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Intervention Summary

Family Foundations

Family Foundations, a program for adult couples expecting their first child, is designed to help them establish positive parenting skills and adjust to the physical, social, and emotional challenges of parenthood. Program topics include coping with postpartum depression and stress, creating a caring environment, and developing the child's social and emotional competence.

Family Foundations is delivered to groups of couples through four prenatal and four postnatal classes of 2 hours each. Prenatal classes are started during the fifth or sixth month of pregnancy, and the postnatal classes end when the children are 6 months old. The classes are designed to foster and enhance the coparenting relationship, and they include conflict resolution strategies, information and communication exercises to help develop realistic and positive expectations about parenthood, and videos presenting couples discussing the family and personal stresses they have experienced as well as the successful strategies they have employed. Key aspects of parenting that are addressed include fostering child emotional security, attending to infant cues, and promoting infant sleep.

Family Foundations is delivered in a community setting by childbirth educators who have received 3 days of training from Family Foundations staff. It is recommended, but not required, that classes be codelivered by a male and a female.

Descriptive Information

Areas of Interest	Mental health promotion
Outcomes	**Review Date: September 2011** 1: Coparenting 2: Parental adjustment 3: Parent-child interaction 4: Child adjustment
Outcome Categories	Family/relationships Mental health Social functioning
Ages	0-5 (Early childhood) 18-25 (Young adult) 26-55 (Adult)
Genders	Male Female
Races/Ethnicities	White Race/ethnicity unspecified
Settings	Other community settings
Geographic Locations	Urban Suburban Rural and/or frontier
Implementation History	Family Foundations has been implemented in about 10 sites since it was first developed in a research context in 2005, and it has served hundreds of expectant couples.

NIH Funding/CER Studies	Partially/fully funded by National Institutes of Health: Yes Evaluated in comparative effectiveness research studies: Yes
Adaptations	Family Foundations has been adapted for teenage parents. Also, a version of Family Foundations featuring a DVD/workbook package has been developed for home use by couples who encounter barriers to class participation (e.g., transportation issues, conflict with work hours).
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the developer.
IOM Prevention Categories	Universal

Learn More - Click on each category bar below or the buttons at the right to expand or collapse the sections.

Expand All | Collapse All

Quality of Research

Review Date: September 2011

Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

Study 1

Feinberg, M. E., Jones, D. E., Kan, M. L., & Goslin, M. C. (2010). Effects of Family Foundations on parents and children: 3.5 years after baseline. Journal of Family Psychology, 24(5), 532-542. Pub Med icon

Feinberg, M. E., & Kan, M. L. (2008). Establishing Family Foundations: Intervention effects on coparenting, parent/infant well-being, and parent-child relations. Journal of Family Psychology, 22(2), 253-263. Pub Med icon

Feinberg, M. E., Kan, M. L., & Goslin, M. C. (2009). Enhancing coparenting, parenting, and child self-regulation: Effects of Family Foundations 1 year after birth. Prevention Science, 10(3), 276-285. Pub Med icon

Outcomes

Outcome 1: Coparenting	
Description of Measures	Coparenting, defined as how parents coordinate their parenting, support or undermine each other, and manage conflict regarding child rearing, was assessed with three measures: • A 15-item coparenting scale, which was developed for this study partly from an adaptation of existing measures and was used to assess multiple dimensions of the coparenting relationship. Participants responded to 5 items on each of three scales: coparental support (e.g., "My partner supports my parenting decisions"), parenting-based closeness (e.g., "I feel close to my partner when I see him or her play with our child"), and coparental undermining (e.g., "My partner sometimes makes jokes or sarcastic comments about the way I am as a parent").

- Videotaped interaction of free play between parents and their child at their home. An interviewer provided a limited set of toys and asked the parents to engage with their child (approximately 1 year old) in 12 minutes of joint free play on the floor. Interviewers then asked the parents to teach their child to accomplish a set of tasks designed to be at the limit of most infants' developmental capacity (e.g., rolling a ball back and forth with a parent, building a tower of blocks). This interaction lasted for 6 minutes and was videotaped. Coparenting behaviors (competition, triangulations, warmth, inclusion, and active cooperation) were then coded from the videotape by trained raters who were blind to the experimental condition.
- The 31-item Coparenting Scale, which was created on the basis of prior work. Participants responded to items regarding coparental agreement, support and undermining of each other, and exposure of the child to conflict.

The 15-item coparenting scale was used to collect data from both parents at posttest (i.e., after parents had completed their last postnatal class, when their baby was around 6 months old). Parents responded to the questionnaires and mailed them to the researchers.

Videotaped interactions were used to collect follow-up data when the parents' baby was approximately 1 year old.

The 31-item Coparenting Scale was used to collect follow-up data from both parents when their child was approximately 3 years old. Researchers administered the questionnaires during a home visit.

Key Findings

Couples who were expecting their first child were randomly assigned to the intervention group, which received Family Foundations, or the comparison group, which received a mailed brochure with information about selecting quality child care.

At the 6-month follow-up, mothers and fathers in the intervention group exhibited higher coparental support relative to mothers and fathers in the comparison group ($p < .05$ and $p < .05$, respectively). In addition, fathers in the intervention group had a higher level of parenting-based closeness relative to fathers in the comparison group ($p < .05$); there was no significant difference in parenting-based closeness between mothers in each group.

At the 1-year follow-up, mothers and fathers in the intervention group exhibited lower levels of negative coparenting behaviors (competition and triangulation) relative to mothers and fathers in the comparison group ($p < .05$ and $p < .05$, respectively). Mothers in the intervention group exhibited a higher level of inclusion relative to mothers in the comparison group ($p < .05$); there was no significant difference in level of inclusion between fathers in each group.

At the 3-year follow-up, parents in the intervention group exhibited a higher level of positive coparenting

	overall relative to parents in the comparison group ($p = .011$).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.6 (0.0-4.0 scale)

Outcome 2: Parental adjustment	
Description of Measures	Parental adjustment was assessed with four measures: • The 20-item short form of the Taylor Manifest Anxiety Scale (TMAS), which measures chronic anxiety. Participants responded to items (e.g., "I am a high-strung person") following a dichotomous yes/no format. • A subset of 7 items from the Center for Epidemiological Studies Depression Scale (CES-D), which measures depressive symptoms. Using a 4-point frequency scale, participants responded to items regarding depressive symptoms experienced during the past week (e.g., "How often did you feel sad?"). • The 16-item Parenting Sense of Competence Scale (PSOC). Using a 7-point Likert scale, participants responded to items asking how they feel about their competence in a parental role (e.g., "I feel confident in my role as a parent"). • The 27-item Parenting Stress Index (PSI), which measures self-reported parental stress. Using a 5-point Likert scale, participants rated their agreement with each item (e.g., "I feel trapped by my responsibilities as a parent"). The TMAS and the CES-D were used to collect data from both parents at posttest (i.e., after parents had completed their last postnatal class, when their baby was around 6 months old). Parents responded to the questionnaires and mailed them to the researchers. The TMAS, the CES-D, the PSOC, and the PSI were used to collect follow-up data from both parents when their child was approximately 3 years old. Researchers administered the questionnaires during a home visit.
Key Findings	Couples who were expecting their first child were randomly assigned to the intervention group, which received Family Foundations, or the comparison group, which received a mailed brochure with information about selecting quality child care. At the 6-month follow-up, mothers in the intervention group had lower levels of anxiety ($p < .01$) and depressive symptoms ($p < .01$) relative to mothers in the comparison group; there were no significant differences in anxiety or depressive symptoms between fathers in each group. At the 3-year follow-up, parents in the intervention group had a higher sense of competence in their parental role ($p = .024$) and a lower level of parenting stress ($p = .031$) relative to parents in the comparison group.

Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.7 (0.0-4.0 scale)

Outcome 3: Parent-child interaction	
Description of Measures	Parent-child interaction was assessed with three measures: • The 6-item Dysfunctional Interaction scale from the Parenting Stress Index. Participants responded to items regarding distress in the parent-child relationship (e.g., "My child smiles at me much less than I expected"). • Videotaped interaction of free play between parents and their child at their home. An interviewer provided a limited set of toys and asked the parents to engage with their child (approximately 1 year old) in 12 minutes of joint free play on the floor. Interviewers then asked the parents to teach their child to accomplish a set of tasks designed to be at the limit of most infants' developmental capacity (e.g., rolling a ball back and forth with a parent, building a tower of blocks). This interaction lasted for 6 minutes and was videotaped. Parenting behaviors (sensitivity, positive affect, support of exploration, irritability, anger, and hostility toward the child) were then coded from the videotape by trained raters who were blind to the experimental condition. • 21 items from the Parenting Scale, which were used to assess the discipline practices of parents of children 18-48 months old. Parents responded to 11 items assessing permissive parenting (laxness), 9 items assessing the degree of authoritarian parenting (overreactivity), and 1 item assessing the likelihood of the parent to "spank, slap, grab, or hit" a misbehaving child (physical punishment). The Dysfunctional Interaction scale was used to collect data from both parents at posttest (i.e., after parents had completed their last postnatal class, when their baby was around 6 months old). Parents responded to the questionnaires and mailed them to the researchers. Videotaped interactions were used to collect follow-up data when the parents' baby was approximately 1 year old. Items from the Parenting Scale were used to collect follow-up data from both parents when their child was approximately 3 years old. Researchers administered the questionnaires during a home visit.
Key Findings	Couples who were expecting their first child were randomly assigned to the intervention group, which received Family Foundations, or the comparison group, which received a mailed brochure with information about selecting quality child care. At the 6-month follow-up, fathers in the intervention group had fewer parent-child dysfunctional interactions relative to fathers in the comparison group ($p < .05$); there was no significant difference

	in parent-child dysfunctional interactions between mothers in each group. At the 1-year follow-up, parents in the intervention group exhibited more positive parenting behaviors relative to parents in the comparison group ($p < .05$). At the 3-year follow-up, parents in the intervention group exhibited fewer negative parenting behaviors relative to parents in the comparison group in regard to overreactivity ($p = .019$), laxness ($p = .049$), and physical punishment ($p = .014$).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.6 (0.0-4.0 scale)

Outcome 4: Child adjustment	
Description of Measures	Child adjustment was assessed with four measures: • The Infant Behavior Questionnaire. Participants responded to 9 subscale items assessing soothability (e.g., "When your baby was upset, how often were you able to comfort him/her by rocking?") and 10 subscale items assessing duration of orienting (e.g., "How often during the last week did your baby play with one toy/object for 5-10 minutes?"). • Videotaped interaction of free play between parents and their child at their home. An interviewer provided a limited set of toys and asked the parents to engage with their child (approximately 1 year old) in 12 minutes of joint free play on the floor. Interviewers then asked the parents to teach their child to accomplish a set of tasks designed to be at the limit of most infants' developmental capacity (e.g., rolling a ball back and forth with a parent, building a tower of blocks). This interaction lasted for 6 minutes and was videotaped. Self-soothing (self-directed comforting, stroking, and sucking) was then coded from the videotape by trained raters who were blind to the experimental condition. • The Child Behavior Checklist (CBCL). From mothers' responses to the 100-item questionnaire, three overall scores (total problems, externalizing problems, and internalizing problems) and scores for two subscales (aggression and attention/hyperactivity) were calculated. • The Head Start Competence Scale, a measure designed for assessing behaviors of young children. Mothers responded to 8 items composing the Social Competence subscale (e.g., "resolves problems with friends on his/her own") and 6 items composing the Emotional Competence subscale (e.g., "copes with sadness"). The Infant Behavior Questionnaire was used to collect data from both parents at posttest (i.e., after parents had completed their last postnatal class, when their baby was around 6 months old). Parents responded to the questionnaires and mailed them to the researchers.

	Videotaped interactions were used to collect follow-up data when the parents' baby was approximately 1 year old. The CBCL and the Head Start Competence Scale were used to collect follow-up data from only mothers when the parents' child was approximately 3 years old. Researchers administered the questionnaires during a home visit.
Key Findings	Couples who were expecting their first child were randomly assigned to the intervention group, which received Family Foundations program, or the comparison group, which received a mailed brochure with information about selecting quality child care. At the 6-month follow-up, fathers in the intervention group had better infant soothability relative to fathers in the comparison group ($p < .05$); there was no significant difference in infant soothability between mothers in each group. At the 1-year follow-up, children of parents in the intervention group demonstrated higher levels of self-soothing behaviors relative to children of parents in the comparison group ($p < .05$). At the 3-year follow-up, children of mothers in the intervention group exhibited lower levels of problem behaviors relative to children of mothers in the comparison group ($p = .022$).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.7 (0.0-4.0 scale)

Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

Study	Age	Gender	Race/Ethnicity
Study 1	0-5 (Early childhood) 18-25 (Young adult) 26-55 (Adult)	50% Female 50% Male	90.5% White 9.5% Race/ethnicity unspecified

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see Quality of Research.

Outcome	Reliability	Validity	Fidelity	Missing	Confounding

	of Measures	of Measures		Data/Attrition	Variables
1: Coparenting	3.5	4.0	4.0	4.0	2.5
2: Parental adjustment	4.0	4.0	4.0	4.0	2.5
3: Parent-child interaction	4.0	3.5	4.0	4.0	2.5
4: Child adjustment	4.0	4.0	4.0	4.0	2.5

Study Strengths

The measures have excellent reliability and validity. The coparenting measure created by the researchers demonstrates criterion-related validity. The researchers demonstrate that intervention fidelity was assured and measured in several ways: the intervention is manualized; group leaders received 3 days of training; and ongoing observations of sessions were conducted, along with regular supervision. In addition, observers assessed whether the program was implemented as planned, and they gave this aspect a very high overall rating. An intent-to-treat analysis was used with all data. Analysis of data from the 3-year follow-up includes an explanation of imputed data. Overall attrition was low for this longitudinal study. By the 3-year follow-up, attrition caused a between-group difference for the education variable, but the researchers accounted for this appropriately in their models. All of the analyses seem to be appropriate, including the methods used to account for time differentials and the nesting of family members within the family. Appropriate types and numbers of data analysis were conducted.

Study Weaknesses

Per the researchers, between-group differences could be related to factors beyond the intervention. Although an intent-to-treat analysis was used, it may mask a dose effect that was not tested.

Readiness for Dissemination

Review Date: September 2011

Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

Feinberg, M. E. (2011). Family Foundations: A Strong Start--Group leader handbook. University Park: Pennsylvania State University.

Feinberg, M. E. (2011). Family Foundations: A Strong Start--Instructional examples #1 [DVD]. University Park: Pennsylvania State University.

Feinberg, M. E. (2011). Family Foundations: A Strong Start--Instructional examples #2 [DVD]. University Park: Pennsylvania State University.

Feinberg, M. E. (2011). Family Foundations: A Strong Start--Postnatal classes instructional DVD [DVD]. University Park: Pennsylvania State University.

Feinberg, M. E. (2011). Family Foundations: A Strong Start--Postnatal parent handbook. University Park: Pennsylvania State University.

Feinberg, M. E. (2011). Family Foundations: A Strong Start--Postnatal parent handbook DVD for home viewing [DVD]. University Park: Pennsylvania State University.

Feinberg, M. E. (2011). Family Foundations: A Strong Start--Prenatal classes instructional DVD [DVD]. University Park: Pennsylvania State University.

Feinberg, M. E. (2011). Family Foundations: A Strong Start--Prenatal parent handbook. University Park: Pennsylvania State University.

Feinberg, M. E. (2011). Family Foundations: A Strong Start--Prenatal parent handbook DVD for home viewing [DVD]. University Park: Pennsylvania State University.

Feinberg, M. E. (2011). Family Foundations: A Strong Start--Program management handbook. University Park: Pennsylvania State University.

Feinberg, M. E. (2011). Family Foundations: A Strong Start--Supplemental material [DVD]. University Park: Pennsylvania State University.

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see Readiness for Dissemination.

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
3.8	3.8	4.0	**3.8**

Dissemination Strengths

The group leader handbook is well organized and of high quality, and it contains detailed implementation guidance, including scripted text, instructions for administering outcome measures, and materials checklists. Participant materials include DVDs with video clips of parents engaged in parenting activities, which serve as a helpful implementation tool to promote learning. The training materials are comprehensive and include easy-to-understand information about the program as well as video clips to demonstrate effective facilitator delivery. Implementers can contact the developer via phone or email for ongoing support or submit tapes of their group facilitation for critique. The quality assurance tools represent the perspectives of participants, facilitators, and observers at multiple points in the intervention. Interactive spreadsheets are available for implementers to easily record data on fidelity and outcome measures, helping them to monitor program effectiveness and quality of implementation and provide feedback to facilitators.

Dissemination Weaknesses

Although the materials contain vast implementation guidance, there is no information concerning the organizational-level preparation needed to start implementing the program. There is no set training calendar or information on the frequency and availability of trainings.

Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items).

The implementation point of contact can provide current information and discuss implementation requirements.

Item Description	Cost	Required by Developer
Facilitator manual (includes PowerPoint slides, facilitator DVDs, and participant feedback forms)	$325 each	Yes
Pre- and postnatal parent handbooks (includes DVDs)	$300 for materials for 10 couples	Yes
3-day facilitator training	$375 per person	No
Videotape review	$100 per session	No
On-site consultation	$500-$750 per day plus travel expenses	No
Phone and email support	Free for the first hour and $50-$100 for each subsequent hour	No
Program manager package (includes group leader handbook, promotional material templates, facilitator and observer rating forms, participant pre- and posttest questionnaire, and data entry template)	$550 per package	No

Replications

No replications were identified by the developer.

Contact Information

To learn more about implementation, contact:
Susan Sulami
(310) 455-2305
communitystrategies@yahoo.com

To learn more about research, contact:
Mark Feinberg, Ph.D.
(814) 865-5205
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Consider these Questions to Ask (PDF, 54KB) as you explore the possible use of this intervention.

Web Site(s):

- **http://www.famfound.net**

Links to SAMHSA Center Home Pages: CSAP CSAT CMHS

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AMCHP

(Association of Maternal & Child Health Programs)

AMCHP
ASSOCIATION OF MATERNAL & CHILD HEALTH PROGRAMS
Innovation Station
Sharing Best Practices in Maternal & Child Health

Family Foundations

Location: Pennsylvania
Date Submitted: 6/2015
Category: **Best Practice**

TITLE V/MCH BLOCK GRANT MEASURES ADDRESSED
N/A

BACKGROUND

Rates of maternal or infant problems at birth are high globally and, in relative terms compared to other developed countries, also high in the U.S. (Blencowe et al., 2012; Clements, Barfield, Ayadi, & Wilber, 2007; Lawn et al., 2010; St John, Nelson, Cliver, Bishnoi, & Goldenberg, 2000). Problems such as low birth weight and medical complications are not only associated with high health care costs, but put children at increased risk for mortality, poor developmental and behavioral outcomes, chronic health problems, low-educational attainment, and psychological disorders into adulthood (Bhutta, Cleves, Casey, Cradock, & Anand, 2002; Clements et al., 2007; Conley, Strully, & Bennett, 2003; Curhan et al., 1996; Gilbert, Nesbitt, & Danielsen, 2003; M. Hack et al., 2002; Maureen Hack, Klein, & Taylor, 1995; Nosarti et al., 2012). Most approaches for improving maternal and neonatal well-being focus on access to prenatal health care, maternal health behaviors, and avoidance of exposure of the fetus to harmful factors via maternal smoking and drug use (Armstrong et al., 2003; Barros et al., 2010).

