CHAPTER 1

Family Violence

Theories and Intervention Approaches for Men

Family violence (FV), which impacts millions of families around the world each year, could be either one partner toward the other, or a parent toward a child. In other contexts, family violence also includes child aggression toward a parent, aggression among siblings, or even elder adult abuse. Interventions are often designed either for those identified as survivors or for those who have used violence. Considerations of family context or how to best conceptualize providing help to an entire family have been lacking, especially when legal systems and child protective services (CPS) are involved with families. Below is an example of a referral a clinician might encounter related to FV with legal and CPS involvement.

George and Susan were referred for assessment and intervention by CPS when a thoughtful social worker was concerned that the case plan was too burdensome for the family and would result in failure to reunify the couple's young children with their parents. George and Susan were homeless and living with Susan's mother when a verbal dispute escalated to yelling and throwing objects. A neighbor called police, resulting in George's arrest. The police notified CPS because the couple's 2- and 3-year-old children were home at the time of the incident. Initially the children remained in their parents' care; however, the parents both tested positive for marijuana and the mother for cocaine upon drug screening. Furthermore, review of CPS records indicated that Susan had been removed from her own mother's care as a child and had aged out of the foster system. Susan's mother's parental rights had been terminated. CPS felt that the home was unsafe for the children, but George and Susan had nowhere else to live. That, coupled with the

intimate partner violence (IPV) and positive drug screens, resulted in CPS removing their children and placing them in a foster home about a 30-minute drive away. The initial case plan required both George and Susan to engage in treatment at separate addiction services agencies given their IPV. Susan had to engage in individual therapy and attend a parenting class. As is common, Susan's use of violence was assumed to be reactionary or in self-defense, so no assessment of her use of violence or recommendation for IPV use intervention was included in her case plan. George was required to complete a domestic violence intervention for offenders and attend a parenting class. Both parents were also required to maintain full-time employment, and they were expected to attain their own apartment that was suitable for the children. They were given 1 hour supervised visitation with their two children once per week, but they had to get transportation to the foster home. Neither had a car, and bus service to the foster home was an hour ride each way.

A TYPICAL CASE

This story is not unique. Referrals to multiple agencies/services without consideration of transportation difficulties, financial resources, and time can be frequent occurrences for parents trying to complete case plans to be reunified with their children. The CPS social worker was right to be concerned about the expectations of the department described in the case plan. Upon meeting with this family, the social worker found the parents to be extremely stressed about the requirements they were asked to fulfill, and they were longing to spend more time with their children. The plan was not in keeping with young children's sense of time: To adults, weekly contact seems frequent, but to young children, a week feels like an eternity. The case plan also did not consider the resources of the parents. Safety of the children was highest priority; however, the plan seemed to give no priority to their relationships with their parents and to setting the parents up for success. As this example illustrates, interventions that can meet the many and varied needs of families such as George and Susan's are needed so they are not hindered by the array of different services they are required to attend.

Individual assessments by the clinician with George and Susan indicated two parents in their early 20s who had no models of healthy relationships provided during their own childhoods. Both had experienced significant trauma that included witnessing IPV and their parents' misuse of substances. George admitted that at times he was aggressive and had trouble managing his anger. Susan also reported that she was aggressive toward George,

hitting and pushing him when upset. Sometimes this was in self-defense and other times she became physical first. George said, "I just want to be a family. I know I can do better." Susan also wanted to maintain her relationship with George and was not fearful of him. Both wanted help with managing their emotions and communicating with each other. Neither parent was substance dependent, but they did use alcohol, marijuana, and occasionally other drugs to manage stress. George had a full-time job at an auto garage, but he found getting to his job by bus and meeting CPS program requirements difficult. The clinician-administered assessment conducted with both parents, along with a review of criminal and CPS records and an observation of the father with his children and the whole family together indicated young parents who required support and understanding. George needed to feel seen by his service providers as valuable to his children.

