Zero to Three journal

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Supporting Fathers and Mothers as Coparents:

The Next Frontier for Infant Mental Health

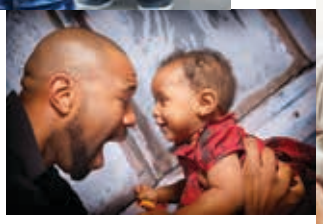
FEATURED IN THIS ISSUE:

Promoting Healthy Father–Child Attachment in Families Affected by Domestic Violence

A Relationship-Based Intervention for Incarcerated Fathers

Engaging Military Fathers in a Reflective Parenting Program

An Australian Perspective on Father-Inclusive Practice



This Issue and Why It Matters

Although research demonstrates that fathers provide a unique and important contribution to parenting and child development, it is also clear that family intervention programs have traditionally focused on the mother–child relationship and dramatically less (or not at all) on the father–child relationship. In a recent review of the literature on parenting interventions, researchers found that few programs included father participation or impact in their evaluations (Panter-Brick, et al., 2014). The researchers argued for an overhaul of program design and delivery to avoid marginalizing fathers and to fully involve them as coparents.

In this issue of *Zero to Three*, we are delighted to collaborate with Guest Editors James McHale and Vicky Phares, professors at the University of South Florida, to explore how fathers are included in services to families with very young children. The articles in this issue describe a new impetus to move from focusing on the mothers and their children to a focus on the family system. We hope that the information presented here provides inspiration and a call to action for concentrated and systematic efforts to more effectively support and engage both fathers and mothers as coparents in the care of their children in all we do.

We would love to hear about your challenges and successes with involving fathers in programs of support for families with young children, and we invite you to share your experiences and insights with a Letter to the Editor.

Stefanie Powers, Editor
spowers@zerotothree.org

Panter-Brick, C., Burgess, A., Eggerman, M., McAllister, F., Pruett, K. and Leckman, J. F. (2014). Practitioner Review: Engaging fathers – recommendations for a game change in parenting interventions based on a systematic review of the global evidence. *Journal of Child Psychology and Psychiatry*. Advanced online publication. doi: 10.1111/jcpp.12280

For a few additional free resources related to fatherhood, the ZERO TO THREE website offers:

- **Assuming a Triadic Lens: Practitioner Stances That Reinforce Coparenting**
  Drawing on cutting-edge conceptual and empirical work, this new tip sheet helps center professionals in their efforts to "think three" and engage with fathers and mothers toward growing and solidifying their coparenting alliance. Available at **www.zerotothree.org/coparentingtipsheet**

- **The Daddy Factor: How Fathers Support Young Children's Development**
  This new fact sheet provides a summary of how fathers make a positive impact on a child's long-term development. Available at **www.zerotothree.org/daddyfactor**

- **Daddy, Papi, Papa, or Baba: The Influence of Fathers on Young Children's Development**
  From ZERO TO THREE's podcast series *Little Kids, Big Questions*, Dr. Kyle Pruett answers questions about the important and unique role of fathers in the lives of young children. Available at **http://zerotothree.org/about-us/funded-projects/parenting-resources/podcast**

- **Tuning in to Dad: Key Findings From a 2009 Parent Survey**
  Findings from ZERO TO THREE's national parent survey revealed what fathers find the most challenging aspect of child rearing and what kind of information fathers want about child development. Read a summary at **www.zerotothree.org/about-us/funded-projects/parenting-resources/fathers_hr.pdf**

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CONTENTS

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ALSO IN THIS ISSUE

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From Dyads to Family Systems: A Bold New Direction for Infant Mental Health Practice

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ABSTRACT

This issue on fathers was conceived as a rallying cry for all professionals to examine their practices of including fathers in their services. For too long, infant mental health professionals have either ignored fathers' important influences on infants and toddlers or have given lip-service to their importance while allowing the status quo of not including fathers to continue. This article provides history and context for the impetus behind—and the hurdles to—moving from focusing on dyads to family systems, and it highlights a few forward-looking new programs and initiatives already transforming practice. It sounds a clarion call for all professionals to dramatically alter the way they deal with fathers and families in the practice of infant mental health, and to begin doing so now.

Every child has two parents biologically. And virtually all children grow up in circumstances where their socialization and development are, continuously or episodically, materially influenced by more than one caregiving adult in a broader family relationship network that operates as the child's "coparenting" system (McHale, 2007, 2009; McHale & Irace, 2011). Yet despite these realities, the professional routines of those in the infant mental health field evaluate and promote safety, attunement, sensitivity, inter-subjectivity, and security in the child's relationship with just a single individual—nearly always, the infant's mother. When concentrating on mother–infant dyads, infant mental health professionals give obligatory acknowledgment to data attesting to the importance of fathers to children, conceding the outcomes of model demonstration projects that show the efficacy of programming that brings fathers into the family life of their infant and toddler-aged children. In addition, infant mental health advocates criticize, indict, and work to influence the systems of health care and law that have wittingly or unwittingly institutionalized father absence, and they vow to see through a change.

But things don't change. Not really—and certainly not at the pace that empirical evidence amassed over the past 40 years would seem to demand. In jurisdictions across the United States, fathers are still often seen as trespassers in work with mothers and infants. Instead of adopting the posture: "Where is the child's father? We cannot begin the work without him. Let's redouble our energies to get him in here, engage with him, help him understand that our efforts on behalf of his baby will not succeed without him", infant mental health professionals reflexively accept that he is not their target. They further rationalize the omission by pointing to data that virtually all domestic violence is perpetrated by men; equate the father's delinquent or altogether-absent child support payments as a proxy for his lack of interest and deservingness in having a relationship with his infant child; and note that in some states—even if the father is seen together with the mother and baby—there is not even a way to substantiate the time devoted to him in the systematized accounting systems that have been developed for "coding" home visiting encounters and billing for the work. In short, infant mental health professionals throw their hands up and accept the fact that, in 2015, the birth to 3 field is still no closer to approaching infancy from a mother–father–infant model than it was in the 1970s.

This is not to say that no progress has been made, or that there have not been champions for fathers. There have been many, their numbers are growing, and their efforts are verifying what is possible when professionals and programs insist on providing services to infants and fathers as well as to mothers. We will briefly highlight a few of these significant efforts in this article, principally to provide some substance to the outwardly Pollyannaish perspective that father engagement—as an obligatory best practice rather than an afterthought or

extravagance—is both prudent and within reach if the collective will can be mobilized.

Step One: Acknowledging Barriers

To achieve the essential transformation, to push forward in the necessary ways, a first step is to mindfully grapple with the reasons why there continues to be invisible resistance. Some of these reasons have been alluded to: reservations about reaching out to any father given concerns about the proportionately small but nevertheless real cluster of dangerous men interspersed among all of the good and decent men, entrenched views that fathers are unworthy and undeserving of relationships with their infant children if they can not or do not provide financially for mother and baby. Other reasons are systemic—well over 95% of all providers in programs and agencies that serve families of infants and toddlers are women, and when asked, female providers acknowledge being not as accustomed to and often also not as comfortable working with men as they are with women (Dion & Strong, 2004). Yet even when clinicians do invite both parents to take part in therapeutic interventions, mothers remain significantly more likely than fathers to engage in treatment (91% versus 63% in one study by Duhig, Phares, & Birkeland, 2002). Clearly, asking for and expecting fathers' involvement, while an important first step, will seldom be sufficient. Operating behind the scenes are less readily visible factors that hold fathers back from taking steps to engage in treatment. And the reality is that unless providers' supervisors are themselves ardent proponents of father engagement, the current status quo is likely to remain steel-clad.

Another key reason why infant mental health professionals remain stuck is historical, yet seldom acknowledged or discussed. Among the champions for fathers have been those affiliated with a variant of a "men's movement" that has actually been more reactionary to the women's movement than it has been promotive and empowering of men's health and well-being. An unfortunate and well-publicized rallying cry from this side group, exhorting men to "take back our families," has fueled the worst stereotypical images of men as possessive, controlling, and domineering. The exhortation to "take back what is ours" also strikes a chord among those well-aware that the most dangerous intimate partner violence of all is that perpetrated by men who believe they have an unalienable right to possess and control other human beings. Hence the small, fringe group of "men's movement" advocates who embraced the inflammatory verbiage (and perhaps also, some of the undesirable sentiments behind it) are, unfortunately, as firmly fixed in the sensibilities of the vanguards of infant mental health as is the work of the sage, forward-thinking contributors to this journal and the hundreds of others doing exemplary work that is truly promoting men's, women's, children's, and families' mental health.

It is disturbing that the sum total of the beneficial movements to empower both men and women has been the disempowerment of infants and toddlers, a casualty of dividing the mother—father–infant "primary triangle" (Fivaz-Depeursinge & Corboz-Warnery, 1999). Supporting only mothers and infants as standard practice,

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The positive presence of a supportive father benefits not only infant but also maternal mental health.

while not itself a misadventure, might be more aptly seen as a worst best practice. Why say this, when conventional wisdom has held that so long as the infant has at least one person in her life who can function effectively as a parent, be a trustworthy and sustained presence, and stay the course through thick and thin, the baby will have a fighting chance in life? Beyond the compelling case that Kyle Pruett (2000) has marshalled for "Fatherneed", it is the last of these three tenets—the one person staying the course through thick and thin—that gives pause. So many of the mothers who come to the attention of infant mental health professionals come precisely because of mental health or substance-related issues affecting her, the baby, or both. Although many of those problems were caused, or perpetrated, by violent fathers, as many or more were not.

Take for example, post-partum depression (PPD), a common concern among the families infant mental health professionals work with. Mothers with PPD heal better when fathers are supportively engaged in the treatment. While few interventions conceptualize PPD treatment within a family context, Misri, Kostaras and colleagues (2000) found that partner support in the treatment of 23–46-year-old mothers suffering from PPD had a palliative effect. Relative to control-group patients, Misri et al.'s support-group patients displayed a significant decline in depressive symptoms and other psychiatric conditions. Partners

of women in the support group were also less likely to show a deterioration of their own general health than were partners of women in the control group. In other studies of higher-risk families where parents face psychiatric challenges themselves, child outcomes are as or more dependent on coparental and family-level functioning than on the quality of the dyadic interaction with the high-risk parent (Seifer & Dickstein, 1993). That is, the quality of family functioning appears to be a particularly significant mediator in the outcomes of children exposed to parental risk and psychopathology (Dickstein et al., 1998). And for every child, especially after infancy, the sustainability and integrity of their family system—whatever configuration the system takes for any particular child and family—is what will ultimately confer to them their grounding, sense of safety, and "family-level security" (Burton & Stack, 2014; McHale, 1997; Minuchin, 1985).

What findings such as these signify is that the positive presence of a supportive father benefits not only infant but also maternal mental health—as a supportive mother undoubtedly supports paternal mental health. Indeed, Gaskin-Butler and colleagues (this issue, p. 49) determined that unmarried African American mothers' post-partum reports of depression were significantly lower following a prenatal mother–father coparenting intervention than they had been prior to the intervention. This finding is especially significant in light of data indicating that rates of post-natal depression among inner-city unmarried black mothers in enhanced usual care are customarily quite high, sometimes approaching 50% (Howell, Balbierz, Wang, Parides, Zlotnick, & Leventhal, 2012). But while coparenting support appears vital, any efforts to support family-level health and functioning must also take into consideration complex family dynamic factors beyond simply presence of the child's father—even when his presence is positive.

During early infancy, mothers' immersion in their new maternal role has been at the core of both theory and clinical practice, in the writings of Freud, Winnicott, Mahler, Bowlby, Stern, and other influential leaders. Fathers, by contrast, have been characterized as a "third wheel" during the early post-partum, excluded from both the developing relationship between mother and baby and from the intimate sexual and romantic union with the baby's mother that pre-dated the baby's arrival. What is so curious, and telling, about these depictions is that they disregard the third leg of the triangle, the third dyadic relationship, the evolving relationship between father and baby. The father–baby relationship is important too in affecting the "family-level dynamic" that is our principal interest and concern in this article.

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Fathers have been characterized as a "third wheel" during the early post-partum period.

In a fascinating report called "Sharing the Love", Jean Talbot and her colleagues (2009) gave careful attention to the sensibilities of both mothers and fathers in the same family as they transitioned to coparenthood and found something very curious. Examining both mothers' and fathers' states of mind with respect to attachment, they found an unexpected tie-in to early coparenting adjustment. Talbot drew on observations of mother–father–baby interactions (the Lausanne Trilogue Play procedure) and identified a number of families in which inter-adult coordination was poor, and interference and "verbal sparring" (jabs at the partner) frequent— dynamics reflecting "coparenting conflict." What was intriguing was that the highest levels of observed coparenting conflict at 3 months post-partum were found in families where mothers had insecure states of mind with respect to attachment—and fathers secure. That is: Rather than being a buffer or protective factor, fathers' security in the face of maternal insecurity was harbinger of a negative coparenting dynamic. It seemed possible that a secure, confident father, if perceived as a threat or interloper upon the evolving relationship between an insecure mother and baby, catalyzed a family-level dynamic that was more conflictual and dissonant than in families where father was himself insecure. A secure paternal state of mind with respect to attachment did not have the same effect when mothers were also secure. This finding is also interesting in light of reports from some parents in home visiting programs where efforts are made to include fathers—the home visitors are seen as being there to support mothers, not to support both mothers and fathers. Father's presence hence may not only be gratuitous (if the home visitor supplants his role as support), but actually unasked for by mother if his presence jeopardizes what she finds to be a positive and supportive relationship with her home visitor. Not addressing these very basic quandaries would seem to compromise the success of any efforts intended to transform dyad-only work into triangular and family-level case conceptualizations.

Pioneering Initiatives Moving From Dyads to Systems

So the problems are many, and ubiquitous. They run broad, and deep. They are reinforced by mindsets, on the part of many professionals, that infant mental health work is dyadic. It has mother and baby at core and at base (Panter-Brick et al., 2014). Fathers or other coparents are auxiliary, good to include if possible, but not necessary. Family-level security is an indiscernible concept. We could spend the rest of this article further exhorting change, but that would probably be futile. Changing the focus from dyads to family systems truly would be a bold and transformative new direction for all of infant mental

health practice, one that most agencies are not ready to take. Yet it is one that can, even now, be navigated with the proper roadmap and resolution. The articles in this issue provide some blueprints that can be embraced and emulated or adapted. They include explorations of how fathers can be portrayed more positively in the mass media (Brown, this issue, p. 11); how even fathers with multiple stresses and challenges or who are at higher risk, or both, can be guided to develop greater sensitivity and attunement to their children (Iwaoka-Scott & Lieberman, this issue, p. 18; Richeda et al., this issue, p. 25) and better reflective functioning (DeVoe & Paris, this issue; p. 43; Stover, this issue, p. 36); how families can be strengthened when mothers, fathers, and infants are conceptualized as a system (Gaskin-Butler et al., this issue, p. 49); and how nationwide changes can be put into place (Fletcher, StGeorge, May, Hartman, & King, this issue, p. 60). Here are a few other pioneering initiatives to stimulate thought about what is possible.

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A key to the transformations needed is an appreciation, buffeted by relevant funding supports, that good parenting—by any parent—requires sound mental health.

INTEGRATING FATHERS INTO HOME VISITING

While there has been increasing attention paid in the United States to the importance of involving fathers in home visiting (Duggan et al., 2004; Holmberg & Olds, 2015; Smith, Duggan, Bair-Merritt, & Cox, 2012), useful blueprints for how to address the entrenched challenges to shifting from a mother–baby to mother–father–baby paradigm are not yet available. Some of the known impediments include (a) lack of training and perhaps discomfort of female home visitors in working with men; (b) lack of incentives to agencies for outreach and engagement of fathers (e.g., expense of truly engaging and "staying with" men to the same extent as mothers are "stayed with", inability in many states to specially code and bill for encounters with fathers even if they are engaged); (c) existing maternal, paternal, and agency views of home visitor as "mother's" resource and attendant unwillingness of some mothers (and home visitors) to relinquish the special supportive relationship they enjoy; (d) unfamiliarity of most agencies with coparenting frameworks and intervention models; (e) home visitors' unfamilarity with conflict management skills if work involves more than one person; and (f) presence in agencies of individuals positioned to work with both mothers and fathers together.

This last consideration can be especially formidable. The cost of providing a family more than one home visitor (in the form of a male–female team) to carry through a coparenting undertaking is one stumbling block, compounded by the absence of male workers in most agencies even if that model were to become a favored one. When there is just a single home visitor to do the work, less experienced female home visitors without the proper training or supervision may be caught unprepared if they encounter uncomfortable dynamics related to authority issues or to interpersonal attraction. Proper training, experience, and professional supervision of parallel process dynamics are critically important to have securely in place if coparenting work is to succeed.

With these known impediments as a starting point, a new initiative in Chicago is asking whether it is possible, on a grand scale, to transform home visiting services—in a manner that will help provide some guidance to other states and jurisdictions about effective methods for identifying, addressing, and solving seemingly insurmountable obstacles. The Dads Matter project is using randomized control methodology to study possibilities for and impediments to affecting change in systems serving families. It tests a modular intervention (Guterman, 2012; Guterman, Bellamy, & Banman, 2014) designed to be flexibly and sustainably "layered" into existing standard home visiting services as currently staffed (e.g., no additional male home visitors, male–female teams, or clinically trained staff are required). The model is implemented using a training and supervision approach designed to re-orient programs at every level, from administration to front line workers, to a coparenting framework for services that begins at the earliest stages of intake and service planning. Training and supervision are designed to explicitly address the concerns, fears, and misgivings of home visitors as they begin to serve fathers to increase motivations and tackle challenging issues such as risk for interpersonal violence. The content of the intervention includes modules on engagement, assessment, coparenting skills, and other issues that may present barriers to fathers' engagement in home visiting services (e.g., difficulty with help seeking, stress and anger management).

This initiative will have much to teach as it evolves. The presumption that study-enrolled fathers will be fully involved in the home visiting program is a core value and premise of the effort, one sure to shed light on the expansive possibilities of approaching work from a frame where the family is the client and the preventive service is at home (as opposed to requiring both parents to attend an office-based appointment). The program's ingenious strategy of randomizing families at the level of supervisors rather than agencies or workers will help disentangle some of the factors associated with differential success by home visitors. And tactics used in the project to help ensure fathers' continued engagement week-by-week so that he remains fully embraced and integrated, even when the father cannot attend given sessions, will provide needed guidance to a field poised for meaningful transformation.

DOCUMENTING COPARENTING AND FAMILY-LEVEL DYNAMICS

In a new Infant-Family Mental Health service being developed at All Children's Hospital in St. Petersburg, Florida, standard intake procedures include routine inquiry about and documentation of the multiple relationships infants share with the important adults in their lives. Beyond answering questions about who resides with the baby, how frequently the child has contact with her father (if he is not co-residential), and what linkages family members' have to informal (e.g., extended family) and formal (e.g., early care and education provider, early intervention provider) supports, parents also complete a child-centered "ecomap" or graphic visualization that provides a clearer and more immediate conceptualization of current relationship dynamics and issues (McHale & Fivaz-Depeursinge, 2010). Ecomaps are child-centered in that the referred infant or toddler is the one placed in the center of a drawing initiated by each coparent. The adults then trace lines that connect the infant or toddler to every adult with whom the child has a bond or "heart connection" (McHale & Fivaz-Depeursinge, 2010). Following conventions that guide traditional ecomap assessments, solid lines are used to signify strong connections and dotted lines to signify more tenuous or unsure ones. Examples of child-centered ecomap drawings can be found in McHale and Dickstein (in press). Reviewing the ecomaps with the family illuminates similarities and differences, orients everyone to begin viewing the family system and dynamics through the child's eyes, and promotes greater parent and clinician sensitivity to the pivotal importance of coordinating among adults within the multi-person relationship system supporting the child's development (McHale, 2007; Minuchin, 1985). It also helps ensure that a coparenting framework will be called upon in case formulations and interventions to support the baby and encourage family-level security.

FAMILY CONSULTATIONS

At the Hinks-Dellcrest Centre in Toronto, Canada, a new approach involves two parents rather than one in a brief family therapy intervention called Reflective Family Play (RFP; Philipp, 2012; Philipp & Hayos, 2015). The model developed in part because many parents were asking to have both caregivers included in treatment instead of the traditional mother–baby dyadic approaches offered at Hinks-Dellcrest at the time. Fathers were already fully included in assessments as there has long been an expectation at the Centre that both coparents participate in the evaluation of their child and family. In the transformed model, play assessments are used to observe not only the child interacting with each parent, but also the family interacting as a whole. Following the assessments, the recommendation may still be dyadic treatment for the child with one parent. However, for other families a course of 8–12 weeks of RFP is suggested. Each session of RFP begins with the whole family playing together using a semi-structured format that ensures that everyone has a chance to engage with one another. The play is videotaped, and in the second half of each session the family and therapist review the interactions together. The focus of treatment is to foster the parents' attunement to their children, to improve coparenting, and to foster the family alliance. The program has seen excellent adherence rates, symptom reduction, and improved parenting confidence as well as improved coparenting communication.

Closing Points and Conclusions

The programs described in this article and the programs highlighted in this issue illustrate how focusing on coparenting and on the mother–father–infant primary triangle can work and does work. Our aims have been to draw attention to the potential for the kinds of system change necessary if the field of infant mental health is ever to transform to a true field of infant–*family* mental health. In this closing section we address a few final issues that will be necessary background for this transformative work to proceed.

SPEAKING MEN'S LANGUAGE

It is perhaps not surprising that in a field where interventions are delivered principally by women to women, language, metaphors, and best practices are in a woman's voice. This is not to suggest that the alternative is buying into stereotypical imagery and crippling metaphors such as those critiqued by Brown in his article (this volume, p. 11). Rather, serving men in a "culturally competent" way requires better understanding of men's sensibilities. Men will not respond positively to suggestions that they feel "overwhelmed." A recommended tactic in trauma-informed work—shifting from the stance "what's wrong with you" to the stance "what happened to you?"—cannot be applied literally with most men, for to suggest that something "happened" to a man is consonant with intimating that he was not properly on guard, or adequately prepared, or strong enough to defend himself from adversity. Professionals know, of course, that is precisely the point—he was not adequately prepared, for he was a child when trauma occurred. And professionals eventually do wish to help fathers to let down their guard and work to develop their own mind-mindedness (Arnott & Meins, 2007). However, insisting that men acknowledge their vulnerability to professionals is a sure-fire way to drive many men away, rather than to draw them in or to help them feel "seen." Understanding men's self-definitions is key. Ron Levant's (1992) reconceptualization and embracing of the positive attributes of "traditional masculinity" (ability to withstand hardship and pain, ability to protect others, willingness to set aside his own needs for the sake of his family, tendency to take care of people and solve their problems as if they were his own) provides a useful primer in learning about men, as does Louise Silverstein's (2002) work. But having men (and not just one man) on the ground in child-serving agencies as everyday colleagues is the best way of all to begin moving this needle.

ADDRESSING MEN'S MENTAL HEALTH

The authors of this article live in a state that is 49th in the country in spending on mental health, but where the key to success is jobs, jobs, jobs. Men are caught in the cross-fire. Somehow, it has escaped everyone's sensibilities that for men (and women) to hold down jobs, pay taxes, and support themselves and their families, they need to be free of debilitating mental health issues. Not

only is men's help-seeking behavior far poorer than women's—for precisely the reasons articulated earlier, an unwillingness to show vulnerability—but professionals then conspire with men to marginalize them, fail to offer services, and hold them culpable for children's woes once they make the determination that their children may, indeed, be better off without them. A key to the transformations needed is an appreciation, buffeted by relevant funding supports, that good parenting—by any parent—requires sound mental health. Research, clinical work, and public health interventions also must target misconceptions among men that a lifestyle involving poor self-care and lack of help seeking is masculine (Sher et al., 2014). The models serving men may be different (Stover, this issue, p. 36): Creative adaptations of cognitive behavioral approaches—not limited to, but including group models—may suit men and fathers well and should be part of any suite of services available in child-serving agencies.

RAISING BOYS TO BE FATHERS

If there is one thing professionals have learned from decades of research on intergenerational transmission, family scripts, unconscious schemata, working models of relationships, and effects of social experience on creation of brain architecture, it is that people do what they know. With the passage of days, weeks, months, years, it becomes increasingly difficult to affect major and enduring change. Although many professional communications about fatherhood maintain that fatherhood begins at the time of the child's birth, others pre-date matters to the point that the father learns of the pregnancy. But neither of these stances is quite right; the roots of fathering really take hold in the father's own infancy, toddlerhood, and early childhood. Specifically, all fathers were once infants and toddlers, and the majority of infant and toddler boys will one day be fathers themselves.

When parents, child care providers, and infant mental health professionals provide infant and toddler-aged children with toy choices that include baby dolls and accoutrements consistent with caregiving roles—and reward them for engaging in caregiving activities—they are teaching the children to give care. This set of experiences is far more endemic in the raising of daughters. But were parents to provide sons with toy choices consistent with caregiving roles and reward them for engaging in those activities, they would have more of a relevant foundation and more readily embrace nurturance and the giving of care as they age. After the first 3 years, providing guided opportunities for elementary and middle school aged boys to help look after and teach younger schoolchildren in supervised settings; assuring that health classes, etiquette classes, and entrepreneurship and leadership classes within existing indigenous cultural contexts incorporate dialogues about relationships and accentuate how to treat ones' partners and children; providing opportunities for both boys and girls to hear from and have conversations with strong males who also model reflective capacity—all of these are life experiences that stand to help play a role in further cultivating brain pathways seeded from birth to 3, and influencing the emergent sensibilities of boys as they begin moving along pathways to fatherhood.

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The roots of fathering really take hold in the father's own infancy, toddlerhood, and early childhood.

It has been hard enough to change the gendered expectations within the infant mental health profession. Imagining the culture shifts necessary to change the societal expectations of how to raise sons and daughters to be engaged and competent fathers and mothers sometimes seems an insurmountable task. But if professionals change what they do to provide services only to the entire family (including the father if he is known) and if they take opportunities to help parents see how their parenting of their sons and daughters will have ramifications for their own grandchildren, then perhaps professionals can have a greater impact on the well-being of infants and toddlers as well as their mothers and fathers. Fletcher and colleagues' work (this issue, p. 60) provides one glimpse of what a blueprint giving comprehensive attention to boys and men can look like, were professionals to seriously consider taking a whole-child, lifespan development, family-level approach. Brown's searching essay (this issue, p. 11) provides food for thought about how media imagery might aid in affecting the societal-level culture change that would be a supportive context for these meaningful shifts. And the infant mental health guild can take the torch and lead the way—or not.

TRANSFORMING AGENCIES

Institutional change needs to be tackled both from the bottom-up and from the top-down. Fletcher and colleagues' article (this issue, p. 60) provides an inspirational account of the sheer scope of transformation that is possible on a grand level if the right people are in synch and involved. But at a "micro-level" system transformations are just as dependent on the readiness of an organization and its people to make and sustain the shift. Providers' attitudes toward innovation, as well the organizational social context in which services are provided, affect the adoption and implementation of innovative approaches to care, including transformed care for infants at risk for poor outcomes. In fact, the organizational culture may yield the greatest influence on

limiting or facilitating the acceptance and willingness of direct service providers to implement new treatment paradigms in routine care (Glisson et al., 2008; Proctor et al., 2009).