However, pregnant women's mental and emotional health represents an emerging prevention target as current research links prenatal anxiety and depression with suboptimal fetal development and birth problems. (Beijers, Jansen, Riksen-Walraven, & de Weerth, 2010; Buss, Davis, et al., 2012; Buss, Entringer, Swanson, & Wadhwa, 2012; Conde et al., 2010; Grote et al., 2010; Schetter & Tanner, 2012). By inducing maternal stress, a parallel literature also links prenatal exposure to poverty and financial strain with these adverse outcomes.(Goldenberg, Culhane, Iams, & Romero, 2008; Moutquin, 2003; Nagahawatte & Goldenberg, 2008; Strully, Rehkopf, & Xuan, 2010).

Family Foundations (FF) is a universal, couple-focused psycho-educational program for first-time parents that focuses on enhancing the co-parenting relationship, the ways that parents support and collaborate with each other in their roles as parents (Feinberg & Kan, 2008).

The program focus is based on research demonstrating that co-parenting relationship quality influences parent mental health and adjustment, parenting quality, and child outcomes (Feinberg, 2002, 2003).

PROGRAM OBJECTIVES

The overall goal of the program is to enhance the parenting quality and child outcomes among cohabiting and/or married couples expecting a first child.

TARGET POPULATION SERVED

Family Foundations (FF) is a program for adult couples expecting their first child, and designed to help them establish positive parenting skills and adjust to the physical, social, and emotional challenges of parenthood. This practice focuses on the key element of new families which affects parents' individual and couple relationship, and child developmental outcomes.

PROGRAM ACTIVITIES

FF began as a series of 8 classes for expectant parents delivered through childbirth education departments of local hospitals. Family Foundations is delivered in a community setting by childbirth educators who have received 3 days of training from Family Foundations staff. It is recommended, but not required, that classes be co-delivered by a male and a female. FF helps prepare couples for parenthood by

fostering attitudes and skills primarily related to positive parenting teamwork (called "co-parenting"). This approach was based on research that co-parenting relations influence family functioning and parent and child well-being.

Program topics for the classes include preventing postpartum depression and stress, supportive co-parenting, creating a caring environment, and developing the child's social and emotional competence. FF also covers topics including emotion regulation (via mindful awareness & cognitive retraining), temperament, secure attachment, and positive parenting.

PROGRAM OUTCOMES/EVALUATION DATA

To examine impact of the Family Foundations in program, a sample of 169 heterosexual, adult couples who were expecting their 1st child was randomized to intervention and control conditions. All participants were at least 18 years of age. The couples resided in rural areas, towns, and small cities. This was not statewide, but across a broad region of central Pennsylvania. Eighty-two percent of couples were married, and the majority of participants (91% of mothers and 90% of fathers) were non-Hispanic White.

In a second, 399 couples were randomized to Family Foundation vs. control conditions. The results of that trial, a multi-site study with sites in three states, are consistent with the outcomes of the first trial. However, as not all outcome papers associated with that second trial have been officially accepted for publication yet, the details of the first trial are described here.

Median annual family income was $65,000 (SD _ $34,372), with a range of $2,500 to $162,500. Average educational attainment was 15.06 years for mothers (SD _ 1.82) and 14.51 years for fathers (SD _ 2.19), with a range of ninth grade to beyond college; 14.4% of mothers and 29.3% of fathers did not complete any postsecondary school education. Mean ages were 28.33 years (SD _ 4.93) for mothers and 29.76 years (SD _ 5.58) for fathers. Although the sample is not representative of U.S. families, it is generally representative of the racial and economic background of families from the regions where the data were collected.

Couples were primarily (81%) recruited from childbirth education programs at two hospitals located in small cities. All other couples were recruited from doctors' offices or health centers (8%), by newspaper ads or flyers (7%), by word of mouth (3%), or by unknown means (including radio advertisement; 1%). Couples recruited from childbirth education programs were sent a letter and then contacted by phone. Couples recruited through health centers returned a postcard, and all other couples called the program office if they were interested in participation. Of eligible couples contacted by phone, 23% agreed to participate; reasons for not participating were a lack of time, inability to attend evening sessions, and a perceived lack of need. Couples in both conditions participated concurrently in standard childbirth education classes.

Outcomes were assessed by parent self-report on reliable and valid questionnaires. Research assistants also videotaped family interactions in the home, and these videos were rated by trained research staff.

Outcomes were assessed at three intervals post-intervention: 6-month; 1 year and 3 years. Additionally, a second trial of Family Foundations was conducted with 400 families which included the following locations: central Pennsylvania, Maryland, Delaware, and Texas.

Outcome Results

Rigorous intent-to-treat analyses were conducted on the data, and results indicated that the Family Foundations families showed better co-parenting, lower parental stress, depression, anxiety; better birth outcomes and shorter hospital stays (for mothers who showed moderate to high levels of prenatal stress or depression); better parenting quality; and better child self-regulation and social competence, lower rates of child depressive/anxious problems and behavior problems, and better academic adjustment at age 7,

Measures

Data were collected to measure the following outcomes:

1. Co-parenting
2. Parental adjustment
3. Birth Outcomes
4. Parent-child interaction
5. Child adjustment

Co-parenting-defined as how parents coordinate their parenting, support or undermine each other, and manage conflict regarding child rearing, was assessed with three measures:

- A 15-item co-parenting scale, which was developed for this study partly from an adaptation of existing measures and was used to assess multiple dimensions of the co-parenting relationship. (Performed during 6months of age; parents responded to the questionnaires and mailed them to the researchers.)
- Videotaped interaction of free play between parents and their child at their home. An interviewer provided a limited set of toys and asked the parents to engage with their child (approximately 1 year old) in 12 minutes of joint free play on the floor. (Performed during 1yr. of age; Videotaped interactions were used to collect follow-up data)

- The 31-item Co-parenting Scale, participants responded to items regarding co-parental agreement, support and undermining of each other, and exposure of the child to conflict. (During 3 yrs. of age; Researchers administered the questionnaires during a home visit.)

Parental adjustment

- The 20-item short form of the Taylor Manifest Anxiety Scale (TMAS), which measures chronic anxiety.
- A subset of 7 items from the Center for Epidemiological Studies Depression Scale (CES-D), which measures depressive symptoms.
- The 16-item Parenting Sense of Competence Scale (PSOC) which measures how parents feel about their competence.
- The 27-item Parenting Stress Index (PSI), which measures self-reported parental stress.

The TMAS, the CES-D, the PSOC, and the PSI were used to collect follow-up data from both parents when their child was approximately 3 years old. Researchers administered the questionnaires during a home visit.

Birth Outcomes

Birth outcomes were measured by maternal report regarding preterm birth (based on reported due date and actual birth date); infant weight at birth; birth complications; and length of maternal and infant stay in hospital after birth.

Parent-Child interaction

Parent-child interaction was assessed with three measures:

- *The 6-item Dysfunctional Interaction scale from the Parenting Stress Index*. Participants responded to items regarding distress in the parent-child relationship.
- *Videotaped interaction of free play between parents and their child at their home*. An interviewer provided a limited set of toys and.
- *21 items from the Parenting Scale*, which were used to assess the discipline practices of parents of children 18-48 months old.

The Dysfunctional Interaction scale was used to collect data from both parents at posttest (i.e., after parents had completed their last postnatal class, when their baby was around 6 months old). Parents responded to the questionnaires and mailed them to the researchers.

Videotaped interactions were used to collect follow-up data when the parents' baby was approximately 1 year old. Items from the Parenting Scale were used to collect follow-up data from both parents when their child was approximately 3 years old. Researchers administered the questionnaires during a home visit.

Child Adjustment

Child adjustment was assessed with four measures:

- *The Infant Behavior Questionnaire.* Participants responded to 9 subscale items assessing soothability.
- *Videotaped interaction* of free play between parents and their child at their home.
- *The Child Behavior Checklist (CBCL*). From mothers' responses to the 100-item questionnaire, three overall scores (total problems, externalizing problems, and internalizing problems) and scores for two subscales (aggression and attention/hyperactivity) were calculated.
- *The Head Start Competence Scale*, a measure designed for assessing behaviors of young children.

The Infant Behavior Questionnaire was used to collect data from both parents at post-test. Parents responded to the questionnaires and mailed them to the researchers.

Videotaped interactions were used to collect follow-up data when the parents' baby was approximately 1 year old. The CBCL and the Head Start Competence Scale were used to collect follow-up data from only mothers when the parents' child was approximately 3 years old. Researchers administered the questionnaires during a home visit.

PROGRAM COST

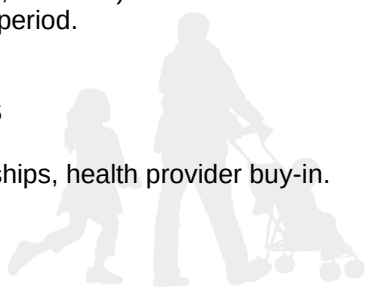
Implementation costs for interested sites are estimated as:

- Materials: Facilitator manual (including PowerPoint slides, facilitator DVDs, participant feedback forms) - $325 / Pre- and postnatal parent handbooks (including DVDs) is $300 for 10 couples
- Optional: Facilitator training ($375 pp / 3 days); onsite consultation is $750/day plus travel; phone and email support is first hr free and then $50-100/hr
- Optional: program manager package = $550; videotape review is $100/session

An academic cost-estimate derived from our research trials indicates that the implementation cost per family is about $700 (based on costs for group leaders, space, supervision, administrative logistics, recruitment, etc.). However, most community sites would be expected to incur significantly lower costs, as costs for space and logistics would be built into existing agency/provider infrastructure. Further, initial start-up costs (e.g., training, manuals) should be amortized over at least a 3- to 5-year period.

ASSETS & CHALLENGES

Assets: State/local partnerships, health provider buy-in.



Challenges: As an innovative program, couples are initially unsure what the program involves or how it could benefit them and their children.

Overcoming Challenges: Focused recruitment through health providers (ob/gyn offices, midwives, etc), clear explanation of program benefits for parents and children, and integrating the program into childbirth education and other services has been successful.

FUTURE STEPS

Currently, FF is taking necessary steps to expand the program colleagues around the country to create versions for Latino parents, adoptive parents, gay/lesbian parents, parents of special needs children, and others. Family Foundations is also considering creative ways to leverage technology in delivering information and tools. Extension of this program to support parents into the "Terrible Two" years and beyond is also on the horizon.

COLLABORATIONS

Lamaze International
University of Maryland
Cincinnati Children's Hospital
Hershey Medical Center
UCLA Medical Center
Father's Institute, UK
U.S. Department of Defense

PEER REVIEW & REPLICATION

The following articles have been published in peer-reviewed journals:

- Feinberg, M. E., Jones, D. E., Kan, M. L., & Goslin, M. C. (2010). Effects of Family Foundations on parents and children: 3.5 years after baseline. Journal of Family Psychology, 24(5), 532-542.
- Feinberg, M. E., & Kan, M. L. (2008). Establishing Family Foundations: Intervention effects on co-parenting, parent/infant well-being, and parent-child relations. Journal of Family Psychology, 22(2), 253-263.
- Feinberg, M. E., Kan, M. L., & Goslin, M. C. (2009). Enhancing co-parenting, parenting, and child self-regulation: Effects of Family Foundations 1 year after birth. Prevention Science, 10(3), 276-285.
- Kan, M.L., Feinberg, M.E., & Solmeyer, A. R. (2012). Intimate partner violence and co-parenting across the transition to parenthood. Journal of Family Issues, 33: 115-135.
- Kan, M.L., & Feinberg, M.E. (2014). Can a family-focused, transition-to-parenthood program prevent parent and partner aggression among couples with young children? Violence and Victims, 29: 967-980.
- Feinberg, M.E., Jones, D.E., Roettger, M.E., Solmeyer, A, & Hostetler, M. (2014). Long-term follow-up of a randomized trial of Family Foundations: Effects on children's emotional, behavioral, and school adjustment. Journal of Family Psychology, 28: 821-831.
- Feinberg, M.E., Roettger, M.E., Jones, D.E., Paul, I., & Kan, M.L. (2015). Effects of a psychosocial couple-based prevention program on adverse birth outcomes. Maternal and Child Health Journal, 19: 102-111.

RESOURCES PROVIDED

Materials developed include a facilitator manual for the Family Foundations class series comprised of:

- A comprehensive, easy-to-use curriculum
- Worksheets, exercises, homework materials
- Video segments on DVD to illustrate points and foster discussion
- Optional PowerPoint slides for each session
- Training and consultation is available.

A DVD/workbook package and an interactive online version for expecting parents are also available.

Information on these materials and about the program is available at: http://www.famfound.net or by emailing info@famfound.net

Key words:
Prenatal stress, Depression, Social Determinants of Health, Low birth weight, Co-parenting

For more information about programs included in AMCHP's Innovation Station database, contact bp@amchp.org. Please be sure to include the title of the program in the subject heading of your email*

EIF

(Early Intervention Foundation in U.K.)

Published March 2017 | Last updated February 2019

Family Foundations

Review: Foundations for Life, July 2016

Family Foundations (FF) is a group-based programme for couples expecting their first child, delivered any time during the mother's pregnancy.

The programme is delivered by male and female co-facilitators with a QCF-level 6 in a helping profession. Parents attend five weekly sessions where they learn strategies for enhancing their communication, conflict resolution and the sharing of childcare duties. Couples return for four more weekly sessions, two to six months after the baby is born, to learn strategies about how to communicate effectively as parents and support their child's development.

Family Foundations seeks to improve children's outcomes by improving the quality of interparental relationships (IPR).

Evidence rating: **4**

Cost rating: **1**

EIF Programme Assessment

Family Foundations has **evidence of a long-term positive impact** on child outcomes through multiple rigorous evaluations.

Evidence rating: **4**

What does the evidence rating mean?

Level 4 indicates **evidence of effectiveness**. This means the programme can be described as evidence-based: it has evidence from at least two rigorously conducted evaluations (RCT/QED) demonstrating positive impacts across populations and environments lasting a year or longer.

Cost rating

A rating of 1 indicates that a programme has a low cost to set up and deliver, compared with other interventions reviewed by EIF. This is equivalent to an estimated unit cost of less than £100.

Cost rating: **1**

Child outcomes

According to the best available evidence for this programme's impact, it can achieve the following positive outcomes for children:

Supporting children's mental health and wellbeing

Improved infant soothability (father report) - based on **study 1**

Improved duration of orienting (mother report) - based on **study 1**

Improved self-soothing (observational measures) - based on **study 1**

Reduced internalising problems (teacher report) - based on **study 1**

Improved soothability (coded observation) - based on **study 2**

Improved orienting (coded observation) - based on **study 2**

Improved sleep (parent report) - based on **study 2**

Enhancing school achievement & employment

Improved prosocial behaviour (parent report) - based on **study 1**

Preventing crime, violence and antisocial behaviour

Reduced externalising problems (teacher report of boys only) - based on **study 1**

This programme also has evidence of supporting positive outcomes for couples, parents or families that may be relevant to a commissioning decision. Please see the 'About the evidence' section for more detail.

Key programme characteristics

Who is it for?

The best available evidence for this programme relates to the following age-groups:

- Perinatal

How is it delivered?

The best available evidence for this programme relates to implementation through these delivery models:

- Group

Where is it delivered?

The best available evidence for this programme relates to its implementation in these settings:

- Sixth-form or FE college
- Community centre
- Out-patient health setting

How is it targeted?

The best available evidence for this programme relates to its implementation as:

- Universal

Where has it been implemented?

United Kingdom, United States

UK provision

This programme has been implemented in the UK.

UK evaluation

This programme's best evidence includes evaluation conducted in the UK.

About the programme

What happens during delivery?

How is it delivered?

- Family Foundations is delivered in eight sessions of two hours' duration each by two facilitators.

What happens during the intervention?

- Parents learn skills to better cope with the transition to parenthood, improved communication skills and better conflict resolution.
- Parents also learn strategies for responding to their child in a sensitive way. Parents learn through a variety of group exercises, role play and group discussion.
- Parents also receive programme packs that contain a homework element. Once the baby is three months old parents attend for more sessions to discuss parenting experiences and explore areas for improvement.

What are the implementation requirements?

Who can deliver it?

- The practitioners that deliver this programme are two facilitators with QCF-6 qualifications.

What are the training requirements?

- The practitioners have 24 hours of programme training. Booster training of practitioners is not required.

How are the practitioners supervised?

- Practitioners are supervised by one highly qualified host-agency supervisor (QCF-7/8).

What are the systems for maintaining fidelity?

- Fidelity self-report forms are completed by practitioners at the end of each session
- Independent observation
- Supervision and accreditation (by videotape)
- Booster training session from programme developer

Is there a licensing requirement?

There is no licence required to run this programme.

How does it work? (Theory of Change)

How does it work?

- Family Foundations assumes that improved parental self regulation will help parents better manage environmental stresses and improve the co-parenting relationship.
- Family Foundations therefore helps couples improve their co-parenting relationship through improved communication and conflict resolution strategies.
- Parents also learn strategies for responding sensitively to their child and developing appropriate sleep routines.
- In the short term, couples will experience an improved co-parenting relationship and reduced family stress.
- In the longer term, children will experience greater attachment security, improved self-regulation, decreased emotional and behavioural problems, and increased academic adjustment.

Contact details

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Commissioning Toolkit Programme Overview
NREPP Programme Overview
Blueprints Programme Overview
RAND Programme Overview

About the evidence

The most rigorous evidence of Family Foundations comes from two RCTs conducted in the USA.

Study 1

Citation: Feinberg, M. E. (2008); Feinberg et al (2009); Feinberg et al (2010); Feinberg et al (2014) | **Design:** RCT

Country: United States

Sample: 169 couples expecting their first child; 160 from the original study; 142 families from the original study; 98 families from the original study

Child outcomes:

Improved infant soothability (father report)

Improved duration of orienting (mother report)

Improved self-soothing (observational measures)

Reduced internalising problems (teacher report)

Improved prosocial behaviour (parent report)

Reduced externalising problems (teacher report of boys only)

Other outcomes:

Improved co-parental support (parent report)

Improved depressive symptoms (mother report)

Improved anxiety (mother report)

Improved parenting-based closeness (father report)

Improved parent-child dysfunctional interaction (father report)

Feinberg, M.E. (2008). Establishing family foundations: Intervention effects on coparenting, parent/infant well-being and parent-child relations. *Journal of family Psychology, 22*, 1-19.

Feinberg, M.E., Kan, M.L., & Goslin, M.C. (2009). Enhancing coparenting, parenting and child self-regulation: Effects of Family Foundation 1 year after birth. *Prevention Science, 10*, 276-285.

Feinberg, M. E., Jones, D. E., Kan, M. L., & Goslin, M. (2010). Effects of a transition to parenthood program on parents, Parenting, and children: 3.5 years after baseline. *Journal of Family Psychology*, *24*(5), 532-542.

