Childcare Involvement, Parenting Satisfaction, and Relationship Satisfaction among Fathers with Substance Use Disorder and their Non-Substance-Abusing Partners

The present study examined the division of childcare among fathers diagnosed with substance use disorder and their non-substance-abusing partners, and how satisfaction with childcare responsibilities and with partners’ parenting were related to relationship satisfaction. Mothers reported more responsibility for the supervision of children’s activities and arranging for childcare, but there were no differences between parents on transporting children to activities, taking care of children when they were ill, and taking time off to attend doctor’s visits and school meetings. Satisfaction with their partners as parents predicted men’s relationship satisfaction. Mothers’ satisfaction with the division of childcare and their partners as parents predicted women’s relationship satisfaction. Paternal involvement in childcare appears important for relationship satisfaction in two-parent families in which fathers have substance use disorder.

Keywords: substance use disorder; dyadic satisfaction; childcare involvement

Despite calls for research on substance-abusing fathers (McMahon & Rounsaville, 2002; McMahon, Winkel, Luthar, & Luthar, 2005; Twomey, 2007), there has been slow progress in understanding the roles that substance-abusing fathers have in the care of their children. The larger literature on fathering shows that fathers’ involvement in childcare contributes to wives’ marital satisfaction (Schober, 2012), whereas less paternal involvement in childcare contributes to their partners’ stress and aggravation (e.g., DeMaris, 2010; McBride, Schoppe, & Rane, 2002). Among couples in which one partner has substance use disorder (SUD), partner support is critical, as romantic partners have both positive and negative in-
fluences on substance use and treatment outcomes (see Gruber & Taylor, 2006, for a discussion). For couples in which fathers have SUD, mothers’ decisions to stay with their partners’ and support their partners’ recovery may in part be based on satisfaction with other areas of their relationships such as the division of childcare and satisfaction with their partners as parents. In the present study, we examined the division of childcare, and whether satisfaction with the division of childcare and satisfaction with one’s partner as a parent were associated with dyadic satisfaction among couples in which fathers had SUD.

**Childcare Involvement among Fathers with Substance Use Disorder**

Fathers spend more time in childcare than in the past (e.g., Craig, Mullan, & Blaxland, 2010). On average, fathers now spend about one-third the time that mothers do in child-care related tasks (see Lamb & Lewis, 2013, for a discussion). In one of the few studies of childcare involvement among fathers with SUD, 331 parents entering substance abuse treatment were asked to indicate the frequency with which they engaged in the following behaviors with their children: (1) leisure activities away from home, (2) working on a project or playing together while at home, (3) helping with reading or homework, and (4) eating meals together. Based on a median split for the total of the item scores, they categorized 56.5% of mothers and 51.5% of fathers as having high involvement (Collins, Grella, & Hser, 2003). Results from the Collins et al. study suggest that mothers and fathers entering treatment for substance abuse appear equally involved in specific activities with their children. In contrast, anecdotal information (i.e., comments made by study participants) from alcohol and drug users indicated that mothers with SUD who live with their children are often their children’s sole or primary caregivers, whereas fathers who reside with their children often lived with other adults (i.e., partners or their mothers) who typically helped them care for their children (Pilowsky et al., 2001).

SUD may impact not only involvement in parenting, but the quality of one’s parenting and perceptions of one’s self as a parent. Substance abuse can interfere with cues for nurturing and impair caregivers’ ability to respond to their children in a consistent and nurturing fashion (e.g., Eiden, Chavez & Leonard, 1999; Kelley et al., 2007; Staton-Tindall, Sprang, Clark, Walker, & Craig, 2012). As compared to fathers with no history of drug or alcohol abuse, men receiving methadone maintenance treatment reported poorer appraisal of themselves as parents and less satisfaction as a father (McMahon, Winkel, & Rounsaville, 2008). Similarly, fathers who drank more alcohol reported less parental satisfaction as compared to fathers who drank less (Watkins, O’Farrell, Suvak, Murphy, & Taft, 2009). Whether lower perceptions of themselves as parents are associated with fathers’ substance use or less involvement in their children’s lives is not clear.

