

A Prenatal Coparenting Intervention With Unmarried Father–Mother Dyads: Fidelity of Intervention Delivery by Male–Female Community Mentor Teams

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ABSTRACT

Background: Most prenatal preventive interventions for unmarried mothers do not integrate fathers or help the parents plan for the development of a functional coparenting alliance after the baby's arrival. Furthermore, properly trained professionals have only rarely examined the fidelity of these interventions.

Purpose: This report examines whether experienced community interventionists (home visitors, health educators, fatherhood service personnel) with no formal couples' therapy training are capable of pairing together to deliver with adequate fidelity a manualized dyadic intervention designed for expectant unmarried mothers and fathers.

Methods: Three male and four female mentors (home visitors, health educators, fatherhood personnel) working in paired male–female co-mentor teams delivered a seven-session “Figuring It Out for the Child” curriculum (six prenatal sessions, one booster) to 14 multirisk, unmarried African American families (parent age ranging from 14 to 40). Parental well-being and views of fatherhood were assessed before the intervention and again 3 months after the baby's birth. Quality assurance analysts evaluated mentor fidelity (adherence to the curriculum, competence in engaging couples with specified curricular content) through a review of the transcripts and audiotapes from the sessions. Mentors also rated their own adherence.

Results: Although the mentors overestimated adherence, quality assurance analyst ratings found acceptable levels of adherence and competence, with no significant male–female differences in fidelity. Adherence and competence were marginally higher in sessions that required fewer direct couples' interventions. Parents reported satisfaction with the interventions and showed statistically significant improvement in the family dimensions of interest at 3–4 months posttreatment.

Conclusions/Implications for Practice: Findings support the wisdom of engaging men both as interventionists and as recipients of prenatal coparenting interventions—even in families where the parents are uncoupled and non-co-residential.

KEY WORDS:

coparenting, African American families, intervention, fidelity.

Introduction

In most urban areas in the United States, preventive prenatal interventions depend on women trained as visiting nurses

and health educators to deliver empirically validated curricula to higher-risk parents. Recipients of these services are almost always mothers (Lu et al., 2010), and most services are delivered at home rather than in community settings (Olds et al., 2007). Conversely, interventions for expectant urban fathers, typically delivered by male paraprofessional fatherhood specialists, reach fewer parents and have almost always been offered in community-based group settings to group gatherings of expectant or new fathers. The Administration for Children and Families and the U.S. Department of Health and Human Services Healthy Marriage “Building Strong Families” (BSF) project (Mathematica Policy Research, Inc.; Dion et al., 2008) broke new ground by attempting to offer services to unmarried mothers and fathers together. Under this project, a lead facilitator with a bachelor's or master's degree in psychology, counseling, family therapy, education, or public health worked with a paraprofessional co-facilitator to deliver the manualized relationship and marriage education (RME) curriculum to couples in a group setting.

Working with two unmarried parents simultaneously is very uncommon in standard nursing practice, and the capacity of those with no formal clinical training to deliver couple-based interventions competently to multiple parties while adequately adhering to intervention models has seldom been studied. Yet, unless interventions are delivered competently and with adequate fidelity, families may not receive a sufficient dosage of the intervention to achieve the sought-after gains. Therefore, the current investigation examines the capacity of experienced community mentors with considerable experience working individually and/or in groups with young higher-risk unmarried mothers or fathers but with no formal clinical or professional training in couples therapy to pair together effectively to co-deliver a couple-based intervention with fidelity.

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Interventions for Unmarried Parents: Extant Approaches and Findings

According to Dion (2005), more than 100 RME curricula exist today, varying widely in content, target population, teaching method, and service delivery approach. Most were created for couples who are Caucasian, middle to upper class, and married or engaged. Most address communication, conflict management, and problem-solving skills. These curricula are usually delivered in group settings over a weekend or longer and cover about 15 hours of material.

Data on the success of RME interventions that were administered to populations that were not Caucasian, middle to upper class, and married or engaged were scarce until the BSF project enrolled more than 2,500 U.S. couples at eight sites. Unfortunately, BSF retention was poor, and no overall benefits were found for intervention couples compared with control couples for father engagement, relationship functioning, or coparenting (Wood, McConnell, Moore, Clarkwest, & Hsueh, 2010). Still, BSF data hinted that some subgroups, including lower-risk African American couples, might have derived benefits. More recently, Owen, Quirk, Bergen, Inch, and France (2012) found some benefits for lower-income African American and Latino couples in the "Prevention and Relationship Enhancement Program" (PREP), which was not one of the three RME curricula chosen for the BSF project, and found that couples who participated in PREP's couple format did better than those in PREP's group format. These findings suggest that, under the appropriate circumstances, RME interventions may hold interest and utility for unmarried families, at least for couples in committed relationships.

