Manuscript Information

Journal name:	Family process
NIHMS ID:	NIHMS662897
Manuscript Title:	Fathers for Change for substance use and intimate partner violence: Initial community pilot
Principal Investigator:	Carla Stover (carlastover@usf.edu)
Submitter:	John Wiley And Sons Publishing (wbnih@sps.co.in, vchnih@wiley.com)

Manuscript Files

Type	Fig/Table #	Filename	Size	Uploaded
manuscript		famp_12136_RevCrx_EV.PDF	127437	2015-02-12 06:51:40

Fathers for Change for Substance Use and Intimate Partner Violence: Initial Community Pilot

CARLA SMITH STOVER

The lack of focus on the role of men as fathers within intervention programs for men with histories of Intimate Partner Violence (IPV) or substance abuse is of significant concern given the large numbers of these men who are actively parenting and coparenting children. Fathers for Change is a new intervention designed to fill this gap. Eighteen fathers with co-occurring IPV and substance abuse were randomly assigned to Fathers for Change or Individual Drug Counseling (IDC). They were assessed at baseline, post-intervention and 3 months following the 16-week intervention period. Men in the Fathers for Change group: (1) were more likely to complete treatment; (2) reported significantly greater satisfaction with the program; (3) reported a trend toward less IPV; and (4) exhibited significantly less intrusiveness in coded play interactions with their children following treatment than fathers in the IDC group. Results indicate further evaluation of this intervention in a larger sample is warranted. Limitations and directions for future research are discussed.

Keywords: Fathers; Coparenting; Intimate Partner Violence; Substance Abuse

Fam Proc x:1–10, 2015

Intervention and treatment programs for men with histories of intimate partner violence (IPV) and/or substance abuse rarely focus on the men's fathering and parenting of their children nor do they address the ongoing coparental relationship they will have with the mother of their children. Batterer intervention programs (BIPs) often devote some group session content to the impact of violence on children and substance abuse treatment programs may include discussion of parenting issues, but they are not a major component of treatment. The lack of focus on the role of men as fathers within intervention programs and a dearth of specific parenting or coparenting intervention for men with these co-occurring issues is alarming; especially given that more than 60% of men entering BIP are fathers (Rothman, Mandel, & Silverman, 2007; Salisbury, Henning, & Holdford, 2009). In community samples, more than half of women who experience IPV continue living or having frequent contact with the male perpetrator due to shared children (Hunter & Graham-Bermann, 2013; Israel & Stover, 2009) and many victims report their child is positively attached to their aggressive father (Israel & Stover, 2009).

Contact with fathers can have positive benefits for children who were previously exposed to IPV (Hunter & Graham-Bermann, 2013; Stover, Van Horn, Turner, Cooper, & Lieberman, 2003). Fathers with histories of IPV often continue their presence within the

University of South Florida Tampa, Tampa FL.

Correspondence concerning this article should be addressed to Carla Stover, University of South Florida Tampa, 13301 Bruce B. Downs Blvd., Tampa, FL 33612. E-mail: carlastover@usf.edu.

This study was supported by the National Institute on Drug Abuse (NIDA) K23 DA023334. The author acknowledges Rodney Webb III, MA, for his work on this project and thanks Drs. Thomas McMahon, Caroline Easton, Nancy Suchman, and Steven Marans for their mentorship and guidance throughout the development and execution of the intervention and study.

Family Process, Vol. x, No. x, 2015 © 2015 Family Process Institute
doi: 10.1111/famp.12136

family following IPV incidents and they can play important roles in the lives of their children. They are in the position to coparent their children, but often have limited skills in this area. They lack understanding and skills related to appropriate communication and mutual support that is imperative for a healthy coparenting relationship regardless of the status of the intimate relationship. Implementation of interventions that will allow these men to have healthy and nurturing relationships with their children, while ensuring the safety and important role of the mother, are desperately needed. Fathers for Change (Stover, 2013) was designed to fill this gap. The current study is an initial evaluation of this novel intervention approach.

