

Involvement of Fathers in Therapy: A Survey of Clinicians

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Clinicians providing treatment for children and families often question which family members to include in therapy. Historically, mothers were included in child-oriented therapy to a greater degree than were fathers. To determine actual rates of including fathers in therapy, 219 clinicians with specialization in clinical child psychology and family therapy were surveyed. In addition, personal and professional characteristics of clinicians were examined to establish the association between these characteristics and inclusion of fathers in treatment. Ways to help clinicians include fathers in child-oriented therapy are discussed in light of the findings.

When referring children for treatment, parents or other family members frequently ask clinicians whom should be present at the first appointment. It is typically in the first contact with the clinician or the office staff that parents are educated as to how the treatment will involve them in their child's therapeutic services. Traditionally, parents' inclusion in treatment has been a theoretical matter—that is, depending on the type of treatment the therapist conducts.

Most cognitive-behavioral therapies focus solely on the child (Hibbs & Jensen, 1996; LeCroy, 1994), including parents in these sessions only in a psychoeducational manner to teach the parents what the children have been taught. Conversely, most family therapies focus on all family members and include parents in nearly all of the therapy sessions (Becvar & Becvar, 1993; Kaslow, Kaslow, & Farber, 1999). In fact, some family therapists do not include the children themselves in treatment depending on the focus of the problem. In a survey of family therapists, Johnson and Thomas (1999) found that family therapists were less likely to include children in therapy sessions when the children's problem was externalizing in nature, perhaps because children with these types of problems are considered challenging and disruptive in

family sessions. Their findings also indicated that children were less likely to be included in sessions when the identified problem focused on one of the parent's issues. The issue of involving parents in child-oriented therapy, other than behavioral parent training or family therapy, has largely been ignored (Kaslow & Thompson, 1998; Mash, 1998), often leaving the clinician with little guidance from an empirical viewpoint as to whom to include in treatment.

Parental issues, such as parental psychopathology, living circumstances, and marital and family functioning, are just a few of the factors that influence the nature and severity of the child's impairment, the degree of change in the therapeutic process, and the extent to which change is maintained at follow-up (e.g., Kazdin, 1995; Webster-Stratton, 1985a). Because of the complexities of treating children and adolescents, Kazdin and Weiss (1998) described child and adolescent therapy as "family-context" therapy, regardless of the conceptual view that underlies treatment.

Even when parents are included in therapy, often only mothers and not fathers are invited to be involved (Phares, 1997). Whether or not fathers are included in therapy may have important ramifications for the effectiveness of the therapy, and there has been speculation that engaging fathers (as well as mothers) in therapy and other services can enhance the therapeutic effectiveness of those services (Burns, Hoagwood, & Mrazek, 1999).

One question that arises when exploring fathers' involvement in therapy is the presence of fathers in children's lives. On the basis of U.S. Census data, Roberts (1993) documented that 61.1% of children under 18 years of age in the United States live with both biological parents, 10.8% of children live with one biological parent and step-parent, 24.2% live with their single mother, and 3.9% live with their single father. In a study examining referrals to an outpatient therapy clinic in a southeastern city, Phares and Lum (1997) found that slightly less than half (42.4%) of children and adolescents lived with their married biological parents. However, of the children who did not live with both biological parents, 40.0% still had at least monthly face-to-face contact with both biological parents. Given these findings, it appears incorrect for clinicians to assume that the majority of children referred for services do not have regular contact with their fathers (Phares & Lum, 1997). The inclusion of fathers in therapy remains an issue for many clinicians.