Depending on where they live and what service systems are available, interventions may not be available to meet the needs of families like that of George and Susan. Programs have historically focused on mothers and reuniting them with their children, especially when IPV is part of the story. This lack of treatment options has left couples who want to remain together and have a history of IPV behaviors without dyadic or family intervention options. This leads them to hide their ongoing relationship or plans to reunite from providers, especially those connected with CPS agencies. Alternative ways of working with families when family violence is identified is the focus of this book. Fathers for Change (F4C) is a flexible individual therapy program that can include coparent and family sessions as deemed appropriate and safe by the treating clinician. It is designed for fathers with a history of FV, either verbal or physical, in the last 12 months who have at least one child age 12 or younger. Coparents who also used FV (mutual or bidirectional violence is happening within the relationship) or those who are primarily survivors of the violence may participate. The intervention provides a phased and flexible intervention approach to family violence that can be implemented by a range of clinicians, from master's-level social workers in community-based agencies to psychologists in private practice. It is a program that can be offered or suggested by CPS agencies, family courts, domestic violence courts, or community providers. It also is a therapeutic approach that fathers or families can seek out on their own. This treatment comprises 18 "topics" that are organized into four phases, and combines attachment, family systems, and cognitive-behavioral theory (see Table 1.1). What makes it different from most other interventions is the focus on the father–child and the coparenting relationships.

It is important for providers of F4C to have background in both adult and child clinical work. Understanding child development and the impact

TABLE 1.1. Phases of F4C and Corresponding Topics and Session Types

Phase	Topic	Participants	Session type
Assessment	Father assessment	Father	Individual
	Coparent assessment	Coparent	Individual
	Child assessment	Child	Individual
	Family	Father, child (coparent optional)	Conjoint
1. Engagement and Motivational Enhancement	1. Introduction to Fathers for Change	Father Coparent	Individual Parallel individual
	2. Fathers' Roles and the Importance of Fathers to Child Development	Father Coparent (optional)	Individual Parallel individual
	3. Reflecting on Father–Child Interactions	Father Coparent (optional)	Individual Parallel individual
	4. Reflecting on the Family of Origin	Father Coparent	Individual Parallel Individual
2. Reflective Functioning and Skills Building	5. Exploring Triggers for FV, Need for Control, and Use of Substances	Father Coparent (optional)	Individual Parallel individual
	6. Understanding Emotional Arousal and the Body's Stress Response	Father Coparent (optional)	Individual Parallel individual
	7. Physiological Reactivity and Management Skills	Father Coparent (optional)	Individual Parallel individual
	8. How Thinking Impacts Behavior	Father Coparent	Individual Parallel individual

3. **Coparenting Communication**	9. Increasing Coparent Positive Interactions	Father Coparent	Individual in parallel OR conjoint
	10. Positive Communication Skills	Father Coparent	Individual in parallel OR conjoint
	11. Coparent Problem Solving, Part I	Father Coparent	Individual in parallel OR conjoint
	12. Coparent Problem Solving, Part II	Father Coparent	Individual in parallel OR conjoint
4. Restorative Parenting	13. Parenting Skills	Father Coparent	Individual in parallel OR conjoint
	14. Preparing to Make Amends	Father	Individual
	15. Taking Responsibility	Father Child	Conjoint
	16. Father–Child Play	Father Child	Conjoint
	17. Father–Child Feelings Identification and Expression	Father Child	Conjoint
Final Session	18. Ending Treatment	Father Coparent	Individual Individual in parallel

on children of witnessing violence is crucial to being able to help fathers develop better reflective functioning related to their children. Without this background, therapists may focus too heavily on the father's individual skills and not enough on helping him hold his children's experiences and needs in mind (which are key features of F4C). Importantly, the intervention addresses reflective functioning, emotion regulation, communication, and relationship difficulties, all while holding the safety and well-being of the children and their mothers as paramount.

