Children and Youth Services Review 35 (2013) 429–438

Contents lists available at SciVerse ScienceDirect

Children and Youth Services Review

journal homepage: www.elsevier.com/locate/childyouth

Is relationship and marriage education relevant and appropriate to child welfare?☆

David G. Schramm [a,*,1], Ted G. Futris [b,1,2], Adam M. Galovan [c,1,3], Kimberly Allen [d,4]

[a] University of Missouri, Human Development and Family Studies, 314 Gentry Hall, Columbia, MO 65211-7700, United States
[b] Dept. of Human Development and Family Science, College of Family & Consumer Sciences, University of Georgia, 225 Hoke Smith Annex, 300 Carlton Street, Athens, GA 30602, United States
[c] University of Missouri, Human Development and Family Studies, 314 Gentry Hall, Columbia, MO 65211-7700, United States
[d] Department of 4-H Youth Development and Family and Consumer Sciences, North Carolina State University, NCSU Campus Box 7606, Raleigh, NC 27695-7606, United States

ARTICLE INFO

Article history:
Received 1 October 2012
Received in revised form 17 December 2012
Accepted 17 December 2012
Available online 6 January 2013

Keywords:
Relationship education
Marriage
Marriage education
Child welfare
Family life education

ABSTRACT

Child welfare professionals (CWPs) have historically been ignored as a potential delivery system of relationship and marriage education (RME). Based on a sample of 1015 CWPs from two states, the current study shows that CWPs believe promoting healthy couple and marital relationships is relevant to the families they serve and their work, and that they are open to receiving RME training. Results from structural equation modeling indicate that CWPs' beliefs about the relevancy and appropriateness of RME may be influenced by their current RME ability and comfort level, their beliefs about the state of marriage and the prevalence of couples in their current caseload of families they serve. Implications related to promoting RME within child welfare and engaging CWPs in RME training are discussed.

© 2013 Elsevier Ltd. All rights reserved.

1. Introduction

There is a growing body of research that indicates children's well-being declines when their parents' relationship quality is poor (e.g., Cummings & Merrilees, 2010). Several grass-roots programs and local initiatives have trained professionals in healthy relationship and marriage education (RME) curricula to educate individuals, couples, and families in an effort to strengthen parents' relationship quality and subsequently children's well-being. Some scholars agree that psychoeducation generally, and specifically education about relationship skills, is an appropriate role for Child Welfare Professionals (CWPs; Orthner, Jones-Sanpei, & Williamson, 2004; Sar, Antle, Bledsoe, Barbee, & Van Zyl, 2010). However, to date, social service professionals and CWPs specifically, who work directly with families in crisis have largely been ignored as a potential delivery system of RME (see Antle, Frey, Sar, Barbee, & van Zyl, 2010 for an exception). Scholars have described possible reasons CWPs may not support the offering of RME (Christensen, Antle, & Johnson, 2008), but what CWPs actually think about RME and the factors correlated with their support of RME have not been empirically examined.

Utilizing a sample of 1015 CWPs from two states, we examine the extent to which CWPs believe healthy couple and marital relationships and services to strengthen those relationships are relevant to the families they serve and how appropriate it may be for CWPs to receive training in providing RME to their clientele. Further, we examine possible barriers to CWPs attending RME training and providing RME to those they serve, including level of knowledge and comfort related to providing RME to clients, concerns about prevalence of divorce and unwed childbearing, attitudes and beliefs about the effort it takes to form and maintain healthy relationships, and the percent and number of actual couples (in comparison to single-parent families) they work with. These attitudes and beliefs may deter or facilitate participation in training and the transfer of training skills to practice (Antle et al., 2010), and thus the findings of this study can inform strategies for engaging CWPs in offering RME.

1.1. Merging relationship and marriage education with child welfare practice

Because the primary roles and responsibilities of child welfare professionals (CWPs) tend to focus on crisis intervention, some have argued that the provision of family life education (FLE), which includes RME, by CWPs may not be appropriate (Myers-Walls, Ballard, Darling, & Myers-Bowman, 2011). However, consistent with the key elements of "good" child welfare practices, which involve child-focused decisions that increase the safety, permanency, and

☆ Funding for this project was provided by the United States Department of Health and Human Services, Administration for Children and Families, Grant: 90CT0151. Any opinions, findings, and conclusions or recommendations expressed in this material are those of the author(s) and do not necessarily reflect the views of the U.S. Department of Health and Human Services, Administration for Children and Families.

* Corresponding author. Tel.: +1 573 884 1995.
E-mail addresses: schrammdg@missouri.edu (D.G. Schramm), tfutris@uga.edu (T.G. Futris), adam.galovan@mizzou.edu (A.M. Galovan), kimberly_allen@ncsu.edu (K. Allen).
[1] First three authors are equal contributors.
[2] Tel.: +1 706 542 7566.
[3] Tel.: +1 573 340 9610.
[4] Tel.: +1 919 515 9139.

0190-7409/$ – see front matter © 2013 Elsevier Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.childyouth.2012.12.013

well-being of children and family-centered engagement that enhances the capacity of caregivers to care for and protect their children, CWPs have been challenged to identify strategies to shift services towards the prevention of family crisis and family breakdown (U.S. Department of Health & Human Services, 2000).

Thus, CWPs are in a unique position to have a positive influence on at-risk children and families if they are provided with the proper training, tools, and skills in RME to help parents (e.g., biological, foster, adoptive) strengthen their couple and/or coparenting relationships or make positive and healthy choices in future relationships. Equipping CWPs with the skills and resources to provide RME to the families they serve is a way to support workers in building protective factors in families, and may prevent future child welfare involvement. That is, rather than reacting to problems after the fact, we argue that it is imperative to provide CWPs with basic RME knowledge, tools, and skills so they 1) can recognize opportunities to provide RME, 2) are ready and able, when needed, to help strengthen couple and/or coparenting relationships, or 3) can understand when the situation better warrants a referral to FLE or counseling services. Recently, scholars have reinforced that integrating RME with services that CWPs provide may be especially desirable and beneficial to home visitation programs (Sar et al., 2010), foster and adoptive parents (Mooradian, Hock, Jackson, & Timm, 2011) and youth aging out of the foster care system (Antle, Johnson, Barbee, & Sullivan, 2009).

Both FLE and child welfare services share the goal of promoting healthy families. Providing CWPs with relationship resources and skills may increase their capacity to foster safety, permanency, and well-being of children in these families by creating stability and strength in couple relationships. The first step in determining whether the roles of CWPs could be expanded to provide RME, when appropriate, is to examine whether CWPs themselves believe fostering healthy couple and marital relationships is relevant for their client families and it is appropriate for them to receive RME training to deliver it. Such beliefs can influence their receptivity to training content and enhance the likelihood that they would apply the skills learned in their practice (Antle et al., 2010). Second, it is important to explore possible beliefs and experiences that may facilitate or deter whether CWPs view trainings centered on RME and teaching RME principles to individuals and families as appropriate.

1.2. The relevance of healthy couple relationships and RME in child welfare

Child welfare experts recommend that CWPs seek to reinforce elements of healthy family functioning (which include healthy parenting dyad relationships) in order to minimize risks to children and maximize the opportunity for children to remain safely with their families (Pecora, Whittaker, Maluccio, Barth, & Plotnick, 2000). Research documents the benefits of healthy couple, marital and coparenting relationships for children (Cummings & Merrilees, 2010). The effects of positive partner/marital relationships often spill over into parenting and lead to more positive child outcomes (Cummings & Merrilees, 2010). Moreover, some research indicates that it is the quality of the family processes, not family structure per se, that predicts positive outcomes for young children and adolescents (Leiber, Mack, & Featherstone, 2009). Other research findings indicate that positive support provided to each other in couple relationships is associated with positive parenting behaviors (e.g., reading to a child) exhibited by both fathers and mothers regardless of marital status, and increased supportiveness is related to less frequent harsh parenting by mothers (Carlson & McLanahan, 2006). The opposite is also true—negativity in the partner/marital relationship spills over and is associated with negative and ineffective parenting, which adds stress to children and puts them at greater risk for abuse and/or neglect (Cowan & Cowan, 2002). Moreover, a higher level of conflict in the couple relationship is associated with lower levels of father engagement (Carlson & McLanahan, 2006).

