

Fatherhood and Intimate Partner Violence: Bringing the Parenting Role Into Intervention Strategies

Carla Smith Stover and Dorothy Morgos
Yale University School of Medicine

A large percentage of men who perpetrate intimate partner violence (IPV) are fathers who continue to live with or have visitation with their children. Yet, providers rarely consider that fathers who perpetrate IPV may benefit from a parent–child focused intervention. Therapeutic work with men who perpetrate IPV, especially with their children, is complex, considering that issues of child safety take precedence. This article is meant to provide (a) a rationale for considering father–child intervention in the context of IPV, (b) specific strategies for assessment, (c) guidelines for determining if a father is appropriate for such intervention, and (d) a review of treatment approaches that have been developed that may assist clinicians in work with this population.

Keywords: intimate partner violence, fathers, parenting, intervention

Estimates suggest that approximately 17 million children are living in homes with intimate partner violence (IPV) in the United States (McDonald, Jouriles, Ramisetty-Mikler, Caetano, & Green, 2006), defined as physical, psychological, or sexual violence perpetrated against an intimate partner. It is well documented that exposure to IPV can result in significant psychological difficulties and negative outcomes for children (Kitzmann, Gaylord, Holt, & Kenny, 2003). Additionally, children living in homes with IPV are at significant risk for child maltreatment; a recent study has indicated that one third of youth exposed to IPV has also reported experiencing child maltreatment in the last year (Hamby, Finkelhor, Turner, & Ormrod, 2010). A biological parent perpetrates

76% of child maltreatment cases, with 43% of those at the hands of biological fathers (Sedlak et al., 2010). Children aged 6 to 14 are significantly more likely to be physically abused than children from birth to 2 years.

Although there are a wide variety of intervention programs designed for men who perpetrate IPV, there are limited nationwide standards that require parenting, coparenting, or fathering interventions to be included as part of court-mandated programs for male batterers (Gewirtz & Menakem, 2004), and child protective-service agencies are often unable to find parenting-intervention programs for fathers who perpetrate IPV. This is despite studies that indicate that more than 60% of men who are arrested for IPV

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CARLA SIMTH STOVER PhD, is a licensed clinical psychologist and Assistant Professor at the Yale University School of Medicine with joint appointments at the Child Study Center and the Department of Psychiatry. She has extensive clinical experience with families impacted by trauma and domestic violence including police-mental health collaboration with the Child Development-Community Policing Program, early intervention, and longer term evidence based treatments including Trauma Focused-CBT and Child Parent Psychotherapy. She has provided trainings in best practices and intervention for children exposed to trauma nationally. She is a faculty member for the Connecticut statewide Trauma Focused-CBT Learning Collaborative training clinicians and child protective services across the state in implementation of screening and assessment of trauma in children and TF-CBT. She is the Research Coordinator for the National Center for Children Exposed to Violence at Yale. Dr. Stover has been the principal investigator on several studies examining the efficacy of outreach and intervention efforts for families impacted by domestic violence and other traumas. Dr. Stover was awarded a K23 grant from the National Institute of Drug Abuse to develop and evaluate an intervention for fathers with co-occurring substance abuse and intimate partner violence histories that specifically targets their roles as fathers. She has developed the program Fathers for Change and is currently running a randomized pilot of the intervention.

DOROTHY MORGOS received her PhD in clinical psychology from Rosemead School of Psychology, California, completed a predoctoral internship at Children's Hospital of Orange County, California, and completed a postdoctoral fellowship and worked as associate research scientist at Yale School of Medicine, Connecticut. Dr. Morgos is a clinical psychologist, international guest lecturer and professional consultant in trauma, grief as well as working with war and other related violence victims. Her research focuses on trauma assessment, treatment planning and therapeutic approaches for diverse children/adolescents, families and adult population. Dr. Morgos has also headed and completed a research studies on the effects of war in places like Sudan, as well as provided consultation for Physician for Human Rights group to develop a measurement to assess traumatic reaction and needs among victimized Sudanese women and refugees in Chad, trained law enforcement and NGO's professionals on psychological issues related to working in conflict zone areas and providing urgent psychosocial and crisis intervention services. Dr. Morgos worked closely with international academic institution in providing consultation on developing a trauma curriculum and starting trauma clinic in war zone area.

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are in a father role (Rothman, Mandel, & Silverman, 2007) and more than 60% of children continue to live with or visit their fathers regularly following an incident of IPV (Israel & Stover, 2009). Add to these numbers the high incidence of psychological symptoms and difficulties of these children that make them more difficult to parent and we have a pressing need for parenting interventions in these families.