Very little research has focused on the coparenting relationships of couples with histories of IPV or substance abuse. There is evidence of greater IPV in the coparenting relationships of opioid-dependent men compared to non-drug abusing coparenting couples (Moore, Easton, & McMahon, 2011), and fathers with co-occurring IPV and substance abuse have more negative coparenting relationships (e.g., disagreement about how to parent, lack of communication about parenting) than men from the same community without histories of IPV and substance abuse (Stover, Easton, & McMahon, 2013). Importantly, more negative coparenting, in addition to more negative and less positive parenting behaviors, has been shown to mediate the relationship between having a father with substance abuse and IPV and child behavioral problems indicating all three components are important intervention targets to improve child outcomes.

These studies suggest a focus on the coparenting relationship can have significant benefit for children of parents with histories of IPV and substance abuse—especially for couples experiencing situational couple violence (Stith, Rosen, & Middleton, 2000) occurring in the context of substance abuse (O'Farrell, Murphy, Stephan, Fals-Stewart, & Murphy, 2004)—where couple sessions have been found to be safe and effective. A focus on coparenting is important because positive coparenting even in the context of a conflicted intimate relationship can be protective and result in better child adjustment (Camara & Resnick, 1989; Katz & Low, 2004). Additionally, coparenting has been shown to have a much stronger influence on parenting and child adjustment than other aspects of the couple relationship (Feinberg, 2003; Snyder, Klein, Gdowski, Faulstich, & LaCombe, 1988) and is associated with greater father involvement in high risk families (Waller, 2012). Fathers for Change is the first program to specifically target coparenting in addition to the father–child relationship as part of an intervention for men with co-occurring IPV and substance abuse.

Fathers for Change was developed based on emerging evidence that (1) men who perpetrate family violence but recognize the impact of their violence and interparental conflict on their children can reduce transmission of IPV across generations (Guille, 2004); (2) a significant subset of men with histories of IPV are concerned about the impact of their violence on their children (Rothman et al., 2007); (3) men's concern about the impact of IPV on their children may be a powerful motivating factor for them to seek and remain in treatment (Litton Fox, Sayers, & Bruce, 2001); (4) fatherhood seems to be a particularly salient motivator for men with co-occurring IPV and substance abuse (Mbilinyi et al., 2009); and (5) integration of intervention to target both IPV and substance abuse has been shown to be effective (Easton et al., 2007), suggesting efficacy of coordinated intervention approaches to deal with multi-pronged problems.

Description of Fathers for Change Intervention

Fathers for Change has both individual and coparenting components. It begins as an individual intervention for fathers of children (under 10 years) with a history of IPV, defined as threatened or actual sexual or physical violence against an intimate partner,

and co-occurring substance abuse. The Fathers for Change intervention includes 14 topics delivered in 60-minute sessions of individual and dyadic treatment over approximately 4 months. The intervention combines attachment, family systems, and cognitive behavioral theory with the goals of: (1) cessation of violence and aggression; (2) abstinence from substances; (3) improved coparenting; (4) decreased negative parenting behaviors; and (5) increased positive parenting behaviors.

Following assessment, treatment begins with individual-focused sessions, followed by coparenting-focused sessions and ending with restorative parenting sessions. Coparents are invited to an initial individual session with the therapist when the program begins and again just before the coparent session segment. These sessions are used to help the mother: (1) feel comfortable with the therapist in advance of coparent sessions; (2) understand the program and its goals; (3) be prepared for the coparent sessions; and (4) be able to talk openly with the therapist about her concerns in the relationship and assure it is safe to engage in conjoint sessions. Once it is determined to be safe for conjoint coparent sessions, mothers can participate in up to six sessions with the father. The final phase of restorative parenting includes the father and his child. Mothers are invited to participate in one of these final phase sessions when deemed appropriate and clinically indicated by the therapist.