Inclusion of fathers in home visiting is a good case in point. In the Chicago research initiative previously outlined, administrators and middle-level managers have been asked to make participation in Dads Matter a priority that is a non-negotiable and expected part of job responsibilities. If workers have a sense that the service is optional, or voluntary, there is potential for slippage into old habits. Yet even with a clear message about transformations needed, very early indicators have seen discrepant rates of enrollment in the Dads Matter project across different programs, where some workers report that well over half of all families eligible to participate in the program agree to do so (Guterman, 2012), whereas others have much lower rates (10%, 5%, even 0%; J. Bellamy, personal communication, February 11, 2015). This variability raises a possibility that workers may play as much, or even more, of a gatekeeping role as mothers. That is, those on the front line may decide on their own whether dads should or should not be engaged. Adopting a stance that so long as safety issues are not of concern, all mothers and fathers should be commended to partake in services for their baby and family together, is not one that comes readily.

Sound familiar? We suspect that this is likely to be the state of affairs in most agencies, institutions, and organizations throughout the United States. Dedicated and deliberate attention to internal resistance of both front-line personnel and middle-level supervisors and managers will need to augment top-down shifts in thinking. In the case of the Dads Matter pilot project much of the early work has involved helping workers and supervisors think creatively not only about how to reach out to fathers but also how to troubleshoot anything difficult or unexpected that comes up either with the father or in the mother–father relationship. The results of the trial being conducted by the Chicago Dads Matter program will provide some needed insights in the coming months and years regarding how well mothers and fathers' attitudes and expectations about participating in home visiting services together are aligned with workers' perceptions—and as importantly, the extent to which worker attitudes are changed by the experience of working with fathers.

Learn More

Coparenting: A Conceptual and Clinical Examination of Family Systems
J. McHale & K. Lindahl (2011)
Washington, DC: American Psychological Association Press

A comprehensive and cutting-edge review of theory and research pertinent to coparenting, across a diverse range of family systems.

Charting the Bumpy Road of Coparenthood: Understanding the Challenges of Family Life
J. McHale (2007)
Washington, DC: ZERO TO THREE

A detailed summary of the first major research investigation to focus specifically on how coparenting alliances evolve in middle-income two-parent families, from pregnancy through the toddler years. Written in a style appropriate for parents as well as for professionals.

Including Fathers in Clinical Interventions for Children and Adolescents
V. Phares, A. Rojas, I. B. Thurston, & J. C. Hankinson (2010)
The Role of the Father in Child Development, 5, 459–485

University of South Florida St. Petersburg's Family Study Center's webinars on coparenting and fathers
http://www.usfsp.edu/fsc

ENGAGING AND SUPPORTING OTHERS

Coparents are sometimes limited to a child's biological mother and father, though in millions of American families the biological parents are not the lone or even the salient coparental partners (McHale, 2009; McHale & Irace, 2011). Certainly, the identities of all coparenting adults—mother or, in some families, mothers, father or fathers, grandparents and other kin caregivers, step-parents, foster parents, and so on—must be known if interventions are to take hold and be effective. But regardless of who the partners in the family's alliance are, the key to adaptive coparenting is that all of the adults principle in the child's care and upbringing communicate cooperatively and in an ongoing way to ensure that the particular needs of each individual child are understood and uniquely met. This definition of coparenting is an inclusive one that acknowledges the life circumstances of all children, including the millions of American children coparented by unmarried fathers and by other family caregivers not formally recognized by the system of law (McHale & Irace, 2011). Assessment procedures and case conceptualizations such as the one described above for the St. Petersburg, Florida, All Children's Hospital initiative that actively seek to engage all actively involved coparents at the point of intake and case conceptualization lay the groundwork for more child-centered and family-sensitive intervention.

As we discuss the significance of integrating fathers into our preventive and clinical practices, it is important to relentlessly be "thinking three" (Gaskin-Butler et al., this issue, p. 49; McHale & Alberts, 2003) and operating with a triadic lens (Iwaoka-Scott & Lieberman, this issue, p. 18; McHale, 2011) toward mutual engagement of both parents. Mutually engaging both parents is different than empowering fathers by vilifying the work of mothers (Silverstein & Auerbach, 1999). Iwaoka-Scott and Lieberman's accounting of the case of Michael and Elena (this issue, p. 18) provides a needed glimpse into the care and sensitivity therapists must muster to resist the temptation of selecting out one good and one bad parent in the millions of families where coparenting conflict occurs. To this point, we also caution against the unintentional but counterproductive negative stereotyping of women that unfortunately often attends use of terms like "maternal gatekeeping", a concept that has increasingly been used to help edify why fathers are not more engaged with their offspring. As Brown (this issue, p. 11) highlights, there certainly do exist mothers who engage in behaviors that intentionally restrict the father's access to the child. However, studies have suggested that such deeds

are not pervasive (Puhlman & Pasley, 2013). Rather, research has documented that mothers—along with fathers—show facilitative as much as restrictive behavior regarding the child's engagement with the other parent (Coates & McHale, 2015; Roy & Burton, 2007; Zvara, Schoppe-Sullivan, & Dush, 2013). Thus, "gatekeeping", to the extent it exists at all in any given family, entails not just "gate-closing" but also "gate-opening" (Zvara et al., 2013). Just as we do not think it appropriate, accurate, or in children's best interests for professionals to reflexively assume that fathers as a group are incompetent and out-of-touch with their children's sensibilities, so too do we think it not generative for professionals to presume that mothers as a group are driven to keep fathers distant from their offspring.

CONCLUSION

In North America, ZERO TO THREE has long set the standard for leading-edge, best practice work on behalf of infants and toddlers. That vision is reflected in this journal issue that challenges—and pushes beyond—the current comfortable practice of giving a nod to dad if he happens to be around and accessible, but pressing forward without him when he is not readily standing by. But for the infant mental health field to transform from a dyadic to a family systems model, where every infant mental health contact in every corner integrates fathers and other coparenting adults in standard care, comprehensive examination of current policies, practices, and procedures is called for. Every indicator suggests that in the overwhelming majority of cases, this transformation will better serve children. Responsible fatherhood programs are helpful, but not enough. Father-friendly agency face-lifts will help, but alone will not do the trick. Leadership will matter, but the questioning of existing practices will need to come from every agency, institutional, and organizational leader, male and female alike, or the transformation needed will never come to fruition. The dim outlines of what is possible have been drawn, and the change is in professionals' hands. We hope this article, together with the collection of extraordinary articles in this journal issue, will sound a clarion call for this change to finally take place.

James McHale, PhD, is professor of psychology and director of the Family Study Center at University of South Florida St. Petersburg. He trained as a family therapist in both Palo Alto and Philadelphia, and is former director of clinical training at Clark University. His research studies of coparenting have been funded since 1996 by the National Institute of Mental Health, National Institute of Child Health and Development, and Brady Education Foundation. In 2004, he was the World Association for Infant Mental Health's "Decade of Behavior" lecturer, and in 2007 delivered ZERO TO THREE's Special Address on coparenting in diverse families at the National Training Institute. His 2007 book, *Charting the Bumpy Road of Coparenthood* received the Harris Award from ZERO TO THREE, and his 2011 book *Coparenting: A Conceptual and Clinical Examination of Family Systems* (with Kristen Lindahl) provided the field's first comprehensive look at research on coparenting in diverse family systems.

Vicky Phares, PhD, is a professor in the University of South Florida Department of Psychology and served for 13 years as the director of clinical training. She has written on fathering and families in numerous articles and books. She received the inaugural Outstanding Graduate Faculty Mentor Award in 2011 and was recently awarded a grant from the Association of Psychological Science Fund for Teaching and Public Understanding of Psychological Science.

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Errata

In the article "Mi Bebé y Yo: A Primary Care Group for Latino/a Infants and Their Spanish-Speaking Caregivers", *Zero to Three, 35*(4), pp. 35–43, the affiliation on page 35 for Rachel Becker Herbst was omitted. It should read:

Rachel Becker Herbst

Children's Hospital Colorado

Americans' Views of Fathers' Competency as Parents Through a Mass Media Lens

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Portrayals of fathers in the mass media influence parents' views of the importance of fathers to the well-being of children and of fathers' competence as parents. Awareness of how these portrayals influence parents is crucial to the effectiveness of professionals as they seek to improve child well-being through their work with parents, particularly through tactics that seek to increase the involvement of fathers in children's lives. This article raises awareness among professionals about how media depictions of fathers influence parents and concludes with recommendations for how professionals can counter negative stereotypes of fathers.

From Jim Anderson in *Father Knows Best*, to Al Bundy in *Married…With Children*, to Jay Pritchett in *Modern Family*, the portrayal of fathers in the mass media has reflected changing norms in America about the father's role in the family. The portrayals have also reflected the general confusion in society, and among parents specifically, about the father's role caused by rapidly changing norms in gender roles and changing family forms.

Awareness of the impact of the mass media is crucial to the effectiveness of professionals in the field of infant mental health as they seek to improve child well-being through their work with parents, particularly through tactics that seek to increase the involvement of fathers in children's lives. Parents' views influence the ease or difficulty with which a professional can engage a father in raising his child. For example, a mother's view of her child's father can influence how much access she will provide the father to her child. The term "maternal gatekeeping" (Pruett, Arthur, & Ebling, 2007) is often used to describe a mother inhibiting or facilitating a father's access to his child. Moreover, if a father has a negative view of his own competency, and doesn't value the role of a father generally, it will make the professional's job much more challenging than if the father believes he is or can become a good parent. A professional's own view of fathers can also influence willingness to proactively engage a father regardless of the father's level of involvement in his child's life or the quality of the relationship between the parents (Iwaoka-Scott & Lieberman, this issue, p. 18; McHale & Phares, this issue, p. 2).

This article raises awareness among professionals in the field of infant mental health about how the mass media positively and negatively influences the views of parents about fathers' competency as parents and, indeed, how it shapes professionals' own views of fathers. It concludes with recommendations for how professionals can counter the negative effects of the mass media on parents' views of fathers' competency and, in the process, address any negative views the professionals themselves might have of fathers.

The Ubiquity of Mass Media

Mass media plays a vital role in shaping Americans' views of men and women as parents, especially since television became a ubiquitous part of American life. Mass media is any form of communication that reaches a mass audience. Until recently, it was easy to identify mass media as television (TV), radio, movies, and print (e.g. newspapers and magazines). The explosion of the Internet, however, has added digital and social media to the mass media mix.

Nevertheless, the traditional forms of mass media, particularly TV, still have a disproportionate effect on shaping Americans' values and perceptions (Allen & Casey, 2007). Moreover, the vast majority of research on the effect of mass media on values and perceptions has focused on the traditional forms with an emphasis on TV (e.g., sitcoms and advertising/commercials). Since TV burst onto the American landscape in the 1940s and 1950s, Americans' consumption of it has soared. Nearly every home (97%) has at least one TV, and the average home contains nearly 3 TVs (Nielsen, 2009; Stelter, 2011). Estimates of the average amount of time Americans watch TV range from 3–5 hours a day (Bureau of Labor Statistics, 2014; Hinckley, 2014). Adults watch nearly 38% more TV than children. African-Americans watch more TV than any other ethnic group (Hinckley, 2014).

Photo from WikiCommons

The father of Jim Anderson's day (*Father Knows Best* ran from 1949–1954 on radio and 1954–1960 on TV) was a competent, married parent who understood his role as a breadwinner.

The Image of Fathers in TV Programs

The father of Jim Anderson's day (*Father Knows Best* ran from 1949–1954 on radio and 1954–1960 on TV) was a competent, married parent who understood his role as a breadwinner. He worked diligently to support his family. His children benefitted from his advice and discipline, did whatever he asked, and did not rebel. He didn't tread on the mother's domain as his children's primary caregiver and caretaker of the household. He was ever present, at least when he was not at work. His role and that of his wife were crystal clear, and they loved and respected each other.

The father of Al Bundy's day (*Married…With Children* ran from 1987–1997) was an incompetent joke of a parent. He was married and struggled and fought against his wife's desire for a life outside the home. He was asked to step up as a parent in ways that he had not been asked to before and for which he was ill-prepared and had no desire. He was emotionally unavailable and, in many ways, a danger to his children. His children were better off without his advice and discipline, scoffed at what he asked them to do, and were in constant rebellion. Even though they loved each other, he and his wife were constantly at odds, rarely agreeing on anything, let alone how to raise their children, and had little respect for each other.

Jay Pritchett of *Modern Family* (who, ironically, is played by Ed O'Neill, the actor who also played Al Bundy) embodies the father of today. He is a more competent parent than Al Bundy. While he is often married, he is often on his second or third marriage. He might be married to someone of a different race and have adult children and infant children. He might be single and living with or without his children, a stay-at-home father, or a gay father. Depending on his age and upbringing, he might or might not struggle with his more expansive role as provider and nurturer. He often embraces the mother's more expansive role as provider and nurturer and today's egalitarian home.

While a bit simplistic, the progression of the portrayal of fathers offered by the preceding comparison of TV dads is supported by research. A study of long-running and top-rated sitcoms from 1950–1990 found that modern TV dads, particularly working-class dads like Al Bundy, were portrayed more foolishly than TV dads of the past (Scharrer, 2001). Other studies have also found sitcoms to portray dads as foolish (Petroski & Edley, 2006; Prinsloo, 2006). Another study of 12 programs from six major networks during the 2004 season found negative and positive portrayals of fathers diverse in race and socioeconomic status, which reflects the struggle of so many fathers in the past few decades to understand their role in the family (Pehlke, Hennon, Radina, & Kuvalanka, 2009).

The Image of Fathers in Advertising

Programs are not the only way in which TV portrays an image of fathers. Commercials do as well. Studies have found that commercials rarely portray men as nurturers (Cantor, 1990; Tsai & Shumow, 2011). In fact, men are rarely portrayed as fathers in any commercials associated with programs for men, women, or children. One study found that when fathers were included in such commercials, none of them were portrayed as nurturers whereas half of mothers were portrayed as nurturers (Gentry & Harrison, 2010).

Commercials, and mass-media advertising in general, play a vital role in how Americans perceive fathers because of their ties to consumer brands. Consumer brands are important transmitters of norms and values in Western cultures. They are powerful symbols because consumers often strongly identify with them. The increased prominence of digital and social media has extended the power of brands through integrated marketing campaigns that reach into every corner of Americans' lives.

I found no recent studies on portrayals of fathers in commercials. My own observations as an anthropologist on how American culture portrays fathers point to a case of extremes in today's portrayals and a double standard in portrayals of parents.

At one extreme, fathers are still often portrayed as incompetent, foolish, emotionally disconnected parents. The double standard involves competent, wise, emotionally connected mothers who must often rescue those fathers. Two recent commercials, by the home improvement company Lowe's and the appliance manufacturer LG, illustrate these points. The Lowe's commercial (titled "Valspar Reserve: Video Call") focused on a line of paint the company carries called Valspar Reserve Paints. A mother

away from home on a business trip video chats with the father of her children who, at the time of the chat, is in the kitchen with their three young children. The scene at home is an unmitigated disaster. Food and other substances cover the walls of the kitchen, appliances, everything in sight. The father makes every attempt to conceal what has happened in the absence of the mother who, clearly, is the only competent parent in the home. The commercial portrays the father as:

- An irresponsible, untrustworthy adolescent.
- A sneak and liar.
- Incapable of meeting his children's most basic needs or appropriately dealing with his children's behavior.
- A manipulator of his wife and children.

The LG commercial (entitled "Just Like Magic") opens with a mother watching her teenage son in front of a refrigerator full of food. Her son has a blank stare. He's clearly not all there. She wonders whether her son thinks that if he stares long enough into the refrigerator that food will suddenly appear. She confidently walks over to the refrigerator and clicks on a button that opens a hidden compartment with more food. She then wonders from where her son gets that behavior. On cue the father appears, opens the refrigerator, and stares into it with the same blank stare as his son.

At the other extreme, fathers are increasingly portrayed as competent, nurturing, emotionally healthy parents. Two recent campaigns, by food giant General Mills Canada and by the car marker Toyota, illustrate this point. The effort of General Mills Canada reflects today's increased reliance of consumer brands on integrated marketing campaigns. They launched a web-based campaign for Peanut Butter Cheerios anchored by a series of ads that portray fathers in a positive light. Known as the "#HowToDad" campaign, it shows dads are competent parents. The campaign transforms Peanut Butter Cheerios into the "Official Cereal of Dadhood." The #HowToDad campaign is a comprehensive web-based campaign that, in addition to the ads, includes static images, infographics, and videos (e.g., of fathers doing inspirational activities with their children) that visitors can share across multiple social media platforms.

Toyota centered their 2015 Super Bowl "One Bold Choice Leads to Another" campaign (also a web-based campaign) for the Toyota Camry on promoting a positive image of fathers through a series of ads of varying length that don't resemble typical commercials. Well-known former and current National Football League players and working dads (e.g., a construction worker and a fireman) appeared with their children and discussed the "bold choices" dads have to make daily for their families. Many of these fathers discussed the impact of being raised without their own fathers in their lives or by present fathers who were poor parents. Some of the children discussed the impact on their lives of having involved fathers.

The differences in these two sets of ads reflect the extremes in portrayals of fathers. On the positive end of the extreme, the General Mills Canada and Toyota efforts better reflect the reality of parenting in today's America. The influence of parents as partners in raising children in all aspects of domestic life has continued to grow. Fathers have taken on a steadily increasing share of the parenting load in recent decades (*USA Today*, 2013). Fathers spend more time than ever with their children generally, grocery and retail shopping for the family, and doing housework (e.g., cooking and cleaning). Fathers are also more focused than ever on the desire to balance work and family. Indeed, they're often more conflicted than mothers in this regard (Aumann, Galinsky, & Matos, 2011).

The Effects of Portrayals of Fathers

Research is clear that children need the presence and involvement of their fathers to stand the best chance of thriving. Children who grow up with involved fathers fare better, on average, across a range of physical, emotional, mental, and social outcomes than do children who grow up without their fathers (National Fatherhood Initiative, 2011). Fathers' involvement is at least as important as mothers' involvement to children's healthy development (Rohner & Veneziano, 2001).

Unfortunately, parents and professionals can be unaware of this evidence, and may not seek out this evidence to inform their views. When unaware of the evidence, their views are more

Photo: © iStockphoto.com/IPGGutenbergUKLtd

Fathers spend more time than ever with their children generally, grocery and retail shopping for the family, and doing housework (e.g., cooking and cleaning).

susceptible to shaping by the ubiquitous presence of mass media's extreme and negative portrayals of fathers—portrayals that run counter to the evidence that children need involved fathers and that fathers can be competent parents. Compounding matters, if parents and professionals have had negative experiences with fathers in their own lives (e.g., their own fathers or husbands/partners of their own children), they are at risk for generalizing the negative views of fathers shaped by their own experiences to all fathers, with those views then reinforced by the mass media's negative portrayals of fathers. This dynamic in which the mass media create and support negative views of fathers can influence professionals' work with parents to the ultimate detriment of children and families. When professionals hold negative views of fathers, they are reluctant to engage fathers and may unwittingly support negative maternal views of fathers by not encouraging the mothers to involve fathers. Professionals also reinforce fathers' negative views of themselves by not proactively engaging fathers to show them they can be good parents.

How the Effects Operate on Views of Fathers

Clients and professionals are often unaware of how vulnerable they are to effects of the mass media. The reason for this lack of awareness is these effects work through several cognitive biases that operate unconsciously (Kahneman, 2011). The three most common biases through which the mass media operate are framing, agenda setting, and priming.

FRAMING

Framing refers to the way in which information is presented in a positive or negative light and the effect of that presentation on an individual's choice about the focus of that information. Just as different frames highlight different aspects of a painting—thus drawing someone's eye to different aspects of a painting—the way in which the mass media portrays fathers creates a frame that draws viewers' attention to specific aspects (positive or negative) of fathers.

AGENDA SETTING

Agenda setting refers to the way in which the mass media influences views of what is and is not important. Just as the agenda for a meeting communicates what is important, news coverage of specific topics (e.g., the economy, terrorism), communicates what is important. Lack of coverage of specific topics communicates, through omission, what is unimportant. As I noted earlier, commercials rarely portray fathers as nurturers, thus communicating that aspect of a father's role is not important.

PRIMING

Priming refers to the effect of exposure to images in the media on subsequent thoughts viewers might have. Those thoughts can lead to actions based on those thoughts. Just as a meeting organizer might prepare (prime) meeting attendees ahead of a meeting by asking them to review specific materials and prepare their thoughts, the way in which the mass media portrays fathers can cause viewers to have related thoughts about fathers in general or fathers they know. A negative portrayal can spark related negative thoughts and vice versa.

In summary, the ways in which the mass media portrays fathers creates a positive or negative frame in which clients and professionals view fathers, communicates what aspects of fathers are important and unimportant, and sparks related positive or negative thoughts among viewers about fathers in general and fathers they know. These three effects feed into two other biases that impact parents and professionals, the availability bias and the confirmation bias.

When professionals hold negative views of fathers, they are reluctant to engage fathers and may unwittingly support negative maternal views of fathers by not encouraging the mothers to involve fathers.

AVAILABILITY BIAS

The *availability bias* refers to people's tendency to recall information that is most readily available. It causes people to overestimate the probability that events will occur. Child abductions and plane crashes, for example, tend to generate lots of coverage in the mass media. As a result, people commonly overestimate the frequency of child abductions and plane crashes. Media coverage frames, sets the agenda, and primes what is readily available for recall. When clients and professionals are exposed to more negative portrayals of fathers in the media than positive ones, they will more readily recall the negative portrayals.

CONFIRMATION BIAS

The *confirmation bias* refers to people's tendency to seek evidence that supports their current views. People naturally want reassurance that their views are correct. They don't typically challenge their own views by seeking evidence to disprove them. It's threatening to people's sense of whom they are to admit when they're wrong. That threat makes the confirmation bias one of the most potent cognitive biases because people don't actively look for evidence that their views might be wrong. When a person views fathers as unnecessary to child well-being, as incompetent parents, or as a danger to children, that person will seek out and pay attention to images in the mass media that confirm that view and ignore images and evidence to the contrary.

What Professionals Can Do to Counteract Negative Portrayals

Professionals can do a lot to endorse fathers' importance to the well-being of children, and the message that fathers are, and can become, competent parents. By doing so, they can also address their own views of fathers' importance and competency. Professionals should keep in mind that mothers and fathers can have negative views of fathers' competency. Professionals should

also recognize that parents may or may not separate their views about an individual father's competence from their views of the competence of fathers generally. Some parents will believe that a specific father is incompetent—but that he can become competent if given a chance and information or training on how to become competent. Other parents will believe that a specific father is incompetent—and that there is no hope for him becoming competent because fathers, in general, are incompetent.

Before offering recommendations for change, it is vital to acknowledge that not all fathers should be involved in the lives of their children. Fathers with violent and abusive tendencies are, in fact, a danger to their children and to the mothers of their children. While representing a very small minority of fathers, professionals must be aware of violent or otherwise abusive histories in the father–child and mother–child relationships of their clients before applying the recommendations.

The following recommendations include some that directly counteract negative portrayals of fathers in the mass media and others that indirectly counteract those portrayals through proactive engagement of fathers that send a clear message about fathers' importance and competence. Although the recommendations that directly counteract negative portrayals focus on TV, professionals can apply them to any form of mass media, and also to digital and social media.

- **Identify whether parents have a positive or negative view of fathers' competency and potential competency.** If a parent's view is not apparent (e.g., the parent has not voiced her or his opinion), ask non-threatening, open-ended questions to identify the parent's view of the father and fathers in general.
- **Identify whether the TV shows and advertising parents watch support or don't support a positive view of fathers' competency.** Ask parents about the ways in which fathers are portrayed in the TV shows and advertising (commercials) parents watch. Ask whether those portrayals are realistic and how they support or don't support parents' views of fathers' competency.
- **Encourage parents to watch TV shows that portray fathers as competent, nurturing parents.** Make a list of TV shows to watch. Identify shows that portray fathers as competent and nurturing. It's fine if the father struggles in his role as long as he is competent and nurturing. It's also important that the shows include a healthy relationship between the father and mother, even if the parents are not together. To expose parents to positive portrayals of fathers in commercials, professionals with access to the Internet during client interactions can show commercials (e.g., via YouTube) with positive portrayals.
- **Encourage parents to pay attention to the TV shows their children watch and how those shows portray fathers.** Children's shows can contain negative portrayals of fathers. These shows shape children's views of fathers in general. They can also reinforce a negative view a child might have of his own father, especially if the child's mother talks negatively about the father to or in front of the child. Encourage parents to talk with their children about the portrayals of fathers in the shows their children watch. Tell parents to expose their children to shows with positive portrayals and even to watch those shows together.
- **Engage fathers right from the start.** There are a number of ways professionals can engage fathers from their very first encounter with clients. Simple acts like including information on program intake forms that capture the father's information and more involved acts like requiring the father's presence

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Professionals can do a lot to endorse fathers' importance to the well-being of children, and the message that fathers are, and can become, competent parents.

Learn More

Web Sites

National Fatherhood Initiative
www.fatherhood.org

FatherSOURCE™
www.fathersource.org

National Responsible Clearinghouse
www.fatherhood.gov

Fatherhood Research and Practice Network
www.frpn.org

Electronic Resources

The Father Friendly Check-Up™ for Social Services and Programs
National Fatherhood Initiative
www.fatherhood.org/ffcu

(when feasible) at initial and subsequent parent engagements (e.g., home visit) send an important message—the father is important and valuable.

- **Provide parents with access to information, such as literature (e.g., brochures and guides) and Web sites, which discuss the importance of father involvement in children's lives or provide advice on how fathers can become more involved generally and in specific areas of children's lives (e.g., education and sports).** Professionals should ensure that the sources of information are appropriate for a parent's literacy level and informed by research.
- **Conduct programs or workshops for fathers on father involvement or refer fathers to organizations that provide such programs or workshops.** Increasing the involvement of fathers doesn't happen overnight. Some fathers need training on how to be a better father. There are fathering programs that last several months and workshops that last a day to a few days. Ensure that the programs and workshops are based on or informed by evidence on what works to increase father involvement.
- **Provide literature or conduct programs or workshops for mothers on improving the relationships they have with the fathers of their children.** As noted in the introduction to this article, maternal gatekeeping is a phenomenon in which a mother can inhibit or facilitate a father's access to his child. A mother can do so consciously or unconsciously whether she and the father are married, cohabitating, or never married. There are resources, programs, and workshops (see Learn More) that seek to address maternal gatekeeping by raising mothers' awareness of this phenomenon and encouraging mothers to loosen unnecessary restrictions on fathers' access to their children.
- **Assess the "father readiness" of professionals' organizations and implement strategies and tactics to increase father readiness.** Professionals rarely practice in a vacuum. They are usually part of an organization that is dedicated to or has a focus on infant mental health and work with parents. The culture and practices of an organization influence the professional's work with parents. An organization that believes, for example, in the value of fathers will encourage a professional to engage fathers and, hopefully, provide resources (e.g., funds and training) to help the professional with that task. An organization that doesn't value fathers will erect barriers to a professional's attempts to engage fathers. Tools exist that help professionals—indeed, entire organizations—assess an organization's willingness and readiness to engage fathers and create no-cost and low-cost strategies and tactics to increase father readiness (see Learn More sidebar for the "Father Friendly Check-Up" tool).