CLARIFYING THE TERMINOLOGY

The terms *intimate partner violence* (IPV), *domestic violence* (DV), and *family violence* (FV) are often used interchangeably despite some notable differences between them. In this book I differentiate and will be as specific as possible when referring to forms of violence as defined below. The Centers for Disease Control and Prevention (2015) defines IPV as physical violence, sexual violence, stalking, or psychological harm by a current or former partner or spouse, occurring between heterosexual or same-sex couples, that does not require sexual intimacy. IPV differs from DV, which was originally introduced to define violence between married partners who were living together; DV has since expanded to include violence broadly among family members, such as an aunt toward a niece, between two adult brothers, and so forth. In this book, I most frequently use the term FV to indicate violence within the nuclear family, which may be either one partner toward the other, or a parent toward a child. In other contexts, FV also includes child aggression toward a parent, aggression among siblings, or elder adult abuse, but for purposes of this book, FV focuses on partner and parental use of violence toward each other or their children. Like IPV, FV occurs in multiple forms, including stalking, physical, sexual, and psychological violence. All forms have harmful consequences for family members. I use the term FV because F4C is an intervention approach designed to address violence between both current or former intimate partners, as well as parental violence toward children. When I use IPV or DV instead of FV, it is because the specific study, sample, or case is describing that form of violence in particular. I want to be consistent with how the research authors defined their sample and findings, or how a case is specific to IPV without other forms of family violence included.

Aside from these definitions, further distinctions have been made between different forms of FV in the literature. IPV, in particular, is often characterized by two frequently used categories: *situational couple violence* and *intimate terrorism* (Johnson, 2010). The first involves violent outbursts in the context of an escalating argument with an intimate

partner. It is not planned and is usually the result of overwhelming emotion. This form of IPV can be used by both partners in the relationship and escalate bidirectionally. In contrast, intimate terrorism involves continuous coercive behavior used to progressively build and maintain power and control over the partner (Nielsen, Hardesty, & Raffaelli, 2016). The violence is manipulative, more frequently planned, and is used more often by men than by women. Sometimes patterns and different FV episodes do not fall neatly into these two categories. However, assessment of the level of power and control dynamics in a relationship and whether violence is reactive or planned are issues to which we return later, as they are important to assessment and intervention planning.

You will also notice the use of person-first language in this book to describe individuals who have inflicted violence. This is a purposeful choice, in that use of words like *abuser, offender,* or *perpetrator* have a negative connotation that sets the frame not for treatment, but instead for punishment. This book focuses on describing a treatment approach and therefore use of those words is minimized to focus on the individual process of changing behaviors that are harmful.

Last, I most frequently use the term *coparent* rather than spouse, wife, partner, husband, or mother throughout the book. Coparent is intended to encompass all the possible coparenting relationships that exist regardless of marital or relationship status, gender, and so forth. If a specific case example includes a mother and father, I may use those terms specifically in the case, but otherwise use the encompassing term *coparent*.

THEORETICAL EXPLANATIONS AND TYPOLOGIES OF FV USED BY MEN

There are multiple theoretical models of FV described in the literature. Some of these models have included feminist/power theory, social learning theory, trauma theory, and personality theory. The feminist or power theory emerged in the 1970s as the first intervention approaches were developed to hold men accountable for violence against women. This theory focuses on patriarchal gender roles and men's use of power and control over women (Burelomova, Gulina, & Tikhomandritskaya, 2018; Dobash & Dobash, 1979). Social learning theory posits that individuals learn violent ways of responding from figures in the home or community environment and fail to learn alternative ways of responding to conflict (O'Leary, Van Hasselt, Morrison, Bellack, & Hersen, 1988). This results in individuals repeating patterns learned in their family of origin related to use of FV. Trauma theory (Taft, Vogt, Marshall, Panuzio, & Niles, 2007) suggests that exposure to traumatic events across

the lifespan leads to activation of neural structures that are related to the body's threat (fight-or-flight) response (Baldwin, 2013), which results in the brain and body being in persistent survival mode (Silove, 1998). Living in this mode can then result in the use of intimidation, threats, and rejection in response to distorted perceptions of threat in interactions with others (Chemtob, Novaco, Hamada, Gross, & Smith, 1997). Finally, personality theory focuses on the development of personality types via formative early experiences and relationships including borderline, antisocial, and narcissistic traits that are present in those who have used FV (Burelomova et al., 2018). Most research on these traits is associated with different typologies or categories of men who use violence. Some studies have also examined how different personality profiles respond to intervention. There is an indication that those with antisocial personality traits are less likely to complete interventions (White & Gondolf, 2000) and that different treatments may be needed depending on the personality characteristics of an individual who causes harm. For example, those with antisocial personality traits may respond better to cognitive-behavioral therapy (CBT), while those with dependent personality traits may do better in a more psychodynamic process-oriented treatment (Saunders, 1996).

