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Perinatal Intervention Desires of New Fathers Who Have a History of Child Maltreatment: A Mixed Methods Study

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Abstract

A history of child maltreatment (CM) can lead to poorer perinatal mental health and early parenting outcomes. New fathers who experienced CM may have unique needs that could be addressed with trauma-specific fatherhood programs. This sequential mixed-methods study compares the intervention desires of fathers with and without a history of CM, explores trauma-specific considerations for intervention development, and identifies barriers to participating in perinatal fatherhood programs. We surveyed 371 first-time fathers of young children (birth - 30 months) online. One third (33%, *n* = 123) had a history of CM, and we interviewed 15 of them. Participants desired basic parenting skills programs with optional trauma-specific add-ons. Trauma-specific topics included managing relationships, sleep, and emotions like low mood, anger, or irritability. Many lacked positive fathering role models and sought connections with other fathers who had experienced CM. Trauma-specific perinatal interventions could support fathers with a history of CM in interrupting the intergenerational transmission of trauma.

Keywords

parenting, early childhood, child maltreatment, fathers, intervention research, trauma-informed care

Background

Long-term Impact of CM

Child maltreatment (CM) causes chronic stress that can disrupt the development of the brain, nervous system and immune system. Later in life, those who experienced CM are at higher risk for mental and behavioral health challenges including posttraumatic stress disorder (PTSD), substance use disorders, and depressive disorders (Centers for Disease Control and Prevention [CDC], 2024b). Chronic life stressors including financial stress, racism, and community violence can also compound the impact of CM for individuals from minoritized socioeconomic groups, potentially worsening the burden of trauma sequelae over time (Bernard et al., 2021).

Impact of Trauma on Fathers with a History of CM

Trauma-related mental health challenges (e.g. PTSD, depression, and other complex sequelae) can make sensitive parenting more challenging. For new fathers, a history of CM is associated with less secure attachment to their child, lower parenting confidence (Berthelot, Lemieux, et al., 2020), and higher levels of parenting stress (Granner et al., 2023). Parenting stress refers to a set of adverse reactions when a person adapts to the demands of parenthood, including parental distress, parent-child dysfunctional interaction, and perceived difficulty of the child (Abidin, 2012). A history of CM can lead to an increased risk of fathers' own children experiencing CM (Berlin et al., 2011; McKenzie et al., 2021), likely related to mental health challenges (e.g. PTSD or MDD), complex or relational trauma sequelae, and higher parenting stress. Thus, trauma can be passed from one generation to the next in intergenerational patterns.

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Addressing Fathers' Own Trauma to Prevent CM

Preventing CM and other Adverse Childhood Experiences (ACEs) by promoting Safe, Stable, and Nurturing parent-child relationships is a priority for the Centers for Disease Control and Prevention (CDC, 2024b). They propose five strategies for programs to prevent CM, including teaching parenting skills and family relationship approaches. However, these strategies to prevent CM are not targeted to address parent's own experiences of trauma. Because having a history of CM can increase individuals' risk of perpetrating violence (CDC, 2024a), targeted trauma-specific interventions may help prevent CM by addressing any long-term behavioral health sequelae. An estimated one in four people have a history of CM (CDC, 2024b); trauma-specific parenting interventions may be an opportunity to promote health at the population level.

The Perinatal Period: An Opportunity for Trauma-Specific Intervention

The perinatal period is an ideal time to intervene with both mothers and fathers who experienced CM for several reasons. First, if parents can be identified and supported during their transition to parenthood—before CM can occur for their children—intergenerational transmission of CM could be interrupted. Second, when individuals who experienced CM become parents themselves, there is a sudden increase in the number and variety of environmental triggers surrounding childhood. For example, a father might feel intense frustration when his infant cries unconsolably, which could evoke memories of his own experiences of CM when his parent felt similar frustration or rage. Frustration with his crying baby could also trigger intense feelings of shame and helplessness, similar to how he felt as a child in an abusive context. In the postpartum context of reduced sleep and sudden changes in social relationships, triggers can lead to worsening symptoms of PTSD related to fathers' own experiences of CM (Price-Robertson, 2012), and a greater need for support. Third, perinatal interventions may be especially effective because the major life transition provides an increased openness to change for many new parents (Lindstedt et al., 2021). Lastly, childbearing people are often closely connected to the healthcare system, which could provide an opportunity to engage fathers alongside mothers. However, the scarcity of programs specific to fathers makes it more difficult to engage them in perinatal and pediatric spaces (Lee et al., 2018).

Challenges in Engaging Fathers

Fatherhood programs often struggle to engage men (Stahlschmidt et al., 2013), partly due to fathers' lack of awareness of father-specific programs (Lee et al., 2011). Many fathers are employed full-time and report they do not have time for a parenting program (Wade et al., 2023). They emphasized that convenience of program's timing is crucial for their participation. Additionally, many fathers believe they do not need outside help and prefer to rely on online searches for information (Wade et al., 2023). Fathers may also perceive that perinatal programs are—and should be—designed for mothers, and strive to take a strong, supportive, and protective role (Darwin et al., 2017; Stahlschmidt et al., 2013). Furthermore, many men experience stigma around seeking help, fearing it undermines their masculinity or would be seen as a failure (Stahlschmidt et al., 2013).

Masculinity and Stigma

Experiences of CM and challenges with mental health are particularly stigmatized for men, and openly discussing these topics conflicts with some fathers' view of masculinity (Chamberlin, 2012; Darwin et al., 2017). Furthermore, avoidance of reminders of trauma is a diagnostic criterion of PTSD (Blevins et al., 2015). Thus, both avoidance symptoms and stigma in the context of traditional norms of masculinity add to the challenge of engaging fathers who experienced CM in programs specific to trauma or mental health. Therefore, when conceptualizing trauma-specific programs for fathers, it is crucial to engage fathers who experienced CM early on in intervention design to increase the likelihood that others will want to engage in the future (Bellg et al., 2004; Israel et al., 2019).

Fathers' Parenting Intervention Desires

For father-inclusive parenting interventions that are not specific to trauma, previous studies report that many fathers are interested in learning about how to have a positive relationship with their child (Sicouri et al., 2018). Specifically, they may wish to learn how to understand their child's emotions and manage their child's behavior and technology use. They may also desire father-specific content, such as understanding their role as a father and its importance in child development, self-care as a father, and managing (as well as normalizing) their emotions, including anger (Sicouri et al., 2018). Lastly, fathers may be interested in learning practical decision-making strategies and positive co-parenting or improving their relationship with their partner. These topics are likely relevant to fathers who have a history of CM, but they may have additional trauma-specific needs.

Trauma-specific Perinatal Interventions and Gaps

Several trauma-specific interventions have been developed for mothers who experienced CM, which show promising results. For example, Survivor Moms' Companion (SMC) is a psychoeducation and social support program that teaches skills for managing PTSD symptoms and triggers, emotion regulation, and interpersonal connecting (Seng et al., 2011; Sperlich & Kabilamany, 2022). Seeking Safety is a cognitive behavioral intervention designed to treat co-occurring trauma,

PTSD, and substance use disorders (Salvador et al., 2020). A literature search revealed no perinatal interventions specific to fathers who experienced CM (Berthelot, Garon-Bissonnette et al., 2020; Stephenson et al., 2018), due in part to the significant barriers to recruiting and engaging fathers. Effective interventions for fathers likely need to target different factors than interventions for mothers (Dayton et al., 2019).

