Published in final edited form as:

Child Abuse Rev. 2018 ; 27(4): 280–300. doi:10.1002/car.2528.

Where's Dad? The Importance of Integrating Fatherhood and Parenting Programming into Substance Use Treatment for Men

Carla Smith Stover, Ph.D.

Yale University Child Study Center and the University of South Florida

Melissa Carlson, Sarika Patel, Raquel Manalich

Department of Mental Health Law and Policy, University of South Florida

Abstract

Large numbers of men enter substance use disorder treatment each year, yet very little attention is paid to the fatherhood and parenting status of these men. Substance use treatment programs rarely incorporate a parenting component into their treatment planning, despite increased success of women's treatment programs that focus on gender and motherhood. This paper provides: 1) a review of the literature on the fathering of substance using men, what has been learned from substance use disorder treatment for mothers, and the implications for children and families; 2) pilot quantitative and qualitative outcomes on implementation of a fatherhood focused intervention for men in a residential substance use treatment program; and 3) recommendations for the application of these findings for fathers in substance use disorder treatment and the implications of program modifications and increased focus on fathers for child welfare.

Keywords

Substance Use; Treatment; Fathers; Intimate Partner Violence

There are approximately 1.2 million men entering substance abuse treatment each year in the United States (SAMHSA, 2011). Although data are limited, several studies suggest 40–60% of those men are fathers of children under 18 (Rubenstein & Stover, 2016; Stover, Hall, McMahon, & Easton, 2012; Stover, McMahon, & Easton, 2011). There is significant evidence of the negative impact paternal substance use can have on children (Famularo, Kinscherff, & Fenton, 1992; Harter & Taylor, 2000; Johnson & Leff, 1999), and men often do not know how to re-engage with their children after long absences due to addiction, incarceration, and/or treatment (Stover, Carlson, & Patel, 2017). Further, although substance use treatment can reduce violence, it alone does not treat all problems related to violence and/or poor parenting (Murphy & Ting, 2010) or assist fathers in developing healthy relationships with their children that may prevent involvement of child protective services. Yet, fatherhood and parenting are rarely addressed as part of substance use treatment programs for men and little attention has been given to how addressing parenting for substance using men may benefit children. This paper will review: 1) the available literature

on what is known about parenting of substance using fathers; 2) how integration of motherhood focused programing has improved outcomes for substance abuse programs for women; 3) describe Fathers for Change intervention for men enrolled in residential substance use treatment and pilot outcomes with a small sample of fathers to describe initial feasibility of the program; 4) provide recommendations for continued development of interventions for fathers with a substance use disorder for the benefit of their children.

Parenting of Substance Using Fathers

Compared to mothers, there have been limited studies on the impact of substance use on the parenting of fathers. There is evidence that substance using fathers may have a more limited role in their children's lives and provide less financial support than non-substance using fathers (McMahon, Winkel, & Rounsaville, 2008). Additionally, studies have revealed substance using fathers are more likely to exhibit hostile-aggressive parenting (Stover, Easton, & McMahon, 2013), lower sensitivity and warmth (Eiden et al, 2009), poorer problem solving skills, higher rates of negativity during interactions (Jacob, Krahn, & Leonard, 1991), more problematic disciplinary practices, and less appropriate oversight of their children (Fals-Stewart, Kelley, Fincham, Golden, & Logsdan, 2004). Important to these findings, depression seems to mediate the association between substance use and hostile-aggressive parenting and paternal sensitivity (Edwards, Eiden, & Leonard, 2004; Eiden & Leonard, 2000; Stover, Urdahl, & Easton, 2012), which suggests assessment and treatment of depression may be important to improved parenting for substance using men.

There is significant evidence of the overlap of substance use, intimate partner violence (IPV) and child-maltreatment (Foran & O'Leary, 2008; Hamby, Finkelhor, Turner, & Ormrod, 2011; Moore et al., 2008), with children who are impacted by the trifecta of these problems at even greater risk for out of home placements, cognitive and psychosocial difficulties. Further, there is some emerging evidence that in the context of drug use, fathers who report IPV also report more hostile-aggressive parenting (Stover & McMahon, 2014). It is not the drug use but instead the propensity for hostility and use of violence that is associated with hostile-aggressive and abusive parenting behaviors (Stover & Kiselica, 2015). This indicates that hostile thinking and emotion regulation problems, common correlates of substance use, IPV and hostile-aggressive parenting may be important intervention targets to improve parenting of substance using fathers. Taken together the evidence related to hostility and depression and hostile aggressive parenting suggest a focus on negative thinking and emotion dysregulation may be useful in treatment.

Despite evidence that fathers with substance use problems would benefit from interventions to improve their parenting, these services have not historically been readily available. Several studies have indicated fathers with substance use problems report lower fatherhood satisfaction, higher feelings of guilt about their parenting, and concern about the kind of role model they have been for their children (McMahon et al., 2008; Rubenstein & Stover, 2016). A survey of fathers entering outpatient substance use treatment found that 27% reported having concerns related to their children, 18% felt they would benefit from a parenting class and 16% reported they would like fatherhood or parenting related issues to be part of their substance use treatment (Stover et al., 2012). Another survey of fathers in residential

substance use disorder treatment found 95% of the fathers said they think about their children all the time, 70% agreed that it would be helpful as part of their treatment to discuss parenting, and father-child issues, and 77% indicated they would be interested in fatherhood and co-parenting centered sessions as part of their residential treatment (Rubenstein & Stover, 2016). These data suggest men in residential treatment may be particularly open to and invested in engaging in interventions that would benefit their relationship with their children.

What has treatment development for substance using mothers taught us?

Research indicates that gender-focused program components that emphasize motherhood are the most effective treatment for substance using women with children (Osterling & Austin, 2008). Interventions that improve a mother's understanding of her own and her child's thoughts and feelings (Niccols et al., 2012; Suchman, DeCoste, Castiglioni, Legow, & Mayes, 2008; Suchman, Decoste, McMahon, Rounsaville, & Mayes, 2011; Suchman, Decoste, Rosenberger, & McMahon, 2012) improve outcomes for substance using mothers and their children (Niccols et al., 2012). Increasing mothers' positive interactions and decreasing stress response in parenting could prevent relapse (Rutherford, Williams, Moy, Mayes, & Johns, 2011). Also, Interventions that integrate partner/family issues into substance use treatment have yielded better outcomes than substance use treatment alone (Kelley & Fals-Stewart, 2002; O'Farrell, Fals-Stewart, Murphy, & Murphy, 2003; O'Farrell, Murphy, Stephan, Fals-Stewart, & Murphy, 2004). The growing evidence for integrated treatment for mothers with substance use problems has led to increasing the availability of such programs for women (Niccols et al., 2012; Suchman, Pajulo, Decoste, & Mayes, 2006). Whether providing fatherhood focused intervention for men in substance use treatment will improve outcomes has not been explored and needs study.

Why Implement a Coordinated IPV and Parenting Intervention into Residential Treatment?