The areas of focus for each of the three phases of Fathers for Change are: (1) abstinence from aggression and substance abuse; (2) coparenting communication; (3) parenting/father–child relationship. Fathers for Change is unique in its focus on the paternal role throughout treatment, both in terms of the father–child and the coparenting relationships. The central premise is focus on men as fathers and increasing their feelings of competence and meaning within their parenting role will provide motivation to change maladaptive patterns that have led to use of aggression and substances to control negative feelings (Stover, 2013). In the coparenting phase, communication practice is focused on coparenting issues (e.g., visitation exchanges; different views of discipline) but not intimate partner-related issues (e.g., sex, jealousy). Participation of the coparent, while encouraged, always depends on the therapist's assessment of safety and on the mother's own wishes to participate. The restorative parenting sessions are designed to assist fathers in talking with their children about the mistakes they have made and building more positive relationships with their children. These include sessions with the father and child together where he can talk with his child about his past behaviors in an age appropriate way, share some of the coping skills he has learned, see the therapist model appropriate parent management techniques, and engage in child-directed play activities. This study was designed to test initial feasibility and efficacy of Fathers for Change compared to evidence-based substance use treatment.

Procedure

Men were referred to the study by the courts or the Department of Children and Families (DCF) after either an arrest for domestic violence or drug related charges or a call for an investigation to DCF due to these co-occurring issues. Men were screened for eligibility and met in person for informed consent procedures. Thirty-five men were referred to the program and 28 met criteria based on initial phone screening and 24 agreed to participate. Of those, 21 attended the initial research assessment and signed informed consent and two were excluded following further assessment. One was excluded due to a lack of physical violence in the relationship and the other due to the severity of violence (attempted strangulation of partner). Men met the following inclusion criteria: (1) current DSM-IV criteria for substance abuse of alcohol, cocaine, or marijuana with use of that substance within the 30 days prior to screening;

(2) reported physical violence in an intimate relationship (pushing, slapping, kicking) within 90 days prior to screening (based on court/police records or self- report); and (3) biological father of at least one child under the age of 10 with whom they lived or had more than once per month visitation. Each agreed to have their female coparents contacted for participation as collateral informants and to give consent for participation of their shared child. If a participant had more than one child in the age range, the oldest child was the target of assessment and treatment. Information on how to contact female coparents was provided by the court or DCF. They were contacted separately, screened, and asked to participate themselves and to allow participation of their child in the study, and if randomized to Fathers for Change, to attend some sessions of the intervention. All 21 female coparents were reached by the research assistant. Of those who were contacted, all gave permission for their child to participate; however, only 10 agreed to participate in research assessments themselves. Men were excluded if they reported suicidal or psychotic symptoms; had a history of bipolar or psychotic disorders; evidenced significant use of coercive control based on review of police records and an interview with the female coparent; had a history of severe violence (strangulation, use of or threats with a weapon, threats to kill); female coparents reported fear of the father or stated they did not want their child participating in the intervention.

At baseline, fathers and their children's mothers completed a series of questionnaires to assess severity of violence, severity of substance abuse, parenting, psychiatric issues, and the father–child relationship. These assessments were conducted on separate days. Fathers also participated in a play assessment with the target child. Parents were paid $50 for participation in baseline assessments, $60 for posttreatment, and $75 for follow-up. Children received a small toy for their participation in each assessment. Following completion of the baseline assessments, men were randomly assigned to the Fathers for Change condition or Individual Drug Counseling (IDC; Mercer & Woody, 1999). To increase the likelihood that treatment groups were balanced with respect to demographic variables (education of father, ethnicity of father, and residence with target child) and prognostic variables (frequency of recent substance use and severity of recent IPV) subjects were assigned to treatment conditions through urn randomization, using a program where an algorithm modifies ongoing randomization probabilities based on prior composition of treatment groups, and maximizes multivariate equivalence of groups to balance allocation of important prognostic variables in the groups while retaining benefits of random assignment (Wei, 1978).

Defining features of Fathers for Change include: (1) Focus on the fathering role as a motivator for change; (2) Integration of strategies for reducing IPV and substance abuse (SA) in each session; (3) Intergenerational transmission of IPV and SA; (4) communication skills and coparenting; (5) the impact of IPV and SA on child development; and (6) parenting skills (Stover, 2013). IDC focuses on the disease model of addiction and 12-step facilitation. Treatments were delivered in individual and conjoint sessions over 16 weeks. Male participants met weekly with the research assistant to complete self-report assessments of SA, IPV, and parenting behaviors. The research assistants were blind to the participants' treatment conditions. Trained independent coders rated therapy session tapes for treatment fidelity using an adapted version of the *Yale Adherence and Competence Scale-II* (Nuro et al., 2007) for Fathers for Change and the *Adherence-Competence Scale for Individual Drug Counseling* (Barber, Mercer, Krakauer, & Calvo, 1996) for IDC. Following intervention, participants completed a posttreatment assessment and a 3-month follow-up with blinded research assistants. All study procedures were approved by the Yale University Human Investigations Committee.

