Final Report:

Pilot Implementation of the *Caring Dads* Program for Abusive and At-Risk Fathers

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Child maltreatment is a major societal problem in Canada and a clear risk-factor for the developmental of psychological and emotional disorders. According to the Canadian Incidence Study of Reported Child Abuse and Neglect, approximately 20 in every 1000 children come to the attention of child protective services each year (Trocme et al., 2001). Prevalence rates based on retrospective community surveys also reveal high rates of maltreatment; approximately 10% to 25% of adults report physical abuse experiences (MacMillan et al., 1997; Straus & Gelles, 1986) and about one in four women and one in eight men report being sexually abused as children or adolescents (World Health Organization Consultation on Child Abuse Prevention 1999).

Child maltreatment is a potent risk factor for the development of behavioural and social difficulties in both childhood and adulthood. Children who grow up in abusive families are significantly more likely to be diagnosed with disorders such as conduct disorder, depression and anxiety disorder (Wekerle & Wolfe, 2002). They are also particularly likely to be aggressive, leading to significant difficulties in peer relationships (Wekerle & Wolfe, 2002). Early developmental disruption in maltreated children often compounds over time, resulting in elevated risk for a number of adjustment problems in adulthood. For example, Stouthammer-Loeber, Loeber, Homish and Wei (2001) found that the risk of court contact was double for individuals who had been abused or neglected as compared to those who had not. Widom (1999) reports that lifetime risk of PTSD is more than one and half times greater for maltreated children compared to demographically matched controls.

Fathers are responsible for a significant portion of child abuse and neglect. In Canadian two-parent families, fathers are alleged perpetrators in an estimated 71% of the physical abuse cases and 69% of the cases involving emotional maltreatment. In sexual abuse cases, fathers or stepfathers are about three and a half times as likely to be investigated as mothers and stepmothers (24% versus 7%), regardless of the family composition (Trocme, 2001). Despite the high number of fathers involved in child abuse and neglect, research and clinical attention has tended to focus on abusive mothers (Phares, 1996) - fathers are not typically included in child abuse intervention or prevention efforts (Featherstone, 2001; Martin, 1984; Sternberg, 1997).

The current study addressed the lack of appropriate parenting interventions for abusive fathers through the creation and examination of *Caring Dads*: *Helping fathers value their children,* a 15-week intervention program for abusive and at-risk fathers. This pilot program has a service and a research component and will be the basis for sustained efforts to develop optimal programming in this area.

Current interventions for abusive parents: Why not send fathers to existing programs?

Many communities have services available for supporting parents, and have developed prevention and intervention programs specifically for high-risk and maltreating mothers (Wang & Daro, 1998). Given this, why should intervention programs

be developed specifically for fathers? The development of *Caring Dads* is predicated on the theory that existing programs do not adequately address the needs of abusive fathers for a number of important reasons. Three of these are the mismatch of intervention goals and fathers' needs, the need for attention to the familial context of father-perpetrated child abuse, and an appreciation of the context of intervention for this population.

One of the mainstays of intervention for child abuse is parent training. Parenting interventions are typically informed by social learning and cognitive-behavioural theories, and as such, focus largely on behavior management techniques, such as reinforcement, appropriate punishment and anger management strategies (e.g. Mathews, Matter, & Montgomery, 1997). Philosophically, we have argued that behaviour management and stress reduction skills are not primary risk factors for maltreating fathers (Scott & Crooks, in press). Rather, abusive fathers' lack of recognition and prioritization of children's needs for love, respect, and autonomy are paramount. Maltreating fathers often speak of conflicts with their children as power battles and tend to feel that they deserve unconditional love and respect, and unquestioning compliance (Francis, Scott, Crooks & Kelly, 2002). Due to this sense of entitlement and associated abuse-supporting attitudes, programs focused on managing stress or developing fathers' parenting skills are not likely to lead to reductions in child abuse or neglect. Instead, fathers need interventions that can directly address and counter attitudes that support their use of abusive control and develop their capacity to appreciate their children's emotional and physical needs. It is only *after* such intervention that men may benefit from learning parenting skills for more effective child management or from broad-based parental support.

