Fathers for Change: A New Approach to Working With Fathers Who Perpetrate Intimate Partner Violence

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Legal and social service systems rarely acknowledge the status of men as fathers in the conceptualization and delivery of interventions for intimate partner violence (IPV). Large percentages of men who are arrested and mandated to intervention programs for IPV are fathers who continue to live with or have consistent contact with their young children despite aggression and substance use. There are currently no evidence-based treatments that address co-morbid substance abuse and domestic violence perpetration with emphasis on paternal parenting for fathers. This article will describe the components of a new intervention, Fathers for Change, which addresses the co-morbidity of substance abuse, domestic violence, and poor parenting in fathers of young children. Fathers for Change is unique in its focus on the paternal role throughout treatment. A case example and initial feasibility of the intervention will be described to provide an understanding of the key ingredients and the gap this intervention could fill in the field once tested in efficacy trials.

J Am Acad Psychiatry Law 41:65–71, 2013

There are 5.8 million victimizations of women by intimate partners in the United States each year, resulting in 2 million injuries[1] and demonstrating a major public health concern that is in dire need of effective intervention and prevention. Approaches that have been developed to intervene, through legal criminal actions, with men who perpetrate intimate partner violence (IPV) have been largely ineffective.[2–4] This broad lack of efficacy highlights the urgent need for the development of alternative approaches to intervention with men after an initial incident of IPV.

There is a need in families affected by IPV for integrated treatment that targets violence, overlapping substance use, and the perpetrator's role as coparent and father. Research has demonstrated a clear association between IPV and substance abuse. Meta-analytic studies report high rates of IPV in association with alcohol[5] and drug abuse.[6] There is significant evidence of the deleterious effects on children of witnessing IPV and the often co-occurring substance abuse (see key findings in Refs. 7–12), and children exposed to IPV are at increased risk for child abuse.[13] These data together suggest that many families affected by IPV are also struggling with substance use and negative parenting behavior. Yet, little work has been done on integration of intervention approaches. This article describes the rationale for and components of Fathers for Change, an integrated approach to IPV intervention for men who are parents. Case material will illustrate key elements of the treatment. Initial implementation feasibility with a small number of pilot cases will be described to support further research evaluation on the efficacy of the intervention.

Why Focus on Fatherhood in an IPV Intervention?

Research has shown that men with IPV histories continue to play an important role in their children's lives.[14,15] Women take an average of eight years to leave a violent relationship, and 68% of women exiting domestic violence shelters return to live with the perpetrator.[16,17] In a community sample of IPV victims, 80% still lived with or had contact with the perpetrator through shared children six months after

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Disclosures of financial or other potential conflicts of interest: None.

a domestic dispute that was reported to the police, and 68% of victims stated that their child was attached to an aggressive father.[18] A study showed that preschool children who had limited or no contact with their previously violent fathers had higher levels of depression and anxiety than did children who had frequent (at least weekly) visits. The effects of paternal contact were significant even when the data were adjusted for the severity of exposure to violence.[19] In addition, preschool children, especially boys, who saw their fathers more regularly had fewer negative representations of their mothers.[20] These data highlight the reality that perpetrators often continue their presence within the family after an incident of domestic violence and may play an important role in their children's lives.

One approach to improving IPV interventions for offenders is to develop programs that are specifically designed for fathers. Several scholars have argued that men who perpetrate violent acts within the family and recognize the impact of their violence and interparental conflict on their children can reduce the transmission of IPV across the generations[21] and that their concern about the impact of IPV on their children may be a powerful motivating factor in seeking and remaining in treatment.[22]

Studies suggest that fatherhood is a potential motivator for change in men who perpetrate IPV. Rothman and colleagues[14] surveyed men entering batterer intervention programs and found that most men believed that their violence negatively affected their parent-child relationship, and more than half (53%) of biological fathers worried about the long-term impact of IPV on their children. Another large-scale survey of 3,824 men attending a court-ordered evaluation subsequent to being convicted of assault against an intimate partner revealed that 66 percent of the men had some type of fathering role with children under the age of 18 and that, in most cases, these relationships continued after the arrest. Most of the men acknowledged that their children had been exposed to interparental conflicts, but fewer perceived that their children had been affected by the arguing.[15] Interventions that build on fathers' existing commitment to their children may be an effective approach in a subset of these men.