Study Purpose and Aims

It is not known what fathers who experienced CM would want in a perinatal intervention. The purpose of this study is to examine unmet perinatal needs of fathers who have a history of CM and their intervention desires (i.e. content and format). First, we aim to compare the intervention desires of fathers who have a history of CM and those who do not. Second, we aim to explore trauma-specific considerations for intervention development, and explore barriers that fathers identify to participating in perinatal fatherhood programs. Answering these questions is a first step in creating interventions to meet the needs of fathers who experienced CM and support them in interrupting intergenerational transmission of CM.

Methods

Study Design

This study used a sequential mixed methods design, with an anonymous internet survey of new fathers leading to purposive sampling of fathers who had a history of CM for individual interviews over online audio calls. The University of Michigan Health and Behavioral Sciences Institutional Review Board determined this study to be exempt from their oversight.

Sample

We recruited a convenience sample of 371 fathers whose first child was under 30 months old on Prolific, a web-based platform that connects survey researchers with eligible participants (Prolific, 2024). Prolific contains tens of thousands of research participants who participate in studies through the platform for fair hourly compensation. The internet was our chosen setting for this project to increase anonymity due to the stigma surrounding CM and mental health challenges, especially for men (Chamberlin, 2012). The survey allowed us to recruit an adequately powered sample to compare responses of fathers who experienced CM with those who did not. However, we expanded initial inclusion criteria of first-time fathers of children under 24 months, to under 30 months, to allow for a larger sample size.

For individual interviews, we purposively sampled a subset of 15 survey participants who experienced CM from the pool of survey respondents. At the end of the survey, we asked participants who endorsed CM if they would be interested in participating in a qualitative interview. From those who said yes, we used purposive sampling with a sampling frame (Table 1) to invite fathers diverse by probable PTSD and MDD diagnoses, level of parenting stress, and self-identified race or ethnicity (Table 4), all assessed during the survey. Figure 1 displays the mixed-methods study recruitment flowchart. Survey respondents were paid approximately $9 per hour (average survey duration: 38 minutes). Qualitative interview participants were offered an additional $20 for completing the interview (average interview duration: 53 minutes).

Data Collection

Survey. The survey component assessed CM exposure using the ACEs questionnaire (Felitti et al., 1998; Murphy et al., 2014). We considered fathers who endorsed any of the first five ACEs assessing physical, emotional, or sexual abuse and physical or emotional neglect to have a history of CM. The survey also contained 11 study-specific items about perinatal program desires in terms of content and format. These items were investigator-generated based on elements of behavioral interventions found in the literature (e.g., type of interventionist, group or individual, mode of delivery, etc.). We report all available data for each item, including the sample size to reflect missingess. To inform our qualitative sampling frame, the survey included validated, gold-standard clinical assessment tools to assess PTSD (PTSD Checklist for DSM-5 [PCL-5], internal consistency reliability Cronbach's $\alpha = .95$), Major Depressive Disorder (Patient Health Questionnaire [PHQ-9], $\alpha = .92$), and parenting stress (Parenting Stress Index-Short Form [PSI-SF]; $\alpha = .91$). Survey measurement is described in more detail elsewhere (Granner et al., 2023).

In-Depth Interviews. After the survey, we conducted in-depth individual interviews with 15 first-time fathers who had a history of CM. A third of survey participants ($n = 123$) were asked if interested in participating in an individual interview because they experienced at least one form of CM. Of those, 83 indicated interest on the survey, 42 responded to the invitation on Prolific, and 15 completed the interview (Figure 1). After consenting, interview participants were sent a Zoom link via Prolific, and asked to turn off their camera and change their name to a pseudonym before joining.

Interviews were semi-structured, following an interview guide based in narrative storytelling methodology. The interview guide was modeled after a similar study interviewing mothers who had a history of trauma conducted by the senior author (Seng et al., 2002). First, we asked participants if and how they saw their childhood experiences affecting them as they became a father. Then, we asked about any unmet needs that they have had at any point in their early parenting journeys, and what could have helped meet those needs. Lastly, we asked about what they thought an ideal program for fathers who had experienced CM or childhood trauma would look like, and what barriers they would anticipate to participating. The interviewer included additional probes on an individual basis. All interviews were conducted by the first author, and were audio recorded and professionally transcribed.

Table 1. Qualitative Sampling Frame (n = 15).

	No PTSD (probable diagnosis)		Subclinical PTSD Symptoms		PTSD+ (probable diagnosis)	
High Parenting Stress	**Jake** (White)	White	**Alan** (White)	**John** (White)	**Trevor** (White)	**Josh** (White)
	Henry (Hispanic)	POC [a]	**Jose** (Latino)	**Steve** (Asian)	**Jason** (White)	**Ben** (White)
				Chris (Turkish/ White)		**Vincent** (Cambodian)
Low Parenting Stress	**Miles** (White)	**Ethan** (White)	White	White	White	White
	POC	POC	POC	POC	**Samuel** (Hispanic)	POC

Note. Participants are listed as **Pseudonym** (Self-identified race and/or ethnicity).
[a]Person of Color.