A second reason to develop intervention programs specifically for abusive and at-risk fathers derives from a consideration of the familial context of father-perpetrated abuse. Physical child abuse and domestic violence have a startlingly high rate of co-occurrence with estimates of the overlap in the range of 30-60% (Appel & Holden, 1998; Edleson, 1999; Jouriles & Norwood, 1995; Ross, 1996). That is, in families where either child maltreatment or women abuse is occurring, one will often find that the other form of violence is also being perpetrated. In addition to the co-occurrence of physical abuse, men abusive toward their spouses often use a variety of tactics that are emotionally harmful to their children (Bancroft & Silverman, 2002). In most group-based parenting programs, there is an implicit assumption that the parents have a non-abusive relationship. In cases where adult relationships seem problematic, the group leader might offer to make a referral to marital counseling or may address difficulties in group by focusing on the need for consistency between parents in the application of child management strategies. Such interventions are not sufficient or appropriate in a family where fathers are abusive towards both their spouse and children. Rather, it is critical that a significant part of intervention with maltreating fathers be devoted to men's relationships with, and potentially abusive behaviors towards, their children's mothers (Salzinger, Feldman, Ng-Mak, Mojica, Stockhammer & Rosario, 2002).

Finally, in developing programs for abusive and at-risk fathers it is important to consider the social context of this form of intervention. Many of the abusive and at-risk fathers most in need of intervention are already involved in legal actions. Some fathers have separated from the mother of their children and are pursuing, or hoping for, changes in child custody or access arrangements. Other men are being monitored by child

protective services, or have their children in protective custody. In this context, an identified concern is that fathers may use their program attendance to try to gain greater custody of, or access to, their children. For example, men may attempt to intimidate or manipulate children's mothers into changing access through threats of court action or other demands. They may also use intervention to try to gain advantage with their children by telling them that their father, but not their mother, is trying to improve the family's situation. Even if fathers do not engage in these behaviours, it is concerning that having undertaken treatment may reflect well on men involved in child welfare or custody proceedings, regardless of individual change. Given this complicated social and legal context, it is essential that treatment programs for abusive fathers be well integrated in the legal and child protective services in the community. Though such integration, policies can be developed so that fathers can be challenged to develop healthier relationships with their children without compromising child safety.

Caring Dads program description

The *Caring Dads: Helping fathers value their children* program (Scott, Francis, Crooks & Kelly, 2001) was developed to specifically target the needs of abusive and at-risk fathers. This 15-week group intervention aims to increase men's awareness of the impact of coercive, shaming and under-involved behaviour on children, enhance fathers' motivation to change, reduce attitudes and perceptions that support maltreatment of children, and improve father-child relationships. It was also designed to reduce men's involvement in child-focused marital conflict and increase fathers' cooperation and problem solving around childcare issues. *Caring Dads* uses motivational interviewing, cognitive-behavioural and psycho-educational techniques to meet these goals.

In recognition of the societal context of father-perpetrated child maltreatment, the *Caring Dads* program was developed with input from individuals in the fields of child protection, custody and access, batterer intervention, research on violence against women, as well as from professionals working with distressed families in community treatment settings. Moreover, groups are run with the support of a multi-disciplinary Advisory Committee of members from community agencies, specifically the London Family Court Clinic, the Centre for Research on Violence Against Women and Children, Probation and Parole Services, Changing Ways, the London and Middlesex Children's Aid Society and Merrymount Children's Centre.

Issues in the Evaluation of Program Effectiveness

Presently, the *Caring Dads* program is in its pilot stage. At this point, there are a number of important issues to consider regarding program evaluation. The committee on the assessment of family violence interventions (Chalk & King, 1998) suggested that in order to be evaluated, a program:

- must be mature enough to warrant evaluation;
- must be different enough from existing services that its critical components can be evaluated;
- should have appropriate data accessible in service records;
- should ensure that satisfactory measures should exist to assess service processes and client outcomes and;

- should ensure that adequate time and resources are available to conduct a quality assessment.

Clearly, at this point in its development, the *Caring Dads* program is not sufficiently mature for evaluation of program effectiveness. However, consideration of client and therapist satisfaction with group, and the identification of satisfactory measures to assess key client outcomes are important precursors. With this in mind, the current study examined the utility of three of the most commonly used assessment measures in programs addressing child abuse and neglect: the Child Abuse Potential Inventory, the Parenting Stress Index and the Adolescent-Adult Parenting Inventory.