How might RME training be received by those in the child welfare system? In general, most individuals have positive attitudes toward RME and would be open to receiving RME. For example, surveys conducted across several states have shown that the majority of adults in the general population would consider using RME to strengthen their relationship or marriage, and those who have participated in RME found the programs to be helpful (e.g., Harris et al., 2008; Karney, Garvan, & Thomas, 2003). Even more telling is the fact that those who were eligible for Temporary Assistance to Needy Families (TANF) were more interested in RME than the general population (Karney et al., 2003). Further, those who cohabit outside of marriage, as well as ethnic minorities and younger adults, are among the most willing to participate in RME (Harris et al., 2008). Thus, at-risk populations are open to RME services (Ooms & Wilson, 2004).

Historically, the vast majority of the efforts to deliver traditional RME have taken place in group settings and have targeted couples premaritally (Halford, Markman, Kline, & Stanley, 2003). Efforts to implement RME services individually are not as common. However, as Rhoades and Stanley (2009) point out, "integrating individual-oriented relationship education into existing systems is likely the most effective way to reach potential participants. Whenever possible, practitioners and policy makers will reach the most people most cost-effectively by adding relationship education to existing programs or communities" (p. 52). Indeed, in recent years, RME programs are being implemented at the individual level in schools, correctional facilities, domestic violence shelters, rehabilitation clinics, and other agencies that provide social services (Hawkins, 2012). Taken together, individuals, couples, and families in the child welfare system may be open to receiving RME, including foster youth (Antle et al., 2009) and adopting parents (Mooradian et al., 2011), and training CWPs in relationship principles and skills could be an ideal delivery system, as low-resource families may be less likely to attend group RME programs (Sar et al., 2010).

Not only do most individuals welcome RME, research indicates that RME is effective in improving couple and coparenting relationship quality (Cowan & Cowan, 2002). In a meta-analysis of 117 studies, Hawkins, Blanchard, Baldwin, and Fawcett (2008) found that RME was related to significant short-term and sustained improvement in relationship quality and communication skills. Hawkins and colleagues explicitly excluded marital therapy and group therapy programs from their analysis, including only psycho-educational programs. Similarly, RME has been found to benefit both distressed and not distressed couples (Blanchard, Hawkins, Baldwin, & Fawcett, 2009), suggesting that RME has universal benefits as well as selective benefits for at-risk couples.

1.3. Barriers to child welfare training in RME

The constructs of role theory provide an approach to the social analysis of behavior. The primary aim of role theory is to explain the ways our social environment directly and indirectly affects behavior (Davis, 1996). Role theory's application to the child welfare field is common; professionals are referred to families due to a family member(s) not adequately fulfilling their "proper" role. Interventions for families are aimed at helping to create an environment that is conducive to adequate role performance. Often the inability to perform a role adequately is due to a lack of knowledge of role expectations and skills (e.g., parenting, relationship). Consequently, CWPs focus on providing basic education or referring family members' to individual or group treatment where those skills can be developed or strengthened.

Role theory may also be useful in understanding the attitudes and behaviors of CWPs themselves. Perlman (1968) contends that society

provides the basic script for behavior but it is the continuing interactions between people where role behaviors are finely tuned. In the case of CWPs, their college education is supplemented with continued, and often basic, training related to their job requirements. However, CWPs experience high stress, resulting in high turnover, partly due to the increasing demands of their caseload families and their inability to understand and meet those needs (Weaver, Chang, Clark, & Rhee, 2007). Role ambiguity may occur for CWPs when they are confronted with situations where their expectations for role performance are unclear or are in the process of being redefined (Davis, 1996).

For instance, child welfare services have expanded to offer FLE-type programs (e.g., parenting, financial, and health education) to parents (Barth et al., 2005) and to youth aging out of foster care (Lemon, Hines, & Merdinger, 2005); only recently has attention been given to offering RME to the families they serve (see Antle et al., 2010). In fact, child welfare services have not historically emphasized prevention strategies such as RME, but instead have focused on addressing a broad range of issues related to child abuse and neglect (e.g., access to stable employment, depression, substance abuse and addictions, finding affordable quality childcare and healthcare, dealing with unsafe neighborhoods and social environments), many of which impact and are impacted by couple relationship quality as well (Pecora et al., 2000). Thus, CWPs may feel unprepared to offer RME and uncomfortable with the subject matter. Findings from focus groups with CWPs carried out by Antle et al. (2010) revealed that talking with clients about their relationships may make CWPs feel as though they are inappropriately intruding into the private lives of their clients. They may also feel discomfort stemming from a lack of experience addressing these issues (Antle et al., 2010). Lack of experience and training in RME may be the true source of this discomfort, as involvement in their clients' private lives is a natural component of child welfare work.

The extent to which CWP's believe healthy couple and marital relationships are relevant to their client's needs and view training to provide RME as appropriate in their work may also be linked to the families they serve. For example, the majority of families they serve consist of single parent households, which may lead CWPs to believe that RME is not relevant to their client base (Antle et al., 2010). However, many of the single mothers in the child welfare system may be involved in romantic relationships or may choose such relationships in the future, and may find RME beneficial (McLanahan & Beck, 2010). Further, nearly one-third of families in the child welfare system do represent married or cohabiting couples (Bellamy, 2008) and approximately 78% of foster and adoptive parents are married (Hansen, 2008), which further illustrates the relevance of RME to child welfare. However, it is assumed that if CWPs serve few couples they may perceive the promotion of healthy couple and marital relationships as being less relevant to their job and RME training as less appropriate for them to receive.

Ambiguity related to their role in fostering healthy couple and marital relationships and their openness to RME training may also stem from their personal values and beliefs about families. Antle et al. (2010) describe “attitudinal barriers” to training in RME and we expand this to include attitudes about marriage, divorce, and unwed childbearing. Increasing rates of unwed childbearing and divorce have resulted in a three-fold increase in children being raised by single parents since 1960, and children raised by single parents are at a significantly greater risk of experiencing numerous disadvantages, including being involved with child welfare services (Turner, Finkelhor, & Ormrod, 2007). Although, research on these and other attitudes among CWPs does not exist, statewide surveys of TANF recipients suggest that they have less favorable views of marriage and are more accepting of cohabitation when compared to the general population (Karney et al., 2003; Harris et al., 2008). If CWPs similarly do not view divorce and unwed childbearing as societal concerns, or that marriage takes consistent effort in order for it to succeed, they may not view services that promote healthy couple and marital relationships as relevant to their families or training to offer these services as appropriate for their role as a CWP.

1.4. Research questions and hypotheses

With the expansion of RME into various sectors of family services (Antle et al., 2009; Christensen et al., 2008; Rhoades & Stanley, 2009; Sar et al., 2010), a better understanding of how CWPs' personal beliefs, social environment, and experiences influence their perception of the relevance of promoting healthy couple and marital relationships (HCMR) and the appropriateness of RME training can help advance the offering of RME training and support to CWPs. In exploring CWPs' beliefs and attitudes, we address the following research questions: (1) Do CWPs believe it is appropriate for them to attend RME training and to help their clients develop the skills they need to have healthy relationships? (2) Do CWPs believe the promotion of HCMR is relevant to their clients and their profession, and how does this influence their belief of the appropriateness of RME training? and (3) How are their beliefs about the relevancy of HCMR and appropriateness of RME influenced by (a) their current RME ability and comfort level (b) their beliefs about the state of marriage (i.e., divorce, unwed childbearing, effort required in marriage), and (c) the prevalence of couples in their current caseload of families they serve? Based on the literature reviewed, we hypothesize that CWPs believe that RME is both relevant and appropriate to help their clients. However, we hypothesize that if CWPs lack an understanding of and comfort with delivering RME, do not believe divorce and unwed childbearing is problematic or that marriage requires more effort, and if they work with fewer families consisting of couple relative to single-parents, they will be less likely to view the promotion of HCMR as relevant and RME training as appropriate. Last, because supervisors/managers will have a strong influence on policies that support efforts to promote HCMR and training to offer RME, we also explored (a) whether variations may exist in the beliefs and attitudes of caseworkers versus supervisors and (b) differences in paths to both relevancy of HCMR and appropriateness of RME training for CWPs.