Several qualitative studies have emphasized that not all men who perpetrate violence against a spouse or partner adopt unhealthy attitudes regarding their fathering role. In their study of interparentally violent fathers, Perel and Peled[23] concluded that most fathers desired more warm, involved, and connected relationships with their children. Their finding is consistent with an interview study by Litton Fox and colleagues,[22] which revealed that men experience a significant amount of shame, guilt, and remorse when thinking about the harm they may have caused their children. There is also evidence that many fathers wish to shield and protect their children from their anger.[24]

IPV and substance abuse are intergenerational problems. Research studies have highlighted the continuation of aggression, alcohol and substance use, and maladaptive parenting from one generation to another within a family.[25] An intervention that emphasizes the multigenerational nature of these problems, allows a father to begin to have an understanding of how his childhood experiences affect his current behavior and choices, and provides him tools to cope and co-parent his child differently could have substantial impact.

An integrated approach may require a change in the current parameters on IPV interventions for offenders. States often prohibit inclusion of partners or families in court-mandated programs for male offenders.[26,27] They are excluded despite mounting evidence that nearly half of acts of IPV are bidirectional and are perpetrated by men and women at equal rates.[28–31] In addition, in cases of men with co-occurring IPV and substance use, their partners often report using violence in the relationship and abusing substances at the outset of treatment and continue this behavior while their partners are in treatment.[32] A lack of assessment of the family system and inclusion of partners can hinder progress in treatment. While the unwillingness to treat couples or families appears justified in the most extreme cases of violence, coercion and control, and maltreatment, fathers who perpetrate mild to moderate IPV could benefit from couples intervention, especially given that several interventions in IPV have shown good outcomes with the inclusion of a couples component in the treatment.[33–36]

Description of the Intervention

Fathers for Change is designed to be offered individually to fathers who have young children (less than 10 years of age) and a history of IPV, defined as threatened or actual sexual or physical violence against an intimate partner. The Fathers for Change

intervention includes 16 topics to be delivered in 60-minute sessions of individual or dyadic treatment over the course of four to six months. The intervention combines psychodynamic family systems and cognitive behavioral theory (CBT) and techniques and builds on previous interventions such as behavioral couple therapy (BCT)[34,37] and substance abuse domestic violence CBT (SADV),[33] with the goals of decreased violence and aggression, decreased alcohol and substance abuse when indicated, improved co-parenting, decreased negative parenting behavior, increased positive parenting behavior, increased positive family interactions and activities, and decreased symptoms in the children.

After assessment, treatment progresses to individual sessions followed by co-parenting sessions and ends with father-child sessions. The areas of focus of each of the three phases of Fathers for Change are abstinence from aggression and substance abuse, co-parenting, and forming a parenting and father-child relationship. Fathers for Change is designed to allow for optional participation of both parents in a portion of the sessions. If parents are living together or not and both want to participate in the treatment, the appropriateness of their combined involvement should be determined during the course of the assessment and evaluation. Fathers must successfully move through the early session components, be active participants, and take some responsibility for their previous behavior for treatment to move into co-parenting or dyadic treatment sessions. Fathers for Change is unique in its focus on the paternal role throughout treatment, both in the father-child and the co-parenting relationships. The central premise is that focusing on men as fathers and increasing their feelings of competence and meaning within their parenting role will provide motivation to change maladaptive patterns that have led to their use of aggression and substances to control negative feelings.