There is significant overlap between IPV and substance use with rates approximately 50% (Easton, Swan, & Sinha, 2000; Rubenstein & Stover, 2016) indicating men in substance use treatment could benefit from a coordinated intervention that could address common antecedents for both issues. Men with IPV are at higher risk for hostile-aggressive and abusive parenting. One study suggests IPV is a stronger predictor of negative parenting and lack of warmth than substance use (Stover & McMahon, 2014), therefore those men are most in need of a parenting focused intervention. There is evidence that hostile thinking is associated with substance use, IPV and child maltreatment. Men at risk for IPV and child maltreatment often misperceive threat especially from their partners (Holtzworth-Munroe & Hutchinson, 1993) and instead respond to innocuous stimuli with hostility and poor emotion regulation (Arenas & Greif, 2000; Dankoski et al., 2006; E. J. Finkel, 2007; Finkel, DeWall, Slotter, Oaten, & Foshee, 2009; Ross & Babcock, 2009), particularly if they have concurrent substance use problems (Kachadourian, Homish, Quigley, & Leonard, 2012; McCormick, 1993; McCormick & Smith, 1995; Schumacher, Homish, Leonard, Quigley, & Kearns-Bodkin, 2008). Experimental studies have demonstrated that hostility and emotion

regulation problems are potential modifiable mediators that could reduce violence (Denson, Capper, Oaten, Friese, & Schofield, 2011; Finkel et al., 2009) and substance relapse (Berking et al., 2011; McCormick & Smith, 1995; Putt, Dowd, & McCormick, 2001) indicating a focus on these factors may be a very effective intervention approach.

Residential substance use treatment provides an excellent environment to teach/rehearse these skills that men need to manage family stress because they have fewer activities competing for their time and attention while in residence. As men exit residential treatment and resume more regular contact with their partners and children, there is risk for substance misuse relapse, IPV, and child maltreatment behaviors due to stress, especially in the context of relationship conflict (McCormick & Smith, 1995).

Fathers for Change (FFC)

In the context of a strong working alliance (Brown & O’Leary, 2000; Taft, Murphy, King, Musser, & DeDeyn, 2003), FFC intervention employs cognitive restructuring and emotion regulation strategies to improve hostility and poor emotion regulation. It is hypothesized that improvement in these mediators in turn will result in reduced substance use relapse, IPV, and child maltreatment. FFC motivates the father to change by continually recognizing his desire to be a better parent and is based on the conceptual model outlined in Figure 1.

FCC’s central premise is that the program’s focus on substance using men’s parenting role provides motivation to change maladaptive patterns that have led to use of substances and violence to control negative feelings. FFC is designed to be offered individually to fathers with histories of IPV and substance use. It is a clinical intervention provided in one-on-one or family sessions with a master’s level clinician. FFC combines family systems and cognitive behavioral approaches, and addresses 14 topics in 60 minute sessions over 16 one hour sessions to achieve: (1) maintained abstinence from substances, (2) cessation of violence and aggression, (3) decreased child maltreatment risk (negative parenting), and (4) improved co-parenting. FFC allows for optional co-parent participation in selected sessions when it is deemed appropriate and safe by the treating clinician reflecting that partner inclusion significantly improves treatment outcomes for men in substance use treatment and their children (Stover, 2013, 2015).

FFC Development.

The initial FFC program (Stover, 2013) was developed and piloted in an outpatient substance use clinic within a department of psychiatry. First, a sample of 10 fathers and their co-parents were referred by the courts or child protective services to participate in an open trial of initial feasibility. Completion rates were 80%. All fathers who completed the program remained non-violent during treatment and reduced their substance use, with 80% were abstinent during treatment. Subsequently, a small randomized pilot was conducted with 18 fathers randomized to FFC (n = 9) or Individual Drug Counseling (n = 9) (IDC (Mercer & Woody, 1999) referred from child protection, the courts or the community. Those randomized to FFC were more likely to complete treatment (67% vs. 33%) and showed a trend toward greater reduction in violence that continued following treatment (Stover, 2015). There were comparable reductions in substance use for the FFC and IDC groups. Last, men

in the FFC intervention showed gains in their video-taped interactions with their children. Fathers' interactions were coded by blind raters. Fathers who received FFC showed less intrusiveness during free-play interactions and more consistency of style post intervention than men who received IDC. Fathers in the IDC condition did not improve in these areas and got worse.

Subsequently FFC was implemented within a 12 to 18-month residential substance use treatment facility for men. It was provided to men during months 5 through 9 prior to men phasing up to begin work in the community. Completion rates for the program were 84% with statistically significant reductions in emotion regulation problems, hostile thinking and angry outbursts (Stover, Carlson, Patel, 2017). Qualitative focus groups with the participants revealed that men were overwhelmingly positive about the program; they enjoyed the individual sessions with a therapist that were focused on their roles as fathers. They indicated that they would like: a greater number of sessions, more sessions with their co-parents, and they would prefer the program continue into their aftercare phase of treatment (following discharge from the facility). Based on these findings, and the recognition that most residential programs are shorter than 12 to 18 months, modifications were made to the FFC model and a pilot feasibility study was implemented.

Current Study of Implementation in 6-Month Residential Treatment

A small pilot was conducted with 10 fathers in a department of corrections affiliated 6-month residential treatment program to assess: (a) initial feasibility within a shorter-term residential program, (b) the engagement of co-parents in co-parenting sessions in this population, and (c) whether men would attend outpatient aftercare sessions following discharge from the facility. Facility staff were skeptical that men in the short-term treatment program would want to participate in a parenting focused intervention and indicated aftercare participation was unlikely. They reported that men in this program were less motivated than those in their longer-term program.

A mixed methods pilot was implemented to collect quantitative measures to assess pre-post treatment changes in hypothesized intervention targets for Fathers for Change (emotion regulation, hostile thinking and anger) and qualitative experiences of fathers through focus groups. The study was designed to test the following hypotheses:

1. Sixty percent of participants will complete at least 13 of 16 offered sessions (12 residential and 4 aftercare);
2. Sixty percent of co-parents will participate in sessions;
3. Men who complete the intervention will have reductions in their hostile thinking, anger and emotion regulation difficulties; and
4. Men will report high satisfaction with the program.

A 60% completion rate was selected since drop-out rates at the residential facility are nearly 60%. Showing more than 50% of fathers would engage in FFC and complete both residential and at least one aftercare session, supports feasibility and acceptability of the program to men. This initial pilot focused on the fathers and co-parents. Although improved father-child

interactions were a significant positive outcome in the outpatient version of FFC, prior work with the longer term residential facility indicated that it would be challenging to conduct assessments that involved father-child observations because many of the children could not visit the facility due to distance and/or transportation issues. The study team did not want child participation to limit engagement in the program so opted to focus on whether co-parents would participate. If co-parents engaged in this pilot study, this would provide evidence that children could be included in future studies.

Participants

Ten fathers were recruited, consented, completed baseline assessments and began the intervention. All fathers were residents in a 6-month residential treatment program in a large southeastern city in the United States and were recruited between October 2015 and December 2015. To participate in the study, participants needed to have: 1) at least one biological child under the age of 10 years, 2) physical and/or verbal IPV history reported on the Conflict Tactics Scale-Revised (CTS2) (Murray, Hamby, Boney-McCoy, & Sugarman, 1996), and 3) have some contact with their children by phone, in-person, or by letter at the time they enrolled in the study. Fathers were excluded from the study if they had: 1) significant cognitive delays, 2) active psychotic symptoms or suicidal ideation, or 3) an active no-contact protective order pertaining to the child or co-parent.