**Fathers’ Childcare Involvement, Parenting Satisfaction, and Dyadic Satisfaction**

From a theoretical perspective, family systems theory contends that functioning of one family member effects other family members (Bowen, 1974). For instance, the literature on parenting has shown that when fathers are involved in childcare, mothers report higher marital satisfaction (Lee & Doherty, 2007; Nangle, Kelley, Fals-Stewart, & Levant, 2003; Schober, 2012). Furthermore, mothers who are unhappy with their partners’ parenting may act as gatekeepers and reduce fathers’ involvement with their children over time (Fagan & Barnett, 2003; Gaunt, 2008). In addition, marital conflict and dissatisfaction may lead fa-
thers to distance themselves from their partners (Gottman, 1994) and reduce their involvement in childcare (Volling & Belsky, 1991).

Women who are happier with the division of childcare may be more likely to stay with their partners who have substance use disorder. Using data from the British Millennium Cohort Study, Schober (2012) found that a one standard deviation increase in fathers’ childcare share at Time 1 (when children were 9 months of age) was associated with a 20% lower risk of couple separation by Time 2 (when children were 3 years of age). Importantly, partner support is a key to men’s recovery attempts (see Gruber & Taylor, 2006, for a discussion; see also Steinberg, Epstein, McCrady & Hirsch, 1997).

Whether the division of childcare is important for fathers’ marital satisfaction is less conclusive. More specifically, the literature on parenting has demonstrated positive (e.g., Lee & Doherty, 2007), negative (Nangle et al., 2003; see Schober, 2012 for a review), and no association between paternal involvement and fathers’ reports of dyadic satisfaction (Carlson, Pilkaukas, McLanahan, & Brooks-Gunn, 2011; Jackson, Miller, Oka, & Henry, 2014). From the vantage of family systems theory, men who report greater dissatisfaction with their partners as parents may be expected to report lower dyadic satisfaction.

**THE PRESENT STUDY**

In the present study, we examined mothers’ and fathers’ reports of childcare involvement in families in which fathers met criteria for SUD and how perceptions of one’s partner as a parent were associated with dyadic satisfaction. We anticipated that fathers diagnosed with SUD would report less involvement in childcare relative to their non-substance-abusing partners. Second, based on the larger literature on parenting, we anticipated that mothers’ satisfaction with the division of childcare responsibilities and better perceptions of their male partners as parents would predict higher dyadic satisfaction controlling for their male SUD partners’ reports on these variables. Third, we anticipated that higher levels of satisfaction with the division of childcare responsibilities and greater satisfaction with their partners’ parenting would predict substance-abusing fathers’ reports of dyadic satisfaction controlling for reports of these variables by their non-substance-abusing female partners. To address these later hypotheses within a dyadic framework, we used the actor-partner interdependence model (APIM; Kenny, Kashy, & Cook, 2006). By employing a dyadic framework, we were able to cross-sectionally test associations between satisfaction with the division of childcare and their partners as parents on relationship satisfaction while controlling for correlations between fathers’ and mothers’ reports (i.e., non-independence in the data).

**METHOD**

**Participants**

Families were recruited for a study of the secondary effects of parental treatment for substance abuse on children in their homes. Given our primary focus (i.e., female partners’ reports of satisfaction with their partners as parents and dyadic satisfaction), we examined data from 52 couples in which fathers met past 3-month *DSM-IV-TR* (American Psychiatric Association, 2000) criteria for an alcohol, drug, or drug and alcohol use disorder and whose female partners did not meet current, past year, or lifetime substance use disorder diagnosis. Among these fathers, 34 had an alcohol and drug use/polydrug use disorder, 10 fathers met criteria for an alcohol use disorder, and eight fathers met criteria for a drug/or...
polydrug use disorder only. Specifically, 6 fathers met criteria for cocaine, 6 fathers met criteria for cannabis, 3 fathers met criteria for opioid, 1 father met criteria for hallucinogen, 1 father met criteria for sedative, and 25 fathers met criteria for a combination of these drug use disorders. Fathers with a drug use diagnosis reported an average length of 9.43 years ($SD = 10.44$ years) of problematic drug use; fathers with an alcohol use diagnosis reported an average length of 10.56 years ($SD = 10.50$ years) of problematic alcohol consumption.

