



Helping professionals
help families affected
by drugs and/or HIV

IN THIS
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Fostering
Father
Involvement

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THE SOURCE



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National AIA
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The National Abandoned Infants Assistance Resource Center's mission is to enhance the quality of social and health services delivered to children who are abandoned or at risk of abandonment due to the presence of drugs and/or HIV in the family by providing training, information, support, and resources to service providers who assist these children and their families. The Resource Center is located at the University of California at Berkeley, and is a service of the Children's Bureau.

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THE SOURCE

- 2** Fathers of Substance-Exposed Infants During the Perinatal Period and Beyond
Jean E. Twomey, PhD
- 8** Promising Interventions for Strengthening Relationships Between Non-Resident Fathers and Their Children
Sonia C. Velazquez, CSS and Stefanie Vincent, MPP
- 11** Fathering Capacity of Incarcerated Substance Users
Sharon Johnson, MS and Heather Hull
- 14** Fatherhood and Recovery
Mark Sanders, LCSW, CADC
- 17** Project Fatherhood: Fathers as a Solution
Hershel K. Swinger, PhD and Jennifer D. Wishner, PhD
- 20** Single Male Caregiver Challenges Following the Mother's Death
Joanne Bobes, MA, LMSW
- 23** The Death of a Child: Bereaved Fathers at Risk for Depression
Lori Wiener, PhD and Haven Battles, PhD
- 24** Telephone Support Groups for Fathers Parenting HIV-Infected Children
Lori Wiener, PhD, Cynthia Fair, LCSW, DrPH, and Haven Battles, PhD
- 27** Good Bets
- 30** Conference Listings
New AIA Grantees

Fathers of Substance-Exposed Infants During the Perinatal Period and Beyond

Jean E. Twomey, PhD

Most treatment providers, researchers, and policymakers now recognize that effective therapeutic services for substance-using pregnant women and mothers need to encompass parenting and relationship issues. Nevertheless, the role of male partners and fathers in the lives of these families remains largely overlooked (Twomey, 2007), and the literature on substance-using parents focuses primarily on mothers.

Some changes have occurred within the past decade. McMahon and his colleagues in particular have been addressing the importance of fatherhood for substance-abusing men themselves and for the lives of their children (McMahon & Giannini, 2003; McMahon, Luthar, & Rounsaville, 2001; McMahon & Rounsaville, 2002; McMahon, Winkel, Luthar, & Rounsaville, 2005; McMahon, Winkel, Suchman, & Rounsaville, 2007). Still, the literature on substance-using fathers remains largely separate from that on substance-using mothers. Additionally, fathers of substance-exposed infants often seem to be invisible to the agencies that provide services to mothers and children (Twomey, Soave, Gil, & Lester, 2005). Even when service providers know that the father

lives with the mother and child, all too often services exclude him. If a father is also a drug user, providers generally do not foster the positive efforts he could make to contribute to family life (McMahon et al., 2005; McMahon et al., 2007).

Neglecting the fathers of substance-exposed infants and children is all the more striking when contrasted with the burgeoning interest in fatherhood over the past two decades. Fatherhood is now considered a significant aspect of male development, and contemporary perspectives offer a greater appreciation of paternal influence on family life, whether or not a father is present in the home. Fathers of substance-exposed children must be considered in the development of services, research, and policy because of the impact these men have on their children, as well as the impact of fatherhood on their own adult functioning.

Expanding Roles, Opportunities, and Expectations for Fathers

Pregnancy and childbirth have been seen as windows of opportunity for intervening in a substance-using woman's life (Curet & Hsi, 2002; Kissin, Svikis, Moylan, Haug, & Stitzer, 2004). Similarly, Palkovitz (2002) has identified transitional times in men's lives as conducive to instituting life changes. The birth of a child may offer opportunities for fathers to reflect on their values and redefine their goals in ways that can be positive for themselves and their children.

With contemporary fatherhood regarded as a multifaceted role involving active participation in family life and the provision of emotional as well as economic support for the mother and children, fathers now experience greater role options, raised expectations, and higher

Fathers of substance-exposed children must be considered in the development of services, research, and policy.

standards. At the same time, an opposing trend has been identified. Large numbers of men live apart from their children and have little or minimal involvement in their children's lives (Furstenberg, 1995; Palkovitz, 2002).

Today's higher standards for fathers may have unintended consequences, widening the discrepancy between idealized and actual parenting abilities, especially in families affected by parental substance use. Grappling with feelings of inadequacy against the backdrop of raised societal expectations, men may respond in a variety of ways along a continuum—from completely abandoning the family to choosing to become full participants in family life. The latter choice will often require family, community, and therapeutic support. It will also require the recognition that many men who may not be perceived as positively involved fathers actually value the role and have the capacity to become good parents.

For example, investigations into the lives of low-income nonresident fathers found that the men valued their roles as fathers as long as there were meaningful ways that they could contribute to family life (Hamer, 2001; Waller, 2002). They defined activities such as spending time with and guiding their children as more important elements of fatherhood than being good financial providers. In this way they adopted alternative standards to form their paternal identities in response to environments that provide them with few opportunities to meet the prescribed idealized standards.

Fathers as Risk or Protective Influences

Service providers working with mothers often see little need to provide outreach to fathers, especially when viewing them in a negative light—as threatening figures with the potential to inflict physical harm on their partners and children, as absent and uninvested in family life, or as unable to fulfill personal or societal expectations of fatherhood. Even when concerns are warranted, an argument can be made for providing these fathers with services to increase their parenting capacities.

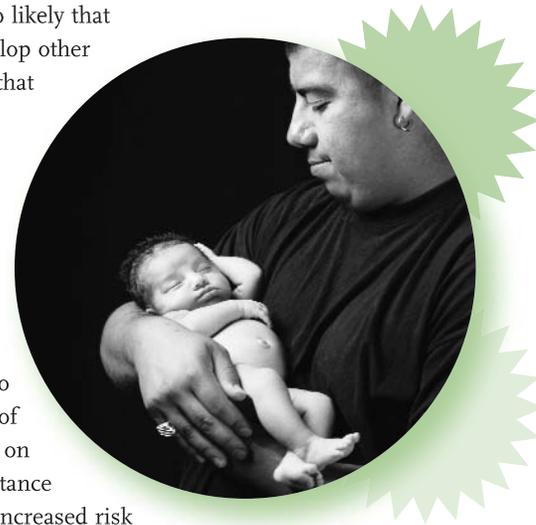
In both the literature and clinical work, frequent concerns are raised about violence and abuse in the relationships substance-using women develop with their intimate partners (Amaro & Hardy-Fanta, 1995; Amaro, Fried, Cabral, & Zuckerman, 1990; Horrigan, Schroeder, & Schaffer, 2000; Martin, Beaumont, & Kupper, 2003; Tuten, Jones, Tran, & Svikis, 2004). However, when treatment programs ignore men or require women to end

relationships with their partners, the women may choose to terminate treatment (Dore, Doris, & Wright, 1995). Although not always apparent, positive aspects to strife-ridden relationships are possible, as well as negative aspects to their ending. Should these relationships end precipitously, the mothers and children may face levels of loss and grief that undermine functioning and inhibit, rather than foster, family cohesion and recovery.

When a woman decides to leave her partner to achieve and sustain abstinence, work with the father should be considered outside the context of the couple's relationship. This is a critical point because fathers remain important to children even after the couple's relationship ends. It is also likely that men will go on to develop other intimate relationships that have the potential to result in the birth of other children, or they will become involved with a new partner's children from earlier relationships (Urban Institute, 2008).

Valid concerns also exist about the impact of parental substance use on children. Paternal substance use is associated with increased risk factors that contribute to compromised child developmental outcomes (McMahon & Giannini, 2003). Children of substance-using fathers have increased exposure to parental conflict and violence and suffer more symptoms of depression and anxiety than children of non-substance abusing fathers (Fals-Stewart, Kelley, Fincham, Golden, & Logsdon, 2004). A study on the impact of parental substance use on three-year-old children found that when fathers were substance users, whether or not they lived with the families, children were at higher risk for poorer health and behavioral outcomes (Osborne & Berger, in press). Another study showed that substance-using fathers were limited in their ability to provide emotional support to their partners or to communicate effectively with their children (Johnson, Cohen, Kasen, & Brook, 2004).

Notwithstanding these findings, whether a father will be a risk or a protective influence in his child's life arguably depends primarily on the nature of his relationships with his partner and children. Fathers serve protective functions when their relationships are loving, empathic, and predictable. Conversely, when the nature of relationships is volatile, uncaring, and conflict-ridden,



fathers become risk factors. Importantly, “The absence of familial hostility is the most consistent correlate of child adjustment, whereas marital conflict is the most consistent and reliable correlate of child maladjustment” (Lamb, 2000, p.113). In order, therefore, to best serve children with substance-using parents, it is essential to engage the fathers in services and assist the parents in managing conflict, which often is exacerbated by substance use.

Because substance use is a behavior so diametrically opposed to idealized notions of parenthood and family life, it may be that treatment providers, policymakers, researchers, and society have been slow to recognize that motherhood and fatherhood are important components of the lives of both perinatal substance users and their partners. When men’s desires to be good parents can be elicited and supported, their children can benefit. One recent study relevant to this point highlights paternal involvement as being positively associated with children exiting the child welfare system more quickly and being reunified with their biological mothers (U.S. Department of Health and Human Services, 2008).

When Men Become Fathers: Examples from Literature and Life

EXAMPLES FROM LITERATURE

Two recent books provide contrasting examples of reactions to fatherhood experienced by substance-using men and of subsequent child outcomes. Bret Ellis, the protagonist of the novel *Lunar Park*, exists in a fast-paced world of art, celebrity, and drug use. He is a substance-dependent father who struggles psychologically to escape his own abusive, threatening alcoholic father. The eleven

When men's desires to be good parents can be elicited and supported, their children can benefit.

year-old child of Bret and his wife, Jayne, has anxiety attacks and feels confused and alienated from his own family. During a couple’s therapy session, Ellis expresses his belief to Jayne that their son does not want him to be a part of the family.

*“I don’t think the father ever needs to be there.’...
‘People are better off without them.’ Jayne stopped crying and regarded me with a cold and genuine interest.
‘Really? You think people are better off without a father?’
‘Yes....I do.’ ‘I think we can disprove that theory right now.’ ‘How? How, Jayne?’ Quietly, and with no effort, she simply said, “Look how you turned out.’ ”
(Ellis, 2005, p. 198).*

Shaped by his father’s emotional abandonment of him, Ellis cannot attach to or understand the son he never wanted. He has no experiences to draw upon to define fatherhood as a vital experience for himself or his child. The impact of a father’s absence has clear generational consequences.

The autobiography of journalist David Carr describes an odyssey of drug addiction that includes fathering twin girls. After Child Protective Services (CPS) involvement and the realization that the twins’ mother is too impaired by her ongoing substance use to parent, Carr becomes determined to obtain full custody of his children. Although Carr’s earlier attempts at recovery were unsuccessful, the possibility of permanently losing his children motivates him. Years later, Carr interviews a friend who speaks about the impact he believes the children had on Carr’s recovery:

*“I thought to myself, ‘This guy is just hanging on, just barely hanging on. Rarely did you smile, did you laugh—that’s one of the things I remember most. Unless you were with your girls. But what you didn’t talk about was how hard it was for you to stay straight. You always knew that you were just one second from going right back over, but you knew your girls depended on you and you were bound and determined to do it’ ”
(Carr, 2008, p. 259).*

Carr ultimately becomes an effective father through the support of family, friends, and treatment providers. For years, he had been the prototype of the father who was a risk to his children: impulsive, aggressive, deceptive, and physically abusive to his partners. His story demonstrates that men who recognize their importance in their children’s lives can make radical and positive changes given intensive and extensive support over time. These changes benefit the men themselves, their children, and potentially future generations.

EXAMPLES FROM LIFE

The following vignettes offer two examples of partners of perinatal substance users who were actively involved in parenting their children. The first follows up on a family that participated in a study of parental functioning after Family Treatment Drug Court (FTDC) involvement (Twomey & Lester, 2007). The second is drawn from a mental health outpatient clinic and illustrates a divorced father's attempt to deal with his young son's behavioral problems.

