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Contents

Special Issue: Integrating Fathers into IMH Care: A Paradigm Change on the Horizon

From the Editor-in-Chief

by **Jane Barlow, DPhil**, Professor of Evidence Based Intervention and Policy Evaluation, University of Oxford, United Kingdom.

Re-centering Fathers in Infant Mental Health: From Inclusion to Transformation

Fathers are increasingly recognised as important contributors to infants' development, wellbeing and early relationships. Yet across infant and early childhood mental health (IECMH) research, policy and practice, they often remain peripheral. The papers brought together in this issue challenge this persistent gap. Collectively, they suggest that the problem is not primarily fathers' willingness or capacity to engage, but systems historically designed around the mother–infant dyad that continue to position fathers as partners, providers or supporters rather than parents and attachment figures in their own right.

This distinction is important. If fathers are understood as secondary to the mother–infant relationship, their involvement becomes something to be encouraged when circumstances permit. If they are understood as integral to infants' relational environments, their inclusion becomes a core component of good infant mental health practice. The papers in this issue make a compelling case for the latter.

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From inclusion to expectation

Kieran Anders' discussion of Dad Matters illustrates the scale of the opportunity. Fathers are frequently engaged late, indirectly or not at all because of the way services are designed and delivered. National and local evidence demonstrates both substantial paternal need and the potential benefits of targeted, relational approaches. Pregnancy represents a particularly important opportunity to engage fathers, when the transition to parenthood may create openness to reflection and change.

Shaligram, Zeshan, Harrison and colleagues make a similar case from a broader clinical and policy perspective. Paternal involvement can contribute to infant development, co-regulation, maternal wellbeing and family resilience, yet cultural expectations and structural arrangements continue to constrain fathers' involvement. Father involvement therefore needs to move from being an exception to an expectation.

Challenging assumptions about fatherhood

Several contributions demonstrate that there is no single way of being a father. Harleen Hutchinson highlights how Western, individualistic assumptions about caregiving can obscure culturally embedded expressions of fatherhood. Fathers may communicate care in ways that are not immediately recognised by professionals, particularly within child protection and other systems where assumptions about parenting can have significant consequences.

The Kenyan contribution by Merab Akinyi Aggrey, Vespus Chenja Sanguli and Harleen Hutchinson similarly demonstrates the importance of understanding fatherhood within its cultural and historical context. Their case study illustrates how colonial legacies can contribute to constructions of fathers primarily as providers rather than relational caregivers. Reflective supervision provides a space in which clinicians can examine these assumptions, integrate cultural knowledge and support fathers' identities as caregivers.

These papers highlight that the inclusion of fathers cannot simply mean adding fathers to existing models of practice. It requires professionals to examine the assumptions embedded within those models: What does a "good father" look like? How is paternal care expressed? Whose knowledge and cultural expectations determine whether a father is perceived as engaged?

Fathers, vulnerability and complexity

Neither should father inclusion be reduced to increasing paternal participation. Katia Poliheszko's exploration of fathers with disabilities illustrates how fatherhood is shaped by relational, social, institutional and temporal conditions. Fathers may experience pressure to demonstrate their legitimacy or encounter barriers that restrict their opportunities to occupy a paternal role.

Ruth Dudman's systematic review of fathers in the context of maternal perinatal severe mental illness similarly identifies substantial paternal distress, role strain and unmet support needs. Yet the father–infant relationship remains relatively underexplored, with interventions tending to focus on psychoeducation or psychosocial support rather than relational outcomes.

Editorial Staff

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Together, these contributions emphasise that fathers are not simply resources for mothers or infants. Their own wellbeing, relationships and experiences are relevant to infant mental health and to the wider relational ecology in which infants develop.

Creating father-inclusive spaces

Other contributions show how these principles can be translated into practice. James P. McHale, Miri Keren and Russia Collins describe organisational efforts to move from dyadic to triadic, coparenting-oriented models. Their experience illustrates the practical challenges of this transition and the importance of institutional commitment, culturally attuned outreach and approaches that engage the whole family.

Justin S. Harty and Lela Rankin offer a complementary example through the Fathers Carrying Collective on Tap. Their feasibility study demonstrates the potential of locating father-focused intervention within community spaces that fathers may find accessible and socially meaningful. Differences between sites suggest that established community partnerships may be more important than the physical venue itself in facilitating engagement.

These examples demonstrate that father-inclusive practice depends not only on *what* services offer, but also on *where, when and how* they engage fathers.

Recognising fathers' contribution to infant wellbeing

Leslie E. Katch adds another dimension by focusing directly on paternal wellbeing. Among fathers experiencing infant crying, perceptions of crying as problematic were more strongly associated with compromised wellbeing than the reported amount of crying. These findings highlight the importance of understanding fathers' interpretations, coping strategies and co-parent relationships rather than assuming that maternal experiences can simply be extrapolated to fathers.

Peji Kwajaleine A. Romo and colleagues similarly emphasise intentional presence, reflection and development within father–child relationships. Findings from a home-visiting programme reinforce the value of relationship-based approaches that explicitly recognise fathers as participants rather than peripheral recipients of services.

Finally, Evandra Catherine, Deon Brown, Icesstrená Burleson, Tatiana Thompson and Kylie Elizabeth draw attention to the experiences of Black fathers. Their analysis challenges deficit-based interpretations of paternal disengagement and highlights structural conditions—including racism, economic marginalisation and father-excluding policies—that shape opportunities for involvement. Their call for policy reform, workforce development and accountability is an important reminder that father inclusion must also be understood through the lens of equity.

From father-friendly practice to father-inclusive systems

Taken together, the papers make a strong case for moving beyond *father-friendly* practice towards father-inclusive systems: systems in which fathers are routinely seen, actively engaged, culturally understood and supported in developing relationships with their infants. Such a shift has implications not only for fathers, but for infants, mothers and families as a whole.

The challenge now is to translate this recognition into routine practice. Fathers should no longer have to demonstrate that they belong in infant mental health services. Their place should be assumed from the beginning.

From the Desk of the President of WAIMH

Dear Colleagues,

The Congress in Toronto is fast approaching, and I hope to see many of you there in October. I am especially grateful that it will take place in Canada, where we can come together in an open and free space to discuss our work from many perspectives.

At the same time, we cannot overlook the conflicts and natural disasters unfolding around our world, nor the particularly harsh effects on families with infants and young children. Many of us may feel that we are merely standing by, uncertain how best to help.

One response is to create a space for listening, dialogue, and collective reflection. At the Conference, several symposia will be held under the heading *Infants in Global Crises*. Contributors from different parts of the world will present the struggles faced by families with infants and young children in contexts of conflict and natural disasters.

As part of these symposia, we will present to delegates our newly drafted WAIMH Position Paper, *Infant and Early Childhood Mental Health in Humanitarian Contexts*. We look forward to a lively and stimulating debate, and perhaps to identifying ways in which we might feel less helpless.

On a more personal note, I have volunteered as a psychotherapist with an organization under the *Early Light Foundation*, which provides culturally grounded war-trauma therapy for children, families, and frontline workers affected by war. Through this work, I hope not only to support affected families, but also to learn more deeply what it means to work at the heart of these human-induced crises.

It has been a steep learning curve—one that has added a new dimension to my more than 30 years of work on the transgenerational transmission of trauma in the South African context. Children and families are profoundly affected by conflict, no matter which side of the divide they are on.

This is beyond politics. It is about the realities on the ground, wherever they are: stressed parents who are unable to contain their children, innumerable losses that are often transgenerational, and ongoing trauma with no clear hope of a "post-trauma" phase.

These complex dynamics need to be held and honoured for what they are in each context and for each individual family. That is our work, and it is what brings us together at WAIMH: shining a light on suffering and trying to alleviate some of it, wherever it occurs.

In this spirit, I hope to see many of you in Toronto for what promises to be a welcoming and stimulating Congress.

Astrid Berg, MB ChB, FCPsych (SA), M Phil (Child & Adolescent Psychiatry), President of WAIMH, Emerita A/Professor at the University of Cape Town, Extraordinary A/Professor at Stellenbosch University, Cape Town, South Africa.

WAIMH Executive Director Corner

Dear colleagues and friends,

Here in the Northern Hemisphere, we are at the end of our summer, with schools and universities starting the autumn term and most people going back to work after their summer vacations. After returning to work, I have had opportunities to be in contact with colleagues and friends across the globe, and one topic came up in each of the discussions I had. Can you guess what it was? I will come back to it later in my text.

I also had the opportunity to go and see Christopher Nolan's movie *The Odyssey*, his version of Homer's famous story. (If you haven't seen the film yet and wish to do so, stop reading now so that I won't spoil it for you!) While the film is somewhat simplified, and many say it is "Americanized", there were several things that resonated with me. First of all, the theme of "Zeus's law is broken" – the familiar or golden principle that we should treat foreigners as we would wish to be treated ourselves – is actually being violated in many ways in the political ethos of several countries. Xenophobia and outright racism have increased in what I would almost say is every corner of the world, and particularly vulnerable minorities have reported feeling more insecure and threatened in today's world than they did ten years ago. Zeus's law is indeed broken.

The second theme was Odysseus's realization of how he had brought such cruel devastation upon Troy's innocent citizens, all for poor reasons such as Agamemnon's greed. (Helen was merely an excuse for starting the war.) And how all wars, in the end, bring only suffering to ordinary people.

The third theme was more hopeful. In the end, Odysseus and Penelope discuss how civilization has experienced a downfall, but that it will rise again and better times will come. I am inclined to think, as some film critics have suggested, that Nolan wanted to make *The Odyssey* an allegory for our current times. It is also, in many ways, a statement against war, greed, and unkindness and ends with a hopeful note.

Many of the friends I mentioned earlier live in countries where politicians want us to believe that unkindness and selfishness have become virtues to be celebrated rather than problems to be remedied. So, what was the one theme that came up in our discussions? It was the sense of being alone and feeling ashamed of what is going on in our countries and in the world. Sharing these feelings was a relief. We also realized that we are not alone in our thoughts, since there are people everywhere who want change.

We are now about four weeks away from the start of the WAIMH 19th World Congress in Toronto, and the journey there has not been smooth. Yet I am happy to tell you that the Congress will be a success, as there are so many of you who believe in the work we do and are willing and able to devote your time and resources to meeting colleagues from other parts of the world. The number of registrations exceeded 1,300 this week, and it will probably continue to rise during the remaining weeks before the Congress begins.

The Congress theme, "Harmony in Diversity", and the content of the program will address many of the hardships that infants, young children, and their families are facing. One of the symposia will focus on ethical issues in infant mental health, and three symposia will deal with infants experiencing different types of crises. As always, approximately half of the presentations will provide insights into current research in the field. The other half will be dedicated to clinical practice in infant and early childhood mental health. There will be many opportunities to learn and to share knowledge with colleagues from 61 different countries. For those of you who are not able to attend in person this time, I can recommend the virtual registration option that has just opened. You will be able to view all the presentations from the main auditorium.

Kaija Puura, PhD, Executive Director of WAIMH, Professor of Child Psychiatry, Tampere University, Faculty of Medicine and Health Technology, Tampere, Finland. Photo credit: Jonna Karekivi

The Toronto Congress will be an opportunity for us to experience that we are many, our work does matter and that we can be generous and kind towards one another – live by the golden principle. It will also give us an opportunity to enjoy good Canadian food and share many moments of joy and fun while meeting old and new friends and colleagues.

Warmly,

Kaija

From 'Partner' to Parent: Integrating Fathers into Infant Mental Health Through Early Engagement and System Change

by **Kieran Anders**, Home-Start UK, United Kingdom.

Abstract

Despite growing recognition of fathers' influence on infant development, they remain inconsistently integrated into infant mental health (IMH) systems. This paper draws on national impact data from the Home-Start powered Dad Matters service, local evaluation findings from Home-Start HOST in Stockport, and practice-based delivery insights to examine why fathers continue to be engaged late, indirectly, or not at all. It argues that this gap is not primarily caused by fathers' lack of motivation, but by service design, professional practice, administrative systems, and language that too often position fathers as secondary caregivers rather than parents in their own right.

Nationally, Dad Matters has engaged more than 50,000 fathers, with the 2025–26 data showing 17,249 dads engaged through in-person Dad Matters universal engagement to date, excluding one-to-one referrals. Current outcomes remain strong, with 84% of fathers reporting improved wellbeing and 81% reporting improved parent-infant knowledge. Local evaluation in Stockport highlights both the scale of need, including fathers reporting mental health difficulties, stress, and anxiety, and the value of targeted, relational, father-inclusive support. The paper strengthens the case for father inclusion by connecting service engagement to early relational health, parent-infant attachment, co-parenting, family resilience, and long-term child development.

Pregnancy is presented as a critical but underused window for engaging fathers, when identity formation, reflection, and openness to change are heightened. The paper concludes that integrating fathers into IMH care requires a paradigm shift: from aspirational inclusion to embedded, equity-informed, system-wide father-inclusive practice beginning in the preconception and antenatal periods.

Photo credit: Andy Jamieson

Introduction: The Missing Parent in Infant Mental Health

Infant mental health is fundamentally concerned with early relationships. In practice, however, these relationships have often been conceptualised and operationalised primarily through the mother–infant dyad. While fathers are increasingly acknowledged in policy and research, their integration into services remains inconsistent, indirect, and frequently peripheral.

In many systems, fathers are visible but not centred. They may attend appointments, occasionally appear in records, and be present in family narratives, yet they are rarely engaged directly as parents with their own needs, experiences, strengths, and influence on the developing infant. This creates a disconnect between what is known about the importance of fathers and how perinatal and early years services are designed and delivered.

This paper draws on practice-based evidence from Dad Matters, a Home-Start UK programme focused on improving outcomes for babies by strengthening father–infant relationships in the first 1,001 days. It uses national and local data to explore the gap between evidence and practice, with a focus on father voice, fatherhood identity, relational health, methodological transparency, and equity.

Why Fathers Matter in the Perinatal Period

The evidence base for paternal influence in the perinatal period is well established. Around one in ten fathers experience postnatal depression, with many more experiencing heightened stress and anxiety. Paternal mental health is closely linked to maternal

wellbeing, relationship quality, co-parenting, and infant outcomes. When fathers are supported, they report increased parenting confidence, stronger attachment to their babies, and improved relationship stability.

For infants, paternal involvement is associated with improved cognitive development, emotional regulation, social confidence, and reduced behavioural difficulties later in life. These outcomes are not achieved simply by fathers being present in services; they depend on the quality of early relationships and the extent to which fathers are helped to see themselves as active, emotionally available parents.

The Engagement Gap: A Systemic Issue

A central finding across both national and local Dad Matters data is that fathers are typically engaged too late. Dad Matters has demonstrated that it is possible to reach fathers at scale, with more than 50,000 fathers engaged in community settings and nearly 3,000 receiving one-to-one support. However, this engagement often occurs despite existing systems rather than because of them.

Late Engagement

Most fathers' first meaningful contact with services occurs during pregnancy, often at antenatal appointments or scans. Even then, engagement is inconsistent and frequently indirect. The earliest opportunities to build trust, ask fathers about their wellbeing, and affirm their role as parents are therefore often missed.

Indirect Practice

Fathers are often engaged through mothers rather than as individuals. Language such as "partner" can unintentionally reinforce a secondary role, positioning fathers as supporters of the mother rather than as parents with a direct relationship to the infant. Moving from "partner" to "father," "co-parent," or "non-birthing parent," where appropriate, is not simply a matter of terminology; it changes what professionals notice, ask, record, and prioritise.

Structural and Cultural Barriers

Service design, workforce confidence, appointment structures, data systems, and cultural expectations all contribute to fathers being overlooked. In Stockport, local evaluation highlighted that some fathers felt included, while others wanted better mental health support and more equal recognition from professionals. These barriers are systemic rather than individual: fathers may be absent from referral forms, invited only through mothers, or addressed as accompanying adults rather than as parents.

Fathers' Voices and Lived Experience

A stronger father-inclusive approach requires more than describing fathers as a group; it requires listening to fathers' own accounts of becoming parents, encountering services, and trying to be involved. Practice learning from Dad Matters suggests that many fathers want to be active and emotionally present, but do not always know whether services are intended for them. Some report feeling peripheral in appointments, unsure how to raise their own mental health needs, or reluctant to ask for help when professional attention appears focused elsewhere.

Father voice also illustrates the relational value of the model. One father described the importance of sustained contact in simple terms: "Someone is reaching out, building a relationship. We speak weekly and feel close… these thoughts are OK." This kind of testimony helps demonstrate how father-inclusive support can normalise difficult feelings, build trust, and create a safer route into help-seeking.

Pregnancy as a Critical Window for Fatherhood Identity

Pregnancy is often the first period in which men begin to move psychologically from being an expectant adult to seeing themselves as a father. This identity transition can involve excitement, uncertainty, protectiveness, anxiety, and a growing awareness of responsibility. For some men, particularly those who did not experience positive fathering themselves, this period may also raise questions about what kind of father they want to become.

From an infant mental health perspective, this transition matters because paternal identity influences caregiving, sensitivity, help-seeking, and attachment. When services address fathers directly during pregnancy, they can support men to imagine themselves in relation to the baby, reflect on their own wellbeing, and develop confidence in early caregiving. Even brief relational interactions—being named, asked about, and included—can signal that fathers are part of the infant's relational world from the beginning.

From Service Engagement to Early Relational Health

Engaging fathers is not the ultimate aim; it is the route through which services can strengthen early relational health. Father-inclusive practice matters because it can improve the quality of parent-infant relationships, support emotional regulation, strengthen co-parenting, and increase family resilience. When fathers feel recognised and supported, they are more likely to engage in sensitive interaction, seek help earlier, and participate confidently in caregiving routines.

Dad Matters outcomes should therefore be understood not only as evidence of successful service reach, but as indicators of relational change. Improvements in fathers' mental health and knowledge of bonding and attachment are meaningful because they affect the emotional conditions in which babies develop. This connects programme outcomes directly to core IMH concepts: attachment, regulation, relational safety, and the infant's experience of being held in a responsive caregiving network.

The Dad Matters Model: A Practice-Based Response

Dad Matters provides a practical example of how fathers can be integrated into IMH systems through intentional design and delivery. The model combines universal outreach, one-to-one peer support, and professional engagement. Universal outreach creates visible, low-pressure opportunities for fathers to connect and learn. One-to-one peer support offers relational, tailored support for fathers who need more sustained help. Professional engagement builds confidence across the wider system so that father inclusion is not dependent on individual champions alone.

National Impact 2017–2026

- More than 50,000 fathers engaged since 2017

- Nearly 3,000 new referrals for one-to-one peer support since 2017
- 17,249 dads engaged through in-person Dad Matters contacts in 2025–26 to date, excluding one-to-one referrals
- 2025–26 reach includes 12,442 dads in universal settings, 2,134 through targeted activities, 1,515 through perinatal and infant mental health routes, 1,096 through NICU/neonatal settings, and 62 through rainbow or bereavement clinic engagements
- 889 new one-to-one referrals in 2025–26, with 171 declined and 124 closed due to no engagement
- Demographic monitoring indicates that in 2025–26, 14% of engaged fathers were from ethnic minority backgrounds, 19% had SEND, and 26% were under 20 years old
- 84% of fathers reported improved wellbeing
- 81% reported improved parent-infant knowledge
- The 2025–26 figures are interim programme monitoring data to date and exclude one-to-one referrals unless stated.

Local Delivery: Stockport Case Study

The Stockport evaluation provides insight into implementation within a Family Hubs context. The project aimed to reach 600–800 fathers in universal settings and support 50–60 through one-to-one work, and it surpassed those targets. It also focused on multi-agency training, peer support pathways, and targeted engagement in areas of disadvantage. Local data highlighted need and impact, including fathers reporting mental health difficulties, stress, anxiety, and limited prior help-seeking.

Evidence, Methods, and Limitations

The data presented in this paper are drawn from programme monitoring, local evaluation, and practice-based learning. Much of the reported impact relies on fathers' self-reported outcomes following engagement with Dad Matters. These data are valuable because they reflect fathers' own perceptions of change, particularly in relation to wellbeing, confidence, and understanding of bonding and attachment. However, they should be interpreted with appropriate caution.

Limitations include variation in local data collection processes, challenges collecting sensitive information without undermining trust, and the absence of independent assessment for some outcomes. The paper therefore presents Dad Matters as practice-based evidence of promising impact rather than as a controlled evaluation. Further research could strengthen the evidence base by examining longer-term outcomes for fathers, infants, co-parents, and service systems.

Future Developments in Evaluation

A future priority is to strengthen the evidence base through a planned full system evaluation in partnership with ECORYS. This evaluation will move beyond service reach and self-reported experience alone to examine impact across fathers, infants, families, and wider service systems. It will use validated tools to measure changes in paternal wellbeing, including the Patient Health Questionnaire (PHQ) and Generalised Anxiety Disorder (GAD) measures, alongside assessment of the parent-infant relationship before and after birth.

The evaluation will also assess parenting confidence, goal-based outcomes, and value for money. This will help Dad Matters demonstrate not only whether fathers report positive change, but how father-inclusive practice contributes to relational health, early intervention, system integration, and the efficient use of resources. Building this evaluation framework into future delivery will provide a stronger foundation for scaling father-inclusive IMH practice and embedding it within mainstream perinatal and early years systems.

Fathers Experiencing Adversity and an Equity Lens

Father exclusion is an equity issue as well as a service design issue. Fathers experiencing poverty, trauma, racism, migration, insecure housing, poor mental health, or social isolation may face additional barriers to being recognised and supported. Some may also have had negative prior experiences of services, making trust-building particularly important.

An equity-informed approach requires services to ask which fathers are missing, whose needs are least visible, and which administrative or cultural assumptions make father engagement harder. This includes examining referral forms, appointment times, digital access, workforce confidence, recording systems, and the language used in service pathways. Father inclusion should therefore be understood not as an optional enhancement but as part of fair, relational, whole-family practice.

Implications for Infant Mental Health Systems

The findings from Dad Matters point to five implications for IMH systems.

1. First, language should recognise fathers and co-parents as parents in their own right.
2. Second, engagement should begin as early as possible, ideally during the preconception and antenatal periods, and include an element of learning and resources.
3. Third, services should be designed with fathers in mind, including accessible entry points, flexible delivery, community-based support, and direct attention to parent-infant relationships.
4. Fourth, professionals need training, confidence, and reflective support to engage fathers effectively.
5. Fifth, father-specific pathways should be embedded within mainstream systems rather than developed as peripheral or short-term additions.

Conclusion: Towards a Paradigm Shift

The integration of fathers into infant mental health care is not a new idea, but it remains unrealised in many systems. The evidence and practice learning presented in this paper suggest that the issue is not fathers' lack of interest or engagement, but the way services are designed and delivered. When fathers are engaged early, directly, relationally, and equitably, outcomes can improve across the family system.

This requires a shift from viewing father inclusion as an optional or additional element to recognising it as a core component of effective IMH practice. If infant mental health is truly about early relationships, then fathers must be present in the system from the start—not as partners on the margins, but as

parents who shape the relational world of the infant.

The paper offers a practice-based model for translating father-inclusive principles into IMH service design, workforce development, and evaluation.

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Father Engagement through Clinical and Policy Interventions for Strengthening Infant and Family Mental Health

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Abstract

Infant mental health practice has historically centered the mother-infant dyad. Globally, cultural norms around gender, provision, and family structure have positioned fathers as peripheral to early caregiving, even as developmental science makes clear that paternal involvement independently shapes infant outcomes. A generational shift in society is creating new opportunities for fathers to be present, engaged, and recognized as caregivers from the beginning of their child's life. Infant mental health practice has an opportunity to meet that shift and treat paternal involvement as a developmental variable to be actively cultivated.

This perspective draws on developmental evidence and sociocultural research to argue for culturally informed inclusion of fathers in infant mental health practice through a redefinition of masculinity. When fathers are engaged infants receive more consistent co-regulation, mothers experience reduced stress and isolation and families move toward secure, resilient relational patterns.

In many low-resource and culturally traditional settings, fathers remain under-engaged despite their profound influence on early relational health. Family and community interventions offer powerful, culturally resonant entry points to normalize attuned, compassionate, and developmentally responsive fathering. This perspective argues for a paradigm shift toward intentional father inclusion, drawing on faith narratives, developmental science, and community health models (e.g., Newborn Observation-informed work in Pakistan) and supportive policies.

Structural, attitudinal, and systemic shifts are needed to move father involvement from exception to expectation. By drawing from our collective clinical and cultural experiences, we highlight interventions for intentional support of father-child bonding which are applicable to healthy family functioning across communities. We believe this framing offers a powerful and universal message, emphasizing themes that resonate with families from many backgrounds.

Introduction

Early caregiving relationships exert a profound influence on child development and mental health. Historically, the study of parent–child bonding focused primarily on mother–child dyads, reflecting patriarchal social structures that conferred family roles of fathers as providers and mothers as caregivers. As gender roles evolve globally and more women enter the workforce, father involvement in caregiving has increased, challenging earlier family models and division of labor. Clinical practice has gradually begun to consider fathers as active participants in early relational health.

Despite these societal and clinical shifts, there is scant research on early caregiving relationships focused on father involvement. This is particularly true in low- and middle-income countries, where much of the world's child population resides and where cultural, economic, and structural factors influence paternal engagement in unique ways. In this paper, we explore father involvement in infancy across

diverse cultural contexts, drawing on developmental perspectives, clinical experience, and policy examples to highlight culturally informed pathways for strengthening father–infant relationships as the foundation for healthy family functioning.

Role of Fathers in Infant and Early Childhood Mental Health

The developing brain is exquisitely sensitive to early childhood relational experience. Responsive caregiving promotes secure attachment, language development, emotion regulation, and stress physiology. Although maternal caregiving has been the sole focus of attention until recently, it is increasingly recognized that paternal caregiving brings a distinct and equally important regulatory influence (Shorey & Ang, 2019). Structural or cultural factors that have excluded fathers during pregnancy, birth, and the early postpartum period have unwittingly deprived infants and families of avenues for co-regulation, shared caregiving, and early paternal bonding, with downstream implications for child, father and family wellbeing.

Child development research provides unequivocal evidence for the importance of father involvement independent of maternal caregiving (Yogman et al, 2016). A meta-analysis of paternal sensitivity demonstrated significant associations with children's cognitive functioning, language development, executive function, and emotion regulation, with effects independent of maternal sensitivity (Rodrigues et al., 2021). Further, father–infant interactions as early as three months predict cognitive outcomes at 24 months after controlling for maternal involvement (Sethna et al., 2017). Additionally, longitudinal data indicate that active paternal engagement is associated with fewer behavioral problems, fewer psychological issues in young women, and stronger cognitive development across childhood (Sarkadi et al., 2008).

On the other hand, poorer paternal engagement early in infancy is linked to elevated risk for adverse outcomes. Ramchandani and colleagues (2013) found that low paternal involvement by three months predicted negative behavioral outcomes by age one, increased infant mortality, and lower child wellbeing. In the United States, children growing up without involved fathers constitute a disproportionately high percentage of homeless youth, school dropouts, and youth suicide deaths, emphasizing the public health costs of paternal disengagement (McLanahan, et al, 2013).

Paternal mental health is often overlooked and may be a pathway for risk and resilience. Paternal postpartum depression affects approximately 8–10% of fathers globally and is more prevalent in low- and middle-income countries (Cameron et al., 2016; Husain et al., 2025). Untreated paternal depression compromises bonding, partner support, and child emotional development. Conversely, paternal postpartum bonding is positively correlated with maternal bonding and inversely associated with maternal stress, underscoring the relational benefits of father involvement for the entire family system (Bieleninik, et al, 2021).

Given the role of family processes in identity development and the intergenerational transmission of trauma, strengthening father–infant bonding may be especially important for promoting resilience and disrupting cycles of adversity. Fathers represent underutilized potential within the family system, particularly in developing contexts, where structural and cultural barriers often impede involvement.

Cultural Models of Fathering and Clinical Implications

Cultural models of father involvement specify ideal paternal roles, provide evaluative frameworks, and articulate the perceived benefits of paternal engagement. These models intersect with broader life stressors—economic precarity, discrimination, migration, and cultural displacement—and are shaped by internalized ethno-theories of masculinity (Pleck, 2010). The absence of father-specific caregiving models can undermine paternal confidence and limit opportunities for engagement, even when desire is present.

Drawing from collective clinical and cultural experience, we argue for intentional, culturally informed interventions that support father–infant bonding across communities. Education, therapeutic engagement, clinical practices, and public policy all present entry points to scaffold paternal involvement. Health professionals must be equipped to understand and support father–infant bonding as a core component of child and family mental health.

India: A Cultural Moment with Clinical Opportunities

A widely publicized episode in India brought the question of father involvement into national focus. When Indian cricket icon Virat Kohli left the 2020 Australian tour to be present for the birth of his daughter, public reaction was sharply divided. Critics framed his decision as a dereliction of national duty, reflecting deeply held assumptions about fatherhood, work, and masculinity. The controversy was amplified by the absence of paternity leave under Indian labor law, leaving both elite athletes and ordinary men without institutional support for early paternal involvement.

The intensity of this debate revealed a tension between entrenched norms and emerging generational shifts. While traditional Indian family structures position fathers as financial providers and decision-makers, with caregiving relegated to mothers and grandmothers, contemporary fathers increasingly express a desire for emotional presence and relational connection with their children.

Qualitative research shows that Indian fathers prioritize their children's education and safety but view financial provision as their primary parental role, with long hours in informal employment structurally limiting day-to-day caregiving (Lobo et al., 2025). Notably, many fathers especially those with histories of adverse childhood experiences, aspire to parent differently and interrupt intergenerational cycles of trauma (Deneault et al., 2026).

However structural and cultural barriers frequently muzzle motivation; the gap between aspiration and action may be misinterpreted as disinterest. For example, while 41% of South Indian fathers demonstrated low involvement in infant feeding, the majority expressed interest in learning and engagement (Mithra et al., 2021). Clinicians who equate structural distance with emotional disengagement risk overlooking paternal motivation. Effective intervention requires understanding of the broader caregiving context, including the influential role of paternal grandmothers in early decision-making

and the importance of paternity leave in fostering father-infant bonding.

Clinical Pearls

Supporting father engagement with infants utilizes the sociocultural entry points below (Table 1):

1. **Reframe** financial provision, protective vigilance, and indirect involvement as meaningful expressions of paternal caregiving rather than deficits relative to Western norms.
2. **Leverage reflective capacity** by inviting fathers' narratives about their own childhood experiences and what they hope to emulate in their parenting while equipping them with practical caregiving skills, especially among those who experienced father absence and/or childhood adversity.
3. **Increase skills for interaction with newborns** and dispel fears about inadvertently hurting the baby through community-based education of fathers about child development, demonstration of caregiving tasks and practical clinical tools that facilitate bonding e.g., Newborn Behavioral Observation (Nugent et al, 2007; Yago et al., 2023)
4. **Encourage participation in simple caregiving tasks** like feeding, diapering, bathing, soothing and playing with their infant, even for a few minutes daily.
5. **Explicitly invite fathers into caregiving spaces**. Structural inclusion is critical e.g., healthcare appointments scheduled at accessible times. Simply adding fathers as an afterthought to programs designed for mothers is ineffective. Evidence from rural India demonstrates that paternal participation increases substantially when programming is intentionally designed with men's roles, schedules, and engagement styles in mind (Nair et al., 2020).
6. **Normalize paternal mental health needs** and screening as part of family adjustment rather than individual psychopathology, to reduce stigma and enhance uptake.

These clinical strategies leveraging sociocultural perspectives are most impactful and sustainable only when backed by robust governmental policy.

Table 1. Sociocultural entry points for Father-infant engagement.

Context	Core Principle	Clinical Implication
1. Valuing culturally grounded expressions of care	Financial provision, protective watchfulness, and indirect involvement should be understood as legitimate expressions of paternal care, not deficits when compared to Western models of expressive fatherhood.	Clinicians should build from existing paternal strengths rather than evaluating fathers against Western norms, using a culturally responsive lens to support engagement and therapeutic alliance.
2. Using fathers' aspirations to explore attachment without jargon	Fathers with histories of childhood adversity often want to parent differently. Asking what they want their child to have, they themselves lacked opens space for reflection on attachment and intergenerational patterns without requiring clinical language.	This approach facilitates meaningful discussion of attachment history in a non-threatening way, enhancing trust and emotional engagement while avoiding stigmatizing or academic terminology.
3. Increase skills for interaction with newborns	Education of fathers about child development, demonstration of caregiving tasks increases father confidence by developing necessary skills	This strategy dispels fathers' common fears about inadvertently hurting the baby. Skill building through Newborn Behavioral Observation, an infant-focused, family-centered tool which helps parents become aware of their baby's abilities and promotes positive parent-child relationships, is implementable across cultures.
4. Encourage participation in simple caregiving tasks	Participation in caregiving tasks like feeding, diapering, bathing, soothing and playing with their infant, even for a few minutes daily.	This approach can build connection, communication with co-caregivers (mothers, extended family, daycare providers etc.) and confidence.
5. Explicitly invite fathers into caregiving spaces	Structural inclusion is critical e.g., healthcare appointments scheduled at accessible times.	Rather than adding fathers as an afterthought to programs designed for mothers, create thoughtful father-centric groups and programming.
6. Framing paternal mental health as family wellbeing and designing father-inclusive care	Mental health screening should be framed as understanding how the family is adapting, not as individual psychiatric evaluation. Fathers must be explicitly invited, accommodated in scheduling, and engaged through programs designed with their caregiving roles and cultural context in mind.	Family-centered framing reduces stigma and increases participation.

Indeed, there may be lessons to learn across cultures as we discuss below.

Policy as Catalyst for Cultural Change

South Korea

South Korea offers an excellent example of how policy can act as a catalyst for cultural change and redefine fathering norms. As a result of a national demographic crisis marked by the world's lowest fertility rate, South Korea transformed its paternity and parental leave policies through successive revisions to the Equal Employment Opportunity and Work–Family Balance Assistance Act (Kim, Byung-Cheol, et al 2025).

Prior to 2008, fathers had virtually no legal recognition as caregivers. Initial reforms introduced minimal unpaid leave, expanding gradually to five days, partly paid. A major shift occurred in 2019 with the introduction of 10 days of fully paid paternity leave, accompanied by broader recognition that incremental change was insufficient to counter deeply entrenched work-first culture (Kim, Yeon-Jin, 2022).

By 2025 and 2026, policy reforms doubled standard paternity leave to 20 days and allowed fathers to initiate leave up to 50 days before birth in cases of maternal medical complications. Fathers were also granted the flexibility to divide leave into multiple segments, reflecting the nonlinear needs of early childhood caregiving. These changes signaled a move from viewing fathers as auxiliary helpers toward a shared parenting model.

Utilization initially lagged behind legislation, constrained by workplace norms and hierarchical corporate structures. However, the introduction of financial incentives, including the "6+6 Parental Leave Scheme," which provided full wage replacement for both parents during the first 18 months of a child's life, markedly increased uptake. By 2025, men accounted for 36.8% of parental leave users, reflecting greater acceptability and possibly reduced stigma associated with leave-taking fathers (Republic of Korea Ministry of Employment and Labor, 2025; Huh, 2025).