The Child Abuse Potential Inventory was designed to assess parents' potential to engage in physical child abuse. This 160-item self-report scale yields an overall "abuse potential" score along with scores in a number of domains of parent functioning. In addition, the CAPI includes validity indices to screen for potential response biases. Although Milner has conducted a number of studies supporting the validity of the CAPI (e.g. Milner et al, 1984), others have raised questions about its sensitivity and specificity. For example, Haapansalo and Aaltonen (1999) examined the CAPI scores of mothers referred to, and not referred to, child protective services (CPS). They found that CPS-referred mothers scored higher on most of the CAPI scales; however, the cut-off for abuse potential was reached for only 32% of the CPS referred mothers, a proportion that did not differ significantly from the non-referred mothers. In addition, Gondolf (1997) examined CAPI scores of men ordered to attend counseling for domestic violence, a population in which high levels of physical child abuse are expected. Only one quarter of the men in this sample scored above cut-off for abuse potential and as many as 34% of the pre-program tests could be considered invalid.

The Parenting Stress Index (PSI-SF) in a self-report measure of stress in the parent-child system. The long version of this scale contains 101-items, the short-form 36-items (PSI-SF). On the short-form, items assess stress in three domains; parent distress, dysfunction in parent-child interaction, and stress associated with "difficult" child behaviour, and a total stress score is computed by summing across items. Scores are not specific to child abuse or neglect, but instead tap stress across a number of parenting domains. Although not designed specifically to predict child abuse, studies have shown relatively high correlations between parenting stress and child maltreatment (e.g. Haskett et al., 2003; Holden & Banez, 1996). Moreover, the predictive validity of the PSI-SF seems fairly good. Lacharite and colleagues (1999) found that 73.5% of a sample of 163 mothers could be correctly classified in logistic regression analysis as maltreating or non-maltreating on the basis of their total PSI-SF score.

Finally, the Adolescent-Adult Parenting Inventory (AAPI-II) is a 32-item self-report questionnaire assessing five domains of parenting attitudes: inappropriate expectations, empathetic awareness of child needs, support for child power and independence, belief in the use of corporal punishment and role reversal. The authors recommend that the AAPI-II be used to assess risk for abusive or neglectful parenting practices or to monitor change in risk status over time. The validity studies reported in the AAPI-II manual, however, do not support this use. No predictive validity is reported and only moderate differences are noted in the mean scores of abusive and non-abusive parents. More informative research is provided by the LONGSCAN study of measures of risk constructs. This study found that attitudes of 217 parents involved with child

protective services on the role reversal subscale of the AAPI-II were significantly associated with social workers judgements of parents' skills and knowledge. However, other AAPI-II subscales were not related to social worker judgement on any child abuse risk domain (English & Graham, 2000).

In summary, there are a number of existing measures with potential to tap into important attitudinal and behavioral dimensions of child abuse and neglect. However, past research has raised some questions about the validity of these self-report measures and few studies have examined their utility with abusive and neglectful fathers.

Current study

In the current report, a description of the first two *Caring Dads* pilot groups is provided. Information is presented on the characteristics of clients and on their attitudes and behavior before and after intervention. Focus is placed on evaluating the appropriateness of measures and on identifying challenges in serving this population. In particular, self-reported attitudes and risk are contrasted with information from referral sources on men's official status in justice and child protection services and with judgements made by trained clinicians on the severity of fathers' abusive and neglectful and healthy parenting behaviours and attitudes. Overall effectiveness of the *Caring Dads* program was not addressed.

Method

***Caring Dads* Groups and Research Participants**

The current report is based on our experience running two pilot *Caring Dads* groups. The first group started in October 2002 and was co-facilitated by a team from Changing Ways and the Children's Aid Society of London and Middlesex, in partnership with Merrymount Children's Centre.

There were a number of challenges with this group from the onset. Of the nine participants that attended the intake session, over half had been attending an unstructured fathering support group. These clients were suspicious of the change in group composition, content and structure. In addition, clients expressed numerous concerns about having a co-facilitator from CAS. As a result of these difficulties, the group failed to cohere and after four or five weeks of variable attendance, the group was closed. Eight of these participants agreed to participate in research. Because the group did not finish, information is available for these men only at time 1 (i.e. before intervention).

A second group started in November of 2002, with co-facilitators from Changing Ways and the Centre for Research on Violence Against Women and Children. This group began with a referral base of approximately 17 clients. Of these 17, 12 attended an intake session. Fewer men attended the first few groups, and by week 4, the group contained nine men. Research information is available for eight of these nine men at time 1. Seven men completed group, and post-group research information is available from six of these men.