Conclusion

The ubiquity of the mass media creates a challenging environment in which to engage fathers in the lives of their children. The explosion of digital and social media only adds to the challenge. Today's portrayals of fathers include many negative portrayals that influence parents' views of fathers by framing, setting the agenda for, and priming parents' views even as these portrayals leverage potent cognitive biases. At the same time, professionals can use the many positive portrayals of fathers to directly counteract negative views. Professionals can also indirectly counteract them through proactive engagement of fathers and engagement of mothers around the importance of father involvement. Proactive engagement sends a powerful message about the importance of fathers to the well-being of children.

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Moving From Dyads to Triads: Implementation of Child-Parent Psychotherapy With Fathers

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Including fathers is the next frontier for infant mental health. In this article, the authors describe the inclusion of fathers as equal partners in Child-Parent Psychotherapy (CPP), an evidence-based treatment for young children experiencing or at risk for mental health problems following exposure to violence and other adversities. The authors present two vignettes in which the father's participation in treatment was pivotal to successful outcomes for the child, and they illustrate some of the considerations, complexities, concerns, and rewards of engaging and working with fathers. They discuss the benefit of using a "triadic lens" (McHale, 2011) for formulation and treatment planning with all families involved with CPP.

The front door opens and the father walks in. His 20-month-old daughter leaps into his arms yelling, "Papa!" The father tosses her into the air and catches her. They giggle as the mother watches with a worried expression. The father sees his wife's concern and slows the game down. The toddler shouts, "More!" After a brief hesitation, the father resumes tossing the child up in the air. As the child becomes giddier, the father says, "My arms are tired. Time to stop!" and they collapse on the sofa, laughing.

This scene is typical of many healthy father–child interactions. The toddler turns to the father for exciting games and exploration, trusting in the father's capacity to keep her safe, while the mother may be alert to the possible risks. Freud (1930/2010) observed, "I cannot think of any need in childhood as strong as the need for a father's protection" (p. 20). Whether or not one agrees with this assertion, it is worth asking "why has infant mental health largely overlooked the father's role and focused on the mother as a safe haven from danger and secure base for exploration (Ainsworth, 1979; Bowlby, 1969/1982) and as the target of intervention?" An evaluation of 786 parenting intervention programs worldwide found that fathers are under-represented in program design and implementation as the result of pervasive and often implicit biases that shape cultural attitudes about the centrality of mothers in early childhood development and result in policies and practices that favor the recruitment of mothers and discourage the inclusion of fathers (Panter-Brick et al., 2014). In this article, we describe the inclusion of fathers as equal partners in Child-Parent Psychotherapy (CPP), an evidence-based treatment for young children experiencing or at risk for mental health problems following exposure to violence and other adversities.

Father–Child Attachment

Fathers are important attachment figures and anchors of their children's healthy development (Lamb, 2010). In a study of attachment with both parents, children who were securely attached to their fathers exhibited few behavior problems and greater competence in the broader ecologies of school and peer groups; those with insecure attachment with their fathers had the most behavior problems and lowest competence (Boldt, Kochanska, Yoon, & Koenig Nordling, 2014). In another study, children insecurely attached to both parents ("double insecure") as toddlers had more overall and externalizing problems at 6.5 years old, but security with either parent offset these risks (Kochanska & Kim, 2013). These findings highlight the importance of a secure relationship with the father as a protective factor in child development.

The Family Triad

Attachment theory uses a dyadic model of development (Bowlby, 1969/1982), but von Klitzing, Simoni, Amsler, and Bürgin (1999) asserted that the "triad is the original relational form into which the child is born" (p. 85). Introducing a third person into the dyadic interaction increases complexity. Once they have a child, the two members of the couple must recalibrate their relationship and synchronize it with their individual relationships with their child. Simultaneously, the child must accept his parents' relationship and learn to share each parent. The emotional context (perceived stress versus safety) affects whether dyadic or triadic interactions are favored. "There is a regressive pull towards two-plus-one relationships under conditions of emotional

dysregulation" and stressful circumstances such as separation and reunion (von Klitzing et al., 1999, p. 71).

Inter-parental conflict may create pressure on the child to choose between the parents. When faced with this untenable dilemma, the child's normative anxieties of loss of love and internal badness become heightened. The child wonders, "Will Mommy love me if I love Daddy? Will Daddy leave me if I love Mommy?"

A treatment goal in such situations is for each parent to allow the child to love the other parent. This approach is based on the premise that children with secure triadic representations are better equipped to achieve object constancy, theory of mind, and the integration of love and hate. In this article, we describe the treatment of families with relational conflicts that interfere with the child's felt safety in loving both parents.

Implementing CPP With Fathers and Triads

CPP is a relationship-based treatment for children from birth to 5 years old experiencing or at risk for mental health problems due to exposure to trauma or other adversities (Lieberman & Van Horn, 2005, 2008). CPP incorporates dual attention to the role of the parents' unresolved childhood experiences and to the immediate impact of environmental stressors in disrupting the parent–child relationship and the child's healthy development. The overarching goal is safety and reciprocity in the parent–child relationship as the primary mechanism to promote the child's mental health. CPP uses play and unstructured interactions as vehicles to promote safe partnership, address trauma reminders, and reframe negative attributions. CPP efficacy is supported by five randomized trials conducted in two independent laboratories (University of California, San Francisco Child Trauma Research Program and University of Rochester Mt. Hope Family Center) with different multicultural samples of infants, toddlers, and preschoolers and their mothers. Different trials used different outcome measures depending on the child's age and sample characteristics, and across studies children receiving CPP improved significantly more than the control group in quality of attachment, cognitive functioning, behavior problems, posttraumatic stress disorder diagnosis and symptoms, mental representation of self and mother, and physiological regulation (see Lieberman, Ippen, & Marans, 2009, for review).

The core CPP model involves joint sessions with the child and the primary caregiver, which in approximately 85% of cases is the biological mother. Treatment lasts from 20–35 sessions depending on clinical need and may be extended if warranted. In addition, the model is adapted to multiple family configurations depending on clinical considerations. Fathers come to CPP as primary or sole caregivers, coparents with the child's mother or same-sex partner in an ongoing relationship or after separation/divorce, and as non-biological father figures. Whether, when, and how to incorporate either parent into CPP treatment is determined during an assessment process that ascertains safety issues, the child's symptoms, and relationships within each dyad and the triad. The therapist holds in mind the concept of the triad as the backdrop for formulation and treatment planning, aiming to maximize participation of the child's attachment figures through outreach and flexibility in scheduling times, frequency, and location of treatment.

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The toddler turns to the father for exciting games and exploration, trusting in the father's capacity to keep her safe, while the mother may be alert to the possible risks.

WORKING IN THE TRIAD

Nico, 3 years old, had long, angry tantrums. His parents, Cristina and Rafael, an immigrant Mexican American couple in their mid-20s, felt unable to calm him. The assessment revealed that both parents had histories of severe trauma and experienced depression after Nico's birth. When Nico was 11 months old, Rafael lost his job and became Nico's primary caregiver while Cristina worked full-time. Parental distress was compounded by their cultural perceptions that a mother should be the primary caregiver and a father the breadwinner. Cristina felt ashamed of her lack of affection for her infant son and quickly became discouraged when her attempts to soothe him or stop his tantrums failed. Cristina and Rafael argued, with the fighting sometimes escalating to throwing things and pushing each other. Both parents denied that Nico saw these fights.

Making Space for Mama

CPP sessions revealed patterns of triadic disconnection. During the first treatment session, Cristina was unsuccessful in engaging Nico with blocks. Rafael found a ball and began playing with Nico, leaving Cristina on the side. Cristina reacted by criticizing

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Once they have a child, the two members of the couple must recalibrate their relationship and synchronize it with their individual relationships with their child.

Rafael's play with Nico and drawing Rafael into an argument. Soon all three were sitting in isolation. The therapist reflected on what happened, saying to Nico, "Mama really wants to play with you. She tried to play blocks with you and you didn't want to. Now she's being very quiet. Papa had the idea to play ball, and you liked that. Hmm, now Mama is all alone." After the therapist made similar comments in successive sessions, Rafael tried to include Cristina by saying, "Nico, can you throw the ball to Mama?" Nico tossed the ball and Cristina caught it and tossed it back to Nico. All three played together for several minutes. The therapist reflected, "Both your mama and papa want to play with you, and you have so much fun when you all play together."

Creating a Parental Team

Rafael took over when Nico became dysregulated even when Cristina was interacting with Nico. At Cristina's request, the therapist provided concrete strategies to help Cristina remain calm and contain Nico's behaviors. Cristina practiced these strategies but needed encouragement to persist until she was successful. The therapist also encouraged Rafael to hold back and give Cristina space to help Nico work through his frustrations. Cristina gained confidence in her ability to comfort and provide boundaries for Nico and felt less anxious and more connected with him. When Nico balked at his mother's limit-setting and went to his father for a different answer, Rafael now responded that he and Mama agreed and that Nico should go back and talk with Mama. Feeling her husband's support and witnessing his wife's growing effectiveness enabled the parents to turn to each other for support during Nico's tantrums, which decreased dramatically as a result of the couple's cooperation.

HEARING THE CHILD

After 2 months of treatment, Nico began to play with a family of toy dinosaurs. The big dinosaurs roared and fought each other, and the little dinosaurs got scared and hid. The therapist described how all the roaring and fighting scared the little dinosaurs. Nico said loudly, "I don't like it when you bang things." The parents froze. The therapist said, "Your mama and papa sometimes yell and fight. They don't like it either. They don't want to scare you. They are coming here so that they can remember to use their words and not fight." Rafael said "I didn't know you heard us." Nico banged the dinosaurs together loudly, saying, "It hurts my ears." Cristina looked at Rafael and then at Nico and said, "The yelling and banging scares you." Rafael added, "We are all learning a new way to talk without yelling and banging." Nico brought the little dinosaurs out of their hiding spot and placed them in the herd. After this conversation and some skill-building practice, the parents' arguments became less frequent and intense.

In this case, the father's participation in treatment facilitated improvement in the mother–child relationship and decreased the parental strife contributing to the child's symptoms. Without a triadic formulation, it would be easy to identify the mother–child dyad as the relationship that needed treatment and overlook the importance of strengthening the coparental relationship and leveraging the secure father–child relationship as keys to the successful outcome. Both parents' involvement in treatment also created the opportunity to address the parents' fighting and its effect on Nico, which led to the establishment of greater safety in the home.

The CPP Coparenting Model: An Adaptation for Parents in High-Conflict Separation and Divorce

The coparenting model is an adaptation of the CPP core model for cases of high-conflict parental separation and divorce (Lieberman & Van Horn, 2008). It is based on the premise that young children have the best chances for healthy development when they have safe access to and nurturing relationships with both parents and when both parents can cooperate in their parenting on behalf of the child. Situations in which a parent has been violent warrant a comprehensive assessment of risk and parent appropriateness for parent–child treatment because safety is the highest priority. Parental violence places children in a bind where their natural protector has become a source of danger, leading to fear and conflicting feelings about the parent. However, since more than 60% of children exposed to interpersonal violence continue to live with or regularly visit their fathers who perpetrated violence (Israel & Stover, 2009), these children may be at significant risk if their fathers are not assessed or treated.

When parents perpetrate interpersonal violence, Lieberman and Van Horn (2008) and Stover and Morgos (2013) recommended careful examination of the following dimensions prior to considering involvement in parent–child treatment:

- the nature and severity of abusive behavior;
- dangerousness or lethality;
- coercion and control;
- substance abuse;

- psychological symptoms;
- personality characteristics and attachment;
- trauma history;
- childhood family life;
- parenting beliefs and behaviors;
- life stress;
- symptoms of the children;
- motivation for change and participation in treatment;
- co-parenting relationship;
- symptoms of the mother and father; and
- criminal and child protection history via record review, interagency contact, or both.

In the CPP coparenting model, a single therapist conducts the assessment, feedback, and treatment phases separately with each parent–child dyad. Using a single therapist helps avoid polarization between therapists who may become aligned with the parent with whom they are working, enacting a parallel process where the therapists are drawn into conflict with each other and lose track of the child's experience. The therapist sets up ground rules about safety, mandated reporting, disclosure of information to the other parent, and the separateness of the therapy from legal custody proceedings. Treatment is tailored to the needs of each dyad within the context of the triad. No randomized studies of the CPP coparenting model have been conducted to date, but the unpublished clinical outcome data indicated improvements in child behavior problems at the termination of treatment.

CPP uses play and unstructured interactions as vehicles to promote safe partnership, address trauma reminders, and reframe negative attributions.

COPARENTING AND CREATING SPACE FOR THE CHILD

The story of Brayden and his parents, Elena and Michael, illustrates the experience of a child caught in the middle of his parents' conflict. Working simultaneously with the father–child and the mother–child dyads, the clinician came to understand the distress that the child felt under each parent's pressure to exclude the other parent. The treatment goal was to establish safety, create space for the child's own experience, and give the child permission to remember and love each parent in the presence of the other.

Michael and Elena, a couple in their mid-30s, fought constantly. When Elena unexpectedly became pregnant, she wanted to have the baby and Michael did not. Tensions increased after Brayden's birth. When Brayden was 31 months old, Elena called the police after a fight. Each parent accused the other of physical violence and each denied having been violent. Elena said Brayden witnessed the altercation and Michael said he did not. Both were ordered to attend parenting and anger management classes. They divorced and were awarded joint legal and physical custody of Brayden.

Elena sought treatment when Brayden was 3 years old. She reported that he was aggressive, afraid of his father, and sleeping poorly. The clinician asked whether Michael agreed with treatment for Brayden, and Elena indicated that she had not informed him. Elena agreed to notify Michael when the clinician explained the legal and clinical reasons to do so. Michael then contacted the clinician requesting to also receive treatment.

Assessment of the Mother

Elena, a second-generation Filipina American with strong ties to her cultural roots, revealed a history of childhood trauma including sexual abuse and showed severe symptoms of traumatic stress. She easily became dissociative and flooded with intrusive thoughts and overwhelming feelings. Elena was anxious and depressed. She worried continuously that Michael, whom she described as "violent, impulsive, and intensely competitive," was following her and hurting Brayden. She worried that Brayden would become "like his father." She called child protective services repeatedly to report Michael, but for every report her claims were determined to be unsubstantiated. During the child protective services interviews, Brayden reported that his father did not hit him but that his mother sometimes hit him and yelled at him. Elena initially denied any violence toward Brayden or Michael and referred to Brayden as "my angel who helps me get through all of this." Child protective services determined Elena's hitting to not meet criteria for child abuse.

Angry and discouraged by what she perceived as a lack of response from the judicial system that would not shield her son from his father, Elena wanted to convince the therapist of Michael's dangerousness so that she might have a stronger case to petition for sole custody. The therapist found Elena's arguments compelling and was vigilant about ongoing monitoring for safety, but was aware of the need to hold a triadic frame and maintain a clinical role. Without entering into fact-finding or taking sides, the therapist recognized how difficult, painful, and frightening Elena's experience was and validated her wish for Brayden's and her own safety, discussing how the therapy could be used to understand Brayden's experience and help him with his fears and aggression so that they could both feel safer.

The therapist recognized that establishing safety and trust in her relationship with Elena was the first stage of the dyadic work. She used grounding techniques to help Elena regulate her emotions through the assessment process and met individually with her for two sessions to provide psychoeducation about trauma reactions, coping strategies, and self-care. The therapist also helped Elena to connect her childhood history of sexual abuse with the vulnerabilities she felt in her relationship with Michael and to separate

her fears of Michael from her experiences with Brayden. With Elena's agreement, the therapist made a referral for individual psychotherapy for further in-depth trauma treatment in addition to CPP.

Assessment of the Father

Because of Michael's busy work schedule, the therapist first met Michael after 1 month of weekly meetings with Elena. During supervision, she became aware of how Elena's descriptions colored her preconceptions and fueled suspicion and fear of the father, and she endeavored to remain open to his experience while monitoring for cues to danger.

Michael initially appeared closed off but became increasingly open as the assessment unfolded. He was European American and an only child. The family had relocated every few years because of his father's job, and Michael spoke of "fending for myself" and covering up his vulnerabilities in front of his father who was distant, valued toughness, and used corporal punishment.

Michael denied following Elena, said he tried to avoid contact with her, and expressed anger that she painted him as a "monster" to Brayden and others. He called Elena "jealous, immature, and irrational" and ridiculed many of her cultural beliefs about child rearing but said he didn't tell Brayden about his feelings. Michael acknowledged that he sometimes became angry, yelled "mean things," and scared others; he knew this was a problem and was working on containing it. He denied being physically violent to Elena or Brayden and abhorred corporal punishment. He admitted he didn't have much of a relationship with Brayden, saying "I don't know what to do with a baby." The clinician helped Michael to connect these self-descriptions and behaviors to his own childhood experiences with his father's violence and to his conception of a father's role.

Michael said that Brayden did not have behavior or sleep problems while in his care but wanted treatment because he thought it might help "protect my son against his crazy mother." The therapist supported Michael's motivation to protect his son and explained how much young children need both their parents to work together on their behalf, regardless of how they feel about each other.

Photo: © iStockphoto.com/YouraPechkin

Inter-parental conflict may create pressure on the child to choose between the parents.

Angels in the Nursery: Opening the Door to a Father's Love

The assessment process included an "Angels in The Nursery" interview designed to evoke the parents' loving and protective memories of childhood in order to facilitate the intergenerational transmission of growth-promoting influences to the child (Lieberman, Padrón, Van Horn, & Harris, 2005). This was a powerful exercise for Michael, who had difficulty identifying childhood memories of feeling loved, cared for, or understood. With gentle, persistent probes from the therapist, Michael reconnected with the affective and sensory experiences of moments when he felt protected and valued by his mother and father. He remembered his mother protecting him from bullying and a very hot summer day when his father took him in a rowboat to teach him to fish. These were long-forgotten memories, and Michael said that now that he was a parent, they brought forth a visceral feeling of understanding his parents and himself as a little boy. He then described feeling lost as a father and said wistfully, "I expected to feel more love for my son." With tears, he talked about his wish for his son to experience "fishing moments" with him.

Feedback

Brayden's assessment revealed that he did not appear depressed or afraid of either parent and had above-average cognitive functioning. Although the parents gave contradictory accounts of what had happened during their fights while they were married, the therapist believed that there had been some violence in the past but ascertained that there was no ongoing violence between them. The mother's hitting, as described by Brayden, was not deemed abusive by CPS, and was targeted for therapeutic intervention. Based on these considerations regarding safety, the clinician recommended that mother and father receive parallel treatment with the child. Both parents agreed to this plan. The clinician cultivated a disciplined practice of examining her countertransference toward each parent in order to avoid taking sides in ways that would mirror and perpetuate the child's experience of his parents' conflict.

The Mother–Child Dyad: A Focus on Safety and Containment

Brayden was very affectionate with his mother. In an early session, Brayden started off in Elena's lap but eventually wriggled down to get to the toys. He gravitated toward the trucks, creating obstacle courses for them using blocks, and said, "Mommy, you be this monster truck." She moved the truck and then, flooded by her thoughts and feelings, she asked Brayden tearfully if Michael had been hitting him. Brayden looked confused and knocked the blocks over. Elena looked afraid and started sobbing. Brayden went to put his hand on her knee. This interaction revealed multiple "ports of entry" (Stern, 1995) for intervention, but the need to help Elena regulate her affect so she would not frighten her child was the immediate priority. In a subsequent session, when Elena

again asked Brayden if his father hit him, Brayden put his hands on his ears and yelled, "Don't!" The therapist asked him what he was trying to tell his mom. He responded, "Don't ask me that, Mommy! He doesn't hit me!" The therapist used this exchange to talk with Elena about Brayden's wish for his mother and his father to get along, but Elena responded that this was impossible. The therapist translated this for Brayden, saying, "Your mommy is still worried and angry with your dad. You feel one way, and she feels another way." The theme of parents and children sometimes having different wishes became a recurrent treatment focus that included Elena's and Brayden's tendency to hit when they disagreed even though they both loved each other. In the context of a growing sense of safety and trust with the therapist, Elena disclosed that she sometimes resorted to physical discipline but didn't want to, and this opened up a discussion of alternatives that Elena could use to communicate with Brayden. However, Elena continued to become upset when Brayden disagreed with her, especially about Michael.

The Father–Child Dyad: Fostering the Bond Through Play

In an early session, Brayden went straight for the trucks. He asked "Daddy, will you play with me?" With reflection from the therapist ("Brayden really wants to play with Daddy right now."), a reluctant Michael got down on the floor to play. Brayden created a scenario called "mud pits," and he and his father built an obstacle course out of blocks, creating hills and muddy ravines. Brayden chose trucks for himself, his father, and the therapist for a race through the course. Dad's truck always went the fastest and Brayden got frustrated and ran over Dad's hand with his truck. Dad calmly said, "You need to play gently or we won't play at all." Brayden stopped and looked at his father. The therapist said to Michael, "You used your calm words with Brayden and you want him to learn to be gentle and use his calm words, too." Brayden backed his truck up. The therapist said, "You were upset because you wanted to win. And sometimes little boys should win." Brayden smiled. Dad said, "But if he wins, I want him to earn it." The therapist reframed this goal for Brayden, explaining "Your daddy wants you to practice so that you can get faster and win, too."

Brayden liked that the therapist almost always came in last, usually because her truck got stuck. He hitched the trucks together to pull the therapist's truck out of the mud. The therapist reflected, "Oh, you're helping me when I'm stuck." Brayden tried to enlist his father, "Daddy, you pull, too." Michael resisted, "She can get out herself." The therapist commented, "Your daddy had to do a lot by himself and he wants us to learn to do that, too."

Dad taught Brayden to make his truck go faster and when Brayden won, Dad gave him a high-five. Brayden got Dad to help the therapist get her truck out of the mud pit and Brayden clapped. The play became more elaborate and enthusiastic. Dad and Brayden began playing "mud pits" at home together. When Michael joked that they were having "mud pit moments," the therapist said, "You are! I think that Brayden will remember how much fun he had with his daddy playing 'mud pits.'"

Opening the Door to Mom

In collateral sessions, Michael was unbridled in his contempt for Elena. When asked, he could name only two good qualities in her: "She's a good cook. And she is not intentionally harming Brayden." The therapist used the latter statement as a port of entry to help Michael see Elena's behaviors as well-intentioned if possibly flawed efforts to care for Brayden, and explained that this was a focus of the mother–child therapy. This framework allowed Michael to encourage Brayden to talk about Elena. He told him, "It's okay to talk about Mommy." Eventually, during a "mud pits" game, the wheel broke off of Brayden's truck. He cried and went to his father for comfort. Michael started to say, "It's only a truck…" but stopped and took Brayden into his arms. Brayden said, "I want Mommy." Michael continued hugging him. The therapist said, "It's nice that you told Daddy about wanting Mommy." Michael said "I know that you want your mommy…. Ummm, do you want to call her?" Brayden burst into tears and nodded while hugging his dad. Michael said, "We'll call her when we get home."

The End of Treatment

In this complex family, the treatment addressed problematic interactions between Elena and Brayden, strengthening their relationship and decreasing the use of physical discipline, but did not attenuate Elena's pull to keep Brayden exclusively in the realm of the mother–child dyad. The treatment enhanced the father–child relationship and helped the child to hold his love for his mother

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in the presence of his father. Had treatment not adopted a "triadic lens" (McHale, 2011), there was a strong possibility that the CPP therapist would be swayed by Michael's descriptions of Elena as irrational and crazy thus becoming yet another provider or system to dismiss Elena's experience of trauma and discount her capacity for healthy parenting. There was also a strong likelihood that the therapist would have been swayed by Elena's descriptions of Michael as abusive and frightening to the child–thus defining him solely as a perpetrator of violence. These views are in line with cultural stereotypes about mothers and fathers in situations of possible violence. The therapist admittedly had moments of being pulled into both of these views at different points during the treatment. However, seeing Brayden consistently with both of his parents in this triadic model allowed the therapist to monitor for safety and hold both parents' strengths, difficulties, and best intentions in mind, seeing and demonstrating how much Brayden needed and loved both parents. The relationships, created in an atmosphere of safety for each parent with their child, helped the therapist to resist acting on their pulls for loyalty.

In this case, although he was portrayed as terrifying by Elena, Michael emerged as a primary source of nurturing and protection for his son. Treatment helped free the love for his child that was blocked by his childhood experiences with his father and his current conflicts with Elena. As he grew into his role as an attachment figure, Michael gave Brayden permission and support to integrate his love for both parents and promoting his capacity for a triadic model of relationships.

Conclusions

In both of the families described above, important gains for the child depended upon the father's involvement. The research literature and clinical experience argue for systematic efforts to promote inclusion of fathers in infant mental health treatment. CPP's multi-theoretical approach allows for the use of a triadic lens to identify and engage the most important attachment figures in a child's life when it is safe to do so. We believe this approach helps open the door to fathers, improves family relations, and promotes child well-being.

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Baby Elmo Leads Dads Back to the Nursery: How a Relationship-Based Intervention for incarcerated Fathers Enhances Father and Child Outcomes

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ABSTRACT

Although children's contact with involved, committed, nonresidential fathers can improve social, emotional, cognitive, and academic outcomes, fathers have largely been absent from parenting interventions that overlook men's role as a critical parenting partner. This article details research showing that young incarcerated fathers' attitudes about—and communication and responsiveness to—their very young children improved following a brief psychoeducational intervention and describes a second pilot project with child-welfare–involved fathers and families. The projects enrolling high-risk, difficult-to-engage parents yielded promising findings, demonstrating how building interventions that are inclusive of fathers stands to benefit child outcomes.

Incarcerated teen fathers in juvenile halls express a deep desire to develop a strong, positive relationship with their children, but they struggle to overcome systemic barriers. When sporadic visitation is possible, interactions typically take place in loud, intimidating areas that increase the baby's stress and stranger anxiety, leaving the father with the impression that the baby has "forgotten about him" and that he has no connection with his child.

The Just Beginning "Baby Elmo" Program (Barr et al. 2014; Youth Law Center, 2012) focuses on assisting these two extremely vulnerable populations—incarcerated teen fathers and their young children—by offering parenting classes paired with visits from his child to help the teen father and child develop a positive relationship with one another.

The curriculum is written simply, so that no technical background is needed to put it into service. It is straightforward and effective. As most incarcerated teens read at a fourth-grade level, the bulk of instruction is conveyed through videos, produced by *Sesame Street's* Early Childhood Education Department, that give clear, visual examples of the parenting skill to be taught. Youth and families are already comfortable with media and the *Sesame Street* characters, making this a strengths-based approach to intervening with this specific population.