Psychosocial benefits have been substantial. Fathers who take extended leave report increased parental self-efficacy and stronger emotional bonds with their infants (Noh, 2021). Maternal stress and postpartum depression risk decrease, household labor becomes more equitable, and marital satisfaction improves. Women's career continuity is also better protected.

Challenges persist, particularly workplace alienation and fears of stalled career advancement, especially among older male supervisors (Lee & Moon,2025; Lee, et al. 2026). Nevertheless, developmental research suggests that children of leave-taking fathers demonstrate improved socioemotional regulation, cognitive flexibility, and parental warmth. South Korea illustrates how structural policy can catalyze cultural transformation, even in historically patriarchal contexts.

El Salvador

The history of civil war in El Salvador percolates to contemporary society as a result of mass displacement, widespread trauma, and the disruption of family systems (United Nations, 1992). Fathers were often forced into roles prioritizing survival and economic provision over emotional presence. Postwar challenges in the form of gang violence, migration, deportation, and transnational family arrangements further fragment caregiving structures. Many Salvadoran fathers work long hours, often 10–12 hours daily including commuting, limiting opportunities for engagement despite desire. Migration may improve financial stability while simultaneously introducing emotional distance and attachment disruptions for children left with extended families.

Traditionally, Latino fatherhood is often framed through the lens of machismo, characterized by emotional restraint and authority. However, the concept of *caballerismo* offers a more nuanced and strengths-based model, emphasizing responsibility, empathy, and commitment to family. Redefining masculinity to include emotional presence and collaboration fosters autonomy, emotional intelligence, and resilience in children and core cultural values such as *familismo*, respect, and prioritization of education further support paternal engagement.

Policy reform has been introduced to support father involvement in families. The 2022 "Nacer con Cariño" ("Born with Love") law allows fathers to accompany mothers during pregnancy, birth, and postpartum care—an important shift from prior restrictions that excluded men from delivery rooms. This policy creates opportunities for early bonding and signals institutional validation of paternal presence (Pan American Health Organization, 2022).

Discussion

From the beginning of life, across diverse contexts, we find that children thrive when their fathers are emotionally engaged and involved. Contemporary societal shifts toward more fluid gender roles presents an opportunity to fortify family caregiving capacity by better engaging fathers especially in developing countries where much of the world's growing child population is located.

Seen in the backdrop of broader social instability driven by globalization, political upheaval, technological transformation, and economic pressures, the critical question is whether we will regress toward authoritarianism or evolve into a more equitable society. We as child and adult psychiatrists, posit that strong father–infant relationships provides a stabilizing force that supports progress.

Two essential catalysts facilitate societal progress. Firstly, structural support from the government, such as state-sponsored parental leave, healthcare policies, and professional endorsement of father involvement are needed. Secondly, concordance with spiritual and cultural narratives such as the Confucian teacher, the faith-based storyteller, or the *familismo*-oriented Latino father may provide community sanction for father-infant emotional connection and caregiving.

Conclusion

Father involvement in early childhood is not a luxury or cultural artifact; it is a developmental necessity with universal relevance. While expressions of fathering vary across cultures, the foundational needs of children for safety, connection, and guidance remain constant. Clinically, recognizing structural constraints, leveraging sociocultural strengths, and explicitly inviting fathers into caregiving spaces enhances outcomes for children and families alike.

Supporting father engagement from conception through education, clinical practice, and policy creates healthier families, more resilient societies; it is an investment in future generations.

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You Don't Have to be Strong Here: Breaking Down the Walls of Bereaved Fatherhood

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Introduction

Bereaved fathers are underrepresented in studies of bereaved parents, with 75% of all parents represented in pediatric palliative care research being mothers (McNeil et al., 2021). This dearth of literature is consistent with bereaved fathers' reports that their experience is overlooked, both by healthcare professionals and the broader community (Jones et al., 2019). Multiple scoping reviews of the available literature pertaining to the bereavement experiences and outcomes of fathers in the last twenty years underline the impact of infant loss on fathers across multiple domains of functioning. The cultural significance of a maternalistic approach in pediatric healthcare has left a gap in the inclusion and support of fathers, which in turn can have a negative impact on infant mental health and family resilience. This paper will discuss enhancements made to the bereavement program at an urban, academic medical center to address this gap in bereavement care from the bedside through the first year after infant loss in order to honor the importance of fathers in infant mental health, the family system, and promoting resilience following infant loss.

Centering Mothers from the Beginning

Throughout pregnancy, the mother baby dyad is the primary focus of care from doctors' appointments to community celebrations. Studies have privileged the mother-infant relationship when considering key factors like attachment and bonding in broader infant mental health research. Mothers were often the sole participants in early relational research due to the connection between mother and child related to pregnancy and birth. In an article by Guillame et. al (2013), fathers reported interacting with the baby to support mother's psychosocial well-being and preferring to speak to the baby rather than hold. In the same study, fathers reported that medical staff would address mothers before addressing fathers, if at all. In another study by Koliouli et al (2016), fathers reported feeling similar strong and mixed emotions though deferred to their partner's experience given the mother's emotional and corporeal trauma. Fathers are typically not included in conversations about physical and mental health prenatally or postnatally. However, fathers' early involvement in their infants' lives is associated with children's longitudinal social-emotional functioning (Zheng et al., 2025) and can even moderate or buffer the effects of maternal stress on infants (Atzaba-Poria et al., 2015). Despite being underrepresented in the literature, fathers' experiences and connection to their infants are essential to infant mental health, early relational health, and attachment.

Hospitalization: Communication, Presence, and Economic Stressors

Infants are identified by their mother's first and last name in the electronic medical records of many pediatric hospitals. The infant's mother is often listed as the primary contact in the child's chart. Medical and interdisciplinary teams repeat the mother's name to identify the infant and discuss all aspects of their care. These seemingly benign practices center the maternal role in the minds of healthcare professionals implicitly and explicitly. Though navigating dynamics between parents and ensuring equitable communication can be complex, care for both parents must begin early in the hospitalization to effectively support the family unit, consistent with infant mental health principles of attending to all caregiver-infant dyads (Zeanah & Zeanah et al., 2019).

Parental roles shift when faced with the hospitalization of an infant, and

these roles are often delineated by the economic structures and expectations of their context. Mothers structurally tend to carry the burden and privilege of a more comprehensive parental leave from the workplace. Statistics from the US Census in 2022 indicate that half of mothers surveyed took some parental leave in the 12 weeks following birth compared to only a third of fathers, suggesting that mothers may be the caregiver most able to be present at bedside throughout an admission. These systemic factors may result in medical teams providing more information to an infant's mother during a hospital admission than the working parent who is "keeping it all together" beyond the hospital walls. Similarly, following the loss of an infant, fathers are more likely to return to work quickly and to use work as a coping mechanism in the bereavement period (McNeil et al., 2021). This is often a continuance of fathers functioning in the family unit prior to the loss of an infant with fathers being more likely to continue working throughout their infant's illness than mothers. Unfortunately, bereaved fathers subsequently report regretting that they did not spend more time with the infant prior to their loss and experienced decreased meaning and satisfaction in their professional lives (McNeil et al., 2021).

Grief Reactions: Gender and Relational Factors

Bereaved fathers identify their partner as being their primary source of support after infant loss, despite increased frustration with partners in the setting of different communication styles around the loss (McNeil et al., 2021). Fathers further report feeling both personal and cultural pressure to center their partner's grief experience over their own, resulting in inhibited ability to seek support beyond this relationship (McNeil et al., 2021). Consequently, fathers feel unrecognized and misunderstood in their grief by family and community members. Their experience of loss is obfuscated by others' reductionist appraisals of their role as being a support person for their partner (Jones et al., 2019) which, while important, may lessen the impact of their own grief (Franz et al., 2021) or prevent men from processing their grief altogether (Obst & Due, 2019).

Fathers' grief is further expressed and embodied differently in bereavement than mothers' grief expressions. Fathers demonstrate increased isolation and avoidance in discussing their grief than mothers, despite reported value in doing so (McNeil et al., 2021). Social expectations are such that mothers are typically expected to be tearful and exhibit intense emotion while fathers are expected to withhold expressions of sadness, presenting instead as angry or somber. This tendency echoes studies that suggest that bereaved fathers' experience of grief is more static over time compared to mothers' grief, which is more pronounced immediately after the loss and subsequently lessens in intensity (McNeil et al., 2021). These behavioral phenomena are understood by many authors to be attributable to culturally situated, gendered expectations of men (Jones et al., 2019) and do not take into account the impact of an individual's culture on the expression of grief, mourning rituals, and even perspectives on death (Aeschlimann et al., 2024) which can widely differ across contexts.

Grief and Family Functioning

Unaddressed paternal grief may further pose negative consequences for family functioning and family resilience in addition to fathers' individual well-being over time. Fathers demonstrate significant anxiety and post-traumatic stress symptoms in subsequent pregnancies following infant loss (Turton et al., 2006). Fathers may utilize avoidant coping for self-protection in future pregnancies by avoiding bonding with an unborn infant, not imagining a future in which the infant lives, and experiencing attachment difficulties following a live birth. Fathers, like mothers, may experience feelings of guilt around bonding issues and/or difficulty separating from a live-born infant after a prior infant loss (Campbell-Jackson et al., 2014). Without proper bereavement and postpartum support, these factors may contribute to insecure infant-parent attachments with future children. Of note, infant loss may further exacerbate any preexisting, complex family dynamics between parents and family members including prior separation, divorce, or estrangement.

Fathers are also more likely to exhibit compensatory behaviors like substance use following infant loss, and they are less likely to seek mental health support than mothers (Due et al., 2017). These unaddressed mental health needs may pose negative consequences for family functioning as well as the health of relationships with living or future children. Unaddressed paternal grief may further be compounded for parents who face systemic inequities associated with race, socioeconomic factors, class, immigration status, and acculturative stress (Mayland et al., 2021). Systemic injustices faced by these populations may complicate access to care due to resource scarcity and mistrust of mental health providers. This is especially salient for minority groups who disproportionately experience infant loss due to institutional racism in the American healthcare system (Jang & Lee, 2022).

These relational, gendered, and sociocultural dynamics are important for hospital care teams to identify and therapeutically support, such that fathers' contributions to infant mental health, experiences of trauma and loss, and critical role in family resilience and meaning making is attended to from the bedside and into bereavement. Providers must acknowledge and understand fathers' roles as attachment figures, caregivers, and support for their partners, other children, and even extended family members. Fathers may not readily express their grief with the same openness as their partners in the hospital setting due to gender-based social expectations.

Fathers may need continued opportunities to process their grief responses with and separately from their families in and beyond the hospital. Providing targeted support for fathers prior to the loss of an infant and in bereavement may mitigate gaps in the grief care of fathers and ensure that their important role in the family system is respected.

Identifying Gaps in Bereavement Care of Fathers

At Hassenfeld Children's Hospital at NYU Langone (HCH), Sala Institute for Child and Family Centered Care (Sala) is committed to providing programs and services centered on the needs of children and families. We have expanded our Sala Bereavement Program in response to the increasing number of families needing bereavement care. All bereavement care is provided by clinicians who are part of Sala Institute and are well known to bereaved families including social workers, creative arts therapists,

child life specialists, psychologists, and chaplaincy. The program provides bereaved parents with twelve months of bereavement follow-up support. Families are engaged through individual, supportive touchpoints at regular intervals, invited to attend monthly bereaved parent support groups, and an annual memorial service. Our bereavement groups are offered virtually and meet monthly in six-month cycles. We offer English-speaking groups, Spanish-speaking groups, and an infant loss group run by our creative arts therapist and infant-family psychologist. An additional group for perinatal loss will be added in the coming year. Groups are held during evening hours to ensure convenient access, with attention to accommodating parent work and childcare schedules. Groups are guided by trauma informed principles of safety, empowerment and choices, and peer support. Facilitators further promote enduring, healthy attachment bonds with the deceased infant in these groups (Bonanno & Kaltman et al., 1999).

Our team observed a gap in our care of bereaved fathers as we have expanded our bereavement services. We noticed a tendency in our practice to communicate with mothers immediately following the infant's death, unwittingly centering mothers' experiences and overlooking the father-infant dyad (Zeanah & Zeanah, 2019). We subsequently observed a higher incidence of mothers' participation in our bereavement groups compared to fathers. Consistent with current literature, we have also noted the tendency of bereaved fathers who do attend support groups to be less verbally participatory. We noticed fathers deferring to their partners' emotional expression and her narrative of their shared experiences. We have identified a need to shift this paradigm in our bereavement care and programmatically attend to the needs of bereaved fathers. We know from research literature and direct experience with bereaved families that the death of an infant is among the most isolating experiences that an individual can endure, and it is incumbent upon us as bereavement providers to provide equitable care (Field & Behrman, 2003). Implementing equitable practices in these early stages of our program is essential to establish quality bereavement care as our program grows.

Addressing Gaps in Bereavement Care of Fathers

This care must begin first at the bedside. Psychosocial providers should endeavor to welcome and establish rapport with both mothers and fathers from the outset of their infant's care. Supportive interventions should be tailored to both parents with attention to the nuances of their respective emotional experiences. In this way, we can collectively ensure that resources are allocated equally. Further, in the infant's dying process and subsequent bereavement, we must engage both parents, supporting both their individual and shared coping.

Our program now ensures the establishment of supportive touchpoints with both parents individually following the loss of an infant to formalize our accountability to the needs of bereaved fathers. These touchpoints provide individualized support and bereavement education in the first year after loss. Further, guided by current literature on the grief expressions of bereaved fathers, support group facilitators are educated about bereaved fathers' grief presentations and needs following infant loss with particular attention to the systemic disenfranchisement of fathers' grief. A summer workshop series for bereaved fathers will also be offered in the future to provide dedicated space for bereaved fathers to receive mutual support.

Additionally, we are establishing a Bereaved Family Navigator Council, an initiative in which one of our bereaved fathers was a catalyst after he expressed the following sentiment: "*I have also come to understand that males tend to deal with the grieving process differently and I believe I can help some other fathers in their grief. Talking about [my infant] and sharing her story has been tremendously helpful in dealing with the grief of losing her. I'd like to continue doing that and in the process help others during such a difficult time*." The council will follow the precedent of our hospital's Sala Family and Youth Advisory Councils to ensure that patient and family feedback guides our clinical practice, with attention to end-of-life and bereavement care. Council members will include parents, caregivers, and adult siblings who have engaged with our bereavement services, want to remain connected with our hospital, and wish to share their insights to enhance our practice.

Conclusion

Father-inclusive bereavement care is an important consideration not only in the context of the loss of an infant, but to address and honor the often-overlooked role of fathers within infant mental health, relational health, and bereavement in general. Fathers are essential contributors to the family system whose presence can buffer and mitigate the impact of stress and bereavement. While fathers' grief expressions and processing of infant loss may look different based on their culture, gender, and other important contexts, it is vital that they receive timely and individualized bereavement support. We are proud that we are taking meaningful steps to close the bereavement gap for fathers experiencing infant loss at the Sala Bereavement Program at Hassenfeld Children's Hospital at NYU Langone. It is our perspective that fathers give the best of themselves to their families and should receive the best in return.

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When Fathers Speak Without Words: Culture, Trauma, and the Ethics of Seeing in Infant Mental Health Systems

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Abstract

Fathers play a critical yet often marginalized role in the developmental ecology of infants and young children across global contexts. Within infant and early childhood mental health (IECMH) and child protection systems, dominant frameworks of caregiving frequently reflect Western, individualistic assumptions (Cabrera et al., 2012; Lamb, 2010; Rogoff, 2003) that inadequately capture culturally embedded expressions of fatherhood. This paper examines the intersection of culture, trauma, and systemic response to fathers, particularly within child welfare and legal systems. Drawing on global literature, decolonizing perspectives, the Diversity-Informed Tenets (ZERO TO THREE, 2012), and clinical case illustrations, this paper explores how cultural misattunement, implicit bias, and epistemic dominance shape how fathers are perceived and engaged. Expanded attention is given to cultural expressions of fatherhood, trauma as cultural memory, systemic bias, and the role of reflective supervision in building the capacity of clinicians to hold complexity. The paper calls for a re-centering of relational, culturally-grounded practice that protects professional integrity and elevates the voices of those who speak for babies.

Introduction

Infant and early childhood mental health (IECMH) is grounded in a relational paradigm in which development emerges through interactions between the child and caregiver within a broader cultural and ecological context (Shonkoff & Phillips, 2000). Yet, despite this foundational understanding, much of the field continues to be shaped by Western epistemologies that prioritize individualism, verbal emotional expression, and maternal caregiving as the primary lens through which attachment and relational health are assessed (Nsamenang, 1992; Pence & Marfo, 2008).

This dominant framing often renders fathers from immigrant, refugee, transnational, and culturally diverse communities invisible or misinterpreted because their caregiving practices and expressions of fatherhood may differ from dominant Western expectations. This dominant framing often renders fathers, particularly those from culturally diverse, immigrant, and Global backgrounds (?) invisible or misinterpreted. The issue is not simply one of omission, but of epistemic imbalance. Systems of care frequently rely on narrow definitions of caregiving that do not reflect the lived realities of many families across the globe (Kirmayer, 2012). As a result, fathers may be evaluated against standards that neither reflect their cultural context nor capture the relational meaning of their interactions.

For infant mental health professionals, this creates a profound ethical responsibility. To truly center the infant, clinicians must also center the relational system in which the infant develops. This requires expanding beyond dominant frameworks, holding multiple cultural lenses, and advocating for a more nuanced understanding of caregiving, particularly when engaging with fathers whose presence, expression, and relational style may not align with Western norms.

Cultural Expressions of Fatherhood Across Contexts

Fatherhood is not a static or universal construct; it is dynamically shaped by cultural values, historical experiences, and social structures. Across the Global, in which caregiving is often embedded within collective systems, where the responsibility for raising children is distributed across extended kin networks and community structures (Nsamenang, 1992; Super & Harkness, 1986). Within these systems, fathers contribute in ways that may not always be immediately visible through Western observational frameworks yet are deeply relational and developmentally significant.

In many African contexts, fatherhood is closely tied to socialization, protection, and identity formation. Fathers play a critical role in guiding children's understanding of social expectations, cultural norms, and resilience in the face of adversity (Abubakar et al., 2014; Richter et al., 2010). These interactions often occur through shared activity, storytelling, and modeling rather than direct verbal emotional expression.

In Latin American cultures, the concept of familismo emphasizes relational

interconnectedness, loyalty, and shared responsibility (Cabrera & Bradley, 2012; Halgunseth et al., 2006). Fathers may demonstrate care through provision, presence, and participation in family life, often within a broader system of interdependent relationships. Emotional expression may be conveyed through action rather than language, reflecting culturally congruent forms of attunement.

Indigenous perspectives on fatherhood further expand this understanding by integrating spiritual, ecological, and relational dimensions (Ball, 2010; Sarche & Spicer, 2008). Fatherhood is not solely about the dyadic relationship with the child but is embedded within a worldview that connects the child to land, ancestry, and community. In these contexts, caregiving is understood as a relational responsibility that extends beyond the individual.

A particularly salient example across cultures is rough-and-tumble play, often central to father-child interaction. Research demonstrates that this type of engagement supports emotional regulation, boundary-setting, and problem-solving skills (Paquette, 2004). However, when assessed through Western frameworks that prioritize calm, verbally mediated interactions, such behaviors may be misinterpreted as aggressive or dysregulated.

These differences underscore the importance of cultural humility in assessment and intervention. Without an understanding of the cultural meaning behind behaviors, systems risk pathologizing normative caregiving practices and overlooking the relational strengths that support infant development.

Trauma, Cultural Memory, and the Dual Lens of Ghosts and Angels

The concept of "ghosts in the nursery" (Fraiberg et al., 1975) has long been used to describe how unresolved trauma is transmitted across generations. However, within a global and decolonizing framework, trauma must also be understood as collective and historical. Fathers from the Global South and diasporic communities often carry the impact of colonization, migration, systemic oppression, and displacement experiences that shape not only their internal worlds but also their caregiving practices (Fernando, 2014; Kirmayer, 2012).

Cultural memory plays a critical role in how trauma is experienced and expressed. It informs beliefs about safety, trust, authority, and relationships. For some fathers, trauma may manifest as vigilance, emotional guardedness, or a need for control, behaviors that may be misinterpreted within systems that lack a trauma-informed lens. At the same time, fathers carry "angels", sources of resilience, cultural wisdom, and relational strength (Liebenberg & Ungar, 2009). These angels may be reflected in their commitment to their children, their capacity to provide stability, and their ability to draw on cultural practices that promote connection and healing.

Holding both ghosts and angels requires clinicians to move beyond binary thinking. It requires the capacity to recognize that trauma and resilience coexist, and that caregiving behaviors must be understood within this dual context. This approach aligns with resilience research that emphasizes the importance of cultural and relational strengths in supporting child development (Ungar, 2011).

Systemic Bias and the Silencing of Fathers

Systemic bias is a pervasive force shaping how fathers are perceived and engaged within child welfare and legal systems. African American fathers, for example, are often disproportionately viewed through lenses of risk, aggression, and threat, influenced by longstanding racial stereotypes (McAdoo, 2007; Guterman et al., 2016). Latino fathers may be characterized as authoritarian, while immigrant fathers may be perceived as resistant or noncompliant when they do not conform to system expectations. These biases are reinforced through institutional practices that prioritize compliance over understanding. Fathers are often evaluated based on their ability to meet system-defined expectations, rather than being understood within their cultural and relational context. This creates a dynamic in which fathers must adapt to the system, rather than the system adapting to the families it serves.

Language is a critical factor in this process. When fathers are unable to engage in their primary language, their capacity to participate meaningfully is diminished (Yoshikawa et al., 2012). Language is not merely a tool for communication; it is a carrier of identity, culture, and relational meaning. The absence of linguistically appropriate services further marginalizes fathers and limits their ability to express themselves authentically.

The silencing of fathers has direct implications for infants. When fathers' voices are not heard, the relational context in which the infant develops is incompletely understood. This can lead to decisions that fail to account for the full scope of the child's experience and needs.

Reflective Supervision and the Capacity to Hold Complexity

Reflective supervision is a cornerstone of infant mental health practice, providing a relational space for clinicians to explore their thoughts, feelings, and responses to the work (Heffron & Murch, 2010). In cases involving fathers, this reflective space becomes essential for building the capacity to hold complexity. Clinicians are often navigating multiple layers of meaning, cultural differences, trauma histories, systemic pressures, and the immediate needs of the infant. Without reflective support, there is a risk of collapsing into simplified narratives that fail to capture the full picture.

Reflective supervision supports clinicians in developing what can be understood as a "both/and" mindset, the ability to hold multiple truths simultaneously. This includes recognizing risk while also identifying strength, acknowledging harm while also holding space for growth, and balancing the needs of the child with the experiences of the parent.

Research suggests that reflective practice enhances cultural responsiveness, reduces burnout, and supports more thoughtful decision-making (Parlakian, 2001; Tomlin et al., 2014). It enables clinicians to remain grounded in the science while engaging in the relational and cultural dimensions of their work.

Clinical Illustrations: Holding the Full Father in Mind

The following clinical cases illustrate how systemic bias, cultural misattunement, and the absence of a trauma-informed lens can shape narratives about fathers in ways that

obscure their relational strengths. They also highlight the critical role of infant mental health professionals in expanding the lens of systems to ensure that both the father and baby are fully seen.

Case 1: The Brazilian Father – When Protection Is Misread as Aggression

The first case involved a Brazilian father who entered the child welfare system following an incident of domestic violence that occurred in the presence of his 15-month-old child and a 6-year-old sibling. The father was physically large in stature, while the mother was notably petite. This visible difference became a defining factor in how the situation was interpreted by responding professionals.

The relational dynamics between the parents were complex and deeply rooted in trauma. The mother had a longstanding history of abandonment and unresolved trauma, which significantly shaped her emotional responses within the relationship. When she perceived that the father was planning to leave the home and possibly end the relationship, her fear of abandonment became activated. This fear manifested in escalating emotional dysregulation, leading to erratic, aggressive, and abusive behavior toward the father.

Recognizing the potential for harm, particularly in the presence of the children, the father made the difficult decision to call law enforcement in an effort to de-escalate the situation and ensure safety. However, upon arrival, the system's response was guided more by implicit bias and surface-level observations than by relational context. The father's physical stature, contrasted with the mother's petite frame, activated stereotypical assumptions about male aggression.

Despite being the individual who sought help, the father was arrested. The narrative of the case quickly shifted, positioning him as the primary aggressor. The mother, whose distress was visible and aligned with societal perceptions of vulnerability, was viewed through a more sympathetic lens. In this process, the father's experience was not meaningfully explored or held.

This initial framing had a cascading effect. As the case progressed, the father was consistently engaged through a risk-oriented lens. His actions were interpreted as controlling rather than

protective. His emotional responses, marked by confusion, frustration, and hurt, were viewed as further evidence of instability. Over time, he began to internalize this narrative, expressing feelings of not being "good enough," of being invisible, and of having no voice in how his story was being told. This dynamic impacted his ability to engage authentically. While he participated in required services, his engagement reflected a lack of relational safety and trust. The system, in turn, interpreted this as resistance, reinforcing the narrative that had been constructed about him.

The trajectory of the case began to shift with the involvement of an infant mental health clinician. Approaching the case through a relational, trauma-informed, and culturally responsive lens, the clinician intentionally slowed the process and created space for reflection within the team. Through reflective supervision and consultation, the clinician invited the team to examine their assumptions and consider how implicit bias may have influenced their interpretations. Critical questions were introduced: What does it mean that the father was the one who called for help? How might his actions be understood as protective? How does the mother's trauma intersect with the father's experience? How do we hold both safety and relational context in service to the child?

This shift in perspective allowed the team to reframe the father's behavior. His actions were recognized as attempts to de-escalate and protect, rather than as acts of aggression. As the father began to feel seen and validated, his engagement changed. He demonstrated increased emotional presence, attunement, and consistency with his child. His relational strengths, which had been obscured by the initial narrative, became visible. This case underscores how quickly bias can shape system response and how essential it is to hold the full relational context in mind.

Case 2: The Congolese–Russian Father – When Narrative Is Taken, Engagement Is Lost

This case involved a Congolese father and a Russian mother whose three-month-old infant entered the child welfare system following an incident in which the mother, who was experiencing untreated postpartum depression, left the infant unattended in a vehicle while she entered a grocery store. The incident resulted in child welfare involvement, the mother's incarceration, and subsequent involvement with immigration authorities, creating significant instability for the family and ultimately leading to transitions across two states. During this period, the father unexpectedly became the primary caregiver for the infant, as well as the family's 8-year-old and 12-year-old children, while simultaneously navigating the child welfare system, legal proceedings, the mother's incarceration, immigration-related

uncertainty, and the emotional impact of sudden family separation. He was expected to assume multiple unfamiliar roles while coping with his own grief, stress, and uncertainty, often within systems that differed significantly from his cultural experiences and expectations.

These cumulative circumstances significantly shaped how the father presented to professionals. His communication style, emotional expression, parenting practices, and responses to stress were frequently interpreted through a Western clinical and child welfare lens rather than understood within the context of his Congolese cultural values, migration experiences, language differences, and trauma history. Rather than recognizing many of his responses as adaptive efforts to protect and care for his family during an overwhelming crisis, the system often interpreted his presentation as guardedness, resistance, or limited engagement.

This case also illuminated the system's difficulty in understanding the cultural nuance of the father's identity, his culture, customs, language, and the ways trauma was embodied and expressed in his parenting and relational style. Despite ongoing efforts by the infant mental health clinician to educate and guide the team, there remained a persistent struggle to fully integrate a culturally responsive and trauma-informed lens. The clinician consistently advocated for a balanced approach, one that honored both safety and relationship, while supporting the court and system in understanding the deeper, often unseen, impact of trauma on this family. However, the system struggled to hold this complexity. The court, in particular, faced challenges in balancing safety with relational integrity, and advocacy with clinical expertise. Rather than integrating this knowledge, the response required resulted in a punitive and defamatory outcome toward the clinician, further reflecting a system under strain when asked to hold multiple truths.

However, within this complexity, a critical shift occurred. The father, through support and skill-building, was able to find and use his voice, a voice that had long been silenced within the system. With increased confidence and support, he began to advocate not only for himself, but for his baby and his partner, ensuring that their experiences were finally heard and understood. His advocacy reflected an emerging ability to name the residual and intergenerational impacts of trauma, particularly when systems are unable to hold both safety and relationship simultaneously. This moment underscores a powerful truth: when systems fail to create space for cultural understanding and relational context, harm can be compounded but when parents are supported to reclaim their voice, healing and advocacy can begin to take root.

Integrative Reflection

Together, these cases illuminate a critical truth: when systems fail to hold the full complexity of fathers, their trauma, culture, language, values strengths, and vulnerabilities, the work becomes constrained, and the child's relational world is incompletely understood. They also highlight the profound impact of narrative. When fathers lose control of their narrative, they risk losing their voice within the system. And when their voice is lost, so too is a critical component of the infant's relational experience.

Infant mental health professionals play a vital role in restoring this balance. By bringing a relational, trauma-informed, and culturally grounded lens, they help systems move beyond simplified narratives toward a more integrated understanding of families.

Because when we hold the full father in mind, we create space for the baby to be fully seen.

And when the baby is fully seen, the work can begin to move from judgment to healing.

Conclusion: A Decolonizing Call to Protect Professional Integrity and Relational Truth

The work of infant mental health exists at the intersection of science, culture, and systems. It requires clinicians to hold complexity, to advocate for those who cannot speak, and to engage with systems that may not always have the capacity to hold the depth of this work.

A decolonizing lens challenges the field to critically examine whose knowledge is privileged and whose is marginalized. It calls for a shift away from universalized models of caregiving toward approaches that honor cultural diversity, relational context, and lived experience (Tuck & Yang, 2012). This is not simply a theoretical exercise, it is an ethical imperative.

Within this context, professional integrity becomes essential. Clinicians must be able to bring forward their expertise, grounded in science, relationship, and cultural understanding, without fear of disparagement. Disagreement is a necessary and valuable part of interdisciplinary work, creating space for dialogue and growth. However, when disagreement becomes disparagement, it silences voices and undermines the integrity of the field.

For clinicians working with fathers, this risk is particularly pronounced. Fathers often enter systems carrying complex histories and cultural identities that challenge dominant narratives. To advocate for these fathers is to

advocate for their children, to ensure that the relational context is fully understood. When systems are unable to hold the full father, when they cannot balance safety with understanding, the complexity of cases becomes overwhelming. It is in these moments that the expertise of infant mental health professionals is most critical. By bridging science and relational understanding, clinicians can support systems in making decisions that truly center the needs of the child. Ultimately, protecting professional integrity is not about protecting individual clinicians. It is about protecting the science, the relationships, and the future of our youngest children.

Because when we fail to see fathers, we fail to see the full story.

And when we fail to see the full story, we fail the baby.

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The International Coparenting Collaborative Approach to Father-Inclusive Infant Mental Health Services: Two Organizational Case Examples and Reflections on Implementation Challenges

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Abstract

Despite the critical role fathers play in child development and family stability, they remain under-represented in infant and early childhood mental health (IECMH) services. This article describes an initiative by the International Coparenting Collaborative (ICC) to implement a family-systems framework that prioritizes coparenting dynamics—specifically engagement, teamwork, conflict mitigation, and child focus. Through two organizational case studies located in Florida, USA, and Northern Israel, the authors reflect on the practical challenges of transitioning from traditional dyadic (mother-infant) models to triadic, father-inclusive approaches. Key implementation hurdles include clinician bias, cultural patriarchal norms, and logistical barriers. Successes were tied to sustained institutional commitment, culturally attuned outreach, and the use of the Lausanne Trilogue Play (LTP) to facilitate reflective conversations. The article concludes that framing father involvement through the metaphor of a "cooperative team" promotes higher engagement toward improving outcomes for early childhood challenges.

Keywords: coparenting, father engagement, infant mental health, family systems, Lausanne Trilogue Play, ICC model

The International Coparenting Collaborative Approach to Father-Inclusive Infant Mental Health Services: Two Organizational Case Examples and Reflections on Implementation Challenges

Fifty years ago, psychologists Ross Parke and Michael Lamb revolutionized developmental psychology by elevating the father's role in a field previously focused on mothers. Decades of research offer evidence that children's safety, socioemotional health, and cognitive development benefit when fathers are positively involved from infancy. While father engagement varies between collectivist and individualist nations, the way parents collaborate as a coparenting team indelibly influences children's lives. Nurturing fatherhood consistently correlates with better outcomes across diverse societies (Jeong et al., 2016; Sardaki et al., 2008); negative outcomes are typically tied to the nature of the interactions such as harshness or intrusiveness—rather than the culture itself.

Regrettably, however, fathers remain under-involved in services for children and families during infancy and early childhood (Carlson et al., 2014; Hodgson et al., 2021; Rubinstein et al., 2024). Meaningful father inclusion in Infant and Early Childhood Mental Health (IECMH) services is vital; it promotes family stability, has salutary effects on intergenerational patterns of caregiving and caregiving expectations, and influences IECMH outcomes, including attachment security, emotion regulation, relational health and resilience following trauma and adversity (Brown et al., 2012; Cimino et al., 2024; McClain & Brown, 2016; Puglisi et al., 2024). Fathers as coparents are sources of co-regulation, protective figures during times of stress and adversity, active agents in supporting maternal wellbeing, and partners in relational repair and healing.

Father under involvement owes to IECMH having historically been organized around mother-infant dyadic models, idealizing (and blaming) biological mothers as primary caregivers. Diversity-Informed Infant Mental Health Tenets arose in response; though they aspire to promote inclusive, culturally responsive attention to all caregiving figures (McClellan et al., 2025), engaging fathers in trauma-

informed services can be difficult. Because IECMH work focuses on intergenerational transmission and caregiver mental health, in groups characterized by strong traditional gender roles or mental health stigma, cultural roles may define fatherhood in ways that conflict with clinical engagement. Though fathering roles encompass caregiving, play, teaching, and serving as role models or authority figures (Cabrera et al., 2018), in regions where patriarchal norms still define fatherhood narrowly as provision and oversight, caregiving and emotional support remain the principal province of women (Tiumelissan et al., 2021).

Framing the Work: Summary of a Novel Paradigm

In 2022, the International Coparenting Collaborative (ICC) introduced family-systems framing for IECMH practice. Unlike dyadic Family-Centered Practice (Rouse, 2012), the ICC approach is triangular, directly involving multiple coparents and the child. The model targets four cross-cultural components: coparental engagement, teamwork, conflict mitigation, and child focus (McHale et al., 2023). To foster family mindfulness, practitioners integrate customizable protocols, including the Lausanne Trilogue Play (LTP), alongside existing services (Fivaz-Depeursinge & Corboz-Warnery, 1999; McHale et al., 2025a; Philipp et al., 2026). The ICC approach replaces mother-only intakes with comprehensive family-system reviews. This transformation requires explicit father outreach, revised scheduling, and updated forms. "Teaming" metaphors help effectively engage men, inviting them to connect through shared action rather than verbal disclosure (McKenzie et al., 2018), and paternal input is viewed as indispensable. Some ICC partners have suggested partial-session attendance, but "incremental engagement" approaches risk framing fathers as optional. As they began implementing intensified father outreach, ICC partners simultaneously undertook reflective conversations internally to identify and eliminate routines that were inadvertently discouraging fathers.