The facility utilized a modified therapeutic community model with two phases of treatment. The first intensive treatment component focused on Twelve-Step Facilitation. Each resident participated in group interventions. During the second phase, residents attained full-time employment during the day while continuing to participate in group treatment and activities in the evening. Fathers started the intervention in between phase one and phase two of their treatment (between months three and four of their residential stay) just prior to beginning the work phase and transition out of the facility.

Procedures

Quantitative Approach.

Fathers were provided information about the program by counselors within the residential treatment program and volunteered to participate. The residential facility staff were instructed by the first author that participants could not be coerced and could receive no sanctions or pressure from staff related to participation in this voluntary research intervention. Prior to beginning the study, all those interested following the offer from the counselor to hear more about the Fathers for Change Program and research study met with a research team member to complete informed consent procedures. Although 100% of the participants who contacted the study team to participate consented, we were not provided information on the number of fathers that may have been eligible for our program but did not speak with our study team.

The study was described to potential participants verbally, with the voluntariness of participation being highlighted and they were given time to review the written consent form and ask any questions. As such, we ensured that participants understood the research

protocol and the voluntary nature of their involvement. The Conflict Tactics Scale Revised (CTS2) was administered by the research assistant following informed consent and was used to assess IPV and ensure study eligibility. Those who endorsed at least one physical or verbal aggression incident toward a partner, within the last year of the baseline assessment were offered participation in the study and completed additional study measures.

Fathers completed paper/pencil baseline assessments with a study research assistant and then were assigned to trained Fathers for Change clinicians. All clinicians were Master's level clinicians who were supervised weekly by the first author who is a licensed clinical psychologist and developer of the intervention. Therapy sessions were video and audio recorded to assess treatment adherence. The first author reviewed 25% of therapy session tapes to ensure adherence and provide corrective feedback if needed to study clinicians. Hour-long treatment sessions were held once per week for 12 weeks while the participants were in the residential program and were then offered 4 aftercare sessions following discharge from the facility. Post-assessments were conducted following treatment completion at approximately week 18 by a research assistant.

Qualitative Approach.

A focus group was conducted to collect qualitative data on the needs of fathers in residential treatment and their responses to the intervention with a portion of study participants. All the study participants were contacted in June 2016 and offered participation in the group. The focus group questions were developed to explore the dynamics of fatherhood and to elicit recommendations for the Fathers for Change program. The discussion was led by a study investigator and a research assistant. Program therapists were not present to allow for honest feedback from the study participants. The focus group was a semi-structured, face-to-face session consisting of open-ended questions posed to the group (see Appendix). The focus group was audio recorded and later transcribed for qualitative analysis by study research assistants; To protect the identities of the fathers who participated in the focus group, their names were omitted in the transcription and instead were identified as 1, 2, and 3 to differentiate each participant from the other. Thematic content analysis was applied to analyze the transcript of the focus group (Hsieh & Shannon, 2005; Braun & Clark, 2006). To analyze data, two research assistants independently read the transcript and inductively analyzed the quotes. They coded the quotes separately. They then compared codes and common findings to determine the central themes of the focus group.

Quantitative Measures

Demographic Questionnaire.

At the baseline assessment, fathers were asked a series of questions regarding their demographics. Information was collected on each participant that included questions about their life prior to treatment, relationship with their children, their childhood, along with previous treatment and arrest history.

Emotion Regulation.

State-Trait Anger Inventory-2 (STAXI).

The STAXI (Spielberger, 1999) is a 34-item questionnaire that assesses state anger, trait anger and anger expression. The STAXI assesses the intensity of anger at a specific time, how often angry feelings are experienced, and how anger is managed. For example: When I get mad, I say nasty things. Participants answer each item based on a 4-point scale including (1) Almost Never, (2) Sometimes, (3) Often, (4) Almost Always. Internal consistency reliability in the current sample for all of the STAXI subscales ranged from .77 to .93 baseline and .56 to .89 at follow-up.

Difficulties with Emotion Regulation (DERS).

The DERS (Gratz & Roemer, 2004) is a 36-item self-report questionnaire designed to assess multiple aspects of emotion dysregulation. For example: When I'm upset, I become angry with myself for feeling that way. Participants answer each item based on a 5-point Likert scale including (1) Almost Never, (2) Sometimes, (3) About half of the time, (4) Most of the time, (5) Almost Always. Internal consistency reliability in the current sample for the DERS total score was .71 at baseline and .96 at follow-up.

Hostile Thinking

Articulated Thoughts in Simulated Situations (ATSS) Task.

The ATSS; Davison, Vogel, & Coffman, 1997) includes presentation of four scenarios (1 control and 3 that are meant to induce jealousy and anger related to an intimate partner or co-parent. The ATSS has been used extensively with IPV populations (Costa & Babcock, 2008; Eckhardt & Jamison, 2002; Eckhardt, Barbour, & Davison, 1998; Eckhardt & Kassino, 1998). Participants were instructed to imagine the situation was happening to them and to state verbally aloud any thoughts that came into their minds related to the situation. Recorded ATSS verbalizations were transcribed and coded for hostility by trained research assistants following the completion of assessments. Coders coded 10 previously recorded interviews from prior studies to reach > .75 reliability to coded recordings prior to beginning coding for the current study.

Coded scales included: 1) personalization, 2) negative affect, 3) coercive behavior, 4) aggression toward partner, 5) anger control and 6) co-parenting language. A 5-point rating scale was used to rate the presence of each type of thinking from (0) Not Present at All to (5) Extremely Present. Following coding of each of the 3 anger inducing scenarios individually for the scales, a total score is generated by summing each scale across the 3 scenarios.

Other Outcomes of Interest

Co-parenting Relationship Scale (CO-PRS).

Co-parenting was measured using three sub-scales of the Co-parenting Relationship Scale (Feinberg, Brown, & Kan, 2012). The survey was developed to measure the many dimensions of co-parenting to further understand the nature of co-parenting conflict in

families in distress. For the current study, the total, agreement, and undermining dimensions were administered. Chronbach's alphas were acceptable at .65 for pre- and .65 for post-assessment.

Satisfaction Survey.

A modified version of the Client Satisfaction 8 (Attkisson, 1999) was used to assess clients overall satisfaction with the intervention. It consists of 8 questions using a 5 point Likert scale including: (1) Very Unhelpful, (2) Unhelpful, (3) Neither helpful or unhelpful, (4) Helpful, (5) Very Helpful. Additional questions were added to assess clients' satisfaction with the different aspects of the Fathers for Change intervention: Focus on hostile thinking, affect regulation skills, co-parenting communication and focusing on his role as a father. Suggestions on how to improve the program were also elicited.

Results

Quantitative Results

Fathers ranged in age from 21 to 44 with an average age of 31. They had an average of 2.0 children. Most participants in this sample were Caucasian (90.0%) with only 10% African American consistent with the population of the residential facility. More than half of the sample (60%) had two biological children, 20% had one biological child, and 10% had 3 biological children. When asked about how often the participants had seen their children within the last 12 months prior to coming to treatment, 60% of fathers had seen their children daily. Five of the fathers were involved with Child Protective Services at the time of the assessment and 3 of the participants' children had been placed in out of home care. Most participants were never married (50%) with 30% separated and 20% married. Forty percent of fathers reported their co-parents were actively using substances and needed treatment. Half of the participants had received some sort of mental health service before entering the residential substance use treatment program, with 40% having received anger management services previously. The average number of times participants had previously sought substance use treatment was 1.8 ranging from 1 to 5 times. One hundred percent of client's (n=10) reported opiates as their primary drug of choice.