In summary, the current research included intake assessments for 17 men, and post-intervention assessments for six men.

Procedures and Measures

All men referred to the *Caring Dads* program were invited to provide both qualitative and quantitative feedback on their experience in the program. Information was collected during men's intake into the program and, for those men who completed treatment, at program termination. The following quantitative measures were used in assessment.

Child Abuse Potential Inventory (CAPI Form VI; Milner, 1989). The CAPI is a 160-item self-report questionnaire designed to assess parental risk for engaging in child abuse. Respondents answer "agree" or "disagree" to each item. To detect response distortions, the CAP Inventory contains three validity scales; a lie scale, a random response scale and an inconsistency scale. This measure is frequently used in clinical settings and research to assess a parent's risk of abusing his or her child.

Parenting Stress Inventory- Short Form (PSI-SF; Abidin, 1995). The PSI-SF is a 36-item clinical assessment instrument tapping three domains of stress parent-child relationship: parental distress, difficult child behaviour, and dysfunction in the parent-child relationship. Internal reliability and concurrent validity of the PSI-SF have been well established (Abidin, 1995).

Adult-Adolescent Parenting Inventory - II (AAPI-II; Bavolek & Keene, 1999). The AAPI-II is a 40-item clinical assessment measure tapping five attitudes domains. Standardized scores for each domain can be compared to endorsements of a normative population. The test developers report that the AAPI-II is reliable and valid, with good construct and criterion validity (Bavolek & Keene, 1999).

Interview-based assessment of risk for maltreatment. A semi-structured interview was designed for the purposes of the current study. This interview assesses the quality of the relationship between men and their partners, presence of a crisis prone family, lack of parent-child connection, child parentification, men's conditioned response to children's behaviour, men's believe that child's behaviour is harmful or threatening and presence of a coercive cycle. Most of these question have been taken from an interview developed to assess risk for child abuse and neglect in a hospital setting (Scott & Coolbear, 2001). Interviewers record responses verbatim and a rating is made for each construct according to a 5-point standardized scale with one end anchored as a healthy father-child relationship with no indication of risk and the other anchored at high levels of risk in a particular domain. As this interview was developed for the purpose of the current study, no information is yet available on its reliability and validity.

Results

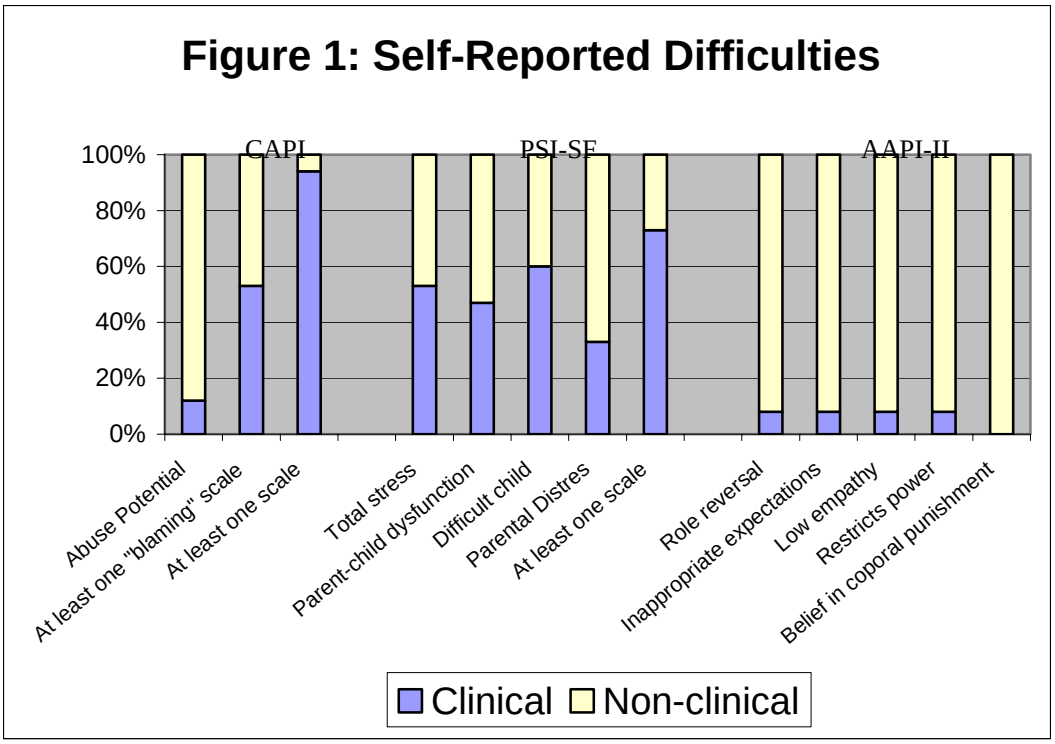
Characteristics of men referred to the program