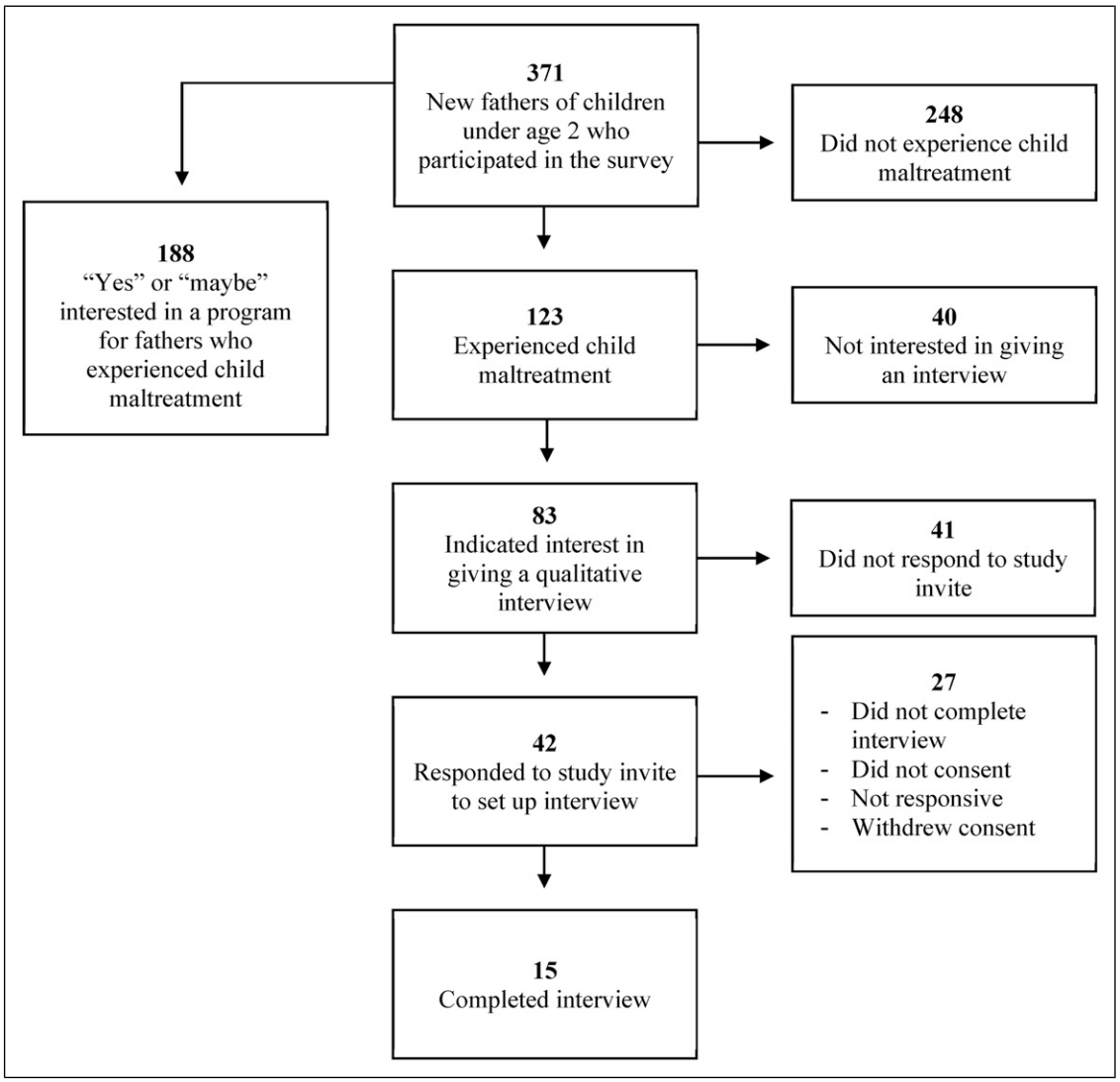

Figure 1. Mixed methods recruitment flowchart of fathers with children under 30 months old.

Table 2. New Fathers' Desired Intervention Format by Child Maltreatment (CM) Status.

	No CM (n = 110)	CM+ (*n* = 78)	Total (*n* = 188)*
	%	%	%
Who should run the program? *(Select all that apply)*			
More experienced dad	80.9	69.2	76.1
Nurse	53.6	33.3**	45.2
Social worker	42.7	41.0	42.0
Community health worker	30.9	38.5	34.0
Home visitor/health visitor	20.0	18.0	19.2
Other	0.9	11.5**	5.3
'Other' responses included therapist, psychiatrist/psychologist, minister, a dad who had outlived trauma and its effects, and group-led			
What gender of person should run the program? *(Select all that apply)*			
Doesn't matter	60	46.2	54.3
Man	30.9	44.9	36.7
Woman	8.2	9.0	8.5
Who would you like to do the program with? *(Select all that apply)*			
With a group of other dads	80.0	65.4**	73.9
Sometimes with the baby's mom, sometime not	40.9	43.6	42
One-on-one with a 'tutor'	37.3	41.0	38.8
With the baby's mom	40.0	35.9	38.3
How would you like to participate in a program? *(Select all that apply)*			
In person	83.6	82.1	83.0
Online	50.9	59.0	54.3
Watching videos	35.5	32.1	34.0
Video calls	30.0	32.1	30.9
Using a workbook	8.2	7.7	8.0
On the phone	5.5	5.1	5.3
When would you have liked to do a program? *(Select all that apply)*			
Both during pregnancy and after the birth	63.6	73.1	67.6
During pregnancy	34.6	29.5	32.5
After the birth	20.9	19.2	20.2
Either during pregnancy or after the birth	12.7	21.8	16.5
How many meetings would you want to participate in?			
1-5	32.7	29.5	31.4
6-10	46.4	43.6	45.2
11-15	13.6	18.0	15.4
16-20	7.3	9.0	8.0
How often would you like meetings to be?			
Twice a week	10.0	14.1	11.7
Weekly	53.6	50.0	52.1
Monthly	28.2	28.2	28.2
Quarterly	4.6	3.9	4.3

Note. Some 'other' responses were not depicted due to small cell sizes.
*Questions were only asked to participants who responded "yes" or "maybe" interested in participating in a program for fathers who experienced CM.
**Chi2 $p < .05$; significantly different than fathers without a history of CM.

Data Analysis

Survey. We used descriptive statistics (frequencies and Chi-Squared tests) to examine survey responses for any significant differences between the preferences of fathers with and without a CM history (Table 2; Table 3). Responses from fathers without a CM history may meaningfully inform ongoing attempts to make universal programming more acceptable and increase uptake. We conducted all statistical analyses using Stata 17 (StataCorp, 2021).

In-Depth Interviews. We analyzed interview transcripts with a content analysis. The qualitative coding team included three analysts—two line-by-line coders (a PhD candidate in nursing science and a family practice resident physician), and a supervising auditor (a content expert with over 30 years of

Table 3. New Fathers' Barriers to Program Participation by Child Maltreatment (CM) Status.

What practical barriers would stop you from participating? *(Select all that apply)*	No CM (*n* = 232) %	CM+ (*n* = 117) %	Total (*n* = 349)* %
Not enough time	60.3	72.7	64.5
I just wouldn't want to	39.7	34.2	37.8
No transportation	16.0	21.4	17.8
No childcare	5.6	11.1	7.5
Other (see below)	10.3	6.0	8.9
Other practical barriers—exemplar responses			
I haven't been a victim of serious trauma and wouldn't think this would be useful	I feel my mental health is in a manageable state on my own		
Ability to take paid time off work	Embarrassment		
Work hour conflict	COVID-19		
Money/too expensive	Being busy with child		
Custody	If baby's mom didn't want to		
What emotional barriers would stop you from participating? *(Select all that apply)*	**No CM (*n* = 216) %**	**CM+ (*n* = 112) %**	**Total (*n* = 328)* %**
I don't want to talk about emotions	30.6	43.8	35.1
I don't need help managing mental health	40.3	23.2**	34.5
I don't want to talk about trauma	28.2	44.6	33.8
I feel like I shouldn't need help with mental health	19.4	19.6	19.5
I feel like I shouldn't need help with parenting	14.8	15.2	14.9
I don't need help with parenting	7.9	9.8	8.5
Other (see below)	13.0	13.4	13.1
Other emotional barriers—exemplar responses			
Didn't think of it as trauma	General embarrassment		
Too tired after work	Feel there's worse off than me		
No trauma that really still affects me	Not good at sharing feelings		
I am quite an anxious person and avoid rather than face things head on	Okay with talking about trauma depending on the environment and how it is done		
I struggle to meet new people outside of a setting I feel comfortable	I have a hard time opening up to people, especially people I don't know		

Note. Some 'other' responses were not depicted due to small cell sizes.
*Questions were only asked to participants who responded "yes" or "maybe" interested in participating in a program for fathers who experienced CM.
**Chi2 $p < .05$; significantly different than fathers without a history of CM.

qualitative research experience). Independently, the coders extracted statements related to the a priori selected topics of intervention content and format (Morgan, 1993). We based our initial coding scheme on the quantitative survey items related to intervention content and format. Each coder created additional codes as necessary when themes raised in the interviews did not map onto the a priori conceptual framework. The coders organized the codes into themes and subthemes, and selected exemplar quotes to illuminate each theme. Then they met to compare their coding choices, selections of quotes, and the structures and names of added themes and subthemes. The analysts used a negotiated coding approach, and easily resolved all discrepancies through discussion, returning to the transcripts, and consulting the senior qualitative expert. After the two coders reached consensus, they drafted a report of the results, illuminated by exemplar quotes. The senior qualitative content expert then reviewed and audited the report, comparing it to the raw interview transcripts and iteratively giving feedback to verify faithfulness to the utterances of participants. We conducted qualitative analyses using NVivo 13 (Lumivero, 2020).