Measures

The *Addiction Severity Index 5th Edition* (ASI; McLellan, Alterman, Cacciola, Metzger, & O'Brien, 1992) is an interview measure assessing the severity of substance use and problems. The ASI was used to determine frequency of alcohol and drug use in the month prior to randomization. The ASI has been validated as an assessment instrument in a variety of populations and self-reported drug use on the ASI has been shown to be comparable to drug detection by urinalysis (Denis et al., 2012).

The *TimeLine Follow-back-Spousal Violence and TimeLine Follow-back-Substance Use* (TLFB-SV and TLFB-SA; Sobell & Sobell, 1995; Fals-Stewart, Birchler & Kelley, 2003), were administered weekly to assess violence and substance abuse during the course of treatment. This is a reliable and valid instrument that has been used to assess relationship violence over time and links to substance use. Each substance and alcohol was assessed separately for each day in addition to types of physical and psychological violence. The number of days of any substance use and days of violence were summed across the 16 weeks of treatment.

The *Revised Conflict Tactics Scale* (CTS2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) was administered to fathers to obtain a self-report measure of their use of violence in the last year with the mother of the target child. The CTS2 was used to assess the presence and severity of IPV. The CTS2 is the most widely used measure in the research literature on IPV. The measure demonstrated high internal consistency reliability for the current sample ($\alpha = .99$).

The *Coparenting Relationship Scale* (CRS; Feinberg, 2003) was used to document quality of the coparenting relationship. The CRS is a comprehensive self-report measure of the quality of coparenting in a family. It is comprised of 35 items and seven subscales. The coparenting conflict and coparenting undermining were the two scales used for this study.

The *Child Interactive Behavior Rating* (Feldman, 1998) is a rating scale developed to evaluate parents and their children during video-recorded interactions. Tasks developed by Crowell and Feldman (1998) were used in this study. Four tasks were selected based on the child's age. Two that were thought to be developmentally below the child's level and two that were considered advanced were given to each dyad. The aim was to select two tasks that the child could do easily and two that the child would be unable to do independently. Tasks included stacking blocks, shape sorting, ring stacking, stringing beads, and puzzles of various levels. Following 15 minutes of free play with toys, fathers were instructed to introduce the tasks to their children one at a time. They were instructed by the research assistant to put the task in front of the child and encourage the child to complete it.

These interactions were video recorded and coded by two trained coders using the Child Interactive Behavior Coding system. The global rating scheme yields 43 scales (22 adult, 16 child, and 5 dyadic scores) rated on a 5-point scale from 1 (*little*) to 5 (*much*). For the purposes of this study, seven scales were selected based on their theoretical relevance. Three adult (intrusiveness, hostility, and consistency) and four dyadic (tension, reciprocity, fluency, and constriction) scales were examined. The CIB has been used extensively to evaluate parent–child interactions across normal and at-risk samples in both U.S. and international samples (e.g., France, Africa; Feldman, 1998). The CIB has good psychometric properties including construct validity with theoretically related constructs, predictive validity of children's adjustment, and up to 2-year test–retest reliability (Feldman, 1988). Each coder who participated in the study achieved CIB coding reliability by attending a 2-day training with the developer, Ruth Feldman. They coded a set of practice interactions and then a set of 10 reliability interactions. A coder is deemed reliable if they attain .75 or higher with the codes given by the developer. In addition to this training, the two coders

who rated the play interactions for this study double coded 20% of the interactions and attained reliability at .75 or higher.

Participants also completed a modified *Client Satisfaction Questionnaire 8* (Donovan et al., 2002; Larsen et al., 1979) to document their satisfaction with treatment.