2. Methods

2.1. Procedure

The survey instrument used in this study was developed by the authors and is based on items from prior statewide surveys (e.g., Karney et al., 2003) and scales previously used with CWPs (Sar & Antle, 2003). CWPs in Missouri and North Carolina were recruited for this study as part of an initial needs assessment conducted for a training curriculum being developed in these states under a federally funded grant from the Children's Bureau. In recruiting participants for the Missouri (MO) sample, the state child welfare agency provided email addresses of 1757 CWPs, with 1364 identified as frontline caseworkers. An initial email invitation describing the survey (with a link to the survey) was sent to all 1757 CWPs with two follow-up email reminders sent one and two weeks later. Only 22 emails were returned as undeliverable. At the close of the survey, 620 individuals agreed to participate and 567 completed the survey online (approximate 32.7% response rate).

The North Carolina (NC) sample was recruited in a similar manner, though there were some notable differences. First, a letter was mailed to 100 Division of Social Services County Directors who then shared the letter with their staff. Second, an announcement was forwarded to two voluntary listservs, with a follow-up reminder sent out two weeks later. The listservs included CWPs (who may have received the letter from their county director) and other professionals who work with social services. In total, it was estimated that

the survey announcement reached the majority of the 2757 child welfare field professionals and their supervisors across the state. At the close of the survey, 649 individuals agreed to participate and 623 completed the survey online (approximate 22.5% response rate).

2.2. Participants

For the current study, our primary focus was on those with the greatest contact with child welfare clients, the county frontline caseworkers. Of the 1190 total respondents, 705 county child welfare caseworkers completed surveys in both MO ($n=347$) and NC ($n=358$). Also, an additional 310 county supervisors from MO ($n=111$) and NC ($n=199$) were included to explore whether variations in their beliefs and attitudes as well as the paths examined (compared to caseworkers) may exist. Table 1 provides a demographic summary of the CWPs from each state and notes significant differences by state and CWP role. In general, the profile of the current sample was fairly consistent with the profile of CWPs from each state; still, given the limitations inherent in how data was collected from this convenience sample (e.g., not every CWP may have received the announcement; a disproportionate number of CWPs with favorable views regarding the survey focus may have replied), caution is warranted in generalizing the findings of this study to all CWPs or those in MO and NC. Using a series of univariate analyses of variance (ANOVAs)—after dummy coding categorical variables—we found some differences in demographic characteristics between the samples from the two states and those of different CWP roles. Compared to CWPs in NC, those in MO were less racially diverse ($F_{(1,\ 976)}=48.863$, $p<.01$), younger ($F_{(1,\ 945)}=25.496$, $p<.01$), had less time in the welfare field ($F_{(1,\ 954)}=8.385$, $p<.01$), had previously receive more RME training ($F_{(1,\ 1009)}=13.712$, $p<.01$), and served significantly more couples in terms of percentage of clients who were in a couple relationship ($F_{(1,\ 658)}=34.467$, $p<.01$). Because of these differences, state was controlled for in the analysis presented below. Compared to supervisors, caseworkers, on average, were younger ($F_{(1,\ 945)}=73.243$, $p<.01$), less likely to be married ($F_{(1,\ 1011)}=8.490$, $p<.01$) and more likely to be single ($F_{(1,\ 1011)}=17.673$, $p<.01$), had completed less education ($F_{(1,\ 993)}=43.024$, $p<.01$), had less time in the welfare field ($F_{(1,\ 954)}=245.882$, $p<.01$) and their current position ($F_{(1,\ 996)}=9.533$, $p<.01$), served fewer total families and couples ($F_{(1,\ 763)}=27.325$, $p<.01$), and had a smaller percentage of client who were couples ($F_{(1,\ 658)}=4.927$, $p<.05$).

2.3. Measures

In addition to the demographic information noted above, respondents also answered a variety of questions about their beliefs and attitudes. Questions centered on several areas: previous RME training, concern about divorce and unwed childbearing, beliefs that strong couple relationships require effort, current comfort and skill level related to healthy couple relationships, relevance of healthy couple relationships to child welfare families, and appropriateness of RME for child welfare to deliver.

2.4. Previous RME training

Respondents indicated whether they had previously participated in any "*trainings to teach or help others form and maintain healthy relationships and marriage*." Those who indicated they had participated in RME-related training also were asked to indicate the types of training in which they had participated. Possible responses were *Multi-day training*, *Part-day training*, *College course*, *Web-based training*, *Conference workshops*, *Single day-long training*, and *Other*. Given the relatively small proportion of workers with previous RME-related training, and the differences in each of these types of training, we used a dichotomous (dummy coded) variable indicating if the worker had received any

Table 1
Demographic characteristics of Missouri and North Carolina samples.

Variable	Total ($N=1015$)		MO ($n=458$)		NC ($n=557$)	
	Caseworker ($N=705$)	Supervisor ($N=310$)	*Caseworker* ($n=347$)	Supervisor ($n=111$)	*Caseworker* ($n=358$)	Supervisor ($n=199$)
Gender (1 = Female, 0 = Male)	.92 (.27)	.89 (.31)	.90 (.30)	.93 (.25)	.94 (.24)	.87 (.33)
Age[a]	37.83 (10.24)	44.67 (9.68)	36.46 (10.24)	41.66 (9.45)	39.11 (10.10)	46.32 (9.43)
Race[b]						
Caucasian	81.69%	82.15%	92.84%	92.31%	70.98%	76.68%
African American	15.81%	16.16%	5.37%	7.69%	25.86%	20.73%
American Indian	1.02%	1.01%	.60%	–	1.44%	1.55%
Other	1.46%	.67%	1.19%	–	1.72%	1.04%
Ethnicity (1 = Hispanic, 0 = Non-Hispanic)	.05 (.22)	.03 (18)	.03 (.18)	.02 (.14)	.07 (.25)	.04 (.20)
Marital status						
Married[c]	62.28%	72.61%	61.98%	70.75%	62.57%	73.60%
Widowed	1.61%	1.98%	1.50%	1.89%	1.71%	2.03%
Divorced separated	12.57%	13.53%	13.47%	16.98%	11.71%	11.68%
Single[c]	23.53%	11.88%	23.05%	10.38%	24.00%	12.69%
Highest degree earned[c, e]						
High school diploma	.43%	–	.58%	–	.28%	–
Bachelor's degree	75.61%	56.58%	78.53%	50.00%	72.80%	60.20%
Advanced degree	23.95%	43.42%	20.88%	50.00%	26.91%	39.80%
Years in child welfare field[a]	8.10 (6.59)	16.44 (8.07)	7.57 (6.62)	15.12 (7.84)	8.55 (6.55)	17.11 (8.12)
Years in current position[c, e]	4.62 (4.52)	5.84 (4.94)	4.75 (4.81)	4.96 (4.03)	4.50 (4.23)	6.33 (5.31)
Prior RME training (1 = Yes, 0 = No)[d]	.24 (.43)	.27 (.44)	.27 (.45)	.36 (.48)	.20 (.40)	.21 (.41)
Families served (last 3 months)						
Total families[c]	29.17 (61.62)	72.63 (152.89)	29.50 (34.34)	68.03 (108.87)	28.88 (78.80)	75.22 (173.18)
Married couples[c]	9.69 (17.47)	27.78 (63.06)	11.14 (17.06)	32.29 (53.67)	8.43 (17.80)	25.23 (67.94)
Cohabiting Couples[c]	10.25 (28.86)	28.55 (57.38)	12.60 (22.17)	30.57 (44.22)	8.24 (33.45)	27.40 (63.86)
Percent of clients in a couple relationship[a]	59.34%	63.73%	66.80%	76.11%	52.85%	56.30%

Notes. Mean (standard deviation) or percentage reported.
[a] Significant mean difference by state and CWP role.
[b] Significant minority/non-minority racial difference between states.
[c] Significant mean difference by CWP role.
[d] Significant mean difference by state.
[e] Significant state by CWP role interaction.

previous RME training (1 = received previous training, 0 = no previous training).