Results

Participant Characteristics

About half of survey participants (total $n = 371$) were from the US (47.1%) and half were from the UK (52.9%). Annual household income of the survey participants (USD) was 4.8% reporting less than $19,000, 34.4% between $20,000-$49,999, 27.9% between $50,000-$79,999, 25.1% between $80,000-$149,999, and 32.5% more than $80,000 per year. Most

identified as White (82.9%), followed by Black (6.3%), Mixed (5%), Asian (4.4%) and Other (1.4%). Age ranged from 19-53 with a mean of 31.4 ($SD = 5.59$). Two thirds of participants (66.9%) did not endorse any forms of CM, 15.4% endorsed one form, 11.6% endorsed two, and 6.3% endorsed three or more. Most participants were living with, and in a relationship with their baby's mother (96.9% and 93.2% respectively). Over two thirds (71.6%) of fathers reported that the pregnancy was intended, meaning both wanted and timed as desired.

Interview participants ($n = 15$) endorsed an average of 2.1 types of CM and had an average total ACE score of 3.1. They were diverse by probable diagnoses of PTSD and MDD, level of parenting stress, and self-identified race or ethnicity (Table 1). Table 4 displays characteristics of interview participants ($n = 15$), including types of CM experienced and child age.

Survey Responses

When asked if interested in participating in a program for fathers who experienced childhood trauma, 22.3% of fathers who experienced CM responded yes, 42.2% said maybe, and 35.5% said no. Fathers with and without a history of CM expressed similar interests in topics related to parenting in general and the life transition to fatherhood. These included parenting skills (80.8% of the total sample indicated interest), learning about child development (80.3%), managing challenging child behaviors (67.2%), planning activities with your child (63.3%), nurturing parenting behaviors (61.4%), responding when your child gets sick or injured (61.4%), increasing financial security (58.6%), making your home environment safe (48.1%), and improving family relationships (41.9%). Some fathers who had a history of CM also desired trauma-specific parenting topics, which are displayed in Figure 2.

Fathers' preferences of intervention format were similar for fathers who experienced CM and those who did not (Table 2). Most fathers with a history of CM preferred a program to be facilitated by a more experienced dad (69.2%) followed by a professional such as a therapist, nurse, social worker, or community health worker. For the item about who should facilitate a program, a significantly greater proportion of fathers who experienced CM wrote in their own response (11.5%), than fathers without a CM history (0.9%; $p < .001$). Many wrote in 'therapist' or 'qualified professional,' which was not included as a multiple-choice option. Significantly fewer fathers who experienced CM wanted a program with a group of other dads (65.4%) compared with fathers who did not experience CM (80.0%; $p = .025$). More than half (59.0%) of fathers who experienced CM also said that they would be interested in an online program. Most participants said they would prefer a weekly program that met a total of 6–10 times, both during pregnancy and after the birth (Table 2). The most

Table 4. Qualitative interview participant Characteristics ($n = 15$).

Participant pseudonym	Age (yrs)	Baby age (mo)	Race/ethnicity	CM types experienced	ACE score (1–10)[a]	Probable PTSD diagnosis[b]	Depression[c]	Parenting stress[d]
John	27	21	White	VA, PA, EN	6	Subthreshold	Mild	Moderate
Vincent	36	18	Cambodian/ Chinese	VA, SA, EN, PN	5	Yes	Mod. Severe	High
Steve	33	7	American Asian	VA, EN, PN	5	Subthreshold	Mild	High
Jose	31	6	Latino	VA, EN	5	Subthreshold	Minimal	Moderate
Jake	28	2	White	PA, EN	5	No	Mild	High
Henry	31	0	Latino & Hispanic	VA, PA, PN	4	No	Mild	High
Trevor	34	10	White	VA, PA	3	Yes	Severe	Moderate
Ben	34	24	White	VA, EN	3	Yes	Mod. Severe	Moderate
Miles	29	10	White	VA	3	No	Minimal	Low
Samuel	30	3	Hispanic	SA, EN	2	Yes	Minimal	Low
Alan	23	18	White	PA, EN	2	Subthreshold	Mod. Severe	Moderate
Ethan	29	21	White	VA	1	No	Mild	Low
Chris	36	19	Turkish/White	VA	1	Yes	Mild	Moderate
Josh	30	23	White	EN	1	Yes	Moderate	Moderate
Jason	29	9	White	EN	1	Yes	Mod. Severe	Moderate

[a]Total ACE score count includes VA, PA, SA, EN, PN, parental separation, intimate partner violence, substance abuse, mental illness, or incarceration of a household member.
[b]Score on PCL-5 <21 = no PTSD, 21-31 = subthreshold, and >31 = PTSD.
[c]Score on PHQ-8 between 1-4 = minimal depression, 5-9 mild depression, 10-14 moderate depression, 15-19 = moderately severe depression, and 20-27 = severe depression.
[d]Score on PSI <50th percentile = low, 50th-80th percentile = moderate, >80-0th percentile = high. Percentiles are calculated based on the quantitative survey sample ($n = 353$).
CM = child maltreatment; ACE = Adverse Childhood Maltreatment; VA = verbal abuse; PA = physical abuse; SA = sexual abuse; EN = emotional neglect; PN = physical neglect.

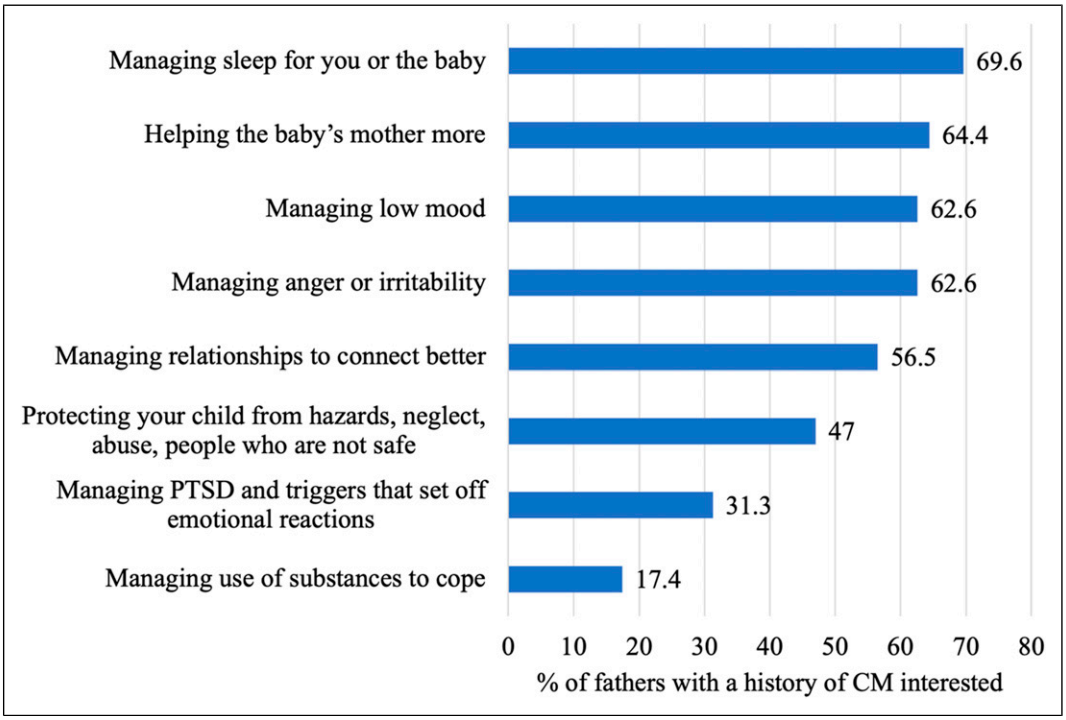

Figure 2. Percentage of fathers with a history of child maltreatment (CM) interested in trauma-specific intervention topics (n = 115).

frequently endorsed barriers to participation for fathers with a history of CM (Table 3) were not having enough time (72.7%), not wanting to talk about trauma (44.6%), and not wanting to talk about emotions (43.8%). Significantly fewer fathers who experienced CM said, "I don't need help managing mental health" (23.2%), compared with fathers who did not experience CM (40.3%; $p < .001$).

