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ORIGINAL ARTICLE

An Investigation of a Community-based Intervention for Socially Isolated Parents with a History of Child Maltreatment

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Abstract A randomized field trial was conducted to test the effectiveness of a community-based intervention to enhance the prosocial interaction and psychological well-being of urban, Head Start parents with a history of child maltreatment. One-hundred and sixteen socially isolated parents participated. Forty of these parents had a history of child maltreatment. Maltreatment and non-maltreatment parents were assigned randomly to intervention and control conditions. The intervention involved 10 group-training sessions focusing on the relationship between stress and social support. Analyses revealed a significant main effect for the intervention group with intervention parents reporting lower levels of stress and higher levels of social activity than controls. No main effects for maltreatment status or maltreatment by intervention group interactions were found. Implications for community-based treatment were discussed.

Keywords Child maltreatment · Parent training · Intervention · Community · Head Start

Child maltreatment is a national problem that threatens the development of our most vulnerable children. According to the most recent national statistics, over 900,000 children in 2001 were victims of abuse and neglect [U.S. Department of Health and Human Services (U.S. DHHS), 2003]. Even more distressing is that approximately 1,300 children died of abuse or neglect. Further inspection of these national data indicates that our youngest children have disproportionately higher rates of maltreatment; children aged 0–7 have the highest rates of victimization at 14.5 per 1,000, respectively (Shonkoff & Phillips, 2000). The youngest age group (aged 0–3) was more likely than any other age group to experience a recurrence of maltreatment (U.S. DHHS, 2003).

According to the National Incidence Study of Child Abuse and Neglect-3 (Sedlak & Broadhurst, 1996), there are significant relationships between other known parental risk factors for adverse child development and child maltreatment. Children from families with the lowest income levels (below $15,000) were over 22 times more likely to be abused or neglected than children from families with higher incomes. Further, children in single parent homes had over a 70% greater risk of being victimized than children living with both parents (Sedlak & Broadhurst, 1996; see also Black, 2000 and Swenson & Kolko, 2000).

Additional risk factors include social isolation and stress (Garbarino & Barry, 1997; Garbarino & Kostelny, 1992; Limber & Hashima, 2002; Thompson, 1995; Thompson, Laible, & Robbennolt, 1997). Parents who have small social networks and/or infrequent contact with members of their social networks are at higher than average risk for abusing or neglecting their children (Bishop & Leadbeater, 1999; Coohey, 1999; Coohey & Braun, 1997; DePanfilis & Zuravin, 1999; Gracia & Musitu, 2003; Hall, Sachs, & Rayens, 1998; Marshall, Noonan, McCartney, Marx, & Keefe, 2001; O'Donnell, Wilson, & Tharp, 2002). Increased stress levels also contribute to decreased parenting effectiveness and higher rates of child maltreatment (Coohey & Braun, 1997; DePanfilis & Zuravin, 1999; McLoyd, 1998; Whipple, 1999). There is a growing literature that indicates that social support can have a buffering effect on the impact of stress associated with daily coping, indicating that these two risk factors often act in tandem (Azar, Barnes, & Twentyman, 1988; Culbertson & Schellenbach, 1992; Limber & Hashima, 2002; Thompson, 1995; Thompson, Laible, & Robbennolt, 1997).

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In response to these risk factors, much of the intervention literature has focused on child behavior management. Typical foci of these parent training programs include increasing child compliance with parental requests and reducing child behavior problems (Azar & Wolfe, 1996; Corcoran, 2000). These programs are usually modifications of parent training programs for non-abusing parents that have been applied to parents at risk of maltreating their children (Altepeter & Walker, 1992). In recent years, developers of parent training programs have focused on other aspects of parental well-being, including improving parental social skills, expanding the social networks and resources of maltreating parents, and teaching coping skills to reduce the negative impact of daily stressors (Corcoran, 2000; Dumka, Garza, Roosa, & Stoerzinger, 1997; Whipple, 1999). The idea behind such programs is that when parents' needs are met they are more able to be nurturing and responsive parents (Corocran, 2000). These studies have demonstrated equivocal results, with some showing reductions in maltreatment rates (Cameron & Birnie-Lefcovitch, 2000; Gaudin, Wodarksi, Arkinson, & Avery, 1990–1991; Kolko, 1996) and others finding no differences in outcomes (Chaffin, Bonner, & Hill, 2001; Lovell & Richey, 1997).