In total, 17 men participated in the pilot study of the Caring Dads program. On average, the men were 40 years of age (range = 27–63 years, SD = 10.2). The men reported living in a variety of different living situations, with approximately half either married (20%) or living with a partner (27%), and half separated, divorced or single. Various levels of education were also reflected within the group. Approximately 47% of the men had not completed high school, 27% received a high school diploma, and 27% went on to pursue further education. Upon intake to the Caring Dads program, 53.3% of the men were employed. On average, men reported having 3.6 children (range = 1–7, SD

= 1.92) in total, with an average of 3.1 being biological children (range 1 – 7, SD = 1.77). Men were referred by probation officers (36%), child protective services (14%) or other agencies such as batterer intervention or child mental health agencies.

Characteristics of men on self-report questionnaires

Clinical and non-clinical elevations in men's scores are shown in Figure 1 and described below.



CAPI-II. Information on the CAPI is available from 12 of 17 men who completed intake assessments. One man met criteria for "faking good", or attempting to create an overly positive impression. Four additional men showed elevations on both the "lie" scale and on the measure of inconsistent responding and two men showed elevations only the measure of response inconsistency. Only five men submitted reports that were entirely non-problematic in terms of validity.

On the overall measure of abuse potential, which was of most interest to the current work, only two (17%) fathers scored above clinical cut-offs, one (8%) scored in the borderline range, and all others (75%) scored clearly in the normative range.

Clinical level endorsements were more frequently noted on subscales of the CAPI. Specifically, two thirds of men scored in the clinical range on the unhappiness scale, which includes items such as "I am a happy person". Three quarters scored in the clinical range on at least one of the following scales: problems with child, problems with family and problems with others. These subscales all assess men's perceptions of difficulties with others, and are perhaps an indication of the extent to which they externalize blame for difficulties. Elevations in rigidity and distress were shown less often, with 17% of men endorsing clinical level elevations in each of these domains.

Overall, all but one of the 12 men who completed the CAPI reported clinically significant elevations on at least one subscale.

PSI-SF. Men also completed the PSI-SF, a more general index of parenting stress. Examination of validity indices for the 15 men with complete information on this measure suggested that three men were reporting in an unrealistically positive light. Somewhat surprisingly, two of these three men showed clinical elevations across PSI-SF scales despite this response bias.

Overall, reports of only 27% of men placed them entirely in the normative range for parenting stress (with the reports of one of those men being of questionable validity). On the overall index of parenting stress, endorsements of 53% of men placed them in the clinical range. This overall score is derived from three subscales: parent distress, parent-child dysfunction and difficult child. Of these subscales, items on the parent-child dysfunction scale seem potentially most relevant to the aims of *Caring Dads*. Items on this scale tap the extent to which a parent attributes blame for problems or stress to the child. For example, the first item on this scale reads: "My child rarely does things for me that make me feel good". Forty-seven percent of men reported clinical level elevations on this subscale. Sixty percent reported that their child was considerably more difficult than they would have expected and one third reported clinical levels of distress in their adjustment to the parenting role.