Phases of Treatment With Case Example

Pretreatment Assessment

Thorough assessment of the father and the family context by a clinician is the first step in the program. The specific needs of a particular father and his family must be carefully assessed and considered when determining the appropriateness of the intervention. Appropriate risk assessment is of particular concern and use of the Danger Assessment Scale[38] and the methods developed by Hilton and colleagues[39] and Farrell[40] are an integral part of the Fathers for Change intake evaluation. Other areas of assessment and measures used include severity of substance use (Addiction Severity Index,[41] Michigan Alcohol Screening Test,[42,43] and urine toxicology); severity of violence (Conflict Tactics Scale-Revised (CTS2),[44] and Timeline Followback Calendar[45]); psychiatric symptoms (Brief Symptom Inventory,[46] Beck Depression Inventory, and Posttraumatic Checklist[47]); parenting behaviors (Adult-Child Relationship Questionnaire,[48,49] IOWA Family Interaction Scale,[50] Parenting Alliance Inventory,[51] and Parental Acceptance Rejection Questionnaire (PARQ)[52]); motivation for change; trauma history (Childhood Trauma Questionnaire[53,54]); and willingness to take responsibility for previous violent behavior. Last, arrest and child protective services records are requested and reviewed with written permission from the father.

The mother must consent to the involvement of her child before treatment begins. Whenever possible, collateral information is gathered from the mother to gain a fuller picture of the family dynamics. This assessment session with the mother is carried out separately from the assessment of the father. She completes a set of measures similar to those completed by the father (described earlier), with a particular emphasis on risk assessment and his violence and substance abuse. Last, the children must be assessed to determine that dyadic treatment with the father is appropriate and not contraindicated at the present time (e.g., the child is extremely symptomatic, and treatment with his father could exacerbate the symptoms). This assessment is performed by using the Child Behavior Checklist[55] in interviews with each parent about symptoms of the child and by observing the child with the father in a dyadic play assessment.

In the following case, names and identifying information have been changed to protect the confidentiality of the clients. The Yale University Human Investigations Committee approved the pilot implementation of Fathers for Change, including written informed consent to participate in the intervention and written permission to video tape sessions and use case material for teaching purposes.

> Zane, the father of Greg, a toddler, was referred to Fathers for Change after two arrests in rapid succession for domestic disputes. Child protective services (CPS) had been involved with the family before the domestic disputes because Greg's mother Amanda had a significant drug history and

was in recovery. The CPS worker referred Zane to the program because she was concerned about his drinking and aggression in the home. She reported that she had observed Zane's strong commitment to Greg and his generally good parenting behavior.

Assessment of Zane and his family revealed that he had a significant history of exposure to domestic violence, psychological abuse, and community violence growing up. He currently was abusing alcohol to deal with stress, but was not alcohol dependent. He was not abusing any other drugs. He had a full-time job and worked to support Greg and Amanda. He reported some moderate symptoms and anxiety. He became quite angry and animated when he talked about Amanda and her addiction problems. He felt strongly that she needed to refrain from using drugs for the sake of Greg and had little empathy for her ongoing struggle to remain clean. He clearly took responsibility for his aggressive behavior. He was worried about his son and what he was witnessing in the home. An interview with Amanda provided corroboration of the reported levels of hostility and aggression in the relationship and Zane's commitment to parenting Greg. A play assessment with Zane and Greg revealed that Greg was developmentally on target and interacted nicely with his father.

Phase I: Individual Sessions With the Father

Individual sessions focus on two areas: first, helping the father to examine how he was parented, how his childhood experiences affect his parenting, and his wishes about the kind of parent he wants to be and, second, coping skill building to aid the father in his affect regulation. These sessions serve to motivate fathers by focusing on their roles in their children's lives. What does it mean to them to be a father? What is a father supposed to do? What were their experiences of being fathered? What did they most want from their fathers as children? Use of genograms and discussion of multigenerational transmission of IPV, substance abuse, and parenting problems are discussed with each father to help him begin to recognize the ways in which he was not prepared to have healthy relationships with his co-parent or his child. Exploration of the unique impact on his children of witnessing IPV and parental conflict is emphasized in these early sessions to increase his motivation to change his behavior. The first four sessions pave the way for a series of coping-skills sessions that use the cognitive behavioral therapy techniques of other treatment approaches for aggression and substance use.[33] Cognitive behavioral therapy (CBT) skills, such as relaxation, feelings identification, and regulation and cognitive processing, are each reviewed in relation to the father's use of aggression, abuse of substances, and negative parenting behavior. Skill modules from other CBT treatments have been adapted to focus more specifically on parenting and relationship cognitions and their association with substance use and aggression.[33]