Couples who are not in committed relationships face additional concerns. For example, many commentators have criticized the coupling thrust of RME interventions in the context of unmarried families. Edin and Reed (2005) and Huston and Melz (2004) argued that interventions should focus on the harmful effects of high-conflict parental relationships and benefits to children of harmonious co-parental functioning rather than seeking to convince poor Americans of the value of marriage (Edin & Reed, 2005). Programs should "meet families where they are" and seek to improve unmarried parents' interparental relationship quality by helping them address real-life challenges such as the presence of children from previous unions and financial instability. Furthermore, helping unmarried parents address impediments to coparenting has ecological validity. The wish to co-parent is evident among both men and women in unmarried families, including two thirds of mothers who were no longer in relationships with fathers (Gaskin-Butler, Engert, Markievitz, Swenson, & McHale, 2012; McLanahan & Carlson, 2002). Hence, at least prenatally, coparenting interventions stand as one viable alternative to healthy marriage/ RME approaches for unmarried parents (McHale, Waller, & Pearson, 2012).

Cultivating coparenting among high-conflict or disengaged parents means mobilizing the motivation and the will to co-parent and building skills to help the adults successfully

form an alliance for the good of their children. Yet, very few interventions, even well-regarded interventions that address both couple and parenting issues before the baby arrives, have attempted to engage both expectant, unmarried parents together to seed positive coparenting alliances. A group intervention explicitly targeting coparenting that was conducted by Feinberg and Kan (2008) is one exception. However, that intervention was delivered to committed residential couples only. Coparenting intervention studies by Adler-Baeder et al. (2004), Cox and Shirer (2009), and Fagan (2008) that enrolled lower-income parents all delivered interventions in groups and to only one parent, not to both. One initiative (Florsheim, McArthur, Hudak, Heavin, & Burrow-Sanchez, 2011) successfully connected with expectant couples around coparenting, although its targeted audience was Hispanic and not African American youth. A new approach was thus needed.

Figuring It Out for the Child: A new dyadic coparenting approach designed for expectant, unmarried African American parents

"Figuring It Out for the Child" (FIOC) is a six-session prenatal intervention co-designed specifically for unmarried, often uncoupled, parents-to-be (McHale, Gaskin-Butler, McKay, & Gallardo, 2013). Unlike RME, FIOC downplays romantic commitment and focuses only on parents' burgeoning relationships with respect to their children, while inculcating communication skills core to extant RME interventions. FIOC follows principles of focused coparenting consultation (FCC; McHale & Irace, 2011), an insight- and skills-based intervention. FCC includes three stages: consciousness raising, which heightens parents' awareness about the beneficial impact of positive coparenting for young children's adaptation and mental health (Sessions 1 and 2); skill building, which helps parents develop communication and problem-solving skills needed to surmount challenges they face in developing a positive and sustained coparenting alliance, in or outside committed cohabitation and/or marriage (Sessions 3 and 4); and enactments, wherein parents-to-be discuss hot-button issues using newly developing skills, while being coached by mentors (Sessions 5 and 6). A booster session was scheduled at 1 month postbirth to remind parents to implement the lessons that were learned in the intervention. The FIOC intervention and specific content covered in each of the six prenatal and one postnatal booster sessions is described in detail by Gaskin-Butler et al. (2015).

FIOC is a dyadic intervention rather than a group intervention. Dyadic delivery facilitates trust of and rapport with parents, allows services to be offered at times that accommodate both parents' schedules, and provides a protected and safe space in which to process and practice the skills being learned. The prenatal dyadic intervention sessions commence after an initial period of one-on-one rapport building in individual sessions between the female mentor and the mother and the male mentor and the father.

Our focus in the present report is on the capacity of experienced community mentors to deliver the child-centered

FIOC intervention to expectant and unmarried mothers and fathers. Because this type of intervention has rarely been attempted with unmarried mother–father dyads, the capacity of community mentors to work with two parents simultaneously while simultaneously implementing a couple-based curriculum with adequate adherence has yet to be explored.

The choice of community mentor as interventionists

Home visitors and other nursing and related professionals are, in many respects, ideal choices for carrying out prenatal coparenting interventions with unmarried mothers and fathers together. This is because, in the United States, there are relatively few mental health professionals of color who hold degrees and are positioned to serve families of color in urban areas. However, home visitations and fatherhood programs already operate in communities throughout the United States, and individuals staffing these programs are typically well versed in effective outreach to reticent parents. Markman and colleagues (2004) believe that interventionist connection to the target community and knowledge about the sociopolitical dynamics that affect the community are key to delivering couple intervention programs effectively. They underscore the importance of program staff who both understand and are knowledgeable about the life issues that face families in the community. Moreover, staff must be aware of the need to convince parents that staff members truly believe in them and will not give up on them. Home visitation and fatherhood program staffs are ideally situated to join families and intervene while the critical window for development of child–parent attachment is still open, before a family “script” has been written and crystallized.

Yet, despite these assets, questions remain as to whether those with no formal clinical training may competently deliver interventions to multiple parties and achieve adequate intervention adherence. This concern was fueled by a meta-analysis report that explored the delivery of couples’ interventions by professionals and by paraprofessionals across transitions to new parenthood. That report suggested that only the interventions led by well-trained interventionists such as family therapists had significant effects on couple adjustment and couple communication (Pinquart & Teubert, 2010). The authors of the meta-analysis suggested that perhaps only professionals are suited to identify couples’ needs for change and to develop and implement adequate strategies to address these needs.