Individual Interviews

Fathers described their desires in terms of intervention content, intervention format, trauma-specific considerations for programs specific to fathers who experienced CM, and barriers to participation.

Intervention Content. Participants shared intervention content preferences in four main themes, 1) Managing emotions and mental health, 2) Relationships, 3) Parenting, and 4) General life needs.

Managing Emotions and Mental Health. Fathers described that *managing strong emotions* was a challenge for them, especially with the presence of many triggers during early parenting. One father said,

> It's really scary to me just how frustrated I'll get… last night I was just very angry. Now I understand why they tell you to not shake the baby…. You've lived so much life before now, and you've overcome so much. Why are you so angry at a baby? It's like, what's wrong with me? How can a child this small bring me to my breaking point every day? … I'm ashamed and disappointed. Every time, it's like it's the first time. (Henry)

Other fathers also described the challenge of *managing triggers that set off emotional reactions.* The baby crying was a common trigger for strong emotions, and *anger or irritability* was the most common reaction described. For instance,

> There was one time where I did end up yelling at my daughter… 'Why wouldn't you just be quiet?' She got startled and then started crying and then it was just like, 'All right. That's exactly what I don't want to be doing. That's great. Good job. Gold star.' I think that's an important thing to address for any fathers. If you do make mistakes, own up to it. Be better. What can you do to prevent it, what are some coping mechanisms, things like that. (Alan)

Another father also said that he would appreciate if a program included content that would help fathers learn to cope with strong emotions and *recentering* when feeling frustrated.

> I would just say maybe practice something to help your patience, go ahead and have routines of breathing techniques, or meditation, or going for runs or jogs, or something that you can do, as corny as it sounds, to recenter yourself or just take a pause in case you are feeling really frustrated with the kid. (Trevor)

In addition to managing strong emotions in specific moments, some fathers said that *low mood* could be challenging.

Some worried about not being present enough for their child due to their low mood. One father described this tension,

> I do get depressed…but when you're around a one-year-old, two-year-old, three-year-old, you need to be strong enough to show him that you're his hero, you're there for him, you'll always be there for him. (Alan)

Several fathers reported the *use of substances to cope*, and said substance use would be important to assess and address in a program. One father, who had participated in therapy and substance use treatment for nine years, reflected on the possible effects of substance misuse.

> I had to learn how to care about myself and just really understand like, "Why am I doing this? What is the root of all of this? Why do I feel the need to have things in excess? Why do I have the need to drink myself into a blackout or get so high that I spend all my money? I can remember when I was younger, I would say that I'm escaping. I craved the escape. But like, with a baby, you can't escape. The baby's here now. If you escape, he escapes too. (Jose)

Another experience that several fathers described was feelings of *stress and anxiety about the baby* during early parenting, especially regarding the wellbeing of their child.

> I do think there's a lot of mental health triggers, specifically with stress and even anxiety. It's like, "Oh, my gosh, is the baby going to be okay?" I can see that with my wife sometimes when you're always thinking about the baby, and so you're ruminating and you're almost catastrophizing. (Jose)

Many of the participants emphasized the importance of *learning to care for and improve themselves* while learning to care for their child. One father shared,

> My childhood experiences serve as a reminder of how I need to find a balance between my own life and also the life that I have as a father. Myself the individual, and myself as the father, because I have to be able to do both. I have to be able to find a balance of taking care of them both equally, so I can provide for him. At the same time, I can be there for him and make time for him which I feel is the main priority. (Samuel)

Overall, many of the participants portrayed a desire to improve themselves during the perinatal period in order to be better fathers. Many *did not want to pass on their mental health problems to their children*, but did not always know how to act on their desire to improve. One father hoped that a program could help with this:

> Hopefully a part of the program is, if you do want to be a better father, you also have to work on yourself. If you're not working on yourself and your issues, they're probably going to ultimately bubble up and your kid's going to experience them…I would think that if those aren't addressed, it just becomes a self-perpetuating cycle. (Trevor)

Relationships. Many participants said that relationships were one of their greatest challenges, and that a program for fathers who have a history of trauma should address relationships with the baby, their partner or coparent, and their own parents. Nearly every participant emphasized the importance of their *coparenting relationship* and wanted to support the baby's mother as much as possible. Some wanted tangible advice on how to help the mother breastfeed or to help with sleep for her and the baby. Other participants emphasized joint parenting decision-making and *navigating family dynamics with their new bab*y. For example,

> I could have used a little better direction for what's going to be happening after the birth as far as the family life that the two of us are trying to build… You're talking about relationship with the child and there are definitely lots of things that have to be worked on together. It's not an individual experience at that point anymore. I feel that…mother-father learning how to do it together is an important part. That's probably the route I would prefer to take. (John)

Several participants described wanting to *connect more* to those around them, especially their partner and their child. However, some found creating secure connections difficult because of their childhood trauma, and did not know what they could do to improve. For example,

> Thinking on it, I'm realizing I didn't feel the amount of love and affection and care from my father, that I feel I wanted or I feel could have bettered me. I just want to be able to show my son that …but I didn't do everything properly to be able to put myself in that position. It's like, well, this makes sense that I would want this, but my actions didn't add up with how my mental state tells me I want things to happen. It's still a little confusing, what did I do wrong? Where does it come from? How can I fix these problems in order to show the people around me, that I care about them, that I love them, that I want the best for them, that I'm here to support them? Things that I feel I should have been shown a little more. I still don't have the specific answer of what I can do differently throughout my daily life. (John)

A common theme fathers shared was wanting to *avoid making the mistakes their parents made* raising them. One father shared his journey striving to be different from his own father.

> My default is to act like my dad, and that's what makes it hard because every day it resets and every day you have to… go back and realign to not to be like that. It's like when you wake up in the morning, your back, "Oh, I got to get it realigned," because in the middle of night it went back to how it was before. But every day gets easier… you get used to doing it. It's like a routine in the morning. (Jose)

Some fathers described the dilemma of how to manage the relationship between their child and their own parents, who they may not see as safe. Several fathers decided to reduce contact with their parents to almost nothing. Others allowed their parents to interact freely and watch the child. Some felt their parent had improved since raising them, while others did not see restricting the grandparent relationship as a viable choice. One father described trying to maintain a relationship, saying,

> My parents do still love him and everything. We're not sure. We haven't decided as far as when he gets a little older if we'll let them really watch him too much by themselves…We want them to be involved and see him and everything still. For now, at least, in more of a supervised setting. (Jake)

Several fathers shared that *bonding with their baby* was difficult, made even harder by strong negative emotions in response to the baby crying.

> I understand that he's got discomfort, and you're trying to alleviate that discomfort, but they don't know. You're trying not to hold it against the baby. They're babies and you're an adult and you know this… Those [survey] questions were like, "Do you feel warmth and love towards your child?" It's like, "Not a lot of times." And I feel bad, it's not fair. (Henry)

Parenting. Many fathers wanted a program that helped with parenting. Nearly all participants felt it would have been useful to learn about *parenting basics* before the child was born, including feeding, changing diapers, holding the baby, putting the baby to bed, baby's schedule for sleeping and eating, soothing, car seat safety, and home safety.

Other participants said they could use help *learning to be more nurturing* with their child. One father said,

> When I see kids, I almost freeze because I hear the kid talk, you're like, "Oh, hey." You're trying to talk to them very sweet and very kind, like baby talk, and I never do that. I still don't do that. (Jose)

Managing challenging child behaviors was another topic fathers wanted to learn more about. One father, along with his wife and child, was living with his own parents who perpetrated CM when he was a child. He wondered if it was ok to spank his child, and what alternatives there are to manage tantrums or other challenging behaviors.