RESULTS

Preliminary Analyses

Fathers in the sample were 52% African American, 14% European American, 19% Latino, and 10% Multiethnic, and 5% other ethnicity. Fathers reported a mean age of 30.19 (SD = 6.90). Sixty-two percent of fathers were employed at least part time, and, on average, they had 11.67 (SD = 2.08) years of education. Thirty-three percent of fathers were married. The target child's mean age was 3.05 (SD = 2.78). The treatment groups did not differ on any of the demographic variables. Fathers' reports of their primary drugs of choice were: 57% alcohol, 38.1% cannabis, and 4.8% opiates. Men averaged 4.14 days of alcohol use (range 0–30), 4.78 days of cannabis use (range 0–30), and 3.5 days of polysubstance use in the 30 days prior to the baseline assessment. Because only 10 female coparents completed baseline assessments, with 6 completing postdata, groups were too small for meaningful analysis and only father report data is presented here. Descriptive statistics for study variables are reported in Table 1.

Substance Use Weekly During Treatment

Analysis of variance examined differences in the number of days of substance use over the 16 weeks of treatment as reported on the Timeline Follow-Back. Both groups reduced their substance use during treatment, with 90% of the sample maintaining abstinence throughout. There were no significant differences between groups, $F(1, 18) = .32$, $p = .58$.

Treatment Completion and Satisfaction

Chi-square analysis was used to examine differences in treatment completion rates by group. Those randomized to Fathers for Change were more likely to complete treatment defined as attendance at 13 of 16 sessions (67% vs. 33%, $p = .10$). Analysis of variance revealed Fathers for Change participants had higher mean scores on all satisfaction items with significantly higher scores on the following items: (1) met my treatment needs and (2) helped me deal more effectively with my problems. They reported liking all three phases of the intervention and were particularly positive about the focus on coparenting and their roles as fathers.

TABLE 1

Minimums, Maximums, Means, and Standard Deviations for Study Variables

Variable	Minimum–maximum	Mean (*SD*)
Father physical violence	0–9	1.91 (2.34)
Partner physical violence	0–37	6.19 (8.84)
Parenting aggression	43–60	57.53 (4.12)
Parental Overriding/Intrusiveness	1.0–3.5	2.12 (.93)
Adult Consistency of Style	4–5	4.94 (.24)
Coparenting Undermining	6–29	13.62 (8.00)
Coparenting Exposure to Conflict	23–49	41.29 (8.91)

Repeated Measures Analyses

Results of repeated measures analysis, reported in Table 2, are summarized here.

Intimate partner violence

Repeated measures models examining reports of physical violence revealed men in both groups reported less violence during and following intervention (see Table 1). There was a main effect for time on IPV. Both intervention groups had significantly less violence over time. There was a trend toward greater reductions in violence in the Fathers for Change group. Men's reports of their own and their partners' violence showed a reduction especially for the Fathers for Change group.

Father–child interactions and reports of coparenting

As shown in Table 1, analyses of video-taped interactions of father–child play revealed that men in the Fathers for Change intervention showed significant improvements. Specifically, men who received Fathers for Change showed significantly less intrusiveness during free-play interactions. There was also a trend approaching significance indicating greater consistency of style post-intervention than was seen among men who received IDC. Fathers who received the intervention allowed more child-led activities by less frequently disrupting or redirecting the child's activities or attention (i.e., lacking abrupt changes in affect, tone of voice, level of activity, or parent's interest in the child activity) following the intervention, whereas fathers in the IDC condition did not improve in this area. Analyses did not reveal any significant differences in men's self-reported coparenting experiences/behaviors, either over time or as a result of the intervention.