The Just Beginning "Baby Elmo" Program is a research-based intervention developed by ZERO TO THREE fellows Rachel Barr of Georgetown University and Carole Shauffer of the Youth Law Center (San Francisco, CA). The program is inexpensive and easy to implement, and it can be integrated into other mental health and education programs within the facilities. Most important, it fits with the rehabilitative mission of these institutions. Trainers and teens are invested in the success of these visits, which are often the only bright spot for the fathers during their incarceration. As one of our participants in Southern California told staff, "I know it was only for an hour, but I'm telling you, it was like I wasn't even at the hall!"

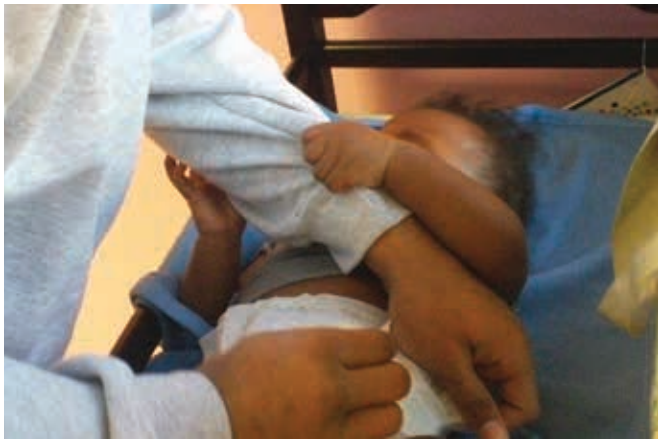


Photo: Francois Smith

Teaching incarcerated fathers to provide warm, supportive parenting could prove extremely beneficial for children, as several studies have shown that contact with involved, committed, nonresidential fathers can improve child outcomes.

Population Description

A large and increasing proportion of incarcerated juveniles are parents. Twenty percent of youth in custody have or are expecting a child, and 15% of males in custody are fathers (Sedlak & Bruce, 2010). Many of these incarcerated teen fathers describe a strong motivation to remain involved in their children's lives and to parent effectively. Shade, Kools, Pinderhughes, and Weiss (2013) conducted in-depth, qualitative interviews with 19 fathers in a juvenile detention center and found that a majority of them said they hoped to play an active and positive role in their children's lives, serving as better role models than their own fathers had been for them. However, few of the fathers could describe a specific strategy for improving their children's lives or their own future prospects, discussing only vague goals like finding a job and providing financial support to the child.

WHY ARE FATHER–CHILD RELATIONSHIPS AN IMPORTANT TARGET FOR INTERVENTION?

Teaching incarcerated fathers to provide warm, supportive parenting could prove extremely beneficial for children, as several studies have shown that contact with involved, committed, nonresidential fathers can improve child outcomes. For instance, low-income children who remain in contact with their biological fathers early in life show (a) better emotion regulation, academic achievement, and father–child relationships later and (b) less aggressive or criminal behavior than those with absent fathers (Cabrera, Shannon, & Tamis-LeMonda, 2007; Vogel, Bradley, Raikes, Boller, & Shears, 2006). Children with a positively engaged father also have better cognitive and social outcomes than do children without an involved father, and these effects are largest if the father takes an active role in the child's life and exhibits sensitive, supportive parenting practices (Cabrera, Tamis-LeMonda, Bradley, Hofferth, & Lamb, 2000). Father sensitivity to the child's emotional state is an important predictor of positive outcomes, including more complex play and later language achievement (Roggman, Boyce, Cook, Christiansen, & Jones, 2004), and sensitive treatment at 5 years old predicts social competence at 8 years old (Gottman, Katz, & Hooven, 1997). Quality of play predicts self-worth, social relationships, and academic achievement. Children whose fathers support their autonomy in play at 2 years old have higher reading and math scores at 6 to 8 years old (National Institute of Child Health and Human Development Early Child Care Research Network, 2008). An interaction characterized by playfulness, patience, and understanding on the father's part is associated with lower levels of child aggression (Hart et al., 1998). Warm, affectionate fathers produce children who grow up to be well-adjusted adults (Franz, McClelland, Weinberger, & Peterson, 1994). Similarly, children's later popularity is predicted by (a) a low level of intrusiveness by fathers during play and (b) children engaging in physically playful, affectionate social interactions with their fathers (McDowell & Parke, 2009; Parke et al., 2004; Parke & O'Neil, 2000). By contrast, frequent interaction with a harsh, intrusive, or disengaged father actually proved detrimental to children and increased the likelihood of an insecure paternal attachment (Brown, McBride, Shin, & Bost, 2007). Therefore, interventions incorporating visitation to teach fathers to behave sensitively and warmly and improve parent–child interaction quality could capitalize on fathers' high levels of motivation in order to promote positive developmental outcomes for their children.

Intervention Design

Interventions have been developed to repair relationships between incarcerated fathers in adult facilities and their children (Bayse, Allgood, & Van Wyk, 1991; Harrison, 1997; Landreth & Lobaugh, 1998). Harrison, for example, compared a 6-week parent education and behavior management training program for incarcerated adult fathers with a control group of fathers who did not receive instruction. The fathers in the former group demonstrated improved attitudes in child rearing, but their children's self-perceptions showed no evidence of change. Landreth and Lobaugh (1998) developed a 10-session program for incarcerated fathers that focused on the development of child-centered play. The goals were to increase fathers' sensitivity to children, help fathers understand their children's emotional needs and be empathic, teach fathers to follow the child's lead, and practice therapeutic limit-setting. This intervention modeled positive parent–child interactions through role play and videos and then asked the fathers to practice in their own role plays. Finally, the fathers were required to practice these skills with their children and report back to the group. Although Landreth and Lobaugh's intervention successfully incorporated visitation and used a control-group design, only self-report data were collected, and father–child visits were not directly observed. However, its findings were promising: Fathers reported an increased acceptance of the child's feelings, a sense of unconditional love, improved recognition of the child's autonomy, a growing sense of competence with the child, and decreased feelings of parenting stress. Upon follow-up, they

reported increased contact with their children and fewer child behavioral problems. The program also directly affected children, with participating children reporting an improved self-concept and a sense of empowerment, although there were no child reports from the control group.

The Just Beginning "Baby Elmo" Program

The Just Beginning "Baby Elmo" Program began in 2008 as a partnership between the Youth Law Center and Georgetown University to provide structured visitation to one incarcerated mother who was serving time in a Los Angeles jail. Six years later, the program has expanded to 10 county juvenile halls and commitment facilities in California, one commitment facility in Connecticut, and one correctional facility in Ohio. In this time, the program has served more than 300 fathers.

The Just Beginning "Baby Elmo" program is designed to create a positive relationship between the incarcerated father and his child. Rather than presenting information in an overly didactic manner focused on learning new skills, the program focuses on the importance of the connection between the father and child. High-quality play during a parent–child interaction is an essential component of quality parenting interventions and is central to developing a lasting positive and warm attitude. On the basis of extensive pilot testing, the program now includes five unique sessions, each centered on how to improve upon a different aspect of the father–child relationship. The sessions are composed of a teaching portion followed by a contact visit where the youth is able to practice the skills learned during instruction.

The five-session curriculum is delivered once a week. In the initial session, the youth learns the basics of attachment theory and stranger anxiety. The next sessions expand upon the initial interactions with the baby. Session 2 introduces the idea of following the baby's lead to help encourage synchrony. The father learns to engage with the child in activities that the child chooses. In Session 3, the father learns how to incorporate language in play time by labeling objects with which the baby is playing. In Session 4, the father learns to praise his child to show his affection. In Session 5, the father reviews and practices all the skills that he has learned.

Members of the correctional staff, trained by the Just Beginning "Baby Elmo" program manager during a full-day training, lead the instructional sessions so that the youth receives instruction from someone with whom he already has a strong relationship. The regular visits with his child make the youth view himself as a father—not simply as an incarcerated youth or gang member.

Each visit lasts for approximately 60 minutes. Participants are encouraged to incorporate into the visit those skills that they have learned in the instructional component. The visits take place in a room designed by the facility and by the young fathers to be baby friendly: There are *Sesame Street* characters painted on the walls, and there are floor mats, fire trucks, mirrors, and other toys meant for the dyad's use. Activities range from "tummy time" with infants to "tag" with older toddlers.

These visits are crucial to the success of the program. The relationship that develops from this visitation structure promotes the positive effects of "experience-dependent" development (Siegel, 2001). Parenting is like driving a car; it takes direct instruction and hands-on experience to really get the hang of it. One trainer in Ohio asks fathers to hold the baby to their chest and feel the baby's heartbeat with theirs during the first visit. After that initial contact, the fathers are ready to learn.

After each of the visits, the father and trainer debrief. The trainer highlights positive parenting techniques that the father has demonstrated and asks about any difficulties that he may have experienced. The tone of the debrief is encouraging, focusing on what went well and how the father can continue his success next time. After the five training sessions and the accompanying visits are completed, visits between the father and child continue until the father leaves the correctional facility.

The program is completely voluntary. Participants are recruited from nine juvenile detention centers located in five California counties—Sacramento (one site), San Bernardino (three sites), Fresno (one site), Orange (one site), and Yolo (one site)—and in Cuyahoga County, Ohio (one site) and Middlesex County, Connecticut (one site). Of the nine centers, five are long-term commitment facilities serving post-dispositional youth, and four are traditional juvenile halls serving youth awaiting hearing. At entry into each facility, incarcerated teen fathers self-identified either during an intake conducted by staff asking whether he had children or in response to an advertisement of the Just Beginning "Baby Elmo" Program. Inclusion criteria for the study sample were that the incarcerated teen father had no direct involvement with child protective services for any of his children and that the caregiver (most frequently, the mother or paternal grandmother) consented to bringing the child into the facility to participate in the study. The incarcerated fathers ranged from 14 to 20 years old, and the children ranged from 2 to 36 months.

Photo: Michelle Coit

Father sensitivity to the child's emotional state is an important predictor of positive outcomes, including more complex play and later language achievement.

PROGRAM EVALUATION

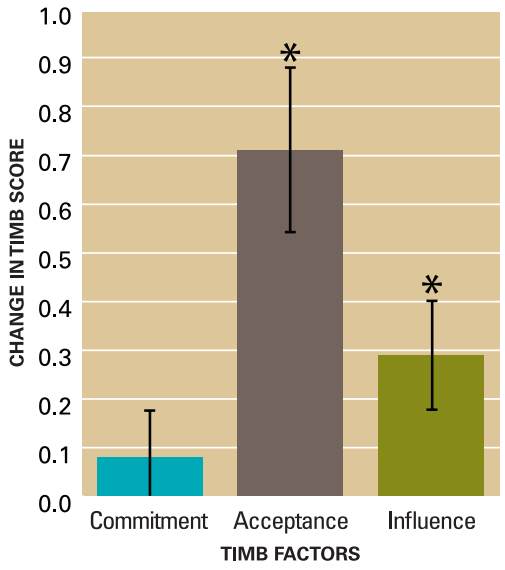
Each facility participates in ongoing evaluation of the program. Evaluations include measures of change in father attitude and interactional quality between fathers and their children during the visit sessions. Changes of behavior in the facilities have been examined as well.

Father's Attitude Change

A subset of 19 fathers from four California facilities (Sacramento, San Bernardino, Fresno, and Yolo counties) completed the entrance and exit "This Is My Baby" (TIMB; Bates & Dozier, 1998) interviews. The TIMB, a 10-minute semistructured interview, consists of eight questions that address parents' perceptions of their child and of the parent–child relationship. The TIMB interviews are administered before and after the intervention. They are scored on three dimensions: (a) *commitment*, which assesses how strongly the parent considers the child his own and strives to build an enduring relationship; (b) *acceptance*, which measures the extent to which the parent views the child as a positive, unique individual; and (c) *influence*, which evaluates how fully the parent recognizes the immediate and long-term effects of his actions on the child's psychological and emotional development. Commitment, acceptance, and influence dimensions were assigned scores between 1 (lowest score) and 5 (highest score), including midpoints, by reliable coders (between-coder reliability: commitment, $r = .74$; acceptance, $r = .87$; influence, $r = .91$). Figure 1 depicts the extent of pre- to post-intervention changes in the fathers' three scores.

Fathers' attitudes at the beginning and end of the intervention were also compared using paired-samples *t* tests. Analyses revealed that acceptance scores (*Mpre* = 1.97, *Mpost* = 2.64) and influence scores (*Mpre* = 1.44, *Mpost* = 2.67) were significantly higher at post-intervention than they were at pre-intervention, $t(17) = 4.08$, $p < .001$, and $t(17) = 2.40$, $p = .03$, respectively. Fathers' commitment scores (*Mpre* = 2.44, *Mpost* = 2.50) did not differ significantly between program entry and exit, $t(17) = 0.77$, $p = .45$. These findings indicate that during the course of the program, fathers developed more specific and positive knowledge of their children's personalities and a greater understanding of their impact on the children's futures.

FIGURE 1. **Pre- to post-intervention change in TIMB scores (±1 *SE*) for each dimension.**



Error bars represent standard error (SE). *p < .05, indicating that change is significant pre- to post-intervention. TIMB = This Is My Baby (Bates & Dozier, 1998).

High-quality play during a parent–child interaction is an essential component of quality parenting interventions and is central to developing a lasting positive and warm attitude.

Facility's Attitude Change

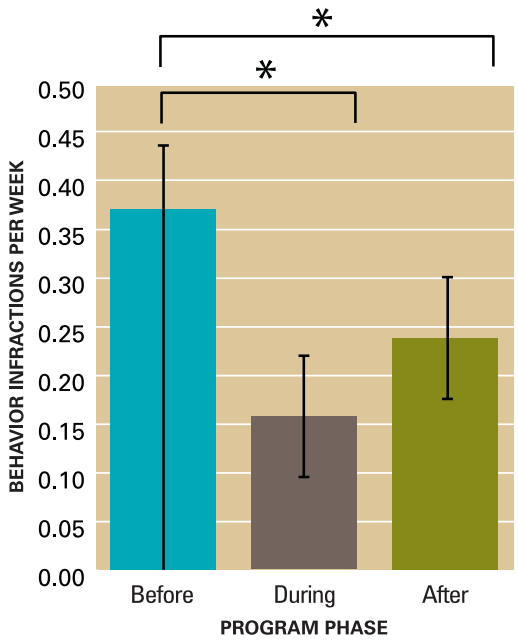
Facilities also became more "father friendly" after the introduction of the program. Some facilities have invited families to graduation celebrations, holiday family gatherings, and even a family christening to bring families and incarcerated teens together. These events increase family engagement with the facility and help these young fathers reinvent their self-image.

Father's Behavior in the Facility

Four facilities (in Fresno [CA], Orange [CA], Sacramento [CA], and Cuyahoga [OH] counties) reported the number of behavioral infractions committed by program participants before, during, and after program participation. The infractions were all Level 1 offenses, which are minor forms of misconduct, such as failure to comply with facility staff or disruptive behavior in school. Two of these facilities recorded the number of incidents committed by 37 program participants at three different time points: (a) for 8 weeks prior to program entry, (b) for the duration of program participation, and (c) for 4 weeks after program completion. To account for the differing lengths of these time periods, we calculated the number of infractions per week. Paired-samples *t* tests were conducted to determine whether the number of behavioral infractions per week prior to program participation differed significantly from the number of weekly infractions during and after the intervention (see Figure 2).

Participants committed significantly fewer behavioral infractions during the intervention than they had done prior to program entry, $t(35) = 3.01$, $p = .004$. The analysis comparing pre- to post-program infractions revealed a trend approaching significance, indicating that for as long as infant–father visits continued, a decline in behavioral incidents was maintained even after program completion, $t(35) = 1.98$, $p = .055$. This pattern shows that fathers' negative behavior in facilities decreased upon program entry and that the positive change was sustained after program completion, providing preliminary evidence that the intervention

FIGURE 2. **Average number of behavioral infractions per week before, during, and after participation in the Just Beginning "Baby Elmo" Program.**



Error bars represent standard error. *$p < .05$, indicating a decrease from before to during the program and a decrease from before to after the program ended.

participation was associated with improvements in fathers' behavior outside of the parent–child relationship. The pattern of results at the other two facilities was the same, with the number of incident reports similarly decreasing by 50% upon program entry. Hence, establishing a more positive relationship between an incarcerated father and his child also had reverberating effects in relationships between the father and others in the institution.

Taken together, evaluations of the Just Beginning "Baby Elmo" Program have shown positive changes in the quality of father–child interactions for children 3–36 months old (Barr et al., 2014), an overall reduction in fathers' misconduct (this report), and increases in fathers' acceptance and awareness of their influence on their children (this report).

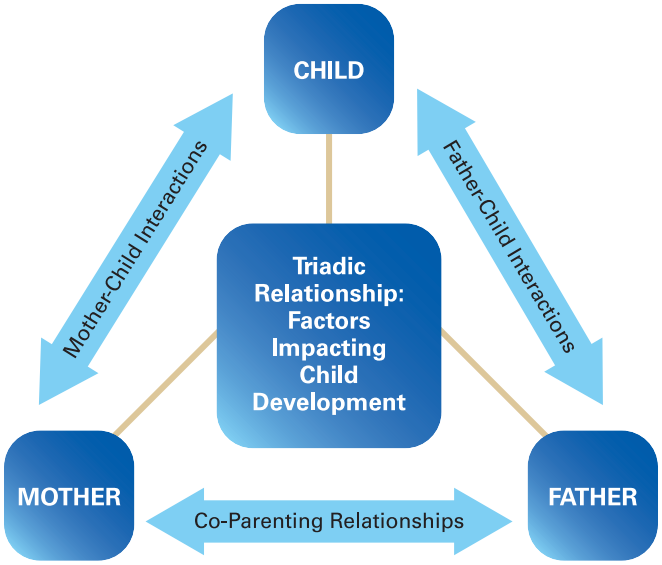
Involving the Child's Co-Parent: The Fresno Fathering Program

The Just Beginning "Baby Elmo" Program can easily be integrated into existing programs. One, the Fresno Fathering Program (FFP), combined elements of the Supporting Father Involvement Program (Cowan, Cowan, Pruett, Pruett, & Gillette, 2014; Cowan, Cowan, Pruett, Pruett, & Wong, 2009) and the Just Beginning "Baby Elmo" Program (Barr et al., 2011, 2014). The project was conceived on the basis of one consistent finding—that the single best predictor of fathers' family involvement across the economic spectrum is the quality of the father's relationship with his co-parent (Carlson, Pilkauskas, McLanahan, & Brooks-Gunn, 2011). This finding holds for married, cohabiting, separated, and divorced co-parents (Pruett & Johnston, 2004). The quality of the co-parent relationship provides a context for mothers and fathers to be more effective parents—more responsive and better able to set limits—and for children to show higher levels of academic achievement, fewer symptoms of depression, and less angry and aggressive behavior (Cowan & Cowan, 2014).

Children with a positively engaged father have better cognitive and social outcomes than do children without an involved father.

The FFP was a couples-focused group intervention that sought to help fathers develop relationships not only with their child but also with their child's co-parent. The intervention connected the mother–father co-parent relationship to the father–child relationship to form a triad, the family unit that is most important to the child's well-being and development (Gaskin-Butler et al., this issue, p. 49; McHale & Phares, this issue, p. 2; see Figure 3). The program was piloted at the Fresno County Department of Social Services with seven co-residential families who had an active child protective services case. Twelve 2-hour group sessions were run by one male and one female facilitator. Four 15- to 20-minute play sessions were built into the curriculum, giving parents a chance to practice the child development and co-parenting communication skills that they had learned in class. Play sessions were followed by a group debrief, where the facilitators and parents could reflect on what went well and what was challenging during the play session. Two

FIGURE 3. **In the Fresno Fathering Program (FFP), the focus is on multiple relationships within the family.**



separate ongoing groups were conducted, one with three couples and one with four couples.

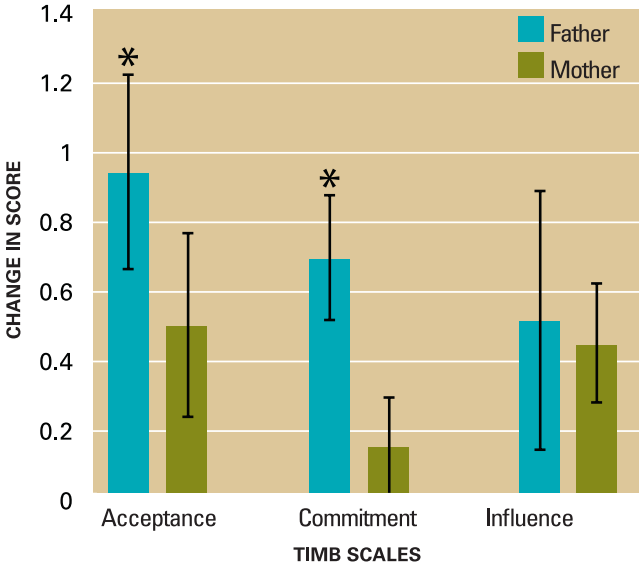
TIMB FINDINGS

Figure 4 shows pre- to post-intervention changes in the three TIMB scores by fathers and mothers in the seven families in this pilot intervention.

Data suggested an improvement in fathers' ability to form relationships with their children and to successfully co-parent. As in the Just Beginning "Baby Elmo" Program, the seven FFP fathers, across both groups, showed significant increases in TIMB interview acceptance scores, $t(6) = 3.54$. $p < .02$, *Mpre* = 3.18, *Mpost* = 4.17, and in TIMB interview commitment scores, $t(6) = 4.14$. $p < .001$, *Mpre* = 3.67, *Mpost* = 4.36, between pre- and post-intervention. No significant differences were found in TIMB interview influence scores, $t(6) = 1.36$, *ns*, *Mpre* = 3.64, *Mpost* = 4.14. Unlike fathers, mothers' TIMB interview scores remained stable across the intervention: acceptance, *Mpre* = 3.55, *Mpost* = 4.03; commitment, *Mpre* = 3.78, *Mpost* = 3.91; and influence, *Mpre* = 3.67, *Mpost* = 4.10 (see Figure 4). These findings indicate that over the course of the program, fathers developed more specific and positive knowledge of their children's personalities and expressed a greater commitment to continuing their involvement in the future.

In previous large-scale studies using the TIMB measure, Bernard and Dozier (2011) found that foster parents with higher commitment scores displayed more positive affect while playing, praised their children more frequently, and attempted to engage their children in interaction more often. Higher commitment scores

FIGURE 4. **Change in TIMB dimensions (±1 *SE*) in the Fresno Fathering Program**



Error bars signify standard error (SE). TIMB = This Is My Baby (Bates & Dozier, 1998). *$p < .05$, indicating a significant increase in fathers' acceptance and commitment scores over the course of the intervention.

During the course of the program, fathers developed more specific and positive knowledge of their children's personalities and a greater understanding of their impact on the children's futures.

were also related to higher rates of adoption by foster parents. Ackerman and Dozier (2005) administered the TIMB interview to foster parents when children were 2 years old; the authors used the acceptance and commitment scores to index caregiver investment. TIMB acceptance at 2 years old was positively correlated with children's self-esteem and their ability to find adaptive coping strategies at 5 years old, even after controlling for behavior and IQ at 5. These studies of foster parents demonstrate that scores on the TIMB interview tap into attitudes that influence parental behavior during interactions, which in turn predicts children's later developmental outcomes. By extension, the increases that fathers showed in both acceptance and commitment scores in our work suggest the possibility of higher paternal investment and thus are promising for both child and father outcomes.

COMMUNICATION AND INTERACTIONAL QUALITY FINDINGS

Videos of parent–child visits were coded for conversational and business talk, praise and complex language, interactional quality (using the Individual Growth and Development Indicators for Infants and Toddlers; Baggett & Carta, 2006), and presence of *triadic play*—that is, interactions that involved both the parents and child in shared activities. For each parent, based on their respective levels of communication during the play sessions, we calculated ratio of conversational talk to business talk, percentage of complex labels, and percentage of expressed praise. Given the small sample size of only seven families, we cannot provide full statistical analyses of the data, but we did run preliminary growth linear models to assess whether there were changes across play sessions on communication and interactional quality.

Examination of these preliminary models suggested increases in communication and supportive interactions between parents and their children across play sessions. Models for changes in communication showed small but significant increases or strong trends for improvements across the play sessions on the ratio of conversational talk to business talk, the percentage of expressed praise and of complex labels. The percentage of time spent in triadic play remained stable across sessions. Scores on the Parent Support Index (range = 0–3) increased across sessions, and a subanalysis revealed statistically significant changes in the "Follows the Child's Lead" component of the Parent Support Index. Paired *t* tests from pre- to post-intervention similarly showed significant changes in overall levels of parental support, $t(13) = 3.15$, $p < .01$, and the subcomponent of "Follows the

Child's Lead," $t(13) = 2.59, p < .03$, as well as significant trends for change in percentage of expressed praise, $t(13) = 1.79, p < .10$, and percentage of complex labels, $t(13) = 2.06, p < .06$. The means are shown in Table 1.

In comparing parent–child conversational talk in high- versus low-income families, Hart and Risley (1995) found a 30-million-word gap that accounted for differences in children's language ability and later school success. In these preliminary analyses of the FFP, parents showed increases in the ratio of conversational talk to business talk and in the number of complex labels and praise words. As in the Just Beginning "Baby Elmo" Program, parents in the FFP pilot program also showed improvements in sensitivity and responsivity to their children, particularly in following the child's lead. Overall, this pattern of results shows increasing quality of communication and parent–child interactions during the course of the intervention, which may help promote children's language and cognitive development.

INDIVIDUAL AND CO-PARENT CHANGES

Before the first group meeting and at the last group meeting, parents filled out several brief questionnaires to assess how they viewed themselves and their relationship. Surveys included (a) the Center for Epidemiological Studies in Depression Scale (CES-D; Radloff, 1977), a nationally standardized measure of symptoms of depression; (b) the Quality of Marriage Index (QMI; Norton, 1983), a six-item inventory that assesses marital satisfaction using broad items such as "Overall, I feel very satisfied in my marriage"; (c) a scale measuring how well the parents were working together to resolve disagreements (Couple Communication Questionnaire; Cowan & Cowan, 1990); and (d) the Parenting Stress Index (PSI; Loyd & Abidin, 1985) assessing the amount of stress encountered in parenting the youngest child. The difficult child subscale of the PSI was analyzed separately. Analyses revealed important improvement on these measures during the 3 months of the intervention. Given the small sample size of just seven families, we report analyses where p values were $< .05$ as well as trends of $p = .10$ or less as indications of positive change.

Significant decreases were seen in fathers' reports of depression on the CES-D, $t(6) = 2.69, p < .05, Mpre = 14.71, Mpost = 10.14$, and in mothers' reports of parenting stress, $t(6) = 3.08, p < .05, Mpre = 71.95, Mpost = 61.86$. In analyses combining maternal and paternal reports, parents also described their children as showing fewer difficult behaviors, $t(12) = 2.81, p < .05, Mpre = 27.79, Mpost = 23.29$. There was a trend approaching significance in analyses combining maternal and paternal QMI reports, which suggested that parents perceived more satisfaction in their relationship with one another, $t(12) = 2.11, p < .08, Mpre = 36.14, Mpost = 39.36$. Another trend was in fathers' reports of more couple collaboration in resolving disagreements, $t(6) = 2, p < .09, Mpre = 2.80, Mpost = 4.14$. Finally, combined maternal and paternal reports on division of household labor showed a positive change on a 1–9 scale (1 = *mother does all the work*, 5 = *equal sharing*, 9 = *father does all the work*), from $Mpre = 4.20$ to $Mpost = 4.60$, although the extent of change fell short of traditional levels of significance, $t(12) = 1.66, p < .14$.