Interventions have been designed based on these theoretical models of why men use violence against their partners or children. Power theorists argue that interventions should aim to shift the dominant discourse around which society is structured, whereby females are consistently perceived as subordinate to their male counterparts (Connell & Messerschmidt, 2005; Rothenberg, 2003). Social learning theory points to learning skills to manage emotions and conflict in nonviolent ways as the best course of intervention given that individuals did not previously learn these skills in their developmental environments (Beck & Fernandez, 1998). Trauma theory interventionists target social information processing related to perceived threat (Taft et al., 2013), while personality theorists assess personality styles and target interventions to specific traits such as narcissism. Generally, the power/feminist theory has had the most traction in intervention development and dissemination, but studies of broad implementation of group interventions based on this theory have not produced consistently effective findings (Arias, Arce, & Vilariñ, 2013; Babcock, Greene, & Robie, 2004; Cheng, Davis, Jonson-Reid, & Yaeger, 2021).

Aside from specific theories of FV, attempts have been made to categorize those who use violence into battering typologies. Gottman and colleagues (1995; Jacobson, Gottman, & Shortt, 1995) defined two: *Type 1 batterers,* who showed cardiac slowing (hypoarousal), and *Type 2 batterers,* who showed cardiac speeding (hyperarousal), each in response to a marital conflict discussion presented in a laboratory setting. Type

1 had more psychopathic traits and were thought to become calm and calculated in their use of violence, whereas Type 2 had greater substance misuse and psychopathology, and were considered reactive in their use of violence. Replication studies have not fully supported the broad distinction of these two types (Babcock, Green, Webb, & Graham, 2004; Meehan, Holtzworth-Munroe, & Herron, 2001). Holtzworth-Munroe, Meehan, Herron, Rehman, and Stuart (2000) proposed that rather than typologies per se, the focus should be on dimensions that fall on a continuum to help with understanding the etiology and nature of violence that may point to intervention. These dimensions include factors such as severity of violence (frequency and intensity), generality of violence (intimate partner only, others in the family, outside the family), psychopathology, and personality characteristics. The use of FV is not a psychiatric diagnosis but a behavior, and there is evidence for varying origins of the use of violence, differing characteristics and dimensions of importance for various individuals (Holtzworth-Munroe et al., 2000), and potential utility to examining individual motivations for the use of FV (Wride, 2020). Therefore, individual assessment that leads to the development of an intervention plan to meet the needs of each person who uses FV is needed, especially for those parenting children who may be impacted directly or indirectly by court-based decisions around custody and visitation.

INTERVENTION APPROACHES FOR MEN WHO HAVE CAUSED HARM

Intervention for FV by men has been addressed most frequently by what are referred to in the field as *batterer intervention programs* (BIPs). Currently, many BIPs comprise men's groups focused on the nature of power, control, and abuse in relationships, and in many states and jurisdictions are the standard response to FV following arrest and court involvement (Karakurt, Koç, Çetinsaya, Ayluçtarhan, & Bolen, 2019). This is not universally true, but is the most typical approach. Broadly and universally applied to all men appearing in court who use violence, without considering traits and typologies, BIPs have not been shown to be effective in randomized controlled trials (Cheng et al., 2021). The restriction and laws requiring use of men's groups as a response to FV is not identical across states, but it is common (Stover & Lent, 2014; Voith, Logan-Greene, Strodthoff, & Bender, 2020). There has been increased focus more recently on development of alternative interventions recognizing heterogeneity of needs of those who cause harm. Below are descriptions of some of the most commonly implemented and known interventions in the field at present.

Gendered Group Interventions

The Duluth model (Pence & Paymar, 1993) is the best known and is considered the most widely implemented BIP. Despite this, there is frequent confusion in the field about what the Duluth model entails, and evaluations of the program have focused on its psychoeducational group aspect. However, the group is intended to be embedded within a coordinated community response that encompasses arrests for IPV, sanctions for noncompliance with court orders, support and safety planning for survivors, and referrals to other agencies. The group component is characterized by its developers as a gender-based cognitive-behavioral approach to counseling and educating men arrested and mandated by the court to attend an IPV program. The group is focused on the *power and control wheel,* which outlines a variety of behaviors that constitute the constellation of possible abusive behaviors. This model also focuses on teaching and developing alternative skills for avoiding abuse and violence (Paymar & Barnes, 2007). Aside from the Duluth model, there are many gender-specific group BIPs. CBT groups focus on teaching ways of recognizing and managing anger. Others are a combination of both the gender-based model and CBT. Most of these models have not been rigorously tested in research trials.

