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Promoting Fathers' Engagement with Children: Preventive Interventions for Low-Income Families

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Few programs to enhance fathers' engagement with children have been systematically evaluated, especially for low-income minority populations. In this study, 289 couples from primarily low-income Mexican American and European American families were randomly assigned to one of three conditions and followed for 18 months: 16-week groups for fathers, 16-week groups for couples, or a 1-time informational meeting. Compared with families in the low-dose comparison condition, intervention families showed positive effects on fathers' engagement with their children, couple relationship quality, and children's problem behaviors. Participants in couples' groups showed more consistent, longer term positive effects than those in fathers-only groups. Intervention effects were similar across family structures, income levels, and ethnicities. Implications of the results for current family policy debates are discussed.

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In the U.S. Deficit Reduction Act of 2006, one third of the $150 million annual budget for family support was allocated to programs promoting fathers' involvement with their children. This unprecedented commitment on the part of government policy makers to providing father-focused services for families was justified by citations of literature from three sources (see the Administration for Children and Families' Promoting Responsible Fatherhood website: http://fatherhood.hhs.gov/index.shtml). First, some observers (e.g., Blankenhorn, 1995; Popenoe, 1996) describe an increase in fathers' absence and disengagement from the family as a consequence of increases in separations, divorces, and single parenthood and conclude that this has posed serious risks for children's development and well-being. Second, findings from the 20-city Fragile Families study of births to primarily low-income unmarried mothers (Carlson & McLanahan, 2002) showed that most biological fathers have an ongoing romantic relationship with the mother when their child

is born, but many faded from their child's life over the next few years.

Third, over the past 3 decades, an expanding body of literature concludes that fathers' engagement with their children is associated with positive cognitive, social, and emotional outcomes for children from infancy to adolescence (P. A. Cowan, Cowan, Cohen, Pruett, & Pruett, 2008; Lamb, Pleck, Charnov, & Levine, 1985; K. D. Pruett, 2000; Tamis-LeMonda & Cabrera, 2002). Conversely, children of disengaged or negatively engaged fathers are at risk for a host of cognitive, social, and emotional difficulties. Father engagement has been defined in many ways but measured primarily in terms of *quantity* of time spent with children, yet studies consistently show that the *quality* of fathers' involvement rather than the sheer quantity of contact is associated with positive outcomes for children (e.g., Amato, 1998).

Two quite different explanations have been advanced to explain why some fathers are more involved in their children's lives whereas others are either less involved or absent. A widely accepted deficit model of father involvement (Hawkins & Dollahite, 1997) assumes that the pervasive social problem of ''fatherlessness'' in America has resulted from a decline in ''family values'' and a lack of motivation on the part of men to maintain relationships with their spouse and child (Blankenhorn, 1995; Popenoe, 1996). These conclusions underlie interventions designed to persuade men to become ''more responsible.'' By contrast, an ecological (Belsky, 1984; Bronfenbrenner, 1979) or family systems risk-protection-outcome model (C. P. Cowan & Cowan, 2000; M. K. Pruett, Insabella, & Gustafson, 2005) assumes that there are multiple systemic factors—a combination of barriers and resources within individuals, families, and environments—that shape both the quantity and quality of fathers' engagement with their children. Our review of the literature suggests that father engagement is associated with risks and protective factors in five aspects of family life (see also Doherty, Kouneski, & Erickson, 1998): (a) individual family members' mental health and psychological distress; (b) the patterns of both couple and parent-child relationships transmitted across the generations from grandparents to parents to children; (c) the quality of the relationship between the parents, including communication styles, conflict resolution, problem-solving styles, and emotion regulation; (d) the quality of the mother-child and father-child relationships; and (e) the balance between life stressors and social supports outside the immediate family.

Not surprisingly, fathers are more likely to be engaged in a positive way with their young children when they have few symptoms of poor mental health, are securely attached to their own parents, communicate effectively with the child's mother, are under less external life stress, and have more social support. By contrast, negative events in each of these domains increase risks for abuse and neglect of children (Rosenberg & Wilcox, 2006). The family systems model suggests that interventions need to focus on reducing the multiple risks and enhancing the multiple protective factors associated with father engagement. The present intervention study, designed to support fathers' positive engagement with their young children, addressed all five family domains in the intervention curricula and focused on changes in father-child relationships, couple relationships, and children's outcomes in the assessment protocols.

Existing Father Engagement Interventions

Before planning the Supporting Father Involvement study, we searched the research literature on interventions to foster fathers' engagement (P. A. Cowan et al., 2008; Doherty et al., 1998; Hawkins, Christiansen, Sargent, & Hill, 1995; Mincy & Pouncy, 2002). We examined accounts of programs from federal and state governments, fatherhood organizations, and family agencies that produced materials providing information about the importance of fatherhood and the availability of support services for fathers (e.g., http://www.fatherhood.org). More direct interventions in the form of single-event contact with fathers are described as fatherhood workshops or mass motivational meetings attended by men, often with an explicitly religious perspective (e.g., http://www.promisekeepers.org). Other programs have a structure of ongoing contact between professional or paraprofessional staff and fathers, one by one or in groups. Some family agencies at the local level and national Headstart and Early Headstart programs have added components that reach out to fathers at home and at center-based programs (http://fatherhood.hhs.gov/Parenting/hs.shtml). Home

visiting programs for parents of young children have focused almost entirely on mothers, but a few include fathers in their purview.

Other family agencies and fatherhood organizations offer ongoing groups for men, led by men, usually meeting up to three or four times a month, although a few extend over 3 months. Different programs extending over time have been addressed to fathers who are teens (Klinman, Sander, Rosen, & Longo, 1986), low-income and single parents (Baltimore Responsible Fatherhood Project: http://www.cfuf.org/BRFP), and in married couples (Fagan & Hawkins, 2001) and divorced couples (Cookston, Braver, Griffin, De Luse, & Jonathan, 2007). The focus of the meetings varies widely, from addressing men's individual physical and mental health, including substance use and abuse, to parenting motivation, parenting skills, and job skills, to a few that attempt to teach men relationship skills to enhance collaboration with the mothers. Very occasionally, individual case management services are provided to supplement group meetings.