Feinberg, M.E., Jones, D.E., Roettger, M.E., Hostettler, M. & Solmeyer, A. (2014). Long-Term Follow-up of a Randomized Trial of Family Foundations: Effects on Children's Emotional, Behavioral, and School Adjustment. *Journal of Family Psychology, 28*, 821- 831.

Available at https://www.ncbi.nlm.nih.gov/pubmed/18410212
https://www.ncbi.nlm.nih.gov/pubmed/19381809
https://www.ncbi.nlm.nih.gov/pubmed/20954763
https://www.ncbi.nlm.nih.gov/pubmed/25485672

Study 2

Citation: Feinberg et al (2015) | **Design:** RCT

Country: United States

Sample: 399 couples expecting their first child

Child outcomes:

Improved soothability (coded observation)

Improved orienting (coded observation)

Improved sleep (parent report)

Other outcomes:

Improved positivity in co-parenting (coded observation)

Reduced competition with partner in co-parenting (coded observation)

Improved overall triadic relationship quality (coded observation)

Improved positive endorsement of parenting (coded observation)

Improved positive communication in couple interaction (coded observation)

Improved quality of marriage (parent report)

Reduced depressive symptoms (parent report)

Reduced anxiety (parent report)

Reduced inter-parent physical violence (parent report)

Reduced parent-child psychological violence (parent report)

Reduced parent-child physical violence (parent report)

Feinberg, M., Jones, D.E., Hostetler, M.L., Roettger, M.E., Paul, I. & Ehrenthal, D. (In press). *Couple-focused prevention at the transition to parenthood: Effects on coparenting, parenting, family violence, and parent and child adjustment*.

Kan, M., & Feinberg, M. (2014). Can a Family-Focused, Transition-to-Parenthood Program Prevent Parent and Partner Aggression Among Couples With Young Children? *Violence And Victims*, *29*(6), 967-980.

Kan, M., & Feinberg, M. (2015). Impacts of a coparenting-focused intervention on links between pre-birth intimate partner violence and observed parenting. *J Fam Viol*, *30*(3), 363-372.

Available at https://www.ncbi.nlm.nih.gov/pubmed/27334116
https://www.ncbi.nlm.nih.gov/pubmed/25905139
https://link.springer.com/article/10.1007/s10896-015-9678-x

Guidebook

The EIF Guidebook provides information about early intervention programmes that have at least preliminary evidence of achieving positive outcomes for children. It provides information based on EIF's assessment of the strength of evidence for a programme's effectiveness, and on detail about programmes shared with us by those who design, run and deliver them.

The Guidebook serves an important starting point for commissioners to find out more about effective early interventions, and for programme providers to find out more about what good evidence of impact looks like and how it can be captured. As just one of our key resources for commissioners and practitioners, the Guidebook is an essential part of EIF's work to support the development of and investment in effective early intervention programmes.

Our assessment of the evidence for a programme's effectiveness can inform and support certain parts of a commissioning decision, but it is not a substitute for professional judgment. Evidence about what has worked in the past offers no guarantee that an approach will work in all circumstances. Crucially, the Guidebook is not a market comparison website: ratings and other information should not be interpreted as a specific recommendation, kite mark or endorsement for any programme.

How to read the Guidebook

EIF evidence standards

About the EIF Guidebook

EIF

The Early Intervention Foundation (EIF) is an independent charity and a member of the What Works network. We support the use of effective early intervention for children, young people and their families: identifying signals of risk, and responding with effective interventions to improve outcomes, reduce hardship and save the public money in the long term.

We work by generating evidence and knowledge of what works in our field, putting this information in the hands of commissioners, practitioners and policymakers, and supporting the adoption of the evidence in local areas and relevant sectors.

www.EIF.org.uk | @TheEIFoundation

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Disclaimer

The EIF Guidebook is designed for the purposes of making available general information in relation to the matters discussed in the documents. Use of this document signifies acceptance of our legal disclaimers which set out the extent of our liability and which are incorporated herein by reference. To access our legal disclaimers regarding our website, documents and their contents, please visit eif.org.uk/terms-conditions/. You can request a copy of the legal disclaimers by emailing info@eif.org.uk or writing to us at Early Intervention Foundation, 10 Salamanca Place, London SE1 7HB.

Blueprints

Blueprints

FOR HEALTHY YOUTH DEVELOPMENT

Family Foundations

A universal prevention program to improve mother, child, and birth outcomes through promoting coparenting quality among couples who are expecting their first child.

Fact Sheet

Program Outcomes

- Antisocial-aggressive Behavior
- Anxiety
- Conduct Problems
- Depression
- Emotional Regulation
- Externalizing
- Healthy Gestation and Birth
- Internalizing
- Prosocial with Peers

Program Type

- Parent Training
- Skills Training

Program Setting

- Hospital/Medical Center
- Community

Continuum of Intervention

- Universal Prevention

Age

- Infant (0-2)
- Adult

Gender

- Both

Race/Ethnicity

- All

Endorsements

Blueprints: Promising
SAMHSA : 3.6-3.7

Program Information Contact

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www.famfound.net (http://www.famfound.net/pages/for-professionals)

Program Developer/Owner

Mark E. Feinberg, Ph.D.
Pennsylvania State University

Brief Description of the Program

Family Foundations is a universal prevention program developed in collaboration with childbirth educators to enhance coparenting quality among couples who are expecting their first child. The program consists of four prenatal and four postnatal sessions, run once a week, with each two-hour session administered to groups of 6-10 couples. Sessions are led by a trained male-female team and follow the Family Foundations curriculum. The female leader is a childbirth educator and the male leaders are from various backgrounds, but experienced in working with families and leading groups. Ongoing observation of sessions facilitates regular supervision discussions.

This program focuses on coparenting and the coparenting relationship, rather than other romantic relationship or parenting qualities. In assisting parents to work together supportively, the program content covers emotional self-management, conflict management, problem solving, communication, and mutual support strategies. Parenting strategies include an understanding of temperament, fostering children's self-regulation, and promoting attachment security. The four prenatal classes introduce the couple to themes and skills, and the four postnatal classes revisit the themes once the couple has experienced life as parents and coparents. The delivery is psychoeducational and skills-based, with didactic presentations, couple communication exercises, written worksheets, videotaped vignettes of other families, and group discussion.

Family Foundations is a universal prevention program developed in collaboration with childbirth educators to enhance coparenting quality among couples who are expecting their first child. The program consists of four prenatal and four postnatal sessions, run once a week, with each two-hour session administered to groups of 6-10 couples. Sessions are led by a trained male-female team and follow the Family Foundations curriculum. The female leader is a childbirth educator. Ongoing observation of sessions facilitates regular supervision discussions.

This program focuses on coparenting and the coparenting relationship, rather than other romantic relationship or parenting qualities. In assisting parents to work together supportively, the program content covers emotional self-management, conflict management, problem solving, communication, and mutual support strategies. The program organizes material into three major domains: Feelings, Thoughts, and Communication. These domains help participants remember and utilize program tools. Parenting strategies include an understanding of temperament, fostering children's self-regulation, and promoting attachment security. However, as the focus is on coparenting, these topics are examined in terms of whole-family dynamics. The prenatal classes introduce the couple to themes and skills, and the postnatal classes revisit the themes once the couple has experienced life as parents and coparents. The delivery is psychoeducational and skills-based, with didactic presentations, couple communication exercises, written worksheets, videotaped vignettes of other families, and group discussion. Skilled facilitators are able to maintain fidelity to the content while engaging parents in an interactive, supportive group learning context.

Developed as a universal group-format program, ongoing research is assessing adaptations of delivery, content, and target population. For example, an adaptation for high-risk, home-visited mothers and partners is currently in a research trial; an adaptation for low-income teens has been piloted; an online version for military reserve and National Guard families is being developed; and an enhanced version for couples at risk of family violence is planned.

Outcomes

At wave 2 (posttest, when children were about six months), the study (Feinberg & Kan, 2008) reported a significant intervention effect for:

- Fathers' coparental support, parenting-based closeness, and parent-child dysfunctional interaction
- Mothers' coparental support, depressive symptoms, and anxiety
- Father-reported infant soothability
- Child duration of orienting

At wave 3 (six-month follow-up, when children were about one year old), intervention participants showed improved (Feinberg et al., 2009):

- Mothers' coparenting competition, coparenting triangulation, warmth to partner, parenting positivity, coparenting inclusion, and negative communication
- Fathers' coparenting competition, coparenting triangulation, warmth to partner, parenting positivity, coparenting warmth, and parenting negativity
- Observed child self-soothing

At wave 4 (2.5-year follow-up, when children were three years old), intervention participants showed program effects for (Feinberg et al., 2010):

- Parent-reported parental stress, parental efficacy, coparenting quality, parenting overreactivity, parenting laxness, and physical punishment
- Mother-reported child total behavior problems, externalizing problems, aggression, and social competence
- Mother-reported child internalizing problems and attention/hyperactivity (boys only)

At wave 5 (six year follow-up, when children were 6-7.5 years old), intervention participants showed improvements in the following child outcomes (Feinberg, Jones et al., 2014)

- Teacher-reported anxious/depressed and internalizing problems
- Teacher-reported attention problems, aggressive behavior, and externalizing problems (boys only)

Pregnancy-related outcomes from mid-program showed a significant intervention effect (Feinberg, Roettger et al., 2014):

- Reduced levels of Caesarian birth

In Feinberg et al. (2015), the program had no main effects on birth weight, maternal length of hospital stay, or neonatal length of hospital stay, but it did help some subgroups by improving

- birth weight at low gestational age among parents with high economic strain or maternal depression
- newborn length of stay among parents with high economic strain, depression, or anxiety
- maternal length of stay among parents with high economic strain

At the 2-year follow-up assessment (approximately two years post-intervention when children were two years old), Jones et al. (2018) found that the intervention group (compared to the control group) showed significantly:

- Greater observational family interaction coparenting triadic relationship quality
- Lower observational family interaction coparenting negativity
- Lower observational family interaction parenting negativity
- Fewer parent-reported child internalizing behaviors
- Fewer parent-reported child nighttime wakings

Brief Evaluation Methodology

A randomized controlled design was used to evaluate Family Foundations. Couples were randomly assigned to an intervention (n=89) or to a no-treatment control condition (n=80), with the control condition consisting of receiving mailed literature on selecting quality childcare and developmental stages. Participants were primarily (81%) recruited from childbirth education programs at two hospitals located in small cities. Presumably, all couples responding to recruitment were enrolled, though no further details on recruitment procedures were provided.

Data were collected on participants five times. Data from 4-5 couples were not utilized in analyses because of developmental difficulties, death of one of the parents, or congenital medical problems for the baby, resulting in a sample size of 164-165. The study gathered pretest data (Wave 1) on all 164-165 couples when mothers were pregnant. Posttest data collection (Wave 2) occurred after the intervention couples had completed the program, when babies were about 6 months old. Of the eligible enrolled couples, 147 mothers completed the posttest (Wave 2) and were included in the analytical sample for posttest results. The study administered a six-month follow-up (Wave 3), when babies were about one year old. For this wave, 93% of mothers and 88% of fathers participated. A two and a half year follow-up (Wave 4) was conducted when children were about three years old (N=137). Wave 5 took place when children were ages 6 to 7.5, or six to seven years after program conclusion. Ninety-eight families provided parent and/or teacher data on child development. Additional analysis was conducted on a subsample (N=123) of mothers consenting to baseline cortisol measurement and completing posttest data collection (Feinberg, Roettger et al., 2014).

Key outcome measures included pregnancy-related indicators, attitudes and behaviors of mothers and fathers, coparenting and parenting behaviors, and child developmental outcomes.

Blueprints Certified Studies

Study 1

Feinberg, M. E., Jones, D. E., Roettger, M., Solmeyer, A., & Hostetler, M. L. (2014). Long-term follow-up of a randomized trial of Family Foundations: Effects on children's emotional, behavioral, and school adjustment. *Journal of Family Psychology, 28*(6), 821-831.

Risk and Protective Factors

Risk Factors

Family: Family conflict/violence, Parent aggravation*, Parent stress*, Poor family management, Psychological aggression/discipline, Violent discipline

Protective Factors

Individual: Skills for social interaction*

Family: Attachment to parents, Nonviolent Discipline*

* *Risk/Protective Factor was significantly impacted by the program*

See also: Family Foundations Logic Model (PDF) (/resources/logic-model/FF.pdf)

Race/Ethnicity/Gender Details

Gender Specific Findings

- Male

Race/Ethnicity/Gender Details

Some child outcomes showed an intervention effect only for boys. These included internalizing, attention/hyperactivity, and relationship satisfaction collected at wave 4 and attention problems, aggressive behavior, and externalizing at wave 5. Supplemental analysis, gathered during the Blueprints review, also showed that anxious/depressed and Internalizing was only significant for the boys at wave 5. Some child outcomes showed intervention effects across gender, but stronger effects for boys. These included total behavior problems, externalizing, and aggression from wave 4.

Training and Technical Assistance

Implementation training is available from Community Strategies/Family Gold trainers. This interactive training prepares trainees to deliver Family Foundations with competence and confidence. Generally, implementation training is offered on-site for agencies and communities as requested, but occasionally we will offer open-enrollment workshops for multiple organizations. The cost of an on-site workshop is $3,000, plus travel and lodging expenses for the trainer(s). Open-enrollment workshops are $375.00 per person for the full training. An on-site training is accompanied by one hour of post-training technical assistance on a complimentary basis, with additional technical assistance available.

Training Process: The training is held in two phases:

- 1.5 day first phase to introduce the program and review the prenatal material,
- 1 day second phase to review prenatal group leading experiences and review the postnatal material.

Training Certification Process

Videotape Review: Trainees videotape themselves practicing sessions in front of an audience (expectant parents or a mock audience), and we review, code, and offer feedback. Cost is $100/class reviewed. Certification as a Family Foundations facilitator requires adequate performance in review of two classes.

Benefits and Costs

Source: Washington State Institute for Public Policy
All benefit-cost ratios are the most recent estimates published by The Washington State Institute for Public Policy for Blueprint programs implemented in Washington State. These ratios are based on a) meta-analysis estimates of effect size and b) monetized benefits and calculated costs for programs as delivered in the State of Washington. Caution is recommended in applying these estimates of the benefit-cost ratio to any other state or local area. They are provided as an illustration of the benefit-cost ratio found in one specific state. When feasible, local costs and monetized benefits should be used to calculate expected local benefit-cost ratios. The formula for this calculation can be found on the WSIPP website (http://www.wsipp.wa.gov/).

Program Costs

Start-Up Costs

Initial Training and Technical Assistance

The cost of an on-site training workshop is $3,000, plus travel and lodging expenses for the trainer(s). Open-enrollment workshops for multiple sites are $375.00 per person for the full training. The training workshops are 2 1/2 days in length -- 1.5 days for overview and prenatal content, and one day for review and postnatal content. An on-site training is accompanied by one hour of post-training technical assistance on a complimentary basis, with additional technical assistance available.

Local supervisor(s) should also be trained, and then observe trainee facilitator sessions and provide supervision support to enhance fidelity and group-leading quality.

Curriculum and Materials

$325/manual.

Licensing

None.

Other Start-Up Costs

No information is available

Intervention Implementation Costs

Ongoing Curriculum and Materials

$30/couple for workbooks.

Staffing

Two co-facilitators (male and female) lead the sessions. Facilitators should have experience and comfort in working with families and in leading groups/classes. The training provides the key information for them to deliver the program effectively.

Other Implementation Costs

No information is available

Implementation Support and Fidelity Monitoring Costs

Ongoing Training and Technical Assistance

No ongoing training is required. An optional videotape review of class is $100.

The first hour of technical assistance is free with the on-site training. Thereafter, $50-$100/hour by phone as needed.

Fidelity Monitoring and Evaluation

An observer at one to two classes per cohort, especially for new trainees, is optimal. Fidelity observation forms are provided for each session.

Ongoing License Fees

None.

Other Implementation Support and Fidelity Monitoring Costs

None.

Other Cost Considerations

No information is available

Year One Cost Example

This example assumes that a community-based organization would deliver the Family Foundations program on-site to 4 cohorts, each including 10 couples. Two co-facilitators (male and female) would be contracted to lead the sessions.

On-site training 2 1/2 days	$3,000.00
Trainer travel expense	$1,500.00
Facilitator manuals: 2 x $325	$650.00
Parent workbooks: 10 couples x 4 cohorts x $30/workbook	$1,200.00
Facilitator salaries: 2 facil x 2 hr x 8 sessn x 4 cohort x $25/hr	$3,200.00
Total One Year Cost	$9,550.00

The Year One expense for delivering the program to 40 couples would be $238.75 per couple. If space on-site is unavailable, an additional cost would be incurred to rent space for the parent group sessions. Other optional costs may include an inexpensive dinner and childcare.

Funding Strategies

Funding Overview

No information is available

Funding Strategies

Improving the Use of Existing Public Funds

No information is available

Allocating State or Local General Funds

Funds may be obtained from prevention, health care organizations focused on healthy marriage, fatherhood, birth outcomes, postpartum depression, women's health, and child well-being.

Maximizing Federal Funds

Formula Funds:

- Title V Maternal and Child Health Block Grant which funds public health activities aimed at supporting healthy pregnancy and early childhood may be a source of funding for Family Foundations.

Entitlement Funds:

- Medicaid reimbursement (state by state) may be used. Some of the approaches used by states include: Negotiated rates with Medicaid funded managed care organizations, State Medicaid "Public Health" program, and State Medicaid "Perinatal Services" program.

Foundation Grants and Public-Private Partnerships

No information is available

Debt Financing

No information is available

Generating New Revenue

No information is available

Data Sources

No information is available

Evaluation Abstract

Program Developer/Owner

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Program Outcomes

- Antisocial-aggressive Behavior
- Anxiety
- Conduct Problems
- Depression
- Emotional Regulation
- Externalizing
- Healthy Gestation and Birth
- Internalizing
- Prosocial with Peers

Program Specifics

Program Type

- Parent Training
- Skills Training

Program Setting

- Hospital/Medical Center
- Community

Continuum of Intervention

- Universal Prevention

Program Goals

A universal prevention program to improve mother, child, and birth outcomes through promoting coparenting quality among couples who are expecting their first child.

Population Demographics

The program targets heterosexual couples expecting their first child.

Target Population

Age

- Infant (0-2)
- Adult

Gender

- Both

Gender Specific Findings

- Male

Race/Ethnicity

- All

Race/Ethnicity/Gender Details

Some child outcomes showed an intervention effect only for boys. These included internalizing, attention/hyperactivity, and relationship satisfaction collected at wave 4 and attention problems, aggressive behavior, and externalizing at wave 5. Supplemental analysis, gathered during the Blueprints review, also showed that anxious/depressed and Internalizing was only significant for the boys at wave 5. Some child outcomes showed intervention effects across gender, but stronger effects for boys. These included total behavior problems, externalizing, and aggression from wave 4.

Other Risk and Protective Factors

Family: Successful coparenting as a protective factor. Mother's stress, mental health, and substance use during gestation.