A series of one-way analysis of variances were conducted to determine if the three father SUD only couples (1 = alcohol diagnosis only, 2 = drug diagnosis only, 3 = both alcohol and drug diagnoses) were significantly different on the background variables. Results demonstrated that mean scores of the father SUD only couple types did not differ significantly on any of the demographic variables assessed ($p$s ranging from .094 to .951). Therefore, these groups were collapsed into a single group termed father SUD couples ($n = 52$).

Data for the present study were collected from assessments conducted prior to the start of treatment (i.e., preassessment). To qualify for the study, couples needed to be married or in a stable relationship (defined as married for at least one year or cohabitating for at least two years) and have at least one child 18 years of age or younger that lived with them full-time, or, in a few cases, the parent in the study had a shared custody arrangement and the study parent had care of the child 50% of the time. For families with more than one child in the age range, to prevent selection biases, parents reported on childcare responsibilities for the child with the closest birthday to the initial screening. Couples were excluded if one or both parents were not fluent in English.

Based on information gathered as part of the Structured Clinical interview for DSM-IV (SCID; First, Spitzer, Gibbon, & Williams, 2002), the average age of the fathers was 39.73 years ($SD = 8.92$), average age of mothers was 38.37 years ($SD = 8.99$), and average age of the target child was 9.91 years ($SD = 5.24$). The mean number of years of education was 12.29 ($SD = 2.44$) for fathers and 13.73 ($SD = 2.31$) for mothers. With regards to employment status, for fathers, 51.9% were employed full-time, 15.4% were employed part-time, 25.0% were not employed (missing data in 7.7%). With regards to employment status for mothers, 36.5% were employed full-time, 13.5% were employed part-time, 36.5% were not employed (missing data in 13.5%).

A series of one-way analysis of variances were conducted to determine if the three father SUD only couples (1 = alcohol diagnosis only, 2 = drug diagnosis only, 3 = both alcohol and drug diagnoses) were significantly different on the background variables. Results demonstrated that mean scores of the father SUD only couple types did not differ significantly on any of the demographic variables assessed ($p$s ranging from .094 to .951). Therefore, these groups were collapsed into a single group termed father SUD couples ($n = 52$).

Kansas Parental Satisfaction Scale (James et al., 1985). Paternal and maternal caregiving was assessed using the Kansas Parental Satisfaction Scale (KPS; James et al., 1985). The KPS contained 22 items that were used to determine parental responsibility and satisfaction with these responsibilities. For the purposes of this study, however, only two KPS sections were used. The first section asks respondents a series of questions about raising children with their partner. Using response anchors: I usually do, My partner and I share equally, My partner usually does, and Neither one of us does it, participants reported who usually stayed home with the children when they were sick, took time off from work for doctor’s visits or meetings with teachers, arranged for childcare, transported children to and from activities, and supervised children’s activities over the previous three months. Data from fathers’ reports were coded as 0 (Neither one of us does it), 3 (My partner usually does), 2 (My partner and I share equally), and 1 (I usually do); whereas data for mothers’
reports were coded as 0 (*Neither one of us does it*), 1 (*My partner usually does*), 2 (*My partner and I share equally*), and 3 (*I usually do*). Using this coding, higher scores reflect more parental responsibility for the *mother*. Table 1 presents descriptive information for fathers with SUD and their non-substance-abusing female partners.

The second section of the KPS used in the present study asked participants to report how satisfied they were over the last three months ranging from 1 (*extremely dissatisfied*) to 7 (*extremely satisfied*) with regards to different aspects of parenting and childcare. Example items include “Over the last three months, how satisfied are you with the way you share these [parental] responsibilities with your partner?” and “Over the last three months, how satisfied are you with your partner as a parent?” Higher scores indicate more satisfaction.