While the literature on parent education programs demonstrates some effectiveness at enhancing parent-child interactions and parenting skills, there is often a lack of attention to the cultural and ecological contexts of the participants. The agencies charged with the prevention of child maltreatment typically offer stand-alone treatment programs that are disconnected from other key social welfare services that affect the lives of maltreating families. Such programs often take place in clinics or other stigmatizing agencies and are led by "experts" who are not part of, or familiar with, the parents' communities. Furthermore, these isolated treatment agencies typically utilize a deficit model that fails to recognize the strengths that families and communities bring with them (MacLeod & Nelson, 2000; Matthews & Hudson, 2001). These aspects, combined with authority-driven and/or mandated treatment, disempower parents and decrease their personal and parental effectiveness (Assemany & McIntosh, 2002; Trivette, Dunst, & Hamby, 1996). Further, when participation in such programs is voluntary, the above limitations often result in difficulty in recruitment of participants, low attendance and engagement levels and high drop-out rates (Assemany & McIntosh, 2002; Dumka et al., 1997; Lundquist & Hansen, 1998). In their meta-analysis of preventive programs for parents, MacLeod and Nelson (2000) found that programs with high levels of participation, an empowerment/strength-based approach, and a component of social support had higher effect sizes than programs without such elements. In order to engage parents, treatment programs must be sensitive to parents' ecological context.

Recent priorities for services have highlighted the need for more appropriate intervention measures in the area of child maltreatment. Recently, the Surgeon General (U.S. DHHS, 1999) called attention to the significant disconnection between service providers and mental health scientist-practitioners in addressing the needs of vulnerable children and their families. Three major mandates were issued by the Surgeon General to address existing needs and disconnections: (a) reduce stigma and increase sensitivity at points of entry and assessment; (b) expand supply and cultivate natural resources; and (c) establish *real* connections among disciplines and between research and practice (DHHS, 1999). These mandates can serve as foundational goals for both researchers and practitioners. The National Advisory Board for Child Abuse and Neglect (1993) called for similar actions in their "Neighbors helping neighbors" strategy. Formulated in response to the increase in social isolation in our nation's communities, the Advisory Board stated that a new national strategy to decrease child maltreatment should be comprehensive, neighborhood-based, child-centered, and family-focused (1993). Both initiatives call for re-orienting the delivery of human services.

Head Start was recognized by the Surgeon General as an exemplar program for prevention and early intervention (DHHS, 1999). As a neighborhood-based, socially organized agency, Head Start is an optimal vehicle for reaching vulnerable families, without the issue of stigma that is tied to so many other intervention agencies. One study found that Head Start centers in one urban area were ideal sites for maltreatment intervention because they were situated in communities with the greatest need (i.e. with the highest maltreatment rates), provided services that were culturally sensitive, and located naturally in children's neighborhoods (Fantuzzo, Weiss, & Coolahan, 1998). Head Start also meets the needs stated by the National Advisory Board for Child Abuse and Neglect (1993), in that the program is neighborhood-based, child-centered, and family-focused. With the Head Start Performance Standards (DHHS, year) mandating community and parental involvement, there are a wealth of untapped natural resources in staff, other parents, and community members.