Risk/Protective Factor Domain

- Family

Risk/Protective Factors

Risk Factors

Family: Family conflict/violence, Parent aggravation*, Parent stress*, Poor family management, Psychological aggression/discipline, Violent discipline

Protective Factors

Individual: Skills for social interaction*

Family: Attachment to parents, Nonviolent Discipline*

*Risk/Protective Factor was significantly impacted by the program

Brief Description of the Program

Family Foundations is a universal prevention program developed in collaboration with childbirth educators to enhance coparenting quality among couples who are expecting their first child. The program consists of four prenatal and four postnatal sessions, run once a week, with each two-hour session administered to groups of 6-10 couples. Sessions are led by a trained male-female team and follow the Family Foundations curriculum. The female leader is a childbirth educator and the male leaders are from various backgrounds, but experienced in working with families and leading groups. Ongoing observation of sessions facilitates regular supervision discussions.

This program focuses on coparenting and the coparenting relationship, rather than other romantic relationship or parenting qualities. In assisting parents to work together supportively, the program content covers emotional self-management, conflict management, problem solving, communication, and mutual support strategies. Parenting strategies include an understanding of temperament, fostering children's self-regulation, and promoting attachment security. The four prenatal classes introduce the couple to themes and skills, and the four postnatal classes revisit the themes once the couple has experienced life as parents and coparents. The delivery is psychoeducational and skills-based, with didactic presentations, couple communication exercises, written worksheets, videotaped vignettes of other families, and group discussion.

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Developed as a universal group-format program, ongoing research is assessing adaptations of delivery, content, and target population. For example, an adaptation for high-risk, home-visited mothers and partners is currently in a research trial; an adaptation for low-income teens has been piloted; an online version for military reserve and National Guard families is being developed; and an enhanced version for couples at risk of family violence is planned.

Theoretical Rationale

This program is based on a theoretical model of coparenting as a key influence on parent adjustment, parenting quality, and child adjustment. Coparenting is defined as the way in which parents (or others in a caregiving role) coordinate and support each other in their roles as parents. Research indicates that the coparenting relationship is more strongly related to parenting and child outcomes than the general couple or marital relationship. As the coparenting construct includes couple conflict about issues related to the child, which is a strong risk factor for child externalizing and internalizing problems, the program directly addresses a central risk factor for child adjustment. Difficulties in coparenting have been found to be linked to a range of child outcomes in addition to internalizing and externalizing problems, including effortful control, peer relations, school adjustment, and substance use.

Coparenting is distinguished from other aspects of the couple's relationship such as romantic, friendship, legal, and financial domains (except as they impact coparenting per se). In this way, the program targets a circumscribed aspect of the couple relationship-which may be more malleable than the overall couple relationship. Moreover, coparenting is viewed as a protective factor (i.e., moderator) of other influences on parents and children. For example, supportive coparenting may reduce the detrimental effects of parent depression on parent-child relationship quality. Evidence from the research on Family Foundations supports this view, as the program buffered families from the negative effect of prenatal couple violence on harsh parenting toward the child.

Because coparenting represents the overlap between the parent-child and parent-parent relationship spheres, coparenting is a key target with regard to a range of important outcomes. For example, as maternal stress and anxiety during pregnancy has been related to poor fetal development and outcomes, reducing maternal stress/anxiety during pregnancy through enhanced couple support may reduce adverse birth outcomes. As father involvement among both residential and non-residential fathers is linked to coparenting quality, a focus on coparenting may enhance responsible fathering. And as partner support is the strongest influence on maternal postpartum depression (after prior history of depression is controlled), enhanced coparenting may reduce levels of this problem with benefits for mothers and babies. Indeed, program evaluation data suggests that families enrolled in the program have demonstrated better birth outcomes (for mothers at risk due to levels of a stress hormone, cortisol), better father-infant relations, and decreased postpartum depression.

Theoretical Orientation

- Skill Oriented
- Cognitive Behavioral

Brief Evaluation Methodology

A randomized controlled design was used to evaluate Family Foundations. Couples were randomly assigned to an intervention (n=89) or to a no-treatment control condition (n=80), with the control condition consisting of receiving mailed literature on selecting quality childcare and developmental stages. Participants were primarily (81%) recruited from childbirth education programs at two hospitals located in small cities. Presumably, all couples responding to recruitment were enrolled, though no further details on recruitment procedures were provided.

Data were collected on participants five times. Data from 4-5 couples were not utilized in analyses because of developmental difficulties, death of one of the parents, or congenital medical problems for the baby, resulting in a sample size of 164-165. The study gathered pretest data (Wave 1) on all 164-165 couples when mothers were pregnant. Posttest data collection (Wave 2) occurred after the intervention couples had completed the program, when babies were about 6 months old. Of the eligible enrolled couples, 147 mothers completed the posttest (Wave 2) and were included in the analytical sample for posttest results. The study administered a six-month follow-up (Wave 3), when babies were about one year old. For this wave, 93% of mothers and 88% of fathers participated. A two and a half year follow-up (Wave 4) was conducted when children were about three years old (N=137). Wave 5 took place when children were ages 6 to 7.5, or six to seven years after program conclusion. Ninety-eight families provided parent and/or teacher data on child development. Additional analysis was conducted on a subsample (N=123) of mothers consenting to baseline cortisol measurement and completing posttest data collection (Feinberg, Roettger et al., 2014).

Key outcome measures included pregnancy-related indicators, attitudes and behaviors of mothers and fathers, coparenting and parenting behaviors, and child developmental outcomes.

Outcomes (Brief, over all studies)

Across posttest and follow-up analyses, 9 of 22 child outcomes and 24 of 40 parent outcomes showed significant program effects. One of seven pregnancy-related outcomes assessed at mid-program showed improvement.

At Wave 2 (posttest, when children were six months old), two of four child outcomes and 6 of 12 parent outcomes showed significant improvement. Mothers and fathers' coparental support, fathers' parent-child dysfunctional and parenting-based closeness, mothers' depressive symptoms and anxiety, father-reported infant soothability, and child duration of orienting all showed significant differences. Mothers' and fathers' coparental undermining, mothers' parent-child dysfunctional interaction and parenting-based closeness, fathers' depressive symptoms and anxiety, mother-reported infant soothability, and child sleep habits did not show a significant program effect.

Of the 18 parenting, couple, and coparenting variables tested at wave 3 (six-month follow-up, when children were one year old), 12 showed significant improvements for the intervention participants. The study reported a program effect for one of two child outcomes. Mothers and fathers in the treatment group showed reduced competition and triangulation in coparenting, increased warmth to partner, and increased parenting positivity. Mothers, but not fathers, improved on coparenting inclusion and negative communication to partner, while fathers significantly increased coparenting warmth and reduced parenting negativity. Neither maternal nor paternal active coparenting cooperation showed a significant effect. For child outcomes, self-soothing improved significantly, but sustained attention did not.

Wave 4 (2.5-year follow-up, when children were about three years old) analyses indicated a significant program effect on six of ten parent, interparental relationship, and parenting outcomes and on four of seven child outcomes. Intervention participants improved parental stress, parental efficacy, coparenting quality, parenting overreactivity, parenting laxness, physical punishment, total behavior problems, child externalizing problems, child aggression, and child social competence. No significant effect emerged for parental depression, relationship satisfaction, child internalizing problems, child attention/hyperactivity, or child emotional competence (Feinberg et al., 2010), or for partner psychological aggression or parent-child physical aggression (Kan & Feinberg, 2013b). Additional analyses showed that among boys, the program had an effect for male children on internalizing, attention/hyperactivity, and relationship satisfaction and showed a stronger effect on total behavior problems, externalizing, and aggression for boys.

Main effects analyses indicated that, of the two parent-reported and nine teacher-reported child academic and behavioral outcomes measured at wave 5 (six-year follow-up, when children were 6-7.5), two showed significant improvements for the intervention group: teacher-reported anxious/depressed and internalizing problems. In looking at program effects by child gender, boys showed significant improvement for attention problems, aggressive behavior, and externalizing. Parent- and teacher-reported conduct problems and emotional problems and teacher-reported classroom participation and academic participation showed no direct or gender moderated program effects.

Pregnancy-related outcomes assessed mid-program (four of eight classes) indicated one main effect of the intervention (fewer Caesarian births). Birth weight, number of weeks born premature, premature status, the number of days the child was in the hospital, pregnancy complications, and the number of days the mother was in the hospital showed no program effects for the full sample.

Moderation analyses indicated the greater effectiveness of the program for high-risk couples. Significant moderators included low parental education, high maternal and paternal attachment insecurity, unmarried mothers, high baseline negative communication levels, high baseline cortisol levels, baseline psychological partner aggression, baseline physical partner aggression, and baseline intimate partner violence, all of which strengthened the relationships between intervention status and different outcomes.

Feinberg et al. (2015) found no direct effects of the program on parent-reported birth weight, neonatal length of stay in hospital, or maternal length of stay in the hospital. They did find that the program helped several subgroups, specifically those with high levels of pretest parental economic strain, depression, and anxiety.

Outcomes

At wave 2 (posttest, when children were about six months), the study (Feinberg & Kan, 2008) reported a significant intervention effect for:

- Fathers' coparental support, parenting-based closeness, and parent-child dysfunctional interaction
- Mothers' coparental support, depressive symptoms, and anxiety
- Father-reported infant soothability

- Child duration of orienting

At wave 3 (six-month follow-up, when children were about one year old), intervention participants showed improved (Feinberg et al., 2009):

- Mothers' coparenting competition, coparenting triangulation, warmth to partner, parenting positivity, coparenting inclusion, and negative communication
- Fathers' coparenting competition, coparenting triangulation, warmth to partner, parenting positivity, coparenting warmth, and parenting negativity
- Observed child self-soothing

At wave 4 (2.5-year follow-up, when children were three years old), intervention participants showed program effects for (Feinberg et al., 2010):

- Parent-reported parental stress, parental efficacy, coparenting quality, parenting overreactivity, parenting laxness, and physical punishment
- Mother-reported child total behavior problems, externalizing problems, aggression, and social competence
- Mother-reported child internalizing problems and attention/hyperactivity (boys only)

At wave 5 (six year follow-up, when children were 6-7.5 years old), intervention participants showed improvements in the following child outcomes (Feinberg, Jones et al., 2014)

- Teacher-reported anxious/depressed and internalizing problems
- Teacher-reported attention problems, aggressive behavior, and externalizing problems (boys only)

Pregnancy-related outcomes from mid-program showed a significant intervention effect (Feinberg, Roettger et al., 2014):

- Reduced levels of Caesarian birth

In Feinberg et al. (2015), the program had no main effects on birth weight, maternal length of hospital stay, or neonatal length of hospital stay, but it did help some subgroups by improving

- birth weight at low gestational age among parents with high economic strain or maternal depression
- newborn length of stay among parents with high economic strain, depression, or anxiety
- maternal length of stay among parents with high economic strain

At the 2-year follow-up assessment (approximately two years post-intervention when children were two years old), Jones et al. (2018) found that the intervention group (compared to the control group) showed significantly:

- Greater observational family interaction coparenting triadic relationship quality
- Lower observational family interaction coparenting negativity
- Lower observational family interaction parenting negativity
- Fewer parent-reported child internalizing behaviors
- Fewer parent-reported child nighttime wakings

Mediating Effects

In Solmeyer et al. (2014), coparenting competition mediated the effect of the intervention on wave 4 child adjustment problems for mother-son and father-child relationships, but not mother-daughter relationships. The proportion of total effects mediated by coparenting competition was 39% for mothers and sons and 55% for fathers. Coparenting positivity did not mediate program effects for mothers or fathers.

Moderated intervention effects:

- Wave 2 posttest outcomes of maternal depression, mother report of coparental support, and child sleep habits were moderated by parental education (Feinberg & Kan, 2008)
- Wave 2 posttest outcomes of maternal depression, mother's coparental support, coparental undermining, maternal dysfunctional interaction, and paternal dysfunctional interaction were moderated by father's insecurity, and maternal depression was moderated by mother's insecurity (Feinberg & Kan, 2008)
- Parental depression across waves 2-4 were moderated by parent gender and marital status (Feinberg et al., 2010)
- Maternal and paternal positivity and negativity toward daughters and reactivity to distress at wave 3 were moderated by baseline intimate partner violence perpetration (Kan & Feinberg, 2013a)
- Fathers' psychological partner aggression was moderated by baseline psychological partner aggression and physical partner aggression and mothers' aggression toward the child was moderated by baseline psychological partner aggression (Kan & Feinberg, 2013b)
- Parent-reported emotional problems and teacher-reported behavioral outcomes at wave 5 (classroom total participation, academic motivation, conduct problems, emotional problems, anxious/depressed, aggressive behavior, internalizing, and externalizing), were moderated by baseline negative communication levels (Feinberg, Jones et al., 2014)
- Pregnancy-related outcomes of birth weight, number of weeks born premature, newborn hospital length-of-stay and maternal length-of-stay in hospital were moderated by baseline cortisol levels (Feinberg, Roettger et al., 2014)
- Participation in the intervention program was moderated by pretest levels of observed couple negative communication (Jones et al., 2018)

Effect Size

As there were many effects across the different outcomes and analyses, the sizes ranged from small to large. Coparenting outcomes generally had small-medium or medium effect sizes, child behavior outcomes generally had medium to medium-large effect size

Generalizability

The sample appears to have limited generalizability. It was composed of a high proportion of couples who were white, married, and of high socioeconomic status and was limited geographically to two small U.S. cities. Moderation analyses indicated the greater effectiveness of the program for high-risk couples. Most of the child outcomes were found only for boys and not for girls.

Potential Limitations

- Program participation rates were not very high. Most couples (66% of mothers and 63% of fathers) attended 5 or more sessions.
- The sample appears to have limited generalizability.
- Of the several dozen outcomes tested, only 11 were independently measured and related to the development of children (two in wave 3 and nine in wave 5), three of which showed significant improvements across the whole sample. In addition, two of these significant findings (wave 5) are from a substantially reduced sample.
- The moderation analyses found stronger results for high-risk families but also that the program did not work as well universally.
- Some parent-reported child outcomes were not independent, but teacher reports and researcher observations were.
- Some coparenting outcomes were closely related to program content, but the child outcomes were more general.
- Low reliability of some teacher measures.

Feinberg et al. (2015)

- Excluded those who did not attend enough sessions
- No significance tests for baseline equivalence
- Not possible to control for baseline outcomes
- Likely no differential attrition but wording is ambiguous
- No main effects of the treatment on outcome measures

Jones et al. (2018)

- No significance tests for baseline equivalence
- No independently measured child outcomes
- Baseline controls not possible, though used other covariates
- No tests for posttest outcomes
- Long-term effects on child outcomes but not for independently rated measures

Endorsements

Blueprints: Promising
SAMHSA : 3.6-3.7

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Study 1

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Study 2

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Study 1

Evaluation Methodology

Design: A randomized controlled design was used to evaluate Family Foundations. Couples were randomly assigned to intervention (n=89) or to no-treatment control conditions (n=80), with the control condition consisting of receiving mailed literature on selecting quality childcare and developmental stages. Data from 4-5 couples were not utilized in analyses because of developmental difficulties, death of one of the parents, or congenital medical problems for the baby, resulting in a sample size of 164-165. Participants were primarily (81%) recruited from childbirth education programs at two hospitals located in small cities. All other couples were recruited from doctors' offices or health centers (8%), by newspaper ads or flyers (7%), by word of mouth (3%), or by unknown means (including radio advertisement, 1%). Presumably, all couples responding to recruitment were enrolled, though no further details on recruitment procedures were provided.

Data were collected on participants five times. The study gathered pretest data (Wave 1) on all 164-165 couples when mothers were pregnant. Posttest data collection (Wave 2) occurred after the intervention couples had completed the postnatal classes, when babies were about 6 months old. Of the eligible enrolled couples, 92% of mothers and 90% of fathers completed wave 2. The study administered a six-month follow-up (Wave 3), when babies were about one year old. For this wave, 93% of mothers and 88% of fathers participated. A two and a half year follow-up (Wave 4) was conducted when children were about three years old and included 137 families. Wave 5 took place when children were ages 6 to 7.5, or six to seven years after program conclusion. Ninety-eight families provided parent and/or teacher data on child development.

Additional analysis was conducted on a subsample (N=123) of mothers consenting to baseline cortisol measurement and completing posttest data collection (Feinberg, Roettger et al., 2014).

The investigators provided Blueprints with exact numbers of valid data for each outcome by each wave. Overall, they report sample sizes of 123 at the birth outcome assessment, 152 at wave 2, 156 at wave 3, 142 at wave 4, and 98 at wave 5. Among these samples of completers, the measures generally had little missing data. In a few instances, however, missing data among completers reached higher levels: 9.2% (138/152) in wave 2 for father's Infant Behavior Questionnaire Duration of Orienting, 22.4% (121/156) in wave 3 for mother and father's Dyadic Couple Communication, 24.6% (107/142) in wave 4 for Child Social Competence, and 27.6% (71/98) in wave 5 for teacher reports of Child Emotional Problems. The analytical sample for adverse birth outcomes (Feinberg et al., 2014) was 147.

Sample: Participants were 169 heterosexual couples who, at the time of recruitment, were expecting their first child and were living together. All participants were at least 18 years of age. The couples resided in rural areas, towns, and small cities. The majority of couples were married (82%) and the sample consisted mostly of non-Hispanic whites (90-91%), with the remaining participants of African American, Asian, Hispanic, or other ethnic descent. For the most part, participants were well-educated and middle class. The median annual family income was $65,000 and mothers attained an average of 15.06 years of education and fathers attained an average of 14.51 years. Mothers averaged 28 years old, and fathers averaged 30 years.

The subsample used to examine program effects on pregnancy-related outcomes was demographically similar to the overall sample. The subsample was 92.7% white and 85% married, and had a mean educational level of 15.1 years.

Measures: The study used the following mother, father, and relationship outcomes:

- Parental depression, taken from a subset of the Center for Epidemiological Studies Depression Scale, developed and validated by others. Cronbach's alphas were .84 for mothers and .66 for fathers across waves 1 and 2, and .86 for mothers and .83 for fathers at wave 4. This survey was administered to mothers and fathers at waves 1, 2, 3, and 4.
- Parental anxiety, taken from the Taylor Manifest Anxiety Scale, developed and validated by others. At baseline, alphas were .85 for mothers and .78 for fathers. This survey was administered to mothers and fathers at baseline and wave 2.
- Parent-reported efficacy, taken from the Parenting Sense of Competence scale, developed and validated by others. This survey was administered at waves 2, 3, and 4, with alpha coefficients of .84 for mothers and .83 for fathers.
- Parent-reported stress, taken from the Parenting Stress Index, developed and validated by others. This survey was administered at waves 2, 3, and 4, with alpha coefficients of .90 for mothers and .87 for fathers.
- Observed couple behaviors, taken from coded videotaped interactions between mother and father. Undergraduate and graduate students used coding systems created for the study or adapted from prior work. Subscales included negative communication and warmth to partner, with inter-rater intraclass correlations ranging from .63 to .88. Couple behaviors were observed at waves 1 and 3.
- Parent-reported relationship satisfaction, taken from the Quality of Marriage Index, developed and validated by others. This survey was administered at wave 4 and had alpha coefficients of .97 for mothers and .95 for fathers.