Most programs designed for batterers focus on anger management, issues of power and control, and providing alternatives to end criminal behaviors. Though programs may use varied intervention methods, most have similar goals, including accountability and legal justice, victim safety, and adaptive emotional and behavioral responses to prevent abuse (Austin & Dankwort, 1997, 1999; Healey, Smith, & O'Sullivan, 1998). According to Bennett and Williams (2001), about 80% of participants in programs designed for abusive men are referred by the court following an arrest. This may result in hostility toward providers and hesitancy to disclose information that may be viewed as negative, making engagement difficult.

In addition, research has shown that batterer-intervention programs, as currently implemented by the criminal justice system, do not work for many men who perpetrate IPV, with drop-out rates estimated at 50% to 75% for most programs (Scott, 2004) and have little overall impact on recidivism rates (Babcock, Green, & Robie, 2004; Feder & Wilson, 2005). The one-size-fits-all approach to intervention has limited efficacy, suggesting that more varied and individually tailored intervention approaches are needed. Consideration of father-child or family-based interventions (especially couple treatment) has long been discounted as dangerous and unethical (Stith, McCollum, & Rosen, 2011). Recently, the field's understanding of IPV and the heterogeneity of dynamics within families suffering from IPV is becoming more nuanced. There is growing evidence of more perpetration of IPV by both men and women (Archer, 2002) and there are clear indications that some perpetrators and their families can benefit from couples intervention (Stith et al., 2011; O'Leary & Cohen, 2007). Although there are perpetrators of IPV who should not be considered for father-child or family intervention, and careful assessment is needed before considering such an approach, some men who have incidents of violence within their relationships can benefit from inclusion of family-focused intervention as part of their treatment (O'Leary & Cohen, 2007; Stith et al., 2011; Stith, Rosen, McCollum, & Thomsen, 2004; Stover, 2013). This paper is intended to focus on those men who are violent in their relationships, but who could nonetheless benefit from intervention focused on their roles as fathers. It will review the importance of considering father-child interventions in families impacted by IPV and effective assessment strategies for screening for compatibility and safety of treatment.

Why Consider Father-Child Treatment in Families Impacted by IPV?

There is now substantial literature to show the importance of nonabusive fathers in the lives of children (Day & Lamb, 2004; Lamb, 1997, 2004; Marsiglio, Amato, Day, & Lamb, 2000). Research has shown that fathers are important to the psychosocial development of children and adolescents (Amato, 1991; Beatty, 1995; Hilton & Desrochers, 2002; Mandara & Murray, 2000) and their absence has differing impact on specific areas of child development such as gender-role development (Mandara, Murray, & Joyner, 2005). This

general finding regarding the importance of father involvement is much more complicated in violent homes, as exposure to IPV has been consistently linked to negative developmental and psychological outcomes for children and youth (e.g., (Crockenberg & Langrock, 2001; Kitzmann et al., 2003; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003); and exposure to violence has significant implications for children's beliefs about family roles and men's positions as dominant to women (Graham-Bermann & Brescoll, 2000).

Although exposure to IPV is of significant developmental concern and stopping further exposure is paramount, dissolution of the family and/or loss of contact with fathers can also cause distress for children. Following domestic violence, children may have conflicted feelings toward their fathers. Peled's (1998) study of preadolescent children showed that children expressed a range of feelings toward their fathers that included love, terror, loyalty and fear. Some of the children tended to reframe or excuse the father's violent behaviors (Peled, 1998). Studies of preschool aged children have also indicated higher internalizing symptoms (e.g., depression, anxiety, withdrawal) and negative maternal representations in play for children who do not have regular visitation with their fathers after dissolution of the family unit (Stover, Van Horn, & Lieberman, 2006; Stover, Van Horn, Turner, Cooper, & Lieberman, 2003). Children's relationships to their fathers and their feelings and reactions following separation from him are complex and varied. Careful assessment of individual family needs to determine the best course of action is important in families impacted by violence. Although treatment and interventions have been developed to target symptoms and problems of children following exposure to domestic violence or maltreatment, inclusion of fathers or what role they may play in the recovery of their children has not been well-explored in the research or clinical literature.

What We Know About Fathering and IPV

Fathers may not be fully aware of the impact of their violence on their children even if they express concern of potential negative impact. There are a few studies that examined violent men's reports about their perceptions of violence or parenting. A survey study conducted with 464 men entering a batterer-intervention group indicated 53% were worried about the long-term effects of their violent behavior on their children (Rothman et al., 2007). Of the biological fathers interviewed, 56% reported they would seek professional help for themselves if they felt their violence was impacting their children, with 42% and 43% reporting they would seek family counseling or professional help for their children, respectively. Another large survey of 3,824 men participating in a court-ordered evaluation following an arrest of IPV found that the majority of the fathers acknowledged that their children had been exposed to interparental conflicts, but few perceived that their children had been affected by this exposure. Risk factors for child maltreatment were highly prevalent in the sample (Salisbury, Henning, & Holdford, 2009). Certainly studies have documented overlap between IPV and child maltreatment, with co-occurrence rates approximated at close to 40% (Edleson, 2001; Hamby et al., 2010).