A handful of university-based programs, such as Dads for Life for divorced fathers (Cookston et al., 2007), Marriage Moments (Hawkins, Lovejoy, Holmes, Blanchard, & Fawcett, 2008), and Parenting Together for new fathers (Doherty, Erickson, & LaRossa, 2006), created curricula based on the type of ecological family systems, risk-outcome model we described above. Dads for Life groups for divorced men, with a curriculum focused heavily on a cognitive-behavioral approach to managing anger and reducing conflict, had positive effects on fathers' relationships with their children and ex-wives. The Marriage Moments program, in two middle-class samples, with videos and workbooks added to a monthly home visiting program at 3 months postpartum, produced relatively strong but marginally significant effects on mothers' views of the men's engagement in their children's daily care. It did not increase relationship satisfaction, the main target of the program. The authors speculated that a group format might have resulted in a greater direct impact on the marriage and a stronger indirect effect on father engagement. The Parenting Together program conducted a randomized assignment design with middle class couples that included a second trimester home visit, four group meetings before the birth of a first child and four meetings postpartum, or a no-treatment condition. Outcome assessments at 5 months postpartum revealed a positive impact on fathers' warmth and emotional support, intrusiveness, and dyadic synchrony when fathers were observed with their babies. Compared to fathers in the no-treatment group, fathers who participated in an ongoing group were more involved with the child on days when they worked outside the home.

Systematic evaluations of father involvement programs are in a distinct minority, and most programs receive no systematic evaluation beyond documentation of the number and characteristics of clients served and surveys of consumer satisfaction. Reports of these programs, usually on websites rather than in journal publications, balance positive testimony from staff and participants with sober reflection on the challenges and obstacles involved in mounting the program. The few with pre- and postintervention evaluations gather data almost immediately after the group meetings end, so we do not know whether effects are maintained over time. Most important, with the exception of several studies cited above, very few fatherhood intervention programs have been evaluated using a research design with randomized assignment to treatment and control conditions. Without this procedure, it is not possible to determine whether observed changes in the intervention participants are more positive than those in similar families without intervention.

With the exception of the Marriage Moments and Parenting Together programs that were designed for couples, almost all father engagement interventions involve men's participation in programs led by male speakers, counselors, or group leaders. The paradox here is that the single most powerful predictor of fathers' engagement with their children is the quality of the men's relationship with the child's mother, regardless of whether the couple is married, divorced, separated, or never married (P. A. Cowan et al., 2008, p. 54). In the present study we evaluated the relative impact of a father-focused and a couple-focused approach by randomly assigning some participants to an ongoing fathers' group, some to an ongoing couples' group, and some to a one-time, low-dose intervention (the comparison group).

Finally, many fatherhood programs target low-income, often minority, participants, but we know of no systematic data that evaluate whether the same program is effective for both low- and middle-income participants or for participants of

different ethnic backgrounds. The current study evaluated the effectiveness of interventions for fathers, mothers, and children in European American and Mexican American families who range from poverty to middle income.

The Supporting Father Involvement Preventive Intervention

The Supporting Father Involvement study followed a sample of predominantly low-income families for 18 months in a randomized clinical trial of two variations of a preventive intervention; two thirds were Mexican American and one third European American. The study compared the impact of a 16-week group for fathers, a 16-week group for couples, and a low-dose comparison condition in which both parents attend one 3-hour group session; all interventions were led by the same trained mental health professionals who focused on the importance of fathers to their children's development and well-being. The one-time meeting and the 16-week curriculum for fathers and couples' groups were based on a family risk model of the central factors that research has shown are associated with fathers' positive involvement with their children.

Because Supporting Father Involvement was conceptualized as a *preventive intervention*, families with current open cases of family violence were not included in the project. Thus, we could not measure the interventions' direct impact on a reduction in documented child abuse and neglect. Furthermore, we did not expect that a 16-week intervention for this high-risk sample would make substantial alterations in mental health symptoms, participants' views of their parents, and the stressors in their daily lives. On the basis of earlier intervention results using the couples' group format (C. P. Cowan & Cowan, 2000; P. A. Cowan, Cowan, & Heming, 2005) we expected that the interventions would affect three risk factors for child abuse—the quality of the father's relationship with the child, the quality of the couple relationship, and the children's behavior.

Method

Procedures and Participants

The Supporting Father Involvement (SFI) project and staff were located within Family Resource Centers in four California counties (San Luis Obispo, Santa Cruz, Tulare, and Yuba) in primarily rural, agricultural, low-income communities with a high proportion of Mexican American residents. Newly hired staff in each setting included a project director, two group leaders, two to three case managers, a data coordinator, and a county liaison who served as a link between the project and the County Health and Human Services administration.

At each site, project staff recruited some participants through direct referrals from within the Family Resource Centers and most participants from other county service agencies, talks at community organizational meetings, ads in the local media, local family fun days, and information tables placed strategically at sports events, malls, and other community public events where fathers were in attendance. Because the project was conceptualized as preventive—to help families early in the family formation years before smaller problems become intractable—the project targeted expectant parents and those with a youngest child from birth to age 7.