This raises two questions: whether male interventionists may be introduced into prenatal programs to help female interventionists engage fathers with mothers in coparenting planning and whether the couple-based FIOC intervention could be delivered competently and with adequate fidelity by experienced community mentors with no formal professional training as couples therapists.

What constitutes fidelity?

Two dimensions of method fidelity have been central in studies of implementation fidelity: adherence to core program criteria as specified in manuals and competent delivery of

the program (Dumas, Lynch, Laughlin, Phillips Smith, & Prinz, 2001; Hogue, Liddle, Singer, & Leckrone, 2005; Perepletchikova, Treat, & Kazdin, 2007). Although adherence (delivering intervention components) is now most commonly assessed using a self-report instrument that is completed by the practitioner, ratings provided by trained nonparticipant observers provide a different and more objective assessment of adherence. Ratings provided by trained nonparticipant observers also allow for more unbiased estimates of competent delivery. We adopted the gold standard for evaluating mentor fidelity in the current study by using trained quality assurance analysts who rated levels of mentor adherence and competence.

Summary and Prospectus

Bringing male community mentors into prenatal programs to help female home visitors engage fathers in a functional coparenting alliance is a novel approach. Little is known about the capacity of experienced community mentors with no formal training to act as couples therapists and to deliver couple-based interventions with fidelity. This pilot study examined whether (a) the mentors effectively engage and work with unmarried couples while competently implementing and adhering to the FIOC curriculum with fidelity and (b) the parents are satisfied with and derive material benefits from participation in the FIOC intervention.

Methods

Before conducting this study, institutional review board approval (University of South Florida IRB Number Pro00004412, Promoting Coparenting Alliances Among Expectant Unmarried African-American Parents) was secured, and informed consent was appropriately obtained from all participants.

Sample

The mentors were three African American men and four African American women with an average of 10.5 years of prior experience working individually or in groups with young men and women in the target community. Purposive, heterogeneous sampling was used to identify both the mentors and the participants. The female mentors were experienced home visitors or health educators, and the male mentors were affiliated with county fatherhood programs. All had track records of connecting successfully with young African American men or women. Despite this experience, mentors brought little to no couples-counseling experience and no experience co-facilitating interventions with couples. Two of the seven indicated having sporadically seen a mother and father together in their capacities in the community, but none brought formal education or training in working with couples in a clinical capacity.

Their clients were unmarried African American mothers and fathers expecting their first baby together, with no mutual domestic violence history. Fifty-six mothers were referred by Health Department Healthy Families staff, faith-based

organizations, and area pregnancy centers and OB/GYNs, with eligibility based on as follows: (a) parents not married, (b) first baby for the two parents together (although one or both parents might have children from previous unions), (c) the baby's father having expressed interest in being involved during the pregnancy, and (d) no known intimate partner violence (IPV) concerns. Of the 56 referred women, 34 (61%) expressed interest in participating, with 2 of the 34 deemed ineligible because of IPV. Successful recruitment of the associated fathers was accomplished in 88% (28) of the 32 cases. Twenty of the 28 consenting families (71%) fully completed the six-session intervention and the seventh (booster) session. Of the eight who did not, only one was formally a noncompleter (discontinuing after five sessions because of legal complications). The other seven noncompleting families never began the FIOC intervention for various reasons (e.g., fetal demise, moved out of the area, encountered work or other time conflicts). The 14 families who were the focus of this report were selected based on the accessibility of full and complete audio recordings and verbatim transcripts of all sessions. There were no statistical differences in dimensions of interest between these 14 families and the excluded families (the other six families who completed the sessions and the eight families who did not complete the intervention).

The mothers-to-be ($M = 21.29$, $SD = 4.46$, range = 14–29) were slightly younger than the fathers-to-be ($M = 24.0$, $SD = 6.45$, range = 14–40), with three mothers and two fathers younger than 18 years old at the time of enrollment. All families had incomes that were 200% or more below the Federal Poverty Level. Although this was the first baby together for all of the FIOC parents, more than half of the families in the sample (8 of 14, including five mothers and three fathers) had children from previous relationships. In 8 of the 14 families, parents reported co-residence at the time of study enrollment (the remainder lived with family members or extended kin).

Project Design

Figure 1 summarizes the project flow-through, design, and data collection points. After recruitment, parents participated in an intake assessment and then participated in the six-session intervention. All sessions were audio-recorded and rated by trained QAAs for mentor competence and adherence. One week after completing the six prenatal sessions, parents were interviewed independently and completed satisfaction surveys. One month after the baby's birth, parents and mentors reunited for a booster session, and finally, at 3 months postpartum, parents took part in a postdischarge assessment and completed the same assessments that were administered at the intake assessment.