Parenting as a Couple

Greg was a first-time father whose wife, Debby, had an extensive history of substance use and psychiatric problems. Greg himself had a history of daily marijuana use, which he stopped soon after becoming involved with Debby. Both parents were distraught when their daughter was placed in out-of-home care following delivery because Debby had reported several instances of cocaine use during pregnancy. Although Greg was given the option to take care of the infant if his wife moved out, he felt unable to assume full responsibility for a newborn and did not want to be separated from Debby. Greg complied with the CPS case plan for reunification, including attending FTDC, substance abuse treatment, and mental health treatment despite believing he did not need these services. The family was reunified when the infant was about 12 months old. There was a second removal for four months followed by a second reunification before the child's second birthday. The now four-year-old child has remained with her parents since that time.

Greg and Debby credit the love of their child and commitment to their marriage and to raising their child together as motivation for remaining abstinent. Debby described Greg as wholeheartedly supporting her recovery, keeping up her spirits, and helping her believe in herself even through times of self-doubt. During the time they were involved with CPS, Debby felt others perceived her as an unfit mother whose return to drug use was inevitable. She could not imagine being able to obtain custody of their daughter without Greg's support, noting she had lost custody of an older child she had had with a former partner.

Greg's ability to provide his family with financial and emotional support contributed greatly to his sense of self-worth, which in turn strengthened his capacity to support his wife as she was going through a challenging recovery process. Their daughter benefited from the parents' joint efforts to create and maintain a stable family life.

There was a time when Greg's second shift schedule created tensions in the family because of the amount of "me time" he allotted himself when he returned home from work. When he realized that his daughter was being

adversely affected by his watching television for hours and sleeping much of the day, he assessed his behavior as "adolescent" and changed his habits. He also learned to be more patient with his daughter and made a conscious effort to control his tendency to become aggravated with her.

Fatherhood helped Greg mature and become more responsible as he learned to put his family's needs ahead of his own. Although he had not felt the need for services, he used them to benefit himself and his family. Greg summarized his feelings about fatherhood this way: "Being a father has changed my life."

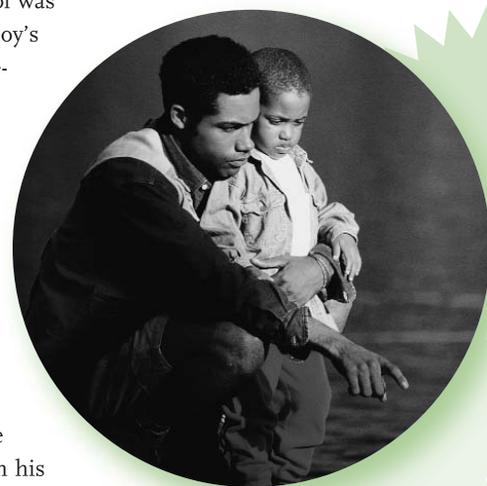
Parenting as a Single Father

Dennis sought help through an outpatient mental health clinic for his four-year-old son, Jason, whose preschool was concerned about the boy's impulsivity, aggressiveness, and poor social skills. Although child behavioral problems were the reason for referral, Dennis primarily talked about his son's mother, Charlene, and her troubled life.

At the time of the referral, Dennis was in his mid-forties, divorced, and had sole custody of his son. He came from an intact, middle-class family and had no history of substance use. Dennis managed several apartment complexes and worked in a variety of municipal services jobs until he suffered a disabling back injury. Subsequently, he supported himself through disability benefits and under-the-table management of rental properties.

Charlene and many of her family members had major psychiatric disorders and substance dependence. She suffered a lifelong history of physical and sexual abuse that reportedly began in infancy and resulted in her permanent removal from her biological mother. By mid-adolescence Charlene was using drugs and engaging in illegal activities to support her habit. The two children she gave birth to before meeting Dennis were removed from her care and placed for adoption.

Dennis met Charlene through a friend who was trying to help her find a place to live when she was homeless. Dennis' work afforded him access to vacant apartments and



he agreed to let her temporarily stay in one until she could make other arrangements. The “other arrangements” turned out to be moving in with Dennis who felt sorry for her and was compelled to try to help her change her life. Beyond wanting to help her, he had no insight into why he had become involved with such a deeply troubled woman. When Charlene became pregnant, Dennis decided to marry her because he believed it was the right thing to do. Charlene used crack and other illicit substances until mid-way through the pregnancy at which time, with Dennis’ encouragement, she agreed to obtain treatment. When their son was born at term, toxicology screens on him were negative for illicit substances and a CPS case was not opened. From the beginning, Dennis assumed primary parenting responsibility and his ongoing care of the child prevented any out-of-home placements.

Conveying a welcoming attitude and openness to fathers’ strengths and needs is a first step in increasing men’s involvement in services.

Charlene resumed her substance use after the child was born, and eventually CPS became involved. Charlene was in and out of Jason’s life, depending on the restrictions imposed on her by CPS, fluctuations in the couple’s relationship, and her own erratic behavior. After multiple separations and reconciliations, Dennis filed for divorce.

Dennis’ medical condition allowed him to be home full-time and he prided himself on taking good care of his son. His understanding of Jason’s psychological and developmental needs, however, was limited. Dennis could not recognize that Charlene’s inappropriate interactions with Jason, her precipitous departures and reappearances, and the couple’s volatile relationship had an impact on their son. Dennis did not talk to Jason about his mother’s absence or try to explain some of the erratic and frightening behaviors the child had witnessed. Dennis saw the world in black and white terms with himself as the good parent and Charlene as the bad parent. He believed that the disruptions Charlene caused during Jason’s early years were of little consequence because the child had one good parent.

Dennis considered it the school’s responsibility to provide appropriate services for his son because school personnel had identified the behavioral problems, which Dennis felt he managed well at home. Dennis equated being a competent father with being able to take care of his son on his own. This belief limited his openness to accepting services that would have focused on the difficulties he had managing his son’s behaviors, understanding his child’s emotional and developmental needs, and recognizing his ex-wife’s impact on family life. As Jason’s behaviors continued to deteriorate, Dennis became engaged in increasingly acrimonious struggles with the school. Citing practical considerations such as distance and scheduling difficulties, he discontinued the therapy that could have addressed his parenting issues and offered a broader perspective on his son’s behavioral problems.

Dennis’ case illustrates the need for early and ongoing interventions for fathers who have assumed parenting responsibilities due to the mother’s drug use or other disorder. Such services are essential for the child’s sake, notwithstanding the fact that the father may have neither substance use nor psychiatric problems that would otherwise trigger concerns.

Conclusion

We are still far from adopting a perspective on parents affected by substance use that incorporates men as partners, fathers, and individuals with their own unique life experiences, needs, and hopes even though doing so may contribute to healthier families. By closely examining the fathers of substance-exposed infants during infancy and beyond, we can gain a better understanding of their roles in family life, how fatherhood affects their own development and functioning, and how their presence may serve as risk or protective factors for their children. Even when warranted concerns about paternal risk to children exist, making services available can increase men’s parenting capacities and improve their prospects for fulfilling meaningful roles as fathers and becoming a positive influence in their children’s lives.

Conveying a welcoming attitude and openness to fathers' strengths and needs is a first step in increasing men's involvement in services. Parke's (1996) observation that paternal involvement only will increase when men are provided with the cultural scaffolding to support them as important figures in their children's lives is highly relevant to work with fathers of substance-affected infants and children. In the absence of clearly articulated, positive expectations, fathers will have little awareness of their impact—positive and negative—on their children's lives. Just as treatment for substance-using women has broadened to include parenting support, similar understandings should be applied to fathers. A more expansive perspective has the potential to yield positive results analogous to the benefits gained when policymakers, researchers, and treatment providers broadened the lenses through which they examined the lives of perinatal substance users.

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Promising Interventions for Strengthening Relationships Between Non-Resident Fathers and Their Children

Sonia C. Velazquez, CSS and Stefanie Vincent, MPP

When the child protection system becomes responsible for the safety, permanency, and well-being of a child, involving the father in services can tip the balance in the system's ability to successfully execute the treatment plan and attain desired goals. However, very little meaningful engagement occurs between child welfare agencies and fathers. This unfortunate reality has been confirmed by the ongoing Federal Child and Family Service Reviews (U.S. Department of Health and Human Services, 2009) and the seminal report, *What About the Dads?* (Malm, Murray, & Geen, 2006).

In 2006, the Children's Bureau responded to this situation by funding the American Humane Association and its partners, the American Bar Association Center on Children and the Law and the National Fatherhood Initiative, to create and administer a National Quality Improvement Center on Non-Resident Fathers and the Child Welfare System (QIC-NRF) for a period of five years. The QIC-NRF mandate is to learn how the

engagement of non-resident fathers (fathers who do not live in the same home as their child) might impact outcomes of their children in the child welfare system; better understand the gaps and barriers related to father involvement; identify best practices for involving non-resident fathers and paternal kin in their children's lives; and disseminate effective methods of father involvement to child welfare agencies. The ultimate goal is to positively impact child safety, permanency, and well-being through enhanced knowledge, services, policies, child welfare training, and coordination across systems.

The QIC-NRF has two phases. Phase One, which ended in 2008, identified sub-themes, knowledge gaps, service gaps, research priorities, and an experimental design. The focus of Phase Two (2008-2011) is to implement the research design in four national sites and to develop a dissemination process to provide the most current information to practitioners, policy makers, administrators, and researchers.

Very little meaningful engagement occurs between child welfare agencies and fathers.

Phase One: Strategies and Findings

Phase One was characterized by three interconnected strategies: 1) a needs assessment and gap analysis based on interactive qualitative methods including interviews, specialized focus groups, multi-disciplinary informational summits, and an expert advisory board; 2) a comprehensive review of social science, legal, programmatic, and research literature, and a review of Child and Family Service Reviews and Program Improvement Plans; and 3) the selection of a research focus as the basis of a request for applications and an overall experimental design. These three methods were created to independently and

inter-dependently support our final selections of pilot projects and assure that our methods of data collection included diverse audiences and approaches.

The QIC-NRF adapted the framework presented in the *What About the Dads* report (2006) to organize the literature review findings around the structural elements of child welfare agency activities related to non-resident fathers: *location, identification, contact, engagement, and interagency collaboration*. Our analysis demonstrated that most gaps and needs concern contact with and engagement of dads.

Specifically, the literature review and qualitative interviews revealed that effective strategies for engaging fathers in the child welfare system are scarce and that child welfare services have been predominantly mother-centered. Approaches to engaging fathers have not generally considered the importance of creating a father-friendly culture, the lack of which operates as a barrier to successful engagement.

Our findings suggest that programs should utilize different approaches for engaging fathers than those used for engaging mothers, taking into account sensitivity to gender and cultural assumptions about gender roles. For successful engagement, fathers must be recognized as equal to mothers in their parental roles and rights. Agencies need to invest as much effort in finding fathers and paternal kin as they do in finding mothers and maternal kin. Agency best practices should also require that both parents (not just the custodial parent) are contacted when problems and the need for decisions arise.

Some of the most revealing information came from the fathers' focus groups. Several participants perceived agency bias, believing that Child Protective Services (CPS) had a tendency to stereotype them as unwilling to participate in the parenting process. This perceived bias exacerbated the tension between fathers and the system and was an obstacle to meaningful engagement. Again, making programs and their related services more gender-specific is a promising way to address this problem. We learned, for instance, that when interacting with male caseworkers, fathers are less defensive because they are not as preoccupied with being perceived negatively or treated unfairly.

Phase One findings shaped and informed the development of an intervention framework focused on experimentation around the elements of contact and engagement. Two distinct practice interventions emerged, spanning policy, protocols, collaboration, workload, training, funding, and other systemic elements. The other elements of identification, location, and collaboration were either included in the experimental design or already in place before agencies could be considered for awards.

Practice Interventions

The rationale for and description of two practice interventions follows.

GENDER-SPECIFIC FIRST CONTACT

Our research indicated that the first contact between the agency and the non-resident father is a unique opportunity to establish the basis for a positive strengths-based relationship free of commonly identified negative assumptions about the father's interest in a relationship with the child. A meaningful first contact between the father and case worker can set the stage for frequent, ongoing, high-quality interactions that ultimately benefit the child. The initial contact is also a time to identify effective strategies that can address concerns expressed by the father.