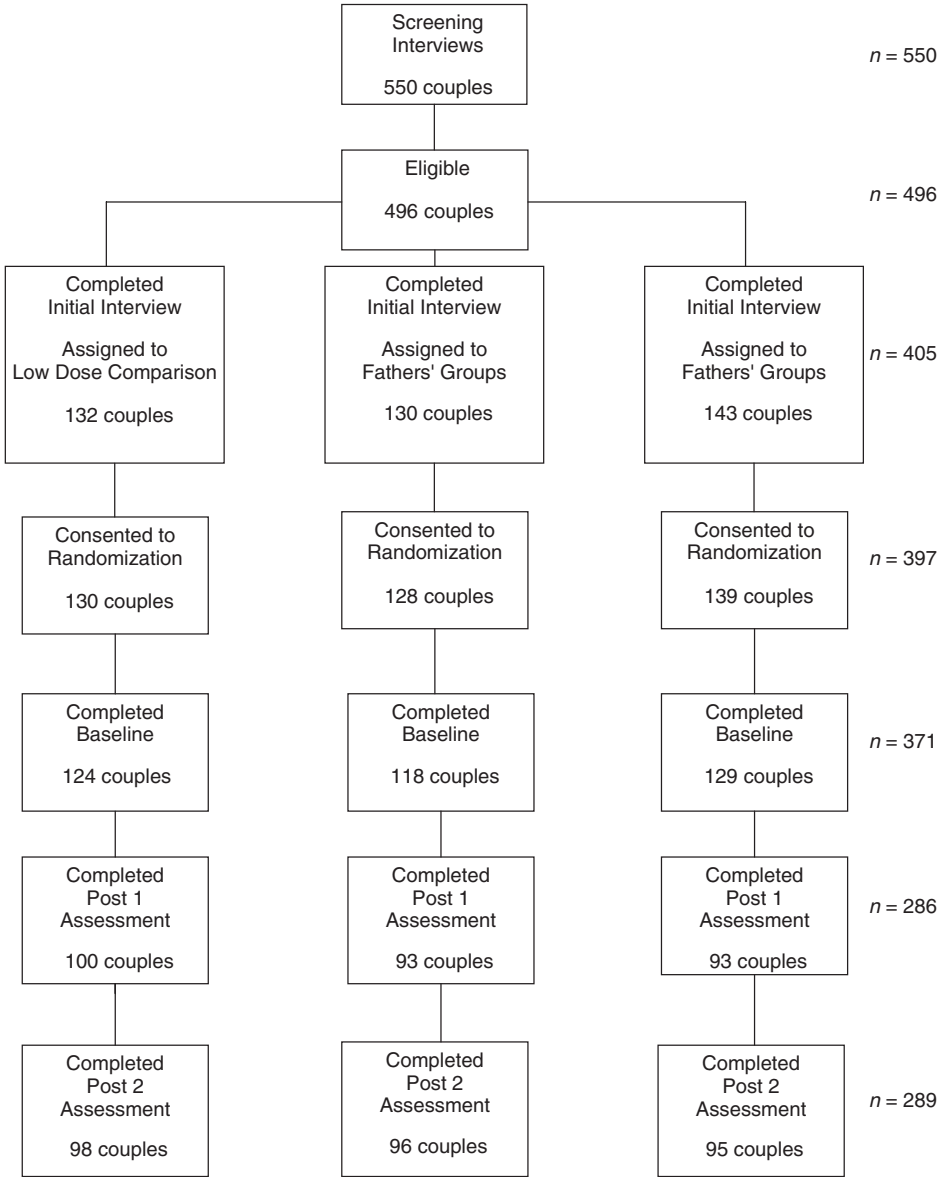
A brief screening interview administered by a case manager assessed whether the parents met four additional criteria: (a) both partners agreed to participate; (b) the father and mother were biological parents of their youngest child and raising the child together, regardless of whether they were married, cohabiting, or living separately; and (c) neither parent suffered from a mental illness or drug or alcohol abuse problems that interfered with their daily functioning at work or in caring for their child(ren)—determined through a set of questions about whether there were mental or emotional conditions that interfered with the parent's ability to look after children or work outside the home. If either parent reported serious problems of this kind, the family was not offered one of the study interventions but referred for other appropriate services. Finally, (d) couples were not accepted into the study if there was a current open child or spousal protection case with Child Protective Services or an instance within the past year of spousal violence or child abuse. This last criterion was designed to exclude participants whose increased participation in daily family life might increase the risks for child abuse or neglect.

Of 550 couples who were administered a screening interview, 496 (90.2%) met the

criteria for eligibility. (See Figure 1 for a flow chart.) Each eligible couple was then scheduled for a joint 1.5-hour initial interview with the group leaders that covered topics in five aspects of family life (individual, couple, parent-child, three-generational, life stress, and social support). The interview acquainted couples with the issues they would be discussing in the study intervention and in the assessments prior to and after the intervention. Of the 496 eligible couples, 405 (81.7%) completed the initial interview.

Until the interview, the couples were not aware of the fact that they were about to be offered a chance to participate in a randomized clinical trial, nor were they aware of which

FIGURE 1. RECRUITMENT AND RETENTION.



condition they would be offered. At the end of the initial interview, 397 of 405 couples agreed to accept random assignment to one of three conditions: a 16-week group for fathers or for couples or the informational one-time meeting (the low-dose comparison condition described above). All parents were then scheduled for individually administered 1.5- to 2.5-hour baseline assessments, consisting of questionnaires administered orally in English or Spanish by one of the site's case managers. Only 26 of the 397 fathers and mothers failed to complete the baseline assessments. The most common reasons given to case managers for not carrying through with the initial interview or the baseline assessment were lack of time, changes in work schedule making attendance at group meetings impossible, and lack of interest in participating.

Of the 371 couples who completed the baseline assessments, just over two thirds of the participants (67%) were Mexican American, 27% were European American, and 6% were Asian American, African American, Native American, or mixed race. On entering the study, 72% of the couples were married and living together, 22% were cohabiting, and 6% were living separately and raising a child together (separated, divorced, or never-married, never-cohabiting couples). Median household income was $29,700 per year, with more than two thirds of the sample falling below twice the Federal poverty line ($40,000 yearly household income for a family of four). We did not screen participants for income; although the sample was heavily weighted toward low incomes, 2.5% had household incomes between $100,000 and $300,000 per year, which enabled us to examine income level as a potential moderator of intervention effects.

A large majority (79%) of the fathers and a minority (39%) of the mothers had worked for pay during the week prior to their baseline assessment. About half of the participants had completed high school or beyond. At baseline, the number of children in the household ranged from 0 (mother was pregnant with a first child) to 7, with a mean of 2.34 children; the median age of the youngest child was 2.25 years.

The assessments conducted by the case managers were repeated with partners in 286 couples (77% of the baseline participants) 2 months after completion of the ongoing groups or 7 months after the one-session informational meeting (Post 1). A second assessment 11 months after the groups ended or 18 months after they entered the study (Post 2) was completed by 289 couples (78% of the baseline participants). Parents were not paid for attending groups or meetings, but each partner was paid $50 for completing the baseline, $50 for the Post 1 assessment, and $100 for the Post 2 assessment (a total of $400 per family over 18 months).

Fathers' Groups and Couples' Groups

After baseline assessments were completed, the single meetings of the low-dose comparison group parents and the 16-week fathers' and couples' groups began. All groups were led by male-female pairs of mental health professionals selected by project directors on the basis of clinical expertise, training, and experience with couples or groups or both, knowledge of family and child development, cultural fluency and sensitivity, and the ability to work collaboratively with other professionals and agencies.

The groups for 6 to 12 fathers or five to nine couples met for 2 hours each week for 16 weeks and involved both a structured curriculum of exercises, discussions, and short presentations and an open-ended time in which participants were free to raise their real-life issues and concerns for discussion and problem solving. As the study proceeded, some sites conducted the interventions with a greater number of participants in their groups and some used a different number of sessions (from 11 to 14), but all preserved a total of 32 hours of face to face meetings between leaders and participants. In total, there were 20 single-session meetings (the comparison condition), 15 fathers' groups, and 18 couples' groups. Child care was provided each week to allow parents to focus on their family issues for the most part undisturbed. In all, 21 of the low-dose comparison group meetings, fathers' groups, and couples' groups were conducted in Spanish and 32 in English.