Eighty percent of the participants completed at least 13 of 16 sessions offered. The two participants who did not complete the program relapsed and left residential treatment. The mean number of total sessions attended was 14.6(2.23) with a mean of 2.9(1.66) aftercare sessions attended. Fifty percent of fathers had sessions with someone identified as a co-parent. Thirty percent were mothers of their children and 20% were their own mothers who were caring for their children while the fathers were in treatment because mothers were using substances.

Data from pre-post assessment revealed that overall, fathers' scores on the intervention targets were improved although not at a statistically significant level. Table 1 presents the results of paired sample t-tests that were used to examine differences in participants' scores on outcome measures from pre-to post-intervention. Men had overall reductions in self-reported affect regulation problems, anger and coded hostile thoughts with trend or

statistically significant levels of change for DERS total affect regulation problems and clarity of emotion. On the ATSS there were significant reductions in thoughts related to coercive behavior and increased positive co-parenting statements. There were significant reductions in co-parenting undermining, but no change in co-parenting agreement.

Fathers were unanimously positive about the Fathers for Change program with 100% of participants indicating they would recommend the program to a friend or come back to the program again themselves. Eighty-eight percent rated the program as excellent and 12% rated it as good. On a scale of one to four, all clients reported the program met most or all of their needs with a mean of 3.25(.462). On a scale of one to five, if they were to seek help again they would come back to our program if given the opportunity with a mean of 4.75(.462). Further, 88% said the program helped them a great deal, while 12% said it helped them somewhat. Seventy-five percent of participants found the focus on recognizing hostile thinking and changing hostile thoughts to be very helpful. Eighty-seven percent found learning about co-parenting very helpful. Importantly, 87% said that the program was helpful to their remaining in the residential program and their motivation to complete residential treatment.

Case Comparison Results

Given the small sample and pilot nature of the study, examination of the individual scores for the 10 fathers was undertaken. This revealed that although most fathers saw a reduction in targeted areas, this was not universal. To examine what factors may moderate the success of the intervention, two cases are presented. Two fathers who completed the Fathers for Change intervention, the full residential treatment program and participated in the 4 aftercare sessions showed marked differences in their responses to treatment. Table 2 represents the comparison results of client 002 and 010. Participant 002 showed an increase in some symptoms from pre-to post assessment rather than a reduction. When examining differences between the two clients, 002 had experienced a high number of different kinds of traumas in his life. These included emotional, physical and sexual abuse, exposure to community violence and war. Participant 010 had a more limited trauma history of physical abuse during his childhood. Participant 002 also had co-occurring PTSD which had not been adequately treated. He was a former US military service member who had seen combat. Although both clients misused substances for more than 15 years, 002 had been admitted to substance use treatment more frequently compared to 010. Importantly, while 010 showed improvement in targeted symptoms related to affect regulation, he also showed significant improvements in psychological distress and symptoms based on the Brief Symptom Inventory, while participant 002 showed significant increases in his psychiatric symptoms following treatment. He often complained to his FFC therapist that the residential facility was not meeting his needs and that he needed more individual therapy sessions like those provided by FFC. He was not finding the therapeutic community supportive and struggled daily.

When comparing 002 and 010, it's clear that 002 had a less positive outcome at the post assessment time point. This could be a result of his mental health diagnosis, severe trauma history, or the problems that he had with the facility and staff members during his time in

residential treatment. He also had no outside family support and his relationship with his children was very limited with occasional phone contact and very limited visits. His co-parent was also battling addiction and was not in treatment. Participant 010 may have improved throughout the program because he had a stronger support system outside the facility, a less severe trauma history and no past psychiatric diagnoses. His co-parent had ongoing collateral contact with his therapist during treatment by phone. She lived far from the facility and could not participate in person.

Qualitative results

Only 3 participants attended the focus group (30% of sample). Some men could not be reached at the time of the focus group (several months after they completed treatment) or were unavailable at the time the group was held. Using the thematic content analysis process, three themes were identified from transcripts of the focus group: (1) feelings of pride upon completion of the program; (2) fears of not being able to provide for their families; (3) benefits of therapy.

Feelings of pride upon completion of the program.—The participants expressed a sense of pride from participating in and completing the program. Fathers made statements like: "... it's great to have something. Like I look at my kids, and I am proud, you know what I mean?... Both my kids are really proud of me," and "Both of my kids told me they're proud of me, so that brought tears to my eyes. They see me doing good, so I am just happy to be with my children."

Fears of not being able to provide for their families.—When reflecting on their greatest challenges as a father the men universally expressed fears of not being able to provide for their children. The fathers were concerned with making sure their children are able to lead good lives and not be influenced by their fathers' past decisions. The participants stated, "More than anything it is just being able to provide for them and give them what they want and need financially is something that's a bit of a stress factor," and "Making sure that I am able to provide for them, that I'm able to put them through college if they need. Wanting them to have a better life and not go down the road that I went down. That's everything."

Benefits of individual therapy sessions and rapport with their therapist.—The fathers all raved about the therapists they worked with throughout the program and the skills they picked up by participating in the intervention. Specifically, the fathers unanimously agreed that working on communication and processing were the most helpful aspects of the therapy sessions. Comments such as, "Working with (therapist) really helped me learn how to communicate with my wife and be soft-spoken when I need to and deliver information and communicate better without creating arguments and just overall having acceptances on some of her feelings, her opinions on some of the damage I've done," and "[Therapist] showed me how to approach it and how to speak to her, how to speak to my wife." The participants also expressed how the sessions helped them communicate with their children, as well. For example: "I am able to talk to my kids better and explain to them everything I've gone through, everything I'm still going through."

The fathers expressed their enjoyment of the support and ability to process and understand their inner thoughts and feelings with their therapist. One participant said, “I was able to run through and get through and get things off my chest with (therapist)...so she was real helpful as far as just letting me vent and process.” The same father also commented:

(Therapist) was great with just helping me process, you know what I mean?... so it was just really more she made me feel comfortable enough to tell her things in my life that not a lot of other people know, and she would always play devil’s advocate... so it was nice to be able to process.

Another father added, “(therapist) made me feel really comfortable with opening up and being honest about my experiences in life, my plans for the future, and providing through guidance, how to handle situations.”

Recommendations made by fathers.

During the focus groups, the men were asked what kind of things they would implement to improve the Fathers for Change program. The most common themes were: increased length of the program and added group therapy sessions among men at the residential treatment facility who are fathers. All participants involved in the focus group agreed that the sessions, as well as the overall program, should be longer in length. “It just seemed like sometimes there should have been two sessions,” The same father added, “Just a little more length to the actual sessions or on the back end there could have been more. There were still things we could have talked about,” Another father suggested, “Just a couple more sessions depending on what you’ve got going on.” For recommendations on the implementation of father support group sessions, participants stated, “I think it would be helpful to talk in a group about what’s going on,” “A small group like this is actually not bad,” Another father added, “Yeah, it keeps you grounded.”