Quality Assurance Strategy

Complete audio recordings of all sessions were available for 14 families and were provided to the trained QAAs, who transcribed and then evaluated adherence and delivery competence for the sessions. Mentors also completed accom-

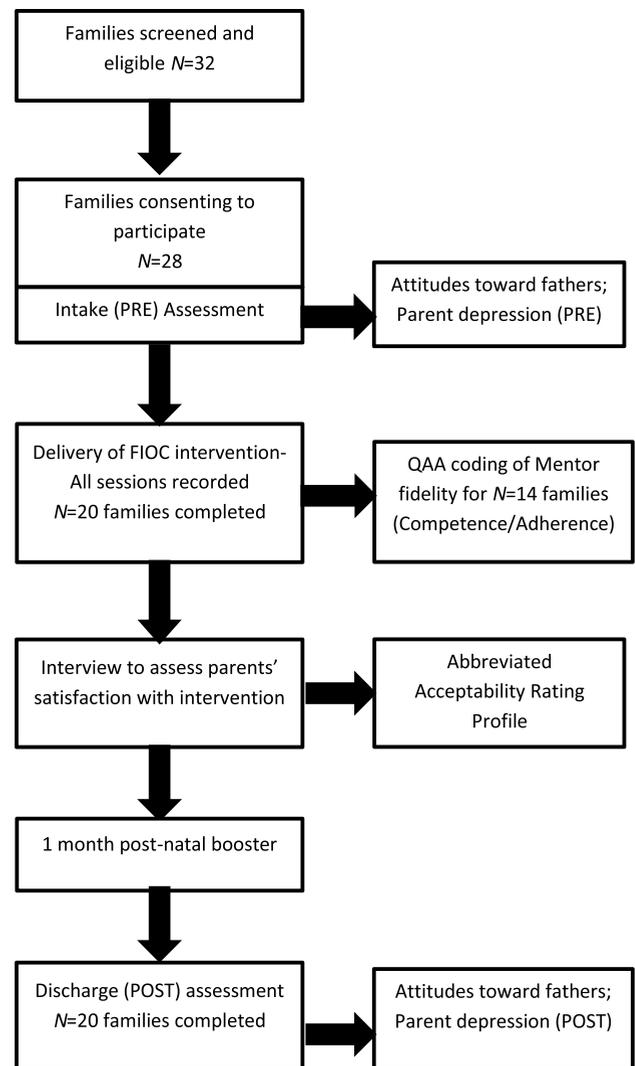


Figure 1. Project flow-through, design, and data collection points.

plishment forms (rating their own adherence) after each session but did not rate their own competence. As this was a pilot test of the FIOC application of the FCC, accomplishment forms underwent minor revisions after feedback obtained from the first few cases. QAAs later rerated these early interventions using the revised accomplishment forms, whereas the mentors started to use the revised forms only after the first few cases. Because of minor differences among the rating forms that mentors completed for the first few families, the analysis compared the adherence ratings given by mentors with those of the QAA (see below) and used the percentage of successful completion scores rather than the exact item adherence scores.

Measures

Measures of mentor fidelity: adherence and competence

Two dimensions of fidelity were assessed: adherence and competence. Adherence, or how well the mentors followed

the program curriculum, was assessed both by QAAs and by mentor self-ratings. FIOC-specific accomplishment forms, developed for each session, enumerated all key activities, which were unique to each session in the curriculum, and indicated how completely the mentors assisted the mother and father in accomplishing each required activity. The number of adherence items ranged from 4 to 10. A score of “0” meant that a specific item had not been accomplished; a score of “1” meant that the deliverable was partially accomplished, and raters specified the reason why they felt it was not fully accomplished; and a score of “2” meant that the item was satisfactorily accomplished as intended. Competence, an assessment of the skillfulness of mentor performance, was assessed using QAAs only. To assess competence, two different competence scales were adapted and combined. These were the following:

1. Fidelity Checklist, developed by Breitenstein et al. (2010): This instrument was originally used to monitor fidelity in the Chicago Parent Program, a community-based parenting intervention program. For the current study, the 16-item competence scale was used. Given the substantive differences between the Chicago Parent Program and the FIOC programs (such as curricular delivery in group vs. individual family sessions), adjustments to certain items and definitions had to be made. Adjustments, informed by the way the Fidelity Checklist items overlapped with FIOC curricular content and intent, were made by the first author working with a doctoral student who later served as one of the QAAs (see Table 1 for a summary of the adjusted items and mean competence scores).

As an example of item adjustment, Breitenstein et al. (2010) worked with a group of parents and created the study instrument for these sessions. In contrast, in the current study, only one family participated in the sessions, so the original Fidelity Checklist item “*actively engages all parents in the discussion*” was reworded as “*actively engages both parents in the discussions and activities*.” The QAAs listened to audio recordings and rated male and female mentors separately for each session using a 9-point scale (1–3 = *needs work*, 4–6 = *acceptable*, 7–9 = *good work*). They also evaluated the overall quality of co-mentors’ interactions and cooperation (1–3 = *intrusive, negative*; 4–6 = *polite, neutral*; 7–9 = *collaborative, positive*).

2. Fidelity of Implementation Rating System: This system was developed by Knutson et al. (2009) to assess the Oregon Model of Parent Management Training (PMTO). Because the PMTO differs from the FIOC in certain important respects, minor adaptations were necessary. For example, the curriculum-specific item in the original instrument “*PMTO Knowledge: Demonstrates proficiency in understanding of PMTO principles and practices and Social Interactional Learning (SIL) theoretical model; shows understanding of core parenting and supporting practices; demonstrates understanding of technical details and procedures*” was

reworded as “*Knowledge: The mentor demonstrates proficiency in understanding of FIOC principles, session-specific objectives, and activities*.” Four of the five Fidelity of Implementation Rating System items (knowledge, structure, process skills, and overall quality) were retained for use in the present investigation. QAAs again evaluated female and male mentors separately on a 9-point scale (1–3 = *needs work*, 4–6 = *acceptable*, 7–9 = *good work*).