2.5. Current RME ability and comfort

To determine their current comfort and skill level in educating clients about healthy relationships and marriages, respondents were asked the degree to which they agreed with 4 statements (Sar & Antle, 2003): (1) I know how to help my clients resolve problems with their relationships; (2) I am comfortable with making suggestions to my clients on ways they can improve their marital/couple relationships; (3) I know how to assess for marital/couple relationship problems with my clients; (4) I am comfortable with discussing with my clients how their marital/couple issues and problems impact their child's safety, permanency and well-being. Responses were given on a 5-point Likert scale ranging from *Strongly Disagree* to *Strongly Agree*. A mean score was computed ($\alpha = .76$ for caseworkers; $\alpha = .82$ for supervisors), with higher scores indicative of greater understanding and comfort in providing RME.

2.6. Concern about divorce and unwed childbearing

Two items evaluated respondents' views about divorce and unwed childbearing: "Some people think that divorce [unwed childbearing] is a serious national problem. Other people think that divorce [unwed childbearing] is not a serious problem at all. Would you say that divorce [unwed childbearing] is:" Responses were given on a 4-point Likert scale with responses *Not a problem at all*, *Not too serious a problem*, *Somewhat serious problem*, and *A very serious problem*. A mean score was computed ($\alpha = .70$ for caseworkers; $\alpha = .55$ for supervisors), with higher scores reflecting greater concern about divorce and unwed childbearing.

2.7. Belief that healthy marriages require effort

Because federally funded HMI efforts are focused on facilitating the formation and sustainability of healthy marriages, participants were asked to respond to a series of statements to gauge their views about marriage. Respondents were asked the degree to which they agreed with the following series of statements: (1) Too many couples rush into marriage; (2) Young couples focus too much on the happiness they expect from marriage and not enough on the hard work a successful marriage requires; (3) There should be a longer waiting period required before marriage; (4) Too many couples rush into child bearing without having a strong couple relationship. Responses were given on a 5-point Likert scale ranging from *Strongly Disagree* to *Strongly Agree*. A mean score was computed ($\alpha = .68$ for caseworkers; $\alpha = .60$ for supervisors), with higher scores indicating a stronger belief that healthy marriages require effort.

2.8. Relevance of healthy couple and marital relationships (HCMR) to child welfare

Respondents were also asked to indicate how relevant they felt HCMR and services to strengthen those relationships are for both the clients they serve and the work they do as professionals. HCMR relevance to welfare clients was assessed with 3 statements: (1) Strong marital/couple relationships lead to successful parenting, (2) The clients I work with can benefit from participating in programs that focus on enhancing marriage/couple relationships; and (3) Child welfare clients participation in marriage/relationship enhancement programs can help reduce incidences of child abuse and neglect. HCMR relevance to welfare workers was also assessed with 3 statements: (1) Child welfare workers need knowledge and skills about enhancing marriage/relationships in order to do their job more effectively; (2) Understanding characteristics of healthy marital/couple relationships will strengthen my assessment and case planning skills to reduce abuse/neglect; (3) Gaining knowledge and skills about working with couples will help me perform my job more effectively. Responses were given on a 5-point Likert scale ranging from *Strongly Disagree* to *Strongly Agree*. Due to the similarity in these subscales, they were highly correlated and were combined into a single measure. A mean score was computed ($\alpha = .89$ for caseworkers; $\alpha = .88$ for supervisors) with higher scores representing greater relevance of HCMR to child welfare.

2.9. Appropriateness of RME for welfare professionals

To better understand whether CWPs would support RME training, questions were asked of respondents to determine their support for RME training. Respondents were asked the extent to which they agreed with 2 statements: (1) Do you think it would be helpful for child welfare professionals to attend training on supporting healthy relationships and marriages?; and (2) In your opinion, how appropriate is it for child welfare professionals to help individuals/families develop skills needed to have healthy relationships/marriages? Responses were given on a 4-point Likert scale with responses: *Not at all helpful/appropriate*, *A little helpful/Not very appropriate*, *Helpful/Somewhat appropriate*, and *Very helpful/appropriate*. A mean score was computed ($\alpha = .69$ for caseworkers; $\alpha = .68$ for supervisors), with higher scores indicative of greater beliefs regarding the appropriateness of RME.

3. Results

3.1. Descriptive results

Taking supervisors and caseworkers together, 24.5% of the CWPs had previously received any type of RME-related training. Of those who had received RME-related training ($n = 248$), most received it through a college course (65.7%) or a conference workshop (46.0%), followed by single-day (22.2%), part-day (14.1%), multi-day (13.7%), or web-based (6.9%) training. Given minimal prior training experience, respondents were, on average, ambivalent or "neutral" regarding how confident and comfortable they were with providing RME to their clients ($M = 3.46$, $SD = .70$). With regard to their views about marriage, on average, respondents felt that divorce and unwed childrearing was a somewhat serious problem ($M = 3.17$, $SD = .68$), while agreeing with statements that strong couple and marital relationships require effort ($M = 3.82$, $SD = .68$). Lastly, CWPs largely agreed that RME was relevant to the clients they serve and to their profession ($M = 3.92$, $SD = .68$) and felt that it was appropriate for CWPs to receive RME training and use it in their work with clients ($M = 3.31$, $SD = .62$) (see Table 2 for descriptives by CWP role).

3.2. Mean comparison and correlation analysis

We first were interested in determining if any differences between states existed on the variables included in our analyses. As previously noted, MO CWPs, on average, had a higher number and proportion of couples that they served. Regarding previous RME training, independent samples *t*-tests revealed that, on average, compared to CWPs in North Carolina ($M = .20$, $SD = .40$), MO CWPs ($M = .29$, $SD = .46$) were more likely to have received RME training ($t_{(1011)} = 3.374$, $p < .01$). We were also interested if mean scores for each of the scales were different between CWPs of different states, genders, marital status, racial/ethnic minority status, and CWP role (caseworkers vs. supervisors). To determine any differences, we conducted a multivariate analysis of variance (MANOVA). The multivariate effects for state (Wilks' $\Lambda = .984$, $F_{(5,\ 918)} = 3.064$, $p < .01$), worker gender (Wilks' $\Lambda = .974$, $F_{(5,\ 918)} = 4.932$, $p < .01$), marital status (Wilks' $\Lambda = .974$, $F_{(10,\ 1836)} = 2.427$, $p < .01$), and CWP role (Wilks' $\Lambda = .979$, $F_{(5,\ 918)} = 3.985$, $p < .01$) were significant, though the effects

Table 2
Descriptive statistics and correlations among variables for CWPs.