Several other group-based approaches have been developed to target FV, including Achieving Change Through Value-Based Behavior (ACTV; Lawrence, Langer Zarling, Orengo, & Aguayo, 2014), Substance Abuse and Domestic Violence (SADV; Easton, Crane, & Mandel, 2018), and Strength at Home (SAH; Taft et al., 2013). All have shown promising evidence for the specific populations for which they were designed. Development of ACTV was based on acceptance and commitment therapy (ACT) principles. ACT builds on CBT and emphasizes using psychological flexibility, focusing on what is most effective rather than acting based on emotions or psychological responses (Hayes, Strosahl, & Wilson, 2009). Destructive behavior patterns are targeted through developing skills such as present-moment awareness, acceptance of difficult emotions or thoughts, decreasing believability of thoughts, perspective taking, identification of values, and committed action in service of values. The ACTV model does not involve teaching or requiring that participants change the *content* of their thoughts but instead involves change in the way they *respond* to their thoughts in order to change their behavior (Zarling, Bannon, & Berta, 2019). ACTV has been shown to reduce IPV recidivism in randomized trials compared to the Duluth model, but it has higher dropout rates (Zarling et al., 2019).

Strength at Home (SAH) is a CBT group model developed using trauma theory. It was implemented initially with veterans or active-duty service members returning from deployment. This model focuses

on information processing deficits that may interfere with partner interactions. The 12-session group includes psychoeducation on IPV and trauma reactions, conflict management skills, identifying and correcting negative thought patterns, and communication skills (Taft et al., 2013). SAH participants had significantly greater reductions in IPV than those in enhanced standard services within the VA setting (Taft et al., 2013).

Delivered in both group and individual formats, SADV targets the intersection of substances misuse and violence in each session (Easton et al., 2007, 2018) and development of coping skills for both violence and substance misuse. Both the group and individual format of SADV showed significantly less use of IPV on days of substance use than either group or individual drug counselling (Easton et al., 2007, 2018).

All these group approaches consider some of the possible factors that can contribute to a person's use of violence (e.g., gendered views on women's roles, distorted cognitions, trauma reactivity, and substance use) and each has strengths. What is lacking in these approaches is an individually tailored focus on family interactions and dynamics, as none of these provide one-on-one sessions with fathers to address the impact of violence on their children. Completion of any one of these programs alone would not address the coparenting and restorative parenting required to make amends with children and develop healthy father–child relationships (see Chapters 8 and 9), or how to safely consider father–child relationships following FV. Coparenting includes the shared responsibilities of raising a child, whether in an intimate relationship or not. Restorative parenting is an approach that focuses on repair rather than punishment. It allows those who have caused harm to take accountability and make amends for their mistakes to those they have hurt. In this case, fathers take accountability for the harms they have caused to their children through use of FV and make amends.

Couple Interventions

Although often controversial (and, in the United States, not acceptable in some states as a court-ordered intervention for IPV offenders), couple interventions have been developed and a few tested in research studies. The intervention with the most clinical and research writing is domestic-violence-focused couple therapy (Stith, McCollum, & Rosen, 2011). It is a solution-focused, brief therapy intended for couples who are experiencing mild to moderate situational couple violence and want to stay together and end the violence in their relationship. It has two possible formats: a multicouple group approach or an individual couple treatment approach (Stith et al., 2011). The 18-week model utilizes two cotherapists who first work separately with the male partner and the female partner (typically for about 6 weeks), bringing them together only after the individual

components are completed and the therapists believe that working with the couple together is clinically appropriate and safe. The intervention continually emphasizes use of violence as a choice. This therapy addresses the interactional nature of relationships and provides treatment for both members of the couple that may support ongoing assessment of safety and change. This could be especially helpful to survivors of violence as they determine whether a healthy relationship is possible with the person who harmed them. This treatment does not address family dynamics and father–child relationships specifically; however, it provides a great framework for how to initiate intervention with each member of a couple when there has been FV and consider how to safely facilitate conjoint sessions. This strategy of parallel sessions with each member of the couple and coming together only when deemed safe and appropriate by the treating clinicians is the same strategy used in F4C. Parallel sessions with coparents are done in the early stages of treatment, with the possibility of conjoint coparenting sessions later in treatment.