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Including Fathers in Therapy

There are clear connections between psychopathology in fathers and their children (Phares, 1997, 1999; Phares & Compas, 1992). When compared with mothers, however, fathers have been ignored to a great extent by clinicians in the treatment of developmental psychopathology (Barrows, 1999; Phares, 1992; Strean, 1997). A number of clinicians and theorists have argued that the inclusion of fathers in child-oriented therapy is important in order to provide comprehensive treatment for the child (Dienhart & Dollahite, 1997; Hecker, 1991). Although the lack of attention to fathers is especially salient in cognitive-behavioral therapies, fathers have been ignored in family therapy as well (Carr, 1998; Hecker, 1991). Fathers were included in only 39% of studies on behavioral parent training (Budd & O'Brien, 1982) and were included in 6–43% of family-oriented intake sessions (Churven, 1978; Szapocznik et al., 1988). In a survey of psychologists and social workers, Lazar, Sagi, and Fraser (1991) found that fathers were included in 6.3% of therapy sessions with children, whereas mothers were included in 38.1% of such sessions. Thus, regardless of the orientation held by the therapist, fathers are rarely included in therapy for children's and adolescents' problems. This pattern is true for single-parent (e.g., separated, divorced, or never-married parents) households as well as intact (e.g., married or remarried parents) families (Phares, 1996).

Therapeutic Benefits Related to Fathers' Inclusion in Treatment

The next logical question relates to whether involving fathers in therapy increases the effectiveness of therapy for children and adolescents. The ramifications of including fathers in therapy have primarily been studied with behavioral parent training. In general, studies have found that the inclusion of either mothers or fathers in behavioral parent training resulted in comparable treatment outcomes (e.g., Nicol et al., 1988; Webster-Stratton, Hollinsworth, & Kolpacoff, 1989). However, other studies have found that the involvement of fathers enhanced maintenance and generalization of parent-training effects. Additionally, parents can help reinforce and encourage each other in their efforts and remind each other of specific parent-training techniques (e.g., Webster-Stratton, 1985b). The inclusion of both mothers and fathers in such treatment can also be important in addressing marital and coparenting issues (Coplin & Houts, 1991; Dienhart & Dollahite, 1997). Findings also suggest that child-parent interactions themselves are affected by including both fathers and mothers in treatment. In her study of conduct-problem children, Webster-Stratton (1985a) found that when fathers and mothers were involved in parent training, mother-child interactions were less negative than when fathers were absent from the therapeutic process. In another investigation, parenting similarities between mothers and fathers (i.e., fathers' reports of parenting alliance and discipline similarity) were found to be associated with lower parenting stress for mothers (Harvey, 2000). Another benefit of including fathers in child-oriented treatment is that this may help uncover underlying difficulties that might have been missed when focusing solely on mothers and children (Prevatt, 1999).

Thus, there is limited evidence of increased effectiveness when fathers are included in behavioral parent training; however, there

are benefits for both the clinician and the family when fathers are included in the process. Given the potential importance of including fathers in treatment for children's and adolescents' emotional/behavioral problems, it is essential to understand whether or not fathers are actually included in treatment. In addition, it is important to know whether there are characteristics of clinicians that might be related to the inclusion of fathers in the therapeutic process.

Characteristics of Clinicians Who Include Fathers in Therapy

Because fathers are rarely included in therapy for children's and adolescents' emotional/behavioral problems, it appears worthwhile to investigate personal characteristics of clinicians associated with the inclusion of fathers in therapy. In a survey of social workers and psychologists working in child welfare agencies and public schools, Lazar and colleagues (1991) found a number of personal and professional characteristics that were related to the inclusion of fathers in therapy. This inclusion was related to attending more family therapy courses in graduate school, being a male therapist, having flexible hours for therapy appointments, and having fewer years of experience as a therapist. In addition, therapists who were maternally oriented and viewed fathers as secondary caretakers were less likely to include fathers in treatment. Unfortunately, it is not clear whether these results are generalizable, given that the participants worked only within child protective agencies and public schools.

The current study was designed to explore and extend these issues with a more generalizable sample—specifically, with professionals who were actively engaged in therapy with children and adolescents. The current study attempted to include therapists working in a diverse array of therapy settings, with a range of experience, professions, and training in order to assess their inclusion of fathers in therapy. In addition, personal and professional characteristics of therapists were explored to ascertain their connection to the inclusion of fathers in child-oriented therapy.