Variable	Mean (*SD*)										
	Caseworkers	Supervisors	1.	2.	3.	4.	5.	6.	7.	8.	9.
1. Appropriateness of RME training[a]	3.30 (.64)	3.33 (.58)	–	.23**	.21**	.14**	.23**	.05	−.16**	.01	−.04
2. Relevancy of HCMR to child welfare[b]	3.91 (.70)	3.96 (.65)	.36**	–	.11**	.12**	.47**	.05	−.16**	.01	−.04
3. Concern about divorce and unwed childbearing[a]	3.14 (.70)	3.25 (.62)	.21**	.15**	–	.24*	.03	.04	.04	−.01	.09*
4. Belief that healthy marriages require effort[b]	3.85 (.59)	3.75 (.54)	.03	.09	.21**	–	.07	.01	.07	.05	−.03
5. Current RME ability and comfort[b]	3.43 (.69)	3.52 (.72)	.20**	.47*	.09	.06	–	.25**	−.13**	−.06	−.02
6. Prior RME training (0 = No, 1 = Yes)	.24 (.43)	.27 (.44)	.14*	−.03	.19**	.06	.26**	–	.00	.03	.04
7. Number of couples served (in the past 3 months)	19.50 (39.67)	55.34 (116.17)	.00	−.05	.04	.11	−.02	.04	–	.30**	.01
8. Percent of clients who are couples	.59 (.28)	.64 (.27)	.16	−.04	−.05	−.05	.12	−.03	.22*	–	−.02
9. Time in the welfare field (years)	8.10 (6.59)	16.44 (8.07)	.07	.05	.10	.00	.02	.02	.07	−.12	–

Notes. Caseworker ($n = 705$) correlations are above the diagonal. Supervisor ($n = 310$) correlations are below the diagonal.
[a] Possible score range is from 1 to 4.
[b] Possible score range is from 1 to 5.
* $p < .05$.
** $p < .01$ (2-tailed).

were small (partial $\eta^2 = .016$, .026,.013, and .021 respectively). The multivariate effect for minority status was not significant.

As follow-up tests to the MANOVA, we conducted a series of univariate tests (ANOVAs) employing the Bonferroni method to control for Type I error. The univariate effect for state on appropriateness of RME for CWPs was significant ($F_{(1, 922)} = 8.441$, $p < .01$, partial $\eta^2 = .009$): those in NC had significantly higher scores ($M = 3.35$) than those in MO ($M = 3.22$). There were also significant univariate differences for those of different genders on concern about divorce and unwed childbearing ($F_{(1, 922)} = 14.422$, $p < .01$, partial $\eta^2 = .015$) and current RME ability and comfort ($F_{(1, 922)} = 9.406$, $p < .01$, partial $\eta^2 = .010$). In both cases, male workers scored higher ($M = 3.40$, 3.65 respectively) than female workers ($M = 3.11$, 3.40 respectively). There was a significant univariate effect for marital status on concern about divorce and unwed childbearing ($F_{(2, 922)} = 9.679$, $p < .01$, partial $\eta^2 = .021$), with married individuals being more concerned ($M = 3.39$) than those who were single ($M = 3.17$) or divorced ($M = 3.21$). Married individuals also saw RME training as more appropriate for CWPs ($M = 3.35$) than did single individuals ($M = 3.21$), $F_{(2, 922)} = 3.774$ ($p < .05$; partial $\eta^2 = .008$). Finally, on average, supervisors were less likely to believe that healthy marriages require effort ($M = 3.73$) when compared to caseworkers ($M = 3.86$), $F_{(1, 922)} = 8.976$ ($p < .01$; partial $\eta^2 = .010$).

3.3. Structural equation model analysis

We constructed a structural equation model (SEM) to examine influences on relevancy of HCMR to child welfare and appropriateness of RME training (see Fig. 1). Prior to conducting SEM analysis, we were interested in how each of the 5 scales correlated with one another and with the professional experience characteristics of the CWPs (see Table 2). We also considered the possibility of multicollinearity by assessing correlations for all of the study variables. All correlation coefficients were less than the standard recommended cutoff of .85 (Kline, 2010). To account for limited missing data we employed full information maximum likelihood (FIML) estimation. After evaluating the model with data from both states for each CWP role (see below), in our final model we did not separate cases by state, instead controlling for state of data collection. In our final model (see Fig. 1), we did, however, use multi-group analysis to compare results for supervisors and caseworkers. We modeled latent variables for the five scales, while demographic variables were included as manifest variables.

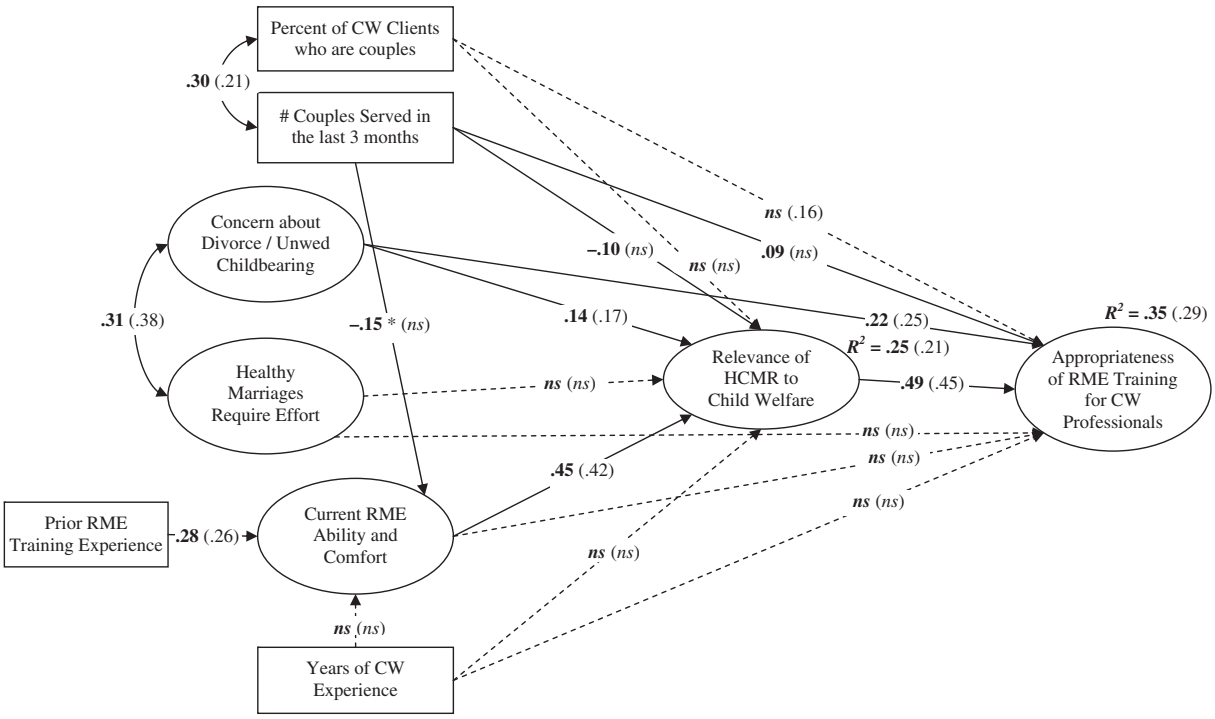
Before evaluating differences between CWP roles, we used multiple group analysis to determine model equivalency across states separately for caseworkers and supervisors. The χ^2 difference comparing the measurement model for caseworkers across states was significant ($\Delta\chi^2_{(13)} = 27.246$, $p < .05$). The χ^2 difference comparing the structural model for caseworkers across states was also significant ($\Delta\chi^2_{(29)} = 43.523$, $p < .05$). Examination of the critical ratios for differences showed that only three of the twenty factor loadings were significantly different across states, and these differences were small ($\Delta\beta < .10$). Furthermore, only two of the structural paths were significantly different. The directionality of effects were consistent across states, and the effect sizes for the differences between states for all but one of the paths were small ($\Delta\beta < .10$; Cohen, 1988; Kline, 2010). The effect size for the difference in the path from total number of couples served to RME ability and comfort was in the small to medium range ($\beta_{diff} = .25$), with no effect seen in MO and a negative effect seen in NC ($\beta = -.23$). As the model was generally similar across states, we grouped all caseworkers together in the final model.