Fourteen families attended seven sessions each, and all 98 sessions were rated independently by two QAAs. To establish the reliability of the ratings, percent agreement was calculated, along with intraclass correlation coefficients (ICCs). An estimate of internal consistency (Cronbach’s alpha) was also calculated for the competence scale. It was not practical to complete a parallel internal consistency estimate for the adherence scales because items varied across sessions. For the adherence and competence scales, the mean perfect percentage agreement across raters for all sessions was 69% and 85%, respectively. In cases of discrepancies between the QAA scores, the consensus scores were used in analyses. ICC analyses employed a two-way random effects model (absolute agreement, average measurements) for raters’ average scores of adherence and competence scales for all sessions. ICCs were .79 and .55 for the adherence and competence scores, respectively. Internal consistency for the competence scale was high (Cronbach’s alpha = .96), and the high intercorrelation between the competence scale item sets adapted from the Breitenstein et al.’s (2010) Fidelity Checklist and Knutson et al.’s (2009) Fidelity of Implementation Rating System ($r = .89, p < .000$) supported the convergent validity of the measurements.

Content/process ratings of “figuring it out for the child” sessions

To evaluate the emotional tenor of each session, QAAs rated parents’ level of conflict (from 0 = *no conflict* to 4 = *very high conflict*) and overall tone of the session (quality and affective tone of conversations) on a 9-point scale (1–3 = *negative*, 4–6 = *neutral*, 7–9 = *positive*) on the Fidelity Checklist (Breitenstein et al., 2010).

Parents’ satisfaction with the “figuring it out for the child” intervention

Parent treatment satisfaction was assessed after the conclusion of the prenatal sessions via a parent report that used items adapted from the Abbreviated Acceptability Rating Profile (AARP) (Tarnowski & Simonian, 1992). The AARP was designed for disadvantaged families and has been successfully used to assess treatment acceptability among culturally diverse populations with limited educational backgrounds. The AARP has been shown to possess acceptable internal consistency, reliability, and validity and has generated no concerns among participants about time intensiveness or item complexity (Tarnowski & Simonian, 1992). Examples

TABLE 1.
Summary of Items Used to Assess the Competence of Mentor Performance

Competence Item	M	Range
2. Mentor actively listens when a parent is talking.	7.25	2.5–9
3. Mentor communicates with the parents in a respectful, positive, and nonjudgmental manner.	7.25	1–9
16. Co-mentors interact and work effectively together (overall rating of quality of co-mentors' work).	7.24	4–9
15. Affective tone of conversations in the session is positive (overall rating of session affective tone).	7.14	2.5–9
20. Overall development: Mentor demonstrates proficiency in engaging parents in practice of FIOC methods that promote their coparenting alliance; shows evidence of incorporating contextual, individual, and family circumstances within the method and theoretical perspective; promotes and accomplishes parents' satisfaction and growth.	7.08	3–9
19. Process skills: Mentor demonstrates effectiveness in interacting with the parents; promotes a safe and supportive learning environment.	6.94	1–9
5. Mentor correctly conveys/communicates program principles.	6.89	2–9
4. Mentor appropriately reinforces parents' ideas and opinions.	6.79	3.5–8.5
9. Mentor appropriately shares their ideas with parents.	6.79	3–9
1. Mentor actively engages both parents in the discussions/activities.	6.78	2.5–9
17. Knowledge: Mentor demonstrates proficiency in understanding of FIOC principles, session-specific objectives, and activities.	6.46	2.5–9
7. Mentor facilitates problem solving.	6.16	2–9
8. Facilitates sharing of ideas between parents.	6.00	2.5–9
11. Mentor effectively manages challenging behavior from parents (e.g., monopolizing, anger, prolonged silence).	5.91	3.5–9
13. Mentor builds on parents' knowledge by incorporating strategies discussed in previous sessions into this session.	5.90	1–9
18. Structure: Mentor demonstrates proficiency in session management: follows an agenda, has an apparent orderly plan, provides direction for the session while being responsive to the parents, makes good transitions between topics, uses sensitive timing and pacing.	5.89	1–8.5
6. Mentor communicates to parents that they will be experts about their own child.	5.77	2–8.5
10. Mentor effectively responds when parents are resistant to new strategies or ideas.	5.67	3.5–9
14. Mentor helps parents anticipate challenges using the new skills at home.	5.53	1–9
12. Mentor maintains a good pace for discussions/activities (not too fast, not too slow).	5.25	1–8

Note. Items are rank ordered from the mentors' strongest to weakest overall performances. Items bearing the numbers 1–16 are those adapted from Breitenstein et al. (2010). Items bearing the numbers 17–20 are those adapted from Knutson, Forgatch, Rains, and Sigmarsdóttir (2009). The items were rated by two independent quality assurance analysts using a 9-point scale (1–3 = *needs work*, 4–6 = *acceptable*, 7–9 = *good work*).

of item adaptations including changing the AARP item “This treatment would not have bad side effects for the child” to “FIOC should have no bad effects for my co-parent/our baby” and the AARP item “I would be willing to use this treatment with my child” to “I am willing to use what we learned in FIOC with my co-parent/our baby.” The reliability coefficient for the 11-item scale in this study (Cronbach's alpha) was .95.