Alternatively, our review showed that a first contact can be a deterrent, particularly when it is biased, dismissive of the father, deficit-focused, or otherwise unsupportive of the unique role that he can play in the parent-child relationship. It was also noted that not only case workers, but also legal professionals and other agency staff, can express unsupportive attitudes during an initial contact. Therefore, designing an effective gender-sensitive first contact surfaced as a critical element worthy of research. The four pilot sites all utilized males to make the first contact with non-resident fathers.



PEER-LED SOLUTION-FOCUSED INTERVENTION

While many states and jurisdictions have adequate policies, protocols, and professional training in place to support the involvement of non-resident fathers, significant barriers to true engagement remain. A father may be unaware of existing resources or unable to overcome internal barriers to engagement, such as low self-worth or frustrations about aspects of his life. The literature review and qualitative interviews revealed that a father's feeling of low self-worth was a barrier to initiating work with agencies. In addition, once a father agrees to involvement, a negative interaction with the system will only add to already existing frustrations, which can grow rapidly and cumulatively if the system is unable to engage him. In the absence of support throughout his

interactions with the child welfare and legal systems, the father's long-term positive agency involvement will be in jeopardy, lessening the potential for successful connection with any children he might have in the child welfare system.

Our research also showed that a peer-led group could release and resolve feelings of low self-worth, offer a gender-sensitive model for father participation, provide mutual support, and assist with problem-solving around current and anticipated frustrations.

Thus, to address the challenge of engagement and other issues identified in the needs assessment, we developed a curriculum-based peer-led intervention to be tested by the four pilot sites. Each site has one or two facilitators trained in teaching the model curriculum. We consider the groups to be "peer-led" because the activities and group discussions are largely based upon the needs of the fathers.

The model curriculum is designed to empower fathers by teaching them to take care of themselves, to utilize community resources and other sources of support, and to navigate various systems, including child protective services, the legal/court system, and child support services. Our literature review also found that the key to helping fathers move more successfully through the child welfare system is to identify and address the barriers of employment, education, substance abuse, and parenting (Boston Public Health Commission-Father Friendly Initiative, 2007; McEwen, 2007). Consequently, the model curriculum includes each of these areas. To address health issues, including substance abuse, activities educate dads about healthy living principles, the importance of their health and well-being to their parenting role, and how their health directly affects their children.

The curriculum also includes several sessions with specific exercises dedicated to helping dads strengthen relationships with their children. Dads are taught how to identify and engage in age-appropriate activities that support the parent-child relationship. Throughout the curriculum, men learn what children need from fathers and how they can meet those needs to promote healthy child development and raise youngsters who are caring and responsible.

Phase Two: Implementation, Evaluation, and Dissemination

A competitive Request for Applications (RFA) process led to the selection of four sites to pilot the peer-led model intervention and evaluate child outcomes. The sites, announced in January 2008, are located in El Paso County, Colorado; Marion County, Indiana; Tarrant County, Texas;

and King County, Washington. The projects are fully operative, with project partners sharing information and resources through formal and informal communication vehicles.

Over the next two years, the sites will pilot the model intervention curriculum, as well as two other curricula geared toward attorneys and social workers. Sites will conduct interviews with the fathers at the beginning, middle, and end of the 20-week curriculum to ascertain outcomes. Outcomes will be tracked and evaluated to inform the development and dissemination of knowledge to broad national audiences by means of the World Wide Web, conferences, journals, and other methods. Collectively, the interventions will add to existing knowledge and become the impetus for system change.

The QIC-NRF, its partners, sub-grantees, and other affiliates are committed to discovering the impact of non-resident father involvement on child welfare outcomes. The latest information on the QIC-NRF can be obtained by visiting its website at: <http://www.fatherhoodqic.org/aboutus.shtml>.

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Fathering Capacity of Incarcerated Substance Users

Sharon Johnson, MS and Heather Hull

In September 2003, the United States Department of Education awarded the Georgia Department of Corrections a grant to evaluate a cognitive-behavioral correctional treatment program called Moral Reconciliation Therapy (MRT) in six transitional centers (residential work-release programs to foster reintegration after incarceration). Applied Research Services was hired to conduct the project evaluation. The fourth and final year of the evaluation included a life course component in which comprehensive interviews of one hour or more were conducted with random samples of male and female program participants and offenders in the control group who did not receive MRT programming. The purpose of the interviews, which yielded detailed information on childhood and adult events, was to supplement quantitative data to better understand offending behavior. As stated by Laub and Sampson (2003, p. 59), "Life histories can provide the human voices to counterbalance the wide range of statistical data in criminology and the social sciences at large."

Our study sample was comprised of Georgia offenders who served at least a portion of their prison sentence at a transitional center between March 2004 and June 2006. During the summer of 2007, interviews were completed with 121 participants, most of whom were

either re-incarcerated or under post-release supervision. In the final interview sample, 51 men, with 130 children among them, identified themselves as both a substance abuser and a father. This article describes the life experiences shared by these 51 men and offers insights into the impact of life events on both their perceptions of fatherhood and their ability to be effective parents.

Early Family Life

Most of the substance-abusing fathers in our study lived in an array of dysfunctional family situations. One in ten never lived with a parent but usually resided with a grandparent or other relative throughout childhood. Many lived with single mothers who were incapable of being fully effective parents. Ten percent of mothers were reported to have problems with drug use, and almost one-third of mothers were reported to have alcohol problems. Additionally, 20% of mothers were arrested during the offenders' childhoods.

Fathers were not an integral part of the lives of these men. Over one-third had no relationship with their father; some did not even know the identity of their father. Another third reported having a relationship with their father that they characterized as poor, usually due to paternal substance abuse, criminality, or violent behavior. The remaining one-third said they had a good relationship with their father, although contact between them was usually limited. Most did not reside in the same home with their father. Nor did their fathers serve a primary parental role in their lives. Substance abuse was common among fathers of offenders, with 22% reporting that their father had a drug problem and nearly half reporting alcohol abuse. Criminality was also common, with 61% of fathers having been arrested and over one-third having served time behind bars, some for very long periods of time.



Respondents reported experiencing other family dysfunction during childhood. One in four was the victim of physical abuse (defined as being punished in a way that caused bruises, burns, cuts, or broken bones). Over half (56%) said that they had seen or heard family violence in their home while growing up. Half described their families as either poor or very poor.

Despite their desire to be good fathers (and for some, grandfathers), most lacked the knowledge, ability, and skills for the job.

Adult Experiences

The fathers in this study provided a somewhat bleak picture of their own adult lives and of their ability to be financial providers and positive role models for their children. Two-thirds said they had spent half or more of their life unemployed (not including time in prison). The men told stories of their struggles to find employment, usually blaming their convicted felon status. Anecdotally, most attributed the majority of their unemployment to substance abuse, which interfered with their interest in attaining gainful employment or their ability to maintain it.

All of the fathers defined themselves as addicts and told many stories concerning the impact of substance use on both themselves and their families. Men with primary custody of their children (18%) expressed much guilt over the fact that they chose drugs or alcohol over the well-being of their children. However, they seemed unable to fully comprehend the impact that their substance abuse and incarceration(s) may have had on their offspring. They reflected more on their own sorrow for years lost with their children than on the actual trauma inflicted on them.

The men without primary custody of their children (82%) were frequently nonchalant about the impact of their substance use on their children. Many stressed that it was best that the children did not reside with them

because they were uninterested in parenting or unfit for the job. These men tended to focus more on the negative impact of their substance use on their own parents (their mothers in particular) than on their current spouses or children.

As fathers, 38% said that they were uninvolved in the lives of their children. Some had no contact at all with their children; others had not spoken to them in many months or years. Just under half (46%) said they had limited contact with their children, and 16% said they were actively a part of their children's lives. It was evident that a large proportion of these men had inflated views of their actual participation as fathers. For example, several men who characterized themselves as actively involved in all aspects of their children's lives were incarcerated when interviewed. Some who cited having limited contact with their children believed that they were integrally involved in parenting. Making a phone call encouraging a child to do well in school or sending a birthday card were offered as examples of important fatherly contributions and proof of their active parental participation.

An important observation was the contrast between the men's perception of the impact of poor fathering on them and their perception of the impact of their own poor fathering on their children. When the majority of offenders talked about their own fathers, they expressed much anger and sadness at their father's lack of involvement in their life. They mentioned longing for their father's love, a lifetime of pain over their father's rejection, turning to early substance use to hide their pain and fury, as well as lashing out and getting into trouble in childhood. One in three



cited not having a father figure as one of the primary reasons for his youthful criminality. However, offenders did not make connections between these past wounds and their lack of involvement with and resulting pain for their own children. When interviewers probed further, most offenders dismissed the idea, asserting that their children were stronger than they had been or were better off without their negative influence. Or they just flatly dismissed the possibility of a repeated pattern.

Despite these offenders' lack of participation in hands-on fathering, interviewers repeatedly heard them cite children as one of their biggest motivators for success upon release. The majority desperately wanted to re-connect with their children and to become both a good role model and a meaningful part of their children's lives. The idea of being a "role model" was pervasive in this group, perhaps because so many reported missing a strong male role model growing up. Many equated being a role model for their children as the ultimate sign of success on the outside. What was clear throughout these conversations, though, was that despite their desire to be good fathers (and for some, grandfathers), most lacked the knowledge, ability, and skills for the job. The majority were forthright about this lack of knowledge, while others clung to the belief that they knew all that was needed.

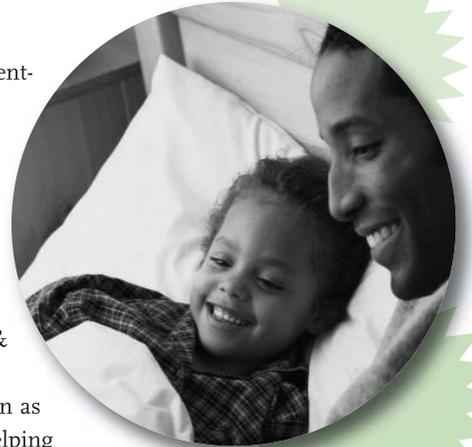
When we look at the lives of these men, it is not difficult to understand why they need parenting skills. Most lacked a strong paternal role model, and some also missed a strong maternal role model. Even with some parenting knowledge, the better part of their adult lives had usually been spent under the influence of drugs and alcohol, which greatly impaired their ability to care for their children and in many cases obliterated their interest in parenting altogether.

As these men served their time in prison, regained sobriety and cognitive functioning, and had time to reflect on their lives, they were able to focus on the future they wanted to create. For most, a strong desire to be a good father emerged. However, the sordid childhoods and adult lives of these men greatly impede their ability to parent, making the need for correctional parenting programs evident.

In addition, we believe that motivational interviewing (MI) techniques could be used to address offender attitudes towards parenting interventions. Nearly all of the addicts interviewed while incarcerated shared a euphoric view of their future outside of prison. Despite personal experiences attesting to the difficulty in maintaining sobriety, obtaining employment, and re-establishing family relationships, the men maintained that "this time" it would be different. While their optimism is admirable, it fails to acknowledge the true challenges faced upon

release. Offenders readily acknowledged that they lacked the skills to be effective fathers, but most believed that as they interacted with their children, fathering would come naturally. Using properly applied evidence-based MI techniques, correctional counselors can hone in on the individual motivations of offenders and then present parenting classes as a way to help them achieve their personal goals. Shown to resolve ambivalence and reduce resistance to interventions (Walters, Clark, Gingerich, & Meltzer, 2007), motivational interviewing can be a valuable complement to parenting programs for offenders.

Research shows that developing supportive parent-child relationships and proper parenting strategies can reduce recidivism among youthful and adult offenders (Bronte-Tinkew, Burkhauser, Erickson, & Metz, 2008; RKC Group & Przybylski, 2008). Many offenders see their children as motivators for success. Helping these men develop needed parenting skills is a critical step in their ability to rebuild family ties and get their lives together. Correctional agencies cannot change the dysfunctional past of these offenders, but parenting classes offer a glimmer of hope that there can be a brighter future for paternal offenders and their children.