Transformations of Existing Agency Services to Uptake the Framing the Work Curriculum

Though applied by individual practitioners, IECMH practice is strongly impacted by agency cultures, policies and procedures. The next sections provide examples of how the ICC "framing" model was introduced to help transform organizational approaches.

Case Study: Florida, Southeastern USA

In St. Petersburg, Florida, the USF Family Study Center operates an Infant-Family Center (IFC) providing mental health services to diverse families with children ages 0–5 who have experienced early adversity. Since 2015, the IFC has operated from a family systems framework, with the clinic's practice manager requesting engagement of multiple caregivers from the initial contact. Consequently, 62% of IFC cases over the past decade included consent for treatment by two or more coparents who received at least one service session. Because most clinical staff at the IFC – including training directors and supervisors - originally trained as dyadic practitioners, their knowledge of LTP practices and family systems applications had to be developed through on-the-job training.

Introduction to the ICC model was incremental, spanning several years of specialized training. While early efforts focused generally on systemic practice and LTP administration, it wasn't until 2025 that formal training in the ICC Framing model took place. By then, IFC staff had already begun integrating child-centered ecomaps and Coparenting Scales (McHale et al., 2025b, c) into their protocols to facilitate dialogue in multi-caregiver cases.

Several factors facilitated a shift toward use of the ICC protocol. These included opportunities to meet and receive relevant in-services from outside LTP experts who stimulated triangular thinking about cases; the presence of senior female clinicians on the team comfortable with father outreach; and a seasoned fatherhood expert who provided a vital male perspective during team conferences. Furthermore, the racial and cultural diversity of the IFC staff mirrored that of the families served, providing essential lived experience with varied coparenting and family constellations.

Despite these assets, uptake of the ICC model was gradual. Clinician experience with fathers varied, and initial outreach—usually conducted by female staff—met with varying success. Weekly case conferences and reflective supervision helped clinicians address both attitudinal and institutional barriers to engaging fathers. Often absent intention, established, well-practiced practitioner leanings required constant awareness-raising and redirection, in clinically safe spaces.

As the ICC model took root, despite persistent outreach it was not always possible to engage a father or coparent to have them initially present. In such cases, however, there was nonetheless intentional "holding" of that coparent in mind as the clinician began work with the present parent. Outreach efforts also did not cease, and frequently a coparent was engaged later for one or more consultations. Such cases invariably could not follow the ICC protocol (wherein input is obtained from the family's multiple caregivers, followed by a formative coparenting dialogue, before initiating treatment). However, with the coparent held in mind, integration of the coparent into casework occurred more readily once they joined later.

Logistical hurdles required flexibility and creative responses, with IFC team members meeting families "where they were". Services for IFC families could be delivered in office, in home or community, or via telehealth sessions to allow for maximal flexibility. This allowed clinicians to see families in their natural environments and at varying times, within the structure of what was feasible for the clinic. Special considerations like transportation barriers, family comfort, and schedules also influenced determinations regarding whether services were delivered at home or out of office, with at least half of the services being delivered out of clinic.

The most sizable challenge in full ICC model implementation has been an "end-of-treatment" review – the coparents complete the same LTP and survey assessments administered at intake and reflect on their coparenting journey. Families have cited this review as pivotal in piquing mindful awareness and ownership, even "embodiment", of their family's ways of coparenting - allowing them to be more deliberate

in the years ahead. But IFC clinicians often viewed this re-assessment as a program evaluation rather than a core clinical component. Consequently, many families have departed before this reflection occurs, attributing their premature exits to life emergencies or competing priorities. To address this problem, the IFC is working to integrate re-assessments of the LTP and key surveys incrementally throughout the termination process rather than leaving them to final closing visits.

In summary, success in uptake of the ICC model at the IFC owed to several key elements:

- Ongoing attention to building organizational capacity and supporting growth.
- Encouraging openness to change as part of staff development and reflection.
- Continued support and engagement from senior leadership.
- Guidance from experienced mentors who model a coparenting approach.
- Collaborative partnerships with external experts to strengthen and support the work.

Anticipating implementation challenges, the IFC fostered a culture of open inquiry. Weekly team meetings created a supportive space to reflect on challenges and explore real-time solutions. Guided by a director and practice manager committed to the ICC model, the weekly conference meetings were co-led by team members and enriched by the range of their professional perspectives. These sessions were complemented by reflective practice with a supervisor committed to father-inclusive practice and skilled in coparenting approaches. By fostering openness, encouraging creative problem-solving, and uplifting clinician perspectives, the IFC supported staff in building confidence and readiness to expand their engagement of fathers, even when facing complex dynamics.

Case Study: Israel

In Northern Israel, a community-based IECMH clinic serves a diverse population, including Secular and Orthodox Jews, Muslims, Druze, and Christians. In this multicultural context, two opposing trends exist: a shift toward Western modernization and a pull toward traditional patriarchal values (Lavee & Katz, 2003). In many traditional families (Haj-Yahia, 2000; 2022), mothers remain solely responsible for the child's health and education during the first five years. Consequently, even as parenting becomes more egalitarian among secular populations, men in traditional families who see themselves as the family head and key authority figure frequently find change difficult (Keren et al., 2024).

We implemented the ICC model in this complex multi-cultural context in efforts to increase both clinician and parent awareness of coparenting's role in child symptomatology. We began by restructuring the initial intake call; secretaries now explain that both parents are expected at the first meeting. While Orthodox fathers often remain reluctant to attend the first session, clinicians use that time to explain the importance of their presence to the mother. This approach has successfully brought many fathers in for subsequent LTP assessments and coparenting interviews. However, several fathers have deferred clinical reporting (typically, the Child Behavior Checklist) to the mother, insisting "she knows the child best."

Now three years in, the centrality of coparenting is apparent. LTPs are standard, coparenting dialogues are evoked during feedback sessions, and robust discussion about coparenting quality is part of weekly team case discussions. Notwithstanding, as in Florida, clinicians still struggle to bring both parents together for a final assessment before termination, citing parent reluctance. Our team continues to explore how a clinician's own conviction can help parents recognize the value of this final reflection.

The ICC frame also shifted our team toward triadic treatment approaches (engaging both parents and the infant) to improve the coparenting alliance, often supplementing or replacing traditional dyadic therapy. For example, when a child's behavior worsens only when both parents are present, we advocate for triadic psychotherapy. Similarly, during recent years of regional conflict, we have actively recruited fathers to join sessions, recognizing their vital role as buffers against maternal overprotection and child post-traumatic symptoms.

The ICC impact on fathers' experiences: Men's voices

Successful outreach can help fathers tackle deep-seated relational challenges, break intergenerational cycles, and foster collaborative, child-focused coparenting. Centering men's lived experiences matters. In Israel, several cases are illustrative. In a case involving an encopretic boy, only the mother attended initially, claiming her husband was uninvolved. Upon the clinic's insistence, the father attended, revealing: "In her eyes, nothing I do is good enough, so it's best not to do anything." Sessions uncovered that their coparenting echoed childhood histories. Having lost his father young to a dominant mother, the husband routinely acquiesced. Realizing he was repeating a pattern, he began speaking up and as coparenting communication improved, the boy's symptoms subsided. In a case involving a defiant 3-year-old, a father who hesitated to enter the consultation room was derided by his wife. He remained sidelined during the LTP. He later came for an individual visit, disclosing past maltreatment by his mother while his own father was disengaged. Seeing a painful parallel, he expressed: "I am afraid of my wife, exactly like my father was in front of my mother." Recognizing these intergenerational patterns brought him resolve, and he thanked the clinician for "inviting" him inside. Without determined clinical outreach, it is likely neither of these hesitant fathers would have become involved.

In a third case regarding an aggressive 3-year-old, the father was initially distant and angry, competing with his wife for attention. He had been the primary caregiver while his wife was ill but felt pushed out once she recovered. After several months of IECMH work, the boy's aggression resolved without requiring medication, and father's views shifted. He conceded: "I never believed in psychology... I understand now how much psychology there is in fatherhood... I was angry at my wife when she became ill and could not handle our son, and then, it made me furious that the boy became more attached to her than to me! Only when he told me he loved riding with me to the clinic did I understand I am important to him!"

In St. Petersburg, in a family seen for over a year, a typically quiet father expressed that "a huge weight has

been lifted" after the coparents mutually decided to change their child's stressful daycare. His disclosure communicated how much he felt the pressures of parenting. In another case, a divorcing father participating in both Child Parent Psychotherapy (CPP) and Focused Coparenting Consultation tearfully shared his gratitude. Though initially skeptical, he voiced that the framework successfully refocused them on shared goals for their daughter. They realized that alignment would ease her transition as both parents took on new partners. Even when the father's own new relationship ended, he decided to meet and honor the mother's new partner as an important figure in his daughter's life, giving the daughter permission to speak freely about him. Ultimately, as the parents worked as a team, their mutual respect became highly apparent.

Men's voices are fundamental in the ICC efforts to center fathers lived experiences and perspectives, as they offer essential evidence regarding the impact of transformed efforts.

Conclusion: Comments on Readiness and Transformations

The ICC framework engages fathers alongside mothers in conceptualizing cases and planning treatment. Male-resonant coparenting narratives, such as framing services around provision of family stability and "teaming" metaphors have been helpful. Successful joining requires culturally attuned communication, including acknowledging and honoring traditional fatherhood; reflective supervision has been key in helping examine clinical biases and address frustrations. Ultimately, organizational commitment transforms clinical trajectories.

As the ICC is a clinical collaborative and not a formal research study, longitudinal outcome data are limited, and so findings cannot be fully generalized. However, sites do collate detailed case analyses and document program implementation and more importantly, ICC sites flexibly adapt to cultural traditions rather than viewing them as barriers. Making protocol adjustments—like honoring a father's request to let mother alone complete a child behavior rating—validates paternal commitment without challenging family identity.

While cultural adaptations require ongoing attention, the ICC frame has already proven useful across multiple professional settings and countries, encouraging fathers' intentional engagement in IECMH casework.

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Being a Father in the Context of Disability: Conditions of Existence and Clinical Configurations of Fatherhood

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Abstract

Fathers are increasingly recognized as important figures in early child development, yet their place within perinatal and Infant Mental Health services remains uncertain, particularly when disability is involved. This article explores how fatherhood is experienced and supported among fathers with disabilities through three clinical situations encountered in a French parenting support service. Rather than focusing on parental competence alone, the analysis identifies three recurring configurations of fatherhood: fatherhood under continuous pressure to demonstrate legitimacy, fatherhood disrupted by traumatic experience, and fatherhood constrained by relational and institutional dynamics.

Drawing on the capability approach developed by Sen and Nussbaum, the paper examines the conditions that enable—or hinder—fathers' opportunities to occupy a paternal position. The clinical material suggests that fatherhood is not simply determined by individual capacities but emerges through a complex interplay of relational, temporal, social, and institutional conditions.

The article argues that supporting fathers with disabilities requires more than promoting paternal involvement. It calls for greater attention to the environmental and relational conditions that allow fathers to exist as fathers and to develop meaningful relationships with their infants. From an Infant Mental Health perspective, strengthening these conditions contributes not only to paternal recognition but also to the richness and diversity of infants' early relational environments.

Keywords: fatherhood; disability; Infant Mental Health; parenting support; capabilities approach; vulnerability; early relationships

Introduction

Over recent decades, increasing attention has been paid to early relationships within perinatal care and Infant Mental Health. This evolution has broadened the focus from the child alone to the relational environments in which development unfolds. Yet fathers continue to occupy an uncertain place within many clinical and institutional settings.

Long regarded as secondary or supportive figures, fathers are now increasingly expected to be present, involved, and actively engaged in caregiving. However, this growing recognition has not always been accompanied by clinical reflection equal to the complexity of these expectations. In practice, perinatal care remains largely organized around a maternal-centred framework, leaving fathers in a position that is acknowledged but often difficult to inhabit.

Research in developmental psychology has shown that fathers cannot be understood simply as substitute maternal figures. They are distinct relational partners whose specific interactional styles enrich children's early relational experiences (Le Camus, 2000). More recently, studies of early father–infant interactions have shifted attention from the mother–infant dyad to the father–infant dyad. Nevertheless, fathers remain far less studied than mothers in situations of vulnerability (Letot et al., 2023). From this perspective, the father is not a peripheral developmental figure but an integral relational partner within dyadic, triadic, and broader family dynamics.

This issue becomes particularly salient when parenting unfolds in the context of disability. Even when guided by inclusive intentions, support services may inadvertently reproduce asymmetries in the recognition of parental roles. Fathers may be expected to participate without being genuinely supported or may encounter implicit norms that make their paternal position difficult to occupy.

The question is therefore not simply whether fathers are present or competent, but under what conditions they are able to exist as fathers.

Drawing on clinical situations encountered in a French parenting support service for parents with disabilities, this article explores three recurring configurations of fatherhood: fatherhood under continuous pressure to demonstrate legitimacy, fatherhood disrupted by traumatic experience, and fatherhood constrained by relational and institutional dynamics.

Rather than constituting a typology, these configurations illustrate ways in which fatherhood may be supported, negotiated or hindered in contexts of disability.

The article examines the relational, social, and institutional conditions that enable—or hinder—fathers' opportunities to occupy a paternal position.

A Recognized Yet Uncertain Place for Fathers

Despite growing recognition of fathers' importance in early child development, their place within perinatal services remains marked by instability. Le Camus (2000) emphasized the importance of fathers' concrete involvement and of the earliest interactions linking fathers and infants. Contemporary work on father–infant interaction further confirms that fathers communicate, adjust, and function as sensitive relational partners from the very beginning of life (Letot et al., 2023).

Nevertheless, a gap persists between theoretical recognition and actual integration into clinical practice. Fathers are increasingly invited to participate, yet remain insufficiently recognized and supported within clinical practice. This tension becomes particularly visible in contexts of disability, where support systems continue to be largely organized around maternal figures and where paternal vulnerabilities often remain less identifiable.

In these situations, the difficulty lies less in what fathers are capable of doing than in the conditions that allow these capacities to become effective. Some fathers possess significant parental abilities, recognized even by professionals, yet remain unable to fully embody these capacities within relational, conjugal, or institutional realities.

The capability framework helps illuminate this discrepancy. It distinguishes available resources from actual opportunities for action. Parenthood is not merely a matter of competence, status, or intention, but depends upon a set of conditions that either enable or prevent individuals from effectively occupying a parental role (Sen, 1999; Nussbaum, 2011).

Clinical Configurations of Fatherhood

The Father Under Pressure: Fatherhood as Continuous Proof

For Mr. A., fatherhood unfolds within a constant logic of demonstration. Living with hereditary optic neuropathy, he developed highly elaborate strategies of anticipation and control.

Our sessions took place every Tuesday at 12:30 p.m. In the hallway, he always arrived at exactly 12:29. Fast pace, upright posture, white cane moving with precise regularity. His punctuality irritated me. I sometimes found myself delaying the beginning of the session slightly, as though attempting to loosen a framework already too rigid.

A telecommunications engineer, Mr. A. organizes, plans, and lists. He does not come to speak, but to solve. "I'll read you the points and you answer them?" Voice messages from his phone punctuate the sessions at an overwhelming pace. This dynamic recalls what Missonnier (2009), within perinatal psychology, describes as a form of anticipation that, when it becomes rigidified, narrows openness to the future into anxious attempts at mastery.

His separation from Emilio's mother and the implementation of shared custody intensified a central fear: not being good enough and ultimately losing his place as a father. Very quickly, sessions became organized around concrete questions: How can he occupy Emilio during holidays? How can he create memories? How can he avoid being disqualified?

A comparative logic progressively emerged regarding the mother's new partner, who built treehouses and taught Emilio roller skating. Mr. A. compensated, organized, and anticipated. He searched for someone willing to accompany him on a tandem bicycle, adapted books into Braille, and modified games to make them accessible. Fatherhood became a position that constantly required proof.

Yet beyond this dynamic, quieter scenes began to emerge. He spoke about dancing, his passion for bachata nights on the banks of the Seine, and a cake mold he insisted on recovering after his mother's death. "We made a clafoutis with Emilio… I tried telling him stories connected to the mold, but he only wanted to know when the cake would be ready."

Something then shifted: from a fatherhood under permanent pressure toward a less controlled form of transmission, one rooted in ordinary gestures and small details.

The Father in Tension: Between Survival and the Renunciation of Limits

For Mr. L., a severe car accident occurring three weeks after the birth of his second daughter profoundly reshaped paternal functioning. He was referred by a rehabilitation unit following a traumatic brain injury. His eldest daughter was five years old.

At the first appointment, he arrived accompanied by his eldest child. The situation immediately felt surprising, as the session was intended to address the accident, its consequences, and possible parenting difficulties. When we suggested that the child be cared for elsewhere during the interview, Mr. L. replied: "She knows everything about my story and understands everything." The child eventually agreed to leave, though she repeatedly returned, seemingly to ensure her father was still present.

Very quickly, one phrase returned insistently: his desire to provide "a safe and secure framework" for his daughters. This repetition appeared less as an educational project than as an attempt to contain a deeply disorganizing experience. When discussing the accident — "I was left for dead" — emotion surfaced, yet his current difficulties were minimized. He acknowledged possible irritability while denying emotional vulnerability that was nevertheless visible throughout the session. A gap emerged between discourse and lived experience.

During a home visit, his partner described difficulties setting limits: late bedtimes, frequent gifts, difficulty saying no. The girls regularly turned to their father, who often redirected them toward their mother: "Ask mommy." Mr. L. himself admitted that "structure was never really my thing," even before the accident.

The core conflict appeared when he stated: "When you've escaped death, it's not to become the authoritarian father."

The experience of survival came into tension with the exercise of limits. Establishing structure became almost incompatible with the imperative to fully enjoy life. The father found himself

caught between protecting and letting live, structuring and not restricting.

The "safe and secure framework" remained present in discourse but struggled to take shape in daily practices. Fatherhood appeared deeply disorganized by traumatic experience and by a profoundly altered relationship to time : the present became saturated by the urgency of living. During a later exchange, Mr. L. would say again: "My rehabilitation now is my wife and daughters." Parenting thus became both what sustained him and what destabilized his ability to reclaim a structuring paternal position.

The Constrained Father: Internalizing Erasure

For Mr. T., difficulty took a quieter form.

Mr. T., age 45, was referred for individual consultation following adapted infant-care support. An IT engineer and manager within a start-up company, he spoke extensively about work—not so much to impress, but rather to discreetly remind others of what he was capable of.

Living with hemiparesis resulting from a probable childhood stroke, he presented significant spasticity in his right arm. With humor, he described himself as "a rather unusual creature," seemingly anticipating the gaze directed toward his disability.

He did not live with the mother of his daughter. The pregnancy resulted from assisted reproductive technology. Very quickly, confusion emerged: it became difficult to determine whether they were truly a couple, or whether they had ever been one outside of the parenting project itself.

The mother was described as anxious, rigid, and highly critical toward him. She regularly questioned his parental abilities despite positive professional observations. Over time, she suggested possible neurodevelopmental disorders and insisted he consult a psychiatrist. Mr. T. complied without opposition. No diagnosis was made.

Sessions unfolded within a relatively stable atmosphere. Mr. T. rarely complained. He rationalized, minimized, and reassured. His daughter was doing well, he said, and "things will eventually settle." When he learned that the mother had registered herself as a single-parent household at daycare, he did not protest.

In parent discussion groups, he was the only father present. He participated actively and echoed conversations about mental load, yet struggled to provide concrete examples involving his daughter. He instead returned to work, management, and professional responsibilities.

Work appeared as a more stable space of legitimacy than fatherhood itself. He also mentioned having few paternal role models, describing his own father as belonging to "another generation." Several months into the follow-up, he stated: "I don't want to damage the bond between my daughter and her mother by seeing her more."

For Mr. T., constraint did not take the form of open conflict. It emerged more quietly through adjustment and preservation of relationships. The restriction of paternal space gradually became internalized as the price to pay for maintaining relational equilibrium.

Discussion: When Can Fathers Exist as Fathers?

These situations raise a central question: under what conditions can a man effectively occupy a paternal position?

As Karsz writes, "by constantly evaluating fathers through the prism of their ideal role, there is a great risk of overlooking both their real power and their real powerlessness" (2014, p. 109). This observation illuminates the situations explored here particularly well: the difficulties encountered by these fathers do not derive solely from individual characteristics, but from the concrete conditions under which their fatherhood may—or may not—unfold.

In all three cases, the fathers were engaged. None occupied a position of indifference. Yet this engagement alone was insufficient to guarantee stable recognition within the paternal role.

The capability approach helps conceptualize this discrepancy. Competencies are present, sometimes even highly developed, but their effectiveness depends upon the conditions that allow them to emerge (Sen, 1999; Nussbaum, 2011).

Across these situations, fatherhood emerges less as a stable position than as a fragile negotiation shaped by relational, temporal, and institutional conditions.

For some fathers, paternal involvement becomes inseparable from a constant need for legitimization, as though fatherhood had to be continuously demonstrated in order to remain credible. In other situations, traumatic experience profoundly alters the relationship to temporality and limits, saturating the present with the urgency of survival and complicating the exercise of a structuring paternal function. Elsewhere, the difficulty lies less in the absence of desire or competence than in the gradual internalization of relational constraints, leading fathers to progressively reduce their own paternal presence in order to preserve fragile relational equilibria.

What these configurations reveal is not a deficit of paternal investment, but the extent to which fatherhood depends upon the conditions that make its enactment possible. Rather than being understood solely at the level of the individual subject, fatherhood unfolds within networks of relationships, norms, and constraints. Temporality emerges here as a central dimension: rigid anticipation, saturated present, and suspended projection. Fatherhood is enacted not only in the immediacy of interaction, but also through the capacity to imagine oneself as a father across time.

Some situations invite an even more radical displacement of perspective. The issue is no longer simply whether fathers can occupy a place, but whether they can maintain a subjective position within systems of multiple constraints. In such configurations, fatherhood may become saturated by caregiving burdens, loyalties, or exhaustion. The question then becomes: how can one remain a father when one is already struggling to remain a subject?

Contemporary Infant Mental Health approaches invite us to think of the father as a full relational partner of the infant, embedded within broader triadic and family dynamics (Letot et al., 2023). These paternal modalities therefore concern not only fathers themselves, but also the infant's early relational environment. Contemporary research highlights how diversification of parental figures and interactional modalities supports socio-emotional development and later adaptive capacities in children (Cabrera et al., 2018).

Supporting the conditions that allow fatherhood to exist in contexts of

vulnerability is therefore not merely a matter of parental recognition. It also contributes to the quality of the child's early relational environment.

These findings also have implications for clinical practice. Clinicians should pay particular attention not only to fathers' abilities but also to the relational and institutional conditions that enable them to occupy a paternal position. This requires actively engaging fathers during consultations, recognizing their specific vulnerabilities, and supporting the emergence of their paternal identity independently of maternal functioning.

Thus, the issue is not simply whether fathers are present or competent, but under what conditions they are actually able to exist as fathers.

Conclusion

These clinical situations invite a shift in perspective. The fathers encountered are neither absent nor disengaged. They demonstrate genuine investment, yet their ability to exist as fathers remains fragile.

What emerges is not a deficit of capacity, but variability in the conditions that allow capacities to unfold. Supporting fatherhood therefore involves more than encouraging paternal presence; it requires questioning the relational and institutional frameworks within which such presence may become effective.

Clinical work is thus called not to adjust fathers to pre-existing norms, but to support the emergence of singular forms of fatherhood. The challenge is less to prescribe a place than to make its inhabitation possible.

Supporting fatherhood may therefore consist less in reinforcing a function than in making its existence possible where it is searching for itself, becoming fragile, or transforming.

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Reclaiming Fatherhood in Infant and Early Childhood Mental Health: Co-Parenting, Culture, and the Decolonization of Paternal Identity in Kenya

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Abstract

Infant and Early Childhood Mental Health (IECMH) underscores the foundational role of early relationships in shaping developmental outcomes; however, fathers remain underrepresented within research and clinical practice. This article expands the IECMH framework by centering fathers as essential co-parents within culturally grounded caregiving systems. Drawing on a decolonizing lens, this paper examines how colonial legacies have disrupted indigenous African constructions of fatherhood, recasting men as distant providers rather than relational caregivers. Through an in-depth case study of a Kenyan father engaged in FirstPlay-informed intervention with a Kenyan male clinician, supported by multi-layered reflective supervision, this article explores the intersection of attachment, bonding, masculinity, and cultural identity. Findings highlight reflective supervision as a critical decolonizing practice that supports clinicians in integrating cultural knowledge, addressing internalized narratives, and restoring dignity to fathers. Implications emphasize the need for culturally responsive, equity-centered approaches that reposition fathers as central figures in early relational health.

Introduction

Infant and Early Childhood Mental Health (IECMH) is grounded in the understanding that early relationships shape neurobiological development, emotional regulation, and long-term well-being (Zero to Three, 2016). These early relational experiences form the foundation through which infants develop a sense of safety, connection, and meaning, ultimately influencing their developmental trajectory across the lifespan. While caregiving has historically been conceptualized within a mother-infant dyad, contemporary frameworks recognize caregiving as embedded within broader relational and cultural systems involving multiple caregivers (Keller, 2018; Super & Harkness, 1986). Despite this expanded understanding, fathers continue to be marginalized within IECMH discourse and practice, often positioned as secondary caregivers or excluded altogether (Cabrera et al., 2018).

This marginalization reflects deeply embedded sociocultural narratives that define fatherhood through provision, authority, and discipline, limiting recognition of fathers' emotional and relational contributions. In Kenya, fatherhood is shaped by the intersection of indigenous traditions, colonial histories, and contemporary societal expectations. Pre-colonial African societies emphasized communal caregiving systems in which fathers were actively engaged in nurturing, teaching, and guiding children (Nsamenang, 1992). Colonization disrupted these systems by imposing rigid patriarchal frameworks that redefined masculinity through economic provision and emotional restraint, distancing fathers from relational caregiving roles (Pence & Marfo, 2008). This article seeks to reclaim fatherhood by examining these disruptions and exploring pathways for restoring fathers' relational roles through culturally grounded IECMH practice.

Colonization and the Disruption of Fatherhood

The disruption of fatherhood within African contexts reflects both historical and relational transformations

shaped by colonial influence and shifting cultural norms. Traditionally, Indigenous caregiving systems were grounded in collectivist values, where the responsibility for raising children was shared across extended family and community networks (Nsamenang, 1992). Within these systems, fathers played an active and meaningful role, engaging in emotional attunement, physical closeness, guidance, and mentorship. Fatherhood was not limited to provision but encompassed relational presence and participation in daily caregiving.

However, colonization introduced Eurocentric patriarchal ideologies that redefined masculinity through dominance, authority, and economic provision, while positioning nurturing as the responsibility of women (Pence & Marfo, 2008). This imposed binary disrupted the fluid and interconnected nature of caregiving roles, creating increasing distance between fathers and their children. Over time, these externally imposed norms became internalized, influencing both individual identities and institutional expectations. Fathers came to be evaluated primarily by their financial contributions rather than their relational engagement. This shift was not only behavioral but epistemological, fundamentally altering how caregiving was understood and valued. Importantly, this disruption did not diminish fathers' innate capacity for nurturing; rather, it obscured it. Reclaiming fatherhood requires intentionally restoring these relational capacities while addressing ongoing systemic and cultural influences that continue to shape paternal identity.

Cultural Lens on Fatherhood

A culturally grounded understanding of fatherhood reveals that nurturing, relational engagement, and caregiving have long been integral to paternal roles across diverse African contexts. Contrary to deficit-based or Western-centric assumptions, research highlights that fathers in many African communities actively participate in the emotional and physical care of their children. For example, studies of Aka fathers in Central Africa demonstrate high levels of physical proximity, responsiveness, and attunement to infants, with fathers spending significant time in direct caregiving interactions (Hewlett, 1991; Hewlett & Lamb, 2005). Within these communities, caregiving roles are fluid, shared, and embedded within daily life, allowing fathers to engage without stigma or rigid gender expectations (Fouts, 2008; Boyette et al., 2020).

Similarly, within Maasai communities, fatherhood is understood through a collectivist lens in which caregiving and attachment are embedded within broader social and cultural systems. Fathers' express connection through provision, protection, mentorship, and participation in cultural rituals and practices, rather than through overt emotional expressiveness as defined by Western frameworks (Keller, 2013; Nsamenang, 1992). These expressions of care reflect deeply rooted cultural values that prioritize responsibility, belonging, and interdependence.

Children in these contexts are raised within extended kinship networks, where caregiving responsibilities are distributed across multiple caregivers, including grandparents, aunts, uncles, and community members (Keller, 2018; Super & Harkness, 1986). Attachment, therefore, is not confined to dyadic parent-child relationships but is embedded within a network of consistent, nurturing relationships that provide stability and continuity. Fathers contribute to their children's sense of security through presence, guidance, and cultural participation. These perspectives challenge dominant Western paradigms that prioritize verbal affection and emotional expressiveness as primary indicators of attachment. Instead, they call for a broader, culturally responsive understanding of fatherhood that honors diverse expressions of care, connection, and relational presence across global contexts.

Case Study: Attachment, Masculinity, and FirstPlay in Kenya

James, a Kenyan father of a two-year-old child, entered therapy with concerns regarding his child's emotional regulation and his own uncertainty about how to engage in caregiving. He initially defined his role primarily as that of a provider, emphasizing financial responsibility as the core of fatherhood. When asked about his interactions with his child, James expressed discomfort and uncertainty, noting that caregiving was traditionally viewed as the mother's responsibility within his cultural context. He further explained that, following childbirth, it is customary for the maternal grandmother (mother-in-law) to provide support to the mother, which often limits early father-child interaction. Cultural norms of respect also require distance between a son-in-law and his in-laws, making it uncommon, and at times taboo for fathers to be closely involved during this period. As a result, fathers may be physically and emotionally removed from early caregiving experiences.

James reflected, "*I thought being a father meant providing, that is what I saw growing up. I did not know how to be close in that way. We are not included in caring for the baby, and even holding or cuddling a baby is almost unheard of. I didn't know I could do that.*"

Intervention was facilitated by a Kenyan male clinician trained in First Play, a treatment modality developed by Dr. Janet Courtney that emphasizes touch, attunement, and co-regulation. The clinician's identity as a male provider was significant, as he simultaneously navigated his own internalized beliefs about masculinity while modeling relational engagement in a culturally respectful manner. James's narrative reflected broader cultural expectations, some of which have been shaped by colonial influence, where masculinity is often associated with provision, authority, and emotional restraint. Beneath these beliefs, however, there was an unexpressed desire for connection with his child. Through therapy, James began to explore alternative understandings of fatherhood, recognizing that his hesitation was not due to lack of capacity, but rather the result of internalized cultural narratives that had limited his engagement. In the early sessions, James remained physically distant, avoided eye contact, and at times attempted to leave the session due to discomfort with the touch-based intervention, which differed significantly from his cultural norms. When invited to engage in nurturing, play-based interactions, he expressed unease, stating that such behaviors felt unfamiliar and inconsistent with his understanding of fatherhood.

James's hesitation reflected a deeper tension between attachment needs and culturally constructed masculinity. He questioned whether emotional closeness might undermine his authority as a father, highlighting the internalized dichotomy between strength and vulnerability (Connell &

Messerschmidt, 2005). Through gradual, culturally attuned engagement, the clinician reframed relational connection as an extension of strength and leadership rather than a departure from masculinity. Over time, James began to participate in shared play and gentle physical touch with his child. In one session, as he cautiously engaged in a nurturing interaction, he observed his child's positive response, marking a pivotal moment in his developing confidence and capacity for relational connection.

Reflective Supervision Across Multiple Layers

Reflective supervision served as a critical foundation for navigating the complexity of this work across intersecting relational, cultural, and systemic layers. At the first level, the Kenyan clinician, as a male provider, worked directly with the father while simultaneously confronting his own internalized beliefs about masculinity, caregiving, and emotional expression. Through reflective supervision with a Kenyan supervisor, the clinician explored how his lived experiences, cultural upbringing, and inherited narratives shaped his clinical stance. This process required him to sit with discomfort, question long-held assumptions, and hold the tension between traditional expectations of fatherhood and emerging relational ways of being.

The Kenyan supervisor created a culturally attuned and psychologically safe space that honored both the clinician's personal journey and the broader sociocultural forces influencing his identity. This included unpacking the enduring impact of colonization, patriarchal norms, and societal expectations of masculinity. Through this reflective process, the clinician developed deeper awareness of how his internal world influenced his engagement with fathers and strengthened his capacity to model nurturing, relational interactions in a culturally respectful manner.

At a second level, the Kenyan supervisor engaged in reflective consultation with an Afro-Caribbean consultant, creating a meta-reflective space that expanded the lens beyond local context to include global, historical, and systemic influences. This additional layer allowed for the integration of diverse cultural perspectives, including the intersections of colonization, migration, and Western-informed attachment frameworks. The supervisor, as a Kenyan woman working with Maasai fathers, engaged in ongoing critical reflection regarding her cultural positioning and the ways Western paradigms may inadvertently shape or constrain understanding of fatherhood.

This reflective dialogue included examining how systems of care often fail to recognize culturally grounded caregiving practices, particularly within collectivist contexts where children are "raised by the village" (Keller, 2013; Nsamenang, 1992). Within these communities, safety, protection, and attachment are expressed through communal belonging rather than solely through dyadic interactions. Across these layers, reflective supervision functioned as a decolonizing practice, creating space to name the unspoken, challenge dominant narratives, and integrate cultural knowledge into clinical work. It supported clinicians and supervisors in holding complexity, moving beyond binary frameworks, and engaging in relationally attuned, culturally responsive, and globally informed practice.

Restoring Dignity Through Infant Mental Health Practice

Restoring dignity to fathers within Infant and Early Childhood Mental Health (IECMH) requires a deliberate decolonizing approach that challenges deficit-based narratives and centers culturally grounded, globally informed understandings of caregiving. In the context of *Reclaiming Fatherhood in Infant and Early Childhood Mental Health: Co-Parenting, Culture, and the Decolonization of Paternal Identity in Kenya*, dignity is restored when fathers are recognized as whole, capable individuals whose relational contributions are valued within both family and systemic contexts. Importantly, a global lens acknowledges that fatherhood is shaped by diverse cultural norms that may differ from Western ideals, where caregiving is often individualized rather than communal.

