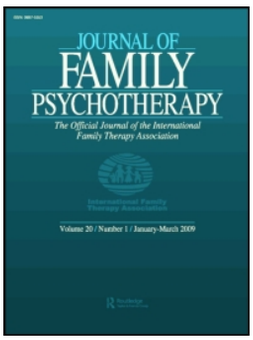

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Engaging Fathers in Parent Training: A Qualitative Study

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ABSTRACT

Numerous studies have described fathers' low participation in child psychotherapy. Few studies, however, have explored the clinical challenges involved in the process of engaging fathers effectively. The present study sought to address this gap by assessing the clinical process that takes place when the father joins therapy. Treatment supporters in a counseling program for child behavior problems were interviewed about clinical cases involving attempts to engage fathers. Qualitative analysis of the interviews revealed three main themes: The father's initial suspiciousness, the father's prior involvement at home, and the mother's perception of the father's help. Based on study results, a new model for fathers' engagement is proposed.

KEYWORDS

Child behavior problems; engagement; fathers; parent training; qualitative research

When scheduling an initial parenting consultation session, mothers frequently ask, "Can we have the session without the father?" This question often poses a dilemma for child therapists: To what extent should they insist on the father's presence at sessions? Is the price of postponing an urgent session in order to wait for the father justified? And, moreover, how should they respond to a mother's inference that the father is peripheral and not needed for discussion of his child's problems? Questions about the importance of recruiting fathers into treatment and possible ways to engage and motivate fathers in treatment are central for any parental counseling program. Nevertheless, in spite of a long history of discussions about fathers' involvement and engagement in counseling programs, the child psychotherapy literature still falls short in systematically studying fathers' involvement and has dedicated little attention to the development of clinical guidelines that could promote meaningful paternal engagement (Fabiano, 2007; Panter-Brick et al., 2014; Tiano & McNeil, 2005).

In the counseling program in non-violent resistance (NVR) for families of children with behavior disorders (Jakob, 2006; Lavi-Levavi, Shachar, & Omer, 2013; Ollefs, Von Schlippe, Omer, & Kritz, 2009; Omer, 2004; Weinblatt & Omer, 2008), the premise that fathers are crucial for treatment is central. In this program, we often told mothers, "No, we cannot have the session without the father" and rescheduled appointments to facilitate fathers' participation. Based on the high

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rates of paternal participation, our initial impression was that we were having success in getting fathers to come to and stay in therapy. However, a closer examination of difficult cases including severe parental dispute and early dropouts led us to conclude that our engagement of fathers was far from optimal. Qualitative research methodology was, therefore, applied to examine 10 cases in which both parents participated in the therapy. The present article summarizes the results of this effort to look systematically at the process of engaging fathers by reviewing the current literature on fathers' involvement and by examining the engagement process from beginning to end of treatment in 10 clinical cases. It includes analysis of the main elements that impacted the engagement process and offers clinical formulations and guidelines for improving fathers' engagement.

Fathers' direct and indirect impact on child behavioral problems

Studies investigating child development and psychopathology refer to the father as a significant figure in all aspects of a child's development and life (Lamb & Lewis, 2010). Fathers' influence is often described from the dyadic and systems perspectives as affecting the child in both direct and indirect ways (Goeke-Morey & Cummings, 2007).

The direct influence refers to the relationship between the child and his father and the impact this dyadic interaction has on the social emotional development of the child. The indirect influence refers to the couple relationship and the impact of the mother–father relationship on the mother's experience of parenting and quality of care for her child (Belsky, 1981; Belsky & Vondra, 1989; Erel & Burman, 1995; Zur-Szpiro & Longfellow, 1982). This multi-dimensional perspective on fathers' involvement explains the large impact fathers have on their children's mental health, even when direct contact between father and child is limited and the mother is the primary caregiver.

Studies conducted by Patterson in the late 1970s in families of children with behavioral problems described ways in which weak and helpless maternal responses to child demands contribute to the development of a coercive relationship that intensifies a child's violent and aggressive behaviors (Patterson & MacCoby, 1980). In their description of the coercive cycle, Patterson and MacCoby referred to fathers as "free floating agents" who can choose whether to engage or withdraw from aggressive interactions with the child and whether to function mainly as socializing agents. Patterson's studies demonstrated that when the father is more directly involved in handling a child's behavior problems, there is a significant decline in problem behavior frequency. Consistent with Patterson's findings, more recent research by DeKlyen, Speltz, and Greenberg (1998) found that both hostile/aggressive paternal behaviors and paternal disengagement can predict a child's externalizing problems above and beyond the impact of the mother's behaviors. Fathers, in the families described in the study, vacillated between punitive reactions to the child's behaviors and disengagement. This was

in contrast to mothers who maintained closer contact with the child even when the relationship was hostile or negative.

