention in control group (CG) and intervention group (IG) by using two methods: (a) cut-offs 80th percentile for CTSPC and 3.1 for PS, (b) cut-offs mean + 1 SD of current study.

		PS		CTSPC		Method
		Non-clinical%	Clinical%	Non-clinical%	Clinical%	
Pre	IG	12	88	75.9	24.1	a
	CG	7	93	82.8	17.2	
Post	IG	55.6	44.4	84.3	15.7	
	CG	3.5	96.5	79.3	20.7	
Pre	IG	85.2	14.8	85.2	14.8	b
	CG	82.8	17.2	84.5	15.5	
Post	IG	94.4	5.6	89.8	10.2	
	CG	89.7	10.3	84.5	15.5	

the PS and CTSPCm at pre- and post-intervention in 2 groups with 2 methods: (a) using the cut-offs of 3.1 for the PS (Arnold et al., 1993) and the 80th percentile (3.5) for CTSPCm (Straus, 2004) and (b) using the mean + 1 SD of current sample for PS (4.36) and CTSPCm (3.77). First, it should be noted that mean of PS total for Iranian mothers are very high compared to previous samples and 88% fall in the "clinical" range. Using each of the alternative criteria, there are large reductions for the treatment group only (see Table 6).

Thus, compared to control, mothers in intervention group reported that their behaviors improved from pre-treatment to post-treatment measured at 8-week follow up.

## Discussion

The aim of this study was to assess whether primary health care settings can be used to engage and provide preventive interventions to mothers of young children. Mothers with a child aged between 2 and 6 years who had come to the health centers in Iran to vaccinate their children were randomly assigned to either CG or IG. Mothers in IG received a parent-training program. The program gave skills for managing misbehavior and preventing child behavior problems. It was hypothesized that parents could learn the necessary skills for the non-abusive control of misbehaviors of children.

According to the results, all means reduced significantly in the intervention group versus the control group. First, the results show that use of a vaccination health care setting which can cover more than 98% of the population in Iran was successful in recruiting and engaging mothers into a parenting program (high engagement, and small drop out for intervention group). Second, using group means, effect sizes, and clinical significance analyses, all showed that the control group remained stable across the study period while those who received the parenting intervention SOS (helps for parents) reported significant improvement in non-abuse, positive parenting. Those effects maintained of 8-week follow up.

A number of important community and public health concerns have been tackled using advertising, public awareness, and education campaigns, such as immunization of children. The need for a primary child abuse prevention campaign is well established (Tucci, Mitchell, & Goddard, 2004), so universal maternal and child health services are excellent platforms from which to deliver primary, secondary, and tertiary child protection prevention strategies. The potential benefits of a comprehensive and integrated child abuse prevention platform include: (a) cost-benefits, as families receive appropriate interventions to meet their needs (that is, they are not over or under-served); (b) enhanced secondary service utilization

through non-stigmatizing entry to secondary prevention services (if all families are accessing some form of intervention, it will not be apparent to others whether they are accessing different levels [primary or secondary] of intervention); and (c) ultimately a reduction in the demand for tertiary interventions (Scott, 2005).

The measurement of the cost benefits of preventing child abuse is another area of evaluation that needs emphasis. It is important to keep in mind, however, that cost savings should not be the only criterion for measuring program worth. Policy makers also need to consider the human benefits of preventing child abuse. Programs that provide such benefits can be worthwhile public investments (US General Accounting Office, 1992). This study examined outcomes from a parent-training program that was modified to be delivered to families at a reduced cost and thus serve more families with the same resources. The program required approximately 5 h of staff time to serve 20 mothers and cost approximately \$20 per family.

It should be noted that 1 of the studies in Iran demonstrated that 55% of doctors do not have sufficient knowledge of child abuse. The physicians were relatively well informed regarding the causative factors (e.g., psychiatric disease in parents) and the physical signs and symptoms, but their knowledge of the psychiatric effects of child abuse was inadequate (Garrusi, Safizadeh, & Bahramnejad, 2007). Therefore, we suggest that as well as contributing to the prevention of abuse, clinicians should be taught about parenting skills. However, they can have a role in recognizing and identifying children who are abused. In Iran, there is not any legislation that requires those who work with children to report suspected abuse to child protection agencies. In addition, health professionals need to work closely with these agencies in ensuring that children are protected from all types of abuse and neglect. They can also assist in determining the health and developmental needs of children who have experienced abuse and referrals can be made through public health services.

The results are based on parent-report only, and no observational measures were included in the study. As such the evidence of program effectiveness could be influenced by parents learning to report differently rather than real changes in behaviors. It is unknown whether changes in parental attitude or increases in parental knowledge actually translate to fewer incidents of child maltreatment. Thus future program evaluations could consider incorporating more direct measures of child wellbeing and/or child maltreatment (for example, statutory child protection service data and child medical records) in order to establish with greater confidence, the utility of prevention programs (Holzer et al., 2006).

In summary, parenting and family interventions based on social-learning theory are powerful resources. As a community we must invest further in promoting the well being of our children through supporting evidence based parenting interventions (Sanders, 2003). Parents, who are unaware of effective discipline strategies, may be abusive or neglectful. Prevention activities such as parent education provide many families the support they need to stay together, prevent child abuse, create healthy family relationships, teach health practices, keep youth in school, prevent substance abuse or early pregnancy and care for their children in their homes and communities. The current study provides the first evidence that the community vaccination program in Iran can be used successfully to engage mothers in a summarized intervention against parent-child problem and child abuse.

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