Baker, Perilla, and Norris (2001) questioned IPV-perpetrating fathers directly about their parenting stress and competence. The study interviewed immigrant Latino couples and found that parenting stress was not related to partner abuse, but that increased

partner abuse was associated with lower feelings of parental competence. Fathers were aware of the impact of their abuse on their children and thus felt less competent as parents. In addition, 70% of the men in the sample felt they had no one to turn to for advice or questions related to parenting (Baker et al., 2001).

Fox and Benson (2004) used data from the National Survey of Families and Households (Sweet, Bumpass, & Call, 1988) to document differences in parenting behavior associated with IPV. Although they found no differences in time spent or types of activities shared with children between fathers with reported relationship aggression and those without, men prone to aggressive behavior with an intimate partner were more likely to demonstrate hostile, coercive parenting behavior (Fox & Benson, 2004). As has long been the concern of domestic violence advocates, Harné (2002) found that there is a category of abusive fathers who carried their expectations and dysfunctional interactions with their partners into their parenting practices. So though these fathers may claim that they love their children and are concerned about their well-being, careful assessment may reveal that such claims are self-serving and manipulative in nature. Some fathers may be motivated to continue interacting with their children following separation due to their own expectations that the children will give them unconditional love and acceptance. Such implicit motives and misconceptions regarding the role of children in fathers' lives may end up becoming the breeding ground for future abuse and psychological turmoil for the children. Fathers may implicitly imply to the children that it is their responsibility to meet the father's emotional needs instead of the adult partner. In such incidents, fathers may attempt to manipulate the therapeutic interventions to claim their children as "emotional property." In these cases, father-child interventions may be detrimental to the child.

However, there are other fathers who may genuinely echo their concerns about parenting skills and effects of intimate violence on their children (Litton Fox, Sayers, & Bruce, 2001). It is in this category of fathers that father-child interventions may be beneficial. Careful assessment of the motivation, potential danger, and psychological functioning of each father is pivotal for intervention success and the overall well-being of the child. The clinician provides a unique insight regarding these issues and in determining the course of treatment that would best serve the child's needs. The clinician is in the position to indicate when and if father-child intervention is appropriate or if individual work with the father would be more beneficial.

Assessing Fathers With IPV History for Treatment

The first and foremost issue that will pose a challenge in father-child interventions following IPV will be the initial phase of engagement and assessment. In many cases, reported domestic violence results in incarceration, removal from the house, restraining and protective orders against the father, job loss, and homelessness. This may result in initial hostility and suspicion toward authorities and therapists alike. Furthermore, these men may be concerned about legal ramifications of any disclosures or information they share (Lamb, 2004). Batterers tend to have the general perception that such programs are biased toward females, given the focus of many programs regarding risk factors, safety, and prevention of future violence (Gewirtz & Menakem, 2004). This perception tends to increase fathers' alienation in treatment programs.

Accordingly, clinical providers have to convey the message that they are not "negative interferences" mandated by Child Protective Services (CPS) and court. Instead, intervention programs are an opportunity to be listened to, learn effective ways to respond rather than react to situations, and learn child-developmental stages and effective parenting skills. They should be used to provide batterers with a chance to get more involved in their children's lives in healthy, developmentally appropriate ways.

At the initial stage, assessing the motivational level and fathers' willingness to engage in treatment, implementation of motivational interviewing techniques (Miller & Rollnick, 2002), and unconditional positive regard may increase a father's sense that he is being heard and that a therapist is interested in helping rather than punishing him. Motivational interviewing has been used with perpetrators of IPV and those with co-occurring substance-abuse disorders. There is evidence that this approach can increase engagement in treatment (Murphy & Maiuro, 2009; Murphy & Ting, 2010), especially for men who are fathers (Mbilinyi et al., 2009; Stover, 2013). Giving men opportunity to tell their side of the story and identify their wants for change helps men feel validated, respected, and more likely to take action (Anderson & Stewart, 1983). Acknowledgment that attending sessions may not be his choice, but the therapist is interested in setting goals that will make the time beneficial for him changes the tenor of the sessions from punitive to positive. First focusing on his strengths and the ways the father sees himself succeeding as a father and partner can build rapport and allow him to become more open to learning new ways of communicating and parenting. Rolling with resistance related to his need for IPV or parenting treatment and instead focusing on his role as a father and his hopes and dreams for his children can be an effective engagement strategy with some men (Stover, 2013).