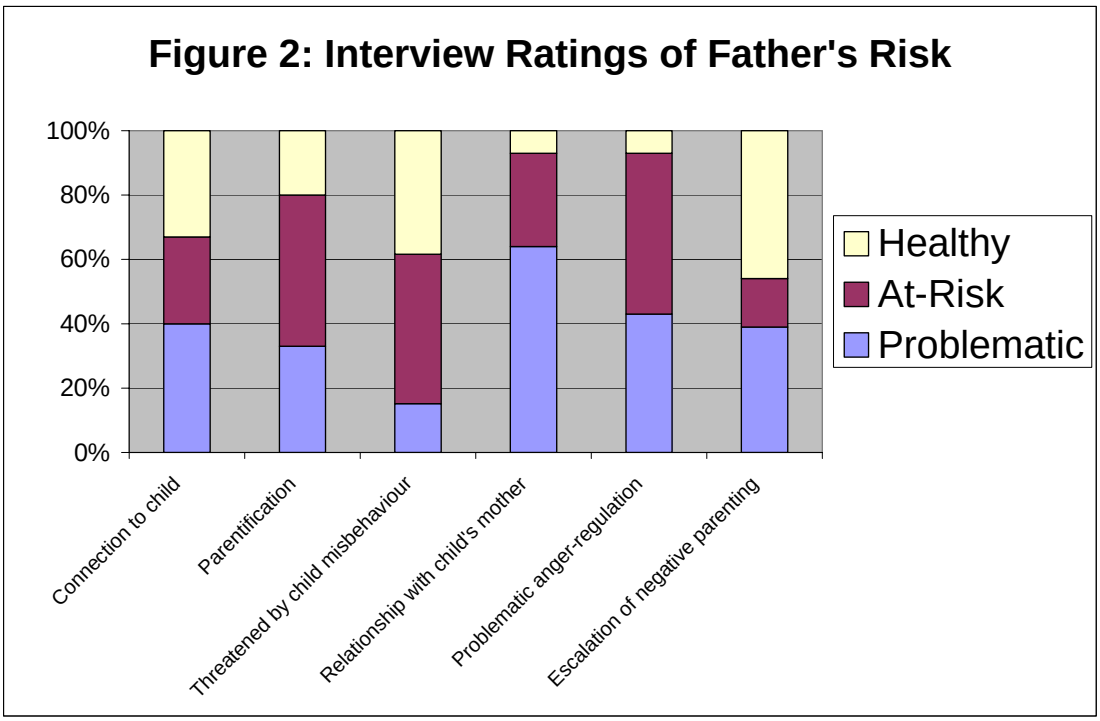
AAPI-II. Finally, men were asked to complete the AAPI-II. At a theoretical level, it might be argued that the AAPI-II is the measure best suited to the evaluation of the *Caring Dads* program. The AAPI-II aims to assess the attitudes that underlie risk for child abuse and neglect. Despite its promise, the AAPI-II proved to be a relatively non-discriminating measure. Of the 13 men for whom information was available on this scale, only 3 scored in the clinical range on any of the five indices of problematic attitudes.

Interview ratings

Six dimensions of risk were assessed in interviews with children's fathers – men's knowledge of, and connection to, their child; parentification of children; extent to which fathers feel threatened by child misbehavior; fathers' anger regulation in response to child misbehavior; the presence of increasingly negative parenting strategies; and whether the relationship between children's fathers and mothers is conflictual and/or physically violent. Results for each domain are show in Figure 2 and discussed in turn.

Ratings of father's connection to their children tap the extent to which fathers show adequate knowledge of and connection with their child or children. Of concern are cases where fathers seem to have little knowledge of their child's interests, hopes and/or activities and where the connection between the father and child appears tenuous. Of the 15 men for whom this rating was available, six (40%) were rated as having clearly insufficient connections with their children. For an additional four (27%) men, interviewers reported some concern about men's connection.

Fathers were also rated on the extent to which they relied on their children for inappropriate levels of emotional support and comfort or for the completion of adult duties. From their responses to interview questions, one third were rated as relying inappropriately on their children for emotional or physical support, and an additional 47% were rated at-risk.



Interviewers also made ratings on three dimensions theoretically and empirically related to risk for physical abuse. Of the 13 men for whom information was available on men's perception of threat from child misbehavior, two (15%) were rated as showing clearly evident levels of threat with an additional 46% were rated at a concerning level. Of greater concern, ratings for one third suggested that men were using controlling emotional or physical means to gain child compliance, with some level of risk shown for an additional 13% of men. Finally, 43% of men were rated as showing problematic levels of anger arousal to child misbehavior, with an additional 50% judged as showing some risk for this behaviour.

Finally, men were rated on the quality of their relationship with children's mothers. Of concern were relationships that were openly conflictual and/or violent. Of the 14 men with information on this dimension, nine (64%) reported involvement in a violent relationship with children's mothers and an additional 28% had highly conflictual, but non-physically violent relations. Only one (7%) man was rated as being in a relatively healthy, non-conflictual relationship with children's mothers.