Restoring dignity therefore requires honoring collectivist traditions, extended family roles, and culturally embedded practices of caregiving, while expanding dominant constructions of masculinity to include emotional presence, vulnerability, attunement, and co-regulation (Connell & Messerschmidt, 2005). This process is not about replacing one model with another, but about integrating multiple ways of knowing that reflect the lived realities of fathers across cultural contexts. IECMH practice must intentionally create inclusive spaces where fathers feel seen, respected, and engaged as co-parents. This includes integrating culturally responsive frameworks, valuing indigenous knowledge systems, and addressing systemic and historical influences that have marginalized fathers' relational roles. Reflective supervision is essential in supporting clinicians to examine implicit biases and Western-centric assumptions about caregiving and masculinity.

Through these efforts, fathers are empowered to reclaim their relational identities in ways that are culturally meaningful, strengthening attachment relationships and promoting the well-being of children and families across diverse global contexts.

Discussion

The findings from this work highlight the need to reframe fatherhood within IECMH practice by addressing both relational behaviors and the cultural narratives that shape those behaviors. Fathers are not inherently disengaged; rather, they are navigating internalized expectations of masculinity that may conflict with relational caregiving. This tension must be understood within the broader context of historical and systemic influences, including colonization and the imposition of Western frameworks of care.

Reflective supervision emerges as a critical mechanism for addressing these complexities, providing a space to hold multiple perspectives, integrate cultural knowledge, and challenge dominant narratives. Through reflective processes, clinicians can develop greater cultural humility and responsiveness, allowing them to engage fathers in ways that honor both their identities and their relational capacities. This approach aligns with liberatory frameworks that emphasize shared power, relational accountability, and the co-construction of meaning within systems of care.

Conclusion

Reclaiming fatherhood within IECMH is an act of cultural restoration, relational healing, and systemic transformation.

It involves reconnecting fathers to ancestral knowledge, redefining paternal roles beyond colonial narratives, and restoring dignity through culturally responsive practice. Reflective supervision plays a central role in this process, providing a space to hold complexity, integrate multiple perspectives, and foster transformation.

When fathers are supported as relational caregivers, the impact extends beyond individual families to strengthen communities and future generations. This work calls for a reimagining of fatherhood that honors cultural knowledge, embraces relational complexity, and promotes equity within systems of care.

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Providing in Economic Precarity: Caregiving Beliefs, Financial Situation and Wellbeing of Fathers of Infants in South Africa

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Introduction

Fatherhood Roles in South Africa

Like all social constructs, parenting roles are shaped by complex, interrelated factors. In South Africa, a number of studies continue to demonstrate links between fatherhood, financial responsibility and the role of provider (Makusha, 2024; Ncayiyane & Nel, 2024; Thompson et al., 2024). Scholars attribute this social construction to intersecting historical, cultural and economic factors. Some argue that the attribution of provider roles to fathers has traditional roots in patriarchal systems (Osbourne & Ahinkorah, 2024). Others attribute it to the impact of Apartheid on labour migration (Muchemwa & Odimegwe, 2026) and assert that fatherhood in Africa has historically encompassed far more than provision, with a strong focus on moral and social development (Malinga and Ratele, 2022). Regardless of its origins, the 'provider identity' of fathers predominates alongside gendered ideas about care provision as women's work (Van den Berg et al., 2024). This has raised gender equity concerns, with the State of South African Fathers Report highlighting that while 85% of South African women report that they supported their children financially, fathers are not taking up a larger proportion of caring responsibilities in response (Van den Berg et al., 2024).

The association between fatherhood and financial obligations in South Africa do not relate exclusively to financial provision for the child's care needs, nutrition, education and health (Osbourne & Ahinkorah, 2024). For many families in South Africa, pregnancy and birth is associated with culturally defined financial obligations such as *inhlawulo* (Makusha, 2024). *Inhlawulo* is an offering, usually a financial contribution, paid by the paternal family to the maternal family in cases of extra-marital pregnancy in acknowledgement of paternity (Makusha, 2024; Malinga & Ratele, 2022). Such local practices function to legitimise paternal recognition and govern access to children and thus, often determines what roles a father occupies and plays in the life of a child (Malinga & Ratele, 2022).

Economic Stress, Fatherhood and Wellbeing

The 'provider identity' linked to fatherhood in South Africa exists alongside stark economic hardships in the country. One in every three job-seeking South Africans is unemployed (Matyana & Thusi, 2023). Such realities inevitably impact the ability of many fathers to meet socially prescribed provider roles (Muchemwa & Odimegwu, 2026). In the context of practices such an *Inhlawulo*, financial hardship can also restrict a man's capacity to formalise recognition of paternity, with consequences for access and co-residence with children (Makusha, 2024).

Makusha (2024) argues that it is the complex intersection of provider identities, cultural expectations and difficult economic conditions centrally determine a father's ability to take up a caregiving role in his child's life. The complex interplay may also contribute to wellbeing of fathers in South Africa. A number of studies have demonstrated an anticipated link between financial circumstances and mental wellbeing for men and fathers in South Africa. One study found that men living in South African townships were highly vulnerable to poor mental health outcomes and problematic alcohol use, explained by stressful economic and social conditions (Oyekunle et al., 2021). In another study, some fathers reported using alcohol as a means of coping with high levels of stress and restricted economic opportunities (Makusha, 2024). These responses suggest unmet needs for accessible psychosocial support tailored to men navigating early fatherhood under constrained circumstances.

Provider Identities, Fatherhood and Maternal and Infant Wellbeing

The link between financial stress, parental depression and negative child outcomes has already been established with regards to mothers of infants. South Africa has extremely high rates of maternal postpartum depression, with prevalence rates estimated at over 30% (Nweke et al., 2024). A South African

study found higher rates of financial stress and precarity in depressed mothers and demonstrated anticipated associations to negative consequences for infant outcomes, in line with international findings (Gordon et al., 2021).

Similar patterns may be anticipated for fathers, given the qualitative studies which highlight the experiences of fathers amidst 'provider identities' and high rates of unemployment. Implications for paternal, maternal and infant wellbeing are anticipated. Advocates are highlighting studies that demonstrate the role of quality of care provided by fathers in attachment security, exploration, resilience, and behavioural problems and calls are being made to increase fatherhood involvement in Africa (Osbourne & Ahinkorah, 2024; Van Den Berg et al., 2024). As we search for improved mental health outcomes for infants and aim to support parental mental health to achieve this, it is important to better understand the care beliefs, financial circumstances and wellbeing of South African fathers of infants.

Methodology

In light of interest into the interplay between caregiving roles, economic circumstances and family wellbeing (infant, maternal and paternal wellbeing) in South Africa, this study sought to investigate the caregiving beliefs, financial circumstances and wellbeing of fathers of infants in South Africa. The study drew on data from the State of the World's Fathers 2026 study – which surveyed 8000 parents from 16 countries, with ethical oversight governed by Equimondo (SOWF2026). Five hundred survey respondents were from South Africa, representing the country in age, region, race and economic demographics. For this study, all female respondents and all survey respondents who did not have a child aged 0 to 3 were excluded from the data set, resulting in a sample of 63 fathers with infants aged 0 to 3, living in South Africa. Descriptive statistics were run for participant demographics, agreement with caregiving belief statements, financial situation reports and wellbeing reports, using SPSS.

Sixty three of the 500 (12,6% of N=500) national survey respondents had a child aged between 0 and 3 years old. Over three quarters of the participants were under the age of 35. Ninety percent identified as Black African. Forty five

Table 1. Demographic characteristics of participants.

Demographic variable	*Categories*	*n=63 (%)*
Age	>20	26(41,3)
	20-35	23(36,4)
	36-50	11(17,5)
	50>	3(4,8)
Race	Black	57(90,5)
	Other	6(9,5)
Sexual orientation	Heterosexual	60(95,2)
	Not heterosexual	3(4,8)
Level of education	Primary school (grades 0-6)	12(19,1)
	Middle and high school (grades 7-12)	23(36,5)
	Vocational/technical college	7(11,1)
	Bachelor's degree	18(28,6)
	Master's degree or higher	3(4,7)
Occupational status	Employed full time	50(79,3)
	Employed part time	2 (3,1)
	Working multiple jobs	1(1,6)
	Student/in education and working	2(3,2)
	Self-employed	1(1,6)
	Informal work	1(1,6)
	Unemployed	3(4,8)
	Other	3(4,8)
Household income	R0-R4999	7(11,1)
(monthly)	R5000-R9999	19(30,2)
	R10000-R19000	12(19,0)
	R20000-R39000	11(17,5)
	R40000 and above	14 (22,2)
Income status of partner	Partner generates an income	18(28,6)
	Partner does not generate an income	37(58,7)
	Unknown	8 (12,7)
Receiving assistance from	No	18(28,6)
South African government	Yes	37(58,7)
	Unknown	8 (12,7)
Dwelling type	Rural area	7(11,1)
	City	28(44,5)
	Suburb	15(23,8)
	Township	13(20,6)

percent of the sample had completed further education and training following completion of formal schooling. Over 40 percent of the participants (44,5%) reported living in a major South African city. Nearly eighty percent of the sample were employed full time (well above the national average), and over fifty eight percent of participants reported that their partner earned an income. Participant income roughly represented country income statistics in upper quintiles, with under-representation of the lowest income quintile. Over fifty seven percent of participants reported that they received financial assistance from the South African government. Over 95 percent of the participants identified as heterosexual.

Results

Financial situation of South African fathers of infants

Nearly thirty five percent of fathers reported that they were in a financially insecure situation or were 'in financial trouble'. A further seventeen percent would struggle financially if there was an emergency. Over sixty percent of fathers reported spending half of their income or more on caregiving responsibilities.

Caregiving beliefs of South African fathers of infants

Survey respondents reported that they were involved with caring for their infant children but appeared to predominantly value their role as a financial provider. Ninety five percent of fathers felt they were competent at taking care of their child, and eighty seven percent felt that their partner believes they are competent at caring for their child. However, three out of four survey respondents (75% of participants) felt that it was better if men do paid work and women do care work at home and nearly forty percent of fathers reported that they 'never seem to get it right' when they do care or housework at home. Despite this, ninety percent of surveyed fathers believed it was more normal for men to do care work than it was in their fathers' generation.

Over eighty seven percent (87,3%) of fathers surveyed felt they and their partner support each other as much as they can with house and care work. Ninety five percent of fathers surveyed reported that, most of the time, they felt caring for their child was the most

Table 2. Financial situation.

Variable	*Categories*	*n=63 (%)*
Financial situation	In financial trouble (insecure)	22 *(34,9)*
	Financially secure (would struggle to cover an emergency)	32 *(50,8)*
	Financially prosperous	9 *(14,3)*
Portion of income spent on caregiving expenses	None	4 *(6,3)*
	Quarter or less	17 *(27,0)*
	Half	30 *(47,6)*
	More than half	12 *(19,1)*

Table 3. Care beliefs.

Variable	*Categories*	*n=63(%)*
Belief that they are competent caregivers	Strongly disagree	1*(1,6)*
	Disagree	2*(3,2)*
	Agree	36*(57,1)*
	Strongly agree	24*(38,1)*
Beliefs that partner perceives them to be a competent caregiver	Strongly disagree	1*(1,6)*
	Disagree	7*(11,1)*
	Agree	28*(44,4)*
	Strongly agree	27*(42,9)*
Belief that things are better when women do housework and men provide financially	Strongly disagree	3*(4,8)*
	Disagree	13*(20,6)*
	Agree	33*(52,4)*
	Strongly agree	14*(22,2)*
Belief that it is more common for men to do care work than in father's generation	Disagree	*6(9,5)*
	Agree	*33(52,4)*
	Strongly agree	*24(38,1)*
Belief that they support partner with house and care work and partner supports them	Disagree	6*(9,5)*
	Agree	24*(38,1)*
	Strongly agree	31*(49,2)*
	Not applicable	2*(3,2)*

enjoyable thing in their life. Nearly half of fathers (47,6%) felt work interfered with their care responsibilities. Over forty percent (41,3%) of fathers felt uncomfortable leaving their child in another persons' care.

Wellbeing of South African fathers of infants

More than one in four fathers ranked their life negatively. Forty percent of survey respondents reported having thoughts of suicide at least once in the last two weeks. Seventy percent of survey respondents stated that they were worried about bad things happening. When asked about their greatest worry as a parent, nearly 1 in 3 fathers (28,6%) reported that their greatest worry was their child's financial future. Two out of three survey respondents reported consuming five or more drinks containing alcohol on more than one occasion in the previous two weeks with 1 in 4 fathers (25,4%) reporting drinking more than five alcoholic drinks between 5 and 14 days out of 14.

Discussion

The findings reported here, drawn from a larger study on the State of the World's Fathers, provides a useful window into the lives of South African fathers of young infants. The findings suggest increased engagement in caregiving activities by fathers, despite persistent endorsement of traditional gender roles. Fathers appear to believe that their caregiving competency lies in their ability to provide financially, and despite gaining pleasure from caring for their infant children, appear to lack confidence and social validation with regards to domestic care work in the home.

This seems to suggest that the preoccupation with financial provision, and a sense of inferiority in competence of home-based care work predominates, despite shifting gender norms and pleasure in care work. That is to say, fathers appear to be actively participating in caregiving while holding internalised norms that position this involvement as secondary to their provider role, and inferior to the direct childcare capabilities of their partners. As infant mental health clinicians, working with African fathers amidst shifting gender norms, it may be particularly important to provide interventions that scaffold confidence and a sense of competence.

Table 3 continued. Care beliefs.

Belief that taking care of a child(ren) is most enjoyable part of life	Strongly disagree	2*(3,2)*
	Disagree	1*(1,6)*
	Agree	29*(46,0)*
	Strongly agree	31*(49,2)*
Belief that home or care work is never done right	Strongly disagree	*11(17,5)*
	Disagree	*27(42,9)*
	Strongly agree	*21(33,3)*
	Agree	*4(6,3)*
Belief that they don't have enough time to engage in caregiving due to work demands	Yes	30*(47,6)*
	No	33*(52,4)*
Belief that it is uncomfortable to leave child in another person's care	Yes	26*(41,3)*
	No	37 (58,7)

Table 4. Father wellbeing.

Variable	***Categories***	***N=63 (%)***
Ranking of life	0-1	1*(1,6)*
	2-3	3*(4,8)*
	4-5	14*(22,2)*
	6-7	18*(28,6)*
	8-9	21*(33,3)*
	10	*6(9,5)*
Frequency of suicidal thoughts (over two weeks)	Rarely/never	38*(60,3)*
	Some of the time (1-4 days)	14*(22,2)*
	A moderate amount of the time (5-9 days)	*9(14,3)*
	Most of the time (10+ days)	*2(3,2)*
Frequency that bad things will happen is worried about (over two weeks)	Rarely / never	19*(30,2)*
	Some /little of the time (1-4 days)	23*(36,5)*
	A moderate amount of the time (5-9 days)	16*(25,4)*
	Most of the time (10+ days)	*5(7,9)*

Interventions such as the Newborn Behavioural Observation system (Nugent et al., 2007) may be helpful in this instance.

The survey findings also forefront the economic pressures and financial insecurity faced by many fathers in South Africa. The persistent provider identity held by fathers of infants in South Africa, occurring alongside economic pressures and financial insecurity, may well account for high levels of psychological distress reported by survey respondents. The high levels of suicidal ideation, pervasive worry, and hazardous alcohol use in the cohort raise concern for fathers and their infants. The findings suggest that many fathers of infants in South Africa are parenting under conditions of pervasive stress, with limited support for their own mental health, with clear consequent implications for the mental health of their infants (Fisher, 2017). The findings highlight the need for infant mental health clinicians to actively include fathers in infant mental health services, screening for paternal distress, and creating spaces where fathers' experiences of pressure and ambivalence can be processed.

Conclusion

This study provides insights into the realities faced by fathers of infants in South Africa. The findings highlight a complex picture of shifting gender roles regarding male involvement in care practices, amidst pervasive, entrenched provider identities. While many are embracing more active caregiving roles than previous generations, these shifts are occurring alongside enduring provider expectations and structural constraints. The study forefronts the complexity of the enduring provider identity in the midst of this precarious economic environment, hinting at potential paternal mental health implications. While causal inferences cannot be drawn, many fathers of infants in South Africa are navigating parenthood amidst significant economic and psychological strain.

For infant mental health practitioners working in this and similar settings, the findings underscore the importance of explicitly including fathers, with a focus on supporting mental wellbeing and boosting parenting confidence. Acknowledging the impact of financial stress in light of the pervasive provider identity, and validating their caregiving competency, could promote healthier developmental environments for infants.

Table 4 continued. Father wellbeing.

Extent that child's financial future is worrying	First biggest worry	18*(28,6)*
	Second biggest worry	10*(15,9)*
	Third or fourth biggest worry	14*(22,2)*
	Fifth or sixth biggest worry	8*(12,7)*
	Seventh or eighth biggest worry	9*(14,3)*
	Nineth biggest worry	4*(6,3)*
Frequency with which five or more alcoholic beverages are consumed (over two weeks)	Rarely/never	29*(46,0)*
	Some of the time (1-4 days)	18*(28,6)*
	A moderate amount of the time (5-9 days)	15*(23,8)*
	Most of the time (10+ days)	1*(1,6)*

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Fathers Carrying Collective on Tap: A Community-Based Feasibility Study of Babywearing for Fathers at Local Breweries

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Abstract

Fathers play a critical role in infant development, yet they remain systematically excluded from the medical, social service, and early intervention systems designed to support caregiving in the first year of life. Babywearing, the practice of carrying an infant in a cloth carrier worn on the body, is an evidence-informed caregiving practice studied almost exclusively with mothers. The Fathers Carrying Collective on Tap (FCCT) is a community-embedded babywearing intervention designed specifically for fathers and delivered at local breweries. This feasibility study examined whether fathers would enroll, engage, and sustain participation across two father-centered events in Arizona in Spring 2026. Feasibility indicators included recruitment yield, event attendance, weekly survey response rates, retention, engagement, and participant-reported satisfaction. Thirteen fathers enrolled at the Tucson event; the Phoenix event, launched without embedded community partnerships, yielded no attendees. Weekly follow-up response rates across the first four weeks were high (100%, 100%, 85%, 92%), and fathers reported approximately 58 minutes of daily babywearing on average, closely tracking the one-hour target. Satisfaction was uniformly positive. The contrast between sites indicates that established community partnerships, not the venue alone, drive recruitment. Findings support the intervention's feasibility and inform the design of a subsequent efficacy-focused trial.

Keywords: paternal involvement; father-infant bonding; father engagement; paternal caregiving; fathers and babywearing; father-centered intervention; paternal mental health

Photo: Fathers Carrying Collective on Tap Event, Tucson, Arizona. *Note*. Photographs from the Fathers Carrying Collective on Tap event held April 19, 2026, at a brewery in Tucson, Arizona. Top panels show research team members and babywearing educators staffing check-in and providing individualized instruction to attending families. Bottom panels show two participating fathers wearing their infants in soft structured carriers. Photo credit: Lela Rankin. Photographs printed with permission of the individuals depicted.

Fathers Carrying Collective on Tap: Preliminary Feasibility of a Community-Embedded Babywearing Intervention

Fathers play a critical role in infant development, yet remain systematically excluded from the medical, social service, and early intervention systems designed to support caregiving in the first year of life. Babywearing, the practice of carrying an infant in a cloth carrier worn on the body, is an evidence-informed caregiving practice that has been studied almost exclusively with mothers. The present feasibility study introduces Fathers Carrying Collective on Tap (FCCT), a community-embedded babywearing intervention designed specifically for fathers and delivered at local breweries, and examines whether fathers will enroll, engage, and sustain participation in a father-centered intervention model.

Background

Paternal Involvement and the Marginalization of Fathers in Early Caregiving

Fathers exert a critical, bi-directional influence on infant development, with positive involvement predicting long-term cognitive, social-emotional, and behavioral wellbeing (Cabrera et al., 2018; Sarkadi et al., 2008; Yoon et al., 2021). Generative fathering frames caregiving as reciprocal, cultivating paternal identity, efficacy, and confidence (Dollahite & Hawkins, 1998; Hawkins & Dollahite, 1997; Lamb, 2000; Pleck, 2010). Yet fathers are routinely positioned as "secondary," excluded from prenatal appointments, postpartum care, home-visiting, and parenting interventions (Bellamy et al., 2024; Buek et al., 2021; Harty & Banman, 2023; Harty et al., 2025; Lee et al., 2025; Walsh et al., 2021), and underrepresented in research (Davison et al., 2017; Parent et al., 2017). Testing whether fathers will participate is therefore a prerequisite to positioning them as essential caregivers.

Infancy as a Critical Developmental Period

Infancy is a sensitive period for the secure base script grounding relationships (Cassidy et al., 2013). Early paternal engagement contributes to secure-organized attachment (Ainsworth, 1978) and shapes enduring involvement (Brown et al., 2012; Fagan, 2022), yet routines formed then are difficult to change (Bellamy et al., 2022; Guterman et al., 2018). Fathers remain largely absent from postpartum care, and practitioners lack strategies to engage them (Bellamy et al., 2024; Buek et al., 2021; Guterman et al., 2018, 2023). This mismatch makes reaching fathers early a central feasibility challenge.

Babywearing and Physical Contact

Sustained contact is foundational for attachment (Bowlby, 1958, 1969). Skin-to-skin contact and babywearing support it through oxytocin release, C-tactile activation, reduced cortisol, and heightened responsiveness (Linde-Krieger & Rankin, 2025; Rankin & Bigelow, 2025). Evidence in fathers is converging: paternal SSC reduces infant pain (Srinath et al., 2016), babywearing supports coping and autonomic synchrony (Rankin Williams et al., 2020; Han et al., 2024), and contact shifts paternal oxytocin, cortisol, and amygdala reactivity (Gettler et al., 2021; Gordon et al., 2010; Vittner et al., 2018; Riem et al., 2021).

Engaging Fathers in Community Spaces

Engaging fathers requires non-clinical, accessible settings (Panter-Brick et al., 2014; Tully et al., 2018), since obstetric, home-visiting, and pediatric contexts signal fathers are peripheral (Walsh et al., 2021; Yogman & Garfield, 2016). Community models show promise: barbershop programs improved men's health outcomes (Releford et al., 2010, 2014; Victor et al., 2018), and effective father programs draw on partnerships and peer engagement (Bellamy et al., 2024; Guterman et al., 2023). FCCT tests whether pairing babywearing education with peers at local breweries, rather than a mother-centered home-visiting model (Rankin Williams & Turner, 2020), can draw fathers in as primary participants.

A Proposed Mechanism of Change

These literatures converge on a theory of change for fathers. Babywearing embeds sustained proximity into daily routines, which is expected to heighten paternal responsiveness and co-regulation through the physiological pathways described above (Linde-Krieger & Rankin, 2025; Rankin & Bigelow, 2025). Repeated responsive caregiving is theorized to build confidence and consolidate paternal identity, consistent with generative fathering (Dollahite & Hawkins, 1998; Pleck, 2010), which in turn supports secure attachment and infant regulation (Ainsworth, 1978; Brown et al., 2012; Cassidy et al., 2013). The present study does not test this chain; establishing whether fathers sustain babywearing is a necessary first step toward doing so.

Positionality

The authors approach this study from distinct yet complementary standpoints. The first, a licensed clinical social worker and former child welfare caseworker, centers fathers of color navigating child welfare and challenges mother-centered frameworks. The second, a developmental researcher and babywearing educator, has spent two decades on parent-infant attachment centered on mothers, prompting this extension to fathers.

Present Study

FCCT is a community-based babywearing intervention for fathers of infants. This paper reports on feasibility, not whether babywearing enhances father-infant engagement and bonding over a ten-week period. Specifically, we examine recruitment yield through community partnerships, event attendance and engagement, baseline and weekly survey response rates, participant-reported satisfaction, and early patterns of babywearing use across the first four weeks. Findings are intended to inform a subsequent efficacy-focused trial.

Methods

Study Design and Recruitment

This feasibility study was approved by the Arizona State University Institutional Review Board (STUDY00023594, approved January 9, 2026). To test whether fathers would enroll and engage, two father-centered events were delivered in Arizona in Spring 2026: April 12 in Phoenix and April 19 in Tucson, both at breweries selected to create a relaxed, family-friendly setting outside clinical or service-system environments. Eligible participants were English-speaking biological fathers aged 18 or older with a biological infant nine months or younger and at least 50% custody. Community partner agencies serving fathers in each metropolitan area invited eligible fathers already engaged in their services. Recruitment feasibility was tested through a brief REDCap screening and RSVP form distributed via QR-code coasters, electronic flyers, and direct partner outreach.

Setting and Event Protocol

Brewery venues were chosen to create a relaxed, family-friendly setting outside clinical or service-system environments. Both events followed the same two-hour protocol. Check-in (2:00–3:00pm) covered consent, the baseline survey, and carrier and swag distribution, with families welcome throughout. A welcome session (3:00–3:20pm) reviewed babywearing benefits, safe positioning, and a demonstration. Four trained educators then provided individualized fitting (3:20–3:50pm). Closing remarks (3:50–4:00pm) covered daily babywearing expectations and the weekly text surveys.

Measures and Data Collection

At the event, participants completed a baseline survey (approximately 20 minutes) capturing demographics, parental bonding, parenting confidence, father engagement, co-parenting quality, and event satisfaction. For ten consecutive weeks, they received a brief weekly text-message survey (2 to 5 minutes) reporting days the carrier was used (0 to 7) and total babywearing time; a final survey follows at ten weeks. Participants received an Ergobaby carrier and up to $100 in Tango electronic gift cards ($25 baseline, $2 per weekly survey, $5 completion bonus, $50 final). All data were collected in REDCap on the Arizona State University secure server. Consistent with the feasibility focus, analyses were primarily descriptive and centered on the study's core feasibility indicators: recruitment yield, event attendance, baseline-to-weekly survey response rates, retention across the ten-week follow-up, and participant-reported satisfaction with both the event and the babywearing experience. These indicators establish whether the model warrants a larger efficacy trial.

Results

Baseline Sample

At the Tucson event, 11 fathers RSVP'd: 7 attended and 4 did not. Six additional fathers attended without an RSVP, for a total of 13 attendees. Although attendance matched the RSVP count, the groups overlapped only partially, as about half of those who RSVP'd did not attend and nearly half of attendees had not RSVP'd. Twelve of the 13 fathers stayed from Welcome to Closing. At the Phoenix event, two fathers RSVP'd, but none attended. Fathers were 25 to 45 years old (M = 34.0); infants were eight male and five female (M = 5.4 months). Seven fathers identified as Hispanic/Latino and 10 as White (not mutually exclusive). Educational attainment ranged from some college (5) to bachelor's (4), associate's (2), and graduate (2) degrees. Twelve were working, seven were first-time fathers, and nine had planned pregnancies. All 13 lived full-time with their infant and the child's mother; 12 reported very positive co-parenting and daily contact with their child. Fathers learned of the event through friends or family (n = 6), social media (n = 5), community organizations (n = 3), and flyers (n = 2). Twelve had prior babywearing experience, nine rated baseline comfort as at least comfortable, and 10 attended with a partner, five with family, four with other children, and three alone.

Feasibility and Engagement

Response rates were strong. All 13 fathers (100%) completed the Week 1 and Week 2 follow-ups, 11 (85%) completed Week 3, and 12 (92%) completed Week 4. In Week 1, fathers reported babywearing a median of four days (M = 4.5, SD = 1.9, range 1 to 7) for a median of 4.0 hours over the week (M = 4.4, SD = 2.6, range 1.0 to 9.5), averaging approximately 58 minutes per day. Usage across Weeks 2 through 4 was comparable, with median days from 4.0 to 4.5 and median hours from 3.0 to 4.4. Between six and nine fathers babywore at least four days per week. With one exception in Week 4, every responding father reported at least some babywearing across the follow-up.

Open-ended comments suggested sustained engagement and evolving investment. In Weeks 1 and 2, fathers framed babywearing through barriers to consistent use (travel, work schedules, teething, weather), with bonding language secondary. By Weeks 3 and 4, comments shifted toward connection, competence, and routine integration, including voluntary sessions exceeding the one-hour target and use in new contexts such as grocery shopping and walks. Event satisfaction, administered with the Week 1 follow-up, was uniformly positive: all 13 fathers reported learning something new, 12 felt more comfortable babywearing afterward, all 13 would recommend the event, and all 13 valued attending with their whole family rather than a fathers-only format. Open-ended feedback reinforced the format's acceptability while surfacing refinements, including requests for indoor or shaded space and clearer advertising. Together, these indicators support the acceptability and engagement feasibility of FCCT.

Discussion

FCCT recruited and engaged fathers in a community-embedded babywearing intervention. Although recruitment was the greatest challenge, fathers who attended stayed engaged for the entire event, gained comfort with babywearing, and sustained participation in weekly surveys and practice. Delivered in a non-clinical, family-inclusive setting that centered fathers, the model produced strong attendance and weekly response rates across the first four weeks (100% in Weeks 1 and 2, 85% in Week 3, 92% in Week 4), aided by donated carriers and a protocol combining instruction, connection, and baseline data collection in one afternoon. Limitations temper these findings: the Tucson sample (N = 13) was small and demographically constrained, most fathers had prior babywearing experience, and email-only recruitment for the Phoenix event yielded no attendees.

Feasibility of a Community-Embedded Father-Centered Intervention

The Tucson event demonstrated that fathers will attend, enroll, and sustain weekly engagement when a babywearing intervention is delivered in an accessible, family-inclusive setting. Consistent baseline and weekly response rates suggest the brewery format and text-based check-ins fit how these fathers integrate caregiving into daily life, and average Week 1 use of approximately 58 minutes per day closely tracked the one-hour target, indicating a realistic dose. The contrasting absence of enrollment at Phoenix is the most consequential feasibility finding. Tucson recruitment relied on dense partnerships with organizations already serving father-infant dyads (e.g., My Gym, Tucson Baby Wearers) and an established babywearing community; Phoenix lacked both, suggesting the venue alone is insufficient. Future sites should begin with a substantive relationship-building phase with father-serving organizations and peer recruiters before scheduling events.

Implications for Research and Practice

The Tucson cohort skewed toward partnered, residential, employed fathers with prior babywearing exposure, limiting inference about how FCCT would function for fathers most often excluded from early caregiving supports. Reaching non-residential fathers, fathers involved with child welfare, fathers of color, and fathers experiencing poverty, trauma, or other adversity will require partnerships with father-serving systems (e.g., fatherhood programs, responsible-fatherhood grantees, child welfare agencies) and recruitment tailored to those contexts. The Tucson model is a starting point, not an endpoint. Still, the patterns across Weeks 1 through

4 support a larger efficacy-focused trial testing whether FCCT improves father-infant engagement and bonding over the full ten weeks. Three design implications follow: build a partnership-building phase into recruitment at each site, intentionally over-sample underrepresented fathers, and retain the event length and tolerable weekly assessment burden.

Conclusion

Early relationships shape lifelong wellbeing, yet fathers remain at the margins of the systems built to support them. This exclusion is not benign: it deprives infants of a critical relational partner, isolates fathers from support, and reinforces the inequities the field claims to address. FCCT challenges that positioning by meeting fathers in the community, on their terms, with their families beside them. Tucson showed what becomes possible when an intervention is built around how fathers actually access support; Phoenix proved that relational infrastructure must be in place before the doors open. Centering fathers is not about inviting them into maternal frameworks. It demands new pathways that recognize them as essential to attachment, caregiving, and healing. Fathers were never the missing piece. The systems built without them were.

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Infant Crying, Father Well-Being, and Implications for Infant Mental Health Practice

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Abstract

Infant excessive crying is a well-documented stressor for caregivers, yet research has overwhelmingly centered on mothers. This paper presents findings from a mixed-methods study (N = 192 fathers) examining how infant crying relates to paternal depression, parenting stress, and parenting self-efficacy. Fathers' perception of crying as a problem was a stronger predictor of compromised well-being than reported crying amount. Qualitative interviews (n = 10) revealed reliance on cognitive reappraisal as a coping strategy and identified the co-parent relationship as a central source of both support and stress. Implications for integrating fathers into IECMH screening and intervention are discussed.

Keywords: paternal depression, infant crying, colic, parenting stress, parenting self-efficacy, fathers, infant mental health, co-parenting

Infant Crying, Father Well-Being, and Implications for Infant Mental Health Practice

Infant crying is the most common parental concern in the first year of life, affecting approximately one in five Western infants with excessive or persistent crying (Keefe et al., 2006). The peak crying period, around six weeks of age, coincides precisely with the window in which new parents form foundational perceptions of themselves and their infant, perceptions that can persist for years (Edhborg et al., 200). Despite robust evidence linking excessive infant crying to maternal depression, reduced parenting self-efficacy, and elevated abuse risk, fathers have been largely absent from this literature.

This absence is consequential. Fathers' direct childcare involvement has increased substantially; married fathers' weekly childcare time rose from 6.9 hours in 2003–2005 to 8.3 hours in 2022–2023 (Bianchi et al., 2025), and fathers in households with children under age 6 now average 2.0 hours of primary childcare per day (Bureau of Labor Statistics, 2025). Contemporary fatherhood norms increasingly expect active, emotionally engaged caregiving from birth (Cabrera et al., 2018). Yet fathers enter this role with limited preparation, often receive ambivalent messages about their competence from co-parents (Schoppe-Sullivan & Fagan, 2020), and confront cultural scripts that equate caregiving vulnerability with inadequacy.

The stakes of this gap are serious and largely unacknowledged. Infant crying is the most consistently reported proximate trigger for abusive head trauma, including shaken baby syndrome (Barr et al., 2006), and male caregivers, most commonly fathers, are the most frequently identified perpetrators (Narang et al., 2025). These two facts appear frequently in separate literatures yet are rarely examined together: crying research centers maternal experience, while AHT research focuses on forensics. The father alone, distressed, and unable to soothe an inconsolable infant sits at this intersection, not as a framing of danger, but as a recognition of unacknowledged stress and a critical opportunity for early support.

This paper presents findings from a mixed-methods study designed to address this gap, one of the first to place fathers, rather than mothers, at the center of infant crying research. We examine how infant crying amount and fathers' perception of the crying relate to paternal depression, parenting stress, and parenting self-efficacy, and we explore qualitatively how fathers experience and cope with inconsolable infants. These findings have direct implications for how IECMH practitioners and systems can integrate fathers into early relational care.

Fathers, Infants, and the Postpartum Period

Paternal depression during the postpartum period is now well-established, with prevalence estimates ranging from 8–13% globally, substantially higher than the general male rate of 4–5% (Cameron et al., 2016; Paulson & Bazemore, 2010). Its effects on infant development, including impaired attachment and cognitive outcomes, are documented through early childhood (Sethna et al., 2018). Yet systematic screening for paternal

depression remains rare in pediatric and obstetric settings.

The transition to fatherhood presents unique stressors. New fathers often describe feeling excluded from the mother-infant dyad, struggling with identity shifts, and confronting a gap between their expectations and the reality of caring for a preverbal infant (Kowlessar et al., 2015). These strains are amplified when caring for an excessively crying, difficult-to-soothe infant. Qualitative accounts from fathers of fussy infants describe feelings of helplessness, inadequacy, and frustration—yet also profound engagement and a desire to be effective caregivers (Ellet et al., 2009; Thomson-Salo & Paul, 2022).