The study used the following parenting and coparenting indicators as outcomes:

- Parent-reported coparenting, taken from a measure developed for the study based in part on adaptation of prior measures. Subscales from this measure included coparental support, parenting-based closeness, and coparental undermining. Cronbach's alphas ranged from .72 to .83 for mothers and from .65 to .80 for fathers. This measure was collected at waves 2, 3, and 4.
- Parent-reported parent-child dysfunctional interaction, taken from a scale in the Parental Stress Index, developed and validated by others. Alphas were .79 for mothers and .77 for fathers. This measure was collected at wave 2.
- Observed coparenting, taken from coded videotaped interactions at wave 3 among mother, father, and child. Undergraduate and graduate students used coding systems created for the study or adapted from prior work. Subscales for coparenting included competition, triangulation, warmth, and inclusion, with inter-rater intraclass correlations ranging from .44 to .87.
- Observed parenting behaviors, taken from coded videotaped interactions at wave 3 among mother, father, and child. Undergraduate and graduate students used coding systems created for the study or adapted from prior work. Subscales for parenting behaviors included positivity, negativity, intrusiveness, and reactivity with inter-rater intraclass correlations ranging from .69 to .73.
- Parenting practices, taken from the Parenting Scale, developed and validated by others. This scale assesses discipline practices in parents of children from 18-48 months. The measure produced three outcomes: laxness, overreactivity, and physical punishment. Alpha coefficients for laxness and overreactivity ranged from .76 to .85. Physical punishment included a single item. The scale was administered at wave 4.
- Parent-reported partner psychological aggression, assessed at waves 1 and 4 with subsets of items from the Revised Conflict Tactics Scales. Behaviors reported by mother and father were combined and summed to create a frequency measure. The mothers' alpha was .65 and the fathers' was .68.
- Parent-reported parent-child physical aggression, assessed at wave 4 with the corporal punishment subscale of the Parent-Child Conflict Tactics Scales. Items in the subscale were summed to create a frequency score. Cronbach's alphas were .55 and .57 for mothers and fathers, respectively.

The following child behavioral and academic outcomes were used:

- Parent-reported infant regulation, taken from the Infant Behavior Questionnaire, developed and validated by others. This measure produced two outcomes for mothers and fathers, duration of orienting and infant soothability, and one outcome reported by mothers, child sleep habits. Alphas ranged from .75 to .86 for these indicators measured at wave 2.
- Observed child behaviors, taken from coded videotaped interactions at wave 3 of the mother, father, and child. Undergraduate and graduate students used coding systems created for the study or adapted from prior work. Subscales for child behaviors included self-soothing and sustained attention, with inter-rater correlations ranging from .67 to .87. The measure of child adjustment problems (alpha=.69) aggregated subscales of anger, activity, resistance to control, and sustained attention.
- Mother-reported child behavior problems, taken from the Child Behavior Checklist and the Head Start Competence Scale, administered at wave 4. The Checklist produced five outcomes, including three overall scores (total problems, externalizing problems, and internalizing problems) and two specific subscales (aggression and attention/hyperactivity). Two subscale outcomes were taken from the Competence Scale: social competence and emotional competence. Alpha coefficients for these indicators ranged from .78 to .90.
- Teacher-rated classroom participation, taken from the Total Classroom Participation, developed and validated by others. This outcome was collected at wave 5 (alpha=.95).
- Teacher-rated academic motivation, taken from the Academic Competence Evaluation Scales, developed and validated by others. This outcome was collected at wave 5 (alpha=.96).
- Teacher- and parent-reported conduct problems and emotional problems. These outcomes were collected at wave 5 from the Strengths and Difficulties Questionnaire, developed and validated by others. Teachers showed alpha coefficients of .72 (conduct) and .62 (emotional), and parents had alphas of .60 (conduct) and .59 (emotional).
- Teacher-reported child behavioral problems, taken from the Child Behavioral Checklist, developed and validated by others. The checklist provided five outcomes at wave 5, composed of three specific scales (anxious/depressed, attention problems, and aggressive behavior) and two broad-band indices (internalizing behavior and externalizing behavior). Alpha coefficients ranged from .55 to .92.

The study used the pregnancy related-outcomes listed below. The data were collected at wave 2, but reflect mid-program assessments when four of the eight classes had been offered. Few details were provided on these outcomes.

- Birth weight, in pounds
- Number of weeks born prior to due date
- Premature status, defined as born three or more weeks early
- Caesarian section
- Pregnancy complications rated from parent reports by research team pediatrician
- Number of days child in hospital after birth
- Number of days mother in hospital after birth

The study used the following measures as moderators:

- Parental education measured by total years of education at baseline.
- Parent-reported attachment insecurity in close relationships, measured at baseline with a 20-item subscale of the Relationships Scale Questionnaire, developed by others. Alphas were .80 for mothers and .79 for fathers.
- Parent gender and marital status indicating married and unmarried mothers or fathers at waves 2, 3, and 4.
- Child gender.
- Maternal cortisol levels at baseline. Trained research assistants collected saliva samples during home visits. The measure reflects residualized cortisol levels from regression models using time of day and gestation weeks to predict sample results.
- Observed parental negative communication level at baseline. Trained coders rated maternal and paternal behaviors in videotaped interactions and averaged scores across the two parents. Cronbach's alpha was .84 for this measure.
- Intimate partner violence at baseline. The overall violence scores multiplied frequency by severity, with frequency of violence created from summing mothers' and fathers' item frequency scores, and severity of violence produced from summing item severity scores. Cronbach's alphas were .77 and .81 for prevalence and .92 and .76 for frequency of mothers' and fathers' behaviors, respectively.

- Parent-reported partner psychological aggression at baseline, as described in the above measure of parent-reported psychological aggression.
- Parent-reported severity of parental physical aggression. This mutually exclusive categorical measure defined couples as perpetrating any severe aggression, perpetrating minor aggression only, or not perpetrating any aggression.

The study used the following mediating measure:

- Observed coparenting subscales of competition and positivity measured at wave 3, as described in the above outcome measure of observed coparenting.

Analysis: Multilevel, general linear model, ordinary least squares, logistic, and negative binomial regression models analyzed program effects. For outcomes available separately for mothers and fathers, multilevel models controlled for within-family dependency. For analyses looking at multiple waves of data, multilevel models nested waves of data within family, aggregated at the parent level (Feinberg et al., 2010). Some analyses used full-information maximum-likelihood techniques to accommodate missing data and allow for inclusion of the full eligible sample (Solmeyer et al., 2013; Kan and Feinberg, 2013a; Kan and Feinberg, 2013b). Condition status was assigned at the couple level. Analyses looking at maternal or paternal outcomes appropriately adjusted for clustering within couples, while other analyses were appropriately conducted at the couple level.

Additional analyses explored moderating effects with interaction terms for intervention by parent education and attachment insecurity (Feinberg and Kan, 2008), child gender (Feinberg et al., 2010; Feinberg, Jones et al., 2014), parent gender and marital status (Feinberg et al., 2010), baseline negative communication levels (Feinberg, Jones et al., 2014), and baseline cortisol level (Feinberg, Roettger et al., 2014). Mediation analyses used path analysis, a bias-corrected bootstrap test and the proportion-mediated measure to determine size and significance of mediators (Solmeyer et al., 2013).

The study used different covariates in analyses including parent age, education, and social desirability (Feinberg and Kan, 2008; Feinberg et al., 2009), respondent age, marital status, family income, respondent educational level, social desirability score, financial strain score, and maternal relationship attachment insecurity (Feinberg et al., 2010), child gender, child age, marital status, and baseline characteristics of parental education, family income, and negative communication (Feinberg, Jones et al., 2014), child gender, baseline maternal education, and marital status (Feinberg, Roettger et al., 2014), wave 1 maternal education and parent reports of social desirability (Solmeyer et al., 2013), mother's education (Kan and Feinberg, 2013a), and parent mean education (Kan and Feinberg, 2013b).

Baseline controls were not collected for coparenting, parenting, or child outcomes, as they would not have been appropriate before birth. Thus, most analyses did not control for baseline outcome levels. Analyses for parental depression and anxiety (wave 2) and couple behaviors (wave 3) controlled for baseline levels through the use of group-by-time interactions (Feinberg and Kan, 2008; Feinberg et al., 2009)

Analyses were run as intent-to-treat and included all parents completing data collection, regardless of level of program participation.

Outcomes

Implementation Fidelity: Though couples did not appear to participate fully in the program, the study showed high fidelity to program content. An observer from the project team attended and rated over 90% of intervention sessions for implementation fidelity, finding that an average of 95% of the curriculum content was delivered. Average attendance was 5.50 classes for mothers and 5.38 classes for fathers, with only 3% of mothers and 5% of fathers attending no sessions. Most couples (66% of mothers and 63% of fathers) attended five or more sessions.

Baseline Equivalence: As child outcomes could not have been collected at pre-birth baseline assessment, equivalence could not be tested for all measures. However, the study reported that "analyses indicated no significant differences between intervention couples and control group couples on a wide range of pretest variables, including age, income, education, marital status, weeks of gestation, mental health, and relationship quality" (Feinberg and Kan, 2008). In addition, the investigators provided Blueprints with comparisons of the intervention and control group on 35 parent variables at the time of birth and at waves 2-5. The results demonstrate group equivalence. Only 4 of 175 comparisons (5 times 35) showed a significance difference, and only one variable - father's insecure attachment - showed consistent significant differences across waves.

Differential Attrition: Attrition differed according to the wave of data collection, with participation declining across the study period. The studies reported partial information on differential attrition for individual waves (described below). However, the investigators provided Blueprints with a more detailed analysis of differential attrition that summarizes the pattern across five waves for 39 variables. The 195 tests (5 times 39) for differences between completers and dropouts showed no significant results at the time of birth and wave 2, one significant result at wave 3, five significant results at wave 4, and two significant results at wave 5. The wave 4 pattern of higher attrition among high risk subjects was found in additional analyses to occur primarily in the control group, which may serve to attenuate differences across conditions.

Participation in posttest data collection was high, with 92% of mothers and 90% of fathers completing wave 2. The rates of participation were similar across control (91%) and intervention (89%) couples, and the study noted that "there were no differences in the association of pretest variables with continued participation across conditions" (Feinberg and Kan, 2008).

For wave 3, 88% of mothers and 93% of fathers of the original 165 couples completed data collection. At both baseline and wave 3, married couples were more likely to have videotaped interactions (Feinberg et al., 2009).

The study reported that 84.6% (N=137) of families provided data at wave 4. Regressions testing whether study participation between intervention and control groups was associated to background characteristics indicated that attriters in the control condition had lower maternal education levels than intervention attriters, though no other significant differences emerged. The study reported that wave 4 analyses using imputation techniques to estimate missing values for attriters supported the reported results for models only including wave 4 participants (Feinberg et al., 2010).

Wave 5 showed substantial attrition, due to the long follow-up period. The study predicted participation in wave 5 using several demographic and key study variables, finding only that family income was a significant predictor (Feinberg, Jones et al., 2014).

Analyses looking at moderation of program effects on mid-program pregnancy-related outcomes by cortisol levels used a subsample of mothers who consented to have cortisol measurements at baseline and completed data at wave 2. Of the 137 mothers who provided cortisol levels, 90% (N=123) completed posttest data. No analyses comparing participation rates were provided (Feinberg, Roettger et al., 2014).

Mid-Program Assessment: Pregnancy-related outcomes assessed mid-program (4 of 8 classes) indicated 1 main effect of the intervention (reduced levels of Caesarian birth), out of 6 outcomes. Birth weight, number of weeks born premature, premature status, the number of days the child was in the hospital, pregnancy complications, and the number of days the mother was in the hospital showed no direct program effects.

Posttest: At wave 2 (posttest when children were six months old), two of four child outcomes and 6 of 12 parent outcomes showed significant improvement. Mothers and fathers' coparental support, fathers' parent-child dysfunctional interaction and parenting-based closeness, mothers' depressive symptoms and anxiety, father-reported infant soothability, and child duration of orienting all showed significant differences. Mothers' and fathers' coparental undermining, mothers' parent-child dysfunctional interaction and parenting-based closeness, fathers' depressive symptoms and anxiety, mother-reported infant soothability, and child sleep habits did not show any significant program effect.

Follow-up: Of the 20 parenting, couple, coparenting, and child outcomes tested at wave 3, 13 showed significant improvements for the intervention participants. Mothers and fathers in the treatment group showed reduced competition and triangulation in coparenting, increased warmth to partner, and increased parenting positivity. Mothers, but not fathers, improved on coparenting inclusion and negative communication to partner, while fathers significantly increased coparenting warmth and reduced parenting negativity. Neither maternal nor paternal active coparenting cooperation showed a significant difference. For child outcomes, self-soothing improved significantly, but sustained attention did not.

Wave 4 analyses indicated a significant program effect on 10 of the 17 parent, interparental relationship, parenting, and child outcomes. Intervention participants improved parental stress, parental efficacy, coparenting quality, parenting overreactivity, parenting laxness, physical punishment, total behavior problems, child externalizing problems, child aggression, and child social competence. No significant effect emerged for parental depression, relationship satisfaction, child internalizing problems, child attention/hyperactivity, or child emotional competence (Feinberg et al., 2010), or for partner psychological aggression or parent-child physical aggression (Kan and Feinberg, 2013b). Additional analyses showed that among families with boys, the program had an effect on internalizing, attention/hyperactivity, and parent relationship satisfaction, and showed a stronger effect on total behavior problems, externalizing, and aggression for boys. For models assessing outcomes available at multiple waves (parental stress, efficacy, depression, and coparenting quality), there was no evidence that intervention and control conditions differed in rates of change across postintervention assessments.

Main effects analyses indicate that of the two parent-reported and nine teacher-reported child academic and behavioral outcomes measured at wave 5, two showed significant improvements for the intervention group: teacher-reported anxious/depressed and internalizing problems. In looking at program effects by child gender, boys but not girls showed significant improvement for attention problems, aggressive behavior, and externalizing. Parent- and teacher-reported conduct problems and emotional problems and teacher-reported classroom participation and academic participation showed no direct or gender moderated program effects.

Moderation: The study reported parental education, maternal and paternal attachment insecurity, the interaction of parent gender and marital status, baseline negative communication levels, baseline cortisol levels, baseline psychological partner aggression, baseline physical partner aggression, and baseline intimate partner violence as significant moderators of relationships between intervention status and different outcomes.

Results of moderation analyses on wave 2 parental and child outcomes indicated that intervention effects were greater for those with less education or higher levels of attachment insecurity. Parental education significantly moderated the intervention effect on maternal depression, mother report of coparental support, and child sleep habits, but did not moderate the other 13 outcomes. Of 16 moderation models determining whether the effects of the intervention depended on maternal or paternal attachment insecurity, seven showed significant results, though one effect was not interpreted as it showed a direction opposite to the other six. Father's insecurity moderated the effect of the intervention on maternal depression, mother's coparental support, coparental undermining, maternal dysfunctional interaction, and paternal dysfunctional interaction. Mother's insecurity moderated maternal depression.

Wave 3 models showed moderation of the treatment by baseline intimate partner violence perpetration for 6 of 12 comparisons. For mothers and fathers, parenting positivity, negativity toward daughters, and reactivity to distress indicated stronger program effects for couples with higher baseline levels of intimate partner violence. Parenting positivity, negativity toward sons, and parenting intrusiveness showed no moderation effects for mothers or fathers.

Models also tested for moderating effects of parent gender and marital status on parent and child outcomes collected at wave 4. One significant result indicated that among nonmarried mothers, intervention participants showed lower levels of depression. No other significant moderating effects of child gender or parent gender and marital status emerged. Additional results looking at moderation effects for wave 4 outcomes showed that the intervention had stronger effects on fathers' psychological partner aggression for couples with higher baseline levels of psychological partner aggression or physical partner aggression and on mothers' aggression toward the child for couples with higher baseline levels of psychological partner aggression. Parents' baseline negative communication moderated program effects on most parent- or teacher-reported child outcomes at wave 5. Parent-reported emotional problems and teacher-reported classroom participation, academic motivation, conduct problems, emotional problems, anxious/depressed, aggressive behavior, internalizing, and externalizing all indicated that the intervention worked best for children whose parents had negative communication at baseline.

Four of the 6 pregnancy-related outcomes indicated moderation, showing that the intervention improved outcomes only for women with high cortisol levels. This effect was observed for birth weight, number of weeks born premature, the number of days the child was in the hospital, and the number of days the mother was in the hospital. Caesarian birth and pregnancy complications showed no moderation effects from cortisol levels.

Mediation: In Solmeyer et al. (2014), coparenting competition mediated the effect of the intervention on wave 4 child adjustment problems for mother-son and father-child relationships, but not mother-daughter relationships. The proportion of total effects mediated by coparenting competition was 39% for mothers and sons and 55% for fathers. Coparenting positivity did not mediate program effects for mothers or fathers.

Study 2

Evaluation Methodology

Design:

Recruitment: In three northwestern and one southwestern state, couples were primarily recruited through hospitals, childbirth education programs and Ob/Gyn clinics, but also through media advertisements and fliers. The study reported identifying 743 eligible couples, of which 399 agreed to participate. Separate cohorts of participants were recruited in succession across study sites between the fall of 2008-2012.

Assignment: The study randomly assigned the 399 couples to the treatment or control condition in a randomized block design, based on pretest data. The intervention sample included 221 couples and the control sample included 178 couples. The control group received only mailed materials on childcare and child development.

Attrition: Of the randomized sample, 259 (64.9%) were included in the analytical sample. Eighty-seven couples were lost to follow-up, and additional exclusions included those with birth complications, low class attendance, missing data, or extreme propensity scores.

In Jones et al. (2018), 302 of 399 (76%) randomized couples were included in the analytical sample approximately 2 years post-intervention when children were two years old. A total of 89 families (22%) were lost to follow-up. However, only 240 provided observational data (40% attrition).

Sample: The average education level in the sample was 15.79 years and the average age among mothers at pretest was 29.3. No information on the race/ethnicity of the sample was given, but the study referred to the sample as low-risk.

Although both Feinberg et al. (2015) and Jones et al. (2018) appear to have used the same sample (though Jones et al. also included both mothers and fathers), additional sample information was reported in the Jones et al. article: the mean age of expectant mothers was 29.1 years and fathers was 31.1 years, mean education level was 15.7 years, median annual household income was $85,000, 87% of couples were married, and most participants (81%) indicated their race as White.

Measures: The study measured birth weight in kg, maternal length of stay in hospital after birth (days), and newborn length of stay in hospital after birth (days) as outcome measures. These measures were obtained from parents up to 10 months after the birth of the child and depended on accurate recall.

Jones et al. (2018) included the following measures in their study: five observational family interaction tasks (coparenting triadic relationship quality, coparenting positivity aggregate, coparenting negativity aggregate, parenting positivity aggregate, parenting positivity aggregate, and parenting negativity aggregate); two self-report parent measures of depressive symptoms and anxiety from the Center for Epidemiological Studies Depression Scale and the revised Penn State Worry Questionnaire; two parent-reported child measures of externalizing and internalizing scales from the Child Behavior Checklist; and two mother-reported number of night wakings and hours child sleeps during night from the Child Sleep Questionnaire. Two research assistant raters unaware of conditions coded the observational family interaction tasks. However, parents helped deliver the program and rated their children.