Taken together, these findings suggest that parents made gains in the program and that they reported improvements for their children. Fathers' attitudes toward and involvement with their children improved. There was a trend for the parents to report more satisfaction in their co-parenting relationship, and there were positive changes in parent–child interaction quality. The program allowed each enrolled father to engage in process-oriented learning that helped him develop a relationship with both his co-parent and his child. Attendance was very good—all seven families started and completed the entire program—and participants expressed interest in continuing to meet together as a group after the program ended to build on a positive social network to support their new parenting goals. These observations support the idea that father involvement can be improved by helping the father negotiate how he interacts with his child within a co-parenting group framework. That is, engaged fathering emerged in the context of a family and peer relationship system. Given the small sample sizes, these results should be interpreted cautiously; however, they support the concept that a

TABLE 1. **Means (standard deviations) of communication and parent–child interactional quality measures as a function of play session.**

Play session	Ratio of conversational talk to business talk	Complex labels (%)	Praise (%)	Triadic play between parents and children (%)	IGDI Supportive Parenting Index	IGDI Follow the Child's Lead
1	2.47 *(1.42)*	0.60 *(0.75)*	4.13 *(3.35)*	33.6 *(28.6)*	0.35 *(0.17)*	0.27 *(0.39)*
2	2.47 *(1.42)*	1.26 *(1.67)*	3.04 *(2.17)*	35.67 *(22.95)*	0.37 *(0.24)*	0.34 *(0.42)*
3	2.24 *(0.78)*	1.88 *(2.06)*	6.10 *(4.96)*	44.76 *(28.77)*	0.72 *(0.21)*	0.75 *(0.44)*
4	3.21 *(1.53)*	2.19 *(2.60)*	9.19 *(10.44)*	25.94 *(9.10)*	0.64 *(0.40)*	0.67 *(0.68)*

Note. Italics represent standard deviations. IGDI = individual growth and development indicator. (Baggett & Carta, 2006)

Photo: Michelle Coit

The Just Beginning "Baby Elmo" program is designed to create a positive relationship between the incarcerated father and his child.

co-parenting program and a play-focused fatherhood program can be successfully integrated, with gains exhibited across multiple domains.

Developing an Integrated Re-Entry Program for Incarcerated Fathers

The Just Beginning "Baby Elmo" Program is developing a relationship-based re-entry intervention that can be used to assist young fathers in their transition back into the community. Community providers who help with fatherhood mentoring, relationship counseling, employment, and legal advice will meet with the youth while they are incarcerated to develop a relationship that will continue once they re-enter the community. In this way, young fathers will have a connection to community resources and will be motivated to take advantage of them. As one of our instructors said, "These fathers really want to walk down the right path, but sometimes they need someone to hold their hand at the beginning." In planned new work, we will be partnering with the Healthy Fathering Collaborative of Cleveland, the Cleveland Department of Social Services, and Cuyahoga County Probation to develop and implement the intervention. The Just Beginning "Baby Elmo" Program will be combined with tested co-parenting and mentoring programs that focus on conflict resolution, communication skills with co-parents, and the establishment of parental rights and visitation schedules. In addition, the youth will connect with the Department of Children and Family Services and community agencies to help with job placement and other social supports for the participants. The success of the program will be evaluated across time using TIMB to assess changes in paternal attitudes and father–child contact postrelease.

Learn More

More information on the Just Beginning "Baby Elmo" Program and other programs is provided by the Youth Law Center, an advocacy group: http://www.ylc.org/

Other research on early learning and memory development can be found at www.elp.georgetown.edu

Conclusion

The traditional view of the father as family provider has become outdated. At-risk fathers often drift from their families at a young age because they are unable to provide for their children. Even if they do want to stay involved, it is difficult to do so if the mother or the mother's family shields the child from contact with the father. Compounding matters is the fact that child support systems mandate that fathers pay mothers money to support their child but fail to acknowledge how fathers can make equally helpful contributions to the family in other ways, particularly in building a significant, positive relationship with the child. Neither the filial systems nor the government support systems have been able to adopt a broader definition of what it means for an at-risk father to contribute to the family, thus alienating a significant population of fathers who would otherwise want to be involved in their child's life.

The Just Beginning "Baby Elmo" Program and the FFP Program focus on building fathers' involvement by broadening the definition of *fatherhood* beyond men's financial contributions. In juvenile correctional facilities, child development research principles were used to develop strategies to enhance father–child relationships. This experience-based learning resulted in improvements in interactional quality and paternal perceptions of acceptance and influence on their children. Of note, youth involved in the Just Beginning "Baby Elmo" Program demonstrated improved behavior in the correctional facility and became more receptive to rehabilitative programming. In the FFP Program, a co-parenting component was successfully added to the "Baby Elmo" intervention, and both parents improved their interactional quality as well as their communication skills. In both interventions, trained staff facilitators provided feedback to enhance father–child interactions. A strengths-based approach delivered by institutional staff well known to families in turn enhances interactions between family and staff. The high-risk fathers whom we serve face many challenges as they strive to become supportive parents, but our participants have taken a powerful first step to a lifelong relationship with their children. As the saying goes, any man can be a father, but it takes a special person (with a little help sometimes) to be a dad. (See box Views From the Fathers, p. 33.)

Acknowledgments

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Views From the Fathers

Direct feedback from fathers who have participated in both programs has been positive and illustrative as outlined below.

The Just Beginning "Baby Elmo" Program

The Just Beginning "Baby Elmo" Program teaches young fathers to care and feel deep love for their children. Most of the youth have never cared more about someone or something than they care about themselves. Being responsible for another human being, so helpless and tiny, without getting anything other than the intrinsic benefit, is the greatest teacher. The Just Beginning "Baby Elmo" program creates an opportunity for youth to open their eyes to this fact of life.

The Just Beginning "Baby Elmo" program offers an opportunity for youth to learn about their roles as parents, but just as important, it provides facility staff with the reward of teaching a curriculum and seeing the benefits firsthand when the youth visit with their children. The Program provides youth with the opportunity to truly bond with their children, despite living in a locked facility. That time with their children is so important to them that it acts as an incentive and encourages appropriate behavior in custody. This is best shown through some examples, which are detailed below.

One program participant said, "Thank you for all you've done for me to have a stronger relationship with my daughter." In an interview about how the Just Beginning "Baby Elmo" program helped him, he said, "With 'Follow the Lead,' they can explore, and you go along with it. You follow their lead, and basically, you're the baby, and you let them teach you." He said that, without the Just Beginning "Baby Elmo" program, he would not have had the opportunity to explore with his daughter and learn from her. The program has changed him and helped him grow. When asked about his future plans with his daughter, he stated, "I just hope to have a good relationship with her, no matter what happens. I just want to be a part of her life."

One young father in Orange County was getting into a fight every 2 weeks. After completing the program, he achieved the highest standard of behavior in the facility. Education and visits with his child allowed him to reimagine himself as a father instead of a gang member.

Another youth from Orange County, when talking about his plans with his child upon release, said, "I want to take him to the beach, and camping, because my dad never took me those places, and I want to give that to my son." Constructive relationship-building allows the incarcerated father to envision a life with his child that extends beyond the world that the father has come to know.

The Fresno Fatherhood Program

At the beginning of the Fresno Fatherhood Program (FFP), Bob appeared to be skeptical of how the classes were going to help him. He asked the trainers on two different occasions about their credentials and associated work experience. His participation during the early sessions seemed to show his somewhat closed-mindedness and tendency to focus only on his own perceptions. However, there was a moment in the second half of the program when something changed. It started when, during a play session, he experienced his daughter crawling for the first time instead of scooting on her bottom.

Bob gained insight into his own parenting style during the session when we discussed the parenting style in which he was raised. It appeared that within a couple of weeks of that session, Bob discovered that a good portion of his frustration with his elementary school–aged son was due to the type of role that he was playing with his co-parent, Susan. Bob initially felt that he was the breadwinner and that Susan, as the mother, should deal with the discipline as well as any issues that arose with the children. Bob and Susan's frustration was voiced in one weekly session, but by the following week it had significantly decreased. Bob stated that he successfully communicated with Susan about how they should work together to discipline their son and back each other up.

At the end of the intervention, Bob commented that when he was on the verge of being mean, disrespectful, or angry toward Susan and the family, he would hear the facilitator's voice in his head telling him to make a better choice.

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Philip Cowan, PhD, a professor of the graduate school at the University of California, Berkeley, focuses his research on family systems and child development. He has developed interventions to improve co-parenting relationships and children's cognitive, social, educational, and mental health outcomes.

Carolyn Pape Cowan, PhD, an adjunct professor emerita at the University of California, Berkeley, has research and clinical interests that center on couple, parent–child, and family relationships, as well as marital and child development and intervention evaluation. Philip Cowan and Carolyn Pape Cowan created the Supporting Father Involvement (SFI) intervention with Marsha Kline Pruett, PhD, from Smith College School of Social Work, and Kyle Pruett, MD, from Yale University Medical School.

Jennifer Rodriguez, JD, is executive director of the Youth Law Center (YLC) in San Francisco, California. She works on child welfare and juvenile justice projects at YLC to ensure that children and youth in both systems live in conditions that meet their developmental and emotional needs and are provided with the opportunities that they need to build a foundation for a healthy adulthood. Rodriguez works to improve incarcerated youths' access to and relationship with their babies; to reduce congregate care, increase quality of care, and improve services for children in foster care; and to expand resources for young people transitioning out of child welfare and probation and into adulthood.

Carole Shauffer, JD, is senior director of strategic initiatives of the Youth Law Center, San Francisco, California, and has a national reputation in child welfare reform and developing strategies that apply developmental research to child welfare and juvenile justice systems. Shauffer piloted the New Beginnings project in Michigan and California to incorporate research on infancy and early childhood development into child welfare practice. She is also leading the Quality Parenting Initiative in Florida and California to improve recruitment and retention of quality foster parents. Carole was a 2005 ZERO TO THREE Fellow.

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Throw-Away Dads? Promoting Healthy Father–Child Attachment in Families Affected by Intimate Partner Violence

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ABSTRACT

Millions of children witness intimate partner violence (IPV) in their homes each year, and large percentages of those children are infants and toddlers. Children often continue to live with or have frequent visits with their fathers following IPV. Social services agencies rarely provide services to target the father–child relationship beyond psychoeducational parenting classes. This article reviews what is known about parenting and father–child attachment for men with histories of IPV, describes how fathers' own early childhood experiences and attachments in their families of origin impact their relationships in adulthood, and describes how interventions could be designed and implemented to improve outcomes for families impacted by violence.

According to the U.S. Census Bureau, one out of three children live without their biological fathers in their homes (Laughlin, 2014). Growing up without a father figure has been linked to a host of psychosocial difficulties, and there is now clear evidence that fathers contribute substantially to the psychosocial development of their children (Lamb, 2004, 2010; Marsiglio, Amato, Day, & Lamb, 2000; McWayne, Downer, Campos, & Harris, 2013). Accessibility of the father, his positive engagement, his supportive involvement, and his warmth and closeness to the child are the critical behavioral dimensions for the father–child relationship that support positive child development (see Biller, 1993; Booth & Crouter, 1998; Lamb, 1997 for reviews). Yet, the majority of programs targeting infants and young children are designed for mothers. Not only are the programs designed for mothers, but fathers are often not included. This is particularly true in the area of interventions for substance abusing and maltreating parents. Social service systems have only begun to acknowledge the status of men as fathers in the conceptualization and delivery of treatment for substance abuse, intimate partner violence (IPV), or child maltreatment. Overall, there has been little research on how men with these issues parent their children; there has been even less focus on the need for interventions for fathers with histories of IPV and substance abuse so that they may have positive and healthy relationships with their children.

It is estimated that nearly 16 million children are witness to violence in their homes each year (McDonald, Jouriles, Ramisetty-Mikler, Caetano, & Green, 2006) and 1.1 million parents with children at home initiate substance abuse treatment each year (NCSACW, 2004). These statistics are of particular concern for the field of infant and early childhood mental health because the risk for IPV is high in young couples in the transition to parenthood (Burch & Gallup, 2004; Saltzman, Johnson, Gilbert, & Goodwin, 2003). Large percentages of men with these issues continue to live with or have consistent contact with their young children despite aggression and substance use (Hunter & Graham-Bermann, 2013; Israel & Stover, 2009). Studies have indicated that complete separation from fathers with these issues can result in more negative developmental outcomes (Stover, Van Horn, & Lieberman, 2006; Stover, Van Horn, Turner, Cooper, & Lieberman, 2003; Tarter, Schultz, Kirisci, & Dunn, 2001) in some cases. Mothers of children whose fathers are perpetrators of IPV often report their children are very attached to and have a strong relationship with their fathers (Israel & Stover, 2009). One study found preschool-aged children who had limited or no contact with their previously violent fathers had higher levels of internalizing symptoms on the Child Behavior Checklist (Achenbach & Rescorla, 2000) than children who had frequent (at least weekly) visits. These associations with father contact were consistent even when the study controlled for the level of violence that had taken place (Stover et al., 2003). In addition, better father–child relationships in the context of substance abuse have been associated with higher child adaptive functioning (Brook et al., 2002). These studies suggest a focus on the father–child relationship and how fathers can have consistent and healthy interactions with their children could prove critically important to child outcomes in families struggling with these issues.

It is imperative that professionals better understand the capacities of men with these issues as fathers and how to intervene for the benefit of the entire family. Although some men who perpetrate violence and abuse substances are dangerous and only cause harm to their children, not all cases are the same. Lack of standard assessments and availability of appropriate treatments to address the issues these fathers are struggling with can result in perpetuation of family violence. This article will review the available research on the overall parenting of men with IPV and substance abuse, with a particular focus on the importance of father–child attachment and attunement with their children, and will consider ways that interventions might be implemented for these fathers.

Parenting of Fathers With Histories of IPV

Studies have found that more than 50% of men entering batterer intervention programs due to police involvement as a result of IPV are fathers (Rothman, Mandel, & Silverman, 2007; Salisbury, Henning, & Holdford, 2009). Rothman and colleagues (2007) found that 73% of biological fathers who perpetrated IPV believed that their violence negatively affected their parent–child relationship, and 53% worried about the long-term impact of IPV on their children. In their qualitative study of interparentally violent fathers, Perel and Peled (2008) concluded that most fathers desired more warm, involved, and connected relationships with their children. This is consistent with another study (Litton Fox, Sayers, & Bruce, 2001) which revealed that men experienced a significant amount of shame, guilt, and remorse when thinking about the harm they may have caused their children. In addition, fathers presenting to IPV intervention programs report high levels of parenting stress and less parental competence (Baker, Perilla, & Norris, 2001). The few existing studies of parenting behaviors of fathers with histories of IPV indicated no differences in their involvement or kinds of activities they do with their children, however they exhibit more hostile-aggressive parenting behaviors (Fox & Benson, 2004; Stover, Easton, & McMahon, 2013). Taylor, Guterman, Lee, and Rathouz (2009) found that mothers who were the target of IPV were more likely to confirm hostile and neglectful parenting behavior by the father than were non-abused women. In addition, there is evidence that some men with IPV histories use their children to manipulate their partner and put them in the middle of relationship conflicts with their partners (Bancroft & Silverman, 2002; Stark, 2009).

In the only known study to use observational measures of father–child interactions in families with a history of IPV, higher severity of IPV was associated with greater dyadic constriction with limited emotional expressiveness and enthusiasm, while greater substance use was associated with more discomfort and tension between father and child. Both severity of IPV and substance abuse were significantly associated with child avoidance of parent during play (Stover & Coates, 2014). Coding and observation of these fathers revealed that many were able to play appropriately with some attunement to their children. Some even showed evidence of child-directed play. Others were distant and detached and appeared uncomfortable playing with their children. It is not surprising the children of those fathers tended to play separately from them and made fewer bids to engage with them during the 15 minutes of free play.

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Attachment theory indicates the importance of parents in a child's development of healthy relationships

IPV history alone raises significant concerns about a father's parenting abilities, but substance abuse and IPV often co-occur with several meta-analyses indicating small to medium effect sizes for IPV in the context of substance use (Foran & O'Leary, 2008; Moore et al., 2008). Studies of men entering both substance abuse treatment and batterers' intervention programs have found approximately 50% of those men have both issues (Easton, Swan, & Sinha, 2000; Schumacher, Fals-Stewart, & Leonard, 2003). A few studies have examined fathers with co-occurring substance abuse and IPV and the impact on parenting. Men with co-occurring substance abuse and IPV self-report more hostile-aggressive parenting behaviors and more negative co-parenting relationships than do comparison fathers without these issues. This association is mediated by the affect regulation and attachment difficulties experienced by fathers with both substance abuse and IPV problems (Stover et al., 2013). These data suggest interventions that target attachment and affect regulation may improve parenting for these fathers.

Attachment and IPV

Insecure attachments are common in men with histories of IPV (Holtzworth-Monroe & Meehan, 2004). Attachment theory indicates the importance of parents in a child's development of healthy relationships: "A young child's experience of an encouraging, supportive, and cooperative mother, and a little later father, gives him a sense of worth, a belief in the helpfulness of others, and a favorable model on which to build future relationships" (Bowlby, 1982, p. 378). Often men who perpetrate IPV had experiences with their own mothers and fathers in childhood that resulted in insecure attachments, with significant associations between childhood maltreatment and exposure to

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Reflective functioning is thought to develop in the context of securely attached parent–infant relationships: The parent is able to recognize and anticipate the child's state of mind and act upon this knowledge to best care for the child.

IPV and later adulthood perpetration of IPV (Stith, Rosen, & Middleton, 2000; Whitfield, Anda, Dube, & Felitti, 2003) Indeed there is evidence that the association of childhood maltreatment to both adult IPV and to poor father–child relationship quality is moderated by insecure attachment characteristics (Whittington & Stover, 2015). Exposure to child maltreatment and IPV alone place a father at risk for IPV perpetration as an adult. This risk is increased when an insecure attachment is present.

Attachment directly impacts relationship functioning and is associated with reflective functioning (RF). RF is the ability to understand others' actions as a function of underlying psychological and emotional states and motivations. It is a skill important to interpersonal functioning (Fonagy, Steele, Steele, Moran, & Higgitt, 1991). RF is thought to develop in the context of securely attached parent–infant relationships: The parent is able to recognize and anticipate the child's state of mind and act upon this knowledge to best care for the child, leading to secure attachment, and passing down the ability to accurately reflect others' states of mind (Fonagy et al., 1991). Fathers who did not develop secure attachments with a caregiver in childhood come to their roles as partners and parents with poor RF capacity.

Applied to parenting, RF is taken to be parents' capacity to understand and take into account the mental states of their children (Slade, 2005). For instance, a father high in RF might acknowledge his child's negative feelings, despite prohibiting a behavior (i.e., "I know you feel sad when you cannot stay at the park, but we really need to go home for lunch."). Theories of parental RF suggest that it can directly affect parenting behavior, because those who are able to envision the internal world of their children may be better able to provide support in the child's regulation of affect and emotional states (Slade, 2005). It is also likely that those with better ability to reflect their child's state of mind may have better capacity to form secure attachments to their children (Slade, 2005). Men with histories of IPV have very limited RF (Stover & Spink, 2012). Examination of Parent Development Interviews (Slade, Aber, Berger, Bresgi, & Kaplan, 2004) conducted with a sample of these fathers suggested they have very limited capacity to describe their own experiences of being parented and their own feelings and experiences as fathers and even less understanding of the feelings and experiences of their children (Stover & Kahn, 2013; Stover & Spink 2012).

JIM'S EXPERIENCE

Jim is a 28–year-old father of a 2-year-old son. He is extremely hostile toward his partner and has been arrested twice for IPV while drinking. He grew up without his biological father, witnessing IPV between his stepfather and mother, experiencing psychological abuse from his stepfather, and living in extreme poverty in a violence-ridden community. When asked to describe his mother, he speaks in broad glowing terms. "She was my father and my mother. She was everything. She was a perfect mother." He is unable to provide specific examples of her "perfect" parenting and is defensive in his descriptions. He vacillates between clinging to the relationship with his child's mother and vehemently condemning her as an addict and poor mother. He describes her in hostile and angry terms. In contrast, he speaks lovingly of his son. He is able to describe how his son needs both his father and his mother and his wish for him to have a better childhood than he had. When asked to describe a time he felt angry as a father, Jim reported a disagreement with his partner about putting socks on his son when they go out. He told the story in an agitated way, pounding the table and raising his voice: "I put up with this [explicative] the whole day. Why doesn't she just put some socks on him? I worry about his health. I worry about him getting freaking sick and dying in the hospital. I don't give a [explicative] where you go. I just want you to freaking put socks on him."

In this quote Jim is talking about extreme concern for his son, but the hostility toward his partner shows he does not recognize the impact of his yelling and hostility toward the mother can have on his son. When asked how his son experienced this argument, he minimized it and indicated his son was not paying any attention. Jim is unable to untangle his feelings or understand their intensity. He has no capacity to reflect on the experience of his partner or alternative reasons she may not put socks on their son. He also was unable to reflect on his son's experience or consider that socks may impact his son less than the yelling he hears from his father. This hostile, rigid thinking was consistent in Jim's stories of arguments about the house and what his partner did with her time during the day. He often reported that his 2-year-old son would have the same feelings he had about a situation (e.g., fury that mom forgot his socks). The poor attachment experiences of Jim as a child, his own experiences of maltreatment and violence, and resulting poor RF are significantly impacting his ability to be a good partner and father to his son.

Father Attachment and Parenting

Fathers' attachment, RF, and attunement to their children are all important to child outcomes. Fathers who are securely attached have less abuse potential, parenting stress, and hostile parenting practices, with greater developmental knowledge and superior parenting self-efficacy (Howard, 2010; McFarland-Piazza, Hazen, Jacobvitz, & Boyd-Soisson, 2012). These benefits of secure father attachment to positive parenting may create more secure father–infant attachments (Brown, McBride, Shin, & Bost, 2007), which in turn are associated with improved childhood outcomes (DeKlyen, Speltz, & Greenberg, 1998; Gaumon & Paquette, 2013; Li, Yin, Cai, & Su, 2012). Fathers' attachment representations have an influence on their parenting and therefore father–child attachments, similar to findings for mothers. Yet, the field has been slow to develop attachment-focused interventions for fathers.

Implications for Policy and Intervention

Although research has indicated fathers with histories of IPV and the often co-occurring substance abuse can be more hostile and aggressive in their parenting and lack RF and attunement to their children, many have a desire to have better father–child relationships and are concerned about their children. Training clinicians to offer appropriate services to these fathers is a critical area of intervention development. Several attachment-focused interventions that have been designed to work with mothers could be adapted for work with fathers (Cicchetti, Rogosch, & Toth, 2006; Lieberman, Van Horn, & Ghosh Ippen, 2005). Of particular importance to this work, however, is the acknowledgment that fathers are not mothers. Adapting an intervention for fathers does not mean simply providing a treatment designed for mothers to father–child dyads. There is evidence that father–child attachment does not develop in the same way as mother–child attachment. Of critical significance is the ways fathers interact with children to develop strong bonds and later outcomes for children that differ from mothers. Quality of infant–father attachment relationship may be more closely associated with fathers' motivational attitude toward fathering and family than it is to their observable sensitivity in interactions with their infants during the first year (Grossmann, Grossmann, Fremmer-Bombik, Kindler, & Scheuerer-Englisch, 2002). It also seems that secure father–child attachments tend to develop a little later during the second year of the child's life (Grossmann et al., 2002; Schaffer & Emerson, 1964). Fathers provide a different kind of care than mothers in many families, and their interactions with their children are different. A greater proportion of fathers' time with their children is spent in active play, pushing the child to try new experiences and expand their boundaries (Grossmann, Grossmann, Kindler, & Zimmermann, 2008). Although different from mothers, this attachment has been shown to support healthy child social–emotional development (Dumont & Paquette, 2013). Interventions to assist fathers, especially those with histories of IPV and substance abuse, must integrate this knowledge into the design and execution of interventions.

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Fathers' attachment, reflective functioning, and attunement to their children are all important to child outcomes.

Programs designed for maltreating mothers that target psychoeducation, cognitive behavioral therapy (CBT) skills and attachment (Toth, Maughan, Manly, Spagnola, & Cicchetti, 2002) have been shown to improve various parenting outcomes for mothers (Van Zeijl et al., 2006) who are struggling with IPV, child maltreatment, and substance abuse. Availability of integrated programs or agencies that can offer a variety of services to fathers with issues of IPV, substance abuse, and poor parenting could significantly improve outcomes for families. Several group programs have been designed for violent or maltreating fathers to focus on either restorative parenting (Mathews, 2010) or a combination of parent education and CBT strategies (Scott & Crooks, 2007). Although not specific to work with fathers of infants and toddlers, a phased approach that involves completion of one of these group programs followed by father–child attachment-focused intervention to build RF and positive father–child relationships may promote the best outcomes for fathers and their families.

One specific intervention has been developed to target the intersection of IPV, substance use, and child maltreatment for fathers. Fathers for Change (Stover, 2013, in press) integrates attachment, family systems, and CBT interventions to target aggression and hostility, affect regulation difficulties, poor co-parenting, and RF to improve outcomes for families impacted

Learn More

Additional resources for working with fathers with histories of interpersonal violence and child maltreatment:

"Something My Father Would Do" video and other resources from Futures without Violence
www.futureswithoutviolence.org/?s=fathers

Caringdads.org

by violence. This is the only individual (not group) treatment approach that has been developed to target these issues for fathers with IPV and substance abuse. It is a phased model that begins with family systems and CBT skill-building sessions with the father and works toward conjoint co-parenting sessions with the mother of his children and ends with father–child sessions to develop positive father–child interactions and increased RF of the father related to his children. It is believed that through increased understanding of his own background and parenting context a father is motivated to engage in CBT, communication, and RF skill-building to improve his affect regulation, co-parenting communication, and understanding of his child. Initial evaluation data indicate Fathers for Change decreases violence and improves father attunement (Stover, in press).

JOSE'S EXPERIENCE

Jose is a 26-year-old father of 2-year-old Isabella. He was referred to Fathers for Change by child protective services (CPS) following an arrest for domestic violence with his wife. The incident escalated to violence after his wife accused him of cheating on her and scratched his face. He grabbed her and pushed her against a wall. Both partners were yelling and accusing each other of infidelity. Police arrived in response to a neighbor's phone call. Due to ongoing concerns from CPS about the couples' use of alcohol and marijuana, previous reports of situational couple violence that occurred in the context of arguments, and the mother's prior history of mental health issues (her children from a prior relationship were in foster care), CPS placed Isabella in a foster home.