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Fatherhood and Recovery

Mark Sanders, LCSW, CADC

Recovery involves making the most of a life that has been rescued from addiction (Kinney, 2002). A primary goal of long-term recovery is learning to have healthy relationships. For chemically dependent men, establishing and repairing relationships with their children is a major recovery task (Kinney, 2002; Kelley & Fals-Stewart, 2002; Larson, 1985).

Children and adolescents are greatly impacted by their father's substance use. Paternal use increases the risk that daughters will experience depression, academic decline, trauma, promiscuity, pregnancy, and substance abuse, while sons will become vulnerable to destructive peer group affiliation, delinquency, crime, emotional distress, academic decline, and substance abuse (McMahon, Winslow, & Rounsaville, 2008; McMahon & Rounsaville, 2002; Sanders & Mayeda, 2008; Cooke, Kelley, Fals-Stewart, & Golden, 2004; Haughland, 2003; Brook et al., 2003; Fals-Stewart, Kelley, Cooke, & Golden, 2003; Parke, 2002).

Depressed men often don't look depressed but instead wear a variety of disguises.

The Challenge

In early recovery, chemically dependent men begin to shift from a primary focus on substance use to repairing damaged relationships, including father/child relationships (Kinney, 2002). In so doing, they confront many core issues that make parenting an ongoing challenge. These issues include:

Father hunger – Many chemically dependent men were abandoned by their fathers, which increases the likelihood that they in turn will abandon their children. Heavy substance use is one method of covering the pain caused by early childhood abandonment (Mayeda & Sanders, 2007).

Father wounds – Many chemically dependent men have been injured by their fathers, whether from physical, verbal, or sexual abuse. Left unaddressed, a history of abuse increases the chances that men will injure their own children—before, during, and after active addiction (Mayeda & Sanders, 2007; Bly, 2004).

Limited role models – Many chemically dependent men report having had limited experience with role models who could exhibit a variety of methods for bonding with their children, other than roughhousing behavior. Without these role models, it is difficult to know how to be a sensitive and caring father. Many men have not experienced firsthand bonding with their fathers. Thus, it is difficult for them to form intimate bonds with their own children (Bly, 2004).

Male depression – Terrence Real, an expert on men's issues and addictions, has identified a type of depression unique to men, which he calls "male depression," the underlying cause of which is early childhood abandonment by fathers (Real, 1997). Depression in men often goes undiagnosed because the great majority do not exhibit classical symptoms of major depression, such as observable apathy and sadness. In fact, women are 50% more likely to be diagnosed with depression than men in

general and six times more likely to be diagnosed with depression than men following the diagnosis of another illness (Substance Abuse and Mental Health Services Administration, 2000; Suicide and Mental Health Association International, 2004). Depressed men often don't look depressed but instead wear a variety of disguises. What Real refers to as "the many masks of male depression" may linger for years into recovery and ultimately impact parenting.

One of the masks described by Real is characterized by the continuum of anger, rage, and violence. Male socialization rarely gives men permission to express vulnerable emotions such as sadness and hurt, which would be normal and expected following father abandonment. Instead, men are taught to hide their vulnerability. Repressed emotions then often emerge in the form of anger, making it difficult for others to suspect that the angry father may actually be depressed. Rage is the end result of anger that has built up over extended periods of time, and violent behavior may be the offshoot of repressed rage. Children may be the targets of their father's anger, rage, and/or violence.

Another mask of male depression is the tendency to push others toward perfection. Sitting in his favorite chair—remote control in hand—a father may bark out orders to his children, leaving them feeling inadequate in themselves and angry towards him. Seeing anger, they are unlikely to suspect his unhappiness. For the father, the mask of anger does not eliminate the physical drain of depression. In truth, a depressed father, lacking the energy to contribute to household matters, pushes others to take over his responsibilities.

Secretly, a father may have feelings of failure as a man, spouse, partner, and parent. The sense of failure can exacerbate depression and increase isolation, including isolation from his kids. Many men respond to feelings of depression and failure by engaging in numbing behaviors, which may include heavy substance use or substituting substance use with process addictions, such as compulsive gambling, overeating, cyberspace addiction, and promiscuity. These behaviors may move him even further away from his children (Real, 1997).

The Good News

When fathers recover, their children can improve emotionally, psychologically, and academically and also become more optimistic (Kelley & Fals-Stewart, 2002; Lowinson, Ruiz, Millman, & Langrod, 2005). In addition, these children can become less anxious and depressed

(Lowinson et al., 2005). Evidence suggests that medical problems among adolescents and children diminish as a result of parental recovery (Kinney, 2002).

Below is a list of suggestions that mental health professionals can use to help men in recovery build and repair relationships with their children.

1. Encourage fathers to seek support from other fathers in recovery (Lowinson et al., 2005). The 12-step literature suggests that the therapeutic value of one addict helping another is unparalleled in successful treatment. This approach may also be valid in helping fathers rebuild relationships with their children that were damaged during active addiction. Additionally, the wisdom of 12-step programming is that it requires a person to take recovery one step at a time—solid advice for fathers during the process of relationship repair.
2. Recommend therapy. Individual and group therapy can help men address issues of early childhood abandonment, which may have triggered their addiction. Therapy may also address the core issues of depression, father hunger, and father wounds.
3. Provide behavioral couples counseling. This evidence-based practice helps couples identify strategies to cope with challenges faced in early recovery, identify obstacles that impede recovery, avoid high-risk situations, prevent relapse, communicate more effectively with each other, and improve their relationship. Behavioral couples counseling has been valuable in increasing recovery rates among parents, which leads to psychosocial improvements in their children and adolescents (Kelley & Fals-Stewart, 2002; Center for Substance Abuse Treatment, 2004).
4. Recommend a parenting course. Many parents find themselves raising children similarly to the way they were raised. Considering how many chemically dependent men have experienced parental abandonment, abuse, and an absence of positive role models, they would be well advised to attend a parenting class. Addiction treatment programs should also routinely offer parenting courses for fathers in recovery, which research suggests is a part of providing gender-responsive treatment for men (McMahon et al., 2008; Lowinson et al., 2005).
5. Organize or refer fathers to weekend retreats. Fathers in recovery can benefit from programs that bring men together on weekend retreats to work on resolving their own father/son issues and identify strategies for being better parents to their own children (Bly, 2004).
6. Encourage fathers to stay sober! This offers men the greatest chance of repairing relationships with children, which also offers the possibility of hope from the children's perspective (Brown, Lewis, & Liotta, 2000).

7. Provide fathers with recovery coaches. Recovery management is an emerging approach in the addiction field that adapts to addiction treatment the long-term treatment model used for other chronic and progressive illnesses, such as cancer and diabetes. Recovery coaches are individuals who themselves are in recovery and have had an extended period of uninterrupted sobriety. They work as paraprofessionals with clients in their natural environments to provide continuous support during treatment and following discharge for tackling the difficult issues of the day, such as repairing relationships with children (White, Kurtz, & Sanders, 2006). Unlike 12-step sponsors who promote one path, recovery coaches are taught to honor the many ways that individuals approach recovery.
8. Discuss expectations. Many fathers in early recovery expect immediate results in rebuilding relationships. It may be helpful to let them know that many years of neglect, anger, and frustration are usually not forgiven immediately. Because this realization may be difficult to handle, it also helps to increase recovery support through the gradual process of repair.

Repairing family relationships is a developmental process. Brown et al. (2000) identifies four developmental phases of family recovery. Most counselors work with clients in the early recovery phase—referred to as the “trauma of early recovery”—which can last three to five years, with numerous ups and downs and crises as the family strives to improve relationships and develop a sober identity. Understanding recovery from a developmental perspective can help recovering fathers develop patience and weather the inevitable disappointments in building connections to their children.

Conclusion

There is a crisis of fatherhood in our society today, as over half of children are being reared without fathers in the home. The cycle of childhood paternal abandonment which accompanies heavy substance use can occur in families across multiple generations. The promise and joy of recovery is that chemically dependent men can do the work of repairing relationships with their children, thus playing an active role in breaking this destructive cycle.

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Project Fatherhood: Fathers as a Solution

Hershel K. Swinger, PhD and Jennifer D. Wishner, PhD

Fathers are a largely untapped resource for supporting healthy child development (Malm, Murray, & Geen, 2006). Despite their tremendous potential, fathers are generally not engaged in programs designed to strengthen at-risk families (Child Abuse and Neglect User Manual Series, 2006; Malm et al., 2006). Some programs are open to father involvement, but in most cases programs do not address the unique perspectives men have as parents or the social stigmas or attitudes associated with their role in child development. Fathers—particularly those from urban and low-income backgrounds—are all too often mistakenly dismissed as disengaged and irrelevant, and as a result no explicit effort is made to involve them in family services.

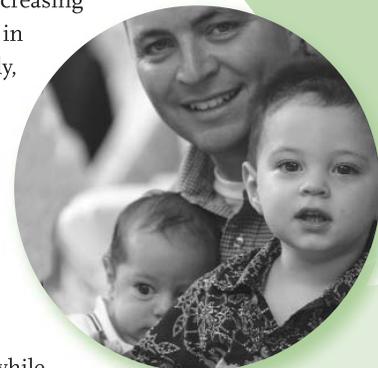
At Project FatherhoodSM, our experience is that most men are eager to participate in raising their children but are often prevented from effectively doing so by poor social and economic conditions, negative cultural and legal biases, and challenges stemming from their life experiences, such as substance abuse, mental health issues, or the absence of a positive male role model. These obstacles create a vicious generational cycle of absentee fatherhood that we believe can be broken by providing services and support that are sensitive to the unique needs of fathers and their children.

The Project Fatherhood Model

In the early 1990s, Children's Institute, Inc. (CII) had a residential shelter for infants and toddlers who had been abused or neglected, often related to parental substance abuse or prenatal exposure to drugs. Most of these children lived in households with single mothers and had little, if any, contact with their fathers before they arrived at the shelter. CII reached out to the fathers and began the process of engaging them in the lives of their children. In time, many of these men wanted custody of

their children, but most were denied due to the legal system's concerns about single fathering absent professional involvement and support. In 1996, CII created Project Fatherhood to address these concerns and help the fathers gain custody of their children.

From the beginning, the goal of Project Fatherhood was to support child development by increasing the positive involvement of fathers in parenting their children. Specifically, the project aims to decrease physical and emotional father absence; ensure that fathers are emotionally and financially supportive parents; and help fathers focus on the child's needs as the top priority. We believe that all fathers can and do love their children and want the best for them. However, while fatherhood itself is a near universal experience for men, the experiences, knowledge, and skills that fathers bring to parenting vary dramatically. Project Fatherhood supports and empowers fathers by encouraging them to honestly address the core issues of their lives, which may include substance abuse, failed relationships, or a childhood history of abuse and/or neglect. By engaging these issues, fathers can then build their parenting skills and begin to play a critical role in supporting their children's healthy emotional, cognitive, and physical development.



Components of the Model

The Project Fatherhood model includes three core components: the Men in Relationships GroupSM (MIRG), the Children's Group, and vocational support. Project Fatherhood also strives to address family needs by providing additional, individualized services, such as one-on-one therapy or family enrichment activities.

* **Men in Relationships Groups (MIRG).** This is the heart of the Project Fatherhood model. The purpose of these groups is to provide a supportive, therapeutic environment in which fathers can address traumatic experiences in their past, understand how their personal history may impact parenting, and build skills that promote positive, responsible fatherhood. To achieve these goals, the MIRG curriculum focuses on four key areas: self-esteem, social and psychological isolation, internal and external stressors, and intergenerational factors. We believe that men cannot fully embrace the role of a parent until they have addressed each of these four areas and developed an understanding of how each has the potential to positively and negatively impact their parenting and other relationships.

Similar to Alcoholics Anonymous, MIRG involves a long-term, open-ended group process. Fathers progress through five stages: Intake, Rapport and Trust, Symptom Relief, Behavior Change, and Internalization and Commitment. On average, fathers move through all five stages in 12 months, but there is significant variation depending on the individual. As fathers advance through the stages, they may be asked to take on additional responsibilities in the group, such as mentoring newer members or co-leading sessions with the Master's level clinicians who facilitate the groups. The expectation is that all fathers make a lifelong commitment to the positive, responsible parenting of their children.