Initial individual sessions with Zane focused on what being a father meant to him. He described two areas: being present in his son's life (unlike his own father) and providing financially for the family. Exploration of other important contributions fathers make to their children's development and what he hoped to teach Greg about how to be a good partner and father were emphasized. These factors were contrasted with his history in his family of origin. He was able to reflect on what he wanted from his parents as a child and begin to think about the emotional needs of his son in addition to his physical needs.

Zane was now motivated to change his behavior and attended sessions without fail. He actively participated in CBT coping skills sessions focused on relaxation techniques and cognitive coping. He typically had negative thoughts about Amanda. Zane and his therapist explored these thoughts and developed alternative, more positive ways of thinking that would lead to less conflict and anger toward her. It was clear that Zane was thinking these negative thoughts on his way home each day (e.g. "She probably didn't clean the house or look for a job today," "She probably sat around all day and the house will be a mess."). He would enter their apartment hostile and would see only negatives. Replacing his negative thinking on the way home was very helpful to Zane. He would think about how well Amanda was taking care of Greg or how happy he would be to see Gregg when he got home. His arrival home in a positive state of mind resulted in far fewer arguments in the evenings.

Phase II: Structured Focus on the Importance of Co-parenting

The second phase of treatment emphasizes the importance and improvement of the co-parenting relationship. These sessions may be implemented individually or as dyadic sessions with the child's mother. Concrete definitions of co-parenting, common co-parenting pitfalls, and methods of strengthening co-parenting distinctly and separately from the intimate or romantic relationship are identified. Communication and problem-solving skills are introduced and practiced in session, similar to other models that work with aggressive and substance-abusing couples.[33,36,37] Communication practice is focused on co-parenting (e.g., visitation exchanges or disagreements about discipline). The focus on co-parenting is important because positive co-parenting, even in the context of a conflicted intimate relationship, can be protective and result in better child adjustment.[56] In addition, co-parenting has been shown to have a much stronger influence on parenting and child adjustment than on other aspects of the couple relationship.[51,57–59] The focus on the importance of each

parent's roles in teaching the children about how to behave in relationships and how they can expect to be treated by their partners and the people they love in the future is a key component of these sessions.

> Co-parenting sessions began with a focus on the difference between co-parenting and intimate relationships and the importance of Zane and Amanda's co-parenting roles beyond the success or failure of their intimate relationship. Zane's concerns about Amanda's addiction and desire for her to move out and focus on her recovery were discussed with them together. Following two dyadic co-parenting sessions, Zane's fury at Amanda about a relapse in drug use prompted him to request an emergency session with his clinician. He was able to talk through his anger at Amanda. His anger was primarily a result of his worries about Greg and his son's need for a mother. Given the previous work on the importance of maintaining a co-parenting relationship with Amanda, he was able to focus on Greg's needs and how he could talk with him about his mother's moving out. Zane needed help with what language to use and how to help Greg cope. The therapist worked with Zane on how to manage his angry feelings at Amanda, while focusing on Greg's need to see his mother, facilitate positive visits, and minimize conflict in front of Greg.

Phase III: Father-Child Relationship Enhancement and Modeling of Parenting Skills

The third phase of treatment is dyadic father-child sessions. These sessions involve the use of aspects of child-parent psychotherapy.[60,61] Studies have shown that dyadic treatments with mothers and young children have a positive impact on the parent-child relationship and decrease symptoms for both mothers and young children.[60,62] Inclusion of parenting and direct work with fathers and their children is a unique aspect of Fathers for Change. The clinician who has been working with the father through the first two phases of treatment now works with him to develop goals for the dyadic sessions. These goals are determined by the specific needs of the father-child pair. Typical goals for the father include taking responsibility for his previous negative behaviors, apologizing, and explaining in age-appropriate terms the work he is doing in treatment to learn new ways of coping with his feelings; gaining greater understanding of the meaning of his child's behavior; improving his play interactions with his child; and improving his implementation of parent management strategies.