TABLE 2
Repeated Measures Models

Outcome Measure	LS Mean (*SE*)			df	*F* (Main effect)	*p*	F (Group × Time)	*p*
	Baseline	Post	3 months					
Physical Aggression by Participant								
FFC	2.56 (2.83)	1.33 (1.73)	.44 (.88)	2	3.73	.035	1.23^{+}	.07
IDC	1.67 (2.06)	1.11 (1.69)	1.11 (1.69)					
Physical Aggression by Partner								
FFC	8.89 (11.93)	1.78 (1.86)	1.11 (1.83)	2	3.67	.037	2.417	.10
IDC	5.33 (5.67)	4.56 (6.11)	4.56 (6.11)					
Parental Overriding Intrusiveness								
FFC	2.00 (.97)	1.50 (.81)		1	.875	.365	7.88*	.01
IDC	2.19 (1.00)	2.44 (.94)						
Adult Consistency of Style								
FFC	4.88 (.35)	4.88 (.23)		1	.78	.407	4.24^{+}	.08
IDC	5.00 (.00)	4.88 (.35)						
Coparenting Undermining								
FFC	14.00 (8.76)	14.11 (9.31)	13.67 (9.50)	2	.502	.610	.626	.54
IDC	13.22 (8.60)	10.67 (7.79)	12.11 (9.31)					
Coparenting Conflict								
FFC	39.78 (10.08)	40.33 (10.59)	40.89 (10.58)	2	.649	.534	1.18	.32
IDC	44.33 (6.06)	38.89 (15.93)	38.67 (15.44)					

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

DISCUSSION

The initial randomized pilot of Fathers for Change revealed an intervention well received by clients. Fathers for Change participants were more likely than the comparison IDC participants to complete the program and reported feeling more highly satisfied and better helped by the programming. These completion and satisfaction results were consistent with the previously reported first open pilot of Fathers for Change that enrolled 10 men (Stover, 2013).

Additionally, there were promising initial findings related to reductions in IPV and improved father–child interactions. There were significant reductions in IPV for both groups, which is consistent with prior studies indicating substance abuse treatment can help reduce IPV (O'Farrell, Fals-Stewart, Murphy, & Murphy, 2003). Interestingly, men reported that their partners' aggression reduced as well as their own. Data suggested decreases somewhat larger for men in the Fathers for Change group. These results, achieved despite the small sample, encourage further examination of this model with a larger sample and with longer follow-up.

Men in the Fathers for Change group also showed significantly lower intrusiveness in their interactions with their children following treatment than the IDC group. This was an encouraging finding. The dual focus on what kind of father men wanted to be and the direct work on strategies to improve their relationship with their children through child-directed play and restorative communication sessions appear to have been important ingredients. Fathers reported enjoying the father–child sessions and the opportunity to build their parenting skills and relationship with their children.

By contrast, there were no significant changes in coparenting for either intervention group. This may have owed to the limited number of sessions (an average of 3) focused on this topic during the intervention. Before they could proceed with coparenting sessions, Fathers for Change required men to have engaged successfully in initial components targeting identification of anger triggers and development of better coping skills for managing hostile thinking. As it happened, most men in the Fathers for Change group required more sessions in this component than originally forecast. That is, rather than the planned-for 6–8 individual sessions, followed by six coparent and 4–6 restorative parenting sessions, cases were more likely to need 8–10 individual sessions, leaving three coparent and three restorative parenting sessions. Increased focus on the coparenting relationship in the next study of Fathers for Change may allow for improved outcomes in this area. Additionally, only five of the nine female coparents came in for coparent sessions as either the fathers preferred not to have conjoint sessions or the mother did not want to participate in sessions. Those that did not have coparents attend discussed the same topics and practiced communication with their therapists, but did not practice together with their coparent. As the work of McHale, Salman-Engin, and Coovert (~~this issue~~) indicates, direct shared practice may be a crucial element to improving coparenting. Given men reported on satisfaction surveys a sense that the coparenting sessions were very helpful, further development of this component of the intervention is warranted especially as improved coparenting is significantly associated with father involvement in at-risk families (Waller, 2012). To meet this goal, the length of the intervention will need to be increased and greater emphasis placed on inclusion of the coparent (see McHale, Waller, & Pearson, 2012).

Limitations

This study was designed as an initial pilot examination of the Fathers for Change model compared to IDC. Due to the small sample, the results must be interpreted with caution. There was limited power to detect differences and small samples are more influenced by a

few individuals. The sample also included a limited range of substance abuse. Most fathers were abusing alcohol or marijuana and were not considered substance dependent. It is unknown if the consistent results in substance abuse reductions would be found if men had more significant addiction problems. Future studies must recruit a larger sample with greater diversity of substance abuse. Although the father–child interaction task was observational, most data were self-reported. It was difficult to maintain coparents in the study as collateral informants and not enough completed post- and follow-up interviews to allow for analysis. Greater emphasis on recruiting and retaining partners in both future studies and treatment itself is needed. Emphasis on explaining the important contribution the partners will make to understanding whether the program is helpful and effective, as well as offering home-based appointments and/or childcare, may increase engagement of coparents in both research and intervention sessions.