**Dyadic Adjustment Scale (Spanger, 1976).** Both fathers and mothers completed the Dyadic Adjustment Scale (DAS; Spanier, 1976) as a measure of overall relationship adjustment. The DAS is a widely used 32-item questionnaire that assesses relationship quality. Example items include “Do you and your partner engage in outside interests together?” and “How often do you and your partner quarrel?” Although response codes vary across items, higher scores represent better relationship quality. Cronbach’s alphas for the present study were $\alpha = .92$ and $\alpha = .94$ for fathers and mothers, respectively.

**Procedure**

Couples were recruited from one of two outpatient treatment centers specializing in SUD treatment or advertising efforts. All potential clients referred from the treatment centers gave permission to be contacted about the study. Parents received a brief phone screening call and short study description. If both parents were interested, a time for the pretreatment assessment was set. At this meeting, the study was described in detail, partners were individually consented, and then were individually administered the SCID (First et al., 2010) by a licensed mental health counselor or psychologist both with over 15 years of clinical research experience. Each parent then independently completed the self-report instruments. In several instances, after the initial phone screening, the SCID was administered by a trained research assistant. The mental health counselor or psychologist reviewed the SCID prior to establishing SUD diagnosis. Couples were compensated $60.00 ($30.00 each). The study was conducted in accordance with the code of ethics of the American Psychological Association. Human subjects approval was granted by the participating research university.

**RESULTS**

**Preliminary Data Analysis**

Data were first examined for missing values. Missing data ranged from 9.62% (5 missing values) on several variables to 19.23% (10 missing values) on fathers’ total summed score on the Dyadic Adjustment Scale. The amount of missing data is typical in research with clinical samples (Little et al., 2012). Little’s (1988) test for examining the pattern of missing data was not statistically significant ($p = .952$). Results imply that missing data were missing completely at random (MCAR). Thus, parameters were estimated via full-information maximum likelihood for hypothesis testing.

Prior to hypothesis testing, the three different substance abuse types based on DSM-IV-TR substance use diagnosis (i.e., father alcohol only diagnosis, father drug only diagnosis, and father both alcohol and drug diagnosis) were compared to determine if couples differed
Table 1
Bivariate Correlations Among Study Variables for Substance Using Fathers and Their Nonsubstance Using Partners

<table>
<thead>
<tr>
<th>Variable</th>
<th>KPS1</th>
<th>KPS2</th>
<th>KPS3</th>
<th>KPS4</th>
<th>KPS5</th>
<th>KPS6</th>
<th>KPS7</th>
<th>DAS</th>
<th>KPS1</th>
<th>KPS2</th>
<th>KPS3</th>
<th>KPS4</th>
<th>KPS5</th>
<th>KPS6</th>
<th>KPS7</th>
<th>DAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>F: KPS1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F: KPS2</td>
<td>.43</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F: KPS4</td>
<td>.26</td>
<td>.32</td>
<td>.36</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F: KPS5</td>
<td>.06</td>
<td>.23</td>
<td>.37</td>
<td>.45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F: KPS6</td>
<td>-.03</td>
<td>.10</td>
<td>-.11</td>
<td>.06</td>
<td>-.02</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F: KPS7</td>
<td>.08</td>
<td>.32</td>
<td>.03</td>
<td>.28</td>
<td>.23</td>
<td>.34</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F: DAS</td>
<td>-.10</td>
<td>-.12</td>
<td>-.05</td>
<td>.30</td>
<td>-.07</td>
<td>.20</td>
<td>.36</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M: KPS1</td>
<td>.26</td>
<td>.02</td>
<td>.30</td>
<td>.25</td>
<td>.40</td>
<td>-.10</td>
<td>-.14</td>
<td>.19</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M: KPS3</td>
<td>-.09</td>
<td>.06</td>
<td>.29</td>
<td>.31</td>
<td>.46</td>
<td>-.01</td>
<td>.18</td>
<td>.20</td>
<td>.46</td>
<td>.47</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M: KPS4</td>
<td>.04</td>
<td>.12</td>
<td>-.10</td>
<td>.26</td>
<td>.38</td>
<td>-.06</td>
<td>.22</td>
<td>.09</td>
<td>.31</td>
<td>.41</td>
<td>.58</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M: KPS5</td>
<td>.02</td>
<td>.10</td>
<td>.18</td>
<td>.06</td>
<td>.33</td>
<td>-.18</td>
<td>.03</td>
<td>-.01</td>
<td>.36</td>
<td>.46</td>
<td>.63</td>
<td>.40</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M: KPS6</td>
<td>-.23</td>
<td>.12</td>
<td>.08</td>
<td>-.04</td>
<td>-.07</td>
<td>.12</td>
<td>.01</td>
<td>.01</td>
<td>-.18</td>
<td>-.25</td>
<td>-.30</td>
<td>-.22</td>
<td>-.33</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M: KPS7</td>
<td>-.02</td>
<td>.09</td>
<td>-.02</td>
<td>-.01</td>
<td>-.01</td>
<td>.13</td>
<td>.04</td>
<td>.18</td>
<td>-.05</td>
<td>-.05</td>
<td>.14</td>
<td>.05</td>
<td>-.27</td>
<td>.68</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M: DAS</td>
<td>-.21</td>
<td>.20</td>
<td>-.07</td>
<td>.18</td>
<td>.08</td>
<td>.08</td>
<td>.07</td>
<td>.35</td>
<td>-.02</td>
<td>-.21</td>
<td>-.04</td>
<td>.04</td>
<td>-.15</td>
<td>.62</td>
<td>.76</td>
<td></td>
</tr>
</tbody>
</table>