> Father-child sessions focused on helping Zane use age-appropriate language to explain to Greg why his parents were not living together and the schedule for visits with his mother. Zane now understood Greg's need to see his mother and the importance of reducing conflict during visitation exchanges. The therapist also focused on Zane's reflective capacity with regard to Greg's feelings and why he might be worrying about being separated from his father. Child-directed play was modeled and implemented during father-child sessions to highlight for Zane how important these interactions were for Greg.
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> At the conclusion of the program, Zane had not had any physically violent incidents with Amanda over the four months of treatment. He had reduced his alcohol use to an occasional drink every few weeks when he went out with friends. He had a solid understanding of the important role he was playing, as not only a financial but also an emotional provider for his son. Zane reported that without help from the program, he was certain he would have become aggressive with Amanda around the time of her relapse. He would not have focused enough on the needs of his son or the impact on Greg of his behavior toward Amanda.

Preliminary Feasibility

Ten fathers have completed the Fathers for Change program. Fathers in this pilot implementation of the program were referred by family relations counselors from the court or child protective services as a result of an arrest for IPV. The fathers were 70 percent Hispanic and 30 percent African American, with an average age of 25 years. Twenty percent of the fathers were married to their youngest child's mother, 30 percent were in a live-in relationship with the mother, 30 percent were in a relationship but did not live with the mother, and 20 percent were single. The men had an average of two children and 50 percent had current involvement with child protective services. At the time of intake assessment, 50 percent of the fathers were abusing alcohol, with an average of 12 days of drinking per month. One father met criteria for alcohol dependence. The other 50 percent of fathers were abusing marijuana, with an average of eight days of use per month. One father met the criteria for marijuana dependence. Mean CTS2 Physical Aggression scores were 8.5 (standard deviation [SD], 6.88) and Psychological Aggression Scores were 19.8 (SD, 17.35). PARQ Parenting Hostility scores averaged 18.75 (SD, 2.63). Ninety percent of the fathers reported experiencing childhood abuse, neglect, or exposure to IPV as a child.

The men completed weekly logs during treatment of their aggression and substance use, according to methods developed by Fals-Stewart and colleagues,[45] and posttreatment satisfaction surveys to provide information about what components of the intervention were helpful. All 10 who completed the program remained nonviolent during treatment and reduced their substance use. Eighty percent became abstinent during treatment. One was referred to a higher level of substance use treatment due to his inability to abstain

from marijuana, and another reduced his alcohol use from several days per week to two times per month.

Dropout rates were low, with 15 fathers initially referred. Of these, two were found inappropriate for the program based on assessment, and three withdrew within the first two sessions. This withdrawal rate of 20 percent is well below the 40 to 50 percent reported in the IPV intervention literature.[63] Those who completed the program unanimously found all three phases of the program helpful and said that they would recommend the program to their friends or family. Based on these promising pilot results, Fathers for Change is now being tested in a small, randomized trial funded by the National Institute of Drug Abuse. A written manual and training material have been developed for use in the trial.[64] Efficacy in a research trial is the next step in the development of this intervention, as we cannot draw conclusions about the broad applicability of Fathers for Change on the basis of this small sample.

Conclusions

Fathers for Change has shown initial feasibility in a small pilot sample and now requires further study to determine its effectiveness in working with fathers with a history of IPV and substance abuse. Focus on men's roles as fathers and their wishes for their children may be a powerful motivator of change. Flexibility and working with men individually can allow for more specific tailoring of intervention needs, which could result in better outcomes for the men and their families. If research evaluation finds Fathers for Change to be an effective intervention to reduce IPV and substance abuse, examination of current state policies around domestic violence interventions will be needed to enable more individually focused intervention approaches that may include partners and children.

Acknowledgments

The author would like to thank Drs. Caroline Easton, Thomas McMahon, and Steven Marans for their guidance and mentorship in developing this work.

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