The present study describes an approach to reach vulnerable families, informed by the Surgeon General's mandates. The intervention, entitled Community Outreach through Parent Empowerment (COPE; Stevenson et al., 1996), has four main, overlapping principles. First, it is *relationship-focused*, placing primary emphasis on trust and respect as the foundation for meaningful activity. Second, the intervention strives toward *ecological fit*, as it takes into account the impact of multiple environmental stressors that influence parents and often serve as barriers to effective parenting. Third, it is *community-based* by utilizing parents' knowledge of their neighborhoods and identifying resilience in parents who have struggled through very

difficult circumstances. Fourth, it is *culturally relevant* in that the distinct and varied cultural expressions of emotions, cognitions, and behaviors of parents are appreciated and encouraged throughout the implementation of parent education. The COPE intervention recognizes the importance of a training sequence that occurs in the context of an existing community program and that focuses on parents' basic needs. There are three target areas of the COPE model, which were developed in partnership with Head Start parents and staff: *Parent as Change Agent for Self*, *Parent as Change Agent for Child*, and *Parent as Change Agent for Community*.

The purpose of the present study was to test the effectiveness of a training module prepared for the target area concentrated on *Parent as Change Agent for Self*. This training module was based on a curriculum co-constructed with parent leaders and university researchers in Head Start. The goals of this module were to increase parents' awareness of stressful events impeding parental functioning and of the benefits of establishing parental support networks. Further, a major emphasis was on helping parents capitalize on Head Start to build those support networks. The present study was driven by two main research questions. First, would parents participating in the COPE training display lower levels of perceived stress and greater levels of perceived parental support than parents receiving traditional Head Start parent training? Second, would parents participating in the COPE training module display lower levels of social isolation than parents receiving traditional Head Start parent training?

Method

Participants

One hundred and sixteen socially isolated Head Start parents participated in this study. Participants were identified by staff in the Fall semester of the Head Start year and were selected from 10 central-city Head Start centers. Overall, 111 of the parents were women and five were men, with an average age of 30.8 years. One hundred percent were African American. The majority of the participants (84%) were the Head Start child's mother and the remaining were grandmothers, aunts (13%) and fathers (3%). Over 70 percent of the families were headed by single mothers who were high school graduates and were not employed at the time of the study. The average number of children and age range of the children in the household were 2.78 and 5.03, respectively.

Forty of the participating parents had a history of maltreatment involving their Head Start child. The maltreatment included minor to moderate physical injuries. There were, on average, 1.4 incidents per child, with the first documented incident appearing, on average, between two and three years of age. These families were involved in Head Start centers as part of a larger collaborative project among Head Start administration, the Department of Human Services, and the University of Pennsylvania (Fantuzzo et al., 1998). This collaboration effort involved helping maltreating parents complete the Head Start enrollment process, maintaining their confidentiality. All Head Start teachers, parents, and research assistants involved in this investigation were blind to the maltreatment status of the participants. The reported existence or nonexistence of maltreatment was verified by Department of Human Services (DHS) personnel who were blind to the Head Start enrollment status of the participants.

Measures

Perceived stressors and supports

Parental support and stressors were assessed by modified forms of the Uplifts and Hassles Scales (DeLongis, Folkman, & Lazarus, 1988). Original instructions were for parents to endorse only relevant items from a list of 61 items on the Uplifts Scale and 51 items on the Hassles Scale. The two scales were modified for this project in two ways. First, items were deleted which were found objectionable by parent staff and replaced with culturally-relevant and acceptable indicators of support and stress. Second, based on parent feedback that the administration procedures may have been confusing for many parents, parents were instructed to rate each item on each scale on a continuum of 1–4 (rather than simply endorsing relevant items). All items on each scale were summed to yield a total score for Uplifts and for Hassles. These scales evidenced high internal consistency (Cronbach's $\alpha = .92$ and .94, respectively), and have been validated with measures of health problems, mood, stress, social networks, and self-esteem (DeLongis, Folkman, & Lazarus, 1988; Fantuzzo & Atkins, 1995).