Project Fatherhood is based on a family systems approach, which means that the group process is critical to the program. The MIRG model emphasizes the role of fathers and their psychosocial health in the context of relationships. Group participants learn skills for understanding and negotiating relationships that they can then apply with their children and partners. The group process is also critical in helping fathers maintain their sobriety. By immersing fathers in an environment that is incompatible with drug use, they learn to meet their social needs in a healthy, responsible way.

The powerful stigma associated with men seeking services creates an obstacle to recruitment.

* **The Children's Group.** While many other fatherhood programs focus on the fathers' needs in the hope that improved functioning will indirectly impact the child, Project Fatherhood immediately and directly addresses the needs of children through the Children's Group. After joining Project Fatherhood, children are screened for psychosocial issues that may require referrals for additional assessment or treatment. Next, children join the ongoing Children's Group, which runs concurrent with the MIRG Groups. Children participate in a variety of activities—including art, yoga, and other enrichment activities—designed to support all aspects of child development, with particular emphasis on social-emotional development and building a developmentally appropriate emotional vocabulary. These groups serve as an interim scaffold to support the child's development while the father addresses his own issues and builds parenting skills that will become the lifelong support for the child.

* **Vocational Support.** Project Fatherhood emphasizes the importance of children seeing their fathers as a financial support (Hawkins, Catalano, & Miller, 1992). Therefore, ensuring that fathers are gainfully employed and able to provide for their family is a significant component of the intervention. Job search and vocational readiness training activities range from information and referral offered by Project Fatherhood participants to more intensive support from program staff, either through a structured Job Club (Azrin, 1980) or a financial literacy course.

Building Support for Project Fatherhood



The most significant challenge experienced by Project Fatherhood has been changing attitudes about fathers and their role in supporting child development. Because neither service providers nor the community expect father involvement, both referring agencies and the men themselves often feel that only fathers who need “treatment” should participate in our program. The powerful stigma associated with men seeking services creates an obstacle to recruitment.

To address this challenge, Project Fatherhood utilizes two approaches: involving program participants in outreach efforts, and training community partners in the program model. Project Fatherhood participants are often the best advocates for the program. Once engaged, they quickly realize that the program goal is to help them be responsible,

positive fathers to their children. They are then able to directly address any concerns of interested and new participants and can also normalize for them the experience of struggling with parenthood.

Sharing the experience of Project Fatherhood has also been effective in building a base of referring agencies. Project Fatherhood regularly conducts five-day Training Institutes on the program model to create community awareness of the unique benefits of father involvement and the value of fatherhood services. During the training, participants learn about the program model and also engage in a group process that closely parallels the Project Fatherhood experience. Subsequently, trainees are more likely to refer fathers to Project Fatherhood, and a significant number of them also develop Project Fatherhood groups at their own organization. To date, more than 150 social service professionals representing more than 90 organizations have participated in the trainings.

The Impact of Project Fatherhood

In the past 12 years, over 7,000 fathers and their families have participated in Project Fatherhood activities. Our primary indicator of success is the number of fathers who are involved in raising their children. To date, over 90% of participating fathers have visitation with their children. We are currently in the process of conducting an outcome evaluation of Project Fatherhood and look forward to sharing results of this study at a future date.

The Future of Project Fatherhood

Our vision is for Project Fatherhood to be available to all fathers in need of support, regardless of socioeconomic status, ethnicity, language, or location. This goal is best described by Project Fatherhood's founder, Dr. Hershel Swinger: "Imagine if the program were like McDonald's—a facility on every corner for fathers to avail themselves of, should the need arise."

Project Fatherhood was therefore designed to be replicated by other organizations, ranging from large, multi-site social service organizations to small community-based agencies. In support of this mission, Project Fatherhood received a grant from the federal government's Administration for Children and Families to provide small grants to community-based agencies, including faith-based agencies, to replicate the program with their constituencies. The project has been a

tremendous success with more than 20 agencies in the Los Angeles area that have launched their own groups under this new funding stream. Through these groups, Project Fatherhood has become available to a broad range of populations, including Latino, Cambodian, and indigenous families, fathers with special needs, and families in faith-based communities.

Our aim is to continue to spread awareness of fatherhood issues and rally communities to increase the availability of fatherhood services. We envision a network of family support resources and services that are seamlessly integrated into the community, rather than a separate and stigmatizing place where only families in trouble go to seek help. Through Project Fatherhood services and supports, we believe that men can learn to be engaged in the care and nurture of their children and to break the cycle of absentee fatherhood.

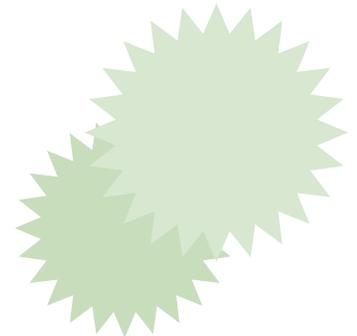
ABOUT CII

Children's Institute, Inc. is one of the nation's premier children's service organizations. For more than a hundred years, CII has helped children and families throughout Los Angeles County recover from the trauma of domestic and community violence. For more information, visit www.childreinsinstitute.org.

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Single Male Caregiver Challenges Following the Mother's Death

Joanne Bobes, MA, LMSW

Overview

During the past 15 years of providing social and legal services to families impacted by HIV and substance abuse, The Family Center (TFC) has typically served households headed by single women. In 2008 we noticed an increase in the number of male clients raising children due to the mother's illness, death, or substance abuse. This new development prompted staff reflection on how best to serve single male caregivers.

Wanting to learn from the men themselves about their needs for and interest in services, we initiated a focus group for them, facilitated by a male peer educator. A meal and party were provided for the families, after which the children went off with a volunteer for structured activities while the men gathered for the focus group. All participants were eager to talk with other men in similar positions. In the group they voiced their concerns, eased their sense of isolation, and learned about the ongoing impact of grief on themselves and their children.

Two of the participants, Chris Walker¹ and Jose Martinez, were already in psychotherapy at TFC when they joined the group. A local hospital had referred them for services immediately after the mother in their respective families had died.

Chris Walker, 33, is the father of a daughter, 4, and a stepson, 8. His wife died from HIV complications after several years of illness. Twenty-four year old Jose Martinez is caring for his two teenage sisters, Marie, 15, and Terri, 17. They had lived with their parents in a homeless shelter for about a decade before losing their father and then their mother to substance-related diseases.

This article opens a window into the first eight months of therapeutic work with two very different families as the men struggle to adapt to their new role of primary caregiver. Written from the therapist's viewpoint,

the article highlights the interplay between the psychodynamic work and concrete, case management tasks during a period of crisis. These complementary interventions have supported the families as they acknowledged the death of a mother, manage emotional and concrete needs, and move towards developing a new family structure. The cases are presented as they have evolved through two therapeutic phases.

Phase 1 - Initial Engagement and Addressing Presenting Problems

Although in many cultures men find it difficult to acknowledge and express their vulnerabilities and needs (Mahalik, Good, & Englar-Carlson, 2003; Wilken & Powell, 1994), engagement was not an issue for Chris and Jose. Both men were open to therapy, motivated by their goal of obtaining support for the family, as well as by the multiple crises they were facing. Given the complex presenting needs, therapy focused on problem solving by accessing formal and informal support for the caregivers and children, while still attending to each individual's emotional needs. A Family Center case manager was closely involved in obtaining appropriate community resources, allowing both families to access a range of concrete and clinical services at TFC and elsewhere.

WALKER FAMILY

Although family therapy was the primary intervention, Chris also agreed to individual sessions. His main presenting problem was bereavement. Struggling with his own grief, Chris readily expressed profound sadness and discussed concerns about insomnia, as well as uncertainty about how to talk with his children about their grief. After reassuring him that we would do this together, the individual sessions focused on normalizing his concerns,

¹ All names of clients mentioned in this article have been changed to protect their identity.

teaching him how to understand and help his children, and encouraging him to express his emotions in therapy, as he had found little comfort in sharing feelings with family and friends. Through our dialogue, he learned the importance of simply being present for the children and of reassuring them about his love and good health. Many children often fear that after one parent dies, the other will follow. He also learned the importance of sharing some of his sadness openly with his children, both in sessions and at home. These private discussions helped Chris become more at ease, while his children engaged in their own therapeutic work during family sessions.

Chris also needed to address some very practical concerns. He felt overwhelmed with responsibilities and wondered how he would balance work and caregiving. While he understood his immediate tasks (i.e., take children to and from school, make dinner, find out when afterschool programming would begin), Chris needed to learn how to prioritize and manage his daily routine. Talking through these concerns during individual sessions helped him make solid decisions and adapt to the new family structure. He also began to focus on obtaining legal custody of his stepson, Tommy, and was appointed a Family Center attorney to prepare him for the process.

Therapy included discussing Chris' ideas about how to help keep his wife's memory alive for himself and his children, along with his fears that doing so might retraumatize them. With my encouragement, Chris began to introduce activities and discussions with the children focused on reminiscing about Mom, both at home and in family therapy sessions. One day we used a Scrabble board to spell out all family names, metaphorically connecting the family members. This method can be effectively used as a healing resource to memorialize family names (McGoldrick, 2005, p. 63). Chris also planned to frame a number of his wife's photographs to hang in their home to keep her presence alive for the children. Father and children shared tender feelings of grief as they began to accept their loss while holding onto memories. Chris started taking the children for monthly visits to their mother's gravesite where Tommy would talk to his mom, a practice that seemed to help him talk about her at home and in therapy. These developments reflected Chris's increased confidence in comforting his children.

MARTINEZ FAMILY

The Martinez family structure and living situation, and therefore their presenting problems, were quite different. Jose had initially requested bereavement counseling for himself and his sisters but during the first few family sessions became preoccupied with obtaining legal

guardianship of his sisters. He was quickly referred to a TFC attorney who helped him initiate the process. He was then prepared to engage in counseling. We decided to start with family sessions based on the siblings' closeness in age and developmental stage, their similar relationships to and memories of their parents, and the need for a quick and dramatic change to the family structure.

The first few sessions took place in the shelter, a bleak apartment where a broken smoke detector buzzed loudly every 30 seconds. Jose was focused on the legal issues and his sisters did not participate readily in conversation. After Jose met with his attorney at The Family Center, he encouraged his sisters to have sessions there instead of at the shelter where the siblings had watched their parents deteriorate. In TFC's cozy family room, the family seemed more at ease. Marie and Terri began to open up, and each sibling began to share intimate feelings of missing their mother.

The collaborative relationship began to take hold as they invited me as therapist to "join" them. I was an active member who structured the work while conveying the belief that they possessed the power, strength, and resources to facilitate change (Bobes & Rothman, 2002, p. 54). Our alliance was strengthened as I supported them to begin sharing more intimate details of their family history, relationships, and upbringing. Although they remembered their parents drinking at home, they also recalled their father making sure that they had food to eat and telling them to be there for one another. In spite of difficult childhood circumstances, they revealed resilience and commitment to one another. Still, they were in shock as newly abandoned children and required significant guidance, especially around learning to communicate openly with each other.

With the guardianship process underway, finding permanent housing emerged as the next salient issue that Jose wanted to address. As the family contemplated leaving the shelter that they had entered with their parents, they revisited their loss. The impending move amplified the inescapable fact that their family was forever changed. The siblings talked about how "dead" it felt in their current shelter apartment without Mom and wondered how to keep her memory alive in another place. Recalling the stuffed animals their mother loved, they resolved to take her favorites with them, symbolically bringing Mom with them to their new home.

As their mother's death was echoed by the formal change in guardianship and housing, the girls began to act out their feelings of grief. Jose's youngest sister, Marie, started to miss school and talk back to and even curse her teachers when she felt she wasn't heard. This was one of the first times that Jose's parental role was put to the test. He was quick to address Marie's behavior, expressing concern but also clearly stating his expectations. When the school

asked her to attend an anger management class, Jose successfully encouraged her to follow through. Therapy offered her a place to vent and feel heard and opened up a discussion among the siblings about their need for respectful listening among themselves and with their teachers and other authority figures.

Phase 2 – Reorganizing into a New Family Structure

Phase 2 is still in process for both families. The most pressing concrete needs (i.e. housing and guardianship) have been addressed and the families have successfully accessed other formal and informal supports, including neighborhood-based preventative service programs. The focus has turned to fortifying the new family structure. This phase of the work can be quite lengthy, lasting from months to years, as both the grief process and evolution into a new family system have their own extended timetables.