Father-Specific Interventions

There are several well-known interventions in the field which have been used with fathers who caused harm that focus on their roles as fathers. These include: the Caring Dads program (Scott, Francis, Crooks, & Kelly, 2006); Child–Parent Psychotherapy (CPP; Lieberman, Ippen, & Van Horn, 2015), and Alternative for Families—Cognitive-Behavioral Therapy (AF-CBT; Kolko, Herschell, Baumann, Hart, & Wisniewswki, 2018).

Caring Dads is a group parenting intervention for fathers who have used violence toward either their partners or children. It includes contact with children's mothers and coordinated case management to mitigate the risk fathers may pose to their partners and children. The intervention has shown promising reductions in FV (Scott & Crooks, 2007; Scott & Lishak, 2012), and focuses on fathers' behaviors and understanding their children's needs but offers no direct treatment of the children together with their fathers. Completion rates in a large implementation study in Australia were 63% of fathers who started the program. The program increased the amount of time fathers spent with their children; however, it did not appear to impact use of violence or mothers' fear of fathers based on the small number of coparenting mothers who provided pre–post data in the evaluation (Diemer et al., 2020).

CPP is a treatment for trauma-exposed children ages 0–5. Typically, children are seen with their primary caregiver, and that dyad is the unit of treatment. The CPP model aims to examine how trauma and the caregiver's relational history affect the caregiver–child relationship

and the child's developmental trajectory. A central goal is to support and strengthen the caregiver–child relationship as a vehicle for restoring and protecting the child's mental health (Lieberman et al., 2015). CPP has been shown to improve posttraumatic stress symptoms for both young children and their mothers who experienced IPV (Lieberman, Ippen, & Van Horn, 2006). CPP was not designed specifically for dyadic work with fathers who have caused harm. It was first developed and tested with survivors of FV and their young children, but it has since been provided to fathers and their young children with anecdotal success (Iwaoka-Scott & Lieberman, 2015; Lieberman & Van Horn, 2011). CPP has been adapted to provide a coparenting model whereby a single therapist provides therapy to both mother–child and father–child dyads in parallel, allowing the therapist to understand the dynamics children are experiencing in their triadic relationship with each of their parents. This approach has not yet been tested in a randomized trial.

AF-CBT is a trauma-informed CBT-based treatment designed for parents who have caused harm and their children. It is intended to reduce the effects of exposure to child or family anger, aggression, and child physical abuse. AF-CBT teaches parents and children (ages 5–17) skills to enhance self-control, promote positive family relations, and reduce violent behavior. Other goals of AF-CBT include promoting nonaggressive discipline and interactions, reducing child physical abuse risk or recidivism, and improving the level of child safety and family functioning (Kolko et al., 2012). The intervention includes both individual sessions with the caregiver and child, and conjoint parent–child sessions. A randomized trial revealed that children who received AF-CBT had lower posttraumatic stress disorder (PTSD) symptoms compared to treatment as usual at 6-month follow-up but not at 18-month follow-up. There was also a greater reduction in family dysfunction, conflict, and reports of child physical abuse for the AF-CBT group (Kolko et al., 2018).

What Is Missing?

Overall, there is now a range of interventions to address FV. Many are group-based, with a few individual or dyadic options that address both the individual and family needs. Few provide guidance on work with coparents together or how to intervene with fathers and their children. Furthermore, the current system of care for FV is often siloed, with those who cause harm and their families being treated separately, without coordination among providers or across systems. This is quite concerning because, in most cases, children from homes where there has been violence continue to see the fathers who have caused harm, either because the family has reunified, the father has shared custody, or the court has

ordered visitation. Thus, not only does intervention for children exposed to FV need to target traumatic stress symptoms and the relationship with the nonoffending parent, but it also needs to consider ensuring an end to children's exposure to violence. This may be achieved in some cases through effective treatment for the parent who caused harm, and reparative intervention for the children to restore a safe and healthy relationship with that parent. There is ample justified concern for how to implement such work, and what is needed for fathers who cause harm to be ready to participate in treatment safely with their children.