The curriculum is detailed in a manual followed by the group leaders. The manual was adapted by Marsha Kline Pruett and Rachel Ebling from the original curricula used in the Cowans' earlier intervention projects (C. P. Cowan & Cowan, 2000; P. A. Cowan et al., 2005) in order to accommodate the cultural and linguistic differences and the broader diversity of family forms represented in this

project. With only several modifications to adapt the fathers' group curriculum for the absence of partners in the room, the curricula for both fathers' and couples' groups were identical. Some of the exercises in the couples' group that involved direct interaction between partners became ''homework'' for the fathers to try out with their partners between group meetings.

After the first meeting, each subsequent session involved an open-ended check-in to discuss unresolved issues from the last group, difficulties in completing any homework, and positive or negative events occurring during the week that an individual or couple wanted to share. The structured part of each meeting was focused on one of the five domains of our model. Leaders' questions, exercises, and games allowed participants to discuss how they were feeling about themselves and what they wanted to change (e.g., examining discrepancies between their actual and ideal self-descriptions on *The Pie*), parenting principles (e.g., defining and role playing different parenting styles), couple communication exercises (e.g., a ''How well do you know your partner?'' game), three generational family patterns (e.g., packing a ''bag'' to include family rituals to be repeated or avoided in their current family), and how to find supports for dealing with life stresses (e.g., compiling a list of helpful personal and community resources). Of the 16 meetings, 2 were devoted to individual issues, 4 to parenting, 4 to the couple relationship, 2 to three-generational issues, and 2 to stresses and supports outside the family. In both fathers' and couples' groups, two of the 16 meetings were conducted separately for fathers and mothers (fathers met with the male coleader and focused on their relationship with their children; mothers met with the female coleader and focused on the process of engaging fathers and sharing family tasks with them). In addition, the mothers were invited to the first meeting of the fathers' groups in order to increase the probability that their partners would participate.

The combination of structure and flexibility allowed group leaders to maintain lesson plans that followed the general model and goals for the groups while using their professional acumen in implementation. For example, the leaders could choose from an exercise that requires moving around the room and acting out scenarios to stimulate discussion of an issue or a similar exercise that involved more storytelling and group responses. On a continuum of intervention styles ranging from open-ended group therapy (Yalom, 1995) to psychoeducational teaching of specific communication skills (Stanley, Blumberg, & Markman, 1999), our approach occupies a middle ground. In the open-ended check-ins and exercises, the leaders do not attempt to provide solutions to couple or parenting issues, but to draw participants out about their own goals and any impasses related to the issue and to encourage their attempts to make headway on them. The structure is provided by the leaders' agendas, the selection of exercises and tasks, and active guiding of the group discussions from week to week.

Given the economic and social hardships experienced by many of the participants in this study, we expected that group meetings over a 4-month period would not be sufficient to maintain families' participation in the study and produce change in all five aspects of the participants' lives. Thus, all couples in both the group intervention and low-dose comparison conditions received the services of a case manager, who was available to make appropriate referrals for assistance with individual, family, medical, employment, or legal issues over the 18 months of each family's participation. The case managers also served as a link to other aspects of the study by following up with participants when they missed a group meeting and maintaining contact with parents in between the three individual assessments.

Measures

Demographic information. Parents were asked to describe their age, household composition, number of children, ethnicity, marital status, employment status, income level, and education.

Father-child relationship: Psychological and behavioral engagement. The Pie (C. P. Cowan & Cowan, 1991) was developed to represent individuals' psychological investment in various aspects of their lives. Beside a circle 4 inches in diameter, they listed the main roles in their life right then, and divided the circle (pie) so that each section reflected the salience or importance of that aspect of self, not the amount of time spent in the role. A coding scheme from prior content analyses included family roles such as *parent* and *partner/lover; worker* and *student* roles; leisure roles such as *artist* and *gardener*;

and ''core'' aspects of the self such as *me* or *myself alone*. In this study, we focus on the size (degrees of the circle) labeled *father* or *parent* in the pies filled out by the men.

Fathers' involvement in the daily care of the children was assessed by a Who Does What? questionnaire (P. A. Cowan & Cowan, 1990). Each parent rated a number of tasks representing the division of labor for care of the youngest child (feeding, taking the child to the doctor) using a $1-9$ scale in which 1 = *she does it all*, $5 =$ *we do it about equally*, and 9 = *he does it all*. Item reliabilities at baseline were high ($\alpha = .80$ for fathers and .81 for mothers). Correlations between fathers' and mothers' descriptions at the three assessment points ranged from .62 to .74, suggesting that both partners described their division of family labor similarly, though not identically.

Parenting stress. We measured each parent's level of distress specifically related to parenting the target child with a 38-item revised version (Loyd & Abidin, 1985) of the original 150-item Parenting Stress Index (PSI). Parents indicated the extent of their agreement or disagreement with statements describing themselves as stressed, their child as difficult to manage, and a lack of fit between what they expected and the child they have ($\alpha = .91$ for fathers and .92 for mothers). The scale has been validated by comparing parents who do and do not have known stressors in childrearing (children with developmental delay, oppositional defiance, or difficult temperaments; Abidin, 1997).

Parenting style attitudes. The Ideas About Parenting questionnaire (Heming, Cowan, & Cowan, 1991) combined items from scales by Baumrind (1971), Block (1971), and Cohler, Grunebaum, Weiss, and Moran (1971). Fathers and mothers indicated the extent of their own agreement or disagreement with each item and what they believed were their partners' opinions. One of three factors, authoritarian parenting, was used in the present study to describe punitive parenting with high structure and demands for conformity. Although the conceptual consistency of the items was high, item reliability at baseline was modest ($\alpha = .60$ for fathers and .63 for mothers). The authoritarian parenting scale differentiated parenting in another study of families with girls with both attention and hyperactivity disorders from girls diagnosed as inattentive but not hyperactive (Hinshaw, 2002).

Couple relationship quality and stability. The Quality of Marriage Index (QMI; Norton, 1983), a six-item questionnaire with one global estimate and five specific questions about marital satisfaction, was used to measure each partner's satisfaction with the couple relationship ($\alpha =$ .93 for fathers and .94 for mothers). This single-factor scale has high overlap with longer, more traditional measures of marital quality (Heyman, Sayers, & Bellack, 1994).