Parents' attitudes toward fathers' responsibility and involvement in the baby's life

To assess whether participant attitudes toward the father's responsibility and involvement in the baby's life changed after the FIOC intervention, both parents completed scales that had been used in large national studies of father involvement among comparable samples at both the preassessment and postassessment points, with pre-to-post change scores calculated. The instruments that were used are discussed below.

Father responsibility scale: The Father Responsibility Scale used in the Fragile Families and Child Well-Being study (Reichman, Teitler, Garfinkel, & McLanahan, 2001) was completed by participants to assess their beliefs about father responsibility in the baby's life. The six items of this scale capture the father's financial contributions, involvement in teaching the child, providing direct care, showing love and affection, providing protection, and serving as an authority figure. Responses are “1” (very important), “2” (somewhat important), and “3” (not important). Total possible scores for the scale range from 6 to 18, with lower scores connoting a belief on the respondent's part that fathers have greater responsibility.

Attitude toward father involvement scale: An internally consistent and valid three-item scale from the Baltimore Multigenerational Family Study (Coley & Chase-Lansdale, 1999) and the Early Head Start Father study (Cabrera et al., 2004) gathered participant perceptions about the importance

of raising a child, the importance that others knew they had a child, and the impact of not being involved in raising their child. Responses ranged from 1 = *strongly agree* to 4 = *strongly disagree*. Total possible scores for this scale ranged from 3 to 12, with lower scores signifying a stronger perception that father involvement is important and valued.

Scores for both the Father Responsibility and Father Involvement scales were reversed and then summed for the couple, with higher overall scores representing a more positive attitude held by the co-parents toward father responsibility and involvement in the baby's life.

Maternal and paternal depression

To assess the effect of the FIOC intervention on parental depression, both parents completed the 10-item Edinburgh Depression Scale (EPDS; Cox, Holden, & Sagovsky, 1987) at preassessment and postassessment. The EPDS questions evaluate symptoms of depression such as inability to laugh, inability to look forward to things with enjoyment, and self-blame over the past week. Each item is scored from 0 to 3, yielding a total range of 0–30. The instrument has satisfactory sensitivity and specificity in both female (Murray & Carothers, 1990) and male (Edmondson, Psychogiou, Vlachos, Netsi, & Ramchandani, 2010) respondents and is sensitive to changes in severity of depression over time (Cox et al., 1987). For mothers, an EPDS cutoff of 12/13 indicates major depression, with a sensitivity of 86% and a specificity of 78%.

Data Analysis

First, descriptive data (mean, standard deviation, range) for key study variables were generated, with *t* test comparisons completed where indicated and appropriate. Next, repeated measures analysis of variance was completed to help determine whether mentors showed differences in competence and adherence across sessions.

Results

Descriptive Data and *t* Test Comparisons

Table 2 summarizes data for mentor fidelity, the overall tenor of sessions, the reactions of participants to the intervention, and pre-to-post changes in parental attitudes and adjustment.

As shown in Table 2, the mentors delivered the FIOC intervention competently. Overall competence, averaged across all sessions and mentors, was 6.47 on a 9-point scale. There was no significant difference between the competence scores of female and male mentors, suggesting that there was no difference in how women and men “carried” the competency ratings. Furthermore, QAA ratings indicated that mentors delivered the curricular components satisfactorily (overall adherence was 1.37 on a scale of 0–2), although mentors' ratings of their adherence to the curriculum were significantly higher than the QAA ratings. The correlation between mentor self-reports of adherence and QAA-rated adherence was not significant.

With respect to the tenor of the sessions, QAA ratings indicated that the meetings were largely respectful and free of substantial conflict. The overall level of conflict between parents was low, whereas the overall affective quality of the sessions was generally positive (Table 2). Participant reactions to the intervention, assessed by the AARP, signified strong levels of satisfaction (5.74 on a 6-point scale). There were no significant associations linking mentor competence or adherence to either the level of conflict or the overall emotional tone seen during the sessions. Moreover, we found no associations linking competence or adherence to participant satisfaction with the intervention.

Did participant attitudes change, or were other benefits noted? Paired *t* tests examined changes in participant views of fatherhood between the preintervention and postintervention assessments (Table 2). These variables improved in the expected directions. First, participants perceived a broader responsibility for fathers to be involved with their children at postintervention than at preintervention. Second, participant views on the meaningfulness of father involvement were more positive at postintervention than at preintervention.