Social contact with peers

The degree to which parents were affiliated with other Head Start parents in their child's center was assessed with a sociometric measure. Parents were asked to rate every other parent at that Head Start center on the degree to which they: (1) talked to that parent at the center (*Talk*), (2) participated in a Head Start activity with that parent (*Activity*), and (3) participated in an activity outside of Head Start with that parent (*Outside*). Ratings were as follows: 0 = no rating, 1 = a little, 2 = some, 3 = a lot. Dependent measures were the percentage of times a parent was given a "no rating" on each dimension (indicating the absence of participation), and the percentage of times a parent was nominated as participating in conversations, activities, and outside of Head Start social events by forming a total score for each dimension. This social contact measure provided a context-specific

Table 1 Demographic data for parent participants in each experimental condition

	Control		Treatment	
	Nonabuse ($n = 37$)	Abuse ($n = 18$)	Nonabuse ($n = 39$)	Abuse ($n = 22$)
Parent age				
M	29.78	30.72	30.36	33.33
SD	8.48	9.64	10.27	13.32
Parent sex				
Females	36.00	16.00	37.00	22.00
Males	1.00	2.00	2.00	0.00
Relationship to child				
Mother	32.00	14.00	33.00	18.00
Father	1.00	1.00	2.00	0.00
Other	4.00	3.00	4.00	4.00
Marital status				
Single-Female	19.00	16.00	15.00	16.00
Two-Adult	6.00	3.00	5.00	2.00
Number of children				
M	2.85	2.94	2.67	2.68
SD	1.49	1.43	1.50	1.70
Age range of children				
M	4.62	5.72	4.55	5.95
SD	4.84	4.83	4.58	6.04
Employment status				
Not employed	26.00	14.00	29.00	18.00
Part-time	5.00	3.00	7.00	1.00
Full-time	6.00	1.00	3.00	3.00
Education				
< High School	11.00	4.00	13.00	5.00
High School Graduate	20.00	10.00	18.00	13.00
> High School	6.00	4.00	8.00	4.00

rating of parental social activity among the community of Head Start parents in their neighborhood. Co-variance among the dimensions demonstrated reliable use of the ratings, with high positive correlations between all three "no" categories ($r = .99, p < .0001$) and between the "a little," "some," and "a lot" categories (with correlations ranging from $r = .64$ to $r = .86, p < .0001$). This measure was used successfully in previous Head Start studies and was validated by measures of parent involvement, as well as measures of stress and depression (Fantuzzo, & Atkins, 1995).

Procedure

Prior to the start of the study, the intervention methods and the potential measures were reviewed by teachers and the Head Start Parent Policy Council. The Policy Council approved of the intervention methods and measures for use in Head Start. Subsequent to obtaining full approval, teachers rated the parents of the children in their classrooms in term of their adult social interaction in Head Start activities. Based on their observations of parents, teachers gave each parent a rating of "low," "medium," or "high" engagement. Parents who were rated as "low" were invited to participate in a study to learn about parents' evaluation of different types of involvement activities in Head Start. Procedures were followed to ensure that the rights of research participants were protected. Confidentiality was carefully reviewed, including the use of identification numbers in place of names on all measures. Parents who agreed to participate in the study signed a consent form describing data collection and participant rights. Of the parents who were invited 90% agreed to participate.

Parents who agreed to participate were blocked by maltreatment status and then randomly assigned to treatment or control conditions. Participating parents were asked to complete a brief demographic questionnaire prior to the start of the study. Statistical analyses revealed that there were no significant demographic differences between experimental conditions (see Table 1). To assess the effectiveness of the COPE intervention to reduce parents' stress and increase their positive social contact with their local community of Head Start parents, participants were assessed post-treatment.

Participants were approached by members of the research team who were blind to parents' group assignment and maltreatment status. Research team members distributed the Uplifts and Hassles scale and had parents complete the

sociometric measure regarding contact with other Head Start parents. During this process, parents were again informed of their rights and the voluntary and confidential nature of this study. Parents were asked to complete the measures at that time, in the presence of the research team member. In a few cases, research team members offered to read items aloud and record responses for respondents who requested it or who seemed to be having a difficult time reading and/or completing the questionnaires.