Conflict About Discipline. From the Couple Communication Questionnaire (C. Cowan & Cowan, 1990) we selected one item that describes the extent of disagreements between partners about disciplining the child on a scale from 0 (*no conflict*) to 6 (*a lot of conflict*).

Children's Behavior Problems. The Child Adaptive Behavior Inventory (P. A. Cowan, Cowan, & Heming, 1995), a 54-item adaptation of the 106-item Child Adaptive Behavior Inventory, was filled out by each parent. This instrument contains items selected from a 60-item Adaptive Behavior Inventory (Schaefer & Hunter, 1983), the downward extension of the Quay-Peterson Behavior Problem Checklist (O'Donnel & Van Tuinen, 1979), and Achenbach and Edelbrock's (1983) Child Behavior Checklist (CBL). It contains both positive and negative descriptors of cognitive and social competence (e.g., ''is smart for his/her age,'' ''has trouble concentrating on what he/she's doing,'' ''is often sad,'' ''breaks or ruins things''). Each item is rated on a 4-point scale ranging from 1 (*not at all like this child*) to 4 (*very much like this child*). To reduce the item-based scales to a manageable number of aspects of adaptation, we composited the scores into four dimensions based on a previous factor analysis of the scale (C. P. Cowan & Cowan, 1992): (a) externalizing-aggression; (b) externalizing-hyperactivity; (c) internalizing-shy withdrawn; and (d) internalizing anxiety, depression. In previous studies (Gottman & Katz, 1989), the interitem consistencies of these composite dimensions filled out by teachers were very high (alphas in the .80s and .90s) and those filled out by parents were moderate (.60s and .70s). In the present study, the alphas for parents' descriptions ranged between .71 (hyperactivity) and .85

(externalizing-aggression) for both mothers and fathers; all of the reliabilities for parents' ratings were higher than those for the corresponding scales in a middle-class sample. Correlations of mothers' and fathers' descriptions on each of the four dimensions were consistently moderate to high at each assessment period; baseline .35 − .45; Post 1 .35. − 54, Post 2, .35 − .53.

Results

First, we present results pertaining to retention of the participants from their first screening for eligibility through the second posttest, 18 months after completing the preintervention baseline assessments. Second, we examine the impact of fathers' groups, couples' groups, and the one-time meeting by examining change in the parents and children over time. Third, we describe our search for potential moderators of the intervention effects—whether there were different findings depending on the demographic or psychological characteristics of the participants.

Factors Affecting Retention

Our first question was whether retention rates differed among those assigned to the single-meeting information condition, a fathers' group, or a couples' group. We found no differences in participants in the three intervention conditions in terms of the proportion of participants retained from condition assignment to baseline completion ($\chi^2 = 1.06$, $p < .60$), from baseline completion to the completion of Post 1 ($\chi^2 = 1.45$, $p < .50$), or from Post 1 to the completion of Post 2 ($\chi^2 = 0.53$, $p < .80$). Neither did χ^2 tests reveal differences in retention rate among the three conditions as a function of ethnic group membership (Mexican American vs. European American), income (below or above federal poverty level), or family status (married vs. cohabiting).

A mixed model GLM analysis (Gender of parent × Baseline measures × Retention) that included all of the measures reported in this study examined whether there were differences at baseline between those who completed or failed to complete the Post 2 assessment. We focus here only on the interaction terms of interest to the retention analysis. There were no significant Retention × Gender of parent interactions. A statistically significant Baseline measure × Retention interaction, $F(15, 299) = 3.31$, $p < .001$, was followed by univariate F tests for each measure.

On 3 of the 10 dependent measures, the 82 couples who completed the baseline but not the Post 2 assessment 18 months later were in more distress at the beginning of the study than the 207 couples who completed the Post 2 follow-up 18 months later. The noncompleters initially showed greater parenting stress on the PSI, $F(1, 333) = 4.22$, $p < .05$, lower satisfaction with the couple relationship on the QMI, $F(1, 333) = 21.20$, $p < .001$, and more conflict about disciplining the child on the Couple Communication Questionnaire, $F(1, 333) = 8.04$, $p < .01$. There were no significant retention effects as a function of fathers' initial level of involvement in the daily tasks of child care, psychological involvement as a parent as measured by The Pie, authoritarian ideas about parenting, or either parent's description of their child on the Child Adaptive Behavior Inventory. Despite the fact that some of the more distressed participants dropped out, there was a full range of adaptation scores among the large majority who continued to the end of the study.

Attendance at the 16-week group meetings was quite high. The median attendance in the fathers' groups was 67%. In terms of range of attendance, 9% of the fathers attended every meeting (32 hours); 40% attended more than 25 hours, 67% more than 19 hours, and 81% more than 13 hours.

In the couples' groups, median attendance was 75% for fathers and 80% for mothers. For fathers, 11% had perfect attendance, 61% attended more than 25 hours, 81% more than 19 hours, and 95% more than 13 hours. For mothers, 18% had perfect attendance, 60% attended more than 25 hours, 87% more than 19 hours, and 96% more than 13 hours. Once a father or couple attended the first or second meeting of the groups, the median attendance rate was close to 90%.

The Impact of Participation in the Intervention Groups

Tables 1 and 2 presents mean scores on the questionnaires as a function of time (baseline, Post 2), condition (low-dose comparison, fathers' group, couples' group), and gender of parent. Data for

Table 1. *Pretest Baseline Means, Standard Deviations, for Time × Condition × Gender Intervention Analyses (*N = 289*)*