CONCLUSIONS

Fathers for Change is a promising new intervention that may be an important addition to the range of interventions available to families impacted by violence and substance abuse. Men were engaged and satisfied with the program and reported a trend toward less IPV. They exhibited significantly less intrusiveness in observed play interactions with their children following treatment than did fathers in the IDC group. These findings indicate further evaluation of this intervention with a larger sample is warranted.

REFERENCES

Barber, J. P., Mercer, D., Krakauer, I., & Calvo, N. (1996). Development of an adherence/competence rating scale for individual drug counseling. *Drug and Alcohol Dependence*, *43*, 125–132.

Camara, K. A., & Resnick, G. (1989). Styles of conflict resolution and cooperation between divorced parents: Effects on child behavior and adjustment. *American Journal of Orthopsychiatry*, *59*(4), 560–575.

Crowell, J. A., & Feldman, S. S. (1988). Mothers' internal models of relationships and children's behavioral and developmental status: A study of mother-child interaction. *Child Development*, *59*, 1273–1285.

Denis, C., Fatsrsd, M. I., Beltran, V., Bonnet, C., Picard, S. p., Combourieu, I. et al. (2012). Validity of the self-reported drug use section of the Addiction Severity Index and associated factors used under naturalistic conditions. *Substance Use & Misuse*, *47*(4), 356–363.

Donovan, D. M., Kadden, R., DiClemente, C., & Carroll, K. (2002). Client satisfaction and three therapies in the treatment of alcohol dependence: Results from project match. *The American Journal on Addictions*, *11*, 291–307.

Easton, C. J., Mandel, D., Hunkele, K., Nich, C., Rounsaville, B. J., & Carroll, K. M. (2007). A cognitive behavioral therapy for alcohol dependent domestic violence offenders: An integrated substance abuse-domestic violence treatment approach (SADV). *The American Journal on Addictions*, *16*, 24–31.

Fals-Stewart, W. (2003). The occurrence of partner physical aggression on days of alcohol consumptions: A longitudinal diary study. *Journal of Consulting & Clinical Psychology*, *71*, 41–52.

Fals-Stewart, W., Birchler, G., & Kelley, M. (2003). The Timeline Followback Spousal Violence Interview to Assess Physical Aggression Between Intimate Partners: Reliability and Validity. *Journal of Family Violence*, *18*, 131–142.

Feinberg, M. E. (2003). The internal structure and ecological context of coparenting: A framework for research and intervention. *Parenting*, *3*(2), 95–131.

Feldman, R. (1998). *Coding interactive behaviour manual*. Ramat Gan, Israel: Bar-Ilan University.

Guille, L. (2004). Men who batter and their children: An integrated review. *Aggression and Violent Behavior*, *9*(2), 129–163.

Hunter, E. C., & Graham-Bermann, S. A. (2013). Intimate partner violence and child adjustment: Moderation by father contact? *Journal of Family Violence*, *28*(5), 435–444.

Israel, E., & Stover, C. S. (2009). Intimate partner violence: The role of the relationship between perpetrators and children who witness violence. *Journal of Interpersonal Violence*, *24*(10), 1755–1764.

Katz, L. F., & Low, S. M. (2004). Marital violence, co-parenting, and family-level processes in relation to children's adjustment. *Journal of Family Psychology*, *18*(2), 372.

Larsen, D. L., Attkisson, C. C., Hargreaves, W. A., & Hguyen, T. D. (1979). Assessment of client/patient satisfaction: Development of a general scale. *Evaluation and Programming Planning*, *2*, 197–207.

Litton Fox, G., Sayers, J., & Bruce, C. (2001). Beyond bravado: Redemption and rehabilitation in the fathering accounts of men who batter. *Marriage & Family Review*, *32*(3–4), 137–163.

Mbilinyi, L., Walker, D., Neighbors, C., Roffman, R., Zegree, J., & Edleson, J. (2009). Motivating substance involved perpetrators of intimate partner violence to seek treatment: A focus on fathers. In C. Murphy & R. Maiuro (Eds.), *Motivational interviewing and stages of change in intimate partner violence* (pp. 181–197). New York: Springer Publishing.