Studies that have focused on the indirect path of fathers' involvement have emphasized the role of parental dispute on the development of child behavior problems. A parent that disagrees with his partner on child-rearing practices will not have the support of his partner and will have difficulty exercising authority or setting appropriate limits for the child (Chamberlain & Patterson, 1995; Omer, 2001). In addition, a mother's ability to cope effectively with her child's behavior problems is related to the supportive resources available to her and to her sense that she does not have to cope with the child alone. Finally, parents of children with behavior problems experience less pressure from their child if their marital relationship is satisfactory and they have less conflict with their partner (Suárez & Baker, 1997).

Fathers in parental training programs for children with behavior problems

Despite overarching agreement that fathers play a significant role in the development and maintenance of children's behavior problems, fathers' presence, and engagement in parent counseling programs for child behavior problems continue to be significantly lower than mothers' (Duhig, Phares, & Birkeland, 2002; Fabiano, 2007; Lazar, Sagi, & Fraser, 1991; Panter-Brick et al., 2014), and child psychotherapy studies involving fathers are relatively scarce.

Results of studies that compared the effectiveness of parent training (PT) with and without fathers for externalizing child problems showed an overall positive impact of paternal involvement, though they varied in the magnitude and type of impact found. In some studies, fathers' involvement in treatment resulted in longer lasting therapeutic effects and better assimilation of skills learned (Bagner & Eyberg, 2003; Webster-Stratton, 1985; Webster-Stratton, Reid, & Hammond, 2004). Other studies have shown that when the father was present at home but not involved in therapy, treatment was less effective and dropout rates were higher (Carr, 1998; Friedlander, Wildman, Heatherington, & Skowron, 1994). In a meta-analysis of outcome studies, Lundahl, Tollefson, Risser, and Lovejoy (2008) found that studies including fathers in treatment showed improvement in child conduct behaviors and parenting practice by the end of treatment but failure to maintain these improvements during follow up. In addition, the meta-analysis revealed that fathers did not report benefiting from treatment as much as mothers did, with less change or improvement reported by fathers by the end of treatment.

The high variability in study results regarding the effects of fathers' participation in their child's treatment is not surprising. Methodologically, many of the studies were not randomized trials (Panter-Brick et al., 2014) and studies lacked consistent definition of fathers' "involvement" (e.g., does it entail only attendance?) or evaluation of the father's engagement in therapy as a possible mediating factor affecting treatment outcome. Lundahl et al. (2008) also

concluded that fathers experience therapy as less relevant in addressing their own parenting needs, which suggests that even when attempting to recruit fathers, programs may overlook or fail to address fathers' specific needs. This concerning finding is consistent with Panter-Brick et al. (2014) review, which indicated that, across the board, counseling programs and psychotherapy studies continue to fall short in engaging fathers effectively.

Previous studies on fathers' attendance and participation attempted to address this problem by identifying factors contributing to improved engagement. Studies' results indicated that fathers tend to participate more when they are actively engaged, when they are accorded the status of "experts" in relation to their child, when they are validated, and when their importance is emphasized (Campbell, Howard, Rayford, & Gordon, 2015; Duhig, Phares & Birkeland, 2002; Foote, Eyberg & Schuhmann, 1998; Dienhart & Avis, 1994; Walters, Tasker, & Bichard, 2001). Studies also identified a need to engage fathers during the initial assessment stage of treatment, as their delayed entry might impact their ability to form trust with the therapist (Carr, 1998). In addition, fathers were found to cooperate more with a direct and task-oriented clinical approach (Carr, 1998; Vetere, 1992), as well as when the therapist assumed a symmetric and non-judgmental position toward both parents (Campbell et al., 2015; Bagner & Eyberg, 2003; Walters et al., 2001). Consistent with it, fathers were more involved in services when therapists were trained in a family therapy approach and skilled in attending to the couple relationship (Duhig et al., 2002; Gordon, Oliveros, Hawes, Iwamoto, & Rayford, 2012).

While shedding important light on common barriers to fathers' participation in therapy, the studies described above did not assess systematically the quality of the fathers' involvement with the therapeutic process or the impact of fathers' partial, half-hearted presence on treatment outcomes. Moreover, a focus on fathers' attendance, participation, and alliance formation with the therapist during sessions cannot answer questions concerning the fathers' attitudes and behaviors outside the session. As a result, information regarding fathers' willingness and attempts to implement treatment recommendations and attempt therapeutic change outside of session remains speculative and inferential. An additional limitation of existing studies is that they have not addressed the extent to which fathers' engagement—both in sessions and at home—influences mothers' engagement in the therapeutic process or their motivation and ability to implement treatment recommendations successfully at home. The lack of attention to the engagement process, limited information about what occurs outside the therapy room and between sessions, and absence of consensus on what comprises meaningful engagement contribute to a broader lack of decisive clinical knowledge about the specific challenges working with both parents imposes on treatment. As a result, effective clinical guidelines for this scenario are lacking.