The limited research that has directly examined fathers of colicky* infants corroborates these concerns. de Kruijff et al. (2021), in a case-control study, found fathers of infants meeting colic criteria showed significantly elevated stress, depression, anxiety, and bonding difficulties compared to control fathers, with depression and anxiety remaining significant after adjusting for maternal distress. This represents one of the few studies to examine paternal distress in the context of infant crying directly.

The co-parent relationship adds another critical dimension to fathers' caregiving experience. Maternal gatekeeping, the degree to which mothers facilitate or restrict fathers' involvement, is linked to fathers' parenting confidence, stress, and well-being, particularly during the early infancy period (Fagan & Barnett, 2003). Co-parent lack of confidence about fathers' skills can effectively restrict fathers' participation in caregiving, narrowing their access to the parenting role before it is fully established.

Methods

A mixed-methods sequential explanatory design was used. One hundred ninety-two fathers of infants under 12 months of age completed an online survey. Participants were recruited through pediatric offices, parenting websites, and infant-focused community organizations. The sample was predominantly White (82%), college-educated, married, and middle-to-upper income, mainly from the United States (97%) representing an important limitation discussed subsequently.

Table 1. MANOVA Results for Effects of Crying Concern and Colic Criteria on Father Well-Being.

	Crying Concern		Colic Criteria	
Outcome Variable	*F*	*p*	*F*	*p*
Depression (EPDS)	11.38	.001	3.12	.079
Parenting Self-Efficacy (MSE)	6.64	.011	1.04	.309
Parenting Stress (PSI/SF)	34.52	< .001	6.64	.030

Note. Crying Concern = father-reported perception of infant crying as a problem or upsetting. Colic Criteria = infant meeting Wessel's Rule of Three (≥3 hours/day, ≥3 days/week, ≥3 weeks). No significant interaction effects were found between Crying Concern × Colic Criteria for any outcome variable. EPDS = Edinburgh Postnatal Depression Scale; MSE = Maternal Efficacy Questionnaire (adapted for fathers); PSI/SF = Parenting Stress Index–Short Form.

Quantitative measures included the Edinburgh Postnatal Depression Scale (EPDS; Cox et al., 1987), the Parenting Stress Index–Short Form (PSI/SF; Abidin, 1995), and the Maternal Efficacy Questionnaire (MEQ; Teti & Gelfand, 1991), adapted for fathers. Infant crying was assessed via two methods: (1) reported hours and minutes per day (categorized using Wessel's Rule of Three colic criteria) (Wessel et al., 1954), and (2) a single-item question asking fathers whether they found the crying to be a problem or upsetting (perceived crying concern). A Co-Parent Confidence Assessment measured fathers' perception of their co-parent's confidence in their parenting skills.

Ten fathers participated in semi-structured phone interviews about their experience of and coping with infant crying, analyzed using thematic analysis (Braun & Clarke, 2006).

Results

Sixteen percent of fathers met the EPDS cut-off score of ≥10 for depression, significantly higher than the national male average. Twenty percent of infants met Wessel's colic criteria based on father-reported crying minutes, consistent with population estimates for mother-reported data, suggesting fathers can serve as independent and reliable reporters of infant crying.

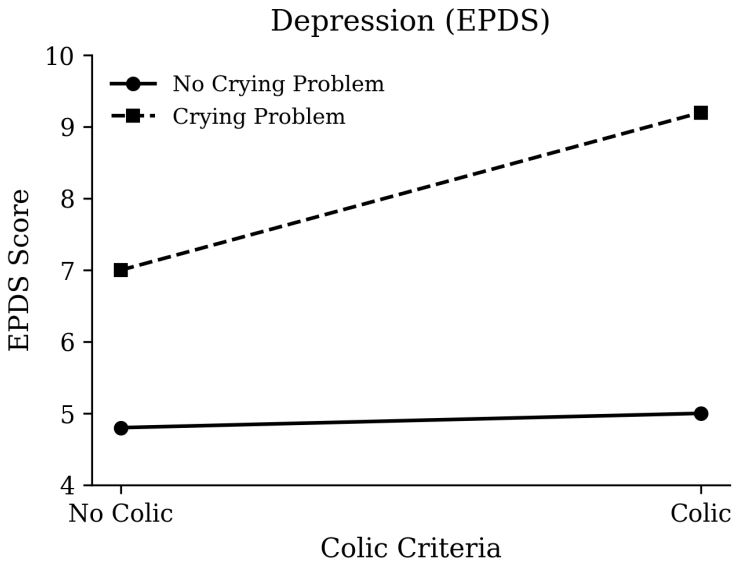

Figure 1. Profile Plots of Father Depression (EPDS) by Colic Criteria and Perceived Crying Concern.

Note. Observed means plotted by colic criteria status (x-axis) and report of crying concern (line type). Solid line = No Crying Problem; dashed line = Crying Problem. No Colic = infant did not meet Wessel's Rule of Three criteria; Colic = infant met Wessel's Rule of Three criteria (≥3 hours crying/day, ≥3 days/week, ≥3 weeks). Means are estimated from observed cell means; see Table 2 for regression statistics. EPDS = Edinburgh Postnatal Depression Scale (higher scores = greater depression).

* Terminology in this paper will use both the clinical term of colic, but also more informal descriptors such as, fussy, excessively crying, inconsolable to represent the varied and diverse terms used throughout the literature.

Thirty percent of fathers reported finding their infant's crying to be a problem or upsetting. Notably, among these fathers, over 50% did not have an infant meeting colic criteria — meaning that a significant proportion of distressed fathers would be "missed" in studies that rely solely on objective crying thresholds.

A MANOVA examining the independent and interactive effects of colic criteria and perceived crying concern on all three well-being outcomes revealed that perceived crying concern had a significant effect on depression ($F = 11.38$, $p = .001$), parenting self-efficacy ($F = 6.64$, $p = .011$), and parenting stress ($F = 34.52$, $p < .001$), while colic criteria reached significance only for parenting stress (see Table 1). Critically, there were no significant interaction effects, indicating that fathers who perceived the crying as a problem showed elevated depression and stress and reduced self-efficacy regardless of whether the reported crying met colic criteria. This pattern is illustrated in Figures 1 and 2, which display observed means for stress and depression outcome by colic criteria status and crying concern group.

Subsequent regression analyses controlling for relevant covariates confirmed these patterns (see Table 2). Perceived crying concern was a significant predictor of depression ($B = 2.39$, $p < .001$), parenting self-efficacy ($B = -2.76$, $p < .001$), and parenting stress ($B = 18.04$, $p < .001$). Colic criteria significantly predicted parenting stress ($B = 7.08$, $p = .030$) but not depression ($p = .144$) or self-efficacy ($p = .616$), indicating that fathers' subjective appraisal of the crying carries greater clinical weight than the absolute amount of crying across most well-being outcomes. Of the three regression models, the model predicting parenting stress accounted for the greatest variance, explaining 46% of PSI/SF score variability ($R^2 = .46$). Co-parent confidence was also a significant predictor across all three outcomes – lower confidence was associated with higher depression and stress and lower self-efficacy, independent of crying variables.

Qualitative interviews illuminated the lived experience behind these numbers. Three primary themes emerged:

Helplessness and loss of control. Fathers described moments during inconsolable crying when they felt close to "losing control," consistently in

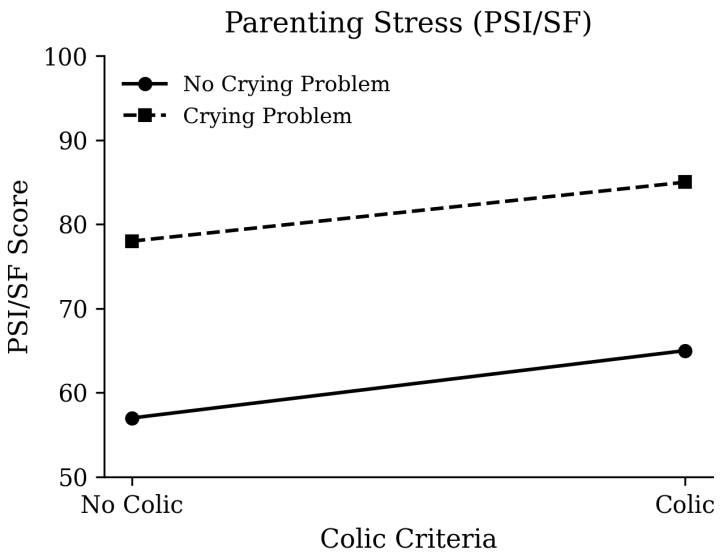

Figure 2. Profile Plots of Parenting Stress (PSI/SF) by Colic Criteria and Perceived Crying Concern.

Note. Observed means plotted by colic criteria status (x-axis) and report of crying concern (line type). Solid line = No Crying Problem; dashed line = Crying Problem. No Colic = infant did not meet Wessel's Rule of Three criteria; Colic = infant met Wessel's Rule of Three criteria (≥3 hours crying/day, ≥3 days/week, ≥3 weeks). Means are estimated from observed cell means; see Table 2 for regression statistics. PSI/SF = Parenting Stress Index–Short Form (higher scores = greater stress).

Table 2. Multiple Regression Results Predicting Father Well-Being from Crying Concern and Colic Criteria.

Outcome	*Predictor*	*B*	*SE*	*t*	*p*
Depression (EPDS) — $R^2 = .24$, $p < .001$, $N = 188$					
	Crying Concern	2.39	0.66	3.61	< .001
	Colic Criteria	1.09	0.74	1.47	.144
	Co-Parent Confidence	−0.33	0.09	−3.74	< .001
Parenting Self-Efficacy (MSE) — $R^2 = .25$, $p < .001$, $N = 181$					
	Crying Concern	−2.76	0.73	−3.78	< .001
	Colic Criteria	−0.40	0.80	−0.50	.616
	Co-Parent Confidence	0.39	0.10	3.97	< .001
Parenting Stress (PSI/SF) — $R^2 = .46$, $p < .001$, $N = 179$					
	Crying Concern	18.04	3.97	4.54	< .001
	Colic Criteria	7.08	3.23	2.19	.030
	Co-Parent Confidence	−2.12	0.41	−5.17	< .001

Note. B values are unstandardized regression coefficients. Crying Concern = father-reported perception of infant crying as a problem or upsetting. Colic Criteria = infant meeting Wessel's Rule of Three. Co-Parent Confidence = father's perception of co-parent confidence in his parenting ability. Additional covariates included in each model (father education, infant age, father involvement, infant sex, family income) are not displayed. EPDS = Edinburgh Postnatal Depression Scale; MSE = Maternal Efficacy Questionnaire (adapted for fathers); PSI/SF = Parenting Stress Index–Short Form.

scenarios where they were alone with the infant, circumstances that parallel risk profiles in abusive head trauma research (Barr et al., 2006).

Cognitive reappraisal as coping. Fathers described a deliberate two-stage process: first, reminding themselves the moment would pass or reconnecting to their identity as a loving parent; second, recognizing that the crying was not intentional, reflecting developmental need rather than relational failure. This process required basic knowledge of infant development, pointing to a clear intervention target.

The co-parent as both resource and stressor. Fathers uniformly identified their co-parent as their primary, often sole, source of support, yet co-parent dynamics also amplified stress when fathers perceived doubt about their caregiving competence.

Discussion

These findings join a growing body of evidence calling for a fundamental reorientation of IECMH practice and research: fathers are not peripheral figures in the infant crying landscape. They are present, affected, and often carrying significant distress that goes undetected and unsupported.

Specifically, these findings align with de Kruijff et al. (2021), who similarly found elevated paternal depression and anxiety independent of maternal distress. Their measure of infant crying, however, was limited to reported crying time and did not capture whether fathers found the crying problematic, a distinction the current study identifies as clinically critical.

The dominance of perception over amount is among the most clinically actionable finding in this study. Standard clinical and research approaches to identifying at-risk families rely on objective crying thresholds (e.g., colic criteria). Yet this study, consistent with more recent work (Wolke et al., 2017), demonstrates that parental perception of the crying as a problem is the stronger predictor of compromised well-being. For practitioners, this means that asking "is the crying a problem for you?" is as important as asking how many hours the infant cries. This is especially true for fathers, whose distress may be masked by social norms discouraging disclosure of vulnerability.

The co-parenting relationship represents both a risk and a protective factor that IECMH practitioners are uniquely positioned to address. Interventions that strengthen co-parent communication and explicitly validate fathers' caregiving competence may reduce gatekeeping dynamics, increase father involvement, and buffer fathers' stress responses to difficult infant behavior. Triadic and family-level approaches to early intervention are increasingly supported in the literature (Schoppe-Sullivan & Fagan, 2020) and should be standard practice rather than supplemental.

The coping strategies fathers described, particularly cognitive reappraisal grounded in infant development knowledge, offer a clear intervention pathway. Fathers who understand that their infant's persistent crying is neurobiologically driven, not a reflection of parental failure, are better equipped to regulate their own distress and remain safe, responsive caregivers. Psychoeducation about infant crying, delivered in accessible formats and through father-inclusive channels, can directly support this coping process (Kurth et al., 2022).

Depression screening must be extended to fathers as a standard component of well-child care. With 16% of fathers in this sample meeting cut-off for depression, the current maternal-only screening paradigm leaves a meaningful proportion of at-risk caregivers undetected. Legislative frameworks governing postpartum depression screening should explicitly name fathers alongside mothers. Integrating fathers into IECMH care is a clinical and public health imperative.

Limitations

The sample was predominantly White, educated, and partnered, limiting generalizability to economically marginalized fathers, single fathers, fathers from racially and ethnically diverse communities - all populations for whom the intersection of fatherhood, infant distress, and systemic barriers to support may present distinct vulnerabilities. This represents a major limitation of the study. Further, the cross-sectional design precludes causal inference, and all measures relied on father self-report at a single time point. Future research should employ longitudinal designs, objective crying measures, and inclusive recruitment strategies.

Implications for Integrating Fathers into IECMH Care

Despite increasing recognition of paternal influences on infant development, fathers remain systematically underrepresented in IECMH assessment, referral, and intervention. Together with growing evidence and these study results, we offer four practice recommendations:

Screen fathers for depression and parenting distress. Well-child visits and pediatric primary care are high-impact access points. The EPDS and PSI/SF are validated for use with fathers and should be offered routinely, particularly when excessive crying is identified or co-parent depression is detected.

Assess parental perception alongside crying amount. Clinical protocols should include standardized inquiry into whether fathers find the crying to be a problem, independent of colic criteria. Over half of fathers in this sample who were distressed about crying would have been 'missed' by objective criteria alone. These findings contributed to the development of the Infant Crying and Parent Well-Being (ICPW) screening tool (Katch & Burkhardt, 2021), since validated in a Dutch sample (de Graaf et al., 2025), offering a practical means of directly addressing crying perception in pediatric and IECMH settings.

Support the co-parent relationship as a clinical target. Assessments that include co-parenting quality and fathers' sense of inclusion and efficacy can identify relational risks early and create space to reinforce fathers' caregiving competence.

Provide father-specific psychoeducation and peer support. Programs centering infant development knowledge, particularly around crying and regulation, align with the coping strategies fathers report as effective and show promise in supporting paternal well-being.

Conclusion

The father-infant relationship and experience should be moved from the periphery to the center of both research and clinical interventions. Father perception of the crying as a problem, more than the amount of crying itself, weakens fathers' sense of themselves as competent, connected parents – in turn increasing stress and limiting the ability to self-regulate reactions to inconsolable crying. When

infants are consistently inconsolable, fathers are distressed, often deeply so, and often alone with that distress. And the co-parent relationship shapes this experience profoundly, for better and for worse.

Integrating fathers into IECMH care is imperative. Fathers who are screened, supported, and recognized as essential partners are better positioned to regulate their own distress (reducing risk of infant abuse), engage positively with their infants, and model the secure, responsive caregiving the field of infant mental health was built upon.

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Unpacking Infant Fatherhood in Alexandra Township, South Africa: Questioning Narratives of Presence, Absence and Involvement

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Photo credit: Siyanda Luzipo

Introduction

Research has linked father involvement to positive child outcomes (Nursyahbani, Munawar & Hariyanti, 2025), and fathers are increasingly viewed as integral partners in shaping early child development (Van den Berg et al, 2024). A current topic of debate is how the presence, or absence, of fathers shapes key developmental outcomes. This is a particularly salient topic in South Africa, where the 2023 Household Census revealed that 65% of children under 18 did not live with their fathers (Statistics South Africa, 2018; Ratele et al, 2012), contributing to a broader concern that South African fathers are absent, uninvolved and problematic (Ammann & Musariri, 2024; Maluleke & Moyer, 2024). Researchers have expressed doubt that the father's personal disinterest is responsible for this statistic (Hopkins & Noble, 2009). Rather, they have argued that cultural systems and structural factors, including the lingering impacts of the Apartheid system and HIV on family constellations, impact family living arrangements (Richter et al, 2010; Ratele et al, 2012). Indeed, men interviewed in South Africa indicated they were not only willing, but eager to be more involved parents for their children (Hopkins & Noble, 2009; Richter et al, 2010). Studies also show that father co-residence does not always equate with a nurturing care environment for children and it is not necessary for meaningful fatherhood involvement (Desmond and Desmond, 2006, Richter 2006, Van den Berg 2024). This raises questions about the experiences of presence, absence and involvement of fatherhood in Alexandra.

Methodology

This study explored father involvement in the first three to six months of an infant's life in Alexandra Township in Johannesburg. Alexandra is a diverse, multilingual neighbourhood that often serves as a temporary home for migrants from South Africa and other countries. Residents usually maintain strong connections with rural areas and neighbouring nations through their extended families. Here, the Ububele Educational and Psychology Trust offers a parental responsiveness programme aimed at fostering child attachment (Frost et al., 2018). Early Childhood Community Practitioners (ECCPs) - multilingual, Black residents who are mothers themselves - visit caregivers of neonates and record their observations after each visit. In these records, ECCPs also include observations of father involvement. The study received ethical clearance from both the University of Stellenbosch (N22/09/110) and Leiden University College.

A mixed-methods analysis of observations of fatherhood involvement in 40 individual families was undertaken based on the anonymised copies of these intervention notes. The visits were conducted between 2012 and 2016 – a similar timeframe to the South African Household survey. The 40 transcripts, compiled by different ECCPs over an average of 12 visits, were coded quantitatively and qualitatively. Quantitative analyses involved a count of the frequency with which the following events occurred: fathers were mentioned, fathers were physically present during the visit, and ECCPs explicitly asked about the father. Qualitative analysis focused on the nature of the father involvement.

This study also reviewed maternal reports of father involvement by 1620 home visit recipients between 2016 and 2023. Mothers were free to define father involvement, and a "yes/no" response was available. Qualitative records were not available during this time period due to a shift in reporting requirements.

The combination of data from the two record types provides an overview of father involvement between 2012 and 2023. A semi-structured interview with two ECCPs was used to triangulate the findings.

Results

Direct Mother Reports of Father Involvement

Table one shows reports of fatherhood involvement for the 1620 mothers visited by Ububele in 2016-2023. In 71% of cases, mothers reported that fathers supported the baby in some capacity after birth. Fathers aged 19 to 39 had the highest level of involvement, followed by fathers aged 40 and over (61%), and fathers aged 18 and under (46%). 71% of mothers stated that they had some form of relationship with the baby's father, indicating the father was providing emotional support, financial support, or engaging in a romantic relationship with them. Fathers aged 19 to 39 were the most likely to be involved with the mother of their babies (73%) in these capacities, compared to 57% of fathers over 40 years of age and 48% of fathers under 18 years of age.

In the 19 to 39 age range, fathers appeared to be involved with the mothers and babies at similar rates. Fathers 40 years and older were involved with the babies at higher rates than with the mothers, suggesting that some fathers remained involved with the baby despite no longer being in a relationship with the mother. Conversely, fathers aged 18 and under were involved with the mothers at higher rates than with the baby, indicating that some fathers maintained romantic relationships with the mother without having contact with the baby. Rates of involvement with the mother before and after birth appeared to remain relatively stable for fathers aged 19 to 39, while the other two age groups appeared less involved after the baby's birth.

ECCP Reports of Involvement Through Observation Transcripts

Across the 40 families, all but one transcript included references to fathers. Fathers and fatherhood were observed and discussed from the perspective of mothers and ECCPs. The extent and depth of these discussions ranged from a few words to extensive dialogue. In six of the transcripts, while the father did not live with or near the mother and baby on a permanent basis, this was not necessarily a reflection of the father's role in caring for the baby. Five transcripts indicated the father was perceived as absent. However, this absence took different forms and is discussed in more detail below.

Table 1. Rates of Father Involvement with Neonates in Alexandra Township (2016-2023).

	n	Involved with Baby (%)	Not Involved with Baby	Unknown	Involved with Mom	Not Involved with Mom	Unknown
Pre-birth	568				421(74,0)	48(8,4)	99(17.4)
18 and under					15(65,2)	4(17,4)	4(17,4)
19 to 39					386 (73,8)	42(8,0)	95(18,2)
40 and over					20 (90,9)	2 (9,1)	0 (0)
Post-birth (all)	1052	751(71,3)	89(8,5)	212(20,2)	749(71,2)	92(8,7)	211(20,1)
18 and under	52	24(46,2)	8(15,4)	20(38,5)	25(48,1)	9(17,2)	18(34,6)
19 to 39	953	698(73,2)	73(7,7)	182(19,1)	697(73,1)	73(7,7)	183(19,2)
40 and over	47	29(61,7)	8(17,0)	10(21,3)	27(57,4)	10(21,27)	10(21,27)

Father absence

Five transcripts described absent fathers. In all cases, the father was not geographically close and provided no emotional or financial support to the mother and baby. The amount of contact, however, differed substantially amongst the fathers described as absent. In one case, there was no contact with the father. In the other four cases, mothers occasionally spoke to the father or knew of their whereabouts. One transcript highlighted a gradual shift from uninvolvement to actively caring for his baby. One mother spoke to the father over the phone every week, whilst another mother was in contact with the paternal grandmother of her baby.

> 'She [paternal grandmother] then told me about the father of the child who doesn't support her. She is trying to call him and his phone doesn't work. She is so worried because he is staying too far in the Eastern Cape and she can't find him.' [23-ZM29-02-01]

Another transcript showed the father promising to return to Alexandra soon, but this was delayed several times, and the ECCP did not witness the father return. The father asked the mother for money to make the journey back to Alexandra, making this the only mention of a father being financially dependent on the mother. ECCPs often perceived the absence of the father as concerning both for the baby, who was missing a father figure, and the mother, who received considerably less support as a single parent.

Involved fathers

In 34 of the 40 transcripts, the fathers were described as involved in their babies' lives. This included both fathers who were physically present and fathers who worked elsewhere but were considered involved. The extent and depth of paternal involvement differed by family. ECCPs often distinguished between emotional and financial support. Eleven transcripts stated that the father supported the mother and baby financially, though it is possible that fathers in other families provided financial support that was not explicitly mentioned. Words such as 'involved', 'supportive', and 'caring' were used

frequently to indicate the father's attitude towards his baby and the mother, often suggesting financial support. Since the mothers were mostly still on maternity leave during the ECCP visits, they tended to rely on the fathers to provide for the babies and themselves.

> 'I [ECCP] found dad seated under an umbrella repairing shoes… while dad was busy fixing shoes, he would play and speak to baby… I felt happy finding dad repairing shoes for people, in return they pay him so that he can provide for his family as he's not working… I think mom also becomes happy seeing her husband making some money by fixing people's shoes.' [37-AN00-00-R15]

> 'Noticing [mother's] face brighten up when she talks about the father of her baby coming to visit them at the month's end. She said she misses him a lot but she doesn't have a choice as he has to work far, so that he can provide for them.' [19-KN27-07-I15]

Emotional or care support from the father was mentioned in 23 transcripts. In 13 cases, the father was present during one or more visits. The physical attendance of fathers during the visit did not reflect the extent of father involvement, as many fathers had to work during the day to provide for their families. However, the presence of the father allowed the ECCP to observe interactions between both father and baby, and father and mother. Where the fathers were present, they always interacted with their babies. They held or played with the baby and were often interested in the attachment programme, appreciating the support the ECCPs were giving to the mothers and babies.

> 'The father came in and the mother introduced him to me, he greeted me and picked up his son and covered him with a blanket.' [21-PN13-04-I15]

> 'Dad came to look at baby on the bed, baby was still asleep. I thought she would wake up but she kept on sleeping. He placed her on his lap, enjoyed looking at his baby. Baby kept on smiling during her sleep, dad also smiled' [36-KM21-08-I15]

Father involvement was also described in terms of the naming their children. In five transcripts, fathers were explicitly mentioned as providing the baby with a name.

Relationship between Father & Mother

The relationship between the father and mother was often not clearly defined. Words such as husband, boyfriend, and father were used interchangeably to describe the father of the baby. Three transcripts stated that the parents were engaged. Biological parents did not necessarily live together at the same address. Several transcripts in which father and mother did not live together clearly discussed their intimate romantic relationship. In fact, except for the fathers who did not have any contact with the mothers, there seemed to be ongoing relationships between all mothers and fathers in most transcripts, with fathers as a source of social support, particularly for mothers who migrated to Alexandra.

> 'The mother said that the most important people in her and the baby's life are her boyfriend and her children. She doesn't have close relatives, so she prefers to be with her boyfriend and kids' [33-JR21-02-01]

There were also four transcripts in which the mother discussed the father engaging in sexual relationships with other women, and a few transcripts in which this was alluded to.

> 'Asking her [mother] why does she think that her husband is having an affair, she said she doesn't know but she thinks that maybe she has one because man can't go on for that long without having sex, and still if he has a girlfriend, she won't blame him' [32-ES07-03-I15]

Some fathers had multiple partners. In one transcript, this only became clear once the mother was pregnant; in another, the mother knew but was not interested in marriage.

> 'She [mother] is not going to marry him [father] she doesn't want to be a second wife. She is going to get someone else who is not going to make her a second wife, she said that relationships are complicated when you have to share your partner and she [is done with] enough about sharing' [08-SS09-02-0]

ECCPs also wrote about mothers feeling envious of the relationship between the baby and the father. Several ECCPs noted that while fathers had been caring and loving towards the baby since birth, the father paid the mother less attention, making them feel slightly neglected.

> 'Mom said Dad is very supportive and bonds well with his son, but he's no longer focusing on her, at times she feels left out, all the love and attention goes to the baby.' [10-TH25-05-I15]

> 'With dad, he loves his father very much and sometimes she is jealous of them when they are playing and feels that she is excluded. The father does not have time anymore. When he comes back from work, he is with the baby and forgets about her.' [17-FM00-00-13]

Partnerships were not always stable. Conflicts included fighting between the mother and partner, the partner not being around during the pregnancy and the partner physically assaulting the mother. Problems related to drugs and/or alcoholism also disrupted the stability of the couple, but reports of these were an exception in the transcripts.

> '[mother] shared that she felt very angry and didn't want to be near her partner. They would constantly fight. [13-VC00-00]

Discussion

This study presents numerous accounts of involved fathers of neonates living in Alexandra, South Africa, who not only provided for their families financially but were also emotionally available and helped their partners with domestic duties and tasks. Fathers of neonates aged 19 to 39 living in Alexandra appear to be significantly involved with both infants and their mothers, although some fathers supported their partners financially and were more distant in the physical and emotional aspects of raising children. Despite a general discourse in South Africa of father absenteeism and neglect (Ratele et al, 2010), few accounts were detected in which the father played absolutely no role in the upbringing and life of their baby. The qualitative data for this study included only five cases in which fathers were absent. However, for four of the five cases of father absence, there was still some form of contact between mother and father. For the other 36 cases in which the father was present, the extent and degree of father involvement differed substantially. However, it was not uncommon for fathers to live separately from their baby and partner. Although there were many examples of caring relations within couples, the arrival of a baby sometimes appeared to strain relationships between fathers and mothers.

These findings are consistent with other reports that suggest despite perceptions of fathers as absent or uninvolved, many fathers in South Africa want to be involved and provide for their families, with this being perceived as central to manhood (van den Berg, 2024). ECCP observations highlight fathers providing financial support and engaging with their babies by holding them, playing with them, and expressing affection. The act of naming also expressed paternal responsibility, declaring that the child belonged to the extended family/lineage (Mkhize & Muthuki, 2019). These findings suggest that discourses of father uninvolvement may fail to account for South African ideas of kinship-making, which differ from Western kinship norms, and in which domestic fluidity and 'stretched households' - the care of children being distributed over an entire extended family - are present and regarded as normal (Richter et al, 2010).

Conclusion

Drawing on maternal reports and community practitioner observations, this study indicates that over 70% of fathers living in Alexandra Township were involved with both their infant and the mother of their infant. As the data covers only the babies' first weeks of life, it is not possible to reach any conclusions about longer-term paternal involvement. The fathers' own perspectives are also missing. Nonetheless, this study challenges the narrative of pervasive father absenteeism and uninvolvement in low-income contexts in South Africa, finding mother and community practitioner perceptions of relatively high rates of involvement during the neonatal period. Thus, the study raises the questions, "Is the narrative of father absenteeism in South Africa related to Western normative ideas about co-residence and couples as a primary unit in which infants are raised?" and "Are Western normative ideas of family units being equated to father involvement?" The study calls practitioners and researchers to centralize local and constantly changing conceptualisations and norms of fatherhood when evaluating and designing interventions aimed at father involvement and child development.

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AI declaration: Generative AI was used to suggest condensed versions of wieldy sentences, and to suggest a title. Every suggestion was carefully reviewed for content.

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Father Involvement in Strengthening Father-Child Relationships: Perspectives From a University-Affiliated Home Visiting Program in the United States

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Abstract

This qualitative descriptive study examined how fathers involved in fatherhood or community playgroups at a university-affiliated home visiting program in the Western United States described their roles in strengthening father-child relationships and how home visitors supported father engagement. Data were collected from 11 participants, including fathers ($n = 5$) and home visitors ($n = 6$), through focus groups and interviews. Using reflexive thematic analysis, three themes were identified: being present and intentional in father-child relationships, growing into fatherhood through reflection and change, and redefining fatherhood through navigating inclusion and support. Results highlight fathers' involvement and engagement, reflective growth, and the importance of father-inclusive, relationship-based approaches to promoting early relational health.

Keywords: father involvement, father-child interactions, father-child relationship, home visiting

Introduction

Early childhood development unfolds within caregiving relationships, where fathers' involvement strengthens father-child relationships. All domains of early development (cognitive, motor, language, communication) are embedded within social-emotional development and caregiving relationships (Brazelton Touchpoints Center, n.d.; National Scientific Council on the Developing Child, 2004; Tronick, 2007). Fathers support development through direct interaction, caregiving, provision, spiritual support, and family processes (Cabrera et al., 2018; Diniz et al., 2021). Moreover, fathering in the first 1,000 days may influence long-term relationships (Bakermans-Kranenburg et al., 2019), particularly through sensitivity, responsiveness, and structuring that support relationship quality (Bakermans-Kranenburg & van IJzendoorn, 2023; Grossmann et al., 2002). Despite barriers such as economic stress, depressive symptoms, and marginalization within child-serving systems that may hinder fathers' involvement (Roggman et al., 2002), many low-income fathers remain resilient and committed to supporting their children's development (Lee et al., 2024).

In this study, home visits refer to services in which trained home visitors work with families with young children to support family well-being, parenting goals, and access to resources (Health Resources and Services Administration [HRSA], 2026). Including fathers in home visits may strengthen family support and fathers' involvement (Guterman et al., 2018), and their engagement is shaped by home visitors' attitudes, training, supervision, and father friendly climates (Stolz & LaGraff, 2025). Work demands and program structural constraints may restrict fathers' participation (Osborne et al., 2022). Although fathers value home visiting as accessible and relationship based, they often feel under included in parenting education (Solberg et al., 2022). Supportive home visitor relationships enhance engagement, whereas limited support may marginalize fathers (Wells, 2016).

Father involvement is often conceptualized behaviorally, with growing attention to relational and reflective processes, including fathers' ability to interpret and respond to children's emotional needs. A relational mental health framework highlights reflective functioning as central to sensitive caregiving (Fonagy et al.,

2002; Slade, 2005). Attachment theory further emphasizes the importance of consistent, attuned caregiving in fostering secure caregiver–child relationships (Ainsworth et al., 1978; Bowlby, 1982). Little is known about how fathers understand their relational roles or how home visitors can support them in developing this understanding. This qualitative study examines home visitors' and fathers' perspectives on strengthening father-child interactions and relationships.

Study Purpose and Research Questions

The purpose of this study was to explore the perspectives of fathers and home visitors on father involvement within a university-affiliated home visiting program in the Western United States. Specifically, the study examined how fathers participating in fatherhood or community playgroups described their roles in strengthening relationships with their young children and how home visitors supported father engagement.

A qualitative descriptive design (Sandelowski, 2000) was employed to explore the following research questions:

1. How do fathers in a home visiting or child care program describe their role in strengthening their relationships with their young children?

   1a. What, if anything, do fathers describe as aiding them in their role to strengthen their relationships?

   1b. What challenges, if any, do fathers describe in their role to strengthen their relationships?

2. How do home visitors describe their experiences in supporting fathers in a home visiting or child care program to strengthen their relationships with their young children?

Method

Design

A qualitative descriptive design informed by Sandelowski (2000) was employed. Reflexive thematic analysis (Braun & Clarke, 2022) was used to explore the research questions using an inductive, experiential approach focusing on participants' lived experiences.

Study Setting

This study was conducted at the Child and Family Research Center (CFRC), a university-affiliated center in the Western United States. The CFRC serves families with young children by providing home visiting and child care services. Fathers in this study participated in fatherhood or community playgroups offered as part of these services, and home visitors supported father engagement in this context. Home visiting services also include correctional-setting support to help incarcerated fathers and their families maintain parent-child relationships. Home visitors described providing this support in jail; however, no incarcerated fathers participated in the father interviews or focus groups.

Participants and Data Collection

A total of 11 individuals participated in the study, including fathers (n = 5) and home visitors (n = 6). Following institutional review board approval, recruitment occurred through program-based outreach at the CFRC, a university-affiliated center in the Western United States. Eligible participants were connected to CFRC services and included: (1) fathers with a child enrolled in CFRC home visiting or child care who participated in a fatherhood or community playgroup led by home visitors, and (2) early childhood home visitors working with fathers in the program. Recruitment flyers in English and Spanish were distributed at the CFRC home visiting and child care classrooms. The second author developed semi-structured interview guides for fathers and a separate guide for home visitors, reviewed by the first author and a qualitative researcher not affiliated with the project, and the second author made minor revisions.

Data collection included two focus groups with fathers (n = 4), one semi-structured interview with a father (n = 1), and one focus group with home visitors (n = 6). The interview followed the same guide as the focus groups, and all participants used pseudonyms. Fathers discussed playgroup experiences, while home visitors described facilitating playgroups and correctional-setting visits; no incarcerated fathers participated in this study. Consent forms were provided in

Table 1. Fathers' Demographic Characteristics (N = 5).