Treatment conditions

COPE intervention

The COPE intervention (Stevenson, Fantuzzo, Abdul-Kabir, & Childs, 1996) involved two major components: (a) the establishment of informal support groups, and (b) the implementation of the *Parent as Change Agent for Self* module. The COPE training teams involved a parent leader and a researcher from the university. The parent leaders had been identified by Head Start staff and other parents as natural leaders, who were well connected with staff and families; it was these parent leaders who developed the format for the COPE intervention. The training teams were familiar with the centers and accepted by the families and staff. Parents were first invited to participate in informal group sessions held in a separate room. These sessions were held early in the day so that parents could come by after dropping off their children. Coffee and light refreshments were served. There was no agenda for these sessions, other than providing an opportunity for parents to get to know each other and talk about common topics, such as the center or their children. These informal sessions allowed for relationships to be established and served as the context for inviting parents to participate in the COPE training sessions.

The implementation of the *Parent as Change Agent for Self* module (Stevenson et al., 1996) took place over 10 sessions during the late Fall and early to mid-Spring semesters. The 10 sessions had two main purposes: to identify major categories of stressful events for urban, African-American, Head Start parents, and to consider and discuss the ways in which friendships and various connections within the community can mitigate these stressors. Topics included relationships with families and friends, race, poverty, gender issues, social isolation, stress, physical health, and emotional well-being. Parent well-being and parent-parent collaboration were emphasized, as was the building of trust between parents and facilitators. Parents were encouraged to identify personal strengths, weaknesses, stressors, coping mechanisms, goals, and barriers to goal attainment.

Each of the 10 sessions began with an informal time when parents gathered and light refreshments were served. Then the training team introduced a topic for discussion. The role of the training team was to serve as facilitators, fostering dialogue and interactions between the parents. Although the leaders provided some examples during the discussions, the focus was primarily on the parents' experiences and what they felt was most relevant and proximal for them. Finally, the training team summarized the discussion and reinforced the points that the parents made. For example, in the first session, parents were asked to identify all of the factors that made parenting difficult. From this list, they were then asked to prioritize, identifying those that were most problematic. This prioritized list then served as the basis for future sessions. All COPE sessions (both the informal and formal) lasted approximately three hours.

Table 2 Descriptive Statistics for Parent Uplifts and Hassles per Experimental Condition

	Control		Treatment	
Variables	Nonabuse ($n = 37$)	Abuse ($n = 18$)	Nonabuse ($n = 39$)	Abuse ($n = 22$)
Uplifts				
M	50.29	48.91	56.45	54.51
SD	9.37	7.58	9.78	10.32
Hassles				
M	55.00	54.84	50.68	51.63
SD	7.07	7.56	7.47	6.40

Control condition

Parents in the control group participated in traditional Head Start parent training activities, which included monthly parent meetings and occasional parent workshops conducted by outside consultants.

Results

Independent checks by research assistants indicated that parent training sessions were carried out as planned. The actual sessions were congruent with the prepared training at least 80% of the time. Parent attendance revealed that parents attended at least 7 of the 10 training sessions. In order to test the impact of the COPE intervention on perceived stressors and supports, a two-way (group $\times$ abuse status) analysis of co-variance was computed. The means and standard deviations are presented in Table 2. The analyses indicated a significant main effect for group, with the parents assigned to the COPE intervention evidencing lower levels of perceived stressors (F (1,112) $= 7.28, p < .01$), and higher levels of perceived parental supports (F (1, 112) $= 5.12, p < .05$). For both analyses, there were no significant main effects for abuse or group $\times$ abuse interaction effects.

To evaluate group differences with respect to parent ratings of isolation and social support, two-way analyses of

Table 3 Descriptive statistics for parent isolation and social support scale per experimental condition

	Control		Treatment	
Variables	Nonabuse ($n = 37$)	Abuse ($n = 18$)	Nonabuse ($n = 39$)	Abuse ($n = 22$)
Talk-No				
M	0.82	0.86	0.72	0.70
SD	0.11	0.08	0.15	0.16
Activity-No				
M	0.84	0.87	0.72	0.75
SD	0.10	0.09	0.15	0.16
Outside Contact-No				
M	0.85	0.88	0.74	0.76
SD	0.10	0.09	0.15	0.16
Talk-Yes total				
M	0.17	0.14	0.30	0.28
SD	0.11	0.09	0.17	0.15
Activity-Yes total				
M	0.15	0.13	0.28	0.25
SD	0.09	0.10	0.15	0.15
Outside contact-yes total				
M	0.15	0.12	0.26	0.24
SD	0.11	0.09	0.15	0.15

variance were conducted on each of the *No-contact* ratings (Talk-No, Activity-No, and Outside-No ratings) and the *Yes-contact* ratings (Talk-Yes Total, Activity-Yes Total, Outside-Yes Total). Table 3 presents means for these rating percentages across experimental groups.