Exploratory Study on Fathers' Involvement in Child Therapy

A total of 219 participants were included in this study: 135 participants were members of the Society of Clinical Child and Adolescent Psychology (Division 53) of the American Psychological Association (APA), and 84 were members of the American Association for Marriage and Family Therapy (AAMFT). By including AAMFT members, we hoped to gain more variability in theoretical orientation and in professional practice experience and settings. It was also our intent to gain a broad perspective from those clinicians practicing in the field of child and adolescent treatment. We hoped that by including a division outside of the APA, we would gain a perspective not attainable by remaining in the Association.

Surveys were mailed to a randomly selected group of 500 members from each of the professional organizations, along with postage-paid envelopes addressed to the researchers. No one returned two surveys due to membership in both organizations. A response rate of 27.0% for Division 53 and 16.8% for AAMFT was obtained. This response rate is somewhat low compared with

that of other surveys of practitioners (e.g., Johnson & Thomas, 1999). Upon examining another survey study that used the AAMFT population with a higher response rate, we found that the demographics in our study (i.e., gender, ethnicity, degree, and years of experience) were well matched with their population characteristics (Deacon, Kirkpatrick, Wetchler, & Niedner, 1999).

Participants ranged in age from 23 to 74 years, with an average age of 45.56 years ($SD = 12.02$). Women constituted 63.8% of the sample, and men, 36.2%. Regarding ethnicity, participants were mainly Caucasian (94.9%), and the others were Latino/Latina (2.3%), African American (1.4%), Asian American (0.9%), or labeled "other" (0.5%). A total of 67.0% of the sample had earned a doctoral degree, 31.2% had earned a master's degree, and 1.8% had earned a bachelor's degree and had some additional graduate training. Participants had been involved in clinical practice with children and/or adolescents for an average of 13.59 years ($SD = 9.45$). Clinicians were diverse in their therapeutic orientations, and most reported more than one orientation: family systems (67.4%), cognitive-behavioral (63.3%), behavioral (41.3%), eclectic/integrative (34.9%), psychodynamic (28.4%), humanistic (15.1%), and other (14.7%). Respondents also worked in a variety of settings and sometimes in multiple settings: private practice/independent practice (57.5%), academic/university (26.0%), community mental health center (20.1%), outpatient/hospital (19.2%), inpatient/hospital (10.5%), medical school (8.7%), and other (16.4%).

Survey Completed by Clinicians

In an attempt to examine the association between training issues, personal characteristics, structural issues of the clinics in which they worked, and the inclusion of mothers and fathers in treatment of children and adolescents, we developed a questionnaire. As can be seen in Table 1, training issues (such as coursework, practicum experience, and continuing education), personal characteristics

(such as years of experience and egalitarian beliefs), and structural issues of the work setting (such as the availability of evening and weekend appointments) were assessed.

Respondents were also asked to estimate the percentage of their treatment sessions that included different constellations of family members in treatment with children (12 years of age and under) and adolescents (13–18 years of age) for both intact (i.e., parents married or living in the same household) and single-parent (where there is still contact with the noncustodial parent, usually the father) households, forming four categories in which to respond. Constellations for which the clinicians could report (i.e., who they included in therapy) were mother and child/adolescent; father and child/adolescent; mother, father, and child/adolescent; only father; only mother; only child; mother and father only; and other family constellations. Participants were asked that the sum of all their responses for each of the four categories equal 100%. Respondents were also asked to estimate what percentage of time fathers and mothers agree to be involved in their child's or adolescent's treatment sessions when asked to participate.