Variable	*n*	%
Program Context		
Home Visiting	4	80.0
Child Care (Early Head Start center-based)	1	20.0
Gender		
Male	5	100.0
Race/Ethnicity		
White	2	40.0
Hispanic or Latino	2	40.0
Black or African American	1	20.0
Education		
High school diploma or GED	3	60.0
Bachelor's degree	2	40.0
Years in Home Visiting		
Less than 1 year	1	20.0
1–3 years	4	80.0
Age (years)		
Mean	40.8	
Median	36	
Standard deviation	12.6	
Minimum	29	
Maximum	62	

Note. Percentages are based on valid responses (N = 5).

English and Spanish. Fathers completed demographic surveys in English, with a Spanish translator present during focus groups. Father focus groups lasted about 40 minutes, the interview 20 minutes, and the home visitor group 90 minutes; all sessions were conducted in person and audio-recorded with participant consent using Otter.ai. After each session, participants could enter a raffle for a $25 gift card. Demographics are summarized in Table 1 (fathers) and Table 2 (home visitors).

Analysis

Data were analyzed using reflexive thematic analysis (Braun & Clarke, 2006, 2022) following the six-phase approach. The first author served as the sole coder, consistent with the interpretive nature of the reflexive thematic analysis. Cleaned Otter.ai transcripts were uploaded to Dedoose (Version 10) to support organization and coding. Analysis began with repeated reading and analytic note-taking. Inductive semantic codes captured features relevant to the research questions. Codes were iteratively reviewed, refined, and merged, resulting in 29 codes (17 father, 12 home visitor), including 11 shared across groups. Themes were developed by patterning across related codes, producing three themes. Analysis was recursive and refined for coherence and clarity.

Results

Program and professional characteristics are presented in Table 3. Descriptive data were collected from consenting fathers (n = 5) and home visitors (n = 6) through demographic and program-related survey questions completed in addition to the focus groups and interviews. Survey items addressed participants' roles, playgroup attendance or facilitation frequency, perceived playgroup helpfulness, and involvement in home visiting within correctional settings.

All fathers were connected to the fatherhood or community playgroup. Participation varied: one was enrolled but had not yet attended, one attended occasionally, and three attended sometimes. For playgroup helpfulness, response options were "not at all helpful," "somewhat helpful," "helpful," and "very helpful"; all fathers selected "helpful." Among home visitors, five were parent educators and one was a lead parent educator. Playgroup facilitation also varied: one reported never facilitating playgroups, two occasionally, one sometimes, and two regularly. Most home visitors reported jail-based home visiting support with fathers.

Table 2. Home Visitor Demographic Characteristics (N = 6).

Variable	*n*	%
Gender		
Female	6	100.0
Race/Ethnicity		
White	2	33.3
Hispanic or Latino	3	50.0
Other	1	16.7
Education		
High school diploma or GED	1	16.7
Associate degree	2	33.3
Bachelor's degree	3	50.0
Home Visitor Role		
Parent educator	5	83.3
Lead parent educator	1	16.7
Years of Experience		
Less than 1 year	1	16.7
1–3 years	1	16.7
4–6 years	2	33.3
More than 10 years	2	33.3
Playgroup Frequency		
Never	1	16.7
Occasionally	2	33.3
Sometimes	1	16.7
Regularly	2	33.3
Home Visit with Father in Jail		
Yes	5	83.3
No	1	16.7
Age (years)		
Mean	39.2	
Median	44	
Standard deviation	10.9	
Minimum	23	
Maximum	51	

Note. N = 6 participants. Percentages may not total 100 due to rounding.

The qualitative analysis generated three themes: (a) being present and intentional in father-child relationships, (b) growing into fatherhood through reflection and change, and (c) redefining fatherhood through navigating inclusion and support.

Being Present and Intentional in Father-Child Relationships

Fathers described strengthening their relationships through intentional involvement. Four fathers were enrolled in home visiting and one in a child care program, with similar descriptions of presence and engagement. Roland, a father enrolled in a home visiting program, characterized his role as "very present and active," explaining that his relationship with his daughter is built

Table 3. Program and Professional Characteristics.

Variable	*n*	%
Fathers (*N* = 5)		
Playgroup participation		
Yes	5	100.0
Playgroup frequency		
Never	1	20.0
Occasionally	1	20.0
Sometimes	3	60.0
Playgroup helpfulness		
Helpful	5	100.0
Home Visitors (*N* = 6)		
Home Visitor Role		
Parent educator	5	83.3
Lead parent educator	1	16.7
Playgroup frequency		
Never	1	16.7
Occasionally	2	33.3
Sometimes	1	16.7
Regularly	2	33.3
Home visits with Fathers in Jail		
Yes	5	83.3
No	1	16.7

Note. Percentages are based on valid responses within each group (Fathers: *N* = 5; Home Visitors: *N* = 6). Program and professional characteristics were collected through demographic and program-related questions completed in addition to the focus groups and interviews. Playgroup helpfulness response options were "not at all helpful," "somewhat helpful," "helpful," and "very helpful."

through everyday interactions such as "changing, feeding, and playing… that's how I feel close to her." Similarly, Mal, a father enrolled in a child care program, emphasized, "not being on my phone… but actually being engaged."

This presence strengthens emotional connection. David shared:

> "I make sure they know they're loved… they always have someone they can lean on. Seeing things from their perspective helps them feel connected… it brings you closer."

Home visitors reinforced this theme, observing that fathers were more engaged when intentionally included. Gel shared, "I put effort to make them feel included and invite them to participate… so they know they play an important role. Millie added, "I leave handouts for the father so both parents are learning on the same page…," noting that "when the father participates… the child behaves differently."

Growing Into Fatherhood Through Reflection and Change

Fathers described a continuous process of growth, becoming more aware of their behaviors and working to improve their parenting. Roland reflected:

> "I realized I still have a lot to learn and grow… how we were raised is so ingrained in us. I'm changing things my parents did, and I want to do things differently."

Similarly, Mal described creating a different future for his daughter, "I think my role is providing her with the lifestyle I didn't have… showing her a different life and more to life." Fathers also emphasized being positive examples. David shared, "There are many benefits to having a good dad… I'm trying to be a good example my children can look up to… a good male role model."

Home visitors described changes in fathers over time. Maria, a home visitor working with fathers in jail, shared that fathers recognize past mistakes and ingrained patterns, becoming more intentional about changing them to improve relationships with their children. Similarly, Gel observed that "the fathers get more confident… begin to feel like, 'yeah, I can do this," marking meaningful growth.

Redefining Fatherhood Through Navigating Inclusion and Support

Fathers described how fatherhood was shaped by barriers and the need to navigate supporting systems. Roland highlighted family and program-based support: "Family… and our home visitor is a very strong support for us," and noted that shared program-based activities strengthened their connection. Migs emphasized that playgroups and program activities offered meaningful opportunities for engagement. Similarly, Lui noted that the fathers' playgroup provided ongoing support.

Fathers also identified challenges, including work demands, emotional stress, and provider roles, that limited time with their children. Lui shared, "We try to make time, but we come home tired, and it's hard." Fathers also described caregiving as challenging gendered parenting roles. As one father stressed:

> "She's very connected with her mom, and I think fathers have to build that from scratch… There's this mindset that these are mom roles and these are dad roles. I can change her diaper, feed her, and put her to bed just as well as my wife can".

Home visitors described both the presence and limits of father-focused programming. Maria shared that many programs are catered to the mothers, and when opportunities for fathers are available, "they really enjoy it." Rhea added that while some services include fathers, the agency is not father specific and is working to increase fatherhood involvement.

Home visitors also described how these challenges and expectations shape fathers' roles. Kayla shared, "Many fathers work all day and miss visits, but small moments like reading or having dinner are an important part of the child's day." Sarah added, "oftentimes they are second choice… I think there is a shift to see dads as partners in parenting, but it's still ingrained in our society that men are primarily seen as the provider." Rhea also acknowledged her own bias, "I catch myself sometimes… it's more comfortable to work with mom."

Findings also highlight how home visiting programs shape fathers' engagement. Home visitors also described several program efforts used to support father involvement in the CFRC home visiting program (see Table 4). These efforts included encouraging fathers' participation in visits, supporting communication and connection for incarcerated fathers and their children, offering fatherhood or community playgroups, adapting curriculum and materials to include fathers and male caregivers, surveying fathers' interests, recognizing fathers' unique needs, and addressing family-centered topics such as nutrition, parent-child interaction, and family well-being.

Table 4. Father Involvement Efforts in the Home Visiting Program.

Effort Category	Description
Participation in Visits	Fathers were encouraged to join visits and engage in discussions on prenatal, infant, and early childhood development.
Supporting Incarcerated Fathers	Efforts supported communication and connection between incarcerated fathers and their children in the community.
Playgroups and Engagement Events	Fathers and male caregivers were encouraged to attend events, including a playgroup designed specifically for them.
Inclusive Curriculum	Curriculum and discussions were designed to include fathers and foster a sense of community.
Father-Focused Materials	Program materials were adapted to explicitly include fathers and male caregivers.
Interest Survey	Fathers and male caregivers were surveyed prior to the playgroup; 17 expressed interest.
Recognizing Unique Needs	The program acknowledged fathers' unique needs; plans for male guest speakers were not implemented within the timeline.
Program Topics	Topics included nutrition, parent–child interaction, and family well-being.

Note. Efforts reflect home visitors' reported practices to support father engagement within the CFRC home visiting program.

Discussion

This study examined father involvement among participants in fatherhood or community playgroups and how home visitors supported father engagement at a university-affiliated center in the Western United States. Specifically, it explored how fathers described their roles in strengthening relationships with their young children, the supports and challenges they encountered, and the ways home visitors facilitated father involvement. Findings highlight three themes that position father involvement as a relational and reflective process embedded within broader systems.

Redefining Fatherhood and Fathers' Roles in Strengthening Relationships

Fathers redefined fatherhood as relational and caregiving, challenging provider-focused roles. Their accounts of hands-on caregiving, emotional connection, and role modeling reflect broader shifts in father involvement (Bakermans-Kranenburg et al., 2019) while highlighting tensions in slower-to-adapt systems. Fathers described strengthening relationships with their young children through intentional, everyday engagement, including caregiving, play, and emotional presence. This aligns with multidimensional models of engagement and responsiveness (Diniz et al., 2021) with attachment theory's emphasis on attuned caregiving in fostering secure relationships (Bowlby, 1982). Fathers' attention to their child's perspective reflects Infant Mental Health (IMH) principles of attunement and co-regulation, reinforcing early relational health (Cabrera et al., 2018). Supporting fathers' strengths remains essential, given their resilience and contributions to child well-being in under-resourced contexts (Lee et al., 2024).

Fathers identified relational and structural factors shaping involvement, including support from home-visiting relationships, family, and father-inclusive activities, underscoring the importance of relationship-based services, a core IMH principle. Barriers included work demands, fatigue, and gendered expectations, with employment constraints often limiting engagement (Toluhi et al., 2023). Fathers' narratives reflected norms positioning mothers as primary caregivers, requiring fathers to assert their role. At the systems level, programs were described as largely mother-centered, consistent with research indicating parenting services often do not address fathers' needs (Wells, 2016). These findings highlight the need to address structural barriers and systemic assumptions that limit father inclusion.

Reflective Growth as a Mechanism of Change

Fathers described ongoing reflection and intentional change, including re-evaluating their upbringing and striving to parent differently. This reflects parental reflective functioning—the capacity to understand behavior in

terms of underlying mental states (Fonagy et al., 2002; Slade, 2005). Fathers' increased awareness, emotional responsiveness, and intentionality suggest reflective functioning as a key mechanism in strengthening father–child relationships. Home visitors observed similar changes, noting increased confidence and engagement over time. These findings highlight the role of IMH-informed, relationship-based practice in fostering reflective capacity. Integrating fathers into dyadic work and using reflective supervision to support providers may further strengthen these processes (Huffhines et al., 2023).

Home Visitors' Roles in Supporting Fathers

Home visitors described intentional strategies to engage fathers, including invitations, inclusive materials, and rapport building. These practices were associated with increased participation, consistent with research showing that provider attitudes and organizational support influence father engagement (Stolz & LaGraff, 2025). However, home visitors also identified challenges, including limited father-focused programming and implicit biases that may prioritize mothers. These findings underscore the importance of reflective supervision and workforce development in supporting father-inclusive practice. Such approaches can help providers examine biases, increase comfort in engaging fathers, and include them in dyadic and triadic (mother–father–child) interactions.

Limitations and Future Directions

The number of fathers in the study was small (n = 5), reflecting participation constraints such as work schedules and competing demands. Findings are situated within a single home visiting program and reflect the perspectives of fathers already engaged in services, offering in-depth insight into this context. Data were based on participants' perspectives, capturing lived experiences rather than direct observation. Future research should examine father involvement across diverse contexts and explore how father–child relationships develop over time.

Implications for Home Visiting

Findings suggest that father engagement should be conceptualized as relational and reflective, rather than solely behavioral. Programs should support fathers' reflective functioning through relationship-based approaches, including dyadic work that centers on father–child interactions and relationships. Home visiting programs should embed father-inclusive practices at structural levels, such as flexible scheduling and targeted programming. Finally, reflective supervision is essential to support home visitors in addressing biases and sustaining inclusive practice.

Conclusion

Fathers' involvement in fatherhood or community playgroups at a university-affiliated center in the Western United States demonstrated intentional engagement, reflective growth, and commitment to their children, while navigating systems that remain only partially inclusive. These findings underscore the crucial role of home visiting support in promoting father engagement. Advancing father-inclusive care requires both relational and structural change. Fully integrating fathers is a necessary step toward fostering early relational health for children and families.

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Dad's Holding the Baby: Supporting Fathers and Their Role in Infant Attachment Security, in the Context of Maternal Perinatal Severe Mental Illness

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Abstract

This paper presents findings from a systematic literature review examining fathers' experiences in the context of maternal perinatal severe mental illness (SMI), and the implications for infant mental health within a developing triadic system. The following research questions are addressed: (1) What do fathers report about their needs, experiences, and (2) their engagement (i.e. barriers and facilitators) with services? (3) What interventions are available to support father-infant relational functioning, and what is known about their impact? A systematic review was conducted using searches of PubMed, Google Scholar, Sage Journals and Semantic Scholar. Seventeen peer-reviewed studies published in English from 2000 onwards were included in the final review, and findings synthesised using thematic analysis.

Across the literature, fathers report significant psychological distress, role strain, and unmet support needs, alongside practical, interpersonal and organisational barriers to engagement. Existing provision is predominantly psychoeducational or psychosocial, with minimal evaluation of relational or infant outcomes. Notably, the father-infant relationship remains underexplored, and the infant's experience is often implicit within the literature. This review considers the findings through a relational and attachment-based framework and argues for more explicitly triadic and father-inclusive models of care that recognise fathers as attachment figures whose experiences shape the developing relational world of the infant.

Introduction

International guidance advocates for inclusive approaches to perinatal mental health care that extend beyond the mother to include partners and the wider family system (WHO, 2022). However, the specific experiences and support needs of fathers in the context of maternal perinatal SMI remain insufficiently recognised. Even in high income countries such as the UK, for example, while recommendations outline efforts and initiatives to address this (Darwin et al., 2021), significant gaps in understanding and provision persist.

Based on a systematic literature review, this paper considers fathers' experiences of maternal perinatal SMI and implications for infant mental health within a developing triadic system. The following questions were addressed (1) What do fathers report about their needs, experiences, and (2) their engagement (i.e. barriers and facilitators) with services? (3) What interventions are available to support father-infant relational functioning, and what is known about their impact?

This review builds on existing syntheses of related literature where increasing attention has been given over the past decade to fathers in the context of maternal perinatal illness. For example, Ruffell et al. (2019) systematically reviewed fathers' experiences across a broad range of maternal postnatal mental health problems, highlighting the psychological impact on fathers and their support needs. Although the father-infant relationship is acknowledged, implications for infants are not the primary focus of the review. Pegg's (2025) doctoral thesis synthesised interventions for mothers and included their impact not only on maternal outcomes, but family functioning too. The accompanying empirical study extended this relational focus by exploring the parent dyad's experiences of perinatal mental health services. However, comparatively little attention was given to the implications of fathers' experiences for infant mental health, the developing father-infant relationship and the wider mother-father-infant triad. This review aims to address this gap.

Methodology

Electronic searches were conducted in PubMed, Google Scholar, Sage Journals and Semantic Scholar using terms relating to fathers, maternal perinatal SMI, infant mental health and support interventions. An inclusive approach incorporating qualitative alongside quantitative, mixed-method and service-level studies was adopted. Empirical, peer-reviewed studies published in English from 2000

onwards were eligible if they reported father or partner specific data during the perinatal period in the context of maternal SMI. Unpublished non-empirical research, studies published prior to 2000, and non-English language publications were excluded. Studies focusing on mild to moderate mental health difficulties, experiences outside the perinatal period, paternal mental health independent of maternal or infant wellbeing, or without father-specific data were also excluded.

Sixteen studies met the inclusion criteria. One additional preliminary study was retained despite unclear peer-review status and was interpreted with caution. The final sample comprised seventeen studies: thirteen qualitative, two quantitative, one mixed-method and one service-level survey.

A narrative, integrative synthesis using thematic analysis identified recurring patterns and three themes were derived through frequency of occurrence and conceptual relevance to the research questions. They were (1) Fathers' Needs and Experiences; (2) Barriers and Facilitators to Engagement; (3) Existing Interventions.

Results

Studies frequently contributed to more than one theme. Four explored existing interventions, fourteen examined fathers' needs and experiences, and nine examined factors influencing fathers' engagement with services. This paper summarises the key findings.

Fathers' Needs and Experiences

Fourteen of the included studies examined fathers' needs and experiences, of which eleven were qualitative. Eight studies were conducted in the UK, two in India, and one each in Australia, Sweden, and Canada, with one study spanning both the UK and Australia. Six studies focussed exclusively on postpartum psychosis, potentially shaping the overall findings.

Across the literature, fathers consistently report significant psychological distress, characterised by shock, anxiety, emotional overwhelm, and the strain of navigating multiple roles and practical demands (Engqvist & Nilsson, 2011; Doucet et al., 2012; Marrs et al., 2014; Reid et al., 2016; Boddy et al., 2017). Quantitative findings reinforce these accounts. For example, Atmore et al. (2023) found that 51% of significant others scored above the clinical threshold on the GHQ-12, indicating clinically significant distress, with most receiving no formal support.

Alongside psychological distress, fathers report needing accessible information about maternal illness, treatment, recovery, and practical strategies for supporting both mother and infant (Marrs et al., 2014; Doucet et al., 2012; Ruffell et al., 2020). Reid et al. (2016) interpret such information-seeking as an attempt to restore feelings of control and reduce uncertainty, highlighting the potential emotional significance of information provision during acute illness.

Fathers also described a desire for opportunities to talk and process their experiences (Ruffell et al., 2020) and expressed preferences for both one-to-one and peer group support (Doucet et al., 2012). Holford et al. (2018) similarly found that fathers often sought informal accounts from others with similar experiences. Alongside the format of support, the timing also emerged as an important consideration. During the acute stages, fathers' attention was often directed towards their partner, their infant and immediate practical demands (Reid et al., 2016). Support needs also differed across the course of MBU admission, discharge and the post-discharge period (Ruffell et al., 2020).

The impact of maternal SMI also had important relational consequences. Couples followed divergent trajectories, with some reporting increased openness and cohesion while others described blame and rupture (Wyatt et al., 2015). Reid et al. (2016) and Marrs et al. (2014) draw explicit attention to the father-infant relationship, highlighting fathers' concerns about bonding and their peripheral positioning during MBU admission. Across the reviewed literature, however, the father-infant relationship is commonly examined in terms of what it reveals about fathers' experiences, with comparatively less attention to its significance for the developing infant. Fathers' accounts of bonding, protection and concern for the infant are consistently embedded within broader themes of paternal distress, adjustment and support needs (Boddy et al., 2017; Marrs et al., 2014; Reid et al., 2016; Ruffell et al., 2020). In an antenatal context, Frayne et al. (2014) found that nearly half of men accompanying partners with SMI to Childhood and Mental Illness (CAMI) clinics in Australia wished to parent differently from their own fathers. The authors interpreted this as reflecting that few fathers had a "strong internal working model of fatherhood" (Frayne et al., 2014:50).

The findings also suggest that where maternal care is compromised by perinatal SMI and paternal availability is uncertain, the infant's attachment landscape becomes fragile. Marrs et al. (2014:17) for example, note that fathers were "not consistently available to babies", raising the question: who is consistently psychologically available to the infant?

Barriers and Facilitators to Engagement

Nine studies examined factors influencing fathers' engagement with services. All were qualitative studies conducted in high-income countries including the UK, Canada, Sweden and Australia. Barriers included masculine norms of self-reliance and self-silencing, feelings of exclusion and marginalisation from care processes, and practical obstacles such as work and childcare responsibilities (Boddy et al., 2017; Doucet et al., 2012; Holford et al., 2018; Marrs et al., 2014; Reid et al., 2016; Ruffell et al., 2020). Facilitators of engagement included proactive enquiry, service-wide father-inclusive practices and flexible, accessible forms of support (Doucet et al., 2012; Ruffell et al., 2020; Roxburgh et al., 2025).

For example, one study found that fathers often minimised their own psychological needs, with a tendency to "be strong" and prioritise the needs of their families over their own (Doucet et al., 2012). Within the same study, fathers expressed a preference for professionals to ask directly whether support was required. Similarly, Roxburgh et al. (2025) found that fathers preferred direct enquiry from professionals, while Holford et al. (2018) reported that fathers were rarely asked about their own wellbeing. Ruffell et al. (2020) highlighted the importance of staff building trusting relationships with fathers, while Marrs et al. (2014) observed that fathers' attachment styles appeared to influence how they established communication with professionals, suggesting that engagement may be shaped by such interpersonal factors.

Additionally, fathers described feeling peripheral to care, uncertain about treatment and wanting greater involvement in clinical discussions (Boddy et al., 2017; Marrs et al., 2014). Doucet et al. (2012) similarly identified fathers feeling unheard and marginalised, while Holford et al. (2018) noted that exclusion from partner care was associated with feelings of powerlessness and uncertainty. Fathers frequently relied on family and friends for practical and emotional support, while some also sought informal peer support online (Reid et al., 2016; Holford et al., 2018). This suggests that where fathers are socially isolated or inhibited by stigma or other social barriers, accessible formal support pathways may become especially important.

Existing Interventions

Evidence relating to interventions was limited and included: one service-level survey (UK; cross-sectional questionnaire-based staff survey), one psychoeducational group (India; preliminary feasibility study with qualitative evaluation), and two papers reporting the same SMS-based programme (Australia; feasibility cohort study and post-intervention qualitative interview study). Overall, interventions were predominantly psychoeducational or psychosocial, with limited evaluation of impact or relational outcomes.

For example, Turner et al. (2017) identify widespread provision of psychosocial support targeting fathers within UK Mother and Baby Units (MBUs), including informal check-ins, telephone support, and written information. However, structured psychological interventions were less frequently reported, with a single intervention facilitated by a parent-infant psychotherapist. No outcome evaluation was included.

However, an SMS-based programme in Australia reported improvements in understanding and perceived connection with the infant. The messages used "the voice of the baby", which fathers identified as particularly impactful. For example: "I will try to communicate with you from a very early age with my face, my voice and my hands. Learn to understand my early signals dad" (Lanning et al., 2022:624). This was the only intervention explicitly targeting father-infant relational functioning, and evaluation relied solely on fathers' self-report.

Discussion

This review identified evidence regarding paternal-infant interventions, fathers' needs and experiences, and service engagement in the context of maternal perinatal SMI. While fathers report significant psychological distress, role strain, and unmet support needs, there was evidence of practical, interpersonal and organisational barriers to engagement with such support. Beyond their impact on fathers themselves, these findings raise important questions about the implications of paternal wellbeing for infant development. Baradon (2019) describes influences within the mother-father-infant triad as fundamentally multidirectional. In the context of maternal perinatal SMI, where maternal availability may be compromised, fathers' wellbeing and capacity for sensitive care may become especially significant. However, few interventions were identified that explicitly support the father-infant relationship, with most being psychoeducational and psychosocial in nature.

Only one rigorous intervention study was identified evaluating the use of the "voice of the baby" within the Australian SMS intervention, which was found to be associated with improvements in fathers' understanding of, and perceived connection with their infant (Lanning et al., 2022). By encouraging fathers to consider the infant's perspective, the intervention engages a process consistent with reflective functioning (Fonagy et al., 2002), whereby the infant is understood as a feeling and responsive subject. This may suggest value in approaches that more explicitly support fathers to reflect on caregiving, the developing father-infant relationship, and the infant's subjective experience.

The findings also point towards the significance of fathers' own internal representations and attachment histories, dimensions that may shape not only caregiving capacity but also how they relate to services and professionals. The findings can be understood through Adshead's (1998) conceptualisation of psychiatric settings as environments in which staff function as attachment figures and the service itself as a secure base. Fathers' ambivalence or withdrawal can therefore be understood as relational responses emerging within contexts of heightened stress rather than as individual resistance. Lim et al. (2023) extend this, arguing that services often implicitly blame fathers for their reluctance to engage and highlight the importance of reflective supervision to consider the 'missing father'.

Reactive service models may unintentionally reinforce masculine norms of self-silencing and reliance on paternal self-disclosure may obscure significant unmet need. This can be considered alongside Addis and Mahalik's (2003:9) proposal that "... potential help-seeking situations are contexts in which various meanings of masculinity are constructed". Their work highlights the role of services not only in responding to help seeking, but also in shaping how fathers think about help-seeking itself. Explicit signalling that services are for fathers alongside proactive invitation may support engagement and create valuable opportunities to explore the intersection of masculine norms, vulnerability and fatherhood.

International guidance advocates family-centred approaches to perinatal mental health and refers to partner screening (WHO, 2022:15). However, no evidence of routine paternal screening emerged from this review, and this suggests an important avenue for future research. The intentional development of a service-wide father-inclusive culture that supports practitioners to respond to fathers in reflective and attuned ways, may strengthen belonging, engagement, and fathers' perception of themselves as active contributors to the care of both mother and infant. Beyond empirical studies included in this review, practice within a Paris MBU admitting fathers alongside the mother-infant dyad (Chevauché and Corfdir, 2023) illustrates the potential for organising care explicitly around the triad.

Limitations

This review draws together qualitative and quantitative literature using a narrative and integrative synthesis, which is necessarily interpretive in nature. While this enables nuance across a diverse evidence base, it limits replicability and standardisation. Although systematic, the search may not have captured all relevant literature. The focus specifically on fathers, while enabling examination of gendered dimensions of caregiving and service access, may limit applicability to the wider range of family configurations in which infants are raised.

Studies are predominantly small-scale qualitative research, providing rich contextual insights but limiting generalisability. Recruitment is frequently tied to clinical services, particularly MBUs, and research focusing on postpartum psychosis is disproportionately represented. Most studies were conducted in high-income Western countries, with limited evidence from culturally diverse populations. Consequently, the influence of cultural attitudes towards fatherhood, masculinity and mental health on service engagement remains insufficiently understood. Fathers who are high-conflict, abusive, or excluded due to safeguarding concerns are largely absent from research samples, a significant gap given the established association between maternal SMI and intimate partner violence (Oram et al., 2013). The absence of longitudinal data, particularly regarding father-infant relational and infant developmental outcomes, further limits understanding of how paternal functioning and intervention impact unfold over time.

Conclusion

A consistent picture emerges from the reviewed literature. Fathers describe shock, emotional overwhelm, and the strain of simultaneously managing new parenthood alongside a partner's acute psychiatric illness, often while feeling peripheral to clinical decisions and unsupported in their own right. Despite this consistent picture of unmet need, interventions remain sparse, predominantly psychoeducational or psychosocial, and rarely evaluated in respect of father-infant relational or developmental outcomes. Fathers' engagement is shaped not only by individual help-seeking but by how services are structured, communicated and delivered, and by the extent to which fathers are actively recognised as participants in the perinatal system.

These findings support more explicitly relational and father-inclusive models of care. Proactive engagement, accessible information, flexible support, and interventions that encourage reflection on fatherhood, caregiving and the developing father-infant relationship may strengthen fathers' engagement and relational capacity. Such approaches may re-frame fathers not solely as supporters of maternal recovery or those in need of support themselves, but as attachment figures whose experiences contribute to the infant's developing relational environment.

Fathers' roles remain insufficiently conceptualised in relation to infant mental health, and this review suggests that the gap is not only empirical but conceptual. Holding mothers, fathers and infants in mind simultaneously as a triad, may represent a meaningful reorientation for both research and practice. Future work should evaluate how father-inclusive approaches influence the father-infant relationship and, ultimately, the relational world in which the infant develops.

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Integrating Fathers' Lived Experience into Neonatal Care: Q&A with a Consumer Academic

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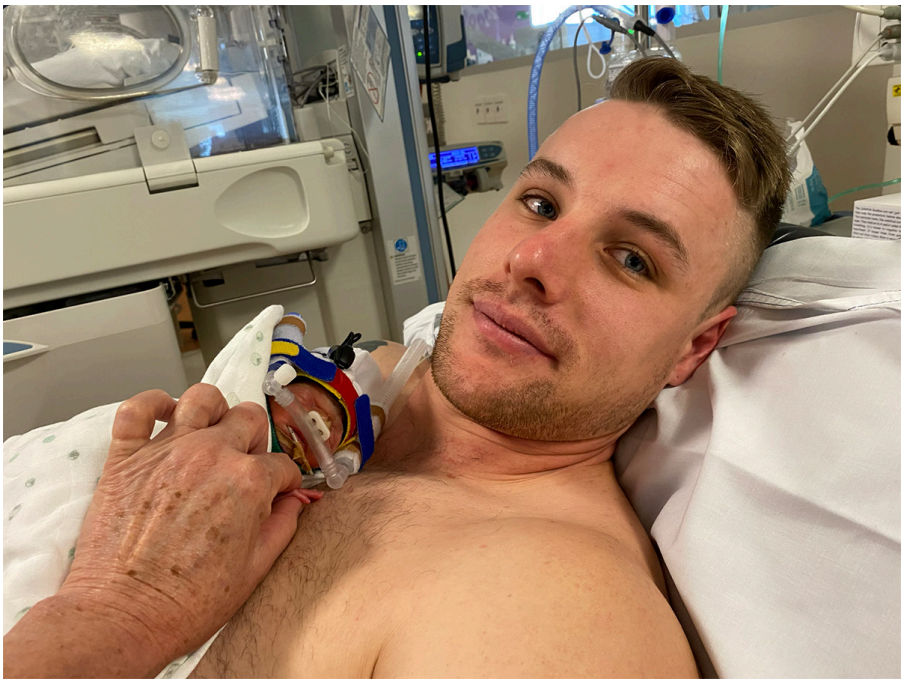

Figure 1. First time holding my first child, born at 25 weeks and 750 grams (2021). Photo credit: the Redfern family.

Admission to the neonatal intensive care unit (NICU) may disrupt the development of healthy parent–infant relationships (Givrad et al. 2021). The NICU often involves parent–infant separation and significant parental emotional distress, limiting opportunities for bonding, co-regulation, and the development of secure attachment. These challenges may persist after discharge, when parents must manage their infant's health without the support of medical staff. Consequently, a NICU admission may have long-term implications for parental and infant mental health and child development.

Contemporary models of neonatal care therefore prioritise parent-infant relationships by supporting parental wellbeing and facilitating parents' involvement in their infant's care Unfortunately, this remains poorly translated into routine care for fathers, whose involvement and support needs remain largely unmet. This gap limits efforts to maximise outcomes for the entire family unit. Supporting fathers in the NICU not only strengthens the father–infant relationship but may also benefit maternal mental health and, in turn, the mother–infant relationship during the NICU admission and after discharge (Baldoni et al. 2021).

Our research addresses this gap by co-designing an intervention to support fathers in Western Australian NICUs and facilitate greater father involvement in their infant's care. As health professionals and researchers, we recognize that fathers' lived experiences must be central to these efforts. Alongside traditional consumer engagement methods such as a steering committee, our project has benefitted from employing a father with lived NICU experience as an academic staff member (a '*consumer academic*'; Happel & Roper, 2002). The consumer academic model was developed within mental health services to facilitate meaningful consumer involvement. While traditional engagement methods provide valuable opportunities for community input, their influence is typically confined to specific activities at discrete timepoints in the research process. In contrast, consumer academics have ongoing involvement and greater decision-making power, enabling more meaningful community involvement.

In our team, this role is held by Kabe Redfern, a father with lived NICU experience. Kabe is employed on a part-time basis. He contributes across all stages of the project, particularly in stakeholder engagement, data collection and knowledge translation activities. He works under the supervision of the project lead and receives professional development support from our institute's dedicated community engagement team.

This Q&A describes Kabe's motivations for becoming a consumer academic, the contributions he has made to our project, and his advice for meaningfully engaging with fathers in the NICU setting.

What motivated you to become a consumer academic?

"I am a father of two NICU children. My first was born four months premature and spent 125 days in hospital, followed by many more months of ongoing care (Figure 1). My second was born eight weeks premature (Figure 2). Throughout these experiences, I could clearly see how fathers were not part of the system of care. The focus (understandably) centres on mother and baby, but I was there too – consumed by fear and uncertainty, whilst being the conduit of information to external family.

Prior to the discharge of my first child, my wife was screened for depression. I was not, but had they asked me the same questions, I don't think I would have been allowed to leave the hospital. In that first year after discharge and returning home, I felt lost, isolated, and unsure where to turn for help.

An unexpected outcome was our son carrying suppressed medical trauma from the NICU. Driving to follow-up appointments, he would vomit and cry from the age of one, recognising the journey. In the clinic, a closed door or donning nitrile gloves would trigger distress because at that age, those things meant something was about to happen to him.

We pushed back on six different clinicians over a 24hr period examining the same body-part with very little gain and asked that the decision-maker look once. We briefed him the night before appointments, asked what would make it more comfortable, used safe words, kept doors open, and let him set the pace. Gloves went on after an explanation directed at him. Where possible, consent came from him directly.

From these experiences, I knew I wanted to help future fathers and their families, but I wasn't sure how. When I saw a job advertisement for a research project on NICU fathers. I knew I would not meet the eligibility criteria for that specific position, the team fought to create a new position for me."

What can fathers add to infant and early childhood mental health research?

"Fathers can offer something genuinely valuable to research, especially when they're involved as more than just participants. My experience as a NICU father helped build a stronger sense of community support for our project. When other dads hear from someone like them, it breaks down barriers in a way academic language never could. This is especially important when the topic is a difficult one like the NICU. It can also shift how clinicians respond to researchers. Once they can see who shaped the research decisions and can put a face and voice to that experience their initial hesitation often gives way to more meaningful conversations. In this way, fathers can lead to richer insights that genuinely strengthen the work and outcomes for families. Additionally, as community members, fathers can also open new channels for advocacy and research dissemination that are less available to researchers. In our project, I've had the opportunity to join hospital and research consumer groups and participate in community events and media outreach, contributing not only my lived experience, but also our knowledge from our project. I also received the best Program or Service Oral Presentation at the 2026 Australian Fatherhood Research Symposium where I discussed how and why researchers and fathers can work together to solve complex child health challenges (Figure 3)."