The field has developed many interventions that focus on maltreating mothers and repairing the mother–child attachment and relationship. The field has not advanced as quickly in work with fathers who have used FV. Clinical treatment for FV largely comprises services aiding survivors. Far fewer treatment providers (individuals and agencies) offer services to those who have caused harm, who are more typically men and often fathers. There is ample need for treatment approaches to work with fathers safely, so they can develop healthier relationships with their children. Adapting those interventions that were designed for survivors and their children (e.g., CPP) must be done carefully with fathers who have caused harm, with deliberate attention to assessment and fathers' readiness to engage in a fully dyadic model. AF-CBT was designed specifically to work with offending parents and their children, but it is not intended for infants, toddlers, or preschool-age children.

In most states, following an incident of FV reported to the police, CPS is notified if children are in the home. In CPS-involved families, mothers and children often receive intensive in-home safety planning and counseling that is focused on their needs. Fathers are often ordered to leave the home and are frequently court-ordered to a batterer intervention group because it is the only treatment option available. This may be because the state where they live requires a gender-based group BIP, or because alternative interventions are not offered in their community. There is limited ability to tailor the topics of this type of group to the specific needs of fathers, or to focus substantial time on parenting and fatherhood, since fathers make up only a proportion of participants, limiting group cohesion around this topic. Services are often not offered to fathers that would address their roles as father or coparents. Instead, they are labeled as batterers, offenders, or perpetrators, putting them in a defensive position that may limit their willingness to engage and minimizes their importance as fathers. This gap also means the burden of protecting the children and addressing their mental health needs is placed on mothers.

F4C was developed to fill these gaps in evidence-based interventions for fathers who use FV and to provide an alternative or adjunctive

treatment when appropriate. F4C was originally developed through funding by the National Institute on Drug Abuse (NIDA) through a K23 career award, with an initial focus on fathers with co-occurring IPV and substance misuse, and was broadened to encompass fathers, with a dual focus on IPV and child maltreatment as the intervention was implemented within the community. This intervention provides services to fathers to benefit their children, an area of significant need in the field (Gordon, Oliveros, Hawes, Iwamoto, & Rayford, 2012; Labarre, Bourassa, Holden, Turcotte, & Letourneau, 2016; Maxwell, Scourfield, Featherstone, Holland, & Tolman, 2012), and is in keeping with calls for interventions that will work with families impacted by FV in different ways to address the needs and wishes of survivors (Arroyo, Lundahl, Butters, Vanderloo, & Wood, 2017).

As stated earlier, F4C was designed to provide detailed guidance on individualized assessment of families and a phased approach toward coparenting and father–child intervention that maps onto individual family needs safely. With F4C, a clinician can assess and understand a father and his family and provide interventions to help him individually (based on what is driving his violent behavior) and in his relationships with his coparent and children. It brings in components of other evidence-based interventions such as motivational interviewing (Miller & Rollnick, 2023), CBT (Beck & Fernandez, 1998), dialectical behavior therapy (DBT; Linehan, 2020), behavioral couples therapy (O'Farrell & Fals Stewart, 2012), CPP (Lieberman et al., 2015), and parent–child interaction therapy (PCIT; McNeil & Hembree-Kigin, 2011). The unique features of F4C are (1) a phased approach to addressing the needs of fathers who use FV that moves from assessment through individual focused work and ends with coparenting and family components, (2) flexible inclusion of coparents and children, and (3) a continual focus on reflective functioning related to self, partner, and children. Chapter 4 provides both a description of the intervention and the theoretical framework.

In the coming chapters I present the theoretical underpinnings of the F4C approach. First, in Chapters 2 and 3, we consider the importance of fathers in the lives of their children, the parenting behaviors of fathers who have caused harm, and what children will need from their fathers following FV, as well as the research supporting F4C. Chapter 5 gives details on how to assess and select appropriate cases, Chapters 6 through 9 provide step-by-step guides for conducting the work—covering 18 topics—in sessions with fathers, their coparents, and children. Chapter 10 gives details on ending treatment and referrals.

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