Measurement of Attitudes Toward Women and Men

In order to further explore Lazar and colleagues' (1991) findings that maternally oriented therapists were less likely to include fathers in treatment with their children, the Sex-Role Egalitarianism Scale (SRES; Beere, King, Beere, & King, 1984) was completed by our population of clinicians. This scale was developed to reflect beliefs about the separate role behaviors of women and men, and it contains items that require judgments about the assumption of nontraditional roles by both women and men (Beere et al., 1984). The short form KK, which contains 25 items, was used for the purposes of the present study. A 5-point rating format was used, ranging from 1 (*strongly agree*) to 5 (*strongly disagree*). Scores ranged from 25 to 125, with higher scores indicating more egalitarian attitudes. Various estimates of reliability (e.g., internal consistency, test-retest, and alternate forms) and validity have been uniformly strong (King & King, 1993).

Table 1

Training Issues, Personal Characteristics, and Characteristics of the Work Setting

Variable	<i>M</i>	<i>SD</i>
Training issues		
No. of family therapy courses completed during graduate training	2.96	3.60
Months of clinical practicum training in family therapy in graduate training	12.60	12.26
No. of continuing education courses/seminars attended in past year	5.34	9.61
No. of family-related continuing education courses/seminars attended in past year	2.19	4.53
No. of family-related books read in past year	2.57	3.27
No. of family-related journal articles read in past year	12.55	17.68
Personal characteristics		
SRES total score	111.49	8.73
Years of clinical practice	14.50	9.63
Years of clinical practice with children/adolescents	13.59	9.45
Structural issues of work setting		
Weekend appointments available (per week)	0.27	0.51
Weekday evening appointments available (per week)	2.33	1.48

Note. SRES = Sex-Role Egalitarianism Scale.

Findings

Reported Paternal and Maternal Involvement in Treatment

The percentage of involvement was computed separately for mothers and fathers by adding up any inclusion of mothers or fathers in therapy (i.e., mother and child; father and child; mother, father, and child; mother only; father only; mother and father only) for each of the four categories (i.e., intact families with children; intact families with adolescents; single-parent households with children where there is contact with noncustodial parent; single-parent households with adolescents where there is contact with noncustodial parent) and dividing by 4. This formula gave us general participation rates in percentages for mothers and fathers separately.

Clinicians reported that, when asked to participate, mothers agreed to be involved in their child's or adolescent's treatment sessions ($M = 91.32$, $SD = 13.47$) a greater percentage of time than fathers ($M = 62.63$, $SD = 28.94$), $t(200) = 15.67$, $p < .01$. Clinicians were also asked to report on their actual rates of includ-

ing mothers and fathers in treatment. Overall, mothers ($M = 58.53$, $SD = 21.58$) were included significantly more frequently than fathers ($M = 30.23$, $SD = 21.23$) in treatment of their children and adolescents, $t(142) = 15.57$, $p < .01$. Inclusion rates were also reported for younger children, adolescents, intact families, and single-parent (usually single-mother) households. The percentage of time fathers were involved in treatment ranged from 21.2% for single-parent families with children and adolescents in treatment to 39.5% for intact families with children and adolescents in treatment. The percentages of time mothers were included in treatment ranged from 51.4% for adolescent treatment sessions to 65.5% for child treatment sessions. We conducted t tests to determine if rates of including parents differed across each of the four categories. Results suggest that overall, mothers are included more frequently than fathers in treatment of both children and adolescents in both intact and single-mother households (see Table 2 for means, standard deviations, and t values). These findings are consistent with previous research (Lazar et al., 1991), suggesting that fathers are included in therapy much less frequently than are mothers.

Training Issues

The training issues that were delineated in Table 1 (e.g., number of family therapy courses during graduate training, number of family-related journal articles read in the past year) were correlated with the percentage of time that the clinicians included mothers and fathers in treatment sessions. Results suggested that the number of family therapy courses taken during graduate training, the months of clinical practicum training in family therapy, and the number of continuing education seminars taken in the past year were not associated significantly with including mothers or fathers in treatment with their children and adolescents. However, the number of family-related continuing education seminars attended by the clinician in the past year was significantly related to including both mothers ($r = .21$, $p < .01$) and fathers ($r = .36$, $p < .01$) in treatment with their children and adolescents.