Analysis: The study used separate regression models for each outcome to examine main and moderated effects of the intervention. Moderation was analyzed using two- and three-way linear and quadratic interactions.

In Jones et al. (2018), the authors used separate regression models to test the main effect of condition (intervention or control) for each outcome. For parent-specific outcomes nested within dyads, the study used multilevel regression models with a random intercept. Ordinary regression models were used for mother-reported child sleep and observed triadic relationship quality, which were outcomes available only at the family level. The authors used separate regression models to test for moderation effects.

Intent-to-Treat: The study violated intent-to-treat by excluding subjects who attended fewer than three of the five prenatal classes, which was deemed insufficient participation. However, it also used propensity score matching to attempt to correct for selection bias created by dropping non-participants.

Jones et al. (2018) used ITT analyses and included multiple imputation procedures for missing data in the intervention and control groups. A total of 302 families had complete data available for analyses, which included 169 of 221 (76%) intervention group families and 133 of 178 (75%) control group families. Seven families from the intervention group and two families from the control group (a total of only 2%) were excluded from analyses due to multiple birth or child heath/development complications.

Outcomes

Implementation Fidelity: The average attendance rate at the five prenatal classes was 87.9% among participants, with an average of 4.3 classes. The authors estimated that attending three of the five prenatal classes would represent minimally adequate dosage. Of the intervention mothers, 91.8% achieved that minimum attendance.

In Jones et al. (2018), more than half of intervention couples attended at least eight of the nine classes (M prenatal = 4.4 and M postnatal =2.3). Nine families assigned to the intervention (4%) did not attend any of the sessions.

Baseline Equivalence: Because all outcomes related to subsequent birth of the child, the study did not examine baseline equivalence in outcome measures. Although it did not provide significance tests for differences in demographic and other measures at baseline, the percentages appear similar (Table 1).

Similar to Feinberg et al. (2015), Jones et al. (2018) did not report significance tests for available baseline outcomes and sociodemographic measures.

Differential Attrition: The Feinberg et al. (2015) study stated that it found no significant condition differences in attrition by demographic measures.

Jones et al. (2018) reported that 46 intervention group families and 73 control group families were lost to follow-up. They tested for effects of baseline measures on posttest participation and the interaction of condition and baseline measures on posttest participation. They stated that these analyses showed "no evidence of differential attrition between conditions" but provided no details.

Posttest: Feinberg et al. (2015) found no main effects of the program on parent-reported birth outcomes.

However, they found significant moderation effects on birth outcomes in 7 of 36 interaction terms ($p < .05$). The significant moderation indicated that the intervention reduced the harm of high economic strain, depression, and anxiety. For birth weight, the study reported significant moderation of the intervention effect by economic strain and maternal depression but only for those with preterm births (at 36 weeks or earlier). For newborn length of stay,

moderation by economic strain and prenatal maternal depression was linear, while a significant curvilinear pattern was reported for prenatal maternal anxiety. For maternal length of hospital stay, the intervention reduced the positive association between economic strain and anxiety found in the control condition.

Long-Term: The Feinberg et al. (2015) study did not conduct a long-term follow-up.

Approximately two years post-intervention (when children were two years old), Jones et al. (2018) found significant positive effects for five of 11 outcomes. The intervention group, compared to the control group, showed greater coparenting triadic relationship quality (d = .39) and lower coparenting negativity (d = .38) and parenting negativity (d = .41) in observational family interaction tasks, and fewer parent-reported child internalizing behaviors (d = .19) and parent-reported child nighttime wakings (incidence ratio rate; IRR = .30).

Moderation results found that intervention impact was moderated by pretest levels of observed couple negative communication in five of nine study outcomes (i.e., a larger overall intervention impact for higher risk families at baseline).

Crime Solutions

Program Profile: Family Foundations

Evidence Rating: Promising - One study

Date: This profile was posted on *August 14, 2013*

Program Snapshot

Age: 0 - 3, 18+

Gender: Both

Race/Ethnicity: Black, Asian/Pacific Islander, Hispanic, White, Other

Geography: Suburban, Urban

Setting (Delivery): Other Community Setting

Program Type: Group Therapy, Parent Training

Targeted Population: Families

Current Program Status: Active

Listed by Other Directories: Model Programs Guide, National Registry of Evidence-based Programs and Practices, Promising Practices Network

Program Developer:
Mark Feinberg
Family Foundations
300 BioBehavioral Health
University Park PA 16802

Program Summary

A psycho-educational, skills-based program for first-time expectant parents delivered through childbirth education departments at local hospitals. The program is rated Promising. Intervention group parents had a higher measure of positive mother and father parenting, coparenting and couple relationships. The program also had positive effects on child behavior compared to the control group.

This program's rating is based on evidence that includes at least one high-quality randomized controlled trial.

Program Description

Program Goals/Target Population

Family Foundations is a psycho-educational, skills-based program for first-time expectant parents. The universal prevention program is delivered through childbirth education departments at local hospitals. It is designed to reduce later child problems such as aggressive and antisocial behavior by enhancing the coparenting relationship among cohabiting and married couples expecting their first child.

Program Theory

Family Foundations focuses on improving the quality of coparenting (defined as how parents coordinate their parenting, support or undermine each other, and manage conflict regarding child rearing). The program focuses on coparental support and undermining because these dynamics are linked to parenting and child outcomes, including externalizing and internalizing behaviors (Feinberg et al. 2005). Improvements in coparenting and parenting relationships should improve children's physiological and emotional self-regulation (Feinberg, Kan, and Goslin 2009).

Program Components

Family Foundations is delivered in a group format across eight sessions. The first four sessions are prenatal classes provided around the fifth or sixth month of pregnancy. The other four sessions are postnatal classes provided when the child is approximately 6 months old. The prenatal classes introduce couples to certain themes and relationship skills. The postnatal classes revisit those themes once the couple has experienced life as parents and coparents.

Most of the program material focuses on enhancing the coparenting relationship, aligning expectant parents' expectations of each other and of parenthood, and introducing positive childrearing strategies. The material on post-birth expectations familiarizes parents with particular issues they may experience after the birth of their child and the way that these issues may affect coparenting. Parenting strategies discussed in the sessions include an understanding of temperament, fostering children's self-regulation, and promoting attachment security.

The program includes a combination of didactic presentations, couple communication exercises, written worksheets, videotaped vignettes of other families, and group discussions.

Key Personnel

The classes are led by a male-female co-leader team, so that a role model is offered for each partner. The female leader is usually a childbirth educator.

Evaluation Outcomes

Phone: 814.865.8796
Email

Study 1
Child Behavior
Feinberg, Kan, and Goslin (2009) found that the Family Foundations intervention group children demonstrated significantly higher levels of self-soothing compared with control group children at the 12-month follow-up. However, there was no significant difference between the groups on sustained attention.

Mother's Parenting Behavior
Intervention group mothers demonstrated significantly higher levels of positive parenting compared with control group mothers. However, there was no significant difference between the groups on negative parenting.

Father's Parenting Behavior
Intervention group fathers demonstrated significantly higher levels of positive parenting compared with control group fathers. Contrary to the results of the mothers, intervention group fathers demonstrated significantly lower levels of negative parenting compared with control group fathers.

Study 2
Child Behavior
At the 36-month follow-up, Feinberg and colleagues (2010) found significant intervention effects for measures on the Child Behavior Checklist (CBCL), although child gender was a factor in these results. There were significant differences between the intervention group boys and the control group boys on the Total Problems, Externalizing Problems, Internalizing Problems, Aggression, and Attention/Hyperactivity scales. However, there were no significant differences on any of the scales between intervention group girls and control group girls.

Parenting
There were significant intervention effects found for all three outcomes measured by the Parenting Scale. Intervention group parents indicated significantly lower levels of Overrreactivity and Laxness, and were less likely to inflict physical punishment.

Coparenting and Couple Relationship
There was also a significant intervention effect found for the overall measure on the Coparenting Scale. Intervention group parents had a higher measure of positive coparenting compared with control group parents. However, for measures of relationship satisfaction, child gender was a factor in this result. Parents of boys in the intervention group showed significantly higher relationship quality compared with parents of boys in the control group. But there was no significant difference for parents of girls in the intervention and control groups.

Evaluation Methodology

Study 1
Feinberg, Kan, and Goslin (2009) used a randomized trial involving 169 heterosexual couples to examine the impact of the Family Foundations program. The couples recruited for the study were expecting their first child, at least 18 years of age, and living together (regardless of marital status). Data was collected between 2003 and 2007. Pretest data was collected during home interviews when the mothers were pregnant (Wave 1). After the pretest, couples were randomly assigned to the intervention condition (n=89) or the no-treatment control condition (n=80). The intervention condition received the Family Foundations program, and the no-treatment control condition received a brief brochure in the mail about selecting quality childcare.

The couples were recruited from medium-sized cities in Pennsylvania (Altoona and Harrisburg). The majority of the study participants (91 percent of the mothers and 90 percent of the fathers) were non-Hispanic White, and the other participants were African American, Asian, Hispanic, or other. The average age was 28.33 years for the mothers and 29.76 years for the fathers. There were no significant differences between the intervention and control groups on demographics and other pretest variables.

A previous study by Feinberg and Kan (2008) examined follow-up data from mail-in questionnaires when the children were roughly 6 months old (Wave 2). For this study, follow-up data collection occurred during homes visits when the children were an average age of 13.7 months old (Wave 3). Family interactions were videotaped at both pretest and follow-up. At pretest, the expectant parents engaged in two couple relationship discussion tasks. At the follow-up, families engaged in two

interactions as a triad. Undergraduate and graduate students were trained to rate the videotapes using a global coding system of 5- to 7-point scales. The codes were developed for this project or adapted from prior work. The coders rated coparenting, parenting, child behavior, and dyadic couple interaction. All coders were blind to experimental condition.

The effects of the Family Foundations intervention were tested using intent-to-treat analyses (meaning data from all parents who completed the follow-up were included regardless of how much they participated in the program). For parallel behaviors by mothers and fathers, analyses were conducted as multivariate multi-level regression models. For child behavior outcomes, analyses were conducted with a general linear model regression approach.

Study 2
The follow-up study by Feinberg and colleagues (2010) examined program impacts on the same sample of parents from the 2009 study. Data was collected from home visits when children were approximately 36 months old (Wave 4). Study attrition was 17 percent for mothers and 23 percent for fathers by Wave 4. There were no significant differences between the intervention and control groups on demographics and pretest variables, except for mother's level of education. Therefore, parent education level was included as a control variable in all regression models.

Analyses of outcomes included three waves of data from the follow-up at 6 months post-birth through 3 years post-birth, when the data was available. For example, some measures of parenting and child outcomes were only available at the last wave of data collection, as these measures were not appropriate at earlier ages. For measures available at three waves, the data was analyzed in a single model to minimize the number of statistical tests. These models were also examined to see if there was a program effect on change (linear or quadratic) in these outcomes across the three waves. In that manner, it was possible to examine whether initial intervention effects apparent at 6 months post-birth declined (or increased) over the following 2.5 years.

Several outcomes measures were examined in the study. Child outcomes were measured using the Child Behavior Checklist (CBCL). Three overall scores from the CBCL were examined: Total Problems, Externalizing Problems, and Internalizing Problems. Scores from two sub-scales were also examined: Aggression and Attention/Hyperactivity. Parenting outcomes were measured using the Parenting Scale, which assess discipline practices in parents of children from 18–48 months. The study focused on three outcomes: the Laxness scale, the Overreactivity scale, and a single item measuring Physical Punishment. Coparenting and couple relationship quality was measured using the Coparenting Scale and the Quality of Marriage Index.

All tests of intervention effects were conducted as intent-to-treat analyses. Analytic models were structured to accommodate the number of waves of data available and the number of respondents per family (both parents versus one parent).

Cost

The Family Foundations DVD series for parents costs $64.50 and is available on the program's Web site: http://www.famfound.net/collections/parents. Costs of materials for educators and organizations range from $300 for the Family Foundations class participant workbooks and DVD, to $700 for the 10 pack of the DVD series. These materials can also be purchased from the program's Web site: http://www.famfound.net/collections/educators.

Implementation Information

Additional information about Family Foundations is available on the program's Web site.

Evidence-Base (Studies Reviewed)

These sources were used in the development of the program profile:

Study 1
Feinberg, Mark E., Marni L. Kan, and Megan C. Goslin. 2009. "Enhancing Coparenting, Parenting, and Child Self-Regulation: Effects of Family Foundations 1 Year After Birth." *Prevention Science* 10:276–85.

Study 2
Feinberg, Mark E., Damon E. Jones, Marni L. Kan, and Megan C. Goslin. 2010. "Effects of Family

Foundations on Parents and Children: 3.5 Years After Baseline." *Journal of Family Psychology* 24(5):532–42.

Additional References

These sources were used in the development of the program profile:

Feinberg, Mark E. and Marni L. Kan. 2008. "Establishing Family Foundations: Intervention Effects on Coparenting, Parent/Infant Well-Being, and Parent-Child Relations." *Journal of Family Psychology* 22(2):253–63.

Feinberg, Mark E., David Reiss, Jenae M. Neiderhisser, and E. Mavis Hetherington. 2005. "Differential Association of Family Subsystem Negativity on Siblings' Maladjustment: Using Behavior Genetic Methods to Test Process Theory." *Journal of Family Psychology* 19:601–10.

Feinberg, Mark E., Damon E. Jones, Michael Roettger, Anna Solmeyer, and Michelle Hostetler. N.d. *Long-Term Effects of Family Foundations: Children's Internalizing, Externalizing, and School Adaptation*. University Park, Pa.: Pennsylvania State University, Prevention Research Center. (This study was reviewed but did not meet CrimeSolutions.gov criteria for inclusion in the overall program rating.)

Promising Practices

Programs That Work, from the Promising Practices Network on Children, Families and Communities

M. Rebecca Kilburn, editor

Jill S. Cannon, Teryn Mattox, Rebecca Shaw, co-editors

Table 2.

PPN Programs, by Age of Child

Proven Programs	Promising Programs	Proven/Promising Programs
Early Childhood (0–8)		
The Abecedarian Project Accelerated Reader Big Brothers Big Sisters of America Child-Parent Centers DARE to be You Early Head Start Family Thriving Program FluText Healthy Families New York (HFNY) HighScope Perry Preschool Program Incredible Years New Hope Project Newborn Individualized Developmental Care and Assessment Program (NIDCAP) Nurse Family Partnership Reading Recovery	Child Development Project Child Sexual Abuse Prevention: Teacher Training Workshop Cognitively Guided Instruction (CGI) Communities In Schools Cooperative Integrated Reading and Composition Coping Cat Core Knowledge Direct Instruction Early Childhood Education and Assistance Program (ECEAP) Early Intervention in Reading Father/Male Involvement Preschool Teacher Education Program Gang Resistance Education and Training (G.R.E.A.T.) Head Start Healthy Start Healthy Steps for Young Children	Family Foundations Family Support and Parenting Education in the Home Infant Health and Development Program

Family Foundations

Program Info

Outcome Areas
Healthy and Safe Children
Children Ready for School
Strong Families

Indicators
Children not experiencing physical, psychological or emotional abuse
Fathers maintaining regular involvement with their children
Children ages 0 to 5 exhibiting age-appropriate mental and physical development
Children and youth not engaging in violent behavior or displaying serious conduct problems

Topic Areas

Age of Child
Early Childhood (0-8)
Type of Setting
Community-Based Service Provider
Health Care Provider
Type of Service
Family Support
Parent Education
Type of Outcome Addressed
Behavior Problems
Mental Health

Evidence Level
Proven/Promising

Program Overview

Family Foundations (FF) is composed of eight pre- and post-natal classes designed for expectant couples who are living together (cohabitating or married). FF classes are interactive and skills-based, focusing on enhancing the "coparenting" relationship. The coparenting relationship is defined as the ways parents organize their parenting, support or undermine each other, and manage conflict regarding parenting. Research shows that coparenting relationship quality has a strong influence on parenting and child outcomes for families regardless of marital status, residential status, and risk level.

Program Participants

Participants include expectant couples who are either cohabitating or married. The evaluation participants were heterosexual couples expecting their first child.

Evaluation Methods

The effectiveness of FF was examined in a trial in which 169 heterosexual adult couples expecting their first child were recruited from hospitals in two small cities. Couples were assigned to either the intervention (89) or comparison (80) groups. Randomization was successful in that both groups were equivalent on all measured variables, including age, income, education, marital status, weeks of gestation, mental health, and relationship quality. Intervention and comparison group couples were assessed before the intervention (pretest) at an average of 22 weeks gestation, and again after the intervention was complete (posttest) when their children were an average of 6.5 months old. Ninety percent of couples who completed the pretest also completed the posttest, and this was not significantly different across groups (Feinberg and Kan, 2008).

Two additional follow-up studies were conducted: The 13-month follow-up was conducted when the children were an average of 13.7 months old, with 91 percent of couples completing the 13-month follow-up (Feinberg, Kan, and Goslin, 2009), and a final follow-up was conducted when the children were an average of 3 years old, with 81 percent of couples completing the 36-month follow-up (Feinberg et al., 2010). (Results from a further follow-up when children were an average of 6 years old are being prepared for publication.)

At pretest and/or posttest, the following measures were assessed:

- Parental mental health of both mothers and fathers was assessed at pretest and posttest and measured by the following scales:
    - Center for Epidemiologic Studies Depression Scale (CES-D)
    - Taylor Manifest anxiety scale.
- The Dysfunctional Interaction subscale from the Parental Stress Index was administered to both parents at pretest and posttest.
- Coparenting, a 37-point scale of self-reported coparenting behaviors, was completed by both mothers and fathers at posttest. This scale was developed by the program developers and includes the following three subscales:
    - coparental support
    - parenting-based closeness
    - coparental undermining.
- Infant regulation subscales of the Infant Behavior Questionnaire were administered to both fathers and mothers at posttest only:
    - infant soothability
    - infant orienting (baby's attention to a single object for a specific length of time).

At the 13-month follow-up, family interactions were videotaped and coded. Parents and the infant engaged in 12 minutes of joint free play on the floor. Parents were then asked to teach their child to accomplish a set of tasks designed to be at the limit of most infants' developmental capacity (e.g., rolling a ball back and forth with a parent, building a tower of blocks). This interaction lasted 6 minutes. Blind coders were trained to rate the videotapes of tasks according to a coding system of 5- to 7-point scales. This coding system was developed for this project by program developers. Measures assessed through videotaped interactions included the following:

- Couple relationship behaviors, including:
    - warmth to partner (physical or verbal affection)
    - negative communication (contempt, hostility, demandingness)
- Parenting behaviors, including:
    - positivity (positive affect, support for exploration)
    - negativity (irritability, hostility toward child)
- Coparenting measures, including:
    - competition (competition for child attention, love)
    - triangulation (use of child as pawn in partner conflict)
    - warmth (caring, affection toward partner)
    - inclusion (active inclusion of partner in play)
    - cooperation (overt cooperation with partner in play)
- Child behaviors, including:

- self-soothing (self-directed comforting: stroking, sucking)
- sustained attention (sustained involvement with objects/people).