Figure 2. Big brother meeting his new little premmie brother at the NICU (2025). Photo credit: the Redfern family.

What advice would you give to researchers or clinicians who are finding it difficult to engage with fathers?

"For researchers: Try recruiting through people and organizations who regularly engage with fathers and have their trust. In a NICU context, that includes mothers and nurses, but it could also extend to workplaces and not-for-profit organizations. Consider compensation, and allow flexibility, given that most fathers work full-time.

If you're interested in hiring a consumer academic, find what motivates a father and build from there. I knew I wanted to contribute but doubted whether I could – I don't come from a strong tertiary education background. What helped was being shown that my lived experience had real value, and being supported to grow professionally within that role. I'm currently completing a Graduate Certificate in Applied Health Management, and I've had the opportunity to attend and present at national and local academic conferences. These experiences have helped build my confidence and develop skills in research and health.

For clinicians: You must make an *active* effort to include fathers. Language is important here, and there are helpful resources available (e.g., Healthy Male 2025). You can empower fathers by simply highlighting what a present, engaged father means for the long-term wellbeing of his children and partner. Last, if a father isn't present at an appointment, follow up with a phone call, email, video consult, or an out-of-hours meeting."

To conclude, fathers are integral members of the family unit should be actively supported and engaged in infant mental health practice. This is especially important in the NICU, where parental distress and parent–infant separation may have long-term implications for parent–infant relationships. Our experience of embedding a father within the research team demonstrates the benefits of meaningful consumer engagement, with implications not only for neonatal research but also for engaging fathers in clinical practice and infant mental health research more broadly.

Figure 3. Best Oral Presentation – Australian Fatherhood Symposium, Melbourne, Victoria (2026) on the benefits of consumer partnership and father involvement. (L-R) Dr Ezra Kneebone, Mr Kabe Redfern, Dr Vincent Mancini.

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Visible but Not Legitimate: Fatherhood, Care Systems, and Early Relational Health in Latin America

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The role of fathers in infant mental health has changed - but mostly at the level of discourse, not practice. Across Latin America, fatherhood is evolving within societies shaped by a strong tradition of gendered caregiving, where women assume primary responsibility and men are providers (Herrera et al., 2018). Today, fathers are increasingly expected to be present, emotionally engaged, and involved in early care. Yet the systems that support families during the perinatal period have not kept pace. Fathers may be more visible in guidelines, research, and policy discussions - but they are seldom recognized as legitimate caregivers in everyday practice. This gap between expectation and recognition reflects a deep uncertainty about what fathers are, and what they are allowed to be, within the caregiving system. And it matters: when fathers are not recognized as caregivers, opportunities to support attachment, co-regulation, and healthy development are lost (Feldman, 2017).

There is a decisive difference between visibility and legitimacy. Across health systems and social policies, fathers occupy an ambiguous position: expected to be present, rarely equipped to be effective, and almost never treated as full partners in the caregiving project. This is not a minor oversight - it is a systemic contradiction, and it costs mothers, infants, families, and societies far more than we acknowledge.

The Discourse Has Changed. The Systems Have Not.

Ask a perinatal health professional in Latin America whether fathers matter, and the answer will probably be "of course." Yet this is often followed by a familiar explanation: fathers are not around, or not interested. Their absence is taken as evidence of disengagement rather than as a question worth examining. Even within clinical settings, fathers continue to be framed through a deficit lens — as unreliable, peripheral, or optional. Many fathers are genuinely willing to be involved, and very little is done to support them. The question is not only why fathers do not engage, but why systems do so little to engage those who would.

A different picture emerges when we examine how systems are actually designed. Was the last antenatal appointment structured to include fathers? Are fathers routinely assessed in perinatal mental health care? Do current leave policies allow men the time needed to enter caregiving meaningfully? The answers are often no. The issue may not be lack of interest - but lack of recognition and structural support.

The field is also implicitly governed by a maternal template. Fathers are expected to engage in the same ways, through the same pathways, and under the same conditions as mothers. Being a "good father" is often equated with approximating a "good mother" - which overlooks fathers' potentially distinct contributions to early caregiving (Volling & Cabrera, 2025) and sets them up for systematic misalignment with services never designed with them in mind.

This is the visibility trap. Fathers are visible enough to carry expectations - of emotional availability, active participation, of being an attachment figure - but not visible enough to receive the institutional scaffolding those expectations require. We have raised the bar without building the ladder.

Chile: A Rapid Transition Under Pressure

Chile offers a sharp illustration of this tension. Over the past two decades, Chilean society has undergone a marked shift in gender ideals, with younger fathers strongly endorsing involved, emotionally engaged caregiving. The aspiration is genuine. The structural reality is not.

Chile's paternity leave remains among the shortest in the Organisation for Economic Co-operation and Development (OECD), with a modest transferable portion of maternity leave that few fathers use, partly because workplace cultures discourage it (OECD, 2023). Perinatal services are organized around maternal care. There is no routine screening for paternal perinatal mental health, no assessment of father–infant bonding, and no standardized pathway for fathers who are struggling. What emerges is a predictable failure: systems invite fathers in ways that do not align with their realities, then

read their limited participation as confirmation of disengagement - reproducing the very exclusion they claim to address.

Involvement Is Not a Personality Trait

Policy and clinical frameworks have long treated paternal involvement as a matter of individual motivation - which is inaccurate and actively harmful. It locates the problem in men rather than in the conditions surrounding them.

The evidence is clear: paternal engagement is profoundly shaped by structural factors (Cabrera et al., 2014). Leave duration and wage replacement rates predict uptake (Patnaik, 2019). Clinical inclusion - being addressed directly, being offered services - predicts fathers' engagement with perinatal mental health systems (Darwin et al., 2021). These conditions directly shape the father–infant relationship: interaction patterns, emotional availability, and the child's developing sense of relational security (Feldman, 2017).

Unsupported fathers are fathers at risk. Paternal perinatal depression affects approximately 8% of fathers globally, with likely higher rates in vulnerable contexts and, in much of Latin America, with no available treatment options. Untreated paternal depression is associated with disrupted father–infant interaction, increased couple conflict, and elevated risk of emotional and behavioral difficulties in children (Bruno et al., 2020; Culpin et al., 2025). The cost of ignoring fathers is ultimately paid by infants. And yet: when fathers are supported as legitimate caregivers, they become active contributors to children's resilience, emotional development, and maternal wellbeing (Volling & Cabrera, 2025).

Legitimating Fathers: From Individual Practice to Systemic Change

For those working in infant mental health, the question is no longer whether fathers should be included, but how each of us promotes or hinders their inclusion. Systems are enacted daily through ordinary decisions: who is addressed in a consultation, whose experience is assessed, who is assumed not to attend. These practices accumulate into patterns of recognition - or misrecognition - that determine whether fathers can take up a legitimate place in the caregiving system.

Expanding the role of fathers requires alignment across levels: from micro-practices of care to macro-decisions by governments. A clinician who speaks directly to a father, a midwife who invites his participation, a service that measures paternal mental health - these are not marginal gestures. They are the infrastructure of change. The question is not whether this transformation is possible, but whether we are willing to recognize our role in making it cumulative.

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Making the Invisible Visible: Fathers, Infants and Video Interactive Guidance in an Irish Neonatal Context

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Neonatal units are often described in terms of technology with ventilators, monitors, survival thresholds. Yet alongside this life-saving work, another process is quietly unfolding: the formation of the earliest relationships in a child's life. For fathers, this beginning can be particularly complex.

A premature or medically fragile birth disrupts not only expectations, but identity. Fathers frequently describe a profound sense of responsibility to remain steady and support their partner. Within the neonatal unit, however, they often describe feeling like there is not much for them to do. Their infant is cared for by professionals, their partner may be recovering physically or pumping, and their own role can become uncertain. They are right there but somehow feeling peripheral.

Psychological distress among parents in neonatal care is well documented, with evidence suggesting significant levels of anxiety and emotional distress across caregivers (Tooten et al., 2012; Van Wyk et al., 2004). While considerable attention has been paid to maternal wellbeing, fathers' experiences can remain less visible often due to structural factors such as limited leave, workplace demands, and cultural expectations around emotional expression.

From an Infant and Early Childhood Mental Health perspective, this invisibility matters. Infants develop within relationships, not in isolation. Fathers are not secondary figures in this process; they are integral to the relational system through which regulation, attachment, and development emerge.

The question, then, is not whether fathers' matter but how we make their role visible, supported, and engaged within high-acuity neonatal environments? One approach that has shown promise in this context is Video Interactive Guidance (VIG). VIG is a strengths-based, video feedback intervention designed to enhance parental sensitivity and attunement. In practice, it involves filming brief moments of interaction between parent and infant, moments which could appear small or be easily overlooked, and then sharing these carefully selected clips with the parent. These clips highlight instances of connection: a pause, a glance, a shift in breathing, a moment of mutual orientation.

In neonatal care, where interactions are often fragmented by medical necessity, VIG does something deceptively simple but profound: it makes the invisible visible.

For many fathers, this moment of seeing is transformative. In the context of incubators, monitors, and clinical uncertainty, fathers may struggle to locate themselves in the relationship with their infant. They may question whether their baby recognises them, responds to them, or needs them in a meaningful way. VIG offers concrete, visual evidence that the relationship is already present. A father watches his baby turn subtly toward his voice. He sees a moment of stillness when he speaks. He notices that his baby is not passive, but responsive to him. These are often described as moments of realisation: "*My baby knows me.*"

Drawing on Stern's (2004) concept of the "present moment," these interactions can be understood as relational meetings. They are brief but powerful instances in which connection is experienced directly. In the unfamiliar and often overwhelming environment of neonatal care, such moments can anchor both parent and infant in relationship.

Clinically, the impact is twofold. First, VIG supports the infant. Research suggests improvements in dyadic synchrony, parental sensitivity, and relational quality. From a neurodevelopmental perspective, these early patterns of interaction contribute to the infant's capacity for regulation and engagement. Second and perhaps more significantly in this context VIG supports the father. By highlighting what is already working, VIG reduces performance anxiety and uncertainty. Fathers do not need to learn how to become attuned; they begin to recognise that they already are. This shift from doubt to confidence is central to the development of paternal identity, particularly in environments where traditional caregiving roles are disrupted.

In our clinical work within Children's Health Ireland, fathers frequently describe the experience of VIG as both reassuring and affirming:

"It's different from looking at photos. This shows me he's actually looking at me."

"I didn't realise he was responding like that."

"It makes me feel like I'm doing something right."

These reflections point to a broader relational theme: fathers are not disengaged; they are often unseen. VIG offers a structured and intentional way of bringing fathers into focus as relational partners. It provides a language that is both visual and emotional through which connection can be recognised and strengthened.

In the Irish context, this work sits within a healthcare system that is increasingly oriented toward family-integrated care. As Ireland moves toward the development of a new national children's hospital, the clinical psychology team see this as an opportunity to embed relational interventions such as VIG more systematically within neonatal services. Innovations such as remote or hybrid VIG delivery may also extend access to fathers who are unable to be physically present due to work or geographical constraints.

The inclusion of fathers in neonatal care is not an optional enhancement; it is a clinical and developmental necessity. VIG represents one way of addressing this. It does not introduce something new into the parent-infant relationship but instead reveals what is already there. In doing so, it challenges a longstanding assumption within high-acuity medical environments: that survival and relationship are separate processes. They are not.

Even within an incubator, a relationship is forming. Even in the presence of machines, communication is taking place. Even in uncertainty, connection exists. When fathers are supported to see this, they begin to see themselves differently - not as observers or supporters at the edge of care, but as central figures in their infant's emotional world.

Making this visible is not simply good practice. It is foundational to Infant Mental Health.

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Centering Black Fathers: Illuminating Their Contributions to Infant Mental Health

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Abstract

Infant mental health (IECMH) emphasizes the importance of early relationships in shaping lifelong wellbeing, yet Black fathers remain largely absent from research, policy, and practice frameworks that support young children and families. This paper examines the historical and structural factors that have contributed to the marginalization of Black fathers within IMH, arguing that their exclusion is often mischaracterized as disengagement rather than understood as the result of systemic barriers. Drawing on scholarship related to Black fatherhood, attachment, racial socialization, and relational health, we highlight the strengths and contributions of Black fathers to infant and early childhood development. We further explore how racism, economic marginalization, and father-excluding policies continue to shape fathers' opportunities for engagement. We conclude by offering recommendations for systems change, policy reform, workforce development, and accountability structures that more fully recognize and support Black fathers as essential partners in infant and early childhood mental health.

Introduction

In infant and early childhood mental health (IECMH), early relationships are understood as the foundation of lifelong wellbeing. Yet, the field has not fully addressed a central question: who has been structurally positioned to participate in those relationships? For Black fathers in the United States, absence in early childhood systems is often framed as individual disengagement rather than the predictable outcome of systemic exclusion. Situating U.S. fatherhood within its historical context is critical. The legacy of chattel slavery disrupted Black family formation by legally severing paternal ties and normalizing forced separation (Johnson & Staples, 2004). This differs from other systems of labor exploitation, such as indentured servitude, where family structures, while constrained, were not erased in the same totalizing way. Although the specific historical conditions vary globally, paternal exclusion from family-serving systems, structural inequities, and culturally shaped expectations of fatherhood are evident across many global contexts (Ball, 2012). Fathers in marginalized communities worldwide often encounter policies and services that privilege maternal caregiving, limiting recognition of their caregiving roles and contributions. These histories continue to shape the meanings of fatherhood, presence, and protection and underscore the need for IECMH approaches that are responsive to the cultural and historical realities of families across diverse contexts.

Across generations, policies have structured how Black fatherhood is enacted and perceived. "Man-in-the-house" rules penalized families for the presence of an adult male, discouraging fathers' involvement. Contemporary programs, such as Women, Infants, and Children (WIC), continue to center mothers as primary participants, rendering fathers peripheral. These designs are not neutral; they signal who belongs. Black fathers navigate parenting while carrying histories shaped by structural racism (Keefe et al., 2017), including incarceration and economic marginalization. To center fathers in IECMH, we must move beyond questions of engagement to examine the conditions that constrain it. Black fathers are not missing; they have been navigating systems that have failed to see or support them.

Black Fathers' Lived Experiences and Relational Health

Research suggests that Black fathers are actively engaged in their children's lives, though their involvement is often underrepresented in mainstream social science. They engage in behaviors that support attachment security, including play and monitoring (Tyrell & Masten, 2022), and are highly involved

in nurturing and caregiving (Leavell et al., 2012). However, these practices are not always recognized within dominant parenting frameworks, which often fail to account for cultural context and the impact of racism.

For example, generative parenting among Black fathers includes emotional honesty, creating space for a range of emotional expression within the father–child relationship (Mattis et al., 2021; Brown et al., 2025). Black fathers may adopt such approaches earlier as a response to lived experiences and a desire to prepare their children to navigate racism (Dunbar et al., 2017). These findings highlight a disconnect between dominant research frameworks and lived experience, and point to how systems informed by these frameworks fail to recognize the full scope of father engagement.

Black fathers' experiences of marginalization also shape the conditions under which parenting occurs. Racism constrains the ability to consistently enact a secure base, not because of individual deficits, but due to chronic stress and structural inequities (Tyrell & Masten, 2022). While the home is often a site of emotional safety (Labella, 2018), racial discrimination can tax the psychological resources needed to support children's emotional regulation. In this context, parenting responses that may be mischaracterized within dominant frameworks can function as adaptive strategies to prepare children for racialized environments (Dunbar et al., 2017). Thus, Black fathers' parenting practices must be understood within the context of structural racism, rather than deficit-based interpretations.

Dismantling Exclusion in Practice and Systems

Addressing the exclusion of Black fathers in IECMH requires more than inviting their participation; it demands dismantling systems that have historically positioned them at the margins. IECMH programs should create father-centered spaces informed by qualitative input from fathers themselves, particularly racially marginalized fathers, to ensure services reflect their experiences, strengths, and needs. Workforce development standards and professional competencies should also include training on fatherhood, paternal mental health, and the historical and structural barriers that shape fathers' engagement with services. Program design must attend to how systems signal belonging. For example, the WIC program explicitly names women as primary recipients, reinforcing a maternal framing of care that can render fathers peripheral, while maternal and child health systems have often overlooked paternal health and well-being. Such policies communicate who is expected to participate and whose needs are prioritized. Father inclusion cannot be performative. It must be embedded in organizational policies, workforce competencies, funding priorities, and accountability measures as a core component of IECMH. When systems are structured in this way, they more accurately reflect the full ecology of care that supports young children's development (Cabrera et al., 2014).

Conclusion

If IECMH is to truly center relationships, it must contend with the systems that have defined whose relationships are recognized and sustained. Efforts to include fathers will fall short without addressing the historical and ongoing exclusion shaping Black fatherhood.

This requires a shift in both lens and practice. Rather than asking why fathers are not engaged, the field must ask how systems make engagement difficult or invisible. Programs must be designed with fathers as essential partners, not afterthoughts. Reframing fatherhood in IECMH is not simply about inclusion. It is about redressing a legacy of exclusion and building systems that reflect the full relational realities of families. This requires intentional action across research, policy, and practice. Black fathers have always been part of the story. It is time for our systems to reflect that truth.

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Ghosts, Angels, and Algorithms in the Nursery: When Reflection Is Replaced by Answers

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The Limits of Looking Backward

The question, "Did you have a father growing up?" has become a familiar entry point for understanding men's experiences of fatherhood. Rooted in the seminal work of Selma Fraiberg (Fraiberg et al, 1975) and later expanded by Alicia Lieberman and colleagues (Lieberman et al, 2005), this perspective recognizes that fathers, like all parents, bring forward internalized relational experiences that influence how they perceive, interpret, and respond to their infants. Ghosts and angels alike shape expectations, emotional responses, and caregiving long before a father ever holds his baby. These intergenerational perspectives remain foundational to infant mental health. However, they primarily explain how fathers arrive at parenthood. They offer less guidance for understanding the relational and developmental conditions that continue shaping fathers after their child is born. This paper proposes a conceptual framework informed by infant mental health theory, fatherhood literature, clinical practice, and emerging evidence regarding digital environments.

Becoming a father is not a single event. It is an ongoing developmental process through which fathers gradually develop both a relationship with their infant and a new paternal identity (patrescence) (Leanderz et al., 2025; Svendsrud et al., 2023). These processes are inseparable and bidirectional. Fathers come to know their infants through repeated experiences of observation, uncertainty, interaction, reflection, mismatch, repair, and discovery (Dinzinger et al., 2023; Johnson et al., 2023; Mora et al., 2023). Through those same experiences, they begin discovering themselves as fathers while constructing their paternal identity. This developmental process unfolds within a relational ecology that both supports and constrains development. Today, that ecology has changed. Contemporary fathers are developing within environments profoundly different from those in which the concepts of ghosts and angels were first described. While early relational histories remain deeply influential, fathers now navigate an unprecedented informational landscape where social media, parenting platforms, artificial intelligence, commercial technologies, and algorithmically curated content increasingly influence how fathers seek knowledge, develop confidence and reflective capacity, construct paternal identity, evaluate themselves, and understand what it means to be a "good father" (Levante et al., 2025; Mora et al., 2023).

The central concern of this paper is not technology itself. Digital resources can increase access to information, reduce isolation, and extend support to fathers who might otherwise have limited opportunities for connection (Fletcher et al, 2017; Frey et al., 2023). Rather, this paper proposes that when externally generated answers begin displacing the developmental work through which fathers come to know their infants, develop confidence, construct paternal identity, and participate in the reciprocal processes that organize early relationships, the relational ecology of fatherhood may be fundamentally altered. Information can enrich caregiving. It cannot substitute for the developmental work of becoming and being a father. This paper explores that proposition and considers its implications for fathers, infants, families, and the early relational health that emerges between them.

The Relational Ecology of Fatherhood

Fatherhood develops within a relational ecology. This ecology includes the biological, interpersonal, institutional, cultural, and increasingly digital conditions that shape fathers' opportunities to connect with, learn from, and develop a relationship with their infants. It is within this ecology that fathers gradually develop paternal identity, confidence, and the capacity to understand and respond to their infant's unique cues and communications. For the purposes of this paper, relational ecology refers to the external conditions surrounding fatherhood, while relational developmental processes refer to the internal developmental work through which fathers become fathers (Mora et al., 2023; Wendelboe et al., 2022). These processes include observation, reflection, meaning-making, relationship formation, confidence, tolerance of uncertainty, mutual influence, serve-and-return, mismatch and repair, and father-infant co-development. Together, these external conditions and internal developmental processes create the developmental container within which fathers, infants, and families grow together.

One increasingly influential component of this relational ecology is the digital environment (Mertens et al., 2024). Social media platforms, parenting applications, artificial intelligence, online communities, commercial products, and algorithmically curated content have become common sources of guidance for many fathers. Rather than existing outside the developmental process, these informational influences now form part of the ecology within which fatherhood develops. Technology is not inherently problematic (McDaniel & Radesky, 2018; McDaniel, 2020). When intentionally designed, digital interventions can increase fathers' access to information, reduce isolation, and strengthen relational engagement. Emerging work, including father-focused digital interventions developed by Dr. Richard Fletcher and colleagues (2017), demonstrates that technology can effectively engage fathers and support relational development when designed with developmental intent. However, these structured interventions differ substantially from the broader digital environments in which most fathers seek guidance. Outside of research-informed applications, parenting content is often fragmented, commercially driven, and embedded within algorithmic systems that prioritize visibility, engagement, and monetization (Chalaganidze & Tsotniashvili, 2026; Guess et al., 2023). Within these environments, the uncertainty inherent in becoming a parent can become a point of entry for commercial products and advice promising clarity, certainty, or improvement. When lived experience differs from these promised outcomes, fathers may become less confident in their own observations and begin questioning either their own competence or their infant's behavior, rather than returning to careful observation of their unique relational developmental experience with their infant. The promise of certainty, therefore, may inadvertently shift fathers' attention away from the infant before them and toward whether they have correctly followed the externally generated answer. Within this context, a subtle but significant shift occurs. The developmental work of becoming a father may gradually shift from observation, interaction, and relational discovery toward externally guided answer-seeking. Rather than asking, "What might be happening with my infant?" fathers may be encouraged, implicitly or explicitly, to ask, "According to this digital source, what is the correct response?" This shift risks collapsing the relational developmental processes through which parents come to understand their children, replacing them with externally generated answers that may not align with the specific relational or developmental context.

Protecting the Relational Developmental Process

The developmental work of becoming a father has always depended upon relationships. Fathers observed their infants, interpreted their cues, made mistakes, repaired those mistakes, sought guidance from trusted others, and gradually developed confidence through lived experience. In doing so, they developed essential skills such as problem solving, critical thinking, reflective capacity, emotional attunement, and flexibility. This developmental work often unfolded despite significant social, cultural, and structural barriers that limited fathers' opportunities for engagement, making these relational learning processes both hard-won and deeply formative. Today's digital environment offers something fundamentally different (McDaniel, 2020). Rather than requiring fathers to remain with uncertainty long enough for observation and reflection to unfold, digital technologies increasingly provide immediate answers, popular recommendations, and algorithmically curated content. These resources are often efficient, accessible, and helpful. Yet they may also shorten or bypass developmental processes that contribute to paternal identity, increasing confidence, and relationship formation, and in doing so may overlook the child's specific needs in that moment by offering generalized guidance that does not fully account for the infant's individual, situational, sensorial, or temperamental conditions.

The concern is not that fathers have access to information. Information has always been an essential component of parenting. The concern is that information may begin to take precedence over the bidirectional relational processes through which development occurs. When easy answers become more highly valued than curiosity, when recommendations replace observation, or when algorithms become more influential than the infant's own communications, fathers may have fewer opportunities to develop confidence as well as engage in the dynamic serve-and-return interactions that are necessary for early relational health through direct relationship with their child. The earliest months of life represent a uniquely sensitive period for both infants and fathers. As infants integrate their expectations of relationships, fathers are simultaneously formulating and organizing their understanding of themselves as fathers. During this period, relational experiences are not simply sources of information. They are the developmental medium through which attachment, confidence, identity, and reciprocal influence emerge.

Repositioning Technology Within Early Relational Health

Digital technologies are now woven into the fabric of contemporary family life and will undoubtedly continue shaping the experiences of fathers and families (McDaniel, 2020). The question, therefore, is not whether technology should be used, but how it can best support early relational health without displacing the developmental work of becoming and being a father. When technology directs fathers back toward their infants, encourages observation before action, supports curiosity rather than certainty, strengthens relationships, or reduces barriers to meaningful participation, it may serve as a valuable extension of early relational practice. Conversely, when technology becomes a simplified solution or one-dimensional answer that overlooks the complexity of individual contexts and encourages mindless decision-making, or privileges efficiency over relationship, opportunities for relational development may gradually diminish. From an infant mental health perspective, the goal is not to replace technology with relationship, but to ensure that technology remains in service of relationship. Information can enrich caregiving. It cannot replace the developmental experiences through which fathers, infants, and families come to know one another.

The propositions advanced in this paper are intended as a conceptual framework to stimulate discussion and future empirical investigation. Research examining paternal reflective functioning, digital parenting practices, and father-infant relationship development will be important

for evaluating and refining these theoretical propositions. Ultimately, the concern raised here is not technology itself, but the possibility that technology may subtly change the reference point from which fathers come to know themselves and their infants. Infant mental health has long emphasized that relationships are the primary context for development. As digital environments continue to evolve, our challenge is not to reject technology, but to ensure that it remains in service of, rather than in place of, those relationships.

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The 'Provider Paradox': What do Masculine Norms Mean for Engaging Fathers as Part of Infant Mental Health Scholarship and Practice?

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For parents, gender role norms do more than describe how mothers and fathers tend to raise their children. They also prescribe what is *expected* of each role and, by extension, which behaviours fall short of these expectations. This opinion piece explores the intersection of masculine norms with fatherhood and its implications for infant mental health. In doing so, I propose a paradox central to father engagement, pose two key questions for the field, and highlight three observations on how current scholarship and practice navigate the role of masculine norms in shaping men's involvement with their baby, their partner, and the systems that support them.

Interest and enthusiasm regarding the role of fathers in shaping the health and development of their infants has expanded both inside and outside of academia, and particularly (though not exclusively) throughout industrialized and Western Nations. The sentiment that *fathers matter* when it comes to infant mental health has been, in part, brought on by social progress contributing to greater gender equity in parenting roles and responsibilities. This parallels the growing field of *fatherhood science*, with studies highlighting the important contributions that male caregivers make in shaping infant health. This includes research that suggests potentially distinct patterns of father-infant attachment and bonding that (on average) differ from mother-infant patterns (Grossmann et al., 2002; Paquette, 2004), links between paternal mental wellbeing and infant health (Le Bas et al., 2025), and the capacity for healthy father-infant bonds to improve relational functioning and the mother-infant relationship (Martin & Brock, 2023). Not only do fathers matter, but science suggests that they *matter from the start* (Cardenas et al., 2022).

Masculine norms are thought to represent one of the key mechanisms that contextualise beliefs and behaviours about fatherhood. Research that has explored the intersection of masculine norms with infant and child development has historically relied on restrictive and deficit-based conceptualisations that have dominated scholarship for over three decades (Fisher et al., 2025). Within this broader constellation of traditional 'hegemonic' masculine traits that also include dimensions such as misogyny and risk-taking, those that are most frequently linked to maladaptive parenting outcomes tend to be those characterised by the restriction of emotion and a reluctance to express vulnerability or seek support (Cherry & Gerstein, 2021). These traits are not all-encompassing of masculinity, and instead reflect a combination of cultural, social, and economic factors that then became the subject of several decades of work due to their relevance to poor mental health outcomes amongst men (Mahalik et al., 2003). Relatedly, many of the prototypically masculine qualities that may be prosocial (e.g., courage, or standing up for those who are vulnerable), or be seen as compatible with high-quality fathering, are only now beginning to be examined in closer detail (Segev, 2025). This distinction alone is crucial – as it is not masculinity as a global construction that is inherently problematic for the father-infant relationship.

Adding to this nuance is the perspective that *certain* masculine qualities may be adaptive at times. Consider the career-driven father who prioritises his career and is rarely present at home, but in doing so, lifts his family from poverty and provides resources that benefit his infant's development. Can we say that this masculine behaviour is certainly detrimental to infant health and wellbeing? Whether this serves his infant will depend on other factors, including how this influences his relationships and own wellbeing. Thus, what emerges is not a case against masculinity, but a case for masculine *flexibility*, where the capacity for fathers to adapt how masculinity is performed across contexts may matter more than whether any given trait is immediately beneficial or harmful.

In my work, I often notice how the masculine norms that place fathers at greatest risk of developing poor attachment relationships with their infants are the same norms that make those fathers hardest to reach, least likely to disclose distress, and most likely to be overlooked by systems not designed with them in mind – a term I refer to as the '*provider paradox*'. Here, '*provider*' means more than breadwinner: it typifies the narrow and gendered expectation that a father's job is to earn, protect, and endure without complaint. The '*paradox*' is that fulfilling

this role well, by staying strong, self-reliant, and uncomplaining, is precisely what renders him hard to reach and easy to overlook in the development and delivery of supports and services. Services then tend to calibrate to the families (and fathers) who do attend, widening the distance to the fathers who do not or cannot. It is because of this irony that we, as infant mental health scholars and practitioners, must continue to hold these men in mind.

Framing parenting behaviours as a matter of individual choice obscures the role of systemic social and structural forces, and by doing so, limits the capacity of systems to respond adequately to the problems they seek to address (Robinson et al., 2026). Masculine norms typify one of these social forces. Thus, when systems fail to account for their influence, the risk is that a father's reluctance to engage or participate is perceived as individual disinterest rather than as a predictable response to structures that were never designed to include him.

To that end, I propose two rhetorical questions:

1. *If men are socialised to suppress emotion, conceal vulnerability, and to restrict their contributions as parents to breadwinning, then is it any wonder that health systems designed around maternal care and involvement have consistently struggled to reach and support them?*
2. *If so, what are the consequences of continuing to design infant mental health care where fathers are incidental to it, for men, women, and their infants?*

To assume that fathers will independently relinquish gendered expectations that shape how they 'should' care for their babies, without any corresponding shifts in the systems around them, is, at best, idealistic and, at worst, irresponsible. However, systems can and do change in ways that promote paternal involvement. For example, father presence at birth, once remarkable, is now an embedded norm in many countries. The known benefits of these changes highlight what is possible when infant systems are designed with fathers in mind.

The observations that follow describe strategies that may enable the field to better involve fathers, and to navigate this 'provider paradox'.

Observation 1: Places and spaces that meet men where they are. Dedicated opportunities for men to engage with professionals and connect with their fellow fathers can improve engagement, especially amongst men who might otherwise be reluctant to express vulnerability in mixed-gender settings. These efforts must not be seen as a way to isolate fathers from their different-gendered coparents, but instead as a new way to provide support to men who may otherwise go without it, and that may work to scaffold their confidence to participate in future initiatives involving their partner and other parents.

Observation 2: Reflecting (and improving) on our own beliefs about father involvement. Scholars and practitioners also possess their own gendered beliefs about masculinity and fatherhood. Our own presumptions about what fathers are willing or able to offer their infants will also inevitably their interactions with the system and is therefore also worthy of inspection.

Observation 3: Using the 'f-word' *(fathers)*. The use of gender-neutral language such as "caregivers" in infant health policy and practice is, still, often perceived by fathers as synonymous for mothers (Leach et al., 2019). This phenomenon is crucial. Too often, services and studies that move toward more gender-neutral terminology may find themselves continuing to engage with mostly maternal clientele, potentially falling into the trap that fathers remain disinterested in participating. Naming "*fathers*" makes paternal involvement visible, reduces ambiguity about men's roles, removes their implicit permission to disengage, and can invite initiatives that target fathers. Importantly, it is possible for this to coexist with language that remains affirming to diverse family structures and caregiving arrangements. For example, a service or study may include father-specific, mother-specific, other gender specific, and gender-neutral recruitment material.

Restrictive and deficit-based constructions of masculinity that once dominated scholarship are now contrasted against strengths-based frameworks. These provide an expansive understanding of "*masculinity*" that repositions paternal warmth and affection as distinctly masculine expressions of care. This reframing carries implications for how we can engage fathers caught up in this '*provider paradox*'.

Involving fathers in the care of their infants need not be framed as an attempt to strip them of their masculine identity, but instead to expand it by positioning nurturing and caregiving as something a man does precisely *because* of who he is, not *despite* it.

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The Absent Father in Mexican Culture: Cultural Representations and Implications for Child Development

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> Machismo represents masculine power in life. The phrase "I am your father" carries no paternal meaning, nor is it said to protect, safeguard, or guide, but rather to impose superiority; that is, to prevail…
>
> — Octavio Paz (1950/2021), *The Labyrinth of Solitude*

> I cannot think of any need in childhood as strong as the need for a father's protection.
>
> — Freud (1930 [1929])

Winnicott (1969) described the father as fulfilling two essential functions. As an environmental father, he protects the environment in which the infant develops; as an object father, he gradually becomes a distinct figure with whom the child forms his or her own emotional bonds. In this sense, cultural representations of fatherhood become part of the symbolic world through which children develop their earliest ideas about fathers, contributing to personality integration.

When a woman must shoulder alone the economic, practical, and emotional demands associated with the birth of a child, the risk of exhaustion, hopelessness, and depression increases. The father's emotional or material absence deprives the mother of an important source of support, potentially affecting her capacity to provide the care necessary for the child's early development.

The attributes that characterize the Mexican father, in songs, film, and painting—that is, in popular culture—have been associated with irresponsible behavior toward life, women, and children.

Consider the song Juan Charrasqueado (Cordero, 1945), where the character is portrayed as a "drunk, reveler, and gambler," as well as promiscuous: "he took the most beautiful women… in those fields not even a flower remained." The film based on this same story further reinforces these traits, adding scenes in which the protagonist appears drunk and maintains a devalued view of women, particularly when they are no longer considered "virgins."

Alongside this folk song, there is also the work of the so-called "children's singer," Cri-Cri, the Singing Cricket, with the song La Patita (Gabilondo Soler, 1963), which describes the hardships of a mother who must go to the market to buy food for her ducklings. The lyrics describe how the little duck searches for "pennies" in her purse, while the father duck is described as lazy and idle, contributing nothing to family sustenance. In this way, the image of an absent or irresponsible father is reinforced.

Similarly, there are nursery rhymes that babies clap along to, which reproduce the same idea: "Little lard tortilla, for mother who breastfeeds," and "Little barley tortilla, for father who gives nothing."

Similar representations can also be found in Mexican painting, where women frequently appear as the central figures of care and support within the family. Passed down from generation to generation, these cultural images contribute to the normalization of paternal absence and become part of the symbolic environment in which children begin to form their earliest relational experiences.