Overall, interviewers tended to agree with referral agents that fathers at *Caring Dads* were showing a number of concerning behaviours that are harmful to children, and when taken to more intense levels, either constitute, or are likely to lead to, abuse or neglect. When considered together, interviews had "clinical" level concerns on at least one domain of fathering for all but two of the clients referred to *Caring Dads.* For those two clients, lower levels of risk were endorsed across a number of domains. On average, men were rated as problematic on 1.9 dimensions of fathering, and either problematic or at risk on 3.7 of the six domains.

Examination of potential change over time

A second purpose of this study was to examine whether existing measures provided a good index of men's change over time. Information was available for men at program intake and termination for only six men.

Men's impressions of group. When asked their impression of group, all men reported that they enjoyed attending group. In particular, men talked of the value they placed in being listened to and in having a chance to talk about parenting issues with other men. Men also acknowledged that their attitude changed over treatment. In the words of one client:

> "I think that, like most people, at the start, I thought that this was not going to be that helpful, but in the end, it really was".

Men were also asked to report about the most valuable thing they learned during group. In response to this question, men talked of both their general approach to children, and to specific strategies they learned. In terms of general approach, men talked of the need to:

> "think things through before you act and try to be aware of all of the possible outcomes of certain situations" and
> "remember that kids will disappoint you and they don't mean to do it on purpose, so you need to be prepared".

Along similar lines, men spoke of developing more patience with their children and of learning to make different choices about their parenting. For some men, learning about developmental variations was important to changing their way of interacting with their children. Another spoke of the value of being challenged by the group to consider the impact of their actions on their children.

Men seemed to be applying some of these lessons to their relationship with their children. They were asked to speculate on areas of their parenting that they could improve following the completion of *Caring Dads.* In response to this question, most men talked of changes that they were already making. These themes were evident. First, men talked of the need to plan for child behavior rather than apply rules once difficulties occurred. Second, men reported having greater awareness of, and appreciation for, their children's developmental stages and whether their expectations were age appropriate. Finally, men spoke of the need to be on guard for their over-reactions to their children's behaviour, and to better manage their anger.

Change on self-report assessments. At program termination, there was some change in men's level and patterns of endorsement on the CAPI. Of the six men who completed group, the two who scored at the clinical level on one or two subscales at intake score entirely in the normative range at program termination, two continued to score in the clinical range over treatment with little change in level or pattern of clinical elevations. The final two clients maintained non-clinical reports over treatment.

Information on the Parenting Stress Inventory was available from five of six men. Of these five men, two showed clinical level elevations on total stress, and another two showed borderline elevations in this area. These four fathers also reported clinical elevations in at least one, and often two, of the PSI-SF component subscales of parent distress, parent-child dysfunction or difficult child. At the end of treatment, one man made significant improvement, from showing elevations on a number of scales to showing no clinical elevations. Three men made moderate improvement, showing improvement to the normative range on some subscales, but clinical level elevations remaining in others. One man showed apparent increases in dysfunction.

The AAPI-II was a non-discriminating measure at program intake and termination. Of the five clients with complete information on the AAPI-II at program intake, only one showed slight elevations on one scale of this measure – all other fathers scored entirely in the non-clinical range. A similar pattern of scores occurred at program termination, where none of the clients scored in the clinical range. These scores are clearly at odds with men's reports on the CAPI and PSI-SF and with interview ratings of father's abuse potential.

In summary, on established self-report measures, *Caring Dads* seemed to lead to some limited improvements in men's relationships with their children. However, scales seemed to differ in their sensitivity to differences over time, with greater potential change sensitivity shown by the PSI-SF than the CAPI and AAPI-II.

Interview analysis of change. All clients began group with indications of risk in their interview, with the nature of these difficulties varying considerably by client. Two fathers had inadequate emotional connection to their children, three tended towards using their children for emotional support, four reported concerning levels of anger dysregulation and a number were rated as having conflictual and abusive relationships with their spouses. On average, men were rated as problematic in 1.7 domains (out of a possible 6), and as problematic or at-risk in 3 of six domains at intake.

By the end of the group, interviewers tended to rate men at lower levels of risk than at the beginning of group. Specifically, men were rated as problematic on an average of 1 domain and as at-risk or problematic in 2.4 domains. As suggested by these numbers, interview-rated changes were not dramatic. A typical change, for example, was from a rating of "somewhat concerning" to "a bit concerning". None of the men for whom termination reports were available were rated as "healthy" across all domains of risk in the parent-child relationship. In total, interviewer ratings seemed sensitive to detecting possible change in men over group.