Discussion

The literature reviewed revealed fathers with substance use histories, especially those with co-occurring IPV, have more hostile-aggressive parenting and other father-child relationship problems. Few studies have been conducted to examine intervention for fathers with histories of substance use. A focus on motherhood and parenting for substance using women has led to better outcomes substance use and parenting outcomes from treatment (Niccols et al., 2012). Adaptation and testing of parenting programs for substance using fathers is needed as there is a high prevalence of parental substance use for children involved with the child welfare system (U.S. Department of Health and Human Services, 2015; Wulczyn, Ernst, & Fisher, 2011). The pilot implementation of Fathers for Change into a 6-month residential substance use disorder treatment program for department of corrections referred men to include co-parent participation and 4 aftercare sessions had some success and revealed important directions for future research. This was the first known study to offer a coordinated individual treatment for IPV and parenting within a shorter term residential treatment program that would include aftercare sessions in the community. The completion rates of the intervention were high for both the residential portion and the aftercare sessions. Men appreciated having continued contact with their therapists once they transitioned to the

community. It would seem this would be particularly important for fathers working case plans to regain parental guardianship of their children. Programs offered in residential facilities can provide a beginning when men are focused on treatment and are not distracted by stresses they experience when they return to the community. Men reported a desire for additional aftercare sessions beyond four, which was related to a wish for ongoing support that wasn't specific to parenting or their children but to their overall recovery. Focus group participants also reported that including group sessions with other fathers would be a helpful addition. This indicates that although men really appreciated the support of an individual therapist, concurrent group sessions with other fathers may increase the success of the intervention.

Fathers for Change is an integrated program with heavy emphasis on the fathers thinking, emotions and reflective functioning. The men who volunteered for this program were receptive to this approach and generally benefited from it. Most reported reductions in affect regulation problems, anger and hostility and co-parent undermining. However, much more research is needed to understand for which clients FFC is helpful and what other fatherhood/parenting programs may be beneficial. Future studies should include larger samples of fathers with longitudinal follow-up to assess the long-term benefits of FFC. Review of individual cases revealed some fathers did not improve on the expected intervention targets. These fathers had more significant trauma histories and greater psychiatric symptoms indicating a need for more intensive treatment for their mental health issues. There is now mounting evidence that treatment for trauma and some co-occurring disorders improves outcomes for residential and other substance use treatment (Amaro et al., 2007; Hesse, 2009; Najavits, 2009; Najavits, Schmitz, Gotthardt, & Weiss, 2005). Interestingly, even men who did not show improvements in symptoms were positive about the experience and felt it was helpful to their remaining in the residential facility.

It was difficult to engage co-parents in the program. In 70% of cases mothers of the children were not reachable or refused participation, which was lower than the 60% hypothesized. Forty percent of co-parents were actively using substances at the time their co-parents participated in the study and could not participate. Others lived far away from the treatment facility and could not attend sessions. This impacted the program's success in improving co-parenting. If additional aftercare sessions were offered or the program transitioned into an outpatient phase in the community that could include home visits with co-parents, success rates of co-parent engagement might be higher. Still with such a high rate of co-parent substance use, successful engagement and implementation of the planned co-parent sessions would be difficult. Given this finding, therapists offered co-parent sessions to other individuals in a co-parenting role (grandmothers of the children or foster parents). Twenty percent of cases included a paternal grandmother who was raising the children in session. Fathers reported benefit to these sessions with their mothers to focus on co-parent communication and transition into a more active parenting role following treatment.

Importantly, given 50% of the fathers had active child protection cases with 30% of their children in out of home care, and 40% of their co-parents also struggling with addiction, improved outcomes for these fathers can have significant impact on their children. Of the children in out of home care, most had case plans involving potential reunification with their

fathers as a caretaker. Currently, residential treatment facilities provide limited to no services related to families and children. Better integration of such services may facilitate recovery and more successful transition into an appropriate and successful parenting role for these men.

Limitations

This study was designed as an initial implementation pilot to test feasibility of the Fathers for Change intervention in a 6-month residential substance use disorder treatment with aftercare sessions. Given the pilot nature of the study, there are important limitations to consider. First, the counselors at the facility referred interested fathers to the study and it is unclear how many fathers who might have been eligible declined referral. The first 10 volunteers who met criteria were accepted into the study. The high acceptance and completion rates cannot be generalized to the population of fathers in residential treatment. The study used a very small sample without adequate power to test for significant differences and did not employ a randomized control design to test the intervention against a no treatment comparison group. These are important next steps. The study also did not follow participants after completion of the aftercare sessions to determine long-term benefit. Although both coded tasks and self-report measures were used, information was gathered from fathers, collateral information from co-parents was not obtained. Although the study team attempted to interview co-parents of all 10 participants, only 2 agreed to participate making the data unusable for analysis.

The high satisfaction scores could be associated with social desirability. Only 3 out of the 10 fathers in the study participated in the focus group. Some of the men were unavailable at the time the group was held and others were not reached to participate. It is possible that those who did not participate had additional negative things to report about the intervention, however with 8 completed satisfaction surveys with positive responses, this seems less likely.

This study included only 'biological' fathers so it is unclear how the intervention might work with other fathers (e.g., social fathers, step-fathers, or male partners of mothers who have children living in the same residence). Future studies of Fathers for Change in residential treatment should employ controlled designs with large samples to test the efficacy of the intervention and collect longitudinal, intent to treat data from multiple informants for biological, social and step-fathers.

Implications for Children involved with Child Welfare

Despite the limitations of the pilot study, these findings and those of the literature reviewed, have important implications for fathers in substance use treatment programs and for their children. Providing fatherhood focused interventions for men in both residential and outpatient substance use treatment may increase their engagement in the program and improve success. This will have major implications for children in child welfare. Improving outcomes for fathers and increasing the likelihood of reunification and successful completion of case plans can benefit children long term. This is especially true for children who have two substance using parents. Forty percent of the men in the program had co-

parents who were active in their addiction and not in treatment. Their successful completion of treatment and improved outcomes could facilitate a greater possibility of children being reunified with or actively parented by their fathers.