	Pretest Baseline								
	Comparison			Fathers' Group			Couples' Group		
	Father	Mother	*M*	Father	Mother	*M*	Father	Mother	*M*
Parents' adaptation									
Psychological involvement									
M	102	—		104	—		101	—	
SD	50			48			48		
Who Does What?									
M	3.7	3.4	3.55	3.8	3.4	3.60	3.4	3.2	3.30
SD	0.9	1.1		1.1	1.2		1.0	1.0	
Ideas about parenting									
M	67.7	68.4	68.05	68.4	66.8	67.60	69.0	65.2	67.10
SD	10.8	11.7		11.8	13.7		12.5	12.6	
Parenting stress									
M	66.4	68.4	67.40	68.0	67.3	67.65	72.6	73.2	72.90
SD	17.9	18.4		14.8	18.7		16.3	18.1	
Couple satisfaction									
M	38.2	36.2	37.20	37.0	35.7	36.35	36.7	35.3	36.00
SD	6.0	8.1		6.9	8.1		7.3	7.9	
Conflict about discipline									
M	5.8	5.7	5.75	5.8	5.9	5.85	5.9	5.4	5.65
SD	1.5	1.6		1.6	1.5		1.4	1.7	
Children's adaptation									
Aggression									
M	1.74	1.71	1.73	1.68	1.69	1.69	1.78	1.78	1.78
SD	0.5	0.6		0.5	0.6		0.5	0.6	
Hyperactivity									
M	2.04	2.03	2.04	2.02	1.94	1.98	2.11	2.04	2.08
SD	0.6	0.6		0.6	0.7		0.6	0.6	
Shy or withdrawn									
M	0.82	1.00	0.91	1.42	1.23	1.33	1.69	1.08	1.39
SD	0.4	0.4		0.4	0.4		0.4	0.4	
Anxiety or depression									
M	1.50	1.42	1.46	1.44	1.43	1.44	1.46	1.41	1.44
SD	0.4	0.4		0.5	0.5		0.4	0.5	

the pretest baseline are in Table 1 and for the Post 2 assessment 18 months later in Table 2. The data from Post 1 were included in the analyses but were not included here, in part for reasons of space and, in part, because all of the post hoc tests focused on longer-term effects from baseline to Post 2; the Post 1 data are available from the first author.

We conducted three-way analyses of variance (ANOVAs; Time × Condition × Gender) to identify significant intervention effects on father engagement, couple relationship quality, and child outcomes. These analyses contained all main effects and two-way and three-way interactions, but, to conserve space, we focus only on the interactions of Time × Condition that signify a significant intervention effect (listed in Tables 1 and 2). In this sample of 572 individuals (286 couples), the power to detect a small interaction effect size of .25 is .99. Four of the 10 measures showed a statistically significant Time × Condition interaction, and one showed a Time × Condition × Gender interaction (see Tables 1 and 2). The intervention affected men's psychological involvement with their children (The Pie) and both partners' views of men's involvement in daily childcare tasks (Who Does What?), parenting stress (PSI), and satisfaction with the couple relationship (QMI). A statistically significant Time × Condition × Gender

Table 2. *Post 2 Means, Standard Deviations, and* F *Tests for Time × Condition × Gender Intervention Analyses (*N = 289*)*

	Post 2									
	Comparison			Fathers' Group			Couples' Group			
	Father	Mother	*M*	Father	Mother	*M*	Father	Mother	*M*	*F* *T* × *C*
Parents' adaptation										
Psychological involvement										
M	109	—		125	—		115	—		2.48*
SD	52			61			49			
Who Does What?										
M	3.9	3.5	3.70	4.2	3.8	4.00	3.9	3.7	3.80	2.99*
SD	1.1	1.1		1.2	1.4		1.1	1.2		
Ideas about parenting										
M	67.8	69.3	68.55	66.8	65.7	67.25	68.0	64.4	66.20	
SD	10.9	12.1		11.7	12.8		10.7	11.1		
Parenting stress										
M	68.0	67.4	67.70	66.5	67.2	66.85	70.4	65.1	67.75	3.12*
SD	17.3	15.8		16.2	17.0		19.4	17.1		
Couple satisfaction										
M	34.0	33.1	33.55	35.0	33.3	34.15	34.9	35.6	35.25	2.78*
SD	8.4	9.9		8.8	9.0		8.6	8.4		
Conflict about discipline										
M	5.8	5.5	5.65	5.8	5.8	5.80	5.6	5.8	5.70	3.52** T × C × G
SD	1.4	1.5		1.3	1.2		1.5	1.3		
Children's adaptation										
Aggression										
M	1.84	1.82	1.83	1.73	1.75	1.74	1.84	1.82	1.83	
SD	0.5	0.4		0.5	0.5		0.5	0.5		
Hyperactivity										
M	2.17	2.19	2.18	2.06	2.02	2.04	2.13	2.04	2.09	
SD	0.6	0.6		0.6	0.6		0.6	0.6		
Shy or withdrawn										
M	1.58	2.21	1.90	2.62	1.51	2.07	2.00	1.21	1.61	
SD	0.4	0.5		0.4	0.5		0.4	0.4		
Anxiety or depression										
M	1.58	1.52	1.55	1.52	1.53	1.53	1.52	1.48	1.50	
SD	0.4	0.4		0.5	0.5		0.4	0.4		

*$p = .05$. **$p = .01$.

interaction revealed that group participants reported fewer parental conflicts about discipline as reflected in fathers' but not mothers' reports (Couple Communication Questionnaire).

Following these five interaction effects, we conducted post hoc tests with a Bonferroni correction for multiple tests to determine the overall change in each condition from baseline to Post 2, because we were interested primarily in whether any changes could be maintained for almost a year beyond the Post 1 follow-up conducted shortly after the groups ended.

We also conducted exploratory post hoc tests, with Bonferroni corrections, on the parents'

descriptions of the child. We realize that the choice to perform post hoc tests when there was no statistically significant interaction capitalizes on chance findings, but in a first randomized clinical trial of these interventions with low-income families, we thought it important to identify trends to test in later research. Our choice was further justified by an examination of the mean changes over time across conditions, which showed a nonrandom pattern of higher increases in problem behavior on aggressive, hyperactive, shy or withdrawn, and anxiety or depressive behaviors in children of the low-dose controls (.10, .14, .99, .09) than in children of fathers' group participants (.05, .06, .74, .09) and especially children of couples' group participants (.05, .01, .22, .06). We interpret these exploratory post hoc results with caution.