Discussion and Implications

The purpose of the current study was to examine the implementation of the *Caring Dads* pilot intervention program for abusive and at-risk fathers. Focus was placed on evaluating the appropriateness of measures and of identifying challenges in serving this population, with the intention of using results to guide future work in this area. A number of conclusions can be drawn from this work.

First, it is evident from this pilot work that dropout is going to be a significant challenge in working with this population. In one of the pilot groups, for example, we

began with 17 referred men. Of these 17, only 12 attended any intervention sessions and 7 finished. Given that these fathers are typically coerced into treatment and are not voluntarily seeking services, this finding is not surprising. However, it does raise a number of implications for community collaboration and for program policy. First, attrition may be reduced by ensuring that programs serving abusive and at-risk fathers are well integrated in the larger intervention system. This integration allows for cross-agency collaboration and leverage for strongly encouraging men to attend and complete group. Consideration should be given to clarifying with referral agents prior to the start of group their level of commitment to maintain pressure to keep fathers in intervention. In addition, program policies should be developed to help reduce attrition. One possibility is to solidify men's commitment to the program by asking them to make a modest upfront payment for service. Another is to develop policies, and secure resources, so that men can be contacted whenever they miss a group session.

Second, results of the current study suggest caution in the use of established self-report measures of abuse-supporting attitudes and abuse-potential. On the AAPI-II, which is a relatively transparent measure of abuse-supporting attitudes, almost none of the men endorsed problematic attitudes. Similarly, on the abuse potential scale of the CAPI, only two men in 17 scored in the clinical range. A greater number of men reported clinically significant levels of parenting stress – a construct that is related to, but not synonymous with, abuse potential. In considering these results, it is useful to remember that the current sample of men were referred to the *Caring Dads* program by individuals concerned about their abuse of their children. Given this identification, self-report measures were expected to show elevations in risk. The fact that they did not can be interpreted as evidence that men's self-reports of abuse-supporting attitudes and abuse potential are not good gauges of their risk of abuse. Other methods of assessment, such as a clinical interview or reports from external judges, are needed in this domain.

This being said, self-report measures appeared to be useful for assessing a number of constructs related to risk for abuse. A large number of men reported significant levels of unhappiness on the CAPI subscale. In addition, many indicated that they perceived their child, family or others as problematic, perhaps in reflection of problem externalization. Clearer information on this domain can be gathered from men's reports on the PSI-SF, where respondents indicate the extent to which they see their child as difficult (difficult child subscale) and attribute difficulties to particular problems with their child (e.g. child being easily upset; parent-child dysfunction scale). These measures also seemed to be relatively sensitive to change over time, with some men showing changes from pre to post-group assessment. These results suggest that self-report measures, in particular the PSI-SF, should be considered as a means to measure the extent to which men attribute difficulties in their relationship to their child, rather than to themselves.

A third conclusion to be drawn is that information derived from interview and self-report in not redundant. In part, this is because self-report measures are not available to tap some of the domains of risk measured in this study, such as the extent to which a father is using escalating levels of coercion to gain child compliance. Also, interviewers seemed better able to assess risk for key aspects of abusive behaviour. For example, despite entirely non-clinical scores on the role-reversal scale of the AAPI-II, a number of men were rated by interviewers as showing concerning reliance on their children from

emotional support and comfort. Thus, it is recommended that interview-based assessments of fathers' abuse potential continue to be employed.

Finally, the results of this study suggest some promise of the *Caring Dads* program as a whole. In qualitative report, fathers reported being satisfied with the program and as having gaining valuable perspective on their style of parenting. Moreover, men reported that they were continuing to make changes in the way they dealt with their children even after treatment.

These conclusions and suggestions must be considered in light of the numerous limitations of current work. This study involved only a small number of men enrolled in two pilot intervention groups. The interview assessment relied mostly on clinical judgment. Data is currently being collected on inter-rater reliability and on cross-time stability in ratings. Moreover, no conclusions can be drawn from this work about the overall efficacy of the *Caring Dads* program.

Despite these limitations, results from this pilot study are still useful for considering the intervention and assessment needs of abusive and at-risk fathers. By examining the progress of men through the first two *Caring Dads* groups, a number of recommendations could be made to future assessment and evaluation of this program. As the *Caring Dads* program expands, this work will form the foundation for decisions on assessment, evaluation and the development of program policy.

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