Note. F = father data; M = mother data; KPS1 = Stays home with child(ren) when child(ren) is/are sick; KPS2 = Takes time off from work for doctor’s visits or meetings with teachers; KPS3 = Arrange for childcare, including summers and long vacations; KPS4 = Transports child(ren) to and from activities, such as friends, lessons or other activities; KPS5 = Supervises children’s activities; KPS6 = How satisfied are you with the way you share these responsibilities?; KPS7 = How satisfied are you with your partner as a parent?; DAS = dyadic adjustment scale; Ns range from 37-49 because missing data. Bold indicates statistical significance at α = .05.
on key study variables. Specifically, a series of one-way analysis of variances (ANOVAs) demonstrated that the mean scores for both fathers’ and mothers’ reports of childcare responsibility (five variables each), childcare satisfaction (two variables each), and relationship satisfaction (one variable each) did not differ as a function of substance abuse type (i.e., alcohol only, drug only, or both alcohol and drug). Therefore, substance abuse type was not modeled in subsequent analyses. Bivariate correlations among study variables are presented in Table 1. Primary hypotheses were tested in Mplus (Muthén & Muthén, 1998-2014); preliminary data analysis and descriptive statistics were estimated in R.

**Hypothesis Testing**

To determine which parent was more likely to be responsible for different aspects of childcare, mean differences were tested using a series of paired sample z-tests (i.e., the analog of a t-test in Mplus). There were five pairs of dependent variables, thus, each test assessed which parent was more likely to: 1) Stay home with child(ren) when child(ren) is/are sick, 2) Take time off from work for doctor’s visits or meetings with teachers, 3) Arrange for childcare, including summers and long vacations, 4) Transport child(ren) to and from activities such as friends’ homes, lessons, or other activities, and 5) Supervise child(ren)’s activities. To account for non-normality, hypothesis testing was done using 99% bias-corrected (BC) confidence intervals (CIs) based on 1,000 bootstrap samples with replacement. The 99% CI coverage was chosen to adjust for Type I error based on the five separate tests of mean differences (i.e., \( \alpha = .05 \) / [5 comparisons] = .01 for adjusted \( \alpha \)).

Results revealed two significant mean differences between mothers and fathers. Specifically, mothers (\( M = 2.17 \)) were significantly more likely to arrange for childcare than fathers (\( M = 1.58 \)), with a \( M_D = -0.59 \) and 99% BC CI [-1.41, -0.01]. In addition, mothers (\( M = 2.40 \)) were significantly more likely to supervise children’s activities than fathers (\( M = 1.94 \)), with a \( M_D = -0.47 \) and 99% BC CI [-0.86, -0.06]. There were no significant differences between parents in terms of which parent stayed home with children when they are sick, for which parents takes time off from work for doctor’s visits or meetings with teachers, or for which parent transports child(ren) to and from activities such as friends’ homes, lessons, or other activities. See Table 2 for a summary of univariate analyses.