We conducted a similar analysis comparing models for supervisors in both states. The constrained measurement model was not significantly different by state ($\Delta\chi^2_{(13)} = 20.365$, *ns*). The χ^2 difference comparing the structural model across states was significant ($\Delta\chi^2 = 26.904$, $df = 16$, $p < .05$). Examination of the critical ratios for differences showed that only one of the structural paths was significantly different: the path from total couples served to appropriateness of RME training for CWPs was larger in MO ($\beta = .31$) than in NC (*ns*). Again, given the overall similarity in models across states, we grouped all supervisors together in our final model.

Given that the measurement and structural models were largely similar across states for both supervisors and caseworkers—and that the differences did not change our substantive interpretation—we assumed partial model invariance (Kline, 2010), added state of data collection as a control variable, and did not do separate analyses by state in the remaining analyses. We then constructed a multi-group SEM comparing supervisors and caseworkers. The χ^2 difference comparing the measurement model across roles was significant ($\Delta\chi^2_{(13)} = 23.688$, $p < .05$). The χ^2 difference comparing the structural model across roles was also significant ($\Delta\chi^2_{(29)} = 48.594$, $p < .05$). Only three of the twenty factor loadings were significantly different across CWP role, and these differences were small ($\Delta\beta < .10$).[5] Only one of the structural paths was significantly different—the path from total couples served to RME ability and comfort was larger for caseworkers ($\beta = -.15$) than for supervisors ($\beta = -.02$, *ns*)—while differences in the path from total couples served to relevancy of HCMR to child welfare) approached significance ($\beta = -.10$ for caseworkers and $\beta = -.03$ for supervisors).

After constructing the multi-group model, we examined the regression weights to ascertain if any were not significant. When we

[5] Even so, it is important to note that for both caseworkers and supervisors the meaning of the "Current RME Ability and Comfort" and "Relevance of HCMR to Child Welfare" variables may be slightly different by CWP role, though the constructs likely have very similar meaning for both states.



Notes. Caseworkers *in boldface* (n = 705) and supervisors in parenthesis (n = 310). All path coefficients are significant at $p < .05$. Asterisks (*) denote significant differences between CWP role at $p < .05$. All latent variable factors loadings were above .45, with most above .55. The state of data collection was included as a control variable. Model fit statistics: $\chi^2_{(406)} = 839.001$, $p < .01$; TLI = .911; CFI = .934; RMSEA = .032.

Fig. 1. Final model with standardized paths to welfare professionals' view of RME training appropriateness.

included gender and marital status as control variables, the model did not differ substantively.[6] Thus, for parsimony we excluded them from the final model. In multi-group analysis a single group of fit indices is computed. Based on fit indices, the final multi-group model fit the data well: $\chi^2_{(406)} = 839.001$, $p < .01$; TLI = .911; CFI = .934; RMSEA = .032 (Byrne, 2010). The final model is shown in Fig. 1. We employed maximum likelihood Monte Carlo bootstrapping to extract 1000 bootstrap samples to obtain the bias corrected significance levels for the indirect, direct, and total effects (see Table 3). This allowed us to evaluate how relevancy of HCMR served as a mediator to appropriateness of RME training, with significant indirect effects suggesting mediation (Shrout & Bolger, 2002).

The final model explained 25% of the variance in relevancy of HCMR to child welfare for caseworkers (CW) and 21% of the variance for supervisors (Sup). The model also explained 35% of the variance in appropriateness of RME training for caseworkers and 29% of the variance for supervisors. As shown in Table 3, the strongest predictor of HCMR relevancy was current RME ability and comfort ($\beta_{CW} = .45$; $\beta_{Sup} = .42$), followed by concern about divorce and unwed childbearing and prior RME training experience ($\beta_{CW} = .14$ and .13, respectively; $\beta_{Sup} = .17$ and .11, respectively). Further, the number of couples served in the last 3 months was negatively associated with HCMR relevancy ($\beta = -.17$) for caseworkers. As expected, the strongest predictor of appropriateness of RME training was relevancy of HCMR to child welfare ($\beta_{CW} = .49$; $\beta_{Sup} = .45$). The next strongest predictors were concern about divorce and unwed childbearing ($\beta_{CW} = .29$; $\beta_{Sup} = .32$) and, for caseworkers, current RME ability and comfort ($\beta = .23$). For supervisors, the percent of their clients who are couples had a positive effect on appropriateness of RME training ($\beta_{Sup} = .17$). Contrary to its influence on HCMR relevancy, for caseworkers the number of couples served in the last 3 months had a *positive* direct effect ($\beta_{CW} = .09$) on appropriateness. This effect, however, was negated by the negative indirect effect through HCMR relevancy. Examination of the significant indirect effects on appropriateness of RME training (see Table 3) revealed that in many cases the effects were mediated by HCMR relevancy. For example, for caseworkers prior RME training had a positive effect on appropriateness of RME training ($\beta_{CW} = .07$) but only through its effect on HCMR relevancy.

4. Discussion and implications

In this study we found that child welfare professionals (CWPs) from samples in MO and NC largely believe that having a healthy couple and marital relationship (HCMR) is relevant to the clients they serve and offering services that would strengthen those relationships—described here as relationship and marriage education (RME)—is appropriate to the work they perform as professionals. Taken apart, this indicates that CWPs from our sample believe that they can benefit from RME training, that understanding the characteristics of healthy couple relationships would assist them in performing their job more effectively, and that ultimately providing RME to their clients can help reduce incidences of child maltreatment. Further, the majority also believe that it is appropriate for CWPs to help their clients develop skills needed to have healthy relationships and marriages, and that attending RME trainings would be useful in this regard. Our model considered several potential barriers to supporting RME training, but these barriers had little direct effect upon their beliefs about the appropriateness of RME training. With a few exceptions (see Table 3), the influence of these barriers was mediated by how relevant they saw the promotion of HCMR to their families and their work. Importantly, the findings were similar for both caseworkers and supervisors.

One notable finding for caseworkers was the positive relationship between the number of couples served in the last three months and appropriateness of RME training, and the negative association between the number of couples served and the relevance of HCMR to

[6] In the model with control variables the largest change in any path was small ($\Delta\beta = .01$).

Table 3
Decomposition of effects from the structural equation model on outcome variables.

	Indirect effects		Direct effects		Total effects	
Variable	Caseworkers	Supervisors	Caseworkers	Supervisors	Caseworkers	Supervisors
Effect on relevancy of HCMR to child welfare						
State (0 = MO, 1 = NC)	−.01	−.07	.06^{+}	.12^{+}	.06	.05
Number of couples served in last 3 months	−.07**	−.01	−.10**	−.03	−.17**	−.04
Percent of clients who are couples	–	–	.04	.00	.04	.03
Prior RME training experience (0 = No, 1 = Yes)	.13**	.11**	–	–	.13**	.11**
Years experience in the child welfare field	−.02	.01	−.04	.06	−.05	.07
Concern about divorce and unwed childbearing	–	–	.14**	.17^{+}	.14**	.17^{+}
Belief that healthy marriages require effort	–	–	.05	−.07	.05	−.07
Current RME ability and comfort	–	–	.45**	.42**	.45**	.42**
Effect on appropriateness of RME training						
State (0 = MO, 1 = NC)	.02	.00	.12**	.10^{+}	.14**	.10^{+}
Number of couples served in last 3 months	−.08**	−.02	.09*	.03	.01	.01
Percent of clients who are couples	.02	.01	.00	.16**	.02	.17**
Prior RME training experience (0 = No, 1 = Yes)	.07**	.02	–	–	.07**	.02
Years experience in the child welfare field	−.03	.03	.06^{+}	.00	.04	.04
Concern about divorce and unwed childbearing	.07**	.08*	.22**	.25**	.29**	.32**
Belief that healthy marriages require effort	.03	−.03	.02	−.09	.05	−.12
Current RME ability and comfort	.22**	.19**	.01	−.11^{+}	.23**	.07
Relevancy of HCMR to child welfare	–	–	.49**	.45**	.49**	.45**