In individual therapy, Chris Walker has begun exploring his desire for female companionship. He has voiced mixed feelings, including concern about the timing and meaning for his children. We agreed that individual work with the children would be the most beneficial next step, offering them a safe environment to explore feelings when Chris is ready to initiate a new relationship. He continues to investigate his ambivalence while staying attuned to his children's needs.

In addition to the family sessions, Jose Martinez is engaged in individual therapy where he has explored his feelings as a single male caregiver. He has also reflected on the strong connection that developed with his mother during her last year of life. This positive memory is supporting him as he continues to adapt to his fathering role. Jose has also enrolled in a parenting class, which he was referred to by the Administration for Child Services. Both his steadfast determination to be a good parent and the willingness of all siblings to engage in open, direct, empathic communication have been instrumental to this family's evolution (Greeff & Human, 2004).

Neither family has yet processed the death of a mother from a stigmatized illness, or examined its impact on their upbringing, family life, and relationships. Chris has only briefly mentioned an interest in doing related HIV community work. Similarly, while the Martinez siblings have acknowledged their parents' substance abuse and alcoholism, it is likely that the illness and associated stigma will only be discussed in the future when their lives are more stable and they can reflect on the past.

Further Consideration

Single male parenting is not unusual in the 21st century. Still, single men who are thrust into a parental role following the death of a mother are presented with a unique set of circumstances and challenges. Working with these men and their children has raised numerous questions:

How do men who have had minor or negligible roles as caregivers in the past learn to take on the "mothering" role for children?

What do single male caregivers need from mental health professionals and from their social networks to help them adapt to this new role and identity?

How can children be best helped in transitioning to a single male caregiver following the loss of a mother?

The Family Center staff has found that a combination of psychotherapy and supportive case management resources can bolster the father or father surrogate and begin to meet these families' needs. The agency is also launching a weekly support group program for single male caregivers that is intended to provide help and encouragement and is considering additional therapeutic programs to assist single male caregivers and their children.

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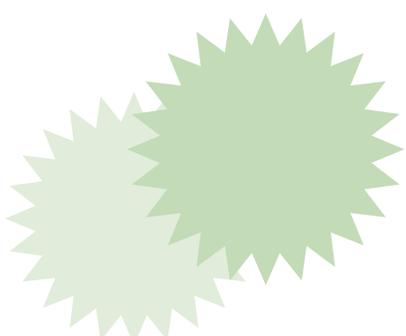
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**Brief
Report**

The Death of a Child: Bereaved Fathers at Risk for Depression

Lori Wiener, PhD and Haven Battles, PhD

Losing a child is a devastating experience for any parent. Losing a child to HIV/AIDS is often complicated by stigma, secrecy around the diagnosis, and guilt. A bereavement study was designed to examine the variables that affect the adaptation of family members who survive a child's AIDS-related death. All primary caregivers whose child had died within the preceding five years were invited to participate. Forty-eight parents from 38 families enrolled and completed two questionnaires through the mail. The first questionnaire obtained information about the parent(s) and about the child's illness and death. The second questionnaire was a multidimensional self-report inventory (SCL-90-R) designed to measure symptomatic distress.

All parents described their relationship with their child within the months prior to his/her death as very close (92%) or close (8%). Forty-two percent of caregivers reported that they openly discussed the impending death with their child, 29% reported that they did not, and another 29% felt that their child was too young to have that type of discussion. Sixty percent of caregivers indicated that the communication with their child about his/her death is something they still think about.

When compared to a sample of parents who had not lost a child, our sample of bereaved caregivers scored significantly higher on all dimensions of the SCL-90-R except for phobic anxiety. Age and gender of the child, parental HIV status, age of caregiver, and length of time since the child died had no significant effect on their scores for symptomatic distress. Significant differences were found on two subscales of the SCL-90-R in terms of the caregivers' relationship to the child. Biological mothers scored highest on the obsessive-compulsive subscale whereas biological fathers scored highest on depression. Differences in caregiver scores on the depression subscale were also found in relation to the number of months since their child's death. Depression scores for both mothers and fathers

were highest at 3 months, followed by 6 and 24, with the lowest scores reported at 9 and 18 months.

Gender differences do exist in bereavement (Stroebe & Hansson, 1993). Mothers tend to find both expected and new sources of support, while fathers are often less comfortable speaking openly about deep emotional issues, grief, or pain (Levang, 1998). When grief is internalized, anguish and depression become less visible. Considering the risk for depression, clinicians working with bereaved fathers need to take a comprehensive history including early losses, perceived support, relationship with the deceased child and his or her mother, and concurrent stresses as each can weigh heavily on the grieving process. Follow-up assessments, supplemented with appropriate services, should be performed several times a year, particularly around holidays, the child's birthday, and the anniversary of the child's death. Paying attention to the father's experience and needs is a powerful way for providers to communicate that the deceased child is remembered and that the father's grief has also not been forgotten.



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Telephone Support Groups for Fathers Parenting HIV-Infected Children

Lori Wiener, PhD, Cynthia Fair, LCSW, DrPH,
and Haven Battles, PhD

Fathers today have taken on a more visible role in caring for their children. Despite the current high divorce rate and growing number of unmarried mothers (Munson & Sutton, 2006; Hoyert, Mathews, Menacker, Strobino, & Guyer, 2006), many men want increased involvement in their children's lives. However, the literature on parenting a child with a chronic or life-threatening illness focuses primarily on the maternal experience. Most often, it is the mother who attends medical appointments. Consequently, medical practitioners are more likely to have relationships with the mother than with the father (Coffey, 2006). Because fathers have been underrepresented in pediatric studies (Phares, Lopez, Fields, Kamboukos, & Duhig, 2005; Seagull, 2000), their experiences, needs, and concerns are not well known.

A growing interest has been noted in the role of fathers whose children have been diagnosed with a chronic illness, particularly cancer. Recent studies show that fathers of children living with cancer experience less post-traumatic stress symptoms (Bruce, 2006), less depression, and better quality of life than mothers (Norberg, Lindblad, & Boman, 2006; von Essen, Sjoden, & Mattsson, 2004). A dearth of literature or scientific inquiry exists, however, concerning the effects of a child's

HIV diagnosis and treatment on fathers (Bachanas et al., 2001; Wiener, Vasquez, & Battles, 2001). This is unfortunate as understanding fathers' perspectives and needs is crucial to creating and providing interventions that can help their children cope with the demands of serious illness and attendant losses.

As most HIV-infected children come from single-mother headed households that are frequently challenged by poverty, substance use, and multiple mental and physical health problems (Mellins et al., 2002), these children commonly shift between family caregivers or foster homes. Still, some children are fortunate to have fathers interested, willing, and motivated to assume the parental role (Strug & Burr, 2003). This article will briefly address what is known about the psychological experiences of fathers caring for an infected child. Additionally, the strengths and limitations of telephone support groups, an intervention that has been found to be of assistance for such fathers, will be discussed.

Two studies designed to explore the psychosocial adjustment, parenting stress, and identified needs associated with fathering a child with HIV infection were identified. The first found that fathers experience heightened psychological distress and also suffer from stress in their parenting roles (Wiener et al., 2001). The results of this study spoke clearly to a need for health care and social service providers to be cognizant of the paternal adjustment process and to make timely interventions. The second study by Strug and Burr (2003) found that men who have caregiving responsibilities for HIV-infected children often have difficulty accessing traditional services since many work during clinic hours. These findings further suggest that clinicians need to develop creative approaches to supporting fathers who may be hesitant or unable to access more traditional forms of psychosocial support, such as face-to-face individual or group counseling.

One intervention that can be useful with difficult-to-access populations is the telephone support group. The

Men who have caregiving responsibilities for HIV-infected children often have difficulty accessing traditional services.

telephone has been used in a variety of clinical contexts including crisis intervention (e.g. suicide prevention hot-lines), counseling (Mohr, Vella, Hart, Heckman, & Simon, 2008), treatment follow-up (Mensingher, Lynch, TenHave, & McKay, 2007), and support groups (Wiener, DuPont-Spencer, Davidson, & Fair, 1993; Nokes, Chew, & Altman, 2003). The telephone is a particularly attractive clinical tool since telephones are widely available and do not require clients to travel to a specific site for services. Individuals who live in rural areas with limited transportation or who have restricted physical mobility can benefit from in-home access to support (Lieberman et al, 2003). With the widespread use of cell phones, it is even possible for participants to “take the group with them” as they go about their daily activities.

Telephone groups can also afford participants more anonymity than face-to-face groups. This can be particularly important for men who are more reticent to share their vulnerability or when group members are dealing with potentially stigmatizing illnesses such as HIV or sensitive topics like sexual orientation (Wiener et al., 1993). With concerns over confidentiality and disclosure still important issues in families affected by HIV (Bogart et al., 2008), telephone groups may be less threatening than in-person groups.

In addition to accessibility and anonymity, research suggests that telephone support groups are effective in addressing the needs of a wide variety of client populations. Much of this literature focuses on the intersection between health concerns and the need for social support. For example, research indicates that women with metastatic breast cancer showed improved well-being and a reduction in negative emotions following participation in a telephone support group (O'Brien, Harris, King, & O'Brien, 2008). Nokes, Chew, and Altman (2003) found that a telephone group for HIV-positive individuals 50 years and over provided participants the opportunity to share concerns regarding symptom management, medication use, and coping with loss. Finlayson (2005) used a telephone support group with adults living with Multiple Sclerosis to teach strategies designed to combat fatigue.

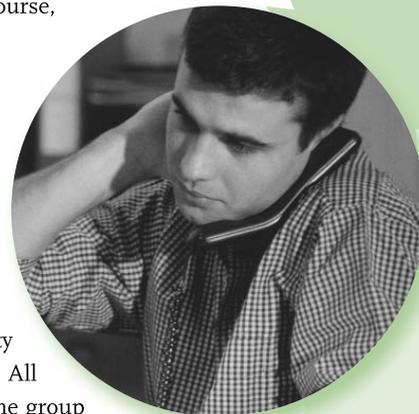
In general, research on telephone support groups indicates positive outcomes for participants. However, several challenges were noted. First, it is not possible to interpret or address nonverbal cues (Nokes et al., 2003), making it difficult to assess the level of engagement of less talkative group members. Second, the benefit of providing services within the daily context of clients' lives—a clear advantage of telephone support groups—is also a drawback. Participants do not have the same level of privacy when on the phone at home or at work. Additionally, anyone who has tried to hold a phone conversation with

children around knows the high likelihood of interruption. Telephone group participants may be less able to focus on the conversation and feel less comfortable speaking freely since others may overhear their conversation.

Telephone Support Groups for Fathers of Children with HIV

Battles, Wiener, Lewis, Patel, and Middleton-Grant (2003) describe a telephone support group conducted in 1996 for non-HIV-infected fathers of HIV-infected children. This group brought together individuals who were geographically diverse and whose children were receiving treatment at the National Institutes of Health. Themes covered during the group included diagnosis disclosure, coping, relationship issues, stigma, anxiety around the uncertainty of their child's or partner's disease course, medical care, and losses.

Members felt the group increased not only their feeling of social support, but their knowledge of sources of concrete support. Fathers reported that the most positive aspects of the group were the common bond they all shared and the opportunity to talk freely with each other. All of the participants believed the group to be a valuable resource and would recommend it to others. These findings suggest that the telephone support group is a cost-effective intervention that provides support to people who are either geographically distanced from each other or who are not emotionally ready to participate in a face-to-face group.



Future Directions

Attention to the perspectives, needs, strengths, and stresses of fathers who are parenting a child infected with, or affected by, HIV is critical. As we now understand, most of these fathers have inadequate support, are overwhelmed with the tasks of providing emotional, medical, and financial assistance to their children, and have limited time to access psychosocial services during traditional hours of operation or attend face-to-face community-based support groups. They may not know how to access guidance, mental health counseling, childcare,

or financial planning and can find talking to daughters about issues associated with puberty, sex, and prevention particularly challenging.