Next, we examined if fathers’ or mothers’ satisfaction with the division of parenting responsibilities predicted their reports of relationship satisfaction. A multivariate regression model was estimated to test these hypotheses. The primary exogenous variables were fathers’ and mothers’ reports of how satisfied he/she was in regards to: 1) The way the couple shares childcare parenting responsibilities, and 2) Their satisfaction with the other partner as a parent. All exogenous variables were allowed to covary and predict both fathers’ and mothers’ reports of relationship satisfaction. Because both fathers’ and mothers’ reports of relationship satisfaction were significantly correlated (\( r = .31, p = .028 \)), the two disturbances in the model were allowed to covary to account for the interdependence in the data. Multivariate outliers were identified using log-likelihood influence statistics (Cook & Weisberg, 1982). The final model was bootstrapped using 1,000 samples with replacement and 95% BC CIs were generated for hypothesis testing.

Two multivariate outliers were identified and removed from the model\(^1\); thus a sample of \( N = 50 \) was used for model testing. Based on bootstrapped results, after controlling for the

---

\(^1\)The data were analyzed with the two outliers included. Results were largely identical and available from the first author upon request.
Table 2

Summary of Univariate Analyses Testing for Mean Differences on Childcare Responsibility Variables Between Substance Using Fathers and their Nonsubstance Using Partners

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Father M</th>
<th>Mother M</th>
<th>M difference</th>
<th>99% BC CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Stays home with child(ren) when child(ren) is/are sick</td>
<td>2.17</td>
<td>2.32</td>
<td>-0.15</td>
<td>-0.64 0.35</td>
</tr>
<tr>
<td>2. Takes time off from work for doctor’s visits or meetings with teachers</td>
<td>2.34</td>
<td>2.47</td>
<td>-0.23</td>
<td>-0.60 0.20</td>
</tr>
<tr>
<td>3. Arranges for childcare, including summers and long vacations</td>
<td>1.58</td>
<td>2.17</td>
<td>-0.59*</td>
<td>-1.41 -0.01</td>
</tr>
<tr>
<td>4. Transports child(ren) to and from activities such as friends’ homes, lessons, or other activities</td>
<td>2.09</td>
<td>2.17</td>
<td>-0.08</td>
<td>-0.56 0.33</td>
</tr>
<tr>
<td>5. Supervises child(ren)’s activities</td>
<td>1.94</td>
<td>2.40</td>
<td>-0.47*</td>
<td>-0.86 -0.06</td>
</tr>
</tbody>
</table>

Note. M = mean; BC = bias-corrected; CI = confidence interval; LL = lower limit; UL = upper limit. Data from fathers’ reports were coded as 0 (Neither one of us does it), 1 (I usually do it), 2 (My partner and I share equally), and 3 (My partner usually does it). Data for mothers’ reports were coded as 0 (Neither one of us does it), 1 (My partner usually does it), 2 (My partner and I share equally), and 3 (I usually do it). Using this coding, higher scores reflect more parental responsibility for the mother. N = 50 due to missing data on all variables for two participants.

* p < .01.
effects of the other three variables (i.e., fathers’ reports of satisfaction with the division of parenting, fathers’ reports of satisfaction with their partners as parents, and mothers’ satisfaction with their partners as parents) mothers’ relationship satisfaction was significantly (positively) associated with mothers’ satisfaction with the way the couple shared parenting responsibilities. Likewise, while controlling for the effects of the other three variables, mothers’ relationship satisfaction was significantly (positively) associated with mothers’ satisfaction with their partners as parents. Of note, the model accounted for approximately 70% of the variance in mothers’ reports of dyadic satisfaction. On the contrary, after controlling for the other three variables (i.e., mothers’ satisfaction with the division of parenting, mothers’ satisfaction with their partners as parents, and fathers’ satisfaction with the division of childcare), fathers’ relationship satisfaction was significantly (positively) associated only with fathers’ reports of the satisfaction with his partner as a parent (see Figure 1). As shown in the figure, 18% of the variance in fathers’ dyadic satisfaction was accounted for by the model.