Notes. Caseworkers $n = 705$; Supervisors $n = 310$. Bootstrap bias-corrected p-values: $^{+}$ $p<.10$, * $p<.05$, ** $p<.01$. Indirect and direct effects may not sum to total due to rounding. Significant indirect effects suggest mediation.

child welfare. We hypothesized that the more couples a CWP worked with, the more relevant and appropriate they would view HCMR and RME training, respectively. One possible explanation for the negative association between number of couples served and relevance of HCMR to child welfare may be that many of the couples CWPs serve exhibit a high rate of domestic violence coupled with substance abuse and mental health issues (Pecora et al., 2000), and thus require more than what RME can offer (e.g., therapy and counseling) to address their needs. However, recent research has shown promising effects for relationship education lowering levels of interpersonal violence among TANF and child welfare clients (Antle, Karam, Christensen, Barbee, & Sar, 2011). Further, child welfare has historically addressed child abuse and neglect at the individual caregiver level as opposed to addressing contextual issues, including the couple relationship (Christensen et al., 2008). Still, the current findings suggest that these same CWPs (those who work with more couples) are more interested in receiving RME training, possibly out of need to better understand the needs of the couples they serve. Similarly, for caseworkers there was an unanticipated negative relationship between number of couples served and current RME knowledge and comfort. Following the same line of reasoning, if CWPs worked with more couples who were in unhealthy relationships, they likely felt uneasy and unsure about helping them improve their relationships by discussing topics that may not be relevant to their situation. It would be unrealistic to assume that RME could be applied to all couples that CWPs work with. Yet, the current sample of CWPs tend to view the promotion of HCMR as relevant and indicate an interest in RME training—perhaps so they can be prepared to use RME in situations where they deem it may be useful. Thus, future child welfare trainings can coach CWPs on strategies to initiate discussions with the individuals and couples they serve in order to assess and best meet their couple relationship needs (see Christensen et al., 2008).

Whereas the number of couples served was found to influence CWPs' views of the relevance of HCMR and the appropriateness of RME, for caseworkers the proportion of total families served that consisted of couples, in contrast to single parents, was not related to either outcome. However, for supervisors it was significantly related to appropriateness. One of the potential barriers to providing RME in child welfare is the misperception that RME is not relevant given that the majority of their clients are single parents and supposedly not in relationships (Antle et al., 2010). The current (non-significant) finding may suggest that this is not the case. Instead, CWPs who work with more couples (vs. single parents) are as likely to view RME as relevant and appropriate as are those who work with a greater proportion of single parents (vs. couples). Still, based on our limited experience and that of a few other scholars (e.g., Christensen et al., 2008) in promoting RME in child welfare, it may be important to clarify and distinguish the benefits and focus of RME for single parents (e.g., relationship development skills) versus cohabiting and married (biological and step) parents when promoting RME in child welfare and engaging CWPs in RME training, especially when working with supervisors.

Regarding "attitudinal barriers" to training, our findings indicate that CWPs' beliefs about the state of marriage positively influence how relevant and appropriate they believe RME is to child welfare. Specifically, those who expressed greater concern about the prevalence of divorce and unwed childbearing were more likely to support RME. Interestingly, endorsement of the belief that healthy marriages require more effort—and specifically that couples today rush into marriage and child bearing and focus too much on happiness and not enough on the hard work a successful marriage requires—was not associated with either HCMR relevance or RME training appropriateness. This finding suggests a need to build greater awareness among CWPs of the benefits of RME in slowing couples down in their relationship decisions to cohabit (Stanley, Rhoades, & Markman, 2004) and marry (Carlson, McLanahan, & England, 2004). RME seems especially relevant for CWPs working with single parents who tend to experience multiple partner transitions (Guzzo & Furstenberg, 2007) as well as with foster care youth who are aging out of the system and may benefit from RME as they transition to adulthood (Antle et al., 2009).

Last, CWPs in the current sample who felt unprepared and uncomfortable with helping their clients improve their couple/marital relationships were also less likely to view the promotion of HCMR as relevant and RME training as appropriate to their work. For many CWPs, their primary responsibilities entail assessment and referral and thus they may not feel comfortable doing more in terms of providing direct educational services. Based on evaluations of RME training for CWPs, those who feel capable and comfortable in supporting the relationships of their clients are more likely to express favorable support for RME in child welfare and apply the skills and tools they learn to practice (Antle et al., 2010). Thus, promoting greater awareness among professionals in the child welfare system of what RME entails may help foster greater comfort with and support of RME. In

fact, the findings showed that those with some sort of prior RME training experience were more likely to report greater RME competency. Therefore, exposing current, and future, CWPs to RME through graduate courses or conference workshops may facilitate greater understanding, comfort, and acceptance of RME.

5. Conclusion

Based on child welfare service's historical efforts to offer FLE-type programming (Barth et al., 2005; Lemon et al., 2005) and recent efforts to integrate RME into their services (Antle et al., 2009; Christensen et al., 2008; Sar et al., 2010), we propose that there may be more overlap of the services CWPs offer with family life education (FLE) than some suggest (Myers-Walls et al., 2011). CWPs are in a unique position to increase the stability, safety, and well-being of children by teaching principles and skills to individuals and couples that enhance knowledge of what constitutes a healthy versus unhealthy and potentially abusive relationship, strengthen current or future couple relationships, and empower individuals to safely exit unhealthy relationships. Consistent with the majority of those who responded to our survey, we contend that CWPs can, and perhaps should, provide information, tools, and strategies related to RME to increase knowledge and skills of individuals and couples they work with. Orthner et al. (2004) note that "those who work with [at-risk] low-income families must understand the interconnection between strengthening families economically and relationally" (p. 166). In addition to helping families acquire economic assets and medical benefits, they further argue that "the value of strengthening relationships should be given equal attention by those who provide support services" (p. 166). Still, caution is warranted in assuming that all CWPs are prepared to offer RME.

Although CWPs have traditionally not been trained to provide RME, the findings of the current study suggest that CWPs do tend to believe that promoting healthy couple and marital relationships is relevant to both the families they serve and their work and that participating in RME training would be appropriate. The reservation of CWPs involvement in providing RME is due, in part, to their primary focus on intervention as opposed to prevention strategies (Pecora et al., 2000) as well as a function of other attitudinal, systemic and cultural barriers within the child welfare system (Christensen et al., 2008). The current findings also suggest how some of these factors may deter or promote child welfare's endorsement and involvement in RME training. Given the expansion of CWPs' role to also offer services related to parenting, financial, health—and now relationship—education, and consistent with the Children's Bureau's vision to provide families comprehensive services and to strengthen and support the child welfare workforce (Mitchell et al., 2012), we would further recommend that those preparing for work in child welfare, or similar professions, consider receiving specialized family life education training during their undergraduate and/or graduate education to qualify them to also become certified family life educators (National Council on Family Relations, n.d.).

Recent efforts to engage CWPs through training to prepare them to support healthy couple and marital relationships shows promise in shifting attitudes regarding the relevance and usefulness of RME training to child welfare, which in turn influences the transfer and application of skills learned (Antle et al., 2010). Additional research is warranted that further examines not only the efficacy of such trainings, but how RME services are best delivered to those in the child welfare system and how effective those services actually are for the families and children. In sum, we suggest that as CWPs assist families with meeting needs, coordinating services and managing problems, that they also offer preventive services that help individuals and couples build healthy relationship knowledge and skills, which can prevent future problems.

References

Antle, B. F., Frey, S. E., Sar, B. K., Barbee, A. P., & van Zyl, M. A. (2010). Training the child welfare workforce in healthy couple relationships: An examination of attitudes and outcomes. *Children and Youth Services Review*, *32*, 223–230.