Because of the absence of gender differences in the interaction tests (with one exception), we describe the means of fathers' and mothers' scores included in Tables 1 and 2 as a function of time and condition. The overall result of couples participating in the low-dose comparison condition was clear. Despite the fact that most parents rated the 3-hour informational meeting as useful, the one-time discussion of the importance of fathers' engagement with children produced little in the way of benefits. Comparisons between those parents' baseline and Post 2 scores revealed no change in fathers' psychological engagement (The Pie), with a nonsignificant increase from 102° to 109° of the circle allocated to the father piece, and no significant change in the Who Does What? behavioral measure of involvement in child-care tasks, with a small increase from 3.55 to 3.70 on a 1−9 scale averaged across 11 daily child-care tasks. Furthermore, baseline to Post 2 changes revealed statistically significant *negative* changes in 4 of 10 measures for the low-dose comparison participants. Couple relationship satisfaction declined from 37.20 to 33.55, $t(94) = 3.46$, $p < .001$, and children's problem behavior increased as perceived by parents—aggression, 1.73 to 1.83 $t(94) = 2.04$, $p < .05$, hyperactivity 2.04 to 2.18, $t(94) = 2.45$, $p < .01$, shy or withdrawn, .91 to 1.90, $t(94) = 2.35$, $p < .05$, and depression or anxiety 1.46 to 1.55, $t(94) = 2.34$, $p < .05$. We should note that on the average, the parents tended to describe their children as low in problems—all of the scales ranged from ratings of 1 (*not at all like*) to 4 (*very much like*). Nevertheless, parents used the full range of items and viewed a few of the children as high in all problem areas. Because the variation in ratings was quite low, small differences in means were statistically significant.

Compared to the results for the low-dose comparison families over 18 months, results were more positive for fathers' group participants, but still slightly mixed. Gains from baseline to Post 2 were evident in fathers' engagement with children on psychological measures (The Pie, $t[87] = 3.78$, $p < .001$); the degrees of the circle labeled father increased from 104° to 125° of The Pie circle. On behavioral measures of daily child-care tasks (Who Does What?), fathers also increased from 3.60 to 4.00, when a rating of 5 means that the tasks are equally shared by the parents, $t(87) = 3.01$, $p < .01$. In contrast with the low-dose comparison participants who reported increases in children's problem behavior, mothers and fathers from families assigned to the fathers' groups reported no statistically significant changes in their children's aggression, 1.69 to 1.74, hyperactivity, 1.98 to 2.04, shy or withdrawn, 1.33 to 2.07, or anxiety or depression, 1.44 to 1.53. On the negative side, both parents from the fathers' group condition mirrored the significant decline in relationship satisfaction over 18 months of mothers and fathers in the comparison condition (QMI), 36.35 to 34.15, $t(87) = 3.07$, $p < .01$.

With couples' group participants, as with those from the fathers' groups, fathers' engagement with the children showed significant increases over time on both psychological engagement, 101° to 115° of The Pie circle, $t(76) = 1.99$, $p < .05$, and behavioral measures, 3.30 to 3.80 on the 9-point scale, $t(92) = 4.35$, $p < .001$. As with fathers' group participants, parents' descriptions of their children's problem behavior remained relatively stable over 18 months, aggression 1.78 to 1.83, hyperactivity 2.08 to 2.09, shy or withdrawn 1.39 to 1.61, and anxiety or depression 1.44 to 1.50. There were two additional noteworthy benefits of participating in a couples' group. For both mothers and fathers, parenting stress declined significantly, $t(91) = 3.79$, $p < .001$, 72.90 to 67.75, and satisfaction with the couple relationship remained stable over 18 months, 36.35 to 35.25. Given the high statistical power to detect differences, we believe that these are reliable findings. One additional finding was

mixed for parents in the couples' groups: At Post 2, the fathers reported a significant decline in conflict and disagreement with the mothers over disciplining their child since baseline, 5.9 to 5.6 on a 1–7 scale, $t(92) = 1.97$, $p < .05$, whereas mothers reported a significant increase in the couple's conflict about discipline, $t(92) = 2.23$, $p < .05$, 5.4 to 5.8. Perhaps the men experienced less conflict, whereas the women experienced more disagreement as they engaged in increased discussion of childrearing issues.

Some of the mean changes in measures reported above appear to be quite small, but of course they reflect only the average scores of participants in each condition. Some of the low-dose control participants made much larger shifts in a negative direction, whereas some participants of the fathers' and couples' groups managed to make important changes in their relationships as couples and with their children, or at least to stave off the normative declines that occur over time without intervention. Overall, the significant *t* tests evaluating change from baseline to Post 2 ranged from 1.99 to 3.79. These results are based on effect sizes equivalent to Cohen's *d* statistics ranging between .40 and .79, indicating moderate to large changes in the intervention participants over an 18-month period.

Moderator Analyses

In separate three-way ANOVAS (Moderator × Time × Condition) we examined whether the intervention effects were different for participants who were initially higher or lower in income, married or cohabiting, Mexican American or European American, and satisfied or dissatisfied with their couple relationship. For the continuous variables (income, relationship satisfaction) dichotomous variables were created from above- or below-median scores. In this sample of 572 individual parents (286 couples), the power to detect a small interaction effect size of .25 is .98. None of the factors that we tested in separate ANOVAs qualified as a moderator of the intervention effects; the positive intervention results held across participants who were low- and higher income, married and cohabiting, and Mexican American and European American, suggesting that the intervention is quite robust and generalizeable within the parameters of our study.

Discussion

Systematic evaluations of father involvement interventions are rare, randomized clinical trials are scarce, especially in primarily low-income and non-White populations, and the comparison of interventions for fathers alone or for fathers and mothers together is unique to this study. The Supporting Father Involvement interventions produced positive results in terms of families' retention in the program and parents' and children's well-being, results that appear to be generalizeable to families from several different backgrounds and income levels.

Retention

There were no selection effects in this study based on the experimental conditions to which participants were randomly assigned. Although significantly more participants with initially high parenting stress, couple relationship dissatisfaction, and disagreements about childrearing dropped out after completing the baseline assessments, there was a full range of scores among the large majority who continued to the end of the study. The high retention rate from the baseline assessment over 18 months (76%) and high attendance over the 11 to 16 weeks of meetings is a testament to the attractiveness of the services to the participants, the skill of the group leaders, and the diligent work of the case managers in supporting participants' continuation through regular contact and referrals to other services.

Impact of the Interventions

Fathers' groups and couples' groups. A randomized clinical trial of a preventive intervention in the form of a 16-week group for fathers or for couples, led by the same trained mental health professionals, showed significant gains for participants in both types of groups—in terms of fathers' engagement in the care of their young children and their growing sense of self as fathers.

Participation in a fathers' or couples' group was associated with stable levels of children's problem behaviors as the parents perceived them over 18 months compared with consistent increases in problem behaviors in children of parents in the low-dose comparison condition. We have stated that these results were derived from post hoc analyses, despite

the fact that the Time × Condition interactions were not statistically significant. The fact that this pattern was observed in all four measures of child behavior argues against the interpretation that the findings were random. In the absence of intervention effects on parenting ideas and without measures of observed parenting behavior, we cannot conclude that intervention-induced changes in more effective parenting were responsible for the child behavior outcomes. Possibly, the parents' experience of the groups themselves, the discussions of children's development, and the relatively greater couple satisfaction and couple communication combined to protect the children against the rise in aggression, hyperactivity, depression, and shy or withdrawn behaviors reported by parents in the low-dose comparison condition.