> Honestly, the whole topic of spanking your kids. Is it really acceptable, or is there a limit to when you should spank the child? Because that's also something that's also come up a lot… How about getting the child to actually listen or sit down to eat because that's also been a problem too. Sometimes, we just raise our voices at her, and we always end up feeling guilty afterwards that we raised our voice at the baby. (Vincent)

Another desired program topic was *child development,* in terms of developmental milestones, how to enrich one's child, and how to play with kids of various ages.

General Life Needs. When asked what would be helpful in a perinatal program, many participants said they could use help learning to budget time and money. One participant said that guidance on balancing their partner relationship, job, child, and the rest of their life would be the most useful perinatal program topic for him.

Intervention Format. When asked who should run a perinatal program for fathers who experienced CM, some dads wanted a more experienced dad to lead the group, and others wanted a trained professional such as a social worker or a therapist. Most participants wanted to meet with a group of other fathers who experienced trauma. One father said, "Just thinking that there's others like me as well helps in itself. Maybe just a safe meeting space together, I feel like would be beneficial for a lot of people." (Steve). However, other fathers preferred doing a program with their partner or coparent.

Opinions varied greatly between participants about mode of intervention delivery. One father said, "I would definitely like to meet up with someone, whether it's online or in person…. It doesn't even have to be face to face… Even being an introvert it would be important for me." (Jason). However, another participant said, "It could be interactive… but as far as actual interaction with a different person, I don't think guys would buy into that" (Chris). Several participants considered various options throughout the interview, and in the end decided that it would be best to have *options*. For example, "I like the idea of being able to have the individual [program] online but then have an option to meet up (John). Another father also said that online would be more feasible for him, and he would like some synchronous and some asynchronous components, to facilitate both connection with others and schedule feasibility

Although several participants were enthusiastic about the opportunity to meet up in person, some also saw the anonymity of the internet as attractive for discussing stigmatized topics. For example, one father shared "I think the anonymous option would be better because I think it breaks down the barriers so people feel less ashamed or nervous about talking about those things" (Miles). All interview participants who were interested in a program would have wanted it to start during pregnancy, and most wanted it to continue into the postpartum period.

Trauma-specific Considerations for Programs Specific to Fathers who Experienced CM. Some fathers preferred a program specific to fathers who experienced CM, although they said there would certainly be overlap between that and a regular parenting program. One participant said he would prefer a program for fathers with difficult childhoods over a general parenting program for the same reason that he would choose to

learn French cooking from a highly rated chef as opposed to learning from the Pizza Hut guy. (Steve). He said that a trauma-specific program would be more authentic.

Another participant thought that although a program should pay attention to trauma, it would be better not to have separate programs for Fathers who experienced CM. He worried that fathers who experienced CM would feel ostracized and more stigmatized if separated from other fathers. He also said,

> I think the basics are universal. Just be a good person, be loving, be caring, be understanding, be patient…. Regardless of your level of trauma, you're still this person who is the most important person to someone in the world… You may be the least important person to yourself, but trying to understand that you're worthy of being that most important person to that child. (Trevor)

Many participants shared that a key part of a program should be the chance to *connect with other dads who experienced trauma.* One father said, "I feel like the trauma has left me scarred socially, so I'd like social aspects, and having discussions about how to deal with trauma is also important." (Alan). Another theme was the desire to meet others with similar experiences because they *understand what I'm going through*. One participant said "Just thinking that there's others like me helps in itself. Maybe just a safe meeting space together would be beneficial for a lot of people." (Jake).

Another reason fathers emphasized a group format, or the program being led by a more experienced dad, was to have *fathering role models*. Nearly all participants said that they could not think of a single role model who showed them what it looks like to be a good father. One father said, "Very few people I knew growing up had their dad in their life and if they did, it wasn't a good example of a dad." (Miles). However, other participants advocated for anonymity over the benefits of a group setting to make it easier to talk about stigmatized topics.

Barriers to Participation. Fathers shared a number of barriers that would impede their participation. Several shared that although ideally, they would prefer an in-person program, they might not have *time to participate* unless it was online. Some participants initially said that they would not be interested in a program but changed their minds when the interviewer suggested that it could take place online. One father said that he probably wouldn't participate because he is a combination of lazy and busy.

Another barrier was *not wanting to talk about trauma*. For example, "[Guys] don't want to talk about things or acknowledge that they happen." (Jake). Several participants said that they themselves did not mind talking about emotions, but thought that most men would not want to. However, another participant expressed significant frustration that people assume men do not want to talk about emotions, when in fact they do. One father shared a strong need to learn parenting basics, but said that *asking for help* was a barrier. He said,

> From an ego-pride perspective, they just don't want to say, "Hey, I don't know how to do this," … They're not going to admit that their confidence levels are low and it's a scary time for them. Because you know how a guy's ego is. They don't want to admit that they don't know… but they don't know, and I didn't know. (Chris)

Discussion

New fathers who experienced CM wanted a program to support them in building relationships, coparenting, managing low mood, managing anger, avoiding repeating their parents' mistakes, and coping with their past trauma, as well as universal basic parenting skills. Participants who were interested in a perinatal program mostly wanted an in-person program with a group of other fathers who also experienced CM. However, many indicated interest in an online program as it would be more feasible for them to attend. In terms of both content and format, participants' intervention desires varied greatly from person to person. Even within the individuals, several fathers wanted a flexible program that could be individually tailored to suit their changing needs and bandwidth throughout the childbearing year.

Interest in a program for fathers with a history of CM was low, with only 22% responding yes they would be interested, and 44% responding maybe. This highlights the need to lower barriers to engagement in program design. The most significant barriers include lack of time, reluctance to discuss trauma or emotions, and hesitation to ask for help. An online, nationwide program could attract enough participants to create a peer support network and build a cohort effect. Additionally, anonymous participation could reduce the barriers to discussing trauma and emotions. Sharing personal information could be optional, allowing those who wish to connect with other fathers who have experienced CM to do so, fostering peer support and positive fathering role models. Groups could establish ground rules to focus on the present impact of trauma without detailing traumatic events that could be triggering. Alternatively, fathers who prefer an in person, whole-family approach may prefer home-visiting programs scheduled at convenient times, which could help them participate despite work commitments.

Our findings suggest that fathers who experienced childhood maltreatment (CM) desire universal early parenting guidance and information (e.g., infant feeding, soothing, sleep, etc.), with optional trauma-specific add-on modules. Focusing initially on general parenting topics may increase fathers' engagement with perinatal programs and provide an opportunity to screen for CM. For fathers identified with a history of CM, trauma-specific add-ons can help them address trauma-related challenges, such as support in regulating emotions and triggers, improving relationships and coparenting, coping with past trauma, and having positive fathering role models. Besides promoting Safe, Stable, and Nurturing parent-child relationships (CDC, 2024b), trauma-specific add-

ons can help fathers who have a history of CM in developing Protected, Connected, and Mentored relationships with their children.

We were successful in engaging a sufficient sample of fathers who experienced CM only after expanding our inclusion criteria to both the US and the UK and increasing the eligible age of their first child from 24 to 30 months. Participants were able to remain completely anonymous, changing their display name to a pseudonym before joining the Zoom meeting. Still, only 15 out of 123 fathers who experienced CM completed an interview (Figure 1). Many interview participants said they participated because the survey first prompted them to reflect on how their trauma affects them as a father. Because fathers may not be aware of how CM can impact them, universal fathering programs could include education on how CM can impact new fathers. Then, screening for CM and offering referrals for a trauma-specific add-on for all who are interested could feel timely and relevant for fathers who experienced CM.

