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. Child Protective Services (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 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: 1) nature and severity of abusive behavior; 2) dangerousness/lethality; 3) coercion and control; 4) substance abuse; 5) psychological symptoms; 6) personality characteristics and attachment; 6) trauma history; 7) childhood family life; 8) parenting beliefs and behaviors; 9) life stress; 10) symptoms of his children; 11) motivation for change and participation in treatment; 12) co-parenting relationship; 13) symptoms of the mother/partner; and 14) criminal and child protection history via record review/interagency contact.

Many standardized measures exist to assess all 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 and colleagues (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 scores above 17 a significant risk factor for recidivism (Hilton, Harris, & Rice, 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 in consideration when assessing the defined parenting gender roles. How men of different cultures define their role 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 (CAPT; Milner, 1986), 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 be carefully 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 that arise are essential. Careful documentation and 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: 1) What was the nature and severity of the abuse? 2) What is the risk for further violence? 3) Does he recognize that his use of violence was wrong and take some responsibility for his actions? 4) What is his legal and mental health status? 5) What is

motivating him to want to participate? 6) Is he engaged in other treatment that will address other mental health or substance abuse concerns? 7) Does the child want to attend treatment with his/her father? 8) Does the child still have significant contact or likely will have contact with the father in the future and intervention could be beneficial? 9) How does the child's mother feel about the child attending sessions with his/her father? 10) What would be the goals of father-child focused treatment sessions?

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 cases examples illustrate ways that collection of assessment data can inform clinician's 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, whereby 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 in the home 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 with both he and his wife engaging 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 assessment of adult Axis II disorders, psychopathy and risk assessment would not be able to adequately assess the appropriateness of a father for intervention. Additionally, an inability to adequately assess the impact of exposure to IPV on the child and the family would also preclude a provider from engaging in this kind of work. In general those 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 both work with IPV perpetrators and children exposed to violence are needed. To ensure clinician safety those engaging in this work should have training in risk assessment, safety planning, verbal de-escalation techniques, and non-violent self-defense prior to engaging in this work (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 towards 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 towards 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, pre-conceived 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 with 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 pre-conceived 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, 2002) 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 father could be particularly beneficial as men prefer hands on intervention approaches that are active.

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, in press). 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), Alternatives for Families-CBT (Kolko, Iselin, & Gully, 2011), Fathers Too (McMahon, 2009), and Fathers for Change (Stover, in press) 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 under researched 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 is 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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