McHale, J., Waller, M. J., & Pearson, J. (2012). Coparenting interventions for fragile families: What do we know and where do we need to go next. *Family Process*, *51*, 284–306.

McLellan, A. T., Alterman, A. I., Cacciola, J., Metzger, D., & O'Brien, C. P. (1992). A new measure of substance abuse treatment: Initial studies of the treatment services review. *Journal of Nervous and Mental Disease*, *180*(2), 101–110.

Mercer, D., & Woody, G. E. (1999). *Individual drug counseling*. NIH Publication No. 99-4380. Rockville, MD: National Institute on Drug Abuse.

Moore, B. C., Easton, C. J., & McMahon, T. J. (2011). Drug abuse and intimate partner violence: A comparative study of opioid-dependent fathers. *American Journal of Orthopsychiatry*, *81*(2), 218–227. doi:10.1111/j.1939-0025.2011.01091.x.

Nuro, K. F., MacCarelli, L., Martino, S., Ball, S. A., Baker, S., Rounsaville, B. J. et al. (2007). *Yale Adherence and Competence Scale (YACSII) Guidelines*. Training Manual. Department of Psychiatry, Yale University.

O'Farrell, T. J., Fals-Stewart, W., Murphy, M., & Murphy, C. M. (2003). Partner violence before and after individually based alcoholism treatment for male alcoholic patients. *Journal of Consulting and Clinical Psychology*, *71*, 92–102.

O'Farrell, T. J., Murphy, C. M., Stephan, S. H., Fals-Stewart, W., & Murphy, M. (2004). Partner violence before and after couples-based alcoholism treatment for male alcoholic patients: The role of treatment involvement and abstinence. *Journal of Consulting and Clinical Psychology*, *72*, 202–217.

Rothman, E. F., Mandel, D., & Silverman, J. (2007). Abusers' perceptions of the effect of their intimate partner violence on children. *Violence Against Women*, *13*(11), 1179–1191.

Salisbury, E. J., Henning, K., & Holdford, R. (2009). Fathering by partner-abusive men. *Child Maltreatment*, *14*(3), 232–242. doi:10.1177/1077559509338407.

Snyder, D. K., Klein, M. A., Gdowski, C. L., Faulstich, C., & LaCombe, J. (1988). Generalized dysfunction in clinic and nonclinic families: A comparative analysis. *Journal of Abnormal Child Psychology*, *16*(1), 97–109.

Sobell, L. C., & Sobell, M. B. (1995). *Alcohol Timeline Followback Users' Manua*l. Toronto, Canada: Addiction Research Foundation.

Stith, S. M., Rosen, K. H., & Middleton, K. (2000). Intergenerational transmission of spouse abuse: A meta-analysis. *Journal of Marriage and the Family*, *62*, 640–652.

Stover, C. S. (2013). Fathers for change: A new approach to working with father with histories of intimate parnter violence and substance abuse. *Journal of the American Academy of Psychiatry and the Law*, *41*(1), 1–9.

Stover, C. S., Easton, C. J., & McMahon, T. J. (2013). Parenting of men with co-occurring intimate partner violence and substance abuse. *Journal of Interpersonal Violence*, *28*(11), 2290–2314.

Stover, C. S., Van Horn, P., Turner, R., Cooper, B., & Lieberman, A. F. (2003). The effects of father visitation on preschool-aged witnesses of domestic violence. *Journal of Interpersonal Violence*, *18*(10), 1149–1166.

Straus, M. A., Hamby, S. L., Boney-McCoy, S., & Sugarman, D. B. (1996). The Revised Conflict Tactics Scales (CTS2): Development and preliminary psychometric data. *Journal of Family Issues*, *17*, 283–316.

Waller, M. R. (2012). Cooperation, conflict, or disengagement? Coparenting styles and father involvement in fragile families. *Family Process*, *51*, 325–342.

Wei, L. J. (1978). An application of an urn model to the design of sequential controlled clinical trials. *Journal of the American Statistical Association*, *73*(363), 559–563.