Furthermore, any form of effective father-child intervention will need to include consideration of how to coordinate with legal systems, CPS, responsible father programs (Edleson & Williams, 2007), and other social services because there is often poor communication among all services involved. Service providers often encounter challenges when there are simultaneous legal/criminal proceedings, community services and CPS operating in an uncoordinated way (Jaffe, Crooks, & Bala, 2005).

Case Example of Case Coordination

The following case illustrates how communication between programs and agencies at the outset of assessment can work to the benefit of the father client and assist his engagement if he sees the clinician as an ally in working within the systems he is confronting.

Leo had been arrested for an incident of IPV. CPS was contacted by the police and conducted an investigation. Leo and his partner Linda were living with Linda's mother due to homelessness. Leo tested positive for marijuana and Linda for cocaine. CPS was concerned about the IPV incident, substance use by both parents, and Linda's mother's prior history with CPS (Linda had been a foster child herself). CPS removed their three children and placed them in foster care. CPS's plan indicated Leo needed to attend anger management, substance-abuse treatment, get a job, and find appropriate housing. Leo enrolled in a coordinated substance-abuse and parenting program and began attending sessions. The court then sent him to a mandated batterer-intervention program that was scheduled twice per week (once on the same day and time as his substance-abuse treatment and another that conflicted with his limited work hours). He became

overwhelmed trying to negotiate between the CPS and court system and indicated that he did not know which program to attend. He was considering giving up and not doing any of the programs. With his permission, his clinician from the substance-abuse and parenting program contacted his CPS social worker, the court-based family-relations counselor, and the batterer-intervention program to discuss possible options. They were able to identify an alternative batterer-intervention program in another town that would fit more appropriately into Leo's schedule and meet the requirements of the court related to his IPV charge. CPS provided Leo with a bus pass so that he could get to the sessions, as he had no vehicle. Leo was able to successfully complete his individual programs and keep his job. This paved the way for father-child and family interventions to further strengthen the family and allow the children to return home.

Areas of Assessment

To assist in making determinations about how to proceed with treatment, a comprehensive assessment should include the following areas: (a) Nature and severity of abusive behavior, (b) dangerousness/lethality, (c) coercion and control, (d) substance abuse, (e) psychological symptoms, (f) personality characteristics and attachment, (g) trauma history, (h) childhood family life, (i) parenting beliefs and behaviors, (j) life stress, (k) symptoms of his children, (l) motivation for change and participation in treatment, (m) coparenting relationship, (n) symptoms of the mother/partner, and (o) criminal and child-protection history via record review/interagency contact.

Many standardized measures exist to assess all of these areas, and although this paper is not intended to review all measures available, clinicians should carefully select assessment tools to determine dangerousness. Some suggested measures to assess critical areas are listed in [Table 1](#). The Danger Assessment Scale was developed and validated as a measure of lethality risk and has sound psychometric properties (see [Campbell, Webster & Glass, 2009](#)). [Hilton, Harris, and Rice \(2010\)](#) have developed several domestic violence risk assessments to be used to predict IPV recidivism. The Ontario Domestic Assault Risk Assessment (ODARA) and the Domestic Violence Risk Appraisal Guide (DVRAG) both have been validated with large samples of criminal IPV offenders. These are similar instruments that utilize history of criminal incidents, use of substances, family characteristics, and severity and type of violence to indicate risk of future violence. The DVRAG also includes use of the Psychopathy Checklist-Revised (PCL-R; [Hare, 2003](#)), with a score above 17 indicating a significant risk factor for recidivism ([Hilton et al., 2010](#)).

Assessment of parenting capacity is also critical. This includes thorough assessment of physical, emotional, and economic factors contributing to effective parenting. This process should take cultural differences into consideration when assessing the defined parenting gender roles. How men of different cultures define their roles and their beliefs about corporal punishment are important areas of inquiry. Helping fathers from differing cultural backgrounds and upbringings to understand the laws in the United States can be an incredibly important intervention that can result in positive outcomes for the family. Taking a stance of curiosity about beliefs and a father's own upbringing can allow for a dialogue that cannot happen if the clinician takes a punitive stance or indicates the father's culture or own parents were wrong in their approach.