To avoid redundancy, only the analyses of variance on the "Yes" ratings are presented. The pattern of results for all three social contact "Yes" rating categories was consistent with the one found above with measures of supports and stressors. Parents in the treatment group were rated significantly higher by other Head Start parents as being a parent who *Talks* with other parents in Head Start ($F\ (1, 112) = 19.3, p < .001$), engages with others in Head Start *Activities* ($F\ (1, 112) = 20.0, p < .001$), and has social contact with other Head Start parents *Outside* of Head Start ($F\ (1, 112) = 17.3, p < .001$) than were parents in the control group post-treatment. The Bonferroni correction was performed for each ANOVA ($p < .017$ per dependent variable) to reduce the likelihood of making a Type I error. For the three analyses, no significant main effects for abuse or group x abuse interaction effects were found.

Discussion

Absence of viable social networks that support positive parenting, and presence of multiple stress factors, has been associated with higher than average risk for child maltreatment. The present study conducted a randomized field trial to test the effectiveness of the COPE intervention to enhance the social contact and well-being of low-income parents with a history of child maltreatment. This intervention is characterized by a focus on parents' collaboration to identify ways in which beneficial connections with others in the community can mitigate stress associated with parenting. Parents responded well to this intervention, with nearly all the parents participating in at least 7 out of the 10 sessions. The content of the sessions was focused on the multiple stressors that parents face and ways in which they could deal with them effectively. Post-intervention, parents who participated in the COPE training reported lower levels of stress than parents who did not participate. This finding is consistent with the literature demonstrating that treatment programs that emphasize teaching coping skills to parents can help to decrease their stress levels (Corcoran, 2000; Thompson, 1995).

Whereas the *content* of the sessions was focused on stressors, the *process* of the sessions emphasized connecting isolated and vulnerable parents with other Head Start parents. Parents were assessed by their peers in three different areas: how often they talked with those parents, how frequently they participated in Head Start activities with those parents, and how frequently they participated in activities outside of Head Start with those parents. At the end of the intervention, parents who received the COPE training displayed significantly higher levels of activity across these three categories than did non-participating parents. This finding corroborates existing literature demonstrating that parents who participate in social support training report higher levels of contacts with informal and formal supports (Cameron & Birnie-Lefcovitch, 2000; Lovell & Richey, 1997). One study explored specifically the effects of parent involvement in Head Start and demonstrated that mothers with higher levels of participation showed significant gains in well-being over the program year, while mothers with low levels of participation showed no such gains (Lamb Parker, Piotrkowski, Horn, & Greene, 1995).

The relationship between stress and social support has been noted to be bi-directional; social support may help to reduce the negative impact of stressors, while stressors may hinder the accessibility of social support (Cohen, Underwood, & Gottlieb, 2000; Thompson, 1995). Social support has been noted to prevent stressors, as well as buffer their effects (Limber & Hashima, 2002; Lovell & Richey, 1997), and has been found to be particularly important for African Americans in mediating stress (Kim & McHenry, 1998). The present study extends the literature by incorporating both components (social support and stress reduction) in a community-based organization. Researchers have noted that social support should be integrated with other prevention interventions, such as schools or other community organizations (Thompson, 1995).

The findings from the current investigation are qualified by the study sample – low-income, urban, African-American

parents of Head Start children. Future research should test the COPE intervention with other urban ethnic groups and in rural areas, where social isolation is a consequence of distance, to see if similar outcomes emerge. The present findings are also limited by the constructs measured – social contact and daily stressors of parents. Future studies should test the effectiveness of the COPE intervention with other constructs. For example, maternal depression is a competing hypothesis for vulnerability to child maltreatment, and is one that is more difficult to impact than those in the present study. Future research could test the COPE intervention with these kinds of constructs to determine if there were similar effects.