When tailoring therapeutic interventions to the specific challenges faced by these men, clinicians should consider alternative models of service delivery such as providing in-home services or care at work sites, scheduling evening/weekend hours for counseling or groups, utilizing additional male staff members, and/or offering telephone-based interventions (Bonhomme, 2007). The telephone support group is one method of addressing fathers' limited support networks. It can provide a safe and accessible means of connecting isolated men who are faced with the demanding responsibility of raising an HIV-infected child. With increasing access to new computer technologies, similar services can be developed through online video groups, where fathers can network from their homes with professionals and other men around the world facing similar challenges.

We recognize that each father's social history, health status, adaptation to the loss of the child's mother, and ability to reach out for support will vary, as will the emotional and physical functioning of their children (Manne et al., 1995). Understanding the challenges these men face is essential if evidenced-based interventions are to be created. However, this will only occur when clinicians and researchers become more inclusive of fathers in both program and study designs.

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Good Bets



Videos

The Dad Difference: Raising Children Birth to Five

A research-based series that motivates fathers to become more connected with their children from pregnancy on and helps them develop parental confidence and skills. Features real dads, candid comments, and practical tips. Cost: \$249.85 (2 Volume Set), \$149.95 (Individual Volume).

InJoy Birth & Parenting Videos, Inc. (2004). 7107 La Vista Place, Longmont, CO 80503. Ph: 800-326-2082 Ext. 2. www.injoyvideos.com.

InsideOut Dad™

A fathers' reentry program standardized in over 10 states, providing practical and innovative ways to help incarcerated fathers overcome physical and psychological challenges while incarcerated and after release, connect to their families, and break the cycle of recidivism. Can be customized for a wide variety of correctional and pre-release facilities. Cost: \$400.00.

National Fatherhood Initiative (2005). 101 Lake Forest Boulevard, Suite 360, Gaithersburg, Maryland 20877. Ph: (301) 948-0599. www.fatherhood.org.

Meth Inside Out

A video-based treatment curriculum (three-part series) on methamphetamine addiction and recovery for meth users, their families, and treating professionals. Includes a comprehensive understanding of the global methamphetamine problem, how methamphetamine affects the brain and behavior, various treatments for addiction, and concrete tools for recovery. Cost: \$950 for 3 DVDs and 3 handbooks.

UCLA Integrated Substance Abuse Programs and Eyes of the World Media Group (2008). Eyes of the World Media Group, 10825 Washington Blvd. Culver City, CA 90232. Ph: 310-876-3686. www.methinsideout.com.

Young Fathers Video and Workshop Guide

An award-winning documentary highlighting the circumstances of many low-income fathers, including those who have been involved with the criminal justice system, through intimate portraits of two young men and their relationships with their children. The two-disc package includes discussion guides and lesson plans appropriate for a range of settings and audiences. Cost: \$59.00.

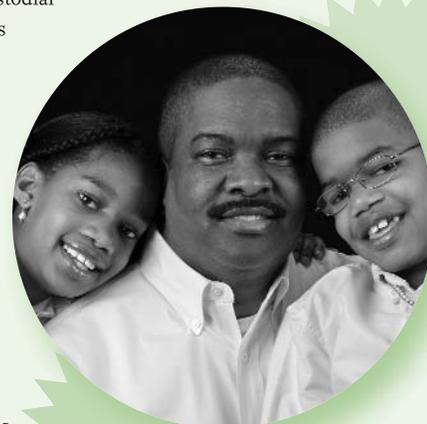
Public/Private Ventures (2007). 2000 Market Street, Suite 600, Philadelphia, PA 19103. Ph: 215-557-4411. www.ppv.org/ppv.

Books, Guides, and Reports

The Best Kept Secret: Single Black Fathers

A qualitative study presenting dynamic interviews and case studies that explore the parenting experience of single, African American custodial fathers who discuss motivations for taking custody of their children, their roles as parents, hopes for their children, socializing children in a diverse society, and the benefits of parenting for them personally. Includes recommendations of policy changes to improve the situations for children and their often-unseen fathers. Cost: \$34.95.

R. Coles (2009). Rowman & Littlefield Publishers, Inc., 4501 Forbes Blvd., Suite 200, Lanham MD 20706. Ph: 800-462-6420. www.rowmanlittlefield.com.



Counseling Fathers: Practical, Theoretical, and Cultural Perspectives

A current and comprehensive resource that provides mental health practitioners with a guide for working with fathers, whether parenting issues are central or in the background. Includes a historical overview of the fathering movement, a strength-based approach to working with fathers, a cross-cultural approach to counseling diverse populations, and consideration of specific populations of fathers. Cost: \$34.95.

Edited by C. Oren & D. Oren (2009). Routledge, 7625 Empire Drive, Florence, KY 41042. Ph: 800-634-7064. www.routledge.com.

Families Without Fathers: Fathers, Marriage and Children in American Society

Examines evidence from social and behavioral science, history, and evolutionary biology to identify the reasons behind father desertion and the weakening commitment of fathers to their children, especially in inner cities. Argues that many of our worst individual and social problems, including substance abuse and child poverty, can be directly traced to fathers' lack of involvement in their children's lives, and offers concrete policies and new ideas to help fathers renew their commitments to their marriages and to their children. Cost: \$24.95.

D. Popenoe (2009). Transaction Publishers, 300 McGaw Drive, Raritan Center, Edison, NJ 08837. Ph: 888-999-6778. www.transactionpub.com.

Fulfilling Fatherhood: Experiences from HIV Positive Fathers

A World AIDS Day publication highlighting the sexual lives, dreams, and desires of thirteen HIV positive fathers around the world who have chosen to speak out and live openly with HIV in their communities. Candid personal stories catalyze greater involvement of men in sexual and reproductive health issues and demonstrate the complexity of parenting within the context of HIV/AIDS. Cost: Free download from website.

International Planned Parenthood Federation (IPPF) & Global Network of People Living with HIV (GNP+) (2005). IPPF, 4 Newhams Row, London, SE1 3UZ, UK. Ph: +44-20-7939-8200. <http://www.ippf.org/en/Resources/Reports-reviews/Fulfilling+Fatherhood.htm>.



The Importance of Fathers in the Healthy Development of Children

A manual designed to help Child Protective Services case-workers appreciate the importance of fathers to children and to the case planning and service provision process; understand the issues unique to working with fathers; effectively involve fathers in all aspects of case management; and work successfully with fathers in the wide range of family situations and structures. Cost: Free download from website.

J. Rosenberg & W. B. Wilcox (2006). Office on Child Abuse and Neglect, Children's Bureau/ACYF, 1250 Maryland Avenue, SW, Eighth Floor, Washington, DC 20024. Ph: 800-394-3366. <http://www.childwelfare.gov/pubs/usermanuals/fatherhood/>.

The Night of the Gun: A Reporter Investigates the Darkest Story of his Life. His Own.

A memoir chronicling a man's journey from crack-house regular to regular columnist for *The New York Times*, as well as to custodial father. Built on sixty videotaped interviews, legal and medical records, and three years of reporting, fact-checking the past reveals that the odyssey through addiction, recovery, cancer, and life as a single parent was both harrowing and miraculous. Cost: \$26.00.

D. Carr (2008). Simon & Schuster, Inc., 1230 Avenue of the Americas, New York, NY 10020. Ph: 800-223-2336. www.simonsays.com.

Responsible Fatherhood Spotlight: Fathers and Substance Use

A fact sheet discussing the implications of drug use for fathers and their families, especially for young, less educated, unmarried men in minority groups. Cost: Free download from website.

National Responsible Fatherhood Clearinghouse (2007). 101 Lake Forest Boulevard, Suite 360, Gaithersburg, MD 20877. Ph: 877-4DAD411. <http://www.fatherhood.gov/documents/nrfcspotlightfathersa.pdf>.

Ten Key Findings from Responsible Fatherhood Initiatives

A brief presenting key evaluative lessons from several important responsible fatherhood initiatives that were developed and implemented during the 1990s and early 2000s to improve the economic status of low-income nonresident fathers and the financial and emotional support provided to their children. Assesses what has been learned and considers how to build on the early programs' successes and challenges. Cost: Free download from website.

K. Martinson & D. Nightingale (2008). Urban Institute, 2100 M Street, NW, Washington, DC 20037. Ph: 202-833-7200. http://www.urban.org/UploadedPDF/411623_fatherhood_initiatives.pdf.

What about the Dads? Child Welfare Agencies' Efforts to Identify, Locate and Involve Nonresident Fathers, & More about the Dads: Exploring Associations Between Nonresident Father Involvement and Child Welfare Case Outcomes

Two studies examining child welfare practices with respect to involving fathers of children in foster care. Original study findings provide empirical evidence on steps child welfare agencies currently take to identify, locate, and involve nonresident fathers in case planning; the barriers encountered; and the policies and practices that affect involvement. The subsequent study examines the relationship between father involvement and case outcomes. Cost: Free downloads from website.

K. Malm, J. Murray, & R. Geen (2006) & K. Malm, E. Zielewski, & H. Chen (2008). Urban Institute, 2100 M Street, NW, Washington, DC 20037. Ph: 202-833-7200.
<http://aspe.hhs.gov/hsp/06/CW-involve-dads/> &
<http://aspe.hhs.gov/hsp/08/moreaboutdads/>.

"What Works" in Fatherhood Programs? Ten Lessons from Evidence-Based Practice

A brief based on the outcomes of several rigorous evaluations of recent fatherhood and parenting programs. Presents preliminary conclusions and identifies 10 common features of "model" fatherhood programs. Cost: Free download from website.

J. Bronte-Tinkew, A. Horowitz, & A. Metz (2008). National Responsible Fatherhood Clearinghouse, 101 Lake Forest Boulevard, Suite 360, Gaithersburg, MD 20877. Ph: 877-4DAD411. <http://www.fatherhood.gov/documents/fatherhoodlunchespracticebriefs.pdf>.

When Boys Become Parents: Adolescent Fatherhood in America

Dispels myths surrounding teenage fatherhood to show that young fathers are often emotionally and physically involved in relationships with their partner and their child but that without adult support and guidance, these relationships often deteriorate in the first year of the child's life. Offers advice for how professionals and policymakers can assist these young men and improve services for them to become more competent and loving parents. Cost: \$32.95.

M. Kiselica (2008). Rutgers University Press, 100 Joyce Kilmer Avenue, Piscataway, NJ 08854-8099. Ph: 732-445-7762.
<http://rutgerspress.rutgers.edu>.

Working with Fathers: A Guide for Everyone Working with Families

A distillation of practitioner experience and insights from the United Kingdom, Europe, Australia, and the United States on engaging individual fathers into family and children's services and ensuring father-inclusive services. Contains a well-developed theoretical argument, key findings from research, and numerous tips and strategies. Complements the *Toolkit for Father-Inclusive Practice* and a range of specialist Fatherhood Institute guides to working with fathers, including fathers in drugs and alcohol services. Cost: £6.95.

Fatherhood Institute (2007). 9 Nevill Street, Abergavenny NP7 5AA, UK. Ph: 0845 634 1328. www.fatherhoodinstitute.org.

Internet Resources

Fathers & Families Coalition of America (FFCA)

<http://azffc.org>

Fathers Network

<http://www.fathersnetwork.org>

Native American Fatherhood & Families Association (NAFFA)

<http://www.nativeamericanfathers.org/>

National Center for Fathering

<http://www.fathers.com>

National Center for Housing and Child Welfare (NCHCW)

<http://www.nchcw.org>

National Fatherhood Initiative

<http://www.fatherhood.org>

National Latino Fatherhood and Family Institute (NLFFI)

<http://www.nlffi.org>

National Partnership for Community Leadership (NPCL)

<http://www.npclstrongfamilies.com>

National Practitioners Network for Fathers and Families, Inc. (NPNFF)

<http://www.npnff.org>

National Quality Improvement Center on Non-Resident Fathers and the Child Welfare System (QIC-NRF)

<http://www.fatherhoodqic.org>

National Responsible Fatherhood Clearinghouse (NRFC)

<http://www.fatherhood.gov>

Promoting Responsible Fatherhood

<http://fatherhood.hhs.gov>

Spanish-Language Child Welfare Resources to Use with Families

Child Welfare Information Gateway

<http://www.childwelfare.gov/spanish>

Supporting Father Involvement Program

<http://supportingfatherinvolvement.org>



Conference Listings

HIV/AIDS 2009: The 21st Annual National Conference on Social Work and HIV/AIDS: "Defining the Future of HIV/AIDS Social Work: What is YOUR Vision?"