Recommendations

Both individual and group focused interventions for fathers in substance use treatment (residential, outpatient, medication assisted, etc.) should be offered to those who would like to participate. This could include family sessions and guidance on talking with children about addiction and treatment, how to structure visits and transitions. There are multiple parenting programs, but few have been designed for substance using parents. Most parenting interventions were originally designed for mothers. However, several parenting programs have been designed specifically for men or have been adapted for fathers. Many parenting programs are designed in group format with a psychoeducational focus such as 24/7 Dads or Fathers for Life (www.fatherhood.org). Others, like the Nurturing Parenting Program are designed to be more adaptable to the family's needs. Nurturing Parenting has a one-to-one model or a group-based model, and can be delivered in a variety of settings (Bavolek, 2000). The program has been used in combination with substance use treatment, with incarcerated individuals and mothers and fathers struggling with addiction. An evaluation of the program with substance abusing mothers has revealed significant reductions in child maltreatment risk scores and lower rates of relapse for mothers who completed the groups (Moore & Finkelstein, 2001). A study of high risk parents in residential substance use treatment and in jail programs revealed significant improvements in parenting risk scores especially for men (Palusci, Crum, Bliss, & Bavolek, 2008). Another program, Fathers Too!, has been described in the literature as an individual psychotherapy program developed to better father-child relationships for men currently in substance use treatment. The program is semi-structured and gender-specific and is built on a developmental-ecological perspective on the parenting of substance using fathers (McMahon, 2013). No efficacy data was found in the research literature highlighting the significant need for further testing and evaluation of parenting focused programs for men in substance use treatment. Programs could offer individual sessions like Fathers for Change for those with co-occurring violence issues or Fathers Too!, along with a group intervention component which focuses more on parenting practices and attachment like Nurturing Parenting or Circle of Security (Cassidy et al., 2010; Hoffman, Cooper, Powell, Benton & Siegel, 2017) to fathers as an enhancement to their treatment. Child welfare agencies could encourage this for those with active case plans. Including co-parent and family sessions is also of significant benefit to fathers. Program evaluation is key to moving the field forward in this direction. If further evaluation reveals improved outcomes related to substance use relapse, violence and child permanency, then programs focused on fatherhood and parenting could be more broadly implemented and become a required component of treatment for substance use.

Appendix: Sample Focus Group Questions

Qualitative questions used to guide the discussion during focus groups:
1. What do you like most about being a dad?

2. What are your biggest challenges as a father?
3. How is the Fathers for Change program helpful?
4. What was your favorite part of the program?
5. What was your least favorite part of the program?
6. If you could change the program, how would you change it?
7. What did you think about the timing of the program in relation to the rest of your residential substance abuse treatment program?
8. Do you think there are ways that the Fathers for Change program can work better with the residential substance abuse treatment program?
9. What are the things that would be helpful to include for fathers in this residential substance abuse treatment program?

References

- Amaro H, Dai J, Arévalo S, Acevedo A, Matsumoto A, Nieves R, & Prado G (2007). Effects of Integrated Trauma Treatment on Outcomes in a Racially/Ethnically Diverse Sample of Women in Urban Community-based Substance Abuse Treatment. *Journal of Urban Health*, 84(4), 508–522. doi: 10.1007/s11524-007-9160-z [PubMed: 17356904]
- Arenas ML, & Greif GL (2000). Issues of fatherhood and recovery for VA substance abuse patients. *Journal of Psychoactive Drugs*, 32(3), 339–341. [PubMed: 11061686]
- Atkisson CC, G. TK (1999). The UCSF client satisfaction scales: I. The client satisfaction questionnaire-8 In Maruish M (Ed.), *The Use of Psychological Testing for Treatment Planning and Outcomes Assessment* (pp. 1333–1346). Mahwah, NJ: Lawrence Erlbaum Associates Publishers.
- Bavolek SJ (2000). *The nurturing parenting programs: US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention* Washington, DC.
- Braun V & Clarke V (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101.
- Berking M, Margraf M, Ebert D, Wupperman P, Hofmann SG, & Junghanns K (2011). Deficits in emotion-regulation skills predict alcohol use during and after cognitive-behavioral therapy for alcohol dependence. *Journal of consulting and clinical psychology*, 79(3), 307–318. doi: 10.1037/a0023421 [PubMed: 21534653]
- Brown PD, & O'Leary KD (2000). Therapeutic alliance: predicting continuance and success in group treatment for spouse abuse. *J Consult Clin Psychol*, 68(2), 340–345. [PubMed: 10780135]
- Cassidy J, Ziv Y, Stupica B, Sherman LJ, Butler H, Karfgin A, Cooper G, Hoffman KT, Powell B (2010). Enhancing attachment security in the infants of women in a jail-diversion program. *Attachment & Human Development*, 12(4), 333–353. [PubMed: 20582844]
- Dankoski M, Keiley M, Thomas V, Choice P, Lloyd S, & Seery B (2006). Affect Regulation and the Cycle of Violence Against Women: New Directions for Understanding the Process. *Journal of Family Violence*, 21(5), 327–339. doi: 10.1007/s10896-006-9028-0
- Davison GC, Vogel RS, & Coffman SG (1997). Think-aloud approaches to cognitive assessment and the articulated thoughts in simulated situations paradigm. *Journal of Consulting & Clinical Psychology*, 65, 950–958. [PubMed: 9420356]
- Denson TF, Capper MM, Oaten M, Friese M, & Schofield TP (2011). Self-control training decreases aggression in response to provocation in aggressive individuals. *Journal of Research in Personality*, 45(2), 252–256. doi: 10.1016/j.jrp.2011.02.001
- Department of Health and Human Services. (2015). *Adoption and foster care analysis and reporting system (AFCARS). The AFCARS Report*, 1.
- Easton C, Swan S, & Sinha R (2000). Prevalence of family violence in clients entering substance abuse treatment. *Journal of Substance Abuse Treatment*, 18, 23–28. [PubMed: 10636603]
- Eckhardt C, & Jamison TR (2002). Articulated Thoughts of Male Dating Violence Perpetrators During Anger Arousal. *Cognitive Therapy & Research*, 26(3), 289–308.