For our qualitative analysis, themes could not be divided into general and trauma-specific topics as initially planned. This distinction was too difficult to make without making undue assumptions. Some participants faced mental health challenges and relationships struggles that they did not explicitly connect to their past trauma. Several participants had significant anxiety surrounding parenting, and it was unclear whether this was related to their histories of CM. Thus, we developed the *managing emotions and mental health* theme. Still, all interview participants identified as fathers who had a history of CM, so their responses can be usefully interpreted through a trauma-specific lens. However, we focused on mental health and the sequelae of trauma because these seem to matter more for parenting outcomes than trauma history itself.

Another consideration when interpreting these results is that recovering from trauma can be a long and complex journey. This is especially true when trauma occurred during early child development. Some participants were very open about their trauma, and were able to readily articulate the traumatic events that occurred, their experience of the events, and the effects they had on them in the past and present (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Other participants did not describe their experiences as traumatic, preferring to refer to their childhood as difficult, or something they don't want to repeat with their own child. Like survivor mothers (Seng et al., 2002), survivor fathers who are at different places on their recovery journeys likely have different needs during the perinatal period. For example, at the time of the interview one participant—along with his wife and child—was living with his parents who had perpetrated maltreatment in his childhood. He described feeling out of control and uneasy about how his child was raised and did not see distancing from his parents as an option. His intervention needs likely differ from another participant who had been in therapy for nine years and had not spoken to his parents for five years. Implications of this are that interventions may need to be modular and flexible to be tailored to individual needs. In addition, it may be helpful for screening and program materials contain behavioral wording instead of labeling trauma, CM, and mental health disorders. Consistent with prior research, those labels may be off-putting to some fathers, especially those who identify with more traditional views of masculinity (Berger et al., 2013).

Another question we hoped to answer was what kind of person fathers with a CM history would prefer to lead an intervention. We found that the gender of the program leader was not as important to fathers as other characteristics. Specifically, most participants wanted a more experienced father to lead an intervention, especially one who had also experienced CM and had overcome trauma-related parenting difficulties. This finding is consistent with prior studies showing that fathers prefer to get parenting information from informal sources including peers (Wade et al., 2023), and that many fathers prefer near-peers to lead father-specific programs (Lee et al., 2011). Other participants wanted a qualified professional to lead an intervention (i.e. a physician, psychologist, social worker, or nurse), and the gender of that qualified individual was not important. Community health workers are one type of leader who could potentially meet these preferences. Fathers who are past the perinatal period could be trained as community health workers, meeting the preferences for a program leader to be an experienced father, a qualified professional, and a 'near-peer' role model. This would also align with SAMHSA's peer support principle of trauma-informed care (SAMHSA, 2014).

Limitations

Although the current study had many strengths, including a multidimensional mixed methods approach and novel interview recruitment strategy, there were also several limitations. The web-based recruitment of the survey sample may limit generalizability to the larger population. In particular, our findings may not be generalizable to extremely adverse contexts (e.g. families experiencing war or severe political unrest, or are refugees, have severe mental illness, are unhoused, or other situations in which basic human needs are not met). The mean age of first-time fathers in our sample is 31.4, which is higher than average. We could not assess the highest level of education achieved by participants. Additionally, differences between fathers with and without a CM history may be confounded by other risk factors that coincide often with CM. Although we were able to include diverse men in the survey and Latino and Asian men in the interviews, no Black fathers were interviewed. We augmented post-survey invitations with additional recruitment methods via flyers and snowballing techniques. Ultimately, we were unsuccessful in recruiting any Black fathers for interviews. Future program developers may need to prioritize recruiting Black fathers who experienced CM to inform the development of trauma-specific

programs, partner closely with community-based organizations that serve Black fathers, and build on existing research (Julion et al., 2021; Lemmons et al., 2022).

Our results should be also interpreted in light of the COVID-19 pandemic, as some participants said that the pandemic changed how they responded to the survey and interview questions. For example, several said that they were less likely to request an in-person program due to risk of infection. Others said that they now preferred meeting online because the pandemic showed them how effective videoconferencing and online platforms could be.

Conclusion

New fathers with a history of CM desired general, father-inclusive parenting programs with optional trauma-specific add-ons to address their trauma-related needs. Currently, there are few perinatal interventions that include fathers. Existing fathering interventions are generally universal, likely leaving trauma-specific needs unmet for the approximately one in four fathers who experienced CM. In addition to parenting basics, an ideal program would support fathers in coparenting, improving relationships, managing strong emotions and triggers, coping with low mood, and addressing past trauma. Many fathers also expressed a desire for peer support from others who had experienced CM, as well as positive fathering role models. Fathers in this study showed interest in both in-person and online programs during pregnancy and the postpartum period. An online program with the option to remain anonymous could address the barriers of stigmatization and lack of time. There is an urgent need to develop trauma-specific interventions for fathers with a history of CM, as these could improve population-level health by preventing CM and breaking intergenerational cycles of trauma.

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References

Abidin, R. (2012). *Parenting stress index 4th edition-professional manual*. Par Inc.

Bellg, A. J., Borrelli, B., Resnick, B., Hecht, J., Minicucci, D. S., Ory, M., Ogedegbe, G., Orwig, D., Ernst, D., & Czajkowski, S. (2004). Enhancing treatment fidelity in health behavior change studies: Best practices and recommendations from the NIH behavior change consortium. *Health Psychology*, *23*(5), 443–451. https://doi.org/10.1037/0278-6133.23.5.443

Berger, J. L., Addis, M. E., Green, J. D., Mackowiak, C., & Goldberg, V. (2013). Men's reactions to mental health labels, forms of help-seeking, and sources of help-seeking advice. *Psychology of Men and Masculinity*, *14*(4), 433–443. https://doi.org/10.1037/a0030175

Berlin, L. J., Appleyard, K., & Dodge, K. A. (2011). Intergenerational continuity in child maltreatment: Mediating mechanisms and implications for prevention. *Child Development*, *82*(1), 162–176. https://doi.org/10.1111/j.1467-8624.2010.01547.x

Bernard, D. L., Calhoun, C. D., Banks, D. E., Halliday, C. A., Hughes-Halbert, C., & Danielson, C. K. (2021). Making the "C-ACE" for a culturally-informed adverse childhood experiences framework to understand the pervasive mental health impact of racism on Black youth. *Journal of Child & Adolescent Trauma*, *14*(2), 233–247. https://doi.org/10.1007/s40653-020-00319-9

Berthelot, N., Garon-Bissonnette, J., Lemieux, R., Drouin-Maziade, C., & Maziade, M. (2020). Paucity of intervention research in childhood maltreatment contrasts with the long known relation with mental health disorders: Is trauma research translational enough? *Mental Health & Prevention*, *19*, 200189. https://doi.org/10.1016/j.mhp.2020.200189

Berthelot, N., Lemieux, R., Garon-Bissonnette, J., & Muzik, M. (2020). Prenatal attachment, parental confidence, and mental health in expecting parents: The role of childhood trauma. *Journal of Midwifery & Women's Health*, *65*(1), 85–95. https://doi.org/10.1111/jmwh.13034

Blevins, C. A., Weathers, F. W., Davis, M. T., Witte, T. K., & Domino, J. L. (2015). The posttraumatic stress disorder checklist for DSM-5 (PCL-5): Development and initial psychometric evaluation. *Journal of Traumatic Stress*, *28*(6), 489–498. https://onlinelibrary.wiley.com/doi/10.1002/jts.22059

Centers for Disease Control and Prevention (CDC). (2024b). *Essentials for Childhood: Creating Safe, Stable, Nurturing Relationships and Environments*. https://www.cdc.gov/child-abuse-neglect/php/guidance/index.html

Centers for Disease Control and Prevention (CDC). (2024a). About child abuse and neglect. https://www.cdc.gov/child-abuse-neglect/about/index.html

Chamberlin, S. M. E. (2012). Emasculated by trauma: A social history of post-traumatic stress disorder, stigma, and masculinity. *The Journal of American Culture*, *35*(4), 358.