In addition to significant shifts in participant attitudes and beliefs about fathers, we also found that mothers' self-reported depression scores were significantly lower at postintervention than at preintervention. The scores of fathers declined as well, although not as significantly. The significant declines in maternal depression scores are particularly interesting. Postnatal depression among inner-city African American mothers in enhanced regular care has been reported to be as high as 46% (Howell et al., 2012). Although declines in EPDS scores for FIOC mothers cannot be definitively attributed to the FIOC intervention, as there was not a control group, we noted that the average EPDS scores for FIOC mothers at baseline (9.1) were comparable with and slightly higher than prenatal EPDS scores reported by low-income African American mothers in a study on neighboring Tampa, FL, Healthy Start Project clients ($M = 8.4$; Luke et al., 2009). Depression among FIOC mothers at baseline was hence broadly reflective of low-income African American mothers receiving prenatal services in the region. By contrast, the average postnatal EPDS score of FIOC mothers was significantly lower than those reported for a neighboring sample of 169 African American mothers of children aged 1–9 months who were recruited from Medicaid Prenatal Care Coordination with similar socioeconomic status, education, and household income characteristics (King, 2012).

Implementation Fidelity Across Sessions

There was a significant linear effect ($F(1, 13) = 8.04, p < .05$) and a significant cubic effect ($F(1, 13) = 14.91, p < .01$) of mentor adherence over sessions. Adherence began around the mean score and peaked at Session 2 and then progressively declined through Session 6 as mentors worked through the skill-building and enactment stages of the FCC model. The scores then rebounded at the booster session. For competence scores, there was a significant cubic effect ($F(1, 13) = 13.23, p < .01$). Scores peaked at Session 2, progressively

TABLE 2.
Summary of Constructs, Measures, and Descriptive Data

Construct	M	M (SD)	Instrument	Source
Mentor fidelity				
Mentor competence ^a			Fidelity Checklist Fidelity of Implementation Rating System	QAAs
Female mentor	6.46	0.75		
Male mentor	6.47	0.58		
Mentor adherence ^b	1.37	0.22	FIOC-specific accomplishment forms	QAAs
Mentor adherence ^c (%)			FIOC-specific accomplishment forms	QAAs and Mentors
QAA ratings	69			
Mentor self-ratings	88			
Session tenor				
Affective tone ^d	7.14	0.78	Fidelity Checklist	QAAs
Conflict ^e	0.40	0.32	Fidelity Checklist	QAAs
Acceptability				
Parent satisfaction ^f	5.74	0.23	Abbrev. Acceptability Rating Profile	Parents
Family data				
Attitude toward father responsibility				
Pre	17.52	0.70	FFCWB Father Responsibility Scale	Parents
Post	17.78	0.42*	Early Head Start Father Involvement Scale	
Attitude toward father involvement				
Pre	10.85	1.49		
Post	11.44	0.80*		
Parental depression				
Mother			Edinburgh Depression Scale	Parents, separately
Pre	9.13	6.28		
Post	6.00**	5.36		
Father				
Pre	7.31	4.64		
Post	4.62	4.98		

Note. FCWB = Fragile Families and Child Well-Being.

^aMentor competence was rated using a 9-point scale (1–3 = *needs work*, 4–6 = *acceptable*, 7–9 = *good work*). ^bQAAs rated adherence on a 0–2 scale: 0 = *deliverable was not accomplished* to 1 = *deliverable was partially/somewhat accomplished* to 2 = *deliverable was successfully accomplished*. ^cFigures reflect percentage of fully successfully completed deliverables, Sessions 1–7 combined. ^dTone of session (quality and affective tone of parents' conversations in the session) was rated by QAAs using a 9-point scale (where scores 1–3 = *negative*, 4–6 = *neutral*, and 7–9 = *positive*). ^eConflict between parents was rated by QAAs using a 5-point scale (0 = *no conflict*, 4 = *very high conflict*). ^fParent satisfaction represents the average of mother and father scores on the 11-item, 6-point rating scale instrument that was used to assess acceptability, with higher overall scores signifying greater parent satisfaction.

*A significant difference in the relevant paired *t* test, $p < .05$. ** $p < .01$.

decreased through the hot-button enactment session (Session 5), then rebounded in Session 6, and peaked at Session 7. These findings suggest that the mentors exhibited the highest levels of adherence and competence during the consciousness-raising sessions and the lowest levels of adherence and competence in the skill-building and enactment phases, although, as shown in Table 1, the scores for overall level and per-deliverable items in each session were all well within the acceptable range.

Discussion

Results from this study substantiate that male and female home visitors, educators, and fatherhood program personnel with no prior formal training in couples' interventions are able to competently co-deliver an intervention that is designed to enhance coparenting skills in unmarried mother–father dyads. Whereas an earlier meta-analysis had reported that couples may not derive intended benefits from inter-

ventions conducted by paraprofessionals, the results of this project suggest acceptable mentor competence and adherence. Although adherence to and competence in delivering modules that required participants to enact conflict discussions (FIOC Sessions 5 and 6) scored marginally poorer than the modules in which discussions of the importance of fatherhood and of coordinated coparenting efforts were more structured (using focused discussions of program materials such as videos, questionnaires; FIOC Sessions 1 and 2), overall accomplishment of deliverables was acceptable, as was the overall competence of mentors in engaging and working with parents. Moreover, because all 14 pairs of African American coparents completed the entire series of seven FIOC sessions, expressed satisfaction with the benefits derived from the intervention, and achieved significant pre–post gains in key family domains, results indicate that, at least under conditions of ongoing supervision and monitoring, there is untapped

potential among paraprofessionals to conduct prenatal coparenting interventions for mother–father teams.