The initial assessment with Jose indicated minimal power and control behaviors. The violence occurred in the context of heated arguments in which both members of the couple lacked trust in the other and struggled with attachment difficulties. Jose was raised by his grandparents due to his own parents' drug addiction and inability to care for him. He had no significant mental health history, but reported some symptoms of generalized anxiety. His use of marijuana was infrequent and was used to relieve stress. He had considerable anxiety about meeting the CPS expectations to get his daughter back. Jose was working full time as a security guard and staying with his grandparents. He initially moved in with them after the arrest to abide by a no-contact protective order. The order had since been lifted, but he did not want to resume his relationship with his wife. He had unsupervised visits twice per week with his daughter for 3 hours. During the initial play assessment, Jose was eager to play with his daughter, but his anxious and intrusive attempts to engage her in play activities did not provide space for her to explore the room or engage in any extended play themes. He rushed about the room bringing out new toys and showing them to her and intruding on any play she was trying to initiate. After about 10 minutes she sat on the floor, overwhelmed by all the toys he had presented and just watched Jose as he moved from toy to toy in an animated fashion. It was also noted in the assessment that Jose seemed to enjoy that his daughter would cry and cling to him at the end of visits and interpreted this as validation that his daughter loved him. He made no attempts to help her with these transitions but instead complained to his CPS case worker that his daughter was distraught she was not with him full-time: "See how much she misses me and wants to come home with me?" Jose's wife was not participating in her case plan and therefore CPS was looking at reunifying Isabella with Jose as her primary caretaker.

Initial sessions with Jose explored his own experience growing up via genogram and discussing the meaning of being a father. Jose had unclear ideas about what being a father meant other than "being there and providing." He felt his own childhood was sad, and he wanted desperately to be there in ways his own parents were not. He was motivated to reunify with his daughter and acknowledged his aggressive behavior toward his wife as harmful to Isabella. Review of the videorecorded play assessment with his daughter was eye-opening for Jose. With the help of the clinician he was able to think about how his daughter experienced the time together. They discussed the structure of the visits with his daughter and activities she may enjoy. Now that Jose was sufficiently motivated to work on his problems with aggression and emotion regulation, the clinician spent several sessions working on Cognitive Behavior Therapy (CBT) skills, helping Jose connect his thoughts to his feelings and behaviors, identify his hostile thinking patterns, and use coping strategies to reduce his anxiety and anger.

Given Jose's investment and progress in treatment, his wife was invited to attend several co-parenting sessions. She did not respond to calls from the clinician inviting her to meet with the clinician individually or to come in for co-parenting sessions with Jose. Therefore, the co-parenting communication sessions were implemented individually with Jose. He reported that his communications with his wife were primarily by text message or nasty voicemails. They were often hostile attacks related to their past intimate issues. He felt the relationship was unhealthy and was planning to file for divorce. He wanted to have a relationship as a co-parent with her and worked with the clinician to practice assertive communication and boundaries without aggression. The CBT skills also helped Jose think of alternate ways to interpret his wife's behavior and to have more empathy toward her. He was proud to tell the clinician that he had ignored several hostile texts from his wife and only communicated information about their daughter and the case plan while avoiding hostile interactions about their relationship.

The last phase of the Fathers for Change intervention was comprised of dyadic sessions with his daughter. The sessions were focused on child-directed play and developing a healthy transition into and out of his visits. The clinician prepared Jose for these sessions by encouraging him to think about the visits from Isabella's 2-year-old perspective. This work included providing information about his daughter's developmental level in terms of her cognitive and emotional capacities. Jose

was able to change his approach to the visits by preparing Isabella for the end of the visits by reading a book together that she loved and giving her a brief hug and a transitional object (a stuffed bear that he had bought for her) for her to love and hug and remind her of him until he saw her in 3 days. At first Jose did not think Isabella could understand time or begin to predict his visits. He learned through repetition of this routine that it soothed her and she was able to transition back to the foster mother. He began to take pride in how well these transitions went, understanding that it did not mean his daughter wasn't sad to say good-bye, but instead that she knew she would see him soon and he had taught her how to cope with her intense feelings when saying good-bye to him. Jose's play with his daughter also changed. He was able to sit and watch her play and let her introduce activities. He was embarrassed at first to play with the baby dolls she often chose, but over several sessions he saw how much she enjoyed this play and he was more open to it. His post treatment assessment revealed a significant improvement in his attunement to his daughter and a reduction in intrusiveness. He also had improved co-parenting communication and had no new incidents of violence during treatment.

Conclusion

Further development, evaluation, and dissemination of treatment programs for fathers that promote healthy father–child attachment could have enormous impact on the health and functioning of families at risk for IPV and co-occurring substance abuse. Training clinicians to assess fathers with histories of IPV for appropriateness for such interventions and the availability of phased programing as a father progresses in his treatment goals would be prerequisite steps in meeting the unmet intervention needs of families impacted by IPV. Positive promotion and nationalization of such programs will ensure successful integration into service systems making them available to families in need. Agencies providing intervention for infants and young children who are involved in child protective services could be leaders in the delivery of such services as they have been with interventions for maltreating, violent, and substance abusing mothers.

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Engaging Military Fathers in a Reflective Parenting Program: Lessons From Strong Families Strong Forces

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ABSTRACT

Through Strong Families Strong Forces, a reflective parenting program for military families with young children, we were privileged to work with contemporary military fathers who served in the post–9/11 conflicts in Afghanistan and Iraq. Due to this work, the authors gained valuable insight into the complexity of fathering during wartime, the critical role of fatherhood as motivation for seeking support during reintegration, and the strong commitment to healthy parenting among military fathers. In this article, the authors describe their positive experiences of engaging fathers in Strong Families Strong Forces and attempt to convey important elements of the fathers' stories as they navigated postdeployment parenting, co-parenting, and family life.

Of the more than 2.7 million U.S. troops who have deployed since 2001, 43% are parents and mostly fathers of dependent children (Institute of Medicine, 2013). Within military families, service member fathers have often been depicted by the media as broken or disengaged dads who are uninterested in reconnecting with their children or incapable of parenting because of combat stress, injury, or war-related impairments. Through our work with military families on the Strong Families Strong Forces (referred to as "Strong Families") project, we have encountered a starkly different picture of military fathers who are highly invested in their relationships with their young children, appropriately concerned about their parenting roles and the impact of deployment separation on their families, and firmly committed to building healthy relationships with their children when they return from deployment. In this brief article, we share a glimpse of what we have come to know about and from military fathers who served in the post–9/11 wars in Afghanistan (Operation Enduring Freedom [OEF]) and Iraq (Operation Iraqi Freedom [OIF]), and we challenge forcefully these damaging portrayals of contemporary military fathers.

Research on post–9/11 military families has expanded greatly over the last decade as practitioners and policymakers alike have struggled to understand and respond to the needs of service members, spouses and partners, military-connected children, and loved ones (Creech, Hadley, & Borsari, 2014). To date, the handful of studies focused on OEF/OIF military fathers offers a snapshot of men who occupy complex, multiple roles in their families and professional lives and who cannot be reduced simply to "deadbeat dads," "damaged goods," or heroes (Cromer & DeMami, 2014). For example, Willerton, Schwarz, MacDermid Wadsworth, and Oglesby (2011) studied 71 fathers at U.S. military installations, across four service branches, who collectively identified their involvement as fathers as a major concern. Fathers in this sample emphasized their interest in obtaining support around the transition to parenthood, effective co-parenting and communication, children's developmental milestones, and appropriate use of discipline. In a qualitative study conducted by Dayton, Walsh, Muzik, Erwin, and Rosenblum (2014), military fathers shared hopes that their young children would develop qualities of confidence and self-sufficiency. They were also able to disclose their difficulty in supporting the development of these qualities in their young children and their understandable struggles with young children's negative affect and difficult behaviors (Walsh et al., 2014). In a similar fashion, Lee and colleagues (2013) highlighted fathers' motivation to develop and maintain positive relationships with their partners and children despite the substantial challenges of military service during wartime, including multiple deployments, family moves, and demanding work responsibilities at home and in theater. In this study, fathers emphasized the importance of receiving information in facilitating the transition to parenthood, specifically in the key domains of (a) effective co-parenting and communication and (b) children's developmental milestones (Lee et al., 2103).

Photo: Kiwi Street Studios

A reflective father is actively wondering about his child's thoughts, emotions, desires, and intentions, in the unfolding developmental context, and can acknowledge the complexity of the process.

Background on the Strong Families Program

Early in these long wars, in response to growing concerns about the impact of military-related separation on very young children and the children's relationships with their deployed parents, we developed the Strong Families reflective parenting program, which aims to support parent–child attachment and reconnection in the context of military deployment. Strong Families is based on an ecological attachment framework for understanding and responding to military parents and their young children during the reintegration period. Guiding principles include cultural humility and responsiveness to the military context, family resilience in the face of deployment, and a strengths-based orientation to prevention and intervention. Strong Families is an eight-module home-based intervention delivered within an 8- to 12-week period. Program content incorporates developmental guidance, exploration of family military identity and deployment narratives, and parenting and co-parenting strategies. The program's primary target of intervention is at the level of parental reflective capacity to support reconnection, understanding, and growth among military fathers (and mothers) as they work to rebalance after prolonged separation.

Parental reflective functioning (*RF*; see also Stover, this issue, p. 36) is conceptualized, in this context, as a military father's ability to be curious about and "envision" his own and his children's mental states in relation to parenting (Slade, 2006). A recently returned service member father who is able to recognize his own internal states is better equipped to reengage in family relationships. For mothers and fathers of very young children, reflection can be particularly challenging given the cognitive capacities of babies and toddlers. A reflective father is actively wondering about his child's thoughts, emotions, desires, and intentions, in the unfolding developmental context, and can acknowledge the complexity of the process. Parental reflective functioning has been shown to promote attuned parenting behaviors and is a factor in the quality of the parent–child relationship. Further, RF is thought to be a primary mechanism through which parents maintain awareness of and sensitivity toward their children (Ordway, Sadler, Dixon, & Slade, 2014).

Research has indicated that parents who possess (or develop) these internal reflective capacities are better able to imagine what a young child is feeling—including distress—and to respond with acceptance and openness (Slade, Grienenberger, Bernbach, Levy, & Locker, 2005). Higher levels of RF have been associated with the development of adaptive means of self-regulation and the establishment of healthy interpersonal relationships in both parents and children. By contrast, parents with lower RF may have an inflexible or distorted sense of their own and their young child's underlying mental states and respond less sensitively to child behaviors and distress. Supporting RF among service member fathers (and mothers) in the Strong Families intervention optimizes the likelihood of changing parental understanding of their young children's mental states and intentions—and, ultimately, modifying parenting behavior and child outcomes in a positive direction.

Vignette: Frank's Story

In the following vignette, we bring to life some of the concepts and processes in Strong Families.

> *Frank was thrilled to be back from 12 months in Afghanistan, and he looked forward to reconnecting with his wife and young daughter, Kaylie, although he understood that things would not be the same as when he left. For one thing, he knew he was jumpy and easily annoyed, and he recognized that some of his "symptoms" might be signs of posttraumatic stress disorder (PTSD). His family lived in a very small, one-bedroom apartment, with Kaylie's toys all over the living room floor. He thought, "How can one toddler need so many things to play with, and why can't they be put away in one place?"*
>
> *When Frank left for deployment, Kaylie was an adorable baby, barely 5 months old. He loved being her father. She cried a little, but he loved holding and cuddling her. She*

would look up at him, and he felt strong and protective. He was sure that she was feeling safe and secure, with both parents there to care for her. Frank sometimes wondered what else she was thinking or feeling, but he was very focused on preparing for deployment. Frank was greatly comforted in the knowledge that Eileen was a good mother and would take good care for Kaylie while he was gone.

Since Frank's return from deployment, he noticed that every time Kaylie shouted in her play or cried for any reason, he felt tense and wanted her to be quiet. What happened to his baby girl? What had he missed while being away? Frank realized that he probably shouted more than he should. Kaylie was so close with Eileen, and Eileen knew their daughter's needs so well. Every time Frank tried to hug his wife, Kaylie would grab his leg and try to pull them apart. This made Frank wonder whether there was room for him in the family or how he could move back into his father role with Kaylie.

Kaylie had full run of the house. She ate and played whenever she wanted, and rarely responded to her father's requests. Frank was raised in a family that sat down together at the table for family dinners and that insisted on well-behaved children. In addition, he was accustomed to the structure and order of his unit. Eileen seemed to think that his attitude and approach to parenting were old fashioned and not what she wanted for their daughter. She also acknowledged that it had been hard to keep up a solid routine during his deployment and that she had been somewhat worried about this while he was away. They had already argued a number of times about these issues, and he had only been home for 7 weeks.

Frank was eager to talk with the family specialist (a clinician) from Strong Families. He wanted help to learn to parent his daughter and to manage his strong reactions. Early in the program, the clinician asked both Frank and Eileen to describe their daughter Kaylie using a few adjectives (adapted from the Internal Working Model of the Child Interview; Zeanah & Benoit, 1995). They wrote their answers separately and then shared them with each other. Frank was reassured when his adjectives—smart, strong, talkative, *and* funny—*were similar to Eileen's portrayal of Kaylie*—intelligent, strong willed, chatty, *and* silly. *Because Eileen and Kaylie had been inseparable during the deployment, Frank viewed his wife as the "expert" on their daughter. He was delighted that his description of Kaylie was similar to his wife's, and he felt more confident that he was learning how to parent a toddler and getting to know his daughter again.*

During the course of the eight modules, the clinician encouraged Frank to wonder about his daughter's needs and emotions and to engage with her in a variety of ways. Frank listened to Eileen's stories about Kaylie's experiences and development during the time that Frank was deployed, and he began to think about how Kaylie might view him. Did she know that he was her father? Did she miss him while he was away?

Frank looked for ways to be involved with Kaylie that were comfortable for both of them. They played games with balls on the floor of the living room; Frank chased her, pretending he was the "big bad wolf," as Kaylie laughed and Frank beamed with pride. The clinician supported Eileen in her efforts to foster father–daughter interaction and to make space for Frank to find his way. On occasion, when playing together as a family, the clinician encouraged Eileen to gradually move farther and farther away (physically) as Frank and Kaylie created special play space for the two of them.

As the weeks passed, Frank came to know his daughter's preferences—for example, which games she liked and which ones she did not like. He also began to take more responsibility (outside the sessions) for Kaylie's routines, such as bath and bedtime. Eileen could see that Frank was re-learning to attune to their daughter, and she began to feel more comfortable when Frank was alone with Kaylie.

By the end of the Strong Families program, Frank was much calmer and was clearly at ease in Kaylie's company. He had begun to participate in treatment for PTSD symptoms, as he was able to see the link between his distress and irritability and his responses to Kaylie. Eileen was delighted to see Kaylie enjoying her father and felt relieved that she and Frank could parent together again. Seeing Frank relax made her feel closer to him. Frank was hopeful that Kaylie was developing a good relationship with him and could see that she had begun to trust and turn to him again.

Criteria and Methodology

As Frank's story highlights, fathers are often highly motivated to reestablish nurturing, positive relationships with their very young

Photo: Kiwi Street Studios

Strong Families Strong Forces is based on an ecological attachment framework for understanding and responding to military parents and their young children during the reintegration period.

Photo: Kiwi Street Studios

Fathers are often highly motivated to reestablish nurturing, positive relationships with their very young children.

children. In framing Strong Families, we lead with a stance that honors the importance of fathers, mothers, and caregivers who support young children through military-related separations. Thus, embedded in our approach is the explicit expectation that military fathers would be full participants in the program. A major criterion for families to enter Strong Families was the experience of parental deployment; however, we were also keenly aware of service member concerns about stigma and confidentiality related to help-seeking. For this reason, we used a community-based participatory approach (DeVoe, Ross, & Paris, 2012) to ensure the program's relevance and helpfulness to military fathers who, as a group, have been characterized as a "hard-to-reach" or "difficult-to-engage" population. Specifically, we conducted in-depth interviews with service member fathers about their experiences of becoming parents, fathering through the deployment cycle, parenting from a war zone, and being back home with their babies and toddlers. Similarly, we interviewed nondeploying spouses and partners to help us understand their experiences and insights about the transition to parenthood in the context of military service, parenting and co-parenting through deployment separations, and the challenges along the way (DeVoe & Ross, 2012).

We also engaged military parents and at-home spouses in the design of Strong Families so that the program would be feasible and useful to reintegrating families (Ross & DeVoe, 2014). For example, we were interested in answering the question, "What do people like us [clinicians, researchers, social workers, psychologists] need to know about families like yours to be helpful?" Parents seemed to appreciate the opportunity to be heard nonjudgmentally and to be viewed as the experts of their own experiences and families. Collectively, these parents strongly endorsed (a) the need for deploying service members and parents at home to receive preparation and information about what to expect and how to manage deployment separation and reintegration, (b) the helpfulness of "military-specific" programs, and (c) the option to receive services in the home.

We next completed a pilot study with nine families, all of whom completed the eight module intervention. On the basis of parents' feedback, we substantially shifted the topical focus of two modules to ensure attention to the unfolding of each family's military cultural identity and to the centrality of co-parenting processes across deployment and separation cycles. Finally, we conducted a randomized clinical trial (N = 115 families) in which we compared families who had participated in Strong Families with those in a wait-list comparison group. We, too, had been concerned that military-connected families—specifically, service member fathers—might be reluctant to participate in a parenting program. For this reason, we became intensively involved in community outreach, which allowed parents to meet members of our team and learn more about Strong Families in person. Military fathers proved to be an easy-to-engage group, as reflected in very high completion rates (92.9% completion in the treatment arm) and positive feedback during exit interviews (DeVoe & Ross, 2012), which we attribute to choosing our port of entry through parenting, our home-based modality, and our strengths-based philosophy. Service member fathers who participated in Strong Families reported reduced parenting stress, reduced mental health distress, and enhanced parental reflective capacity. However, our preliminary findings also suggest that fathers who entered the program with higher levels of posttraumatic stress, anxiety, or depression symptoms had more difficulty with the reflective process.

Learn More

Parenting Resource for Online Military Members and Veterans

www.veterantraining.va.gov/parenting/

ZERO TO THREE Resources for Military Families and Providers

www.zerotothree.org/about-us/funded-projects/military-families/

www.nctsn.org/resources/topics/military-children-and-families

Implications and Future Directions

Strong Families is a reflective parenting intervention founded on the assumptions that all parents want to be good parents and that prolonged parent–child separation—in this case, deployment—is stressful for all families. Through this normalizing approach, military parents were able to access resources on the basis of their status as parents of young children rather than as adult clients within mental or behavioral health systems. For some families, parenting support is sufficient to rebalance relationships and validate adaptive parenting efforts, whereas, for others, this port of entry enables parents to have a positive experience with service providers that can serve as a bridge to more targeted mental health services when needed (DeVoe & Ross, 2013).

Conclusion

Our experiences with military fathers strongly affirm the primacy of the fathering role in the lives of these men. The breadth and creativity of strategies that fathers use to maintain connection to their young children (and spouses/partners) throughout deployment cycles are inspiring. Although military fathers who are deployed need support from their spouses and families at home to maintain strong relationships and communication with their very young children, they are powerfully motivated to be present and engaged in their children's lives—even from war zones, and especially when they are reunited with their loved ones.

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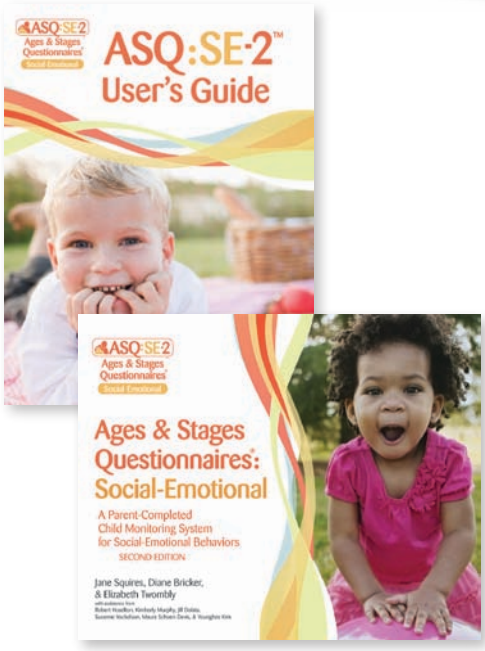

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Thinking 3 Rather Than 2 + 1: How a Coparenting Framework Can Transform Infant Mental Health Efforts With Unmarried African American Parents

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ABSTRACT

More than half of poor African American infants are born into "fragile families" and nearly half grow up in single-mother families with little or no father involvement. However, most prenatal interventions fail to help unmarried mothers talk and plan together with their baby's father, especially when fathers are nonresidential. This article details one of the nation's first interventions explicitly designed to support coparenting and triangular (mother–father–infant) relationships in African American families where the parents are unmarried, be they coupled or uncoupled. The Figuring It Out for the Child (FIOC) project in St. Petersburg, FL, successfully partnered with local community leaders in designing, implementing, and evaluating a novel dyadic, prenatal intervention enrolling both coresidential and non-coresidential African American parents. The authors provide an overview of the state of the field when the project began, explain the significance of the project's community connectedness, summarize details of outreach efforts, and highlight noteworthy findings relevant to this issue.

In the United States, enduring birth and health outcome gaps between African American and White families can be tied to failures at every system level—individual, familial, educational, societal, and governmental—to effectively engage African American fathers in their infants' lives (Lu et al., 2010). Despite the fact that children growing up in father-absent families face greater risk for poorer developmental and life outcomes, prenatal interventions with unmarried mothers typically channel all education and supports to the mother (Olds, Sadler, & Kitzman, 2007). Although independently functioning fatherhood groups do exist and children's fathers are sometimes invited to join home visits (McHale & Phares, this issue, p. 2), rarely does work systematically help the mother and father talk and plan together for the postnatal family situation, especially when fathers are nonresidential (Lu et al., 2010). This omission is unfortunate, as positive coparenting alliances help promote infant mental health

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FIOC was designed to be a preventive family-strengthening approach that sought to help unmarried and uncoupled African American parents coordinate effectively to coparent their babies.

across a wide range of diverse family systems and structures. However, such positive alliances are most likely to be achieved when parents are able to communicate, coordinate, and problem solve in the child's best interests.

This was the situation when we set out to build a prenatal program to help unmarried and uncoupled African American families develop strong, supportive coparenting alliances for their child. We recognized that, to succeed, the program had to acknowledge and respect the sensibilities of families in our community, often portrayed as hard to reach, wary, and even distrustful of new community programs geared to serve African American families. Together with local community leaders, we crafted a dyadic, prenatal intervention to engage unmarried mothers and fathers together—always together—so that they might begin to develop coparenting and triangular (mother–father–infant) relationships, even in the context of non-coresidentiality. This report summarizes the Figuring It Out for the Child (FIOC) story and ties its lessons learned to the theme of this special issue—that even purportedly "disinterested" fathers can be engaged in infant mental health efforts, given the resolve and the right conceptual model.

Background

In this issue's lead article, McHale and Phares (p. 2) argue that supporting infant mental health in all corners of the United States equates to supporting babies' mothers. Virtually never do community approaches targeting unmarried, uncoupled mothers, as standard operating procedure, unambiguously set out to engage fathers and mothers together. Perhaps the most well-known exception was the Department of Health and Human Services/Administration for Children and Families' bold, large-scale "Building Strong Families" (BSF) initiative (Dion, Avellar, Zaveri, & Hershey, 2006), which sought to bring mothers and fathers together through a relationship and marriage enhancement (RME) program offering. BSF's aims were to promote healthy adult–adult relationships in higher risk families. However, although there is some evidence that African American couples in committed relationships receive RME benefits (Owen et al., 2012), such programming has largely missed the mark with higher risk uncoupled parents (Wood, McConnell, Moore, Clarkwest, & Hsueh, 2010). In fact, Dion et al.'s (2006) report on the BSF pilot study recruitment estimated that fewer than 1 in 10 families served by Healthy Start actually even qualified for the BSF intervention based on the project's inclusion criteria (mother and father romantically involved, not living together). Moreover, only about 10% of recruited couples actually stayed involved long enough to receive a strong dosage of the BSF curriculum (Wood et al., 2010).

Other well-intentioned, potentially worthwhile programs ostensibly geared to support coparenting between non-coresidential parents have also met with skepticism and resistance from the parents they were designed to serve. For example, many nonresidential coparents who were offered an opportunity to gain access and visitation to their child as part of grants offered in Colorado, Texas, and Tennessee did not participate (Davis, Pearson, & Thoennes, 2010; Pearson, Davis, & Thoennes, 2007); this was most commonly because one or both parents refused to respond and/or cooperate or could not be contacted. Fathers participating in multisite federally funded fatherhood initiatives have reported frustration and conflict in their relationships with their child's mother, with coordination especially difficult if one or both parents have children with more than one partner. However, although non-coresidential parents have articulated more need for help with coparenting relationships than programs currently offer, the use of existing services such as mediation—especially by custodial parents—is poor (Martinson & Nightingale, 2008).

The reasons why parents do not participate in promising programs are important to understand. When programs are connected with child support enforcement, trust issues are pronounced, with both mothers and fathers often concerned that taking part may worsen rather than improve their relationship. In the BSF initiative, the intensive coupling focus that undergirded the effort appeared to have been in poor sync with the challenges facing African American families in the underclass. Poverty, economic instability, and formidable relationship obstacles influence the family decisions that parents make before, during, and after transitions to new parenthood (Furstenberg, 2001; Wilson, 1987). Gender mistrust; concerns about readiness to commit, immaturity, and sexual infidelity; and the presence of children from previous unions all influence strategic relational choices (Carlson, McLanahan, & England, 2004; Edin, 2000; McLanahan et al., 2003; Ooms & Wilson, 2004). Many young, low-income African American women deliberately choose not to marry the fathers of their children if they believe the fathers will not be breadwinners (Wilson, 1987), but as Roy and Burton (2007) have outlined, they also endeavor

to keep the fathers engaged in their children's lives over time and through episodic absences.

With this understanding of previous programs' challenges as a backdrop, FIOC took a different approach. It was designed to be a preventive family-strengthening approach, an alternate method to RME that sought to help unmarried and uncoupled African American parents coordinate effectively to coparent their babies. Although distinctions between coparenting and marital relations were first documented in the mid-1990s, and a conceptual model outlining coparenting in diverse family systems was first articulated by McHale and colleagues in 2002, it has only been in the past decade that the coparenting model has caught fire (McHale, 2009; McHale & Irace, 2011). Interventionists appear to have finally begun to take seriously the possibility that effective coparenting in support of infant mental health is possible in family systems other than two-parent nuclear family structures.

Development of the Prenatal Coparenting Intervention

Drawing on lessons learned from RME initiatives as a starting base (McHale, Waller, & Pearson, 2012), FIOC's curriculum developers designed a six-session prenatal intervention based on McHale and Irace's (2010) focused coparenting consultation (FCC) model. FCC is an insight- and skills-based intervention. It heightens parents' awareness about the beneficial impact of positive coparenting for young children's adaptation and mental health, enhances rapport and solidarity, and helps parents develop communication and problem-solving skills needed to surmount the challenges they face in developing a positive and sustained coparenting alliance in or outside of committed cohabitation and/or marriage. FCC has three stages: consciousness raising, skill building, and enactment (see Table 1).