Finally, both the number of family-related books read in the past year and the number of family-related journal articles read in the past year were significantly related to including mothers ($r = .22$, $p < .01$ and $r = .24$, $p < .01$, respectively) and fathers ($r = .44$, $p < .01$, and $r = .24$, $p < .01$, respectively) in treatment with their children and adolescents. These findings are consistent with research that has shown continuing education in family therapy to be associated with more professional involvement in family therapy

(Guttman, Feldman, Engelsmann, Spector, & Buonvino, 1999). The directionality of these associations is not clear, given that clinicians may seek out these educational opportunities if they are already including parents in therapy. It may be, however, that these types of educational opportunities increase the likelihood that clinicians include parents in therapy sessions for children's and adolescents' emotional/behavioral problems (Allison, Powrie, Pearce, & Martin, 1995; Guttman et al., 1999).

Personal Characteristics of Clinicians

Using correlational procedures, we examined several personal characteristics of clinicians (i.e., therapeutic orientation, gender of clinician, egalitarian beliefs regarding gender roles, years of clinical practice, years of clinical practice with children and adolescents, and affiliation with AAMFT or APA Division 53) to determine their relation to clinicians' inclusion of parents in treatment with their children and adolescents. Results suggested that having a family systems orientation was significantly associated with including fathers ($r = .30$, $p < .01$), but not mothers ($r = .14$, $p > .05$), in treatment with their children and adolescents. All other correlations between therapeutic orientation and parental involvement were nonsignificant. The association between having a family systems orientation and including fathers in therapy is consistent with previous research (Guttman et al., 1999) that has shown connections between clinicians' orientations and their actual practices.

We also examined the gender of the clinician, and results suggested that men and women included mothers and fathers in treatment with their children and adolescents to a similar degree. Regarding egalitarian role beliefs as measured by the SRES, results suggested that there were no significant associations between these beliefs and involving either mothers or fathers in treatment. These findings are inconsistent with previous research (Lazar et al., 1991). One possible explanation for the lack of findings between egalitarian beliefs and parental participation is that the average score on the SRES was 111.49 ($SD = 8.73$). Because the upper limit on the scale is 125, it is possible that a ceiling effect occurred and that not enough variability was present to find such an effect.

There was a positive, significant association between number of years of clinical practice and involving fathers in treatment ($r = .32$, $p < .01$), but there was no significant association between variables for mothers ($r = .04$, $p > .05$). A similar pattern of results was found for number of years of clinical practice with

Table 2
Rates of Including Fathers and Mothers in Treatment With Children and Adolescents

Variable	Fathers involved (% of time)		Mothers involved (% of time)		$t(200)$
	M	SD	M	SD	
Intact families	39.46	26.85	62.00	26.07	-13.68*
Single-parent families ^a	21.22	23.13	55.64	24.53	-15.87*
Children (12 years and under)	29.79	23.36	65.45	25.13	-18.04*
Adolescents (13-18 years)	31.04	23.27	51.39	26.24	-11.27*

^a Usually single-mother families.

* $p < .01$.

children and adolescents; length of time was positively associated with including fathers ($r = .32, p < .01$) but not with including mothers ($r = .06, p > .05$). Given that the number of years of experience is associated with overall therapeutic effectiveness (Beutler, 1997) and given that there is some speculation that including fathers in therapy is more effective in treating family- and couple-related issues than not including them (Coplin & Houts, 1991; Prevatt, 1999), it is not surprising to find that more experienced clinicians are more likely to include fathers in therapy than are less experienced clinicians.

We conducted a series of independent t tests to determine if therapists' use of parental involvement differed by affiliation with AAMFT and APA Division 53. Results suggested that clinicians affiliated with AAMFT ($M = 63.66, SD = 21.99$) included mothers in treatment more often than did clinicians in APA Division 53 ($M = 55.22, SD = 20.78$), $t(141) = 2.32, p < .05$. A similar pattern of results was found for the inclusion of fathers, with AAMFT members involving fathers more frequently than did APA Division 53 members ($M = 37.94, SD = 24.05$ and $M = 25.28, SD = 17.64$, respectively), $t(141) = 3.63, p < .01$. The directionality of these findings is unclear, however, because clinicians' orientations and interests may lead to membership in these two divergent groups (Guttman et al., 1999).