Issues regarding manipulation of children and partners and the child's sense of safety when alone with father should be thoroughly assessed before the initiation of father-child therapeutic

interventions. Unfortunately, there are no empirically based standardized screening tools that assess all these areas ([Bancroft & Silverman, 2002](#)). However, several measures exist to measure child abuse potential. The Child Abuse Potential Inventory (CAPI; [Milner, 1990](#)), Adolescent-Adult Parenting Inventory (AAPI; [Bavolek & Keene, 2001](#)) and the Parental Acceptance-Rejection Questionnaire (PARQ; [Rohner & Khaleque, 2005](#)) are three measures that can assist in gathering information about abuse potential. These measures can be administered as self-report to the fathers, but also to collateral informants (e.g., mother or other family members) who could report on the behavior of the child's father toward the child. Although the CAPI and AAPI have both been found to have predictive validity for child maltreatment, with high scores on these measures associated with substantiated abuse, these measures can be significantly influenced by social desirability. For many of the items, it is obvious what the socially acceptable answer might be, resulting in a potentially skewed assessment of risk. Inclusion of direct observation of fathers and children in free play and completing specific tasks (puzzles, building towers, cleaning up toys) can be quite informative with regard to the father's parenting and the nature of the father-child relationship, in conjunction with administration of parenting questionnaires.

Assessment must include collection of information directly and individually from fathers, mothers, and when possible, directly from children who might participate in intervention. Gaining permission to talk with other family members and friends can provide additional information to aid assessment. Collateral information from other agencies and systems involved with the family is vital. Contact with schools, records from child protective services, police, and courts can provide important information about the nature and severity of violence, coercive control being exerted by the father, and his motivation for change. Clinicians conducting evaluations must keep careful documentation about procedures used, results, and implications for treatment. Behaviors and risk assessment must also be documented, along with clinical recommendations related to father-child intervention. Written notes related to progress during treatment and contact with other systems such as the court, CPS, police, or probation when concerns about risks arise are essential. Recorded rationale for clinical decisions made can provide protection for clinicians in the unfortunate circumstance that a father perpetrates further violence against his female partner or his child.

Determining if Father-Child Sessions Are Appropriate

Some of the questions that must be answered to determine appropriateness of father-child intervention are: (a) What was the nature and severity of the abuse? (b) What is the risk for further violence? (c) Does he recognize that his use of violence was wrong and take some responsibility for his actions? (d) What is his legal and mental-health status? (e) What is motivating him to want to participate? (f) Is he engaged in other treatment that will address other mental-health or substance-abuse concerns? (g) Does the child want to attend treatment with his or her father? (h) Does the child still have significant contact or will he or she likely have contact with the father in the future, in which case intervention could be beneficial? (i) How does the child's mother feel about the child attending sessions with his or her father? (j) What would be the goals of father-child-focused treatment sessions?

Table 1
Domains of Assessment To Assist in Determining if Fathers Are Appropriate for Inclusion in Treatment in Cases of IPV

Assessment domain	Possible measures	Outcomes that may preclude father inclusion in treatment
Nature and severity of domestic violence	Conflict Tactics Scale–Revised (Straus, Hamby, Boney-McCoy, & Sugarman, 1996) Police/criminal records Child protective services records	Current no-contact protective order Severe violence (attempted strangulation, use of weapon) Father's denial of past history of violence despite reports of violence in the criminal record or by his female partner
Dangerousness/lethality	Danger Assessment Scale (Campbell, Webster, & Glass, 2009) Ontario Risk Assessment Domestic Assault (Hilton et al., 2010) Domestic Violence Risk Assessment Guide (Hilton et al., 2010) Psychopathy Checklist Revised (Hare, 2003)	High score on any measure of lethality (combination of suicidal/homicidal intent, increasing severity of violence, substance use, etc.).
Coercion and control	Coercive Control Survey (Dutton, Goodman, & Schmidt, 2005) Fear of Partner Scale (Cohen & O'Leary, 2007)	High use of coercion and control whereby the father controls most aspects of the mother and family life Father blames the mother for his violence Significant current fear of father by his current or former partner that cannot be resolved with safety planning
Alcohol and drug use	Addiction Severity Index (McLellan, Luborsky, Woody, & O'Brien, 1980) Drug Abuse Screening Test (Westermeyer, Yargic, & Thuras, 2004) Michigan Alcohol Screening Test (Selzer, 1971) Urinalysis screening	Substance dependence that is currently untreated
Psychological/psychiatric symptoms	Brief Symptom Inventory (Derogatis, 1975) Structured Clinical Interview for the DSM-IV (SCID-IV; First, Spitzer, Gibbon, & Williams, 1995)	Untreated psychotic or bipolar illness Suicidal ideation and intent
Personality characteristics and attachment	Antisocial Action Scale (Levenson, Kiehl, & Fitzpatrick, 1995) Psychopathy Checklist (Hare, 2003) Experiences in Close Relationships-Revised (Fairchild & Finney, 2006)	Scores indicating high criminality, lack of empathy, and manipulation of others to get what he wants
Trauma history	Traumatic Events Screening Inventory Childhood Trauma Questionnaire (Bernstein, Ahluvalia, Pogge, & Handelsman, 1997)	N/A
Parenting behaviors	Adult Adolescent Parenting Inventory (Bavolek & Keene, 2001) Child Abuse Potential Inventory (Milner, 1990) Parental Acceptance–Rejection Questionnaire (Rohner & Khaleque, 2005) Play observation such as the Crowell Structured Play Tasks (Crowell & Feldman, 1988)	Scores that would indicate high levels of hostility and aggression toward the child and strong beliefs in corporal punishment would require individual intervention before considering father–child work Fear on the part of the child about being with his/her father