With draft in hand, the FIOC developers then relied on seasoned African American activists, interventionists, and educational leaders in the community in which FIOC was piloted to evaluate and critique the curriculum and propose adjustments that would allow the program to better address the actual life circumstances of families to be served. This process led to several important changes, including the introduction of preintervention one-on-one mentorship sessions between male mentors and fathers, and between female mentors and mothers, to ready the parents for the six-session intervention to follow, as well as inclusion of a booster session 1 month postbirth to celebrate the child's birth and reinforce lessons learned during the intervention.

The explicit intent of the intervention was to meet families "where they were," advocate for their creation of a positive and intentional coparenting alliance to support the baby on the way, and help them take the all-important first steps toward developing that alliance in whatever form it might take for their child and family. If successfully accomplished, the quality of the socialization environment supporting early infant mental health would be strengthened immeasurably. The key was in promoting fathers' and mothers' connections and rapport with each other in

TABLE 1. **Summary of the Focused Coparenting Consultation (FCC) Model and Overview of Figuring It Out for the Child (FIOC) sessions**

Session number and stage	Overview
1. Consciousness raising	Mentors provide parents with an overview of FIOC, why it was developed, and how it is expected to affect the baby and family. They also affirm parents' commitments to program participation.
2. Consciousness raising	Trigger videos evoke parent awareness about how fathers affect children. Parents discuss challenges facing African American children and how experiences with their own fathers could shape the type of coparents they become.
3. Consciousness raising, skill building	Parents examine their ideas about parenting. Differences in the two parents' ideas are the explicit focus. Communication skills to resolve differences in parenting ideologies are introduced. Parents learn to use active listening techniques, with mentor demonstration and coaching.
4. Skill building	Mentors broach current life issues that provoke parent anger. They model and coach parents in the use of a stylized way of communicating to effectively manage anger and resolve conflict to help build the coparenting alliance for their baby.
5. Skill building and enactment	Parents confront their own real-life conflicts (e.g., children from previous relationships, concerns with child safety around in-laws, grandmaternal gatekeeping). Mentors coach parents in the use of their new skills and continually reinforce the parents' commitment to figure it out for their child.
6. Enactment, wrap up	Symbolizing their emerging role as a coparenting team, parents complete this last session largely on their own, using the skills they've acquired to develop a common set of goals for the child and a jointly crafted commitment statement.
7. Booster session	Mentors celebrate the baby's arrival and how far parents have come. Parents talk about their baby, discuss the challenges of working together as coparents, review lessons learned prenatally, and practice the use of acquired skills to address one current concern they self-identify.

their coparenting roles, a precondition for positive and sustained father involvement in the lives of their infants and toddlers. In this regard, the FIOC program sought to create a true "3-together" family system, communicating to both the father and the mother from the very beginning that the family-strengthening work could not proceed without the father.

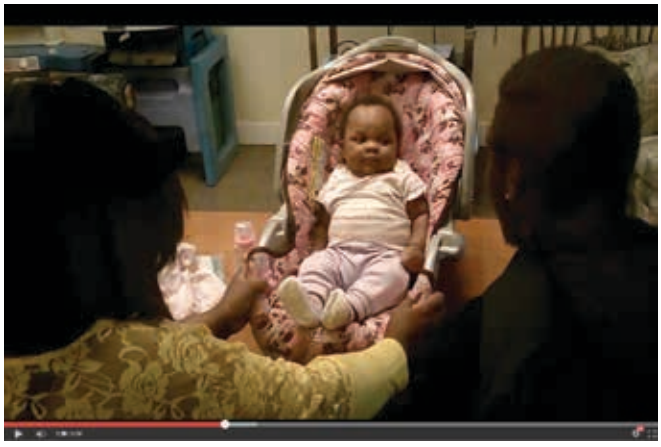
The insistence that the father was pivotal to the work, not an optional luxury, set FIOC apart from "2 + 1" models in which father is conceptualized principally as an ally of or support for mother. In a 3-together conceptualization, the father is affirmed relentlessly as a coparent in his own right, working collaboratively with the mother so that the two of them can chart the healthiest, most positive course for their baby (Figure 1).

Delivering FIOC: Who Were the Correct Individuals to Serve as Interventionists?

Unlike most prenatal interventions designed for expectant African American parents, the FIOC program was delivered to the mother and father together by a male–female mentor dyad. Unlike BSF interventionists, FIOC mentors were paraprofessionals who had no advanced education or degree in the counseling field. Serving two parents simultaneously remains very uncommon for service systems operating in most urban areas throughout the United States. Rather, preventive prenatal interventions for higher risk mothers are delivered by female visiting nurses and health educators in home settings, while preventive prenatal interventions for higher risk fathers are delivered by male paraprofessional fatherhood specialists to group gatherings of expectant or new fathers in community-based agency settings. The paired-mentor dyad approach was a novel undertaking for the St. Petersburg community.

Our initial instinct was that home visitors, working together with fatherhood personnel, would be ideal choices as male–female mentor teams, for several reasons. First, the unfortunate reality is that degreed mental health professionals of color are in very short supply in urban communities. Home visiting and fatherhood programs, by contrast, are already operative frontline services throughout the United States. Second, and more important to us, individuals staffing home visiting and fatherhood programs are also gifted at outreach to reticent parents. They understand and are knowledgeable about the life issues facing families in the community and are aware that they must provide "something extra" to convince parents that they believe in them, want to help them take their lives to the next level, and will not give up on them. Third, frontline personnel typically receive foundational (and sometimes more extensive) training in addressing domestic violence in the agencies where they work. Fourth, these individuals are ideally situated to join families and intervene at a "magic moment,"—with the critical window for the development of parent–child attachment still open and before a family "script" is written and enshrined. In a groundbreaking prospective study examining the evolution of coparenting alliances in working-class families, McHale and Rotman (2007) documented that signature coparenting and family dynamics are already firmly in place by 3 months postpartum and that coparenting solidarity remains coherent from 3 to 30 months postpartum.

FIGURE 1. **A 3-month-old signals her father as her mother reorients her seat during a 3-together triadic interaction.**



Although frontline interventionists seemed an ideal choice, there were concerns, too. Could those with no formal clinical training competently deliver interventions to multiple parties while adequately adhering to intervention models? Pinquart and Teubert's (2010) meta-analytic study of couples' interventions delivered by professionals (e.g., clinical psychologists, social workers) and by paraprofessionals across transitions to new parenthood suggested that only professional-led interventions had significant effects on couple adjustment and couple communication. They speculated that, perhaps, only well-trained family therapists and other professionals are aptly suited to identify couples' needs for change and to develop and implement adequate strategies to address these needs. Hence, a major question for FIOC—beyond whether we could bring male interventionists into prenatal programs to help female interventionists engage fathers with mothers in coparenting planning—was whether the dyadic, couple-based FIOC intervention could be delivered competently and with adequate fidelity by experienced community mentors with no formal professional training as couples' therapists.

Aptitude of Mentors in Delivering the FIOC Curriculum

The FIOC pilot study, funded by the Brady Education Foundation, provided beginning evidence that well-trained mentors can effectively engage and work with unmarried couples while competently implementing and adhering to the FIOC curriculum with fidelity. In the pilot study, FIOC's mentors were three African American men and four African American women. They averaged 10.5 years of previous experience working individually or in groups with young men and women in the targeted community but had no formal education or training in working with couples in a clinical capacity. Mentors included seasoned fatherhood service personnel, lay and pastoral counselors, health educators, and home visitors. They completed

a comprehensive 1-week training covering the FIOC curriculum, principles and techniques of couple intervention, addressing domestic violence, rating session accomplishments, and making use of clinical supervision. Vikki T. Gaskin-Butler and Katherine McKay, both licensed clinical psychologists experienced in couples' interventions, provided supervision by means of weekly conference calls involving all mentors and quarterly live-group supervision sessions or in-service trainings. Mentor-pairing assignments for families were made, taking into consideration mentors' accumulating experience with the FIOC intervention, so that mentors who had not yet seen many FIOC families were paired with mentors amassing FIOC experience.

To intensively monitor mentors' work, we scrutinized both audiotapes and transcriptions of the FIOC sessions—all 138 of them. We used validated fidelity assessment instruments as well as independent blind coding of audiotapes and transcriptions of FIOC sessions. We learned that, once mentors gained their "sea legs," they proved capable of implementing the FIOC curriculum as designed. Salman-Engin and colleagues (2013) found that the average levels of adherence to (and competence in delivering) modules requiring mentors to assist parents in enacting conflict discussions were marginally poorer than those for modules requiring discussions of videos or questionnaires. Nevertheless, the overall accomplishment of deliverables across all sessions and the overall levels of competence in engaging and working with parents were acceptable to good (see Table 2).

Analyses indicated that both coleader mentors participated in intervention delivery, contributed to ensuring that key elements of the curriculum were delivered, and supported each other in the work of engaging couples during the intervention. Mentors reported being challenged most when they had to redirect the conversations of parents seeking to discuss current life predicaments unrelated to the focus on coparenting. With time, mentors became more at ease in giving some time and voice to truly urgent issues but gradually guiding parents back to the FCC curriculum so that the core components of each session could be delivered. As Table 2 shows, overall levels of conflict during sessions were low, even during conflict discussion sessions. The relevance and acceptability of the session content were borne out by two indicators. First, of the 40 coparents (20 men, 20 women) served in the Brady-sponsored project who completed an intake and went on to participate in Session 1 of the intervention, 38 (19 coparenting teams) completed all seven sessions, and 100% of these completers returned as a family threesome for a 3-month postpartum assessment, regardless of their present living circumstances (living together, 52%; living apart, 48%). Second, parents uniformly expressed satisfaction with the benefits derived from the intervention (Salman-Engin et al., 2013).

Outcomes of the FIOC Intervention

Although parent comfort and satisfaction are absolutely critical to retention, and a prerequisite for delivering sufficient dosages of any intervention to make a difference, the key question was: Did families benefit? Programs that boast high satisfaction ratings often capitalize on the wistfulness of their participants as they wrestle with saying good-bye to interventionists with whom they had forged a connection. The proof of whether parents derive benefit lies in whether the intervention has "moved the needle"; that is, whether domains targeted for improvement (in our case, observed rapport, problem solving, and communication) have improved for the better after the work has ended. In this regard, FIOC was a success. Parents who participated in the FIOC prenatal intervention showed improved coparenting communication and problem solving as observed during mother–father conflict discussions (McHale, Salman-Engin, & Coovert, 2015). Moreover, we found statistically significant declines in maternal depression and increased endorsement of fathers' roles and responsibilities. Beyond these pilot findings showing material improvements in coparenting communication and collaboration,

TABLE 2. **Mean Scores of Adherence, Competence, Family Satisfaction, Conflict During Sessions, and Tone of Session Across Families**

	Adherence[a] (overall)	Competence[b]		Family satisfaction[c]		Conflict during session[d]	Tone of session[e]
		Female mentor	Male mentor	Mother	Father		
M	1.47	6.10	6.10	5.67	5.74	0.47	6.96
SD	0.24	0.70	0.65	0.33	0.30	0.32	0.74

[a] Adherence was rated from audiotapes and transcripts by quality assurance analysts (QAAs) on a scale on which 0 = *not accomplished*, 1 = *partially/somewhat accomplished*, and 2 = *successfully accomplished*.

[b] Competence was rated from audiotapes and transcripts by QAAs on a scale ranging from 1 to 9: 1–3 = *needs work*; 4–6 = *acceptable*; 7–9 = *good work*.

[c] Family satisfaction was rated by parents on a scale ranging from 1 = *least satisfaction* to 6 = *highest satisfaction*.

[d] Conflict was rated by QAAs on a 5-point scale ranging from 0 (*no conflict*) to 4 (*very high conflict*).

[e] Tone of session (quality and affective tone of conversations in the session) was rated by QAAs on a 9-point scale: 1–3 = *negative*; 4–6 = *neutral*; 7–9 = *positive*.

we documented another phenomenon of especially great relevance to the field of infant–family mental health.

Before the FIOC study, early coparenting and triangular interactions in African American fragile families had never been studied by means of observational methods. Again, we believe that this owes to the stereotypic view of the African American infant's family—reinforced by the infant mental health field itself—as being dyadic (infant–mother) in nature, buoyed at times by "support systems" (that may or may not include the father) to assist the mother. This 2 + 1 perspective, we argue, is the one that needs to transform if we are to serve families in ways that will most benefit children. In 1999, Fivaz-Depeursinge and Corboz-Warnery made a case for the mother–father–child connection as a "primary triangle." For 20 years, McHale's work, building on Minuchin et al.'s clinical writing (Minuchin, 1974; Minuchin, Rosman, Baker, & Minuchin, 2009), has carefully illustrated and outlined why the essence of any and every coparenting system is at least triangular in nature, never just dyadic as some derivative perspectives have mistakenly portrayed. For example, different children within the same family may be coparented differently by the same coparenting adults (McHale, 2007), and coparenting alliances are actively shaped and influenced by unique child traits and contributions (McHale et al., 2004; Phillip, Fivaz-Depeursinge, Corboz-Warnery, & Favez, 2009).

However, it is only possible to see and understand the emerging mother–father–infant coparenting alliance in unmarried family systems if interventionists think "three" and look for three (Iwaoka-Scott & Lieberman, this issue, p. 18; McHale, 2011; McHale & Alberts, 2003; McHale & Phares, this issue, p. 2). If the father is de facto dismissed as being uninvolved, uninterested, or worse, a bad influence—an occurrence that unfortunately happens every day in millions of agencies and infant mental health interventions around the world—then it is impossible to assess, understand, support, and strengthen the coparenting of the adults in the child's primary triangle.

McHale and Coates (2014) reported on the triangular dynamics of 19 families in the FIOC feasibility study as mothers, fathers, and infants navigated the Lausanne Trilogue Play together. Parents' interactions during the Lausanne Trilogue Play provide important glimpses into coparenting dynamics such as cooperation, warmth, sensitivity, conflict, and withdrawal. As illustrated in Figure 2, babies engaged with and drew in both their fathers and mothers during play interactions. Formal coding of video records of the interactions revealed that, in 16 of the 19 families (84%), parents displayed moderate-to-high levels of cooperation, warmth, and/or sensitivity, as ascertained on the Coparenting and Family Rating System (McHale, Kuersten-Hogan, & Lauretti, 2000), a widely used and well-validated rating system that evaluates coparenting dynamics in diverse family systems. Moreover, in 9 of those 16 families, not only were ratings signifying coparenting collaboration and connection high, but also ratings signifying coparenting challenges and strains were low (McHale & Coates, 2014).

The remaining seven families exhibiting moderate levels of cooperation, warmth, sensitivity, or all of these also showed signs of competition, disengagement, or both. Such families were of special interest in that they revealed some level of coparenting and family strength along with the evident signs of coparenting strain and challenge—affording a window for interventionists working from a family strengths perspective (Frascarolo, Fivaz, & Favez, 2011). Of particular significance, McHale and Coates (2014) ascertained that highly positive coparenting alliances were no more likely among residential than nonresidential families; several fathers and mothers managed to coparent successfully across different domiciles.

In many of our communications about the FIOC project, we have used the term "fragile families," but that term is one that we inherited from a research literature concerned with the adjustment of unmarried families with young children. In our experience, the word "fragile" did not properly explain so much of what we saw; all the men and women we worked with were

FIGURE 2. **Over the course of 6 minutes, a 3-month-old divides his attention between his two parents during an Lausanne Trilogue Play interaction, signaling to them both and drawing them in to engage.**

motivated not only to do best by their children but also to work diligently, even through challenges, to successfully complete the prenatal intervention. We stood by them as they dealt with day-to-day trials and tribulations beyond the project. We allowed them to go "off the radar" for days (and, sometimes, weeks) at a time if they needed to but stayed with them and did not write off their mutual commitment to the project—and their baby. Perhaps, for this reason, we lost virtually no one from the pilot program once it had begun, and the proof was in the family dynamic at 3 months postpartum. All families were coparenting, whether within the same residence or across domiciles, and the nature of the interactions we observed between parents and babies indicated that most children were having experiences of warm, supportive, and positive exchanges between their parents in their family triangle.

Conclusions and the Road Ahead

In this special issue addressing what is possible in bringing fathers squarely into the everyday practice of infant mental health efforts, one essential message of pivotal importance is that the nature of the coparenting alliance that unmarried parents create (or fail to create) helps determine whether nonresidential fathers will engage and stay engaged with their babies and toddlers. In a 2008 analysis of data from the Fragile Families and Child Well-Being Study, Carlson and colleagues (2004) found that coparenting between non-coresident parents during infancy strongly predicted later father involvement but that early father involvement only weakly predicted later coparenting. Prenatal fatherhood programs that encourage father involvement without also involving mothers are unlikely to materially influence coparenting cooperation and coordination (McHale et al., 2012), as unwelcome father involvement triggers more, not less, coparenting conflict (Talbot, Baker, & McHale, 2009). For programs aspiring to promote father involvement in African American fragile families, these latter findings must give serious pause. Federally funded responsible fatherhood programs seldom engage mothers in efforts to help the parents collaborate to surmount obstacles and coordinate as coparents (McHale, 2009). Working with both parents is key.

As we presented this work at various conferences around the United States, audience members have asked, "Who are these fathers, and where did they come from?" The most correct answer is that they are every man. We intentionally set out not to "cherry-pick" only parents already in committed long-term relationships. We served teenagers, men who had previously fathered other children, parents who had known each other for only a month or so before the mother became pregnant, and parents with significant risk histories. The only men we did not reach out to and seek to serve were those in relationships marred by ongoing intimate partner violence (IPV). We were duly cautious in the pilot program, given that we did not know whether the intervention would stir levels of conflict that were unmanageable for parents or whether our mentors would stand ready to address issues of IPV if and when they surfaced. Indeed, the BSF study actually found that, at one of its eight sites, parents who participated in their curriculum—particularly those couples in on-again, off-again relationships—had more occurrences of IPV than did control-group families who did not receive the intervention (Wood, McConnell, Moore, Clarkwest, & Hsueh, 2010). Although it is possible that the BSF study may have unwittingly placed such participants in potentially harmful circumstances by emphasizing couple relationship issues over developing cooperative coparenting, we took the BSF findings very seriously and so screened out families who had nonzero scores on a Danger Assessment Scale.

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Enjoining fathers as fathers and as coparents for their children is what will allow more men to take their just roles as protectors, allies, and lifelong attachment figures for their children.

We will say more about this shortly; what we want to emphasize here, though, is that violence and out-of-control aggression were not part of our experience with the many parents referred by community agencies who enrolled in the FIOC program. Rather, the expectant higher risk parents we came to know—fathers and mothers alike—wanted to do what was right by their child and committed to (and succeeded in creating) a safe and violence-free family environment. Aside from one episode in which a father who came home inebriated was locked out of the house by the mother's family member and broke a window to try to get inside, the FIOC project saw no occurrences of threats, violence, or hazard in any form. Conflict levels at intake were often high, but situations in which mothers and fathers needed help resolving conflict were the precise reasons our program was founded. Helping parents learn to negotiate the conflicts that can affect their capacity to coparent collaboratively is precisely what will ultimately make for a safer, healthier, and growth-promoting environment for any baby, promoting optimal infant mental health.

In the next instantiation of the FIOC project, we will seek, through randomized controlled trial methodology, to more definitively establish causal effects of the FIOC project in promoting coparenting and early family adjustment. In that work, we will also partner with Carla Stover (this issue, p. 36), who has been among the few researchers examining fatherhood and treatment interventions for men at risk for IPV (Stover, Berkman, Desai, & Marans, 2010; Stover, Poole & Marans, 2009;

Stover, Rainey, Berkman & Marans, 2008). Our aim will be to determine whether the FIOC project can also be safely and effectively offered to families where there has been situational IPV (but not families in which IPV is controlling, premeditated, and dangerous) so as to promote coparenting and help prevent prenatal and early emergence of IPV (Stover, 2013; Stover, Easton, & McMahon, 2013). One preliminary study, enrolling primarily Hispanic fathers and mothers (Florsheim, McArthur, Hudak, Heavin, & Burrow-Sanchez, 2011), indicated that such preventive aims may indeed be possible to achieve.

We do not want to close on a note discussing IPV, for this is precisely the trap we need to get out of as a field. Indeed, there are dangerous, violent, uncaring men who become fathers. Estimates on how many of these men are truly virulent and the kinds of individuals who should be kept away from their children at all costs are not clear, but they may number 1 in 10, or 2 in 10 at the most. Our targets are the other 80–90%. Everyone involved (e.g., individuals, coparents, families, educational systems, health care systems, social service agencies, the mental health field, funding agencies, the government) needs to be responsible for engaging fathers in their children's lives in ways that lead to healthy outcomes for all involved. First, each of us needs to stop reflexively viewing every hard-to-reach father in terms of his absenteeism or violence potential. Enjoining fathers as fathers and as coparents for their children—in whatever form the coparenting alliance may take for any particular family—is what will allow more men to take their just roles as protectors, allies, and lifelong attachment figures for their children. Richeda, Barr, and colleagues' work with incarcerated fathers (Richeda et al., this issue, p. 25) provides a promising case in point of what can happen if frameworks transform. However, for men to take a place in their children's lives, they have to be around, and for men to be around, strong coparenting alliances are necessary. The FIOC project is one example of what is possible with the right model. It is time for the infant mental health field to begin thinking "three." Good things will follow.

Vikki T. Gaskin-Butler, MDiv, PhD, is instructor of psychology and recipient of the 2012 Clinical Teaching Award at the University of South Florida, St. Petersburg. She served as co-investigator, clinical supervisor, and project safety officer for the Figuring It Out for the Child (FIOC) project, which she codeveloped. In preparatory work for the FIOC project, she codirected a research initiative with Mt. Zion Human Services as partner and collaborator on the FIOC project, documenting the prenatal expectancies of first-time African American mothers about postnatal coparenting. Findings from that initiative appeared in a special September 2012 section of the journal *Family Process* concerning coparenting in fragile families.

Katherine McKay, PhD, is a clinical psychologist and private practitioner (LLC) and is an affiliate with Bay Pines VA Medical Center and Eckerd College's Leadership Development Institute. She has had extensive experience in working with couples and families and serves as a clinical supervisor for the Figuring It Out for the Child (FIOC) project. Her work in helping to refine the training of the health educators, pastoral counselors, and paraprofessional lay professionals who serve as FIOC mentors so that they might effectively blend couples intervention techniques with their (more familiar) psychoeducational and individual counseling skills when delivering the FIOC curriculum has been instrumental in promoting clinically competent delivery of the intervention.

Gypsy Gallardo, MPP, is the chief executive officer of The Power Broker Media Group and holds a master's degree in public policy from Harvard University's Kennedy School of Government. Over the course of 2 decades, she has developed and codeveloped leading-edge models that help make measurable progress on issues that disproportionately and stubbornly affect African Americans. In addition to her involvement as a lead developer of the initial version of the Figuring It Out for the Child (FIOC) curriculum, she is also codeveloper of an award-winning model for financing commercial development projects in inner-city communities and is the founder of The Village Corporation. She also designed a media platform that launched the longest surviving, most widely circulated

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Prenatal Representations of Coparenting in Unmarried African American Mothers
V. Gaskin-Butler, T. Engert, M. Markewitz, C. Swenson, & J. McHale (2012)
Family Process, 51, 357–372
An investigation completed in advance of the FIOC pilot established how unmarried first-time African American mothers are thinking about the postnatal coparenting environment for their baby before the child arrives.

Coparenting Interventions for Fragile Families: What Do We Know and Where Do We Need to Go Next?
J. McHale, M. Waller, & J. Pearson (2012)
Family Process, 51, 284–306
A review of the literature concerning earlier efforts that sought to encourage fragile family coparenting, with commentary about needed paths ahead.

Coparenting: A Conceptual and Clinical Examination of Family Systems
J. McHale & K. Lindahl (2011)
Washington, DC: American Psychological Association
A comprehensive and cutting-edge review of theory and research pertinent to coparenting, across a diverse range of family systems.

Charting the Bumpy Road of Coparenthood: Understanding the Challenges of Family Life
J. McHale (2007)
Washington, DC: ZERO TO THREE
A detailed summary of the first major research investigation to focus specifically on how coparenting alliances evolve in middle-income, two-parent families from pregnancy through the toddler years. Written in a style appropriate for parents as well as for professionals.

When Infants Grow Up in Multiperson Relationship Systems
J. McHale (2007)
Infant Mental Health Journal, 28, 1–23
Based on the 2004 "Decade of Behavior" lecture to the World Association for Infant Mental Health, this article on coparenting was written specifically for an infant mental health audience.

Figuring It Out for the Child

To learn more about the FIOC project, visit: **www.usfsp.edu/fsc/research/figuring-it-out-for-the-child**

magazine and e-zine targeting Tampa Bay's African American community; cofounded The PACT (People Advocating Change Together), which includes a school-level model for closing the achievement gap; and served as lead organizer of the Seven x 7 movement, which grew to become the largest faith-based coalition ever forged in Pinellas County, FL. Her contributions in helping to bring word of the FIOC mission and message to African American community leaders and families helped fortify its message and guide many future coparents to take part in the initiative.

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Father-Inclusive Practice in a Family Center: An Australian Perspective

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ABSTRACT

Because fathers are clearly important to family well-being, including fathers in services for families seems a straightforward idea. How hard can it be? Yet across health, education, and welfare services it is still mothers who attend and engage on behalf of their infants and children. The Family Action Centre, located on the east coast of Australia, has been addressing the need for father-inclusive practice though research, program development, and by disseminating good practice examples. The story of their progress over the last decade includes the national context of changing gender expectations in families, funding strategies for father-inclusive practice, and the strength of linking practice with education and research.