Characteristics of the Work Environment

Correlations were also conducted to determine if working in certain settings (e.g., academia, community mental health center, private/independent practice), working weekend and evening hours, and level of commitment of the work setting toward family involvement in treatment were associated with including mothers and fathers in treatment with their children and adolescents. Results suggested that working in private practice was related to including fathers ($r = .25, p < .01$) but not mothers ($r = -.09, p > .05$) in treatment with their children and adolescents. All other correlations were nonsignificant. The finding that greater inclusion of fathers (but not mothers) was related to working in a private/independent practice setting may relate to these clinicians' greater control over the therapeutic process. Although clinicians who work in private or independent practice settings are influenced increasingly by health maintenance organizations and health insurance limitations (Crespi & Steir, 1996; Wolf, 1999), it appears that these clinicians may be freer to include fathers in therapy than are clinicians in other settings. Additionally, it is possible that the fathers themselves are contributing to these increased rates of participation in private/independent practice; that is, because they likely have a higher socioeconomic status, these fathers may have more personal freedom or resources that make them more physically available to attend these sessions.

We also examined the availability of weekend and weekday evening times for treatment. Results suggested that having weekday evening times available was not significantly related to including mothers or fathers in treatment with children or adolescents, nor was having weekend times available. Finally, clinicians were asked to report whether their work setting was committed, open, or not committed to family involvement in treatment. Correlations were conducted to determine if level of commitment was associated with including parents in treatment. Results suggested that there was a nonsignificant association between level of com-

mitment of work setting and including mothers and fathers in treatment. Although this finding is inconsistent with previous research in child welfare agencies and school settings (Lazar et al., 1991), it may be that the clinicians in the current sample had more control over their own practices, and thus their own personal characteristics were more influential in parental inclusion in treatment than were any work-setting variables.

Implications and Discussion

Overall, this study extends what was known previously about the involvement of fathers and mothers in therapy related to children's and adolescents' emotional/behavioral problems. The inclusion of parents (either mothers or fathers) in therapy with children and adolescents remains somewhat limited. Including parents in child-oriented therapy, however, has been shown to be effective in addressing interparental conflict, coparenting issues, and marital issues that are related to child functioning (Carr, 1998; Coplin & Houts, 1991; Prevatt, 1999) and in allowing parents to be supportive of the therapeutic gains that their children make in therapy (Burns et al., 1999). Because there are connections between the psychological functioning of fathers, mothers, and children (Phares & Compas, 1992), it makes sense that fathers and mothers would be considered for inclusion in therapy when children and adolescents show dysfunctional behavior. Thus, it appears that there is some rationale for identifying and enhancing the characteristics associated with including parents (especially fathers) in therapy for children and adolescents.

Overall, fathers were included in therapy to a lesser extent than were mothers. One potential reason for this pattern of less paternal involvement in therapy may be related to clinicians' reports that fathers were much less likely to attend therapy sessions when compared with mothers. Hecker (1991) noted that, consistent with these findings, many clinicians assume that fathers are more resistant to involvement in therapy. Hecker also noted, however, that even if fathers do not initially express interest in therapeutic involvement, it is incumbent upon clinicians to try to engage fathers in the therapeutic process. Specifically, fathers can be provided with a rationale for their involvement in therapy that emphasizes what they might gain from such involvement (Carr, 1998).

It appears that continuing education related to family therapy and reading books and journals on family therapy may help clinicians realize the importance of including fathers in therapy for children and adolescents (Guttman et al., 1999). Perhaps clinicians also find additional techniques for engaging fathers in the therapeutic process from these continuing education activities on family therapy and in their family-related readings. One of the most salient implications from this study is that clinicians should increase their involvement in family-related continuing education and professional reading. These professional activities will probably be associated with increased paternal and maternal involvement in clinicians' therapy sessions.