- Eckhardt CI, Barbour KA, & Davison GC (1998). Articulated thoughts of maritally violent and nonviolent men during anger arousal. *Journal of Consulting and Clinical Psychology*, 66(2), 259–269. doi: 10.1037/0022-006x.66.2.259 [PubMed: 9583329]
- Eckhardt CI, & Kassonov H (1998). Articulated Cognitive Distortions and Cognitive Deficiencies in Maritally Violent Men. *Journal of Cognitive Psychotherapy*, 12(3), 231–250.
- Edwards EP, Eiden RD, & Leonard KE (2004). Impact of father's alcoholism and associated risk factors on parent-infant attachment stability from 12 to 18 months. *Infant Mental Health Journal*, 25, 556–579. [PubMed: 19436769]
- Eiden RD, & Leonard KE (2000). Paternal alcoholism, parental psychopathology, and aggravation with infants. *Journal of Substance Abuse*, 11, 17–29. [PubMed: 10756511]
- Fals-Stewart W, Kelley ML, Fincham FD, Golden JC, & Logsdan T (2004). The emotional and behavioral problems of children living with drug-abusing fathers: Comparisons of children living with alcohol-abusing and non-substance-abusing fathers. *Journal of Family Psychology*, 18, 319–330. [PubMed: 15222839]
- Famularo R, Kinscherff R, & Fenton T (1992). Parental substance abuse and the nature of child maltreatment. *Child Abuse and Neglect*, 16, 475–483. [PubMed: 1393711]
- Feinberg ME, Brown LD, & Kan ML (2012). A multi-domain self-report measure of coparenting. *Parenting: Science and Practice*, 12(1), 1–21.
- Finkel EJ (2007). Impelling and inhibiting forces in the perpetration of intimate partner violence. *Review of general psychology*, 11(2), 193–207.
- Finkel EJ, DeWall CN, Slotter EB, Oaten M, & Foshee VA (2009). Self-Regulatory Failure and Intimate Partner Violence Perpetration. *Journal of Personality and Social Psychology*, 97(3), 483–499. [PubMed: 19686003]
- Foran HM, & O'Leary KD (2008). Alcohol and intimate partner violence: A meta-analytic review. *Clinical Psychology Review*, 28, 1222–1234. [PubMed: 18550239]
- Gratz KL, & Roemer L (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the Difficulties in Emotion Regulation Scale. *Journal of Psychopathology and Behavioral Assessment*, 26, 41–54.
- Hamby S, Finkelhor D, Turner H, & Ormrod R (2011). Children's exposure to intimate partner violence and other family violence. Washington, D.C.: U.S. Department of Justice.
- Harter SL, & Taylor TL (2000). Parental alcoholism, child abuse, and adult adjustment. *Journal of Substance Abuse*, 11, 31–44. [PubMed: 10756512]
- Hesse M (2009). Integrated psychological treatment for substance use and co-morbid anxiety or depression vs. treatment for substance use alone. A systematic review of the published literature. *BMC Psychiatry*, 9, 6. [PubMed: 19232121]
- Holtzworth-Munroe A, & Hutchinson G (1993). Attributing negative intent to wife behavior: the attributions of maritally violent versus nonviolent men. *Journal of abnormal psychology*, 102(2), 206. [PubMed: 8315133]
- Hoffman K, Cooper G, Powell B, Benton CM, & Siegel DJ (2017). *Raising a Secure Child: How Circle of Security Parenting Can Help You Nurture Your Child's Attachment, Emotional Resilience, and Freedom to Explore*: Guilford Publications.
- Hsieh HF, & Shannon SE (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, 15 (9), 1277–88. [PubMed: 16204405]
- Johnson JL, & Leff M (1999). Children of substance abusers: Overview of research finding. *Pediatrics*, 103, 1085–1099. [PubMed: 10224196]
- Kachadourian LK, Homish G, Quigley B, & Leonard K (2012). Alcohol expectancies, alcohol use, and hostility as longitudinal predictors of alcohol related aggression. *Psychology of Addictive Behaviors*, 26, 414–422. [PubMed: 22004128]
- Kelley ML, & Fals-Stewart W (2002). Couples-versus individual-based therapy for alcohol and drug abuse: Effects on children's psychosocial functioning. *Journal of Consulting and Clinical Psychology*, 70, 417–427. [PubMed: 11952200]
- McCormick RA (1993). Disinhibition and negative affectivity in substance abusers with and without a gambling problem. *Addictive Behaviors*, 18(3), 331–336. doi: 10.1016/0306-4603(93)90034-7 [PubMed: 8342445]

- McCormick RA, & Smith M (1995). Aggression and hostility in substance abusers: The relationship to abuse patterns, coping style, and relapse triggers. *Addictive Behaviors*, 20(5), 555–562. doi: 10.1016/0306-4603(95)00015-5 [PubMed: 8712053]
- McMahon TJ, Winkel JD, & Rounsaville BJ (2008). Drug-abuse and responsible fathering: A comparative study of men enrolled in methadone maintenance treatment. *Addiction*, 103, 269–283. [PubMed: 18199306]
- Mercer D, & Woody GE (1999). Individual drug counseling. (NIH Publication No. 99–4380). Rockville, MD: National Institute on Drug Abuse.
- Moore J, & Finkelstein N (2001). Parenting Services for Families Impacted by Substance Abuse. *Child Welfare*, 2, 221–238.
- Moore TM, Stuart GL, Meehan JC, Rhatigan D, Hellmuth JC, & Keen SM (2008). Drug abuse and aggression between intimate partners: A meta-analytic review. *Clinical Psychology Review*, 28, 247–274. [PubMed: 17604891]
- Murphy CM, & Ting L (2010). The effects of treatment for substance use problems on intimate partner violence: A review of empirical data. *Aggression and Violent Behavior*, 15, 325–333. doi: 10.1016/j.avb.2010.01.006
- Najavits LM (2009). Psychotherapies for Trauma and Substance Abuse in Women. *Trauma, Violence, & Abuse*, 10(3), 290–298. doi: 10.1177/1524838009334455
- Najavits LM, Schmitz M, Gotthardt S, & Weiss RD (2005). Seeking safety plus exposure therapy: An outcome study on dual diagnosis men. *Journal of Psychoactive Drugs*, 27(4), 425–435.
- Niccols A, Milligan K, Sword W, Thabane L, Henderson J, & Smith A (2012). Integrated programs for mothers with substance abuse issues: A systematic review of studies reporting on parenting outcomes. *Harm Reduction Journal*, 9. doi: 10.1186/1477-7517-9-14
- O'Farrell TJ, Fals-Stewart W, Murphy M, & Murphy CM (2003). Partner violence before and after individually based alcoholism treatment for male alcoholic patients. *Journal of Consulting & Clinical Psychology*, 71, 92–102. [PubMed: 12602429]
- O'Farrell TJ, Murphy CM, Stephan SH, Fals-Stewart W, & Murphy M (2004). Partner violence before and after couples-based alcoholism treatment for male alcoholic patients for male alcoholic patients: The role of treatment involvement and abstinence. *Journal of Consulting and Clinical Psychology*, 72, 202–217. [PubMed: 15065955]
- Osterling KL, & Austin MJ (2008). Substance abuse interventions for parents involved in the child welfare system: evidence and implications. *J Evid Based Soc Work*, 5(1–2), 157–189. doi: 10.1300/J394v05n01_07 [PubMed: 19064448]
- Palusci VJ, Crum P, Bliss R, & Bavolek SJ (2008). Changes in parenting attitudes and knowledge among inmates and other at-risk populations after a family nurturing program. *Children and Youth Services Review*, 30(1), 79–89. doi: 10.1016/j.childyouth.2007.06.006
- Putt CA, Dowd ET, & McCormick RA (2001). Impact of pre-existing levels of hostility and aggression on substance abuse treatment outcome. *Counselling Psychology Quarterly*, 14(2), 139–147. doi: 10.1080/09515070126333
- Ross JM, & Babcock JC (2009). Proactive and reactive violence among intimate partner violent men diagnosed with antisocial and borderline personality disorder. *Journal of Family Violence*, 24(8), 607–617.
- Rubenstein B, & Stover CS (2016). Intimate partner violence, fatherhood, and co-parenting of men in residential substance misuse treatment. *Advances in Dual Diagnosis*, 9, 1–10.
- Rutherford HJV, Williams SK, Moy S, Mayes LC, & Johns JM (2011). Disruption of Maternal Parenting Circuitry by Addictive Process: Rewiring of Reward and Stress Systems. *Frontiers in Psychiatry*, 2, 37. doi: 10.3389/fpsy.2011.00037 [PubMed: 21779252]
- SAMHSA. (2011). National Survey of Substance Abuse Treatment Services: Data on Substance Abuse Treatment Facilities. (HHS Publication No. (SMA) 12–4730). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Schumacher J, Homish G, Leonard K, Quigley B, & Kearns-Bodkin JN (2008). Longitudinal Moderators of the relationship between excessive drinking and intimate partner violence in the early years of marriage. *Journal of Family Psychology*, 22(894–904). [PubMed: 19102610]