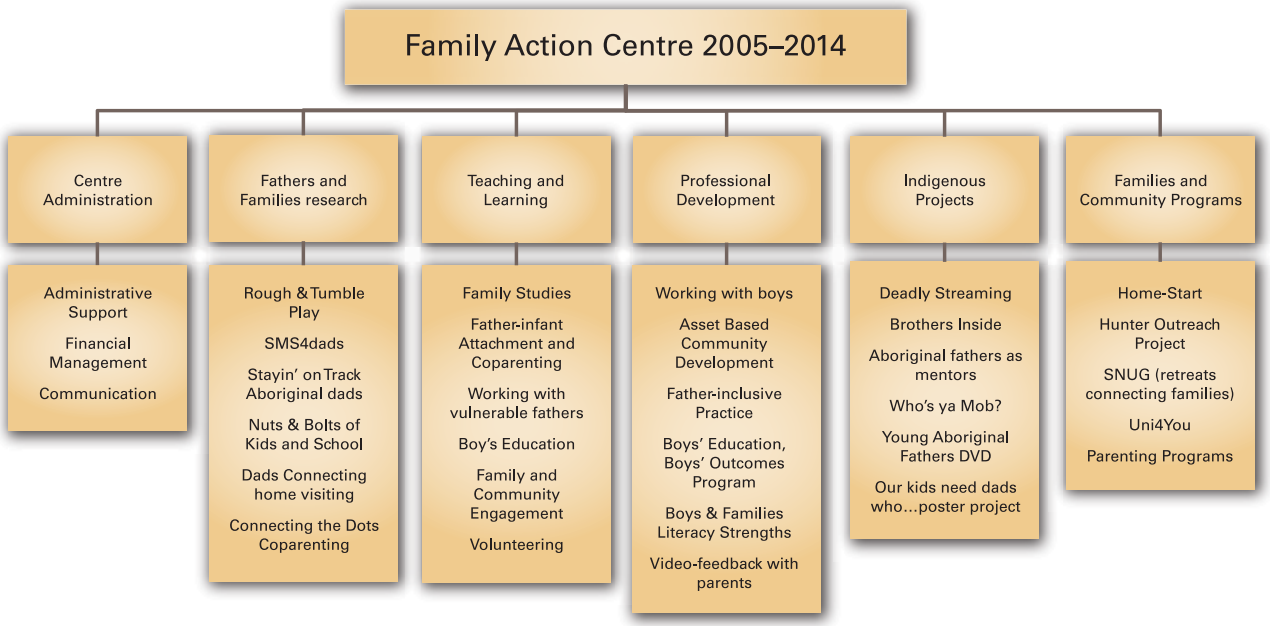
A decade ago in 2005, the Family Action Centre (FAC) at the University of Newcastle reached a watershed moment in the development of its work with fathers in Australia. Practitioners, managers, and researchers came together in a national Forum on Father-Inclusive Practice. Child-focused services spanning the whole of childhood from before birth to the end of school were included. Unlike the usual process, speakers were asked to present not only how their program or initiative worked with fathers but how their organization had changed to embed fathers into their procedures, policies, and practice. The aim of the forum was to raise the possibility of an embedded father-inclusive approach to family work, one where fathers were not an optional extra but were "built in" to the organizational framework of the service. The outcomes from this forum continue to inform practice within a service environment that reflects, as well as influences, social arrangements for fathering. In this article, we describe the practice and research initiatives at the FAC (see Figure 1) which interweaved with major changes in Australian society to generate new ways of father inclusion for the benefit of all the family.

Australian Societal Changes

As in other developed countries, commencing in the 1960s, the women's movement in Australia drew attention to discriminatory practices which led to girls' lower academic achievement in math and sciences, lower pay for women, and a "double shift" for mothers who were caring for children and managing housework while also taking up paid employment outside the home. A distinctive feature in the Australian response to these changes was to create sex-specific policies and services for women and girls. Although a clear implication of the change in women's status was that men's roles should transform, the desired changes for men were framed in terms of righting the disadvantages suffered by women: men doing a fair share of housework, men being held accountable for violence against women, men sharing societies' resources.

The idea that men's needs were being overlooked or minimised by human services was given little consideration at that time. In a highly publicised court case during 1992, the director of health planning for the State of Victoria was asked if women's

FIGURE 1.



services were funded because women were assessed as having a greater need than men. "No," he replied, "We assume that the health system is working for somebody, and it's not working for women, so it must be working for men" (Fletcher, 1996, p. 12). This assumption appears to have been widely shared across all human services.

Recognizing Australian Men's and Boys' Needs

The first group to recognize that Australian men might have particular needs were not senior managers or policymakers but front-line service staff and family members. During the 1990s, nurses in health services and parents in school settings, mostly mothers, raised the alarm about the dire outcomes for men and for boys. In the case of testicular cancer, for example, the mother of a young man diagnosed with this cancer lobbied successfully to raise community awareness of this condition and to develop resources and programs providing information and support for affected men. Hospital-based nurses who were frustrated at men's lack of preparedness for surgery created their own education sessions and lobbied surgeons to better attend to the social aspects of the men's conditions (Fletcher, 2001).

Teachers began documenting boys' unwillingness to take leadership roles in schools and boys' underachievement in basic literacy and even in scientific curriculum areas. The alarming rates of suicide among young men, including school-aged boys from all levels of society, highlighted the seriousness of the issue. Although girls' suicide attempts were more common, the lethality of the boys' methods—guns and hanging—underlined their desperation and their "no turning back" mentality. The deaths of boys at 6 times that of girls galvanised attention to the struggles that many boys were experiencing. Parents and teachers began to call for boys' education programs to sit alongside those for girls, and news items comparing male and female outcome indicators led to public discussion of men's poor health status and boys' low educational performance.

Community concern also fuelled attention at the policy level to the evidence that men and boys too had identifiable needs. In 2000, following a government inquiry into boys' education, "lighthouse schools" were funded to develop boys' programs (Commonwealth of Australia, 2008). Over time, "girls' education" policies were replaced by "gender-equity" or "boys' and girls' education" policies to accommodate attention to boys' needs. The evidence of men's higher mortality and chronic disease rates led to the acceptance that men's health, addressing male-specific conditions and male-typical aspects of illness and treatment, deserved attention. In 2010, Australia's first National Male Health Policy was released with the subtitle, "Building on the Strengths of Australian Males" (Australian Government, 2010).

References to new fathers were included in the Male Health Policy and the question of role models for boys in schools led to fathers' involvement, for example, in reading programs with young children. As part of a shift during this period to be more inclusive of men's needs, a national *Mensline* was established. This free telephone service offered information and referral for men (fathers) with family and relationship concerns. When the adversarial, court-based system for settling custody disputes between parents was overhauled in 2006, the new arrangements followed the United Nations Convention on the Rights of the Child by recognizing children's right to enjoy an ongoing relationship with both parents. An important shift in the new legislation was the presumption in law that fathers and mothers would share the care after separation (Kaspiew et al., 2011).

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A third barrier to taking effective action among professionals contemplating father inclusion is the widely held belief that fathering is identical to mothering and that mothers provide the model of optimal infant and child care for fathers to copy.

Although only a tiny fraction of separated families took their disputes to court, the adoption of "shared care" as a preferred option, in place of the standard arrangement of fathers' access every second weekend, implied valuing fathers' role in raising children.

This shift to recognize fathers' role was also dramatically reflected in reformed approaches to family violence and to the role of the national Child Support Agency whose mission was to ensure that non-resident parents (typically fathers) made payments to support their children. Until this point, the only advocates for fathers' needs were groups arguing for fathers' access to children following divorce and separation. There was little public sympathy for these men, as media coverage of fathers' assaults on their estranged partners portrayed separated fathers as a group who will readily resort to violence to get their own way. As part of the national Partnerships Against Domestic Violence, the Australian government developed a Men and Family Relationships (MFR) program that offered support to fathers (O'Brien & Rich, 2002). Although the initial round of funding focused on men's engagement with domestic violence programs, the later expansion included a broader range of primary prevention programs that targeted men by building on men's positive contribution to family well-being. Under this program, many family services employed male staff for the first time, and funding allowed MFR staff to meet annually and to network within each region. The Child Support Agency service model changed from ensuring compliance by threat of punitive consequences to assessing the immediate needs of fathers, such as inadequate housing, ill-health, or financial strain, and then linking them to existing services. At its peak, the MFR program funded 52 organisations to provide programs across 84 areas to more than 8,000 men per annum.

Working With Fathers at the FAC Engaging Fathers Project

While the FAC was active in advising on and supporting the development of a men's health agenda, it also piloted a number of specific boys' education and fathering projects during this period. With funding from the Bernard van Leer Foundation, the Engaging Fathers Project was launched in 2001 to develop models of father-inclusion in child-related services. The basic premise of the project was that if fathers were not attending and engaging in a child-related service then there must be something missing from the service, not from the fathers. The project plan was simple: ask if the service wished fathers to be more involved and then facilitate activities to engage fathers from the services' catchment group. Having four men in the project team meant that all-female services could be offered by a male project worker to help to "break the ice" with fathers.

To prove the worth of this approach, services in the most disadvantaged areas of a declining steel-making region, the Hunter Valley, were invited to work with the Engaging Fathers program. The response from service staff was universally positive; they believed strongly that involved fathers could benefit the family, and they were keen to have support in recruiting fathers to be more involved with their children's lives through participation in the service. Novel father-engagement programs were commenced in elementary schools, neonatal intensive care units (NICU), antenatal classes, prisons, and home visiting with newborns. Inspired by some of these programs and the resources developed for them, some local secondary schools also undertook successful father-inclusive initiatives such as dad and son orientation camps or literacy initiatives to ease the transition of boys on the cusp of adolescence into high school. The national conferences organised at the FAC under the title "Boys to Fine Men" emphasised the links between boys' social and emotional development and their future roles as men and fathers.

Although several of the programs were initially successful, the "add-on" nature of father involvement persisted; if key staff moved away, or new priorities were taken up by management, efforts to engage fathers fell by the wayside. Isolated negative incidents, such as when one volunteer father arrived at the school half-drunk, also derailed otherwise promising initiatives. The fragility of these father-inclusive initiatives made it apparent that supporting fathers needed to be recognized as a core business in the delivery of human services. The need to embed father-awareness in services had important implications for the formulation of father-inclusive practice and stimulated the development of the Forum on Father-Inclusive Practice.

Forum on Father-Inclusive Practice

The 2005 forum referenced at the beginning of the article was attended by practitioners, managers, and researchers. Although services were keen to showcase their innovative programs, discussions with potential speakers on the organizational change aspects of their presentations were sometimes difficult. For many,

the existence of their program targeting fathers was a result of personal energy and drive in the face of organizational lethargy or even resistance; seeking further organizational change seemed too much to ask. Nevertheless, among the presentations were examples of seemingly small changes enabling service orientation to include fathers, which led to a number of common successful strategies being identified. Among these were: the benefits of recruiting fathers through multiple service entry points, the importance of publicizing initial successes (however small), and the importance of incorporating active learning styles and directing invitations specifically to fathers. Absence of all necessary skills needed to effectively engage with fathers was also identified as an issue. Many staff, male staff included, felt unprepared to talk to fathers in a way that drew them in to be involved. At the forum, skills were presented as situation-specific; for example, the competencies needed to engage men in antenatal classes were different to those needed for addressing school dads (see box Father-Inclusive Practice Skills).

An important outcome of the forum was establishment of a set of Principles for Father-Inclusive Practice, which provided a framework for services to consider when planning father-focused initiatives. The principles include Father Awareness (identifying the fathers in the service catchment areas), Respect for Fathers (avoiding deficit perspectives focused on fathers' inadequacies), and Staff Strengths (recognizing the personal value placed on fathers by staff even when fathers were not involved professionally). The language of the principles acknowledges the role of father-figures and stepfathers while not losing sight of the importance of fathers' biological link to their children.

Linking Practice and Research

The forum contributed to the community-wide, developing acceptance of fathers as an important resource for families which went well beyond the realms of financial support. The term "father-inclusive practice" began circulating alongside the widely used "child-inclusive practice" which had been successfully applied to parenting dispute resolution and social research. For services attempting to support fathers, this recognition of the value of fathering provided the background for incorporating fathers into their work. For the FAC, which was facing significant funding challenges once the initial Bernard van Leer funding ceased, the work of developing father-inclusive practice was dictated by funding opportunities. At the time of the forum, fathers did not exist as a category for any Australian research funding, no Australian research centers had fathering as a prime target, and presentations on father-focused studies constituted minor themes at conferences. However, services and individual staff were seeking assistance in their efforts to engage male parents.

An important survival activity of the FAC was to offer consultancy to services wishing to engage with fathers. Workshops and seminars with health staff from midwives and child health nurses to trainee psychiatrists and general practitioners were conducted across Australia. In many locations, education, welfare, child protection, and early education staff also attended workshops and presentations. Crucial to the ongoing reputation of the FAC in what was sometimes a contested area was the development of an evidence base through summarising and synthesising existing research and also FAC conducting primary research in priority areas of service delivery to fathers.

In a field where theory and research lagged behind practice, the collation and circulation of relevant research evidence and of practitioners' experiences in delivering father-inclusive practice was a vital step. The *Fatherhood Research Bulletin* was founded to distribute research evidence from a range of journals to researchers and practitioners. Drawing attention to Australian studies related to fathers and fathering was intended to raise

Father-Inclusive Practice Skills

Consultations with experienced practitioners revealed a variety of specific skills related to the practitioner's purpose in engaging the fathers.

RUNNING A FATHERS' GROUP

Skills: Maintains the focus of the discussion on the importance of the relationship between the father and the child.

Knowledge: Has had exposure to a wide range of people. This will include dads from different socioeconomic backgrounds.

Attitudes: Believes that dads have the ability and interest in improving relationships.

RECRUITING FATHERS TO EARLY CHILDHOOD CENTRES

Skills: Ability to relate to fathers in a meaningful and respectful way, where they are viewed as primary carers.

Knowledge: Fathers like to meet other fathers and their children.

Attitudes: Every father has something to offer.

TALKING TO MEN ABOUT VIOLENCE

Skills: Listening for values, for ideas of right and wrong, for how life works. Listening with curiosity rather than a "fix-it, categorize and process this" approach.

Knowledge: Awareness of the variety of controlling behaviors that are commonly used in intimate relationships.

Attitudes: A positive regard for men.

WORKING WITH ANTENATAL DADS

Skills: Approach the session in a relaxed and flexible way rather than as the "parenting expert."

Knowledge: Issues that first-time fathers encounter in relation to parenting.

Attitudes: That these sessions, although a small intervention in the wider scheme of things, may be significant for individuals.

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Societal changes recognizing the importance of fathers' relationships with their children, which were evident in earlier periods, have continued.

awareness of the evidence base for father-targeted programs and to contribute to the identity of fatherhood research as a field. While there had been a trickle of researchers investigating fathers, including one on father–infant attachment completed within the FAC (Fletcher, 2008), professors who investigate fathers do so in addition to their main research interest, and few of them nominated fathering as their primary research area. A collection of practitioner accounts garnered through FAC workshops was published in 2004 as *Bringing Fathers in: How to Engage With Men for the Benefit of Everyone in the Family* (Fletcher, 2004). The following year, FAC staff acted as mentors assisting services to introduce father-inclusive practice in a federal government-funded project which resulted in a jointly authored *Father-Inclusive Practice Guide* (Commonwealth of Australia, 2009) which continues to be distributed across the human services sector.

FAC program initiatives also included pilot programs supporting fathers and mothers with infants and young children. Programs evolved from discussions with service providers and were usually funded with short-term grants. The short-term funding made evaluation difficult and sustainability unlikely. Examples of program initiatives developed by the FAC included the following:

NUTS AND BOLTS OF KIDS AND SCHOOL

A 10-week school-based program for fathers of children 5–12 years old in low income areas to discuss child development and fathers' roles in supporting their young children's education. This program was first designed as a series of presentations with discussion led by a facilitator. However, following a suicide during the third offering of the program, the model was changed to have two facilitators and counselling support available at each session. This program has continued through other services' use of a *Nuts and Bolts of Kids and School* manual (Bright, Fletcher, Silberberg, D'Arcy, & Hammond, 2005).

FATHERS' GROUP IN NICU

A 5-week group program was trialled over a 2-year period in the NICU of a large teaching hospital. Topics included cardiopulmonary resuscitation (CPR) training and home safety (including shaken baby syndrome). This group was requested following an incident with an angry father who was distressed over his infant's care. Staff discussion of the incident drew attention to the lack of support for fathers of very sick infants. This program ceased after 2 years.

ABORIGINAL FATHERS

Brothers Inside for Indigenous inmates focused on father–child relationship issues (rather than usual drug and employment topics). In the Aboriginal Fathers as Mentors school project, young Aboriginal fathers led small groups of Aboriginal children in skill-building activities. Activity kits were provided to link the literacy activities with home-based parent–child activities. The leaders were recognized as male role models in the school setting for Aboriginal children who had little contact with their father.

ANTENATAL FATHERS' GROUPS

A 1-hour session added on to the six-session Birth Preparation course for mothers and partners. The session was later extended to 2 hours and run in parallel to the breastfeeding information session for mothers. These groups continue to be hospital-funded.

POSTNATAL DEPRESSION GROUP FOR FATHERS

Partners of mothers attending a 6-week postnatal depression support group are invited for two evening sessions. Understanding of mothers' depression, fathers' role with infant development, and strategies for dealing with criticism are discussed. This group continues to be offered.

FATHERS BUILDING STRONGER CONNECTION WITH THEIR CHILDREN

Dads Connecting: Fathers Reconnecting With Their Young Children was developed for fathers who, for a variety of reasons such as work rosters, family separation, or child protection intervention, had been separated from their preschool children. Fathers review video of their play (including rough and tumble play) with a facilitator. The strengths-based guidance delivered through the video feedback process has been adapted from the Video-feedback Interaction to Promote Positive Parenting (VIPPP) program developed at the Centre for Child & Family Studies, Leiden University in the Netherlands. This program has ceased.

Alongside the program initiatives, topics for research projects were selected to influence the uptake of father-inclusive practice by bringing evidence to bear on barriers to father involvement. For example, one barrier is the promotion of programs as "for parents" even when those attending were overwhelmingly mothers and no attention was given to targeting fathers. The widely publicised Triple P parenting program asserted that fathers were equally included, even though practitioners reported low participation by fathers. A meta-analysis of Triple P studies was completed by the FAC to offer a detailed scholarly critique of the assumption among this program and others that so-called "'parenting' programs meet fathers' needs" (Fletcher, Freeman, & Matthey 2011).

Another barrier to effectively including fathers, particularly in early intervention initiatives, is the general understanding of attachment theory as essentially concerned with mother–infant relationships. An important implication of this view was the exclusive focus on the impact of mothers' mood disorders on infant development. In Australia, a comprehensive national postnatal depression scheme offered universal screening and referral for new mothers but ignored fathers. The researchers analysed an Australian representative longitudinal data set to demonstrate that children whose fathers reported symptoms of distress in the first year were 2–3 times more likely to have behavior problems compared to children of symptom-free fathers (Fletcher, Freeman, Garfield, & Vimpani, 2011). This research contributed to later initiatives, described below, addressing fathers' mental health in the perinatal period.

A third barrier to taking effective action among professionals contemplating father inclusion is the widely held belief that fathering is identical to mothering and that mothers provide the model of optimal infant and child care for fathers to copy. In addressing this area, we at the FAC developed research studies and programs focused on "rough and tumble" (R&TP) father–child play. As well as formulating a quality measure for R&TP and publishing fathers' views of this activity, the practice of inviting fathers and their young children to "rough and tumble" was built into programs linked to pre-school literacy and to a program targeting overweight fathers (Fletcher, StGeorge, & Freeman, 2013). Researchers developing family-based weight-loss programs had recognized the fathers' influence on family eating and exercise. FAC staff were invited as co-investigators to contribute the father–child interaction (R&TP) elements for a Healthy Dads Healthy Kids weight-loss program for overweight fathers. The enjoyment for both boys' and girls' of "wrestling with dad" motivated fathers to attend the program, which included diet and exercise with a family focus. Fathers reported clinically significant weight loss following the 6-week program (Morgan et al., 2011). R&TP was also incorporated into the Dads Connecting program described above.

Fathers in Family Studies

One factor that has consistently limited services' ability to implement father-inclusive practice is a lack of training and education to effectively reorient services to address fathers' needs. While workshops and seminars addressing fathers' inclusion have continued to be well received, it is also apparent that once-only injections of awareness have limited ability to influence practice. Some father-inclusion initiatives at a state-wide and national level have included ongoing staff development in an action research model. In the state of South Australia, a 2-year program targeting Children's Centres included a series of staff development workshops aiming to build staff awareness of and competency in father-inclusive practice (Government of South Australia, 2011). However, even in these cases, the characterization of father-inclusion as something which can be dealt with in a workshop format suggests that heightened awareness of fathers and some discussion are all that is required. To promote

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The evidentiary base documenting benefits of fathers' involvement in their children's lives, commencing before birth, has grown and is now compelling.

in-depth engagement with the complexities of father-inclusion, we at the FAC have developed post-graduate courses explicitly aimed at father-inclusive practice as part of a Masters in Family Studies program. The courses, Father-Infant Attachment and Coparenting: Theory and Intervention, Working With Fathers in Vulnerable Families, and Engaging Men and Fathers in Human Services: Theory and Practice are offered online as part of a specialization in Working With Men and Fathers. An

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The Family Action Centre
https://www.newcastle.edu.au/research-and-innovation/centre/fac/research

The Dad Factor: How Father-Baby Bonding Helps a Child for Life
R. Fletcher (2011)
Finch Publishing: Sydney, Australia

Young Aboriginal Fathers: The Findings and Impact of a Research Project Undertaken in the Hunter Valley, NSW
C. Hammond, J. Lester, R. Fletcher, & S. Pascoe (2004)
Aboriginal and Islander Health Worker Journal, 28, 5–7

Educating Boys: The Good News—40 Case Studies by Leading Academics and Practitioners
D. Hartman (Ed.). (2006)
Family Action Centre, University of Newcastle

undergraduate elective course, Working With Men and Boys in Human Services has also been developed and attracts students from teaching, nursing, social work, and other allied health professions.

Father-Inclusive Practice in Australia in 2015

Societal changes recognizing the importance of fathers' relationships with their children, which were evident in earlier periods, have continued. Australia now has a paid paternity leave scheme (2 weeks at the minimum wage) to accompany maternity leave for new parents, including same-sex parents (Australian Government, 2015). The adoption of father-inclusive practices and procedures also continues across human services although unevenly and with setbacks as well as advances. When an audit of attendance at government-supported children's services found only meager improvement in the percentages of fathers involved over the last decade, the Australian Government commissioned not only a review of recent research on father-inclusive practice but also the development of policy options. Midwives have incorporated "including fathers" in their core competencies (May & Fletcher, 2013) and national programs such as Strong Fathers Strong Families for Indigenous communities are continuing. Movember (a charity that raises money by having men grow a moustache in November), has raised more than $550 million across 21 countries since its beginning in 2003, and is now linking with a major Australian charity, beyondblue, to address fathers' mental health.

At the FAC, signs are favorable for further developing the way that human services engage with fathers as key players in family well-being. One promising development has seen research funding to use mobile phone technology to link new fathers with information and support. In association with beyondblue, the feasibility of a web-optimised mobile phone program (SMS4dads) is being tested wherein fathers will receive text messages on father–infant care, supporting the coparenting relationship, and self-care. The "Mood Tracker" (a notification requesting a response by rating mood) and a "Dad Tracker" (a notification requesting a response by rating satisfaction with being a father) will be embedded within a set of fathering-related text messages sent to the mobile phones of new fathers and responses indicating distress will trigger phone contact from a specialist perinatal depression hotline.

While there remain areas where fathers are still not properly recognized and where there are gaps in research addressing father engagement, signs are that father-inclusive practice is becoming accepted as a "normal" component of support to families in Australia. Across the family services sector there have been repeated calls to include fathers and to find ways to do so even when violence and abuse must be addressed. In addition, the evidentiary base documenting benefits of fathers' involvement in their children's lives, commencing before birth, has grown and is now compelling.

Although there is still no one program or policy to ensure fathers' inclusion, we at the FAC have established clear priorities and directions. Begin early in family formation, target coparenting rather than mother-only or father-only approaches, facilitate bridging across men's anti-violence and fathering programs, link community-wide initiatives with staff education to foster a culture of father-engagement, and support community-based Indigenous programs addressing fathering. The next decade should provide even better strategies to ensure fathers' and father-figures' contribution to healthier, safer, socially resilient communities. When a female Indigenous child protection worker attending the Father-Inclusive Practice Forum was asked "What would it be like if fathers were as involved as mothers in children's services?" she replied "It would be just perfect…"

Richard Fletcher, PhD, MMSc, Graduate Diploma Infant Mental Health, is a senior lecturer in the Family Action Centre, Faculty of Health and Medicine, The University of Newcastle, Australia. Richard has been conducting programs and research with boys, fathers, and families for more than 20 years and is the convenor of the Australian Fatherhood Research Network.

Jennifer StGeorge, PhD, is senior lecturer in family studies at the University of Newcastle, Australia. Jennifer's work in family research explores several related areas including father engagement in human services, fathers' role in child development, and parenting processes. She has a particular interest in using qualitative and observational methodologies to explore personal and developmental aspects of family life.

Chris May, PhD, MBA, is a senior project officer with more than 25 years of experience in pediatric nursing and 10 years (ongoing) facilitating men's antenatal groups. He is currently working on two projects at the Family Action Centre. One project is exploring novel approaches to facilitating and supporting parenting partnerships in everyday practice while the other (SMS4dads) is exploring the feasibility and acceptability of supporting new fathers through text messaging.

Deborah Hartman, PhD, MEd, Graduate Diploma Teachers of English to Speakers of Other Languages TESOL, Diploma Teaching, currently leads teaching and research in International Family Studies at the Family Action Centre, with a focus on children, cultural diversity, and gender. She has also led the Family Action Centre's research and teaching programs in boys' education. As a teacher, teacher educator, and curriculum developer, she collaborated with Arrernte teachers and community elders in Central Australia to produce early and middle childhood curriculum materials incorporating important cultural and language knowledge into mainstream school curriculums.

Andrew King, MAdEd; Cert IV in Training and Education, is a consultant trainer and program developer in group work, working with men and strengths-based practice. He is a specialist trainer in group work and fathering, and he trains professionals throughout Australia, Asia, and Canada. He is also an experienced practitioner and has established and operated for 10 years an intensive fathers programs for men with children from birth to 5 years old.

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Jargon Buster

Given the multidisciplinary nature of our work with infants, toddlers, and families, we often come across words or acronyms that are new or unfamiliar to us. To enhance your reading experience of this issue of *Zero to Three*, we offer a glossary of selected technical words or terms used by the contributing authors in this issue. Please note that these definitions specifically address how these terms are used by the authors in their articles and are not intended to be formal or authoritative definitions.

"2+1" models	In a traditional "2+1" model of family intervention, the father is conceptualized principally as an ally of or support for mother. In a "3 together" conceptualization, the father is affirmed, relentlessly, as a coparent in his own right, working collaboratively with the mother so that the two of them can chart the healthiest, most positive course for their baby. The family-strengthening work *could not proceed* without the father. [Find it in Gaskin-Butler et al., page 49]
Framing	*Framing* refers to the way in which information is presented in a positive or negative light and the effect of that presentation on an individual's choice about the focus of that information. Just as different frames highlight different aspects of a painting—thus drawing someone's eye to different aspects of a painting—the way in which the mass media portrays fathers creates a frame that draws viewers' attention to specific aspects (positive or negative) of fathers. [Find it in Brown, page 11]
Fatherneed	In his book *Fatherneed: Why Father Care Is as Essential as Mother Care for Your Child* (2001), Dr. Kyle D. Pruett described how fathers parent differently from mothers, and why that difference is so important to a child's physical, cognitive, and emotional development. [Find it in McHale & Phares, page 2]
Maternal Gatekeeping	The term "maternal gatekeeping" (Pruett, Arthur, & Ebling, 2007) is often used to describe a mother inhibiting or facilitating a father's access to his child. [Find it in Brown, page 11]
Reflective Functioning (RF)	RF is the ability to understand others' actions as a function of underlying psychological and emotional states and motivations. RF is thought to develop in the context of securely attached parent–infant relationships: The parent is able to recognize and anticipate the child's state of mind and act upon this knowledge to best care for the child, leading to secure attachment, and passing down the ability to accurately reflect others' states of mind (Fonagy, Steele, Steele, Moran, & Higgit, 1991). Fathers who did not develop secure attachments with a caregiver in childhood come to their roles as partners and parents with poor RF capacity. [Find it in DeVoe & Paris, p. 43]

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