Regarding the family systems orientation, it appears that family therapists are becoming increasingly aware of the importance of including fathers in family therapy. Although mother-blaming has been documented in clinicians from a variety of theoretical orientations (Phares, 1999), research with family therapists found no evidence of mother-blaming in relation to a hypothetical vignette

(McCullum & Russell, 1992). Interestingly, more parental culpability was assigned to whichever parent expressed more concern about the child's emotional/behavioral problems (McCullum & Russell). By attending to both mothers and fathers, family therapists are apparently following their training to explore the family as a system rather than focusing on the mother-child relationship exclusively (Becvar & Becvar, 1993). One obvious implication of this work is for clinicians to reflect on their own possible mother-blaming tendencies and to explore whether these thoughts have any relevance for their own clients. Even if clinicians believe that a particular child client's problems are due to his or her mother, it is incumbent upon the clinician to also explore the father's culpability for that client's problems (or for the mother's problems).

Because the goal in treatment of children's and adolescents' problems is to achieve generalization beyond the treatment setting (Stokes & Baer, 1977), treatment must include key elements of other settings. Parents represent the most obvious social elements in the child's home environment, and therefore several additional suggestions are offered to help clinicians engage mothers and particularly fathers in the therapeutic process.

1. Clinicians should be cognizant of the roles that parents play in the therapeutic process and should simply ask them to be involved. It would be helpful for the clinician to talk to the father directly; this technique is typically and effectively used in engaging reluctant family members (Anderson & Stewart, 1983).

2. Prospective clients can be told that all family members, or both parents, are expected to attend the initial session (Hecker, 1991). Hecker also suggested that the father should be reassured about his importance in the family and in relation to the therapeutic change of the child, because fathers sometimes feel marginalized in the therapeutic process.

3. During the assessment process, parents can complete questionnaires about child symptomatology and also about themselves and their family. Assessment information should be gathered by a variety of informants to include fathers, mothers, teachers, and the children themselves because of the unique contributions of each informant (Achenbach, McConaughy, & Howell, 1987; Duhig, Renk, Epstein, & Phares, 2000) to help guide treatment conceptualization. If fathers participate in the assessment process, they may realize that their input is valuable, and they may be more willing to engage in the treatment process.

4. Clinicians can point out to parents, especially fathers, that changes in the family situation depend on their participation (Hecker, 1991). In addition, it may be helpful to inform families of the current knowledge of how fathers can facilitate the child's therapeutic change and maintenance of change and to highlight the added benefits that studies have found for mothers involved in child-focused treatment with their partners.

5. Within family therapy sessions, fathers appear to respond better to more structured and directive interactions, so these types of interactions appear to be appropriate when fathers are involved in therapy sessions (Carr, 1998).

6. Fathers as well as mothers appear to respond well to being offered extra therapy sessions that can focus on parental concerns, such as job stress and personal concerns (Carr, 1998). Thus, clinicians may want to offer therapy sessions that would focus on parental concerns rather than on the concerns of the child.

7. Clinicians can seek advice from more experienced therapists on ways they engage parents, especially fathers, in therapy. For

additional suggestions about how to include fathers in therapy, see Carr (1998) and Hecker (1991). Interested clinicians are also encouraged to read more about fathers in contemporary society (Cabrera, Tamis-LeMonda, Bradley, Hofferth, & Lamb, 2000); the special needs of low-income, unmarried, and minority fathers (Coley, 2001), and the therapeutic issues that arise when working with gay fathers (Barret & Robinson, 2000; Bigner, 1996).

Overall, this study highlights the need to help clinicians learn about the benefits of including parents (and especially fathers) in child-oriented therapy and to learn ways in which parents (and especially fathers) can be engaged in therapy. This goal can be accomplished through training in family therapy in doctoral programs or through continuing education programs in family therapy.

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