Darwin, Z., Galdas, P., Hinchliff, S., Littlewood, E., McMillan, D., McGowan, L., Gilbody, S., Born, & team, B. i. Y. (2017). Fathers' views and experiences of their own mental health during pregnancy and the first postnatal year: A qualitative interview study of men participating in the UK born and bred in Yorkshire (BaBY) cohort. *BMC Pregnancy and Childbirth*, *17*(1), 1–15. https://doi.org/10.1186/s12884-017-1229-4

Dayton, C. J., Brown, S., Goletz, J., Hicks, L., Barron, C., Sperlich, M., & Smith-Darden, J. (2019). Pathways to parenting: Predictors of prenatal bonding in a sample of expectant mothers and fathers exposed to contextual risk. *Journal of Child and Family Studies*, *28*(4), 1134–1144. https://doi.org/10.1007/s10826-019-01343-6

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, *14*(4), 245–258. https://doi.org/10.1016/s0749-3797(98)00017-8

Granner, J. R., Lee, S. J., Burns, J., Herrenkohl, T. I., Miller, A. L., & Seng, J. S. (2023). Childhood maltreatment history and trauma-specific predictors of parenting stress in new fathers. *Infant Mental Health Journal*, *44*(6), 767–780. https://doi.org/10.1002/imhj.22084

Israel, B. A., Schulz, A. J., Coombe, C. M., Parker, E. A., Reyes, A. G., Rowe, Z., & Lichtenstein, R. L. (2019). *Community-based participatory research* (*272*). Urban Health.

Julion, W., Sumo, J. n., Schoeny, M. E., Breitenstein, S. M., & Bounds, D. T. (2021). Recruitment, retention, and intervention outcomes from the dedicated African American dad (DAAD) study. *Journal of Urban Health*, *98*(Suppl 2), 133–148. https://doi.org/10.1007/s11524-021-00549-8

Lee, J. Y., Knauer, H. A., Lee, S. J., MacEachern, M. P., & Garfield, C. F. (2018). Father-inclusive perinatal parent education programs: A systematic review. *Pediatrics*, *142*(1), e20180437. https://doi.org/10.1542/peds.2018-0437

Lee, S. J., Yelick, A., Brisebois, K., & Banks, K. L. (2011). Low-income fathers' barriers to participation in family and parenting programs. *Journal of Family Strengths*, *11*(1), 12. https://doi.org/10.58464/2168-670x.1007

Lemmons, B. P., Dennis, G. Y., & Rollins, L. S. (2022). Framing father engagement. In *Social work practice with fathers: Engagement, assessment, and intervention* (pp. 11–32). Springer. https://doi.org/10.1007/978-3-031-13686-3_2

Lindstedt, J., Korja, R., Vilja, S., & Ahlqvist-Björkroth, S. (2021). Fathers' prenatal attachment representations and the quality of father–child interaction in infancy and toddlerhood. *Journal of Family Psychology*, *35*(4), 478–488. https://doi.org/10.1037/fam0000813

Lumivero. (2020). NVivo. *(Version 13)*. https://www.lumivero.com

McKenzie, E. F., Thompson, C. M., Hurren, E., Tzoumakis, S., & Stewart, A. (2021). Who maltreats? Distinct pathways of intergenerational (dis) continuity of child maltreatment. *Child Abuse & Neglect*, *118*, 105105. https://doi.org/10.1016/j.chiabu.2021.105105

Morgan, D. L. (1993). Qualitative content analysis: A guide to paths not taken. *Qualitative Health Research*, *3*(1), 112–121. https://doi.org/10.1177/104973239300300107

Murphy, A., Steele, M., Dube, S. R., Bate, J., Bonuck, K., Meissner, P., Goldman, H., & Steele, H. (2014). Adverse childhood experiences (ACEs) questionnaire and adult attachment interview (AAI): Implications for parent child relationships. *Child Abuse & Neglect*, *38*(2), 224–233. https://doi.org/10.1016/j.chiabu.2013.09.004

Price-Robertson, R. (2012). Child sexual abuse, masculinity and fatherhood. *Journal of Family Studies*, *18*(2-3), 130–142. https://doi.org/10.5172/jfs.2012.18.2-3.130

Prolific. (2024). https://www.prolific.com/about

Salvador, J. G., Bonham, C. A., Duran, D. K., & Crisanti, A. S. (2020). Impact of seeking safety dose on depression and PTSD symptoms among pregnant and post-partum women. *Journal of Child and Family Studies*, *29*(8), 2146–2154. https://doi.org/10.1007/s10826-020-01747-9

Seng, J. S., Sparbel, K. J., Low, L. K., & Killion, C. (2002). Abuse-related posttraumatic stress and desired maternity care practices: Women's perspectives. *Journal of Midwifery & Women's Health*, *47*(5), 360–370. https://doi.org/10.1016/s1526-9523(02)00284-2

Seng, J. S., Sperlich, M., Rowe, H., Cameron, H., Harris, A., Rauch, S. A., & Bell, S. A. (2011). The survivor moms' companion: Open pilot of a posttraumatic stress specific psychoeducation program for pregnant survivors of childhood maltreatment and sexual trauma. *International Journal of Childbirth*, *1*(2), 111–121. https://doi.org/10.1891/2156-5287.1.2.111

Sicouri, G., Tully, L., Collins, D., Burn, M., Sargeant, K., Frick, P., Anderson, V., Hawes, D., Kimonis, E., Moul, C., Lenroot, R., & Dadds, M. (2018). Toward father-friendly parenting interventions: A qualitative study. *Australian and New Zealand Journal of Family Therapy*, *39*(2), 218–231. https://doi.org/10.1002/anzf.1307

Sperlich, M., & Kabilamany, P. (2022). The survivor moms' companion trauma-specific perinatal psychoeducation intervention in a community outreach program: An open pilot. *Journal of Midwifery & Women's Health*, *67*(5), 569–579. https://doi.org/10.1111/jmwh.13380

Stahlschmidt, M. J., Threlfall, J., Seay, K. D., Lewis, E. M., & Kohl, P. L. (2013). Recruiting fathers to parenting programs: Advice from dads and fatherhood program providers. *Children and Youth Services Review*, *35*(10), 1734–1741. https://doi.org/10.1016/j.childyouth.2013.07.004

StataCorp. (2021). *Stata statistical software 17*. StataCorp LLC.

Stephenson, L. A., Beck, K., Busuulwa, P., Rosan, C., Pariante, C. M., Pawlby, S., & Sethna, V. (2018). Perinatal interventions for mothers and fathers who are survivors of childhood sexual abuse. *Child Abuse & Neglect*, *80*, 1873-7757. https://doi.org/10.1016/j.chiabu.2018.03.018

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2014). SAMHSA's concept of trauma and guidance for a trauma-informed approach. https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884.html

Wade, C., Matthews, J., Forbes, F., Burn, M., May, F., & Cann, W. (2023). Influences on fathers' information-and support-seeking for parenting. *Journal of Family Issues*, *44*(11), 2824–2845. https://doi.org/10.1177/0192513x221107450