_Figure 1._ Fitted multivariate regression model. Numbers are unstandardized parameter estimates; bootstrap confidence intervals are presented in brackets. F = father data; M = mother data; KPS6 = How satisfied are you with the way you share these responsibilities?; KPS7 = How satisfied are you with your partner as a parent?; DAS = dyadic adjustment scale; All exogenous variables were allowed to covary, however, these paths are omitted for clarity.
The purpose of the present study was to examine the division of childcare responsibilities among fathers with SUD who reside with their children, and whether satisfaction with the division of childcare and perceptions of parenting were related to their own and their partners’ relationship satisfaction. To examine the latter aim, we examined an API framework which was able to account for the nonindependence between self and partner reports.

Although we anticipated that fathers would be less likely to perform all childcare activities, parents’ shared three of the five childcare activities (e.g., stays home with ill children, takes time off from work for doctor’s visits or meetings with teachers, and transports children to and from activities), equally. The finding that fathers with SUD were equally likely to transport children to and from activities is concerning. During periods of heavy use, it is possible that fathers may have transported children while under the influence of substances. Our findings are also somewhat counter to previous research in two-parent dual-income homes in which mothers are often responsible for child transportation. Specifically, among Australian two-parent dual-income families, Craig (2006) found that mothers’ reported four times more child-related travel as compared to fathers. One explanation for the finding that fathers shared equally in taking children to and from activities, in going to doctor’s appointments and other meetings, and caring for ill children is that 25% of fathers were not employed and 15.4% were employed part-time. The relatively large number of fathers who were not employed full-time may have afforded fathers greater opportunity to take part in childcare. More globally, the finding that many fathers had tenuous work histories is similar to results of McMahon et al. (2008) in their study of fathers receiving methadone maintenance.

In general, most investigators have found a positive association between mothers’ relationship satisfaction and fathers’ involvement in childcare (e.g., Nangle et al., 2006; Schober, 2012; Sigle-Rushton, 2010). While it might be assumed that non-substance-abusing mothers might not want their partners to be responsible for childcare, this did not appear to be the case. Rather, our findings extend previous literature conducted with a community sample (e.g., Bonney, Kelley & Levant, 1999) that greater paternal involvement in childcare is associated with more positive relationship satisfaction by mothers. Furthermore, mothers’ satisfaction with fathers as parents predicted women’s relationship satisfaction. Of note, mothers’ satisfaction with the division of childcare and satisfaction with their partners as parents were strongly associated with women’s dyadic satisfaction.

These findings are important for several reasons. The family environment and the degree of interparental conflict are frequent concerns in families in which one or both parents have SUD (Kelley et al., 2010; Stover, Easton, & McMahon, 2013). Although there are different forms of interparental conflict (Krishnakumar & Buehler, 2000), the overtly hostile style (Ahrons, 1981; Camara & Resnick, 1988), fits many substance-abusing couples (Kelley et al., 2010). As would be predicted from a number of theories including family systems theory, the overtly hostile style may spillover into parent-child interactions (e.g., Krishnakumar & Buehler, 2000). Thus, it is possible that greater relationship satisfaction and positive interactions with a spouse may contribute to a positive state of mind and reinforce parents’ desire to be involved in childcare (e.g., Aldous, Mulligan, & Bjarnason, 1998). Furthermore, Brook et al. (2002) demonstrated that even when fathers were drug-abusing, positive father-child relationships may protect their children from drug use.

These findings may also have important implications for recovery. Romantic partners have both positive and negative influences on substance use and treatment outcomes (see...
Thus, relationship satisfaction and partner support are linked to recovery attempts (Steinberg et al., 1997). Furthermore, positive support from partners, extended family members, and health professionals appears associated with women’s substance abuse recovery attempts and connection to their children (Silva et al., 2013). Conversely, the lack of partner support was one of the reasons women entering treatment for alcohol abuse chose individual versus couples’ treatment (McCready, Epstein, Cook, Jensen, & Ladd, 2011). For couples in which fathers have SUD, mothers’ decisions to stay with their partners’ and support their partners’ recovery may in part be based on satisfaction with other areas of their relationships such as the division of childcare and satisfaction with their partners as parents.