Although the curricula for both fathers' and couples' groups contain almost identical units that focus on the couple relationship, the participants in the couples' groups were the only ones to maintain satisfaction with their relationships as couples over the period of the study—a finding that runs counter to well-established normative downward trends in satisfaction for parents with children from birth through adolescence (Twenge, Campbell, & Foster, 2003). Given the similarity of the curricula, we conclude that the format in which both partners were present had a specific impact on the couple domain. Although this was not psychotherapy per se, the therapeutic effects of having both key players and their dynamics in the room provided a more salient opportunity for reinforcing change between as well as within the partners. This is consistent with the fact that the parents from the couples' groups, but not those from the fathers' groups, also showed significant declines in parenting stress. In light of the context of this study as an effort to prevent child abuse, this is a particularly welcome finding, because parents' stress, irritability, and feelings of being ineffective as parents and children's problem behaviors are key risk factors for child maltreatment (Haskett, Ahern, Ward, & Allaire, 2006).

Limitations and Next Steps

There are a number of limitations to the present study. First, like any intervention study, we recruited a sample of convenience rather than a representative sample of families in the four California counties. The participants were men and women willing to consider taking part in an intervention to enhance fathers' involvement in family life. Second, the measures reported here rely on parent reports. We have obtained videotaped interactions between mother and child and father and child at the follow-up 11 months after the intervention ended. We are now in the process of developing coding systems relevant to both Mexican American and European American families with children of varying ages. Third, we have examined intervention effects only in Mexican American and European American families. It remains to be seen whether Latino families in other locales and members of other ethnic groups will benefit from these interventions. We have a trial underway at a fifth site in a predominantly African American community, and adaptations for other populations are currently under consideration. Fourth, our intervention approach was intended to provide a safe environment for fathers and couples to explore how they want to strengthen their relationships as parents and partners, rather than to learn specific skills that suggest ''right'' answers to deal with complex family issues. This approach left room for cultural variations within and between intervention sites, one that could provide a culturally sensitive framework for intervention in other ethnic groups. Whether other intervention approaches could produce even better results remains to be tested empirically.

Like many randomized clinical trials, ours involved multiple variables in the contrast between a low-dose comparison and more intensive intervention conditions. From our own observations and the testimony of the parents, we infer that the group format had a powerful, normalizing, and supportive effect on the participants (see Hawkins et al., 2008, who failed to find a couple relationship effect in a program administered to individual couples at home).

The interventions did not affect parenting attitudes as we assessed them. It is possible that the null findings reflect the modest reliability of the items. Before concluding that the intervention did not affect parenting *behavior*, we must complete our analysis of videotaped father-child and mother-child interactions from the final follow-up.

Finally, because this study has been funded by the Office of Child Abuse Prevention as a *prevention* project, open cases of abuse and neglect were referred out. This makes it a challenge to demonstrate that the interventions are effective in preventing child abuse, at least in the short run. What we do know, consistent with our risk model, is that the positive effects of the fathers' groups and couples' groups involved improvements in family risk and protective factors (father engagement, parenting stress, couple relationship quality, and children's problem behavior) that are known to be associated with problematic outcomes for children such as emotional distress, child abuse, and neglect (Cicchetti, Toth, & Maughan, 2000).

Policy Implications

The results of this randomized clinical trial are relevant to discussions of current attempts at the federal and state level to foster positive father engagement and healthy family relationships. Given the caveats listed above—that this is a single study of two ethnic groups—we have shown that our intensive preventive intervention constitutes an evidence-based practice that can increase fathers' engagement with their children and buffer the normatively expected decline in couple relationship satisfaction. Despite the caveats, we should not underestimate the importance of the finding that the interventions were equally successful in both ethnic groups and for cohabiting and married couples at lower and higher income levels.

The findings from this study further suggest that interventions involving a single meeting with participants are unlikely to have a positive effect. Of course, this remains to be tested with other single-meeting formats and curriculum content. The results also suggest that a curriculum that focuses on the risk and protective factors in multiple aspects of family life was successful in producing positive changes in the quality of both father-child relationships and, when mothers participated fully as part of the couples' groups, in maintaining both partners' relationship satisfaction. In addition, we learned that engaging fathers in a fathers' group was facilitated when the mothers came to the first meeting with the fathers and attended two additional meetings with the other mothers. That is, the question is not whether to intervene with fathers or with couples but, in either approach, how to involve both parents in the intervention program.

The most salient policy questions, pending further positive outcomes from additional studies, is whether this type of intervention could feasibly be brought to scale in a climate of decreasing government resources or whether the intensity and staffing levels could be reduced to make it less costly without sacrificing its effectiveness. To address the practical issues of whether fewer resources could produce the same effects, studies must vary features of the intervention systematically—risk status of the participants, leader qualifications, number of contact hours, the contribution of case managers, compensation to participants, and the provision of food and child care during group meetings. Given the complexity of the issues raised in our bimonthly telephone consultations with the staff, we doubt that leaders with less experience could handle the individual and couple distress that often spills over into the group process as effectively as our experienced clinicians did. Could the program be administered in fewer sessions? We know that one meeting was not sufficient to produce positive results. We know that 11 to 16 meetings with a total of 32 hours were effective. We do not have systematic information about the time point at which additional hours stop producing positive gains. We were not able to examine self-selected dosage effects because there was very little variability in attendance at the low end of the continuum; participants who came to very few sessions tended to be the ones who dropped out of the study, so we could not analyze their baseline-to-postintervention changes.

We believe that a program like Supporting Father Involvement could be mounted on a larger scale if it could be embedded within existing service delivery systems—Family Resource Centers, hospitals, mental health centers, schools, other community agencies such as the YMCA, or faith-based organizations—with trained family service providers. In the absence of new funds for additional staff, existing staff might be convinced to take on such a program if they believed that this evidence-based practice could substitute for parenting classes or family programs that they offer now. The argument would be more compelling if we could show that the program was able to prevent future family distress with its associated increase in programmatic costs. Plans are underway for

a formal cost-benefit analysis of the current study to determine whether this argument can be supported empirically.

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