Antle, B. F., Johnson, L., Barbee, A., & Sullivan, D. (2009). Fostering interdependent versus independent living in youth aging out of care through healthy relationships. *Families in Society*, *90*(3), 309–315.

Antle, B. F., Karam, E. A., Christensen, D. N., Barbee, A. P., & Sar, B. S. (2011). The effectiveness of healthy relationship education to reduce intimate partner violence. *Journal of Family Social Work*, *14*, 1–21.

Barth, R. P., Landsverk, J., Chamberlain, P., Reid, J. B., Rolls, J. A., Hurlburt, M. S., et al. (2005). Parent-training programs in child welfare services: Planning for a more evidence-based approach to serving biological parents. *Research on Social Work Practice*, *15*, 353–371.

Bellamy, J. L. (2008). Behavioral problems following reunification of children who have experienced long term foster care. *Children and Youth Services Review*, *30*, 216–228.

Blanchard, V. L., Hawkins, A. J., Baldwin, S. A., & Fawcett, E. B. (2009). Investigating the effects of marriage and relationship education on couples' communication skills: A meta-analytic study. *Journal of Family Psychology*, *23*, 203–214.

Byrne, B. (2010). *Structural equation modeling with AMOS: Basic concepts, applications, and programming* (2nd ed.). New York: Taylor and Francis Group.

Carlson, M. J., & McLanahan, S. S. (2006). Strengthening unmarried families: Could enhancing couple relationships also improve parenting? *Social Services Review*, *80*, 297–321.

Carlson, M. J., McLanahan, S., & England, P. (2004). Union formation and stability in fragile families. *Demography*, *41*, 237–262.

Christensen, D., Antle, B., & Johnson, L. (2008). Integrating couple teamwork conversations into child welfare practice. *Journal of Family Social Work*, *11*, 303–322.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum.

Cowan, P. A., & Cowan, C. P. (2002). Interventions as tests of family systems theories: Marital and family relationships in children's development and psychopathology. *Development and Psychopathology*, *14*, 731–760.

Cummings, E. M., & Merrilees, C. E. (2010). Identifying the dynamic processes underlying links between marital conflict and child adjustment. In M. S. Schulz, M. K. Pruett, P. K. Kerig, & R. D. Parke (Eds.), *Strengthening couple relationships for optimal child development* (pp. 27–40). Washington, D. C.: American Psychological Association.

Davis, L. V. (1996). Role theory and social work treatment. In F. J. Turner (Ed.), *Social work treatment* (pp. 581–600) (4th ed.). . New York: Free Press.

Guzzo, K. B., & Furstenberg, F., Jr. (2007). Multi-partnered fertility among American men. *Demography*, *44*, 583–601.

Halford, K. W., Markman, H. J., Kline, G. H., & Stanley, S. M. (2003). Best practice in couple relationship education. *Journal of Marital and Family Therapy*, *29*, 385–406.

Hansen, M. E. (2008). The structure of families who adopt children from foster care. *Journal of Public Child Welfare*, *2*, 427–449.

Harris, S. M., Glenn, N. D., Rappleyea, D. L., Diaz-Loving, R., Hawkins, A. J., Daire, A. P., et al. (2008). *Twogether in Texas: Baseline report on marriage in the Lone Star state.* Austin, TX: Health and Human Services Commission.

Hawkins, A. J. (2012). Promoting positive pathways for youth and young adults to healthy relationships. In P. Noller, & G. Karantzas (Eds.), *The Wiley handbook of couples and family relationships* (pp. 423–436). West Sussex, UK: Wiley-Blackwell.

Hawkins, A. J., Blanchard, V. L., Baldwin, S. A., & Fawcett, E. B. (2008). Does marriage and relationship education work? A meta-analytic study. *Journal of Consulting and Clinical Psychology*, *76*, 723–734.

Karney, B. R., Garvan, C. W., & Thomas, M. S. (2003). *Family formation in Florida: 2003 baseline survey of attitudes, beliefs, and demographics relating to marriage and family formation.* Gainesville: University of Florida, Department of Psychology.

Kline, R. B. (2010). *Principles and practice of structure equation modeling* (3rd ed.). New York: The Guilford Press.

Leiber, M. J., Mack, K. Y., & Featherston, R. A. (2009). Family structure, family processes, economic factors and delinquency. *Youth Violence and Juvenile Justice*, *7*, 79–99.

Lemon, K., Hines, A. M., & Merdinger, J. (2005). From foster care to young adulthood: The role of independent living programs in supporting successful transitions. *Children and Youth Services Review*, *27*(3), 251–270.

McLanahan, S., & Beck, A. N. (2010). Parental relationships in fragile families. *The Future of Children*, *20*, 17–31.

Mitchell, L., Walters, R., Thomas, M. L., Denniston, J., McIntosh, H., & Brodowski, M. (2012). The Children's Bureau vision for the future of child welfare. *Journal of Public Child Welfare*, *6*, 550–567.

Mooradian, J. K., Hock, R. M., Jackson, R., & Timm, T. M. (2011). What couples who adopt children from child welfare want professionals to know about supporting their marriages. *Families in Society*, *92*(4), 390–396.

Myers-Walls, J. A., Ballard, S. M., Darling, C. A., & Myers-Bowman, K. S. (2011). Reconceptualizing the domain and boundaries of family life education. *Family Relations*, *60*, 357–372.

National Council on Family Relations (n.d.) CFLE Certification. Retrieved December 15, 2012, from http://www.ncfr.org/cfle-certification.

Ooms, T., & Wilson, P. (2004). The challenges of offering relationship and marriage education to low-income populations. *Family Relations*, *53*, 440–447.

Orthner, D. K., Jones-Sanpei, H., & Williamson, S. (2004). The resilience and strengths of low-income families. *Family Relations*, *53*, 159–167.

Pecora, P., Whittaker, J. K., Maluccio, A. N., Barth, R. P., & Plotnick, R. D. (2000). *The child welfare challenge: Policy, practice, and research* (2nd ed.). New York: Child Welfare League Press.

Perlman, H. H. (1968). *Persona: Social role and personality*. Chicago: University of Chicago Press.

Rhoades, G., & Stanley, S. (2009). Relationship education for individuals: The benefits and challenges of intervening early. In H. Benson, & S. Callan (Eds.), *What works in relationship education: Lessons from academics and service deliverers in the United States and Europe* (pp. 45–54). Doha, Qatar: Doha International Institute for Family Studies and Development.

Sar, B. K. & Antle, B. F. (2003). *The U-5 questionnaire: A measure of child welfare workers' values and beliefs about marriage and couple relationships among child welfare clients*. Unpublished Instrument. University of Louisville: Author.

Sar, B. K., Antle, B. F., Bledsoe, L. K., Barbee, A. P., & Van Zyl, M. A. (2010). The importance of expanding home visitation services to include strengthening family relationships for the benefit of children. *Children and Youth Services Review*, *32*, 198–205.

Shrout, P. E., & Bolger, N. (2002). Mediation in experimental and non-experimental studies: New procedures and recommendations. *Psychological Methods*, *7*, 422–445.

Stanley, S. M., Rhoades, G. K., & Markman, H. J. (2004). Sliding versus deciding: Inertia and the premarital cohabitation effect. *Family Relations*, *55*, 499–509.

Turner, H. A., Finkelhor, D., & Ormrod, R. (2007). Family structure variations in patterns and predictors of child victimization. *The American Journal of Orthopsychiatry*, *77*, 282–295.

U.S. Department of Health and Human Services (2000). *Rethinking child welfare practice under the Adoption and Safe Families Act of 1997: A resource guide*. Washington, DC: U.S. Government Printing Office.

Weaver, D., Chang, J., Clark, S., & Rhee, S. (2007). Keeping public child welfare workers on the job. *Administration in Social Work*, *31*, 5–25.