Recent data on caregiving in Mexico reveal a persistent gender imbalance, reinforcing the cultural expectation that mothers are primarily responsible for child-rearing and daily caregiving tasks, while fathers play a more limited role in these activities (INEGI, 2023). As a result, responsibilities related to care, feeding, and socialization continue to fall predominantly on mothers, perpetuating the cultural image of the absent father and the centrality of the mother in children's daily lives, while also sustaining the infant's perception of maternal omnipotence.

Moreover, accompanying women in the care of babies or children has culturally been associated with a supposed feminization of men, which has contributed to the perpetuation of limited paternal participation in childrearing. However, it is important to note that these practices are socially sustained by both women and men, as they form part of deeply rooted beliefs within the cultural imagination.

One example can be observed in situations of family conflict or separation, where mothers may conceal the father's identity from their children or openly devalue him. These experiences of paternal abandonment may be associated with early depressive states, difficulties in self-integration, and disturbances in emotional development.

It is not coincidental that one of the most influential works of Mexican literature, Pedro Páramo (Rulfo, 1955), portrays a protagonist who, along with others in similar circumstances, seeks his father to demand what he did not receive in life.

In clinical practice, it is common to encounter young children struggling to make sense of paternal absence. Through play, drawings, and direct questions, they attempt to understand why their father is not present. Explanations often emerge that are marked by guilt or fantasies of loss: "My dad left because he didn't love me," "Maybe I did something wrong," or "Maybe he died and that's why he's not here." Such narratives reflect children's efforts to give meaning to an absence that often exceeds both their emotional and cognitive capacities.

In some cases, a mother's resentment toward the father who abandoned the relationship may influence the image the child develops of that figure. When unresolved conflict with the absent parent is displaced onto the child born from that relationship, additional difficulties may arise in the integration of important aspects of identity and personal history.

Paternal absence is also evident in contemporary social phenomena such as migration, where mothers frequently remain responsible for raising children while fathers are physically absent. In these circumstances, fathers themselves often face significant hardships, including displacement, economic insecurity, physical and emotional risks, humiliation, and, at times, the formation of new families, all of which add complexity to family relationships.

Within this context, it becomes necessary to encourage literary, musical, and artistic productions that promote the image of a protective father committed to childrearing and emotional support of his partner.

Fortunately, in the legal sphere, recent years have seen the emergence of laws that sanction parents who fail to provide child support, as well as Supreme Court rulings recognizing the right of minors to know their biological identity. Nevertheless, these measures are insufficient if they are not accompanied by a cultural transformation that encourages fathers' loving commitment and active participation in their children's lives.

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Who Gets to Care? Reflections on the Absence of Men in Early Childhood Settings

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The field of infant and early childhood mental health is grounded in the understanding that healthy relationships between young children and their caregivers provide the foundation for lifelong development. Over the past several decades, the field has made advances in recognizing and supporting fathers as essential contributors to children's healthy development. At the same time, comparatively little attention has been given to welcoming men as caregivers and professionals within the systems that serve infants, young children and their families. The striking absence of male caregivers across early childhood services is evident in countries throughout the world and invites reflection on how our assumptions about caregiving shape the environments we create for children.

Kyle Pruett (Pruett 2000; & Pruett, 2020) a scholar and advocate for father involvement with infants and young children stated, "fathers do not mother and mothers do not father". He contrasted how fathers play, interact and nurture that varies from the ways that mothers approach these activities. Michael Lamb (Lamb, 2010) elaborated the how fathers were more likely to include active physical play and a willingness to allow for a bit more frustration to build in a way that encouraged problem solving or working together. Together with many international researchers, their work demonstrates that fathers contribute important dimensions to caregiving, nurturing and learning experiences for infants and young children and underscore the importance of a father's continuing engagement with his children even if the relationship with the mother has faltered.

Globally the conceptualization of fatherhood is in the process of evolving due to urbanization and exposure to other communities and belief systems (Mncanca et al, 2016). Ironically while researchers note these changes and continue to affirm the contributions of fathers and male caregivers to children's development, men remain extremely scarce in most early care and education settings around the globe as well as other service sectors working with infants, young children and families. Male caregivers make up 1-3 percent of the caregivers employed in education and childcare settings in the U.S., U.K. and Australia. Norway and Denmark report 8-10% of male caregivers. These higher numbers probably relate to the fact that some European countries driven by severe labor shortages and a push for gender equality have implemented policy targets, financial incentives, and targeted campaigns to increase male caregivers in Early Childhood Education and Care (Peeters, 2007). The continuing paucity of male figures as caregivers and teachers worldwide are undoubtedly influenced by several factors. These include salaries in most but not all cases that are lower than other areas of education, as well as a myth that men don't have the capacity for nurturing and caregiving, which implies that early education is "women's work". We believe that there is both a devaluing of the importance of early care and education and nurturing in general, and a lack of understanding or appreciation of the fact that men typically interact with children differently than women. In reading the statistics about the absence of men, we also wondered if there is an appreciation of the formal and informal parent education that can happen in early care and education settings. We wondered how these learning and mentoring possibilities are constrained for fathers when all or most of the staff are women?

Recent policy shifts in some countries that attempted to involve more male caregivers have resulted only in small gains and many questions arose given the extent of these policies. Why, despite all this evidence and effort, are infant and early care and education, and family support services still mostly a male desert? To what extent do negative perceptions about men's caregiving abilities play a role in limiting male employment in these professions? All programs that hire staff to serve children are required to check applicants for criminal histories as part of the due diligence to protect children and families. Could it be that in some cases, unsubstantiated views of men as potential dangers to children could influence hiring decisions despite the evidence provided by these mandatory background checks?

We began to wonder if implicit bias about men might arise when anyone in a caregiving profession has had negative experiences with a father, or a male romantic or marriage partner. Many administrators and caregivers may not have had the resources to work through and understand how the continuing emotional imprint of past relationships with men might be transferred onto others. Internalized negative expectations generated by one's personal experience might be projected broadly onto men, in ways that limits their recruitment or consideration. We questioned how these individual negative experiences might feed cultural stereotypes about men being unable to provide a safe environment for infants and young children. We also wondered how mothers participating as clients in centers might also be uncomfortable with males in caregiving roles.

Child development research attests to the benefits of children being exposed to both male and female staff. Gender imbalance in early care and education programs raises significant questions about what is lost or muted when men are absent from professional roles in these settings. These centers provide both care and education for children, parent support, education and guidance with center staff at times becoming role models. When the atmosphere at a center is matricentric, fathers are less likely to ask questions about caregiving and opportunities for men to observe male caregivers as role models are constrained. These imbalances raise questions about how policies, program structures, training and staff development could counteract these effects.

Some of the issues and imbalances we believe could be addressed through policy education, and in-service efforts related to licensure, certification and on-going training including: 1) addressing how different cultures view the role of fathers and male caregiving which often include deep-rooted stereotypes about men's insufficiency as caregivers for babies and young children, 2) exploring collectively and individually the power of negative transference onto men caused by the losses and disappointments and fears of women providers in these settings and negative transference that men entering these situations might have about their own early care, or relationship difficulties, 3) recognizing the importance of parent education for both mothers and fathers that is possible in early care settings and services, and 4) the general lack of knowledge about gender and cultural differences in child rearing and the value of children experiencing variations in caregiving styles.

As we continue to examine how relationships support infant and early childhood well-being, we to ask ourselves: What possibilities emerge for children, families and communities when caregiving is understood not through the lens of gender, but through the capacity to form safe, nurturing and responsible relationships? A ten-year program in Alameda County (2025) that promoted father friendly approaches in a variety of agency services for infants and young children demonstrated the benefits to both fathers and children and it inspired our explorations of this topic. The long-term tenure of this program is a reminder that meaningful change takes time, trust building, and persistence.

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Development Follows Conditions: A Relational Ecology Framework for Early Relational Health

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Introduction

Across early childhood, this principle is widely accepted. Infants require opportunities to move if motor development is to emerge. Language develops through repeated interaction. Emotional regulation is organized through co-regulation. Across developmental domains, growth is understood not as something that can simply be taught, delivered, or prescribed, but as something that emerges through repeated experiences within supportive conditions over time (Bronfenbrenner, 1979; Hertzman & Boyce, 2010; Sameroff, 2009). Curiously, we do not always apply this same developmental logic to fathers. Although infancy is widely understood as a period of rapid developmental change, far less attention has been given to the parallel, bidirectional developmental process occurring within fathers themselves (patrescence). Fatherhood has often been conceptualized as a functional identity, defined primarily through tasks, responsibilities, behaviors, and social expectations, rather than a bidirectional developmental process emerging within and between the father-infant relationship (Cabrera et al., 2018). It is within this relationship, through serve-and-return interactions, mismatch and repair, co-regulation, shared meaning-making, and countless repeated relational experiences, that both father and infant develop together over time (Bakermans-Kranenburg et al., 2019; Feldman, 2007; Tronick, 2007). This paper introduces a Relational Ecology Framework to examine the conditions under which these developmental processes emerge. Within this framework, relational ecology refers to the interconnected historical, structural, institutional, relational, and developmental conditions that organize opportunities for father-infant relationships to develop. These conditions are neither neutral nor equally distributed. If development truly follows conditions, relational ecology becomes clearest where those conditions have been systematically constrained or eliminated. For generations, Black, Indigenous, immigrant, incarcerated, and other historically marginalized fathers have navigated relational ecologies shaped by slavery, colonization, racism, discrimination, xenophobia, family separation, carceral injustice, and inequitable public policy. Their experiences do not exist outside the framework presented here. They expose it. By examining where father-infant relationships have been persistently eliminated, relational ecology becomes unmistakably visible, revealing how that systematic deprivation continues to reverberate across generations.

Relational Ecology

A relational ecology is more than the setting in which development occurs. It is the dynamic network of conditions that shapes whether relationships are able to emerge, deepen, adapt, and transform in the moment and over time. These conditions include historical experience, institutional structures, professional practice, cultural narratives, language, expectations, and everyday interactions that communicate who belongs and whose relationships are expected to develop. Because these conditions are often experienced rather than recognized, their influence becomes visible through the relationships they foster or constrain. This perspective shifts attention from isolated interventions or individual behaviors toward the broader ecology within which father-infant relationships, maternal wellbeing, and infant development are continuously organized. The examples that follow illustrate how relational ecology operates across familiar settings within maternal and child health, demonstrating how seemingly ordinary interactions can either strengthen or constrain the developmental conditions through which fathers, infants, mothers, and families grow together.

Conditions and Relational Ecology

Relational ecologies are not observed directly. They become visible through the conditions they create and the developmental opportunities they afford or constrain. Every interaction, policy, expectation, environment, and relationship communicates something about who belongs, who is expected to participate, whose contributions are valued, and whose relationships are intentionally cultivated. Simply acknowledging fathers, inviting their participation and contribution, recognizing their developmental significance, and viewing them as protective factors for infant, maternal, and family wellbeing are themselves conditions that shape the emerging father-infant relationship.

These conditions are also influenced by the assumptions carried into every encounter. Fathers who have been historically marginalized may enter systems of care already subject to implicit expectations regarding their availability, competence, motivation, or safety as caregivers. Such assumptions become part of the relational ecology before the first conversation even begins. From this perspective, the question is no longer simply whether fathers are present within maternal and child health systems, but whether the conditions necessary for father-infant relationships to emerge are intentionally cultivated. The examples that follow invite readers to examine familiar settings through this lens, asking not simply what services are provided, but what conditions are being created for father-infant relationships to emerge, and how those conditions shape developmental opportunities for fathers, infants, mothers, and families.

Prenatal Relational Ecology

Prenatal care represents one of the earliest relational ecologies in which father-infant relationships have the opportunity to emerge. Long before birth, fathers begin constructing expectations about themselves, their baby, their partner, and their role within the developing family (Dayton et al., 2016; Leanderz et al., 2025). Every interaction within prenatal care contributes to these early conditions. Registration, educational materials, provider language, clinical priorities, and opportunities for participation all communicate whether fathers are viewed as peripheral supporters or as developmentally significant partners in early relational health.

Within most prenatal systems, clinical attention is appropriately directed toward maternal assessment, fetal development, preparation for childbirth, and the identification of medical concerns requiring ongoing monitoring or intervention. Fathers are frequently encouraged to support their partner through these experiences, yet comparatively few opportunities exist for them to begin developing a relationship with their unborn infant. Fathers are seldom invited to observe fetal behavior, notice movement, speak or read to their baby, and understand how these interactions begin organizing the father-infant relationship before birth (Dayton et al., 2016; Nugent, 2015). Likewise, fathers are rarely included in discussions regarding prenatal warning signs, high-risk pregnancies, pre-eclampsia, reduced fetal movement, or other clinical situations in ways that position them as informed relational partners capable of supporting maternal wellbeing through shared observation and decision-making.

Increasingly, relationship-centered models of maternity care, including midwives and doulas, recognize fathers as active participants in birth rather than observers, representing meaningful shifts in the relational ecology of birth. Yet participation alone does not fully capture the developmental opportunity. Beyond involvement in specific tasks, labor and delivery also create opportunities for fathers to begin observing their infant's behavioral organization, understanding newborn communication, reflecting on their own emotional experience, and recognizing themselves as participants in an unfolding developmental relationship. These relational processes remain less consistently cultivated within routine maternity care. From a relational ecology perspective, these omissions are not simply missed educational opportunities. They shape the developmental conditions through which father-infant relationships begin to emerge. When fathers are acknowledged, invited into observation, encouraged to ask questions, and recognized as protective factors for infant, maternal, and family wellbeing, the ecology itself changes. Fathers begin developing not only knowledge, but also attentiveness, confidence, curiosity, and relational presence through direct participation with both mother and baby (Feldman, 2007; Tronick, 2007). In this way, support for maternal wellbeing becomes more than a prescribed responsibility. It emerges organically from the developing father-infant relationship itself.

Labor and Delivery

Labor and delivery represent a relational ecology of extraordinary developmental intensity. Birth marks not only the arrival of an infant, but the simultaneous emergence of a father, a mother, and a new family system. For many fathers, this is a singular developmental moment. Months of anticipation, hope, fear, and shared experience with their partner culminate in the first encounter with *their* baby. In an instant, identity, responsibility, belonging, and the future may be experienced differently. This transition is not simply emotional. It is developmental (Bakermans-Kranenburg et al., 2019).

When birth unfolds as hoped, fathers may experience profound joy, awe, gratitude, and connection while beginning to organize their understanding of themselves in relationship with their infant and partner. Increasingly, relationship-centered maternity care recognizes fathers as active participants in birth. The growing influence of midwives, doulas, and other relationship-centered models of care has further expanded opportunities for fathers to be recognized as active participants in the birth experience. These represent meaningful advances in the relational ecology of birth.

Yet birth also carries the possibility of unexpected complications, emergency interventions, neonatal illness, maternal distress, or loss. Fathers may suddenly find themselves expected to remain calm, make complex decisions, support their partner, protect their infant, and manage their own fear and uncertainty, often simultaneously. These experiences do not simply influence fathers emotionally. They reorganize the relational ecology into which the father-infant relationship is emerging. Depending upon the conditions that surround these moments, fathers may leave birth feeling connected, capable, and increasingly organized within their new role, or they may leave carrying unresolved helplessness, uncertainty, grief, traumatic stress, and potentially develop symptoms of paternal perinatal mood and anxiety disorders in the ensuing months (Leanderz et al., 2025). In either circumstance, labor and delivery are not merely medical events. They establish the earliest relational conditions through which father, infant, and mother begin developing together.

Postpartum and Public Contexts

Following birth, fathers enter a relational ecology characterized by repeated opportunities for interaction, observation, adaptation, and mutual development with their infant. Daily caregiving activities such as feeding, holding, diapering, soothing, bathing, playing, and responding to infant cues become more than caregiving tasks. They become the repeated relational experiences through which fathers and infants learn one another, organize co-regulation, develop shared meaning,

and establish patterns of interaction that continue to evolve over time (Feldman, 2007; Tronick, 2007). These everyday moments provide the developmental conditions through which confidence, attunement, relational presence, and paternal identity gradually emerge. The conditions supporting these relational experiences, however, are not equally available to all families. Family leave policies, employment demands, financial pressures, breastfeeding support, pediatric care, home visiting services, access to culturally responsive programs, and opportunities for repeated father-infant interaction all influence the development of early relationships. Public environments likewise communicate whether fathers are expected to care for infants independently or remain peripheral to early caregiving. These messages become part of the relational ecology long before anyone asks whether fathers are "engaged."

For many historically marginalized fathers, these conditions are further shaped by structural inequities, discrimination, economic insecurity, immigration concerns, child welfare involvement, and disproportionate contact with carceral systems (Boyd, Jr., & Oakley, 2020). These realities do not diminish fathers' capacity for relationship. They alter the conditions under which relationships are able to emerge, deepen, and endure. At one end of this continuum, incarceration represents an extreme relational ecology in which many of the conditions necessary for father-infant relationship development are systematically constrained or removed, disproportionately affecting Black fathers and other historically marginalized communities (Boyd, Jr., & Oakley, 2020). From a relational ecology perspective, postpartum care extends beyond supporting maternal recovery or infant health alone. It represents an ongoing opportunity to cultivate the conditions through which father-infant relationships, maternal wellbeing, and family resilience continue developing together.

Research and Language

Many studies continue to use the term "parent" while relying predominantly on maternal participants or maternal report, leaving fathers underrepresented within the evidence base used to guide policy and practice (Cabrera et al., 2018). When fathers are included, measures frequently emphasize participation, caregiving tasks, financial provision, or frequency of involvement rather than relational processes such as co-regulation, shared meaning-making, observation, attunement, and reciprocal developmental change (Feldman, 2007; Tronick, 2007). Consequently, fathers may be conceptualized primarily through what they do rather than through the relationships within which both father and infant develop together. This emphasis may also contribute to a more limited understanding of fathers' internal developmental experiences. When professional attention is directed primarily toward what fathers do, fewer opportunities remain to explore what fathers notice, wonder about, struggle with, or feel as they undergo their own developmental transition into parenthood (Bakermans-Kranenburg et al., 2019; Leanderz et al., 2025). Ironically, fathers are often criticized for being less emotionally expressive while simultaneously participating in systems that ask far more about their behaviors than their emotional lives.

Language similarly shapes relational ecology. Terms such as "father involvement" or "father engagement," while well intentioned, may inadvertently position fathers as incidental, temporary, or optional contributors rather than developmentally significant participants whose relationships are protective factors for maternal wellbeing, infant development, and family health. Professional language reflects disciplinary priorities. Specialized terms may narrow attention toward concepts easier to study than to understand within the broader relational ecology, leaving families with fragmented ideas that often fail to reflect lived experience.

Reframing Early Relational Health

Viewed collectively, these examples point toward a common conclusion. Fathers are not consistently absent from early relational health. Rather, they frequently participate within relational ecologies that have not been intentionally organized to support the development of father-infant relationships. The issue is therefore not simply one of father inclusion. It is one of relational design. This distinction has important implications for practice. Efforts to improve father engagement have often focused on increasing participation, changing behaviors, expanding services, or providing additional information. While each of these approaches offers value, they may have limited impact when the relational conditions necessary for development remain unchanged. Information alone does not create confidence. Services alone do not create belonging. Development emerges through repeated relational experiences that occur within conditions intentionally organized to support them (Bronfenbrenner, 1979; Sameroff, 2009).

From this perspective, father-inclusive practice becomes more than inviting fathers into existing systems. It involves designing systems in which fathers are expected, welcomed, and recognized as developmentally significant participants from the earliest stages of family formation. These reimagined systems intentionally cultivate opportunities for father-infant relationships to emerge while simultaneously supporting the father's own bidirectional developmental transition into fatherhood (patrescence) (Bakermans-Kranenburg et al., 2019). As fathers and infants grow together through repeated relational experiences, both are changed by the relationship itself. This includes policies that reduce structural barriers, professional education that recognizes fathers as protective factors, research that measures relational processes rather than isolated behaviors, and clinical practices intentionally designed to cultivate these developmental conditions over time (Cabrera et al., 2018; Mora et al., 2023; Levante et al., 2025). These redesigns benefit more than fathers alone. As father-infant relationships strengthen, so too do the relational conditions that support maternal wellbeing, infant development, and family resilience. The question is therefore no longer whether fathers should be included. The question is whether our systems are intentionally creating the relational conditions through which families develop as living relational systems where fathers, infants, mothers, and the family itself continuously shape one another through shared experience over time.

Implications for Practice and Systems

A relational ecology framework invites a shift from promoting early relational health to intentionally designing and continuously cultivating the relational

conditions through which it emerges across practice, policy, and systems. Rather than asking how fathers can become more engaged within existing systems, it asks how systems themselves might intentionally cultivate the conditions through which father-infant relationships, paternal development (patrescence), maternal wellbeing, infant development, and family resilience emerge together. This shift moves father-inclusive practice beyond invitation toward intentional relational design.

For providers, this perspective expands professional practice beyond the delivery of information, services, or interventions. Every interaction, every expectation, every policy, and every opportunity for participation contributes to the relational ecology experienced by families. Small changes in language, clinical routines, educational approaches, and opportunities for shared observation may significantly influence whether fathers are recognized as developmentally significant participants or continue to occupy a functional, secondary, or incidental role.

At the systems level, this framework encourages policies and service models that intentionally support repeated opportunities for father-infant interaction, equitable parental leave, father-inclusive prenatal and postpartum care, culturally responsive services, workforce development, and research methodologies that examine relational processes rather than isolated behaviors. Such efforts are particularly important for Black, Indigenous, immigrant, incarcerated, and other historically marginalized fathers whose opportunities for relationship have too often been constrained by structural inequities rather than individual capacity (Boyd, Jr., & Oakley, 2020).

Ultimately, the question is no longer whether fathers matter within early relational health. The more important question is whether our systems are intentionally creating the relational conditions through which the family is able to develop as a living relational system, in which fathers, infants, mothers, and the family as a whole are continuously shaping, reorganizing, and transforming one another through shared relational experience over time. When intentionally cultivated, father-inclusive practice becomes more than an act of inclusion. It becomes an investment in the relational ecology from which early relational health emerges.

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Book Review: Fathers in Charge: Hungarian Stay-at-Home Fathers in Light of Sociological Research

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One of the most salient sociological shifts in modern societies is the transformation of parental roles. While the traditional family model identified the mother with caregiving and the father with the breadwinner role, the boundaries between parental responsibilities are increasingly blurring today. The joint monograph by Éva Sztáray Kézdy and Zsófia Drjenovszky, titled *Fathers in Charge*, provides profound insight into this current and—in Hungary—still under-explored topic, specifically focusing on the lived experiences of Hungarian fathers who stay at home with their children.

The scholarly significance of the volume lies in the fact that stay-at-home fatherhood in Hungary is not only a rare phenomenon but also an under-researched area. Within the framework of their Family Sociology Research Group founded in 2019, the authors set out to map the motivations, experiences, and social perceptions of fathers who step into the role of primary caregiver. The novelty of the research lies in its comprehensive approach: in addition to thirty-one in-depth interviews conducted with fathers, the authors also gathered the perspectives of mothers through questionnaires, thereby examining parental roles in their mutual interdependence.

The structure of the book logically follows the stages of the research. The introductory chapters place the historical evolution of the paternal role and the Hungarian family support system into an international context. By embedding the analysis within European family policy models—such as the explicit familialism characteristic of Central-Eastern Europe and the degenderized systems of Nordic countries—the book provides a framework for cross-cultural comparison. The authors demonstrate how Hungary's long, transferable leave scheme (e.g., GYED and GYES) enables full paternal caregiving, even though the absence of dedicated non-transferable 'daddy quotas' sets it apart from Northern European practices, reflecting distinct cultural expectations regarding paternal care. Consequently, the authors introduce the concept of the "stay-at-home father," distinguishing them from those who only claim these subsidies on paper.

The decision to stay at home can rarely be attributed to a single reason; it is typically the result of complex family considerations. The authors emphasize that in the studied sample, the decision was either driven by external factors or based on strong internal motivation: fathers consciously wanted to spend more time with their children and participate in every stage of their development. This was often coupled with rational arguments, such as the mother's higher earning potential, favorable career opportunities, or the father's current workplace burnout and desire for a career change. An interesting finding is that, contrary to international trends, financial considerations in the Hungarian sample were often secondary to emotional and relational factors.

In the process of redefining fatherhood and masculinity, the research identified three distinct types. The most populous group consists of fathers who reject hegemonic masculinity; due to their egalitarian outlook, they view caregiving as an integral part of manhood and do not feel their male identity is diminished by the absence of breadwinning work. The second group adheres to traditional elements (e.g., the provider role) and attempts to maintain some level of income-generating activity while at home. However, active involvement in the child's life and the fulfillment of (at least part of) the caregiving duties remain important to them. The third type experiences the situation as a complete role reversal, struggling with social expectations. The authors conclude that male identity can be redefined through caregiving practices, even within a traditional worldview. Importantly, the monograph underscores fathers' unique strengths as nurturing caregivers and attachment figures. Rather than acting as mere secondary helpers, these fathers actively build foundational attachment bonds, demonstrating that paternal nurturance is an essential pillar in fostering family resilience.

Book cover: Drjenovszky, Z., & Sztáray Kézdy, É. (2026). *Apákra bízva. Gyermekükkel otthon maradó apákról egy szociológiai kutatás alapján [Fathers in Charge: Hungarian stay-at-home fathers in light of a sociological research]*. Budapest: L'Harmattan Publishing House.

Regarding family well-being and work-life balance, the monograph highlights that a father staying at home can significantly alleviate the mother's role conflicts, allowing her to focus on work without guilt, knowing the child is in "good hands." The research describes four patterns: the father's presence at home helped either the mother or both parents achieve balance, and in some cases, provided a specific solution to the father's career crisis. This period of intensive togetherness also offers an opportunity for self-reflection and the development of parental competencies.

From an infant mental health perspective, the volume offers rich qualitative evidence regarding the profound impact of early paternal care. The continuous, daily presence of fathers fosters strong father-infant attachment and secure emotional bonding during the perinatal and infancy periods. By stepping into primary caregiving roles, fathers actively participate in the infant's co-regulation and relational health. Furthermore,

this equitable sharing of caregiving responsibilities during early infancy significantly reduces parental stress and enhances overall family well-being, creating a stable, emotionally supportive environment that positively shapes long-term infant development.

Among the effects of stay-at-home fatherhood, the most vital is the clear strengthening of the father-child relationship and the formation of a deep bond of trust. Within the parental relationship, mutual appreciation increased, and partners became more empathetic toward each other's responsibilities. Although difficulties arose—such as social isolation or the challenges of establishing a daily routine—the majority of fathers concluded this period with a sense of pride and a positive overall balance.

The methodological chapter honestly reflects on the study's limitations. Through expert sampling, the researchers primarily reached urban families with higher education, which may bias the results regarding the acceptance of "new-type" fatherhood.

In summary, *Fathers in charge* is a gap-filling work. It provides valuable data not only for sociologists and social researchers but also offers an inspiring alternative for the broader public—practicing and future parents alike—regarding the division of parental roles. One of the book's most important messages is that a father's active caregiving presence is not merely "help" for the mother, but an intrinsically valuable lifestyle that enriches the entire family. The work of Éva Sztáray Kézdy and Zsófia Drjenovszky is a significant milestone in Hungarian family sociology, highlighting that caregiving is not a gendered competence, but a human one.

Reference

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WAIMH 2026
19TH WORLD CONGRESS | TORONTO, CANADA

The World Association for Infant Mental Health

19th WORLD CONGRESS

TORONTO, CANADA

Sheraton Centre Toronto Hotel

October 2-6, 2026

With the theme:
Harmony in Diversity — Nurturing the Youngest Minds Around the World, this international event brings the world's top voices in infant mental health together. Dive into new thinking, inclusive solutions, and global collaboration—live from vibrant Toronto!

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IEMHP is a national organization advancing lifelong outcomes by applying early mental health science in pregnancy, infancy, and early childhood.

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ORGANIZED BY

WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

WAIMH is a not-for-profit organization for scientific and educational professionals.

www.waimh.org

WORLD ASSOCIATION FOR
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PERSPECTIVES IN INFANT MENTAL HEALTH

Perspectives in Infant Mental Health (formerly, The Signal) is a Professional Publication of the World Association for Infant Mental Health (WAIMH).

It provides a platform for WAIMH members, WAIMH Affiliate members, and allied infant mental health colleagues to share scientific articles, clinical case studies, articles describing innovative thinking, intervention approaches, research studies, and book reviews, to name a few. It also serves as a nexus for the establishment of a communication network, and informs members of upcoming events and conferences.

It is a free open access publication at www.waimh.org

During the past 50 years, infant mental health has emerged as a significant approach for the promotion, prevention, and treatment of social, emotional, relational, and physical wellbeing in infants and young children, in relationship with their parents and caregivers, in their families and communities.

Within this same time frame, the infant mental health movement has expanded to a global network of professionals from many disciplines. This infant mental health global network community of research, practice, and policy advocates, all share a common goal of enhancing the facilitating conditions that promote intergenerational wellbeing; including intergenerational mental health and wellbeing relationships, between infants and young children, parents, and other caregivers, in their communities.

The global reach of infant mental health demands attention to the cultural context in which a young child and family lives, as well as critical attention to issues that affect child development, child health, child mental health, parental mental health and early relationship development.

Invitation to contribute

We invite all members of WAIMH and WAIMH Affiliate members to contribute to Perspectives in Infant Mental Health.

WAIMH is a member-based organization, and as such, we invite each of you to think creatively and consider submitting an article that provides a "window on the world" of babies and their families. We are especially interested in papers that incorporate diverse perspectives and center the cultural contexts and experiences of babies and families across the globe. We encourage submissions that reflect on how cultural, social, and economic factors shape early childhood development and highlight the unique strengths, challenges, and traditions that influence family systems and infant mental health.

In the spirit of sharing new perspectives, we welcome your manuscripts. Manuscripts are accepted throughout the year. Articles are reviewed by the Editors, all of whom are committed to identifying authors from around the world and assisting them to best prepare their papers for publication.

Full issue publication dates

April issue:

Papers received by January 1
will be considered for inclusion in this issue.

August issue:

Papers received by May 1
will be considered for inclusion in this issue.

December issue:

Papers received by September 1
will be considered for inclusion in this issue.

Perspectives in Infant Mental Health Submission Guidelines

APA 7th Edition.

12-point font.

1.5 or double spaced.

All in-text citations, references, tables, and figures to be in APA 7th edition format.

Papers with tables and figures: Please submit the paper as a word-format document with separate files attached for each table and/or figure.

We welcome photos of babies and families. All photos need to be sent in a separate file with a resolution of at least 72 pixels/inch.

All photos need to include a permission statement from the author for WAIMH to publish the photo in Perspectives and also on WAIMH online social media platforms.

Submission categories:

a. Research Papers (max 3000 words, including references)
b. Clinical Papers (max 3000 words, including references)
c. Professional Development (max 3000 words, including references)
d. Ethics (max 3000 words, including references)
e. Community Voices (max 800 words, including references)
f. Letters (max 800 words, including references)
g. Opinion pieces/Policy/Advocacy (max 1000 words, including references)
h. Book Review (max 800 words, including references)

Further details:
www.waimh.org

Contact

To inquire about Perspectives in Infant Mental Health or to submit articles, please contact:

Jane Barlow (DPhil, FFPH Hon), Editor-in-Chief
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WORLD ASSOCIATION FOR
INFANT MENTAL HEALTH
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WHAT IS WAIMH?

The World Association for Infant Mental Health (WAIMH) is a non-profit organization for scientific and educational professionals. WAIMH's central aim is to promote the mental wellbeing and healthy development of infants throughout the world, taking into account cultural, regional, and environmental variations, and to generate and disseminate scientific knowledge.

Why become a WAIMH member?

- To promote principles of infant and child health, development and mental health.
- To become part of a global learning community and professional network that speaks for infants, young children and families around the world.
- To have access to resources that promote infant mental health.
- To learn from world experts about the health, mental health and optimal development of infants, toddlers and their families across cultures and around the world.
- To expand your professional, social network.
- To exchange information about infants and infant-family programs.
- To contribute to the protection of health and well-being in infancy, early childhood and parenthood on a global level.
- To get opportunities to keep pace with new findings and innovations in scientific, clinical, and educational research and programs involving infants and their caregivers
- To contribute to a professional global learning community: WAIMH.

WAIMH AFFILIATES

WAIMH encourages individuals in geographic regions (states, provinces, nations, multi-nations) to develop Affiliate Associations to improve its international network of communication, and to allow individuals to focus on relevant local issues. Currently, there are 65 affiliates spanning six continents.

Affiliate Council Chair: Juané Voges

Affiliate Council Representative: Azhar Abu Ali

THE BEACON CLUB

The Beacon Club helps members fulfill WAIMH's mission in international development.

Beacon Club donations:

- Extend the influence of infant mental health to countries now developing new approaches to issues of infancy.
- Make it possible to build capacity for promoting the well-being of infants and their families.

Beacon Club donations sponsor WAIMH memberships and Infant Mental Health Journal subscriptions for individuals from developing countries.

Donation forms and applications for Beacon Club sponsorship are available online at www.waimh.org

CONGRESSES

WAIMH hosts a World Congress every two years, each in a different country. Our 19th World Congress will be in Toronto, Canada, 2026. WAIMH also hosts Regional Conferences.

E-mail: office@waimh.org

PUBLICATIONS

Infant Mental Health Journal: Infancy and Early Childhood

The Infant Mental Health Journal: Infancy and Early Childhood publishes research perspectives and clinical practices. It provides an interdisciplinary forum for publication of research findings, literature reviews, clinical techniques and case studies, prevention/intervention research, and book reviews related to the biological, social, emotional, and cognitive development of infants and their families in various ecological contexts. Special emphasis is given to high risk infants and high risk families, psychodynamic views of developmental process, and systems approaches to emergent organizational structure.

Editor: Ann M. Stacks
E-mail: amstacks@wayne.edu

Perspectives in Infant Mental Health

Perspectives in Infant Mental Health, WAIMH's quarterly newsletter, gives members an opportunity to share research of interest, provides a forum for the exchange of news and views from around the world, and informs members of upcoming events and conferences.

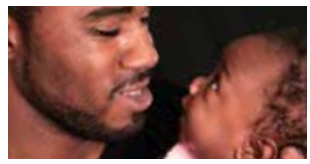
Editor: Jane Barlow
E-mail: perspectives@waimh.org

BECOME A MEMBER

- You can subscribe to the scientific journal, the Infant Mental Health Journal, at a greatly reduced member rate. The subscription fee includes access to the Wiley database of the electronic journal.
- You can download Perspectives in Infant Mental Health (formerly, The Signal), WAIMH's quarterly newsletter from WAIMH's website. This major interdisciplinary, international communication link for infant mental health professionals is an open access publication.
- You'll get reduced registration rates for regional conferences and for WAIMH's World Congresses.
- You'll have access to WAIMH database, an information network for infant mental health professionals.

The Professional membership rate is $75 annually. Student members pay $45. The membership fee is a yearly cost (Jan-Dec).

Both Professional and Student members may subscribe to the Infant Mental Health Journal at an additional cost. The additional cost of the journal subscription is $40. The subscription is easily completed through the WAIMH Online Store: www.waimh.org/store



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