The challenge for the mentors in this project was twofold: None had received clinical training in couples interventions, nor had they worked with opposite-sex co-leaders to deliver unfamiliar types of individual or group interventions. Although working with co-leaders may be challenging (Atieno Okech & Kline, 2006), analyses of QAA raters in the current project indicated that co-leaders participated in intervention delivery, assured that key elements of the curriculum were delivered, and supported one another in the work of engaging couples during the interventions. Given the rarity of interventions that recruit and retain fathers who are not in committed relationships with their babies' mothers, the success of the men and women who served as mentors in this project is worth noting.

Best practice in the delivery of new interventions during field trials requires ongoing monitoring of mentors to detect drift and provide corrective feedback. It is possible that the satisfactory levels of mentor adherence in this project were because of weekly feedback. Diligent monitoring of novice mentors and of the relatively higher-risk families, many of whom faced hardships and challenges beyond those related to their burgeoning coparenting relationship, is recommended for any similar project.

It is important to emphasize that, although the mentors in this project were new to couples interventions, they had worked with the targeted population and stated that they would be comfortable engaging with men and actively reaching out to young people who were ambivalent about continuing with the program. Men recruited for the study were skeptical of couples interventions, as has been noted (Doss, Atkins, & Christensen, 2003), and involving mentors who believed in and were committed to the inclusion of fathers in the prenatal intervention was essential. So too was the cultural competence of mentors, who understood the challenges faced in the community by African American children and parents and who could connect with parents in these realities (Armstrong, Crum, Rieger, Bennett, & Edwards, 1999). Future research would benefit from further examination of mentor background and competencies.

In terms of study limitations, given the exploratory nature of the current study, we were not in a position to randomly assign mentors to cases or to systematically experiment with mentor matches. Assignments to cases were based principally on the scheduling convenience of each mentor. The only factor that we aimed explicitly and intentionally to vary was matching one mentor with no prior experience with one who had at least one session of experience, although even this was not possible in every case. Therefore, we were unable to complete our analyses of whether mentor adherence improved over successive cases, as would be expected. Second, the instruments used to assess fidelity, although adapted from existing field-tested protocols, were new to this kind of work. Moreover, QAA reliability estimates may have been affected by the restriction of the ranges for mentor adherence and

competence. Most fidelity scores were adequate (4–6) to strong (7–9). Few were unacceptable (1–3), which influenced the overall estimate that was obtained (Hallgren, 2012). Despite this drawback, the estimates of agreement provide adequate evidence that different raters judged the sessions similarly.

Implications for Practice

This study found that women and men who have experience working with expectant parents are able to work together to deliver with adequate fidelity a coparenting intervention that targets unmarried African American parents. The fact that both co-residing and non-co-residing fathers- and mothers-to-be attended, stayed, expressed satisfaction with their experience, and witnessed positive gains indicates that the mentors succeeded in focusing both fathers and mothers on the importance of coparenting and of FIOC. Engaging nonresidential unmarried fathers in prenatal interventions with babies' mothers is uncommon in North America. Myriad barriers, including lack of knowledge and skill deficits, and philosophical ambivalence about the wisdom of engaging babies' fathers at all, when fathers are not co-residential or in committed relationships, inhibit home visitors and other prevention specialists and prevent unmarried fathers from becoming equal partners with stakes in their babies' future. It is important to remember that the FIOC was delivered in the current study by mentors who maintained unwavering beliefs that engaging and retaining fathers was worth concerted effort. The successes that were achieved justify the mentors' resolve and provide valuable guideposts for future efforts that uphold the coparenting approach to prenatal intervention.

In conclusion, the results of this project suggest the potential for seasoned home visitors, health educators, and fatherhood program personnel with competence in working with high-risk populations to deliver coparenting interventions that are designed for uncoupled, expectant African American parents. These pilot results suggest the clear value in conducting further, more rigorous studies on this topic. It remains necessary to establish whether mentor competence and adherence improve, as might be anticipated, with accumulated experience in curricular delivery. Mentor capacity to address parental resistance and noncompliance effectively must be examined. The key elements of mentor matching (experience, race, personality, or therapeutic style) that affect effectiveness of delivery or degree of parental gain must be determined. Whether assigning the intervention to male–female mentors who are initially unfamiliar to the parents is a better choice than involving the mother's existing home visitor or nurse must be ascertained; unmarried mothers often cherish the special bond they share with their home visitor and, in some cases, may be reticent to welcome fathers or male mentors to share in the valued woman-to-woman relationship. Finally, further work is needed to determine whether parents who share a history of immature, situational IPV may also benefit from FIOC's preventive emphasis.

Although dyadic interventions are clearly contraindicated for couples in which the nature of the IPV is controlling and menacing, new evidence suggests that parents who engage in low-level situational IPV may be able to derive benefits from interventions where the child, rather than the intimate couple relationship, is the focus of intervention (Florsheim et al., 2011; Stover, 2013). Further rigorous investigations of this topic would be of great value.

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