Determining if a father is appropriate will require consideration of multiple factors gleaned from a comprehensive assessment. It may be that a father must first engage in individual treatment focused on substance use or other psychiatric symptoms. Potential indicators that a father is inappropriate for father–child intervention at the time of assessment are outlined in Table 1.

Sifting through all the suggested assessment data can be a daunting task for a clinician. Prioritization of risk assessment is crucial. Information that suggests significant risk to the mother or child cannot be ignored.

Examples for Appropriate Use of Assessment Data to Determine Risk

The following two case examples illustrate ways that collection of assessment data can inform clinicians' decisions about how to best proceed to protect the safety of mothers and children.

John was referred for an assessment by the courts following an IPV-related arrest. He was drunk at the time of the incident in which he punched his wife. He reports that he blacked out and when he awoke and saw what he did to his wife, he told her to call the police.

He was then arrested. John wants to participate in family-focused intervention to address his IPV. John denies use of physical violence with his wife (other than the arresting incident). He reports that he used to drink several times per week but has given it up "cold turkey" since the incident. He has a full-time job and no reported psychiatric symptoms. John alludes that arguments with his wife typically occurred in the past because she would question his drinking. He felt if she had not bothered him about it, they would not have fought and he would not be in his current situation.

An interview with John's wife reveals there is weekly verbal and psychological aggression. He controls all their money, even though she also works, and her use of the car. The violence has escalated in frequency and severity with physical violence happening almost weekly over the last couple months. She states that John continues to drink one to two times per week and the violence always happens when he drinks. A father-child play session with John and his 3-year-old son shows no signs of hostile parenting, but the father does not seem to know how to play with his son. It is clear they do not typically play together at home. He also subtly encourages his son's use of violent play, and seems eager for the play session to end. His son is quiet and compliant with his father with almost no child-initiated contact with the father. This is in sharp contrast to the boy's behavior with the mother, in that he does not want to leave his mother's side and is quite affectionate with her.

There are significant concerns about this case. The father's controlling behaviors, denial of violence that contradicts the mother's reports, problem drinking, blaming of the mother, and reticence by his son all indicate individual work with the father to address his alcohol use and violence is needed prior to proceeding with any family work.

Carl was arrested following an incident of IPV in which he was drunk and bit his wife on the hand during an altercation. The police report indicated he was uncooperative at the time of arrest and had to be forcefully removed from the home in front of his three children aged 8, 3, and 1. Carl was referred for assessment by the courts to an integrated, substance-abuse, IPV and parenting program. Interview with Carl revealed a man with significant remorse. He was aware that the incident was causing significant sleep problems and worry for his children. He described that he was drunk at home and his wife jumped on him in the bed and was yelling at him about his drinking. He bit her to get her off him. He reported moderate IPV in the home; both he and his wife engaged in significant verbal aggression and moderate physical aggression (pushing, shoving, grabbing, slapping, and throwing objects). His wife reported a similar story both about the incident resulting in arrest and the nature of the violence in their relationship. She reported no coercion and control behaviors by Carl. She was not afraid of him and felt his drinking was their main problem. She felt his drinking compromised his parenting and she was worried about leaving their children with him. She reported a wish for the family to stay together and planned that when the protective order was modified he would move back home.

Carl had been abstinent from alcohol for the last four weeks and had engaged in substance-abuse treatment. He indicated some symptoms of depression and was open to a meeting with a psychiatrist. He was eager to participate in family-focused work both to improve his relationship with his wife and to help his children recover. Carl had deficits in his parenting knowledge and understanding of child development, but his interactions with his children in play assessment were positive. They were interested in playing with him, showed no signs

of fear, and he was able to be supportive and engage in child-directed play.

This case illustrates a father who is more appropriate for family intervention. The nature of the violence is bidirectional, not related to one-sided power and control by the father, and is significantly associated with his alcohol use. He has engaged in substance-abuse intervention and is motivated for treatment. He appears to have a nice relationship with his children that could be enhanced by father-child work.