Turning to men, fathers’ satisfaction with their partners as parents contributed to men’s reports of relationship satisfaction. This association, however, was not as strong as that of mothers. Also, fathers’ satisfaction with the division of childcare did not contribute to men’s reports of dyadic satisfaction. The literature on fathering has shown inconsistent findings with respect to paternal involvement in childcare and dyadic satisfaction with some studies showing positive (e.g., Lee & Doherty, 2007), negative (Nangle et al., 2003; see Schober, 2012, for a review), and no association between paternal involvement and fathers’ reports of dyadic satisfaction (Carlson, Pilkuskas, McLanahan, & Brooks-Gunn, 2011; Jackson, Miller, Oka, & Henry, 2014).

Clinical Implications

In recent years, there has been a growing interest in providing integrated services for mothers who abuse substances to support them in their parenting roles (Center for Substance Abuse Treatment, 2009). Some have noted that services for mothers that provide integrated and comprehensive programs are more effective at reducing substance use disorders, improving mental health, and improving parenting skills (Milligan et al., 2010, 2011; Niccols et al., 2010, 2012). Sword and colleagues (2009, 2013) found mothers who participate in integrated programs benefit in terms of maternal well-being, gain a sense of personal agency, develop more positive social support networks, gain greater insight into and capacity for relationships, and improve maternal-child communication (Sword et al., 2009; Sword, Niccols, Yousefi-Nooraie, Dobbins, Lipman, & Smith, 2013). Although programs for fathers with SUD are in development (e.g., McMahon, 2013), programs that incorporate parenting information for fathers with SUD are few (e.g., Stover & Kiselica, 2014). The point at which men with SUD enter substance treatment may provide a brief window of opportunity to engage these fathers and mothers in parent education or provide online and other resources that may support fathering and have potentially important implications for their families and children.

Limitations

Our study was marked by several important limitations. Most importantly, our sample was limited to couples in which fathers met criteria for alcohol or drug use disorder. Thus, the nature of our sample limits generalizability. Also, our sample contained fathers with SUD who indicated they were interested in receiving substance abuse services. Ideally, we would have been able to examine age and SES matched couples in which fathers did not have SUD. Furthermore, our results are limited by a small sample size. In addition, only 67% of the fathers reported full- or part-time employment which may have afforded greater op-
portunity to be involved in childcare. However, it is also possible that some fathers who did not report working were involved in the underground economy (e.g., selling drugs or other activities). Importantly, all data were self-report. Future research should attempt to include daily diaries or other methods of verifying parent reports of childcare responsibilities. Furthermore, future research should examine other aspects of dyadic relationship, such as intimate partner violence, that may contribute to relationship satisfaction. Despite these concerns, this is an extremely difficult-to-reach subpopulation of fathers. Taking account of these fathers’ point of view, especially with respect to parental involvement, is important. Moreover, the ability to examine data from an actor-partner framework (Kenny et al., 2006) which accounts for the nonindependence of partner reports is valuable.

**CONCLUSIONS**

Findings suggest that in two-parent families in which fathers met criteria for SUD and live with their children, fathers and mothers share many childcare tasks. We also found support for what Kenny et al. (2006) refers to as actor-oriented effects, in which a person’s outcomes are a function of that person’s characteristics only. Specifically, mothers’ relationship satisfaction was predicted by mothers’ reports of satisfaction with the way the couple shared parenting responsibilities and mothers’ reports of the satisfaction with their partners. These results parallel much of the larger literature on parenting (e.g., Schober, 2012). In contrast, fathers’ relationship satisfaction was predicted by fathers’ reports of the satisfaction with their respective partner as a parent. Importantly, our findings demonstrate that fathers with SUD who reside with their children are involved in childcare and that their partners’ satisfaction with men’s involvement in childcare is important for dyadic relationships.

**REFERENCES**