At the 36-month follow-up, the following outcomes were assessed by researchers during a home visit:

- The Parenting Sense of Competence scale was administered to both parents, asking parents about their confidence in their parental role.
- The Parenting Stress Index was administered to both parents, asking parents to respond to their agreement with certain questions, such as, "I feel trapped by my responsibilities as a parent."
- Parental depression was assessed for both parents with the Center for Epidemiological Studies Depression Scale (CES-D).
- A Coparenting Scale was administered to both mothers and fathers and assessed items such as coparental agreement, support, undermining, and exposure of the child to conflict.
- The Quality of Marriage Index asked parents to rate their agreement with certain statements about their relationship, such as, "We have a good relationship."
- The Parenting Scale was administered to both parents, assessing discipline practices in parents of children from 18-48 months. Three subscales were used:
  - laxness
  - over-reactivity
  - physical punishment.
- Child outcomes were assessed using the Child Behavior Checklist (CBCL), which was reported by mothers only. Researchers assessed the following dimensions:
  - total problems
  - externalizing problems
  - internalizing problems
  - aggression
  - attention/hyperactivity.
- Emotional competence was assessed using the Head Start Competence scale, with mothers reporting on the child's interactions.

Key Evaluation Findings

At posttest, study authors found the following:

- Coparenting outcomes:
  - Both mother and father report of coparental support was significantly higher for the FF group than for the comparison group.
  - Father report of parental-based closeness was significantly higher among fathers in the FF group than those in the comparison group, and no significant difference was found for mothers.
  - No significant differences were found in coparental undermining.
- Parental mental health:
  - Maternal depression exhibited greater reductions in the FF group than the comparison group, and no significant difference was found for fathers.
  - Maternal anxiety exhibited greater reductions in the FF group than in the comparison group, and no significant difference was found for fathers.

- Dysfunctional interaction was significantly improved for both fathers and mothers in the FF group versus parents in the comparison group.
- Infant regulation:
    - Combined mother/father report of infant orienting was significantly improved for FF parents versus comparison group parents.
    - Parental report of infant soothability was not significantly different across groups.

At the 13-month follow-up, in which family interactions were videotaped, study authors found the following:

- Coparenting outcomes:
    - FF mothers and fathers performed significantly better (i.e., lower scores) on parental competition compared with the comparison group.
    - FF mothers and fathers performed significantly better (i.e., lower scores) on parental triangulation compared with the comparison group.
    - FF fathers performed significantly better on parental warmth than fathers in the comparison group, but there was no significant difference in parental warmth for FF mothers versus comparison group mothers.
    - FF mothers performed significantly better than those in the comparison group on parental inclusion, but this was not true for FF fathers.
    - There were no significant differences between FF and the comparison group in parental cooperation.
- Parenting:
    - Mothers and fathers were both significantly more positive in their parenting practices than those in the comparison group.
    - Fathers were significantly less negative in their parenting practices than fathers in the comparison group, but the difference was not significant for mothers.
- Child behavior:
    - Infants belonging to couples in the FF group were better at self-soothing than those in the control group.
    - There were no differences across groups in sustained attention.
- Dyadic couple behaviors:
    - Mothers in the FF group exhibited significantly less negative communication than mothers in the comparison group, but the difference was not significant for FF fathers versus fathers in the comparison group.
    - Both mothers and fathers exhibited significantly more warmth to their partner than those in the comparison group.

At the 36-month follow-up, study authors found the following:

- Parenting stress and parenting efficacy were significantly improved for both mothers and fathers in the FF group versus the comparison group on average across all follow-up waves; however, results were not reported for the 36-month follow-up alone.
- Coparenting and Couple Relationship:
    - FF parents scored significantly higher on the overall measure of coparenting than parents in the comparison group.
    - FF parents were not significantly different than comparison parents on relationship quality; however, relationship quality among parents of boys was significantly improved in the FF

versus the comparison group.

- Parenting Scale:
  - Parents in the FF group exhibited significantly lower levels of over reactivity than parents in the comparison group.
  - FF parents exhibited significantly lower levels of laxness than those in the comparison group.
  - FF parents exhibited significantly lower levels of physical punishment than parents in the comparison group.
- Child outcomes Child Behavior Checklist (CBCL):
  - There were significantly lower levels of behavior problems among children of couples in the FF group as measured by the Total Problems Scale. Analyses showed that this effect was driven by differences among boys, and, when analyzed separately, girls did not show significantly different levels of problem behaviors.
  - Children of couples in the FF group showed significantly lower levels of externalizing behaviors and aggressive behaviors compared with the control group. Again, subgroup analyses revealed that these differences were driven by the boys in the FF group.
  - There were no significant differences found for FF versus comparison group children on Internalizing Problems or the Attention/Hyperactivity scale. However, when examining the scores for boys alone, boys in the FF group were significantly improved on both of these measures compared with boys in the comparison group.

Probable Implementers

Many different organizations and individuals might implement Family Foundations, including health care organizations, social service agencies, childbirth educators, teen parenting programs, faith-based organizations, and employee assistance providers.

Funding

Grant writing support is available through the Family Foundations website: http://www.famfound.net/pages/for-professionals

Implementation Detail

Program Design

The goal of FF is to support parents as they adjust to the stress that new parenthood can put on the parental relationship through increased conflict, changes in the division of labor, and reduced couple companionship and sex. FF does this by enhancing positive support and coordination in the coparenting relationship.

The program as evaluated was delivered by a trained facilitator over four prenatal and four post-natal in-person sessions, with accompanying worksheets and homework materials.

Staffing

A facilitator is trained in the approach, and the facilitator does not need to be from a particular field.

Curriculum

Curricular materials are available online at http://www.famfound.net/collections/educators

Issues to Consider

This program is rated "proven" for the indicators *Children ages 0 to 5 exhibiting age-appropriate mental and physical development* and *Children not experiencing physical, psychological, or emotional abuse.* This program is rated "promising" for the indicators *Fathers maintaining regular involvement with their children* and *Children and youth not engaging in violent behavior or displaying serious conduct problems.*

The program evaluation utilized a rigorous research design. However for the two "promising" indicators, the outcomes measured are considered "intermediate" because while there is existing evidence that they impact the PPN indicators, specific PPN indicators were not directly measured.

Example Sites

The study authors implemented the FF program in two small cities in the United States.

Contact Information

For general questions about the FF program, email Info@FamFound.net.

For questions about training, consultation, or large-scale implementation of the classes, contact Jill Zeruth at Jill@FamFound.net, phone: 814-954-0262.

For questions about the research and/or program development, contact program developer Mark Feinberg at Mark@FamFound.net.

Available Resources

Materials and information can be found at http://www.famfound.net/.

Bibliography

Feinberg, Mark E., and Marni L. Kan, "Establishing Family Foundations: Intervention Effects on Coparenting, Parent/Infant Well-Being, and Parent-Child Relations," *Journal of Family Psychology,* Vol. 22, No. 2, April 2008, pp. 253-263.

Feinberg, Mark E., Damon E. Jones, Marni L. Kan and Megan C. Goslin, "Effects of Family Foundations on Parents and Children: 3.5 Years After Baseline," *Journal of Family Psychology,* Vol. 24, No. 5, 2010, pp. 532-542.

Feinberg, Mark E., Marni L. Kan, and Megan C. Goslin, "Enhancing Coparenting, Parenting, and Child Self-Regulation: Effects of Family Foundations 1 Year After Birth," *Prevention Science,* Vol. 10, No. 3, September 2009, pp. 276-285.

Last Reviewed

June 2013

Evidence-Based Clearinghouse for Child Welfare, CA

CEBC

THE CALIFORNIA EVIDENCE-BASED CLEARINGHOUSE FOR CHILD WELFARE
Information and Resources for Child Welfare Professionals

Family Foundations

Topic Areas	Scientific Rating	Child Welfare Relevance
Parent Training Programs that Address Child Abuse and Neglect	2 — Supported by Research Evidence	Low

About This Program

Target Population: Expectant mothers and fathers

Program Overview

Family Foundations is a series of classes delivered before and after birth that focuses on supporting couples having a baby. The classes focus on individual parent adjustment (stress, depression, anxiety) and self-regulation; coparenting cooperation and support; and early parenting sensitivity. Variations of ***Family Foundations*** exist for other populations (e.g., low-income teen parents, low-income and lower-education adult parents, military families, and parents with a child recently diagnosed with autism), but have not been reviewed by the CEBC.

Program Goals

The goals of ***Family Foundations*** are:

- Reduced parental stress
- Reduced parent depression and anxiety

- Increased parent self-efficacy
- Enhanced coparental support and cooperation
- Reduced coparental conflict and undermining
- Enhanced parental warmth and sensitivity
- Reduced harsh and physically aggressive parenting
- Reduced family violence
- Enhanced child social-emotion competence and academic adjustment
- Reduced child internalizing and externalizing

Essential Components

The essential components of ***Family Foundations*** include:

- Nine parenting classes with 5 of them occurring before the child is born and 4 occurring after birth:
  - Class 1. Building a Family: The facilitators set the foundation of the coparenting team by providing activities and discussions that promote communication, while focusing on the positive parenting strengths of the team.
  - Class 2. Feelings & Conflicts: This class focuses on feelings and emotions, how parents' emotions affect the child, especially conflict, and how parents can avoid and manage conflict.
  - Class 3. Good Sport Teamwork: This class teaches couples to identify behaviors that upset them, how to recognize negative storylines, and how to change those thoughts.
  - Class 4. Working it Out: Throughout the series, couples have practiced communication skills but this class addresses how best to hold difficult conversations.
  - Class 5. Here We Go! This class ends the prenatal series by helping couples both see each other as supportive partners and build each others' confidence as parents.
  - Birth of child
  - Class 6. New Parent Experiences: This class allows parents to discuss the challenges of adjusting to parenthood and recognize the normalcy of their experiences. The class focuses on helping parents recognize their child’s temperament and moods.
  - Class 7. Security: This class focuses on attachment and security between parent and child. The issue of problem solving is introduced.
  - Class 8. Problem Solving: This class focuses on dynamics within the parenting team and couple problem-solving.

    - Class 9. Keeping Things Positive: This class reviews how to best encourage security with the child, how couples handle sex and intimacy, and how parents can be supportive by communicating appreciation for their partner.

- Provide additional support and referrals as needed

Program Delivery

Parent/Caregiver Services

Family Foundations directly provides services to parents/caregivers and addresses the following:

- Couple pregnant with a due date about 4 weeks away with potential coparenting difficulties and stress

Recommended Intensity:

2-3 hour weekly classes

Recommended Duration:

8 weeks: 4 weeks before birth and 4 weeks after birth

Delivery Settings

This program is typically conducted in a(n):

- Hospital
- Outpatient Clinic
- Community-based Agency / Organization / Provider

Homework

This program does not include a homework component.

Resources Needed to Run Program

The typical resources for implementing the program are:

Room with flip charts/white board and A/V equipment to display video clips

Education and Training

Prerequisite/Minimum Provider Qualifications

College education is recommended along with experience in leading groups and working with families.

Education and Training Resources

There is a manual that describes how to implement this program , and there is training available for this program.

Training Contact:

- **Jill Zeruth**
  info@famfound.net

Training is obtained:

Provided onsite

Number of days/hours:

Training requires total of 2-3 days

Implementation Information

Pre-Implementation Materials

There are no pre-implementation materials to measure organizational or provider readiness for ***Family Foundations***.

Formal Support for Implementation

There is formal support available for implementation of ***Family Foundations*** as listed below:

Technical assistance on implementation is available. There are program management materials, such as participant feedback forms, evaluation data spreadsheets, etc.

Fidelity Measures

There are fidelity measures for ***Family Foundations*** as listed below:

Fidelity measures are available for observers and facilitators to fill out after each session.

Implementation Guides or Manuals

There are no implementation guides or manuals for ***Family Foundations***.

Research on How to Implement the Program

Research has not been conducted on how to implement ***Family Foundations***.

Relevant Published, Peer-Reviewed Research

Child Welfare Outcome: Child/Family Well-Being

Feinberg, M. E., & Kan, M. L. (2008). Establishing Family Foundations: Intervention effects on coparenting, parent/infant well-being, and parent-child relations. *Journal of Family Psychology, 22*(2), 253-263. doi:10.1037/0893-3200.22.2.253

Type of Study: Randomized controlled trial
Number of Participants: 169

Population:

- **Age —** 28-29 years
- **Race/Ethnicity —** 90% Non-Hispanic White
- **Gender —** 50% Female and 50% Male
- **Status —** Participants were couples expecting their first child.

Location/Institution: Pennsylvania—Altoona and Harrisburg

Summary: *(To include comparison groups, outcomes, measures, notable limitations)*
The current study evaluated the effectiveness of the ***Family Foundations (FF)*** program on coparenting; parental depression and anxiety; distress in the parent-infant relationship; and infant regulatory competence (sleep, attention duration, soothability). Couples were randomly assigned to intervention or to no-treatment control conditions. Measures utilized include the *Center for Epidemiological Studies Depression Scale*, *Parental Stress Index*, *Infant Behavior Questionnaire*, and *Relationships Scale Questionnaire*. Results indicate ***FF*** participants displayed significant improvement on coparental support; maternal depression and anxiety; distress in the parent-child relationship; and several indicators of infant regulation. Effects from ***FF*** were not moderated by income, but greater positive impact of the program was found for lower educated parents and for families with a father who reported higher levels of insecure attachment in close relationships. Limitations include reliance on self-reported measures, lack of generalizability due to ethnicity, and lack of follow-up.

Length of postintervention follow-up: None.

***Feinberg, M. E., Kan, M. L., & Goslin, M. C. (2009).** Enhancing coparenting, parenting, and child self-regulation: Effects of Family Foundations 1 year after birth. *Prevention Science, 10*(3), 276-285. doi:10.1007/s11121-009-0130-4

Type of Study: Randomized controlled trial
Number of Participants: 169

Population:

- **Age —** 28-29 years

- **Race/Ethnicity —** 90% Non-Hispanic White
- **Gender —** 50% Female and 50% Male
- **Status —** Participants were couples expecting their first child.

Location/Institution: Pennsylvania—Altoona and Harrisburg

Summary: *(To include comparison groups, outcomes, measures, notable limitations)*
This study utilizes data from Feinberg, et al. (2008). The current study examines follow-up data collected when the infants were 1-year old regarding the ***Family Foundations (FF)*** program target of the coparental relationship, the more general construct of couple relationship quality, parenting quality, and child self-regulatory capacity. Couples were randomly assigned to intervention or to no-treatment control conditions. Measures utilized include the *Center for Epidemiological Studies Depression Scale*, *Parental Stress Index*, *Infant Behavior Questionnaire* and *Relationships Scale Questionnaire*. Results indicate significant program effects at follow-up emerged in all four domains in the ***FF*** group. Limitations include reliance on self-reported measures, lack of generalizability due to ethnicity, and intervention effects on maternal depression or on dyadic couple relationship quality may have led to enhanced coparenting.

Length of postintervention follow-up: Approximately 6 months.

***Feinberg, M. E., Jones, D. E., Kan, M. L., & Goslin, M. C. (2010).** Effects of family foundations on parents and children: 3.5 years after baseline. *Journal of Family Psychology, 24*(5), 532-542. doi:10.1037/a0020837

Type of Study: Randomized controlled trial
Number of Participants: 169

Population:

- **Age —** 28-29 years
- **Race/Ethnicity —** 90% Non-Hispanic White
- **Gender —** 50% Female and 50% Male
- **Status —** Participants were couples expecting their first child.

Location/Institution: Pennsylvania—Altoona and Harrisburg

Summary: *(To include comparison groups, outcomes, measures, notable limitations)*
This study utilizes data from Feinberg, et al. (2008). The current study assessed the outcomes of ***Family Foundations (FF)*** when children were 3 years old. Couples were randomly assigned to ***FF*** or to no-treatment control conditions. Measures utilized include the *Parenting Sense of Competence*, *Child Behavior Checklist (CBCL)*, *Parenting Scale*, and *The Coparenting Relationship Scale*. Results indicate all families in the ***FF*** group experienced significant program effects on parental stress and self-efficacy, coparenting, harsh parenting, and children's emotional adjustment. Cohabiting couples in the ***FF*** group experienced significant program effects on maternal depression. Among families of boys in the ***FF*** group, program effects were found for child behavior problems and couple relationship quality. Limitations include reliance on self-reported measures and lack of generalizability due to ethnicity and educational level.

Length of postintervention follow-up: 6, 12, and 36 months.

Kan, M. L., & Feinberg, M. E., & Solmeyer, A. R. (2012). Intimate partner violence and coparenting across the transition to parenthood. *Journal of Family Issues, 33*(2), 115-135. doi:10.1177/0192513X11412037

Type of Study: Randomized controlled trial
Number of Participants: 156

Population:

- **Age —** 28-29 years
- **Race/Ethnicity —** Not specified
- **Gender —** 50% Female and 50% Male
- **Status —** Participants were couples expecting their first child.

Location/Institution: Pennsylvania—Altoona and Harrisburg

Summary: *(To include comparison groups, outcomes, measures, notable limitations)*
This study utilizes data from Feinberg, et al. (2008). The current study examined violence prior to the birth of a first child as a predictor of coparenting quality when children reached 1 year of age in a community sample of first-time parents utilizing the ***Family Foundations (FF)*** program. Couples were randomly assigned to FF or a control condition. Measures utilized include the *Revised Center for Epidemiological Studies Depression Scale (CES-D)*, *Conflict Tactics Scales (CTS2)*, and *The Coparenting Relationship Scale*. Results found ***FF*** participation was associated with self-reported and observed improvements in parent mental health, coparenting, and parenting as a function of the intervention. Couple relationship quality and parent mental health problems accounted for the links between prenatal interpersonal violence and coparenting issues. Limitations include lack of generalizability due to ethnicity, self-reported measures, and lack of follow-up.

Length of postintervention follow-up: None.

Kan, M. L., & Feinberg, M. E. (2014). Can a family-focused, transition-to-parenthood program prevent parent and partner aggression among couples with young children? *Violence and Victims, 29*, 967-980. doi:10.1891/0886-6708.VV-D-12-00162

Type of Study: Randomized controlled trial
Number of Participants: 169

Population:

- **Age —** Parents: 28-29 years, Children Mean=36.82 months
- **Race/Ethnicity —** Parents: 90% Non-Hispanic White; Children: Not specified
- **Gender —** Parents: 50% Female and 50% Male; Children 56% Male
- **Status —** Participants were couples expecting their 1st child.

Location/Institution: Pennsylvania—Altoona and Harrisburg

Summary: *(To include comparison groups, outcomes, measures, notable limitations)*
This study utilizes data from previous study [Feinberg et al 2008]. This study examined moderated effects of ***Family Foundations (FF)*** program for couples on partner psychological aggression and parent-child physical aggression when the child was 3 years old. Couples were randomly assigned to intervention (n=89) or to no-treatment control conditions (n=80). Measures utilized *Revised Conflict Tactics Scales (CTS2)* and *the Parent-Child Conflict Tactics Scales*. Results indicate significant program effects reduced partner psychological aggression by fathers and reduced parent-child physical aggression by mothers for couples with frequent preprogram partner psychological aggression and reduced partner psychological aggression by fathers for couples with severe preprogram partner physical aggression. Limitations include reliance on self-reported measures, generalizability to community samples of primarily White, married couple and lack of follow-up.