Counselor/Therapist Training

In order to provide treatment for abusive fathers and their children, it is important for providers to have training and experience in both adult and child psychopathology. A clinician who does not have a solid training in the assessment of adult Axis II disorders in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*; American Psychiatric Association, 2000), psychopathy, and risk assessment would not be able to adequately assess the appropriateness of a father for intervention, nor would he or she be able to adequately assess the impact of exposure to IPV on the child and family. A lack of such training would therefore preclude a provider from engaging in this kind of work. In general, individuals trained as psychologists have greater depth of training in assessment and work with both adults and children, however it is possible that those in other disciplines (psychiatry/social work) could provide such treatment if they received training and supervision in clinical assessment with this population of perpetrators, victims, and their children. Overall training in work with IPV perpetrators and children exposed to violence is needed. To ensure clinician safety, those engaging in this work should have training in risk assessment, safety planning, verbal de-escalation techniques, and nonviolent self-defense (NASW, 2001).

Clinician Reaction to Involving Fathers

One of the most commonly ignored areas in engaging fathers in treatment is the provider's own biases and reactions to men who perpetrate IPV. It is not uncommon for providers who work with victimized women and children to have initial reactions in engaging fathers in treatment. Providers may unknowingly avoid engaging fathers in treatment due to their own fatigue, fears for their safety, misconception and biases toward these men and frustration related to the abusive cycle perpetrated against women and children. Providers may also take upon themselves the role of protecting women and children, without examining the potential of including the fathers as part of the solution. Furthermore, personal and uninformed biasness toward all abusive fathers may prevent good candidates from benefiting from treatment. Involving abusive fathers in treatment needs to be viewed not only as an intervention method but also as a preventative measure for future abuse. Providers need to have a safe place to process their own potential vicarious traumatic reactions and biases in terms of race, gender, and class in order to be effective in their treatment.

Example of How Clinician Bias May Impact Treatment Decisions

The following case illustrates the ways that biases, preconceived notions, and fear could prevent a clinician from engaging a father who might benefit from intervention.

Sally is a postdoctoral psychology trainee working in a clinic that specializes in providing services to children exposed to violence. Sally has spent the last year working with victims and their children in dyadic treatment following domestic violence. Prior to her doctoral training, she also worked as a children's advocate in a domestic violence shelter. She was providing treatment for a 7-year-old boy who had witnessed his father attempt to strangle his mother. The boy's older sister had phoned the police and the father was arrested. The father had untreated bipolar disorder at the time of the incident. Following his arrest and incarceration, the father engaged in mental-health treatment to address his bipolar disorder. He completed a batterer-intervention program and was awarded supervised visits with his children. Sally sided with the mother and felt the father should have no visits with his children. The father contacted Sally and asked to meet with her to discuss his son's treatment and what would be in his best interest with regard to visitation. Sally was frightened of the idea of meeting with this father and felt he should not have any information about his son's treatment. She went to her supervisor and reported she did not intend to respond to the father. Sally's supervisor asked her whether her client, Tom, brought up the visits with his father. Sally reported Tom appeared uncomfortable talking about the visits. Sally took this to mean he did not like them. When asked about the father's legal standing, Sally reported the father still had shared legal custody of his son with physical custody awarded to the mother. After processing with her supervisor, it was clear that Sally was making assumptions that the father was trying to manipulate her, the family and the courts by saying he was interested in his son's treatment. Her supervisor processed her feelings with her and she was able to identify that her time in a battered women's shelter had left her feeling that all men who perpetrated violence were dangerous, could not benefit from intervention, and should never be included in treatment planning. Her supervisor helped her make a plan to contact the father and invite him in for a meeting with her to discuss his concerns. They planned that Sally could use this time to provide the father with information about how consistency of visitation would help Tom (which had been an issue). They planned a session time that would ensure multiple other providers in the offices at the time of the appointment with knowledge of the father and his history to ensure safety. The supervisor reviewed safety strategies for treating volatile clients (sitting closest to the door, access to phone to call for help, using an office with a window or observation mirror with others observing the session) and they made a plan of how Sally could feel safe and supported at the time of the appointment.

Sally met with the father. She was surprised when he arrived at the offices in a suit and tie. He was nervous and sweaty when greeted by Sally in the waiting room. He indicated how nervous he was because he knew that Sally probably had not wanted to meet with him and had ideas about him based on the incident with the mother. Sally was able to hear from this father that he wanted to know how his son was doing, how the treatment was helping him process the violent incident and subsequent divorce, and how he could help his son based on Sally's knowledge. Sally was able to provide some recommendations and she and the father agreed to meet periodically for collateral sessions that could assist in treatment planning. She also recommended a therapeutic component to the father's supervised visits, whereby a clinician provided father-child sessions at the time of the visits with Tom to improve his parenting skills. This recommendation from Sally was

welcomed by the CPS social worker involved in the case and resulted in significant improvement in the visits and Tom's comfort with them.