- Stover C, & McMahon TJ (2014). Opioid Abuse and Intimate Partner Violence: Associations with a History of Childhood Abuse and Current Parenting Behavior. *Advances in Dual Diagnosis*, 7, 1–12
- Stover C, Urdahl A, & Easton C (2012). Depression as a Mediator of the Association Between Substance Abuse and Negative American Journal of Drug and Alcohol Abuse, 38, 344–349. [PubMed: 22243417]
- Stover CS (2013). Fathers for Change: A new approach to working with father with histories of intimate partner violence and substance abuse. *Journal of the American Academy of Psychiatry and the Law*, 41(1), 1–9.
- Stover CS (2015). Fathers for Change for intimate partner violence and substance abuse: Initial community pilot. *Family Process*, 54(4), 600–609. [PubMed: 25683252]
- Stover CS, Easton CJ, & McMahon TJ (2013). Parenting of men with co-occurring intimate partner violence and substance abuse. *Journal of Interpersonal Violence*, 28(11), 2290–2314. [PubMed: 23422845]
- Stover CS, Hall C, McMahon TJ, & Easton CJ (2012). Fathers entering substance abuse treatment: An examination of substance abuse, trauma symptoms and parenting behaviors. *Journal of Substance Abuse Treatment*, 43, 335–343. doi: 10.1016/j.jsat.2011.12.012 [PubMed: 22305235]
- Stover CS, & Kiselica A (2015). Hostility and substance use in relation to intimate partner violence and parenting among fathers. *Aggressive Behavior*, 41(3), 205–213. [PubMed: 25043704]
- Stover CS, McMahon TJ, & Easton CJ (2011). The impact of fatherhood on treatment response for men with co-occurring alcohol dependence and intimate partner violence. *The American Journal of Drug and Alcohol Abuse*, 37(0), 74–78. doi: doi:10.3109/00952990.2010.535585 [PubMed: 21090960]
- Suchman N, DeCoste C, Castiglioni N, Legow N, & Mayes L (2008). The Mothers and Toddlers Program: Preliminary findings from an attachment-based parenting intervention for substance-abusing mothers. *Psychoanalytic Psychology*, 25(3), 499–517. [PubMed: 20057923]
- Suchman N, Pajulo M, Decoste C, & Mayes L (2006). Parenting interventions for drug-dependent mothers and their young children: The case for an attachment-based approach. *Fam Relat*, 55(2), 211–226. doi: 10.1111/j.1741-3729.2006.00371.x [PubMed: 17417669]
- Suchman NE, Decoste C, McMahon TJ, Rounsaville B, & Mayes L (2011). The mothers and toddlers program, an attachment-based parenting intervention for substance-using women: Results at 6-week follow-up in a randomized clinical pilot. *Infant Mental Health Journal*, 32(4), 427–449. doi: 10.1002/imhj.20303 [PubMed: 22685361]
- Suchman NE, Decoste C, Rosenberger P, & McMahon TJ (2012). Attachment-based intervention for substance-using mothers: A preliminary test of the proposed mechanisms of change. *Infant Mental Health Journal*, 33(4), 360–371. doi: 10.1002/imhj.21311 [PubMed: 23024442]
- Taft CT, Murphy CM, King DW, Musser PH, & DeDeyn JM (2003). Process and treatment adherence factors in group cognitive-behavioral therapy for partner violent men. *Journal of consulting and clinical psychology*, 71(4), 812–820. doi: 10.1037/0022-006X.71.4.812 [PubMed: 12924686]
- Wulczyn F, Ernst M, & Fisher P (2011). *Who are the Infants in Out-of-home Care?: An Epidemiological and Developmental Snapshot*. Chicago, IL: Chapin Hall.

Key Practitioner Messages

- Despite significant need, parenting and fatherhood focused interventions are typically not provided within substance abuse treatment facilities.
- Motherhood focused programs have improved parenting and substance use outcomes for women.
- Integration of fatherhood and parenting intervention into residential substance use treatment for men shows promise.
- Fathers for Change Intervention was feasible within the residential treatment program and aftercare setting with high completion rates and satisfaction and reductions in affect regulation problems and hostility.

Figure 1.
Proposed Theory of Change

Table 1.

Pre-post Intervention Outcomes

<i>N</i> =8	Baseline <i>M</i> (<i>SD</i>)	Follow-Up <i>M</i> (<i>SD</i>)	Paired <i>t</i> -test <i>t</i>
Trait Anger Total	20.50 (7.70)	18.37 (6.73)	.69
Anger Temperament	7.25 (3.95)	6.50 (2.26)	.46
Anger Reaction	13.25 (4.20)	11.87 (4.67)	.90
Anger-Expression Out	16.75 (4.26)	16.37 (4.24)	1.17
Anger-Expression In	19.75 (7.06)	16.75 (6.60)	1.36
DERS Total Score	86.00(34.28)	70.00(20.96)	2.08 ⁺
DERS Lack of Emotional Clarity	11.75(5.44)	9.25(3.11)	-1.99 [*]
Co-parenting Brief Total	72.50 (11.16)	69.12 (9.5)	.471
Agreement in Co-parenting	9.12 (2.47)	9.00 (1.92)	.879
Undermining in Co-parenting	9.00 (1.85)	7.87 (2.10)	3.81 ^{**}
ATSS			
Personalization	2.62 (4.30)	1.87 (.515)	.513
Hostile Attributions	.375 (.744)	.125 (.353)	1.00
Anger Implicit	8.25 (8.24)	6.37 (3.77)	.966
Anger Control Strategies	.125 (.353)	.500 (.925)	-1.01
Verbal Aggression toward Partner	.250 (.462)	.00 (.00)	1.52
Coercive Behavior	.625(.744)	.00(.00)	2.37 [*]
Reference to Positive Co-Parenting	.125 (.353)	1.50 (1.69)	-2.76 [*]

⁺ $p < .10$;^{*} $p < .05$;^{**} $p < .01$

Note: DERS=Difficulties with Emotion Regulation Scale; ATSS=Articulated Thoughts in Simulated Situations

Table 2.

Case Comparison Results

Measure	002 Pre	002 Post	010 Pre	010 Post
STAXI				
Trait Anger Total	24	32	36	18
Trait Anger Temperament	7	10	1810	4
Trait Anger Reaction	17	23	20	13
Trait Anger Expression Out	20	23	24	16
Trait Anger Control Out	14	15	25	24
DERS				
DERS Total	93	94	143	100
Non-Acceptance of Emotion	6	11	28	19
Limited Emotion Regulation Strategies	18	25	34	20
CoPRS				
Brief Total	33	27	30	32
BSI				
Somatization	.29	.86	.57	.00
Obsessive-Compulsive	.00	1.67	2.00	.67
Interpersonal Sensitivity	.00	.75	1.75	1.25
Depression	.00	1.50	1.50	.67
Anxiety	.83	2.50	2.33	.67
Hostility	1.40	2.80	2.00	.40
Phobic Anxiety	.60	2.40	2.60	.60
Paranoid Ideation	1.40	2.60	2.40	.80
Psychoticism	.40	2.60	2.20	1.00
Global Index Severity	.53	2.11	2.02	.68
Years of Substance Use				
	15	N/A	18	N/A
Number of Times Admitted to Substance Use Treatment				
	4	N/A	1	N/A
Previous Number of Incarcerations				
	5	N/A	4	N/A
Childhood Trauma				
Emotional Neglect	Yes	N/A	No	N/A
Psychological Abuse	No	N/A	No	N/A
Physical Abuse	Yes	N/A	Yes	N/A
Sexual Abuse	Yes	N/A	No	N/A