Additionally, future investigations of the COPE intervention should examine potential affects not only on participating parents' well-being, but also on their interactions with their children. For example, do the changes in parental feelings and behavior translate into different interactions with their child? Taking this idea a step further, the impact of the intervention directly on children's behavior could be explored. For instance, do the parental changes translate into changes in the child's behavior and how the child interacts with others? Although only a few studies have investigated the relations of these constructs, findings have shown that parental social networks are related to positive child-rearing and subsequent child development (Culbertson & Schellenbach, 1992; Marshall et al., 2001).

Other investigations could also focus on the remaining two target areas of the COPE intervention: *Parent as Change Agent for Child* and *Parent as Change Agent for Community* (Stevenson et al., 1996). The former target area was conceptualized to emphasize further the role of parenting, the parents' relationship with the child, parental competence, intimacy with the child, and parenting style. Parents are encouraged to understand their own responses to stress when their children are present that may contribute to the exacerbation of that stress; identification of how parent-child relationships contribute to educational failure or low motivation in young children; and teaching of basic stress-reducing child management strategies. The latter target area, *Parent as Change Agent for Community*, was conceptualized to teach parents about how best to work within school systems and other community agencies, and how to secure resources for themselves and their family. A specific focus of this module is to increase parents' involvement in their child's academic work. Examples of topics may include the politics of advocacy for children's education, understanding the world of the teacher, and learning negotiation and conflict resolution skills. Issues of trust and mistrust are a potential focus, in specific relation to parent-teacher communication (Stevenson et al., 1996). Future research could investigate the potential benefits of these modules independently, as well as in combination with one another.

The present investigation utilizing the COPE intervention is consistent with the Surgeon General's mandates for bridging the divide between service providers and mental health scientist-practitioners in addressing the needs of vulnerable children and families (U.S. DHHS, 1999). The COPE model works to reduce the stigma often associated with mental health treatment by targeting vulnerable and at-risk parents without labeling them or causing them to feel deviant. It cultivates natural resources by utilizing an existing and well-accepted community agency designed to serve vulnerable children and families. Additionally, the present investigation benefited from the wisdom and knowledge of parents and community members by allowing them to occupy leadership roles in the development and implementation of the COPE training. Finally, the current study sought to establish connections between research and practice by utilizing a partnership approach. Head Start administrators, teachers, and parents, together with professionals from the Department of Human Services and university researchers, collaborated to determine the needs of families within the Head Start program and the best ways in which to meet those needs.

Effectiveness of the COPE intervention also validates Head Start as a strategic context for intervention. The program is located in communities with the greatest need and is located naturally in children's neighborhoods. As an accepted and well-utilized agency, it is in an optimal position to reach families who may not otherwise seek help or accept services. Further, Head Start is designed to be a two-generational program, offering services not only for children, but also for their parents. One of the aims of Head Start is to promote the self-confidence and personal well-being of parents, with the knowledge that this will help propel parents toward self-sufficiency, as well as benefit their relationships with their children (Lamb Parker et al., 1995). Some researchers note that although parent education is a primary focus of Head Start, there has been a lack of comprehensive and empirically validated parenting programs to help parents strengthen their parenting skills (Baydar, Reid, & Webster-Stratton, 2003). The present study makes a significant contribution to this literature.

Aspects of the COPE model and training can easily be incorporated into early childhood education programs. In fact, as previous work has shown, a program model that holds similar tenets as the COPE model (i.e., relationship-focused, ecological fit, community-based, and culturally relevant) is more likely to be successful than those that don't. Programs that utilize mentoring approaches have been found to be more effective than parent and child development oriented programming, and center based services have been found to be more effective than home-based, especially for higher risk parents (Chaffin, Bonner, & Hill, 2001). Parents are more likely to feel supported in a context that they

regard as non-threatening, affirming, and community-based (Thompson et al., 1997). The COPE intervention provides such a context.

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