This case illustrates a potential missed opportunity by Sally based on her preconceived notions, biases, and fear to engage a father who had a history of IPV. Without feedback and a focus on safety planning from her supervisor, Sally would not have met with the father and had an opportunity to improve her treatment by working with the father who was visiting his son and had been participating in other individual treatment.

Available Interventions

Once a clinician determines from their assessment a father-child intervention would be beneficial or helpful, planning the course of intervention is the next step. Currently, there are no evidence based treatment approaches available specifically for father-child treatment in cases of IPV. A handful of programs developed for batterers such as the Evolve Program (Donnelly, Norquist, Williams, & Wilson, 2000) devote several group sessions to issues related to fatherhood and domestic violence. Another promising program, Caring Dads: Helping Fathers Value Their Children (Scott & Crooks, 2007), provides direct parenting guidance for fathers over 17 group sessions. The Restorative Parenting Program (Mathews, 2011) is another group intervention designed to help men who perpetrate IPV restore their relationships with their children by taking responsibility for their abusive behavior and the impact it has had on their families. None of these interventions include father-child sessions. Alternatives for Families: A Cognitive Behavior Therapy (AF-CBT; Kolko, Iselin, Gully, 2011) is an individual cognitive-behavioral intervention designed for parents who maltreat their children. It could have potential implications for fathers with histories of IPV, but it has not been evaluated specifically with this population to date. In fact, there are currently no published studies presenting rigorously evaluated intervention programs targeting parenting for fathers who perpetrate IPV. Still these programs may be a great first step for fathers in which a clinician is concerned at the time of assessment about motives or the impact of dyadic sessions on the child. Implementing a group or individually focused parenting skills program with the father first, may pave the way to more targeted dyadic work later.

The field is lagging in evidence based treatment for fathers that are dyadic in nature. Multiple interventions designed for work with mothers focus on in vivo modeling of parenting skills and have been used effectively with maltreating mothers (Lieberman, Ghosh Ippen, & Van Horn, 2007; Zisser & Eyberg, 2010). These interventions could be adapted for use with fathers who perpetrate IPV. Specifically use of in vivo techniques with fathers could be particularly beneficial, as men prefer active hands-on intervention approaches.

There are several father-focused interventions that are currently being developed that have a specific focus on violence and include father-child sessions (McMahon, 2009; Stover, 2009, 2013). They have shown promise in early clinical application, but their efficacy has not yet been rigorously tested. At the present time, providers who have experience and training with evidence-based interventions designed for use with maltreating mothers, could adapt these interventions to work with fathers. Consultation with the treatment

developers in this regard could be useful. Use of in vivo techniques to provide adequate modeling for fathers related to appropriate parent management skills could have substantial benefit for fathers struggling with how to decrease their negative parenting behaviors.

Recommendations for Future Research

More work is needed in the area of treatment development and evaluation to determine the effectiveness of intervention approaches with maltreating fathers. Evaluation studies of interventions like child–parent psychotherapy (Lieberman & Van Horn, 2005), parent–child interaction therapy (Eyberg & Boggs, 1998), AF-CBT (Kolko et al., 2011), Fathers too! (McMahon, 2009), and Fathers for Change (Stover, 2013) with large samples of fathers with histories of IPV and maltreatment are necessary. These studies should include evaluation of key ingredients of treatment, characteristics of fathers that make them more or less appropriate for such interventions, and clinician training needs. Another area that is underresearched is the use of IPV interventions with homosexual couples. How these approaches may differ for gay fathers should be part of future research.

Conclusion

Involving fathers in treatment with their children is one of the most neglected areas in mental-health services. Though abusive fathers may be provided with some parenting and anger-management skills, they do not receive the needed guidance in interacting with their children in a structured manner following an abusive episode. Furthermore, there is a dire need to develop assessment tools to match fathers' compatibility to treatment approaches that would yield the best outcomes for families. Finally, providers play a major role in involving fathers in treatment. Well-trained providers who can engage and treat abusive fathers both individually and in relation to their partners and children comprise an area of significant need. Fathers are an important fabric in the canvas of family and child development. Fathers who have perpetrated domestic violence often remain in the lives of their children, and excluding them from interventions creates a patched attempt at best in bringing an end to abuse. Not all fathers who perpetrate IPV are appropriate for family-based treatment; however, some fathers and their children may benefit from treatment focused on parenting and their roles as fathers.

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