Length of postintervention follow-up: None.

Feinberg, M. E., Jones, D. E., Roettger, M. E., Solmeyer, A., & Hostetler, M. L. (2014). Long-term follow-up of a randomized trial of family foundations: Effects on children's emotional, behavioral, and school adjustment. *Journal of Family Psychology, 28*(6), 821-831. doi:10.1037/fam0000037

Type of Study: Randomized controlled trial
Number of Participants: 98

Population:

- **Age —** 28-29 years
- **Race/Ethnicity —** 90% Non-Hispanic White
- **Gender —** 50% Female and 50% Male
- **Status —** Participants were couples expecting their first child.

Location/Institution: Pennsylvania—Altoona and Harrisburg

Summary: *(To include comparison groups, outcomes, measures, notable limitations)*
This study utilizes data from Feinberg, et al. (2008) and Feinberg, et al. (2010). The current study evaluated the effectiveness of the ***Family Foundations (FF)*** program on internalizing and externalizing problems and school adjustment. Couples were randomly assigned to ***FF*** or to no-treatment control conditions. Measures utilized include the *Strengths and Difficulties Questionnaire (SDQ)* and the *Child Behavior Checklist (CBCL)*. Results indicate teachers reported significantly lower levels of internalizing problems among children in the ***FF*** group compared with children in the control group. Also, consistent with prior findings at 3 years of age, lower levels of externalizing problems for boys in the ***FF*** group. Limitations include high attrition rate, reliance on self-reported measures, and lack of generalizability due to ethnicity.

Length of postintervention follow-up: Approximately 5-7 years.

Solmeyer, A. R., Feinberg, M. E., Coffman, D. L., & Jones, D. E. (2014). The effects of the Family Foundations prevention program on coparenting and child adjustment: A mediation analysis. *Prevention Science, 15*, 213–223. doi:10.1007/s11121-013-0366-x

Type of Study: Randomized controlled trial
Number of Participants: 167

Population:

- **Age —** 28-29 years
- **Race/Ethnicity —** Not specified
- **Gender —** 50% Female and 50% Male
- **Status —** Participants were couples expecting their first child.

Location/Institution: Pennsylvania—Altoona and Harrisburg

Summary: *(To include comparison groups, outcomes, measures, notable limitations)*
This study utilizes data from Feinberg, et al. (2010). The current study tested coparenting competition and positivity as potential mediators (influencers) of the impact of ***Family Foundations (FF)*** on child adjustment problems 3.5 years after baseline, and explored child gender as a moderator (cause) of the mediated effects. Couples were

randomly assigned to ***FF*** or a control condition. Measures utilized include *Parenting Sense of Competence*, *Child Behavior Checklist (CBCL)*, *Parenting Scale* and *The Coparenting Relationship Scale*. Results indicate ***FF*** participation was associated with significant mediated (influenced) effects for coparenting competition for fathers with both sons and daughters and for mothers with sons, but not for mothers with daughters. Coparenting positivity did not mediate (influence) program effects. Limitations include lack of generalizability due to ethnicity, not able to pinpoint exactly which parts of the intervention were effective, and reliance on self-reported measures.

Length of postintervention follow-up: Approximately 3 years.

Kan, M. L., & Feinberg, M. E. (2015). Impacts of a coparenting-focused intervention on links between pre-birth intimate partner violence and observed parenting. *Journal of Family Violence, 30*(3), 363-372. doi:10.1007/s10896-015-9678-x

Type of Study: Randomized controlled trial
Number of Participants: 167

Population:

- **Age —** 28-29 years
- **Race/Ethnicity —** Not specified
- **Gender —** 50% Female and 50% Male
- **Status —** Participants were couples expecting their first child.

Location/Institution: Pennsylvania—Altoona and Harrisburg

Summary: *(To include comparison groups, outcomes, measures, notable limitations)*
This study utilizes data from Feinberg, et al. (2008). The current study examines Intimate Partner Violence (IPV) prior to the birth of a first child as a predictor of observed parenting when the child was one-year old utilizing the ***Family Foundations (FF)*** program. Couples were randomly assigned to ***FF*** or a control condition. Data was collected during prenatal home interview (Time 1), through mailed questionnaires 4 to 8 months after the birth of the baby (Time 2) and during another home interview approximately 13 months after the birth of the baby (Time 3). Measures utilized *Revised Conflict Tactics Scales (CTS2)* and *The Coparenting Relationship Scale*. Results indicate links between mother and father violence and parenting was significant; however, this was only for participants in the control group. Coparenting did not significantly mediate associations between IPV and parenting among control group couples. Limitations include lack of generalizability due to ethnicity and limited by a past-year measure of IPV that was assessed prenatally.

Length of postintervention follow-up: 3-7 months and 12 months.

Feinberg, M. E., Jones, D., Roettger, M., Hostetler, M., Sakuma, K., Paul, I., & Ethrenthal, D. (2016). Preventive effects on birth outcomes: Buffering impact of maternal stress, depression, & anxiety. *Maternal and Child Health Journal, 20*(1), 56-65. doi:10.1007/s10995-015-1801-3

Type of Study: Randomized block design with propensity scoring
Number of Participants: 250

- **Gender —** 50% Female and 50% Male
- **Status —** Participants were couples expecting their 1st child.

Location/Institution: 3 mid-Atlantic and 1 southwestern US states

Summary: *(To include comparison groups, outcomes, measures, notable limitations)*
This study utilizes data from Feinberg, et al. (2010). The current study assessed the outcomes of ***Family Foundations (FF)*** when children were 3 years old. Couples were randomly assigned to intervention or control conditions after pretest data collection using a randomized block design. Measures utilized include *Center for Epidemiological Studies Depression Scale (CES-D)*, *State-Trait Anxiety Inventory*, and demographic information. Results indicate ***FF*** buffered the negative impact of maternal mental health problems on birth weight and both mother and infant length of postpartum hospital stay. For birth weight, assignment to ***FF*** was associated with higher birth weight for infants born before term. Limitations include reliance on self-reported measures, lack of generalizability due to ethnicity and educational level, and lack of follow-up.

Length of postintervention follow-up: 6, 12, and 36 months.

Feinberg, M. E., Jones, D., Hostetler, M., Roettger, M., Paul, I., & Ehrenthal, D. (2016). Couple-focused prevention at the transition to parenthood, a randomized trial: Effects on coparenting, parenting, family violence, and parent and child adjustment. *Prevention Science, 17*(6), 751-764. doi:10.1007/s11121-016-0674-z

Type of Study: Randomized controlled trial
Number of Participants: 399

Population:

- **Age —** 29-31 years
- **Race/Ethnicity —** 85% Non-Hispanic White
- **Gender —** 50% Female and 50% Male
- **Status —** Participants were couples expecting their first child.

Location/Institution: 3 Mid-Atlantic States and 1 southern state

Summary: *(To include comparison groups, outcomes, measures, notable limitations)*
The purpose of this study is to test the short-term efficacy of ***Family Foundations (FF)***. Couples were randomly assigned to ***FF*** or control conditions after pretest. ***FF*** couples received a manualized 9-session (5 prenatal and 4 postnatal classes) psychoeducational program delivered in small groups. Measures utilized include the *Coparenting Relationship Scale*, *Center for Epidemiological Studies Depression Scale (CESD)*, *Infant Behavior Questionnaire*, *Child Sleep Questionnaire*, *Conflict Tactics Scale*, and the *Parent-Child Conflict Tactics Scale*. Results found significant positive impact across all domains of outcomes examined: parent mental health and adjustment, coparenting and couple relations, parenting quality, family violence, and early indicators of child self-regulation (soothability, attention, sleep). Results also indicated that the relatively well-educated and high-functioning nature of the sample may have reduced the potential for finding overall preventive intervention impact. Limitations include reliability on self-reported measures, lack of generalizability due to ethnicity and educational level, and lack of follow-up.

Length of postintervention follow-up: None.

Additional References

Feinberg, M. E. (2002). Coparenting and the transition to parenthood: A framework for prevention. *Clinical Child & Family Psychology Review, 5*, 173-195.

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

Contact Information

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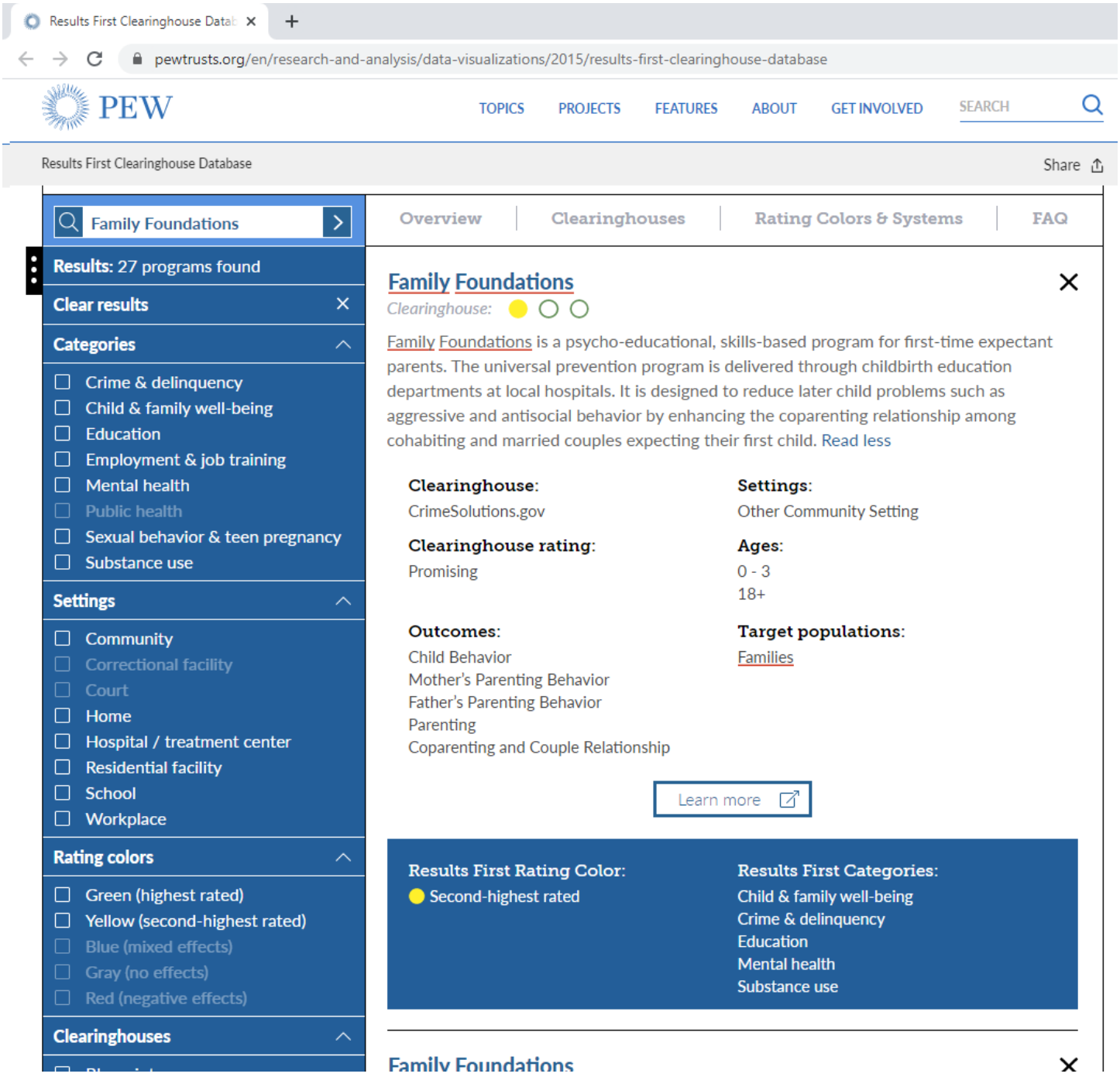
Date Research Evidence Last Reviewed by CEBC: October 2017

Date Program Content Last Reviewed by Program Staff: June 2019

Date Program Originally Loaded onto CEBC: April 2017

The CEBC is funded by the California Department of Social Services' (CDSS') Office of Child Abuse Prevention and is one of their targeted efforts to improve the lives of children and families served within child welfare system.

Results First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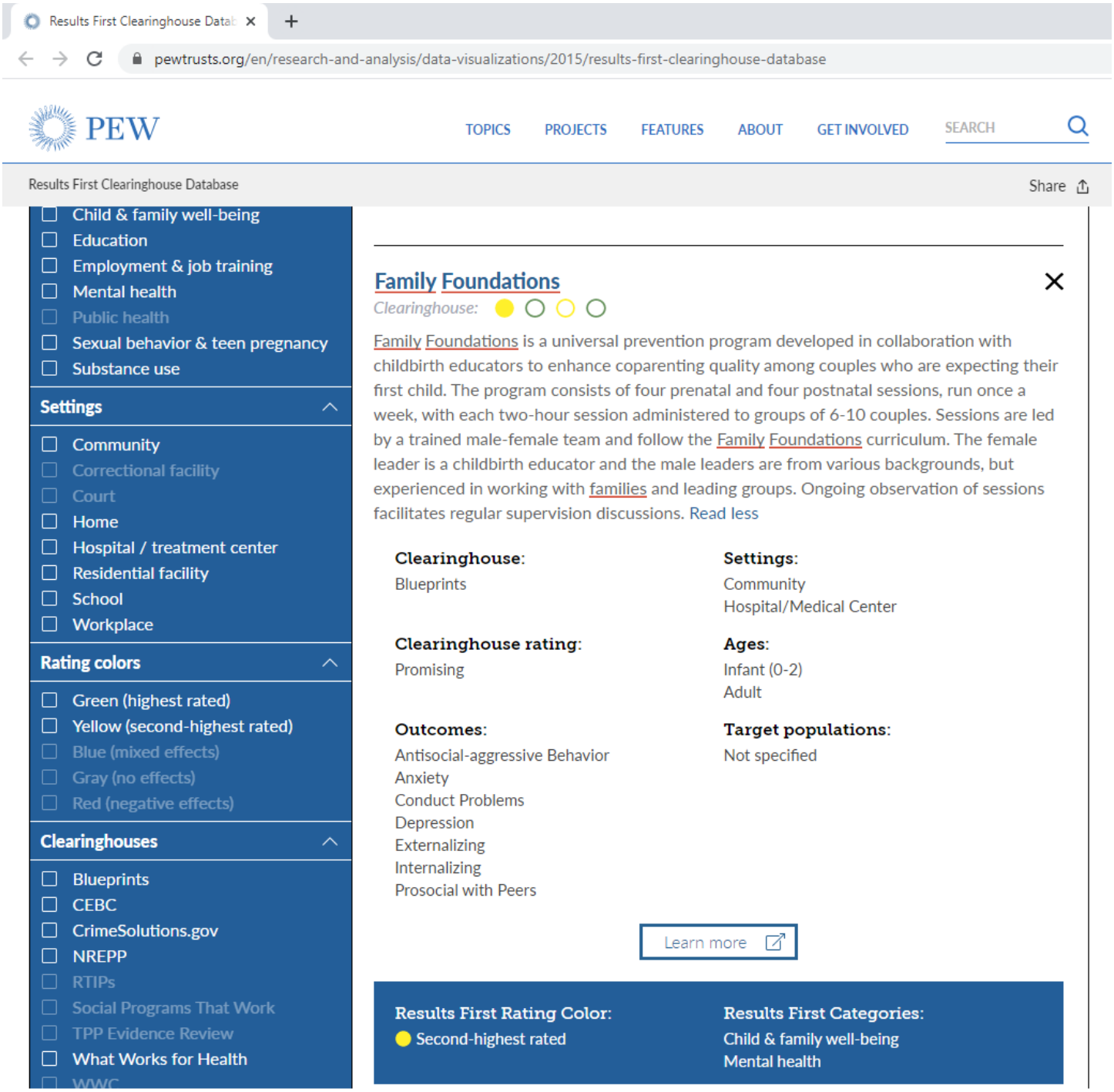
PEW
TOPICS
PROJECTS
FEATURES
ABOUT
GET INVOLVED
SEARCH
Results First Clearinghouse Database
Share
Family Foundations
Results: 27 programs found
Clear results
Categories
Crime & delinquency
Child & family well-being
Education
Employment & job training
Mental health
Public health
Sexual behavior & teen pregnancy
Substance use
Settings
Community
Correctional facility
Court
Home
Hospital / treatment center
Residential facility
School
Workplace
Rating colors
Green (highest rated)
Yellow (second-highest rated)
Blue (mixed effects)
Gray (no effects)
Red (negative effects)
Clearinghouses
Overview
Clearinghouses
Rating Colors & Systems
FAQ
Family Foundations
Clearinghouse:
Family Foundations is a psycho-educational, skills-based program for first-time expectant parents. The universal prevention program is delivered through childbirth education departments at local hospitals. It is designed to reduce later child problems such as aggressive and antisocial behavior by enhancing the coparenting relationship among cohabiting and married couples expecting their first child. Read less
Clearinghouse:
CrimeSolutions.gov
Clearinghouse rating:
Promising
Settings:
Other Community Setting
Ages:
0 - 3
18+
Outcomes:
Child Behavior
Mother's Parenting Behavior
Father's Parenting Behavior
Parenting
Coparenting and Couple Relationship
Target populations:
Families
Learn more
Results First Rating Color:
Second-highest rated
Results First Categories:
Child & family well-being
Crime & delinquency
Education
Mental health
Substance use
Family Foundations


Results First Clearinghouse Datab
pewtrusts.org/en/research-and-analysis/data-visualizations/2015/results-first-clearinghouse-database
PEW
TOPICS
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Share
Child & family well-being
Education
Employment & job training
Mental health
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Rating colors
Green (highest rated)
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Red (negative effects)
Clearinghouses
Blueprints
CEBC
CrimeSolutions.gov
NREPP
RTIPs
Social Programs That Work
TPP Evidence Review
What Works for Health
Family Foundations
Clearinghouse:
Family Foundations is a universal prevention program developed in collaboration with childbirth educators to enhance coparenting quality among couples who are expecting their first child. The program consists of four prenatal and four postnatal sessions, run once a week, with each two-hour session administered to groups of 6-10 couples. Sessions are led by a trained male-female team and follow the Family Foundations curriculum. The female leader is a childbirth educator and the male leaders are from various backgrounds, but experienced in working with families and leading groups. Ongoing observation of sessions facilitates regular supervision discussions. Read less
Clearinghouse:
Blueprints
Settings:
Community
Hospital/Medical Center
Clearinghouse rating:
Promising
Ages:
Infant (0-2)
Adult
Outcomes:
Antisocial-aggressive Behavior
Anxiety
Conduct Problems
Depression
Externalizing
Internalizing
Prosocial with Peers
Target populations:
Not specified
Learn more
Results First Rating Color:
Second-highest rated
Results First Categories:
Child & family well-being
Mental health