A national conference organized by and for AIDS-care social workers with over 120 conference presentations on AIDS social work service delivery contributed by social workers in the field at hospitals, clinics, universities, AIDS service organizations, community-based organizations, and social agencies.

Dates: May 21-24, 2009
Sponsor: Boston College, Graduate School of Social Work
Location: New Orleans, LA; Hotel InterContinental New Orleans
Contact: <http://www.bc.edu/schools/gssw/programs/continuing-education/hiv-aids-conference.html>

The National Summit on the Intersection of Domestic Violence and Child Welfare

With the theme, "From Inspiration to Innovation: Leadership, Partnerships, and Change," provides an opportunity for professionals around the country working on issues related to domestic violence and child welfare (co-occurrence) to share strategies for transforming the way child welfare agencies, domestic violence organizations, courts, other service providers, and communities respond to families in need.

Dates: June 2-4, 2009
Sponsors: The National Council of Juvenile and Family Court Judges and the Family Violence Prevention Fund, in partnership with the U.S. Department of Justice, Office on Violence Against Women
Location: Jackson Hole, WY
Contact: <http://endabuse.org/content/features/detail/1081>

American Humane's 2009 Family Group Decision Making and Other Family Engagement Approaches

An opportunity for communities to gain knowledge from one another about their family engagement approaches, policies, and effectiveness. Provides interactive training on family engagement approaches for entry-level and advanced practitioners, supervisors, and administrators of child welfare programs; professionals in disciplines that are connected with family group decision-making initiatives; and interested researchers, evaluators, and policymakers.

Dates: June 2-5, 2009
Sponsor: American Humane Association
Location: Pittsburgh, PA; The Westin Convention Center
Contact: <http://www.americanhumane.org/protecting-children/conferences-trainings>

One Child, Many Hands: A Multidisciplinary Conference on Child Welfare

Offers four distinct and compelling conference-wide plenary sessions, each designed to address a unique yet timely issue for child welfare workers in challenging times: child welfare in the new administration, risk assessment in child welfare, making your agency legally bulletproof, and the use and abuse of psychotropic medication in foster care.

Dates: June 3-5, 2009
Sponsor: The Field Center for Children's Policy, Practice & Research at the University of Pennsylvania
Location: Philadelphia, PA; Wharton School
Contact: <http://www.sp2.upenn.edu/onechild>

Mental Health America's Centennial Conference: Celebrating the Legacy, Shaping the Future

A premiere gathering bringing together advocates, educators, researchers, health professionals, and business and community leaders as the new Administration and Congress set new health care priorities for the nation. Offers the latest inside information on the role mental health will play in healthcare reform efforts; the evolving opinions of Americans on mental health and health care; new advances and innovations in research and treatment from leading experts; and effective means for changing the face of mental health in the years ahead.

Dates: June 10-13, 2009
Sponsor: Mental Health America
Location: Washington, DC; Hyatt Regency Washington on Capitol Hill
Contact: <http://www.nmha.org/go/conference>

National Association of Drug Court Professionals (NADCP) 15th Annual Training Conference

The largest training conference in the nation to address issues of substance abuse, mental health, child neglect and abuse, and criminality for drug court and other problem solving court professionals from the U.S. and abroad. Provides skill-building training for experienced practitioners; a showcase for best-practice models; a springboard for more responsive public policy; and a catalyst for local, national, and international collaborations.

Dates: June 10-13, 2009
Sponsor: NADCP
Location: Anaheim, CA; Anaheim Marriott and Anaheim Hilton
Contact: <http://www.nadcp.org/annual.html>

The Fifth International Interdisciplinary Conference on Clinical Supervision

An opportunity for a wide range of mental health professionals and educators to meet and learn from each other about theory, practice, research findings, and cross-cutting current issues related to clinical supervision of students and practitioners.

Dates: June 11-13, 2009
Sponsor: University at Buffalo, School of Social Work
Location: Amherst, NY; Buffalo Marriott Niagara
Contact: <http://www.socialwork.buffalo.edu/csconference>

11th Annual International Fatherhood Conference: "Maximizing Father Engagement: Celebrating 100 Years of Father's Day in America"

A gathering to salute and encourage existing fathers, advise and assist new fathers, and re-define what fatherhood means. Fathers at the conference will take a pledge together to work with their families and others to reconnect and reawaken the passion to serve families and communities.

Dates: June 16-19, 2009
Sponsor: National Partnership for Community Leadership (NPCL)
Location: Baltimore, MD; Tremont Plaza Hotel
Contact: <http://www.npclstrongfamilies.com>

17th Annual American Professional Society on the Abuse of Children (APSAC) Colloquium

Fosters professional excellence in the field of child maltreatment by providing interdisciplinary education for professionals in mental health, medicine and nursing, law, law enforcement, education, research, advocacy, child protection services, and allied fields. Addresses all aspects of child maltreatment, including the prevention, assessment, and treatment of victims, perpetrators, and families affected by physical, sexual, and psychological abuse and neglect, and cultural considerations.

Dates: June 17-20, 2009
Sponsor: APSAC
Location: Atlanta, GA; Omni at CNN Center
Contact: <http://www.apsac.org>

Fourth North American Conference on Spirituality and Social Work: "Diverse Faces of Spirituality: Oasis of Empowerment and Tranquility, Crucible of Discrimination and Conflict"

Brings together American, Canadian, and international academics, practitioners, and students to explore the important role spirituality plays in social work practice and education, to exchange scholarship and knowledge, and to stimulate dialogue on spirituality in research, professional education, social work practice, and social action.

Dates: June 18-20, 2009
Sponsor: The Canadian Society for Spirituality and Social Work
Location: Los Angeles, CA; Loyola Marymount University
Contact: <http://w3.stu.ca/stu/sites/spirituality/conference.html>

13th Annual Birth To Three Institute: The Future Is In Our Hands! Celebrating Our Work with Infants, Toddlers, and Families

A meeting to honor and support Early Childhood Professionals by providing knowledge, skills, and collaborative opportunities to help them improve their practice and reach their full potential.

Dates: June 22-25, 2009
Sponsor: Birth To Three Institute
Location: Washington, DC; Marriott Wardman Park Hotel
Contact: <http://www.ehsnrc.org/Activities/BirthToThreeInstitute.htm>

Generations United 15th International Conference: Because We're Stronger Together

Offers the opportunity to learn about state-of-the art intergenerational programs, practices, policies, and research; to network with international, national, and local experts on intergenerational programs; and to share the latest public policy issues and initiatives aimed at positively impacting the lives of individuals of all ages.

Dates: July 27-31, 2009
Sponsor: Generations United
Location: Washington, DC; Hyatt Regency Washington on Capitol Hill
Contact: http://www.gu.org/GU_Co7281494.asp

Foster Family-Based Treatment Association (FFTA) 23rd Annual Conference on Treatment Foster Care

The only North American-based annual conference developed by and for treatment foster care professionals and foster parents. Featuring over 70 workshops, brings together a broad expanse of professionals and treatment foster parents to improve competency and stimulate an exchange of information, best practices, and techniques being used in the field of Treatment Foster Care and related family-based services.

Dates: August 2-5, 2009
Sponsor: FFTA
Location: Atlanta, GA; Hyatt Regency Atlanta
Contact: <http://www.ffa.org/conference/index.html>

35th Annual North American Council on Adoptable Children (NACAC) Conference

The most comprehensive adoption conference in North America, with close to 100 workshops by expert professionals and parents addressing a wide variety of topics: parenting; race, culture, and diversity; therapeutic techniques; agency issues and concerns; parenting children with challenges; search/open adoption; post-adoption services; and international adoption.

Dates: August 13-15, 2009
Sponsor: NACAC
Location: Columbus, OH; Hyatt Regency Columbus
Contact: <http://www.nacac.org/conference/conference.html>

Sowing the Seeds for Recovery 2009 Conference

An addiction-focused meeting with a broad range of workshop topics, including addiction history, co-occurring disorders, current research, clinical techniques, ethics, special populations, professional development, alternative therapies, faith-based approaches, and prevention.

Dates: August 18-22, 2009
Sponsors: The National Association for Addiction Professionals; the Utah Division of Substance Abuse and Mental Health; the Association of Utah Substance Abuse Professional; the National Association for Lesbian, Gay, Bi-Sexual, Transgender & Their Allies; and the Mountain West Addiction Technology Transfer Center
Location: Salt Lake City, UT; Grand and Little America Hotels
Contact: http://naadac.org/index.php?option=com_content&view=article&id=351&Itemid=56

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Contact: FamilyConnections
825 East 53 Street, Bldg E-101
Austin, TX 78751
Phone: 512-478-5725 x217

Early Support for Lifelong Success

Contact: The Family Center
315 West 36th Street, 4th Floor
New York, NY 10018
Phone: 212-766-4522 x144

Family Connection

Contact: Family Resources, Inc.
5180 62nd Avenue, North
Pinellas Park, FL 33781
Phone: 727-298-3910

Family Options III

Contact: FCAN (Families' and Children's AIDS Network)
53 W. Jackson Blvd., Suite 304
Chicago, IL 60604
Phone: 312-786-9255

Family Ties Project

Contact: Consortium for Child Welfare
1438 Rhode Island Avenue, NE
Washington, DC 20018
Phone: 202-547-3349

National Association of Counsel for Children (NACC) 32nd National Juvenile and Family Law Conference

A meeting comprised of general sessions and workshops that are organized along five tracks: Abuse and Neglect, Juvenile Justice, Family Law, Policy Advocacy, and Children's Law Office Program.

Dates: August 19-22, 2009
Sponsor: NACC
Location: New York, NY; New York Marriott at the Brooklyn Bridge
Contact: http://www.naccchildlaw.org/?page=National_Conference

New National Training: "Treating Parents with Co-occurring Disorders: Substance Abuse, Mental Illness, HIV"

Increase knowledge and skills in treating co-occurring disordered clients, particularly focused on families with young children. Expert Dennis C. Daley, PhD, LCSW integrates cutting-edge knowledge from research with evidence-based practices and solid clinical techniques to maximize participants' competence and confidence in working with these challenging and complex problems.

Dates: August 20-21, 2009
Sponsor: National AIA Resource Center
Location: Berkeley, CA; Claremont Resort & Spa
Contact: <http://aia.berkeley.edu/training/CODseminar>

2009 National HIV Prevention Conference

Covering the entire spectrum of HIV prevention, from science to programs, convenes national HIV prevention experts and advocates in government, community, and academia to share effective prevention approaches and research findings and strengthen collaborations between program practitioners and researchers.

Dates: August 23-26, 2009
Sponsor: Center for Disease Control and Prevention (CDC)
Location: Atlanta, Georgia; Hyatt Regency Atlanta Hotel & Atlanta Marriott Marquis
Contact: <http://www.2009nhpc.org>

Healthy Connections for Intact Families

Contact: St. Vincent Mercy Medical Center
2213 Franklin Avenue
Toledo, OH 43620
Phone: 419-251-2453

Helping Hands for Infants and Their Families

Contact: Massachusetts Department of Public Health
250 Washington Street, 5th Floor
Boston, MA 02108
Phone: 617-624-5967

Project Stable Home

Contact: Children's Institute, Inc.
21810 Normandie Avenue
Torrance, CA 90502
Phone: 310-783-4677 x3018

Reflejos Familiares (Family Reflections)

Contact: UNM/CDD FOCUS Program
2300 Menaul Blvd., NE
Albuquerque, NM 87107
Phone: 505-272-0325

Visit the National AIA Resource Center at <http://aia.berkeley.edu>

Website Features

- * Numerous monographs, fact sheets, issue briefs, and other publications—most of which are available for free download in PDF format
- * Archived issues of *The Source* from 1993—present available for download
- * Information about Resource Center trainings and conferences, including our ongoing 2009 teleconference training series
- * Archived proceedings from past Resource Center trainings and conferences, including recordings and handouts
- * Profiles of federally funded Abandoned Infant Assistance (AIA) projects

The site also features extensive information and resources about families affected by HIV and/or substance abuse, including special topics such as:

- * Kinship Care
- * Standby Guardianship and Future Care and Custody Planning
- * Shared Family Care
- * Substance Exposed Newborns
- * Child Welfare

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