The present study aims to expand the clinical discussion on fathers' engagement in parent counseling programs. It focuses on fathers' continued

engagement in therapy—both inside and outside the therapy room—once the initial attempt to bring them to the therapy room has been successful. It investigates fathers' reactions to treatment goals and recommendations, dynamics between fathers and mothers during treatment, and the impact of these factors on the course and outcome of treatment for the child. Ultimately, the goal of this article is to provide clinical insights into barriers to and strategies for engaging fathers in child-focused therapy in order to lay the groundwork for evidence-based clinical guidelines for working with fathers in parent counseling programs for behavioral problems.

Method

Participants

The present study was conducted at a parent-counseling unit in Israel. Parents arriving for parental consultation received a short-term PT in NVR that was delivered by masters level clinical psychologists. In the format of PT practiced in Israel, the therapist is assisted by a treatment supporter, an undergraduate psychology student, who joins therapy sessions as an observer, documents the sessions, and keeps in phone contact with the parents at least twice a week for the duration of treatment. Phone contact with the family involves direct discussions with each parent on the assigned homework and treatment recommendations. The treatment supporter also provides parents with opportunities to consult between sessions about the child's behaviors and discuss challenges to treatment implementation.

In designing the study, we were interested in observing the process of fathers' engagement from a family-systems perspective. Though we acknowledge that interviewing fathers or the mothers directly may have provided their individual perspective on the therapeutic process, we felt it would capture less of the system's dynamics (e.g., how the father's engagement impacted and was impacted by all the parties involved in the process, including the child, the mother, and the therapist). Additionally, as we were interested in studying both successful and less successful engagement processes, we worried that targeting fathers as primary informants would bias the sample toward fathers with successful experiences in therapy and those who were easier to engage. In other words, if we had selected fathers rather than supporters as our target participants, we would likely have created bias in the results, losing richness of data regarding fathers who were most reluctant to engage. Likewise, while interviewing therapists could have offered an alternative, more informed perspective of fathers' engagement in the therapeutic process, therapists were less acquainted with family dynamics at home relative to the supporters. As a result, with ambivalent or reluctant fathers, therapists often had almost no direct access to these fathers' view point or response to the therapeutic recommendations.

Considering the advantages and disadvantages of each informant, we selected treatment supporters as the participants for this study. The supporters were external to the family system in a way that enabled a broad perspective but also intimate enough with the family to have access to the parents' experience. Thus, for this study, eight treatment supporters; seven females and one male, were interviewed regarding 10 different families. Two supporters were interviewed twice, regarding two families each. The families were treated by three therapists, two males and one female. Families were included in the study if the treatment involved attempts to recruit the fathers and the fathers had been present in at least two therapy sessions. All families sought consult voluntarily from the clinic and paid for each treatment session. All parents were married and resided at home. Children's age ranged between 7- and 16-years-old and included four girls and six boys. The presenting problems involved wide range of behavioral symptoms, including running away, truancy, stealing, and verbal and physical violence.

Treatment

The counseling program in NVR for families of children with behavior disorders was developed and validated in Israel (NVR; Omer, 2001, 2004; Weinblatt & Omer, 2008). It is currently practiced in Israel, Germany (Ollefs et al., 2009), Switzerland, Austria, England (Newman, Fagan & Webb, 2014), the Netherlands, and Belgium. The program involves 8 to 12 therapy sessions conducted by trained clinical psychologists. The approach was developed to help parents deal effectively, non-violently, and with minimum escalation with the challenge posed by violent and self-destructive children. The main elements of the program include helping the parents achieve better self-control, establish clear house rules, improve their level of supervision and presence at home and recruit supporters among their friends and relatives. The community supporters help by being present in person or on the phone when the child behaves violently, creating a public opinion against violence, serving as mediators, and helping the child develop acceptable solutions.

Procedure

Treatment supporters were invited to participate in the study following the end of their work with target families. Each treatment supporter met individually with the primary investigator for a 30–60-minute interview. The interviewees were asked to de-identify the families they discussed and the interviews were audio recorded. The interview assessed the engagement of fathers throughout treatment. It was partially structured and consisted of the following questions:

(1) What was the problem that brought the family to therapy? What was the father's description of the problem? What was the mother's?

(2) What was done in therapy to influence the father's participation?
(3) How did engaging the father affect the course of therapy?

Interviews were transcribed and analyzed using the "Grounded Theory," a qualitative research methodology developed by Glaser and Strauss (1967) and further elaborated by other investigators (Bachelor, 1995; Gevaton, 2001; Hill, Thompson, & Williams, 1997; Strauss & Corbin, 1990). The method is based on a recurrent and systematic process of data analysis, that consists of the following stages: (a) sections of the text that constituted "units of meaning" were identified by the main investigator (b) the text, thus divided into units, was given to two independent judges who were instructed to classify the units into clusters with similar thematic content and to give a name to the cluster ("a thematic category") in a way that best characterized each cluster; (c) a list of all thematic categories was prepared and given to the judges, who were then asked to go over the list, find commonalities, and then reorganize and simplify the list according to the thematic categories for which there seemed to be agreement between them. They were also required to organize the categories into a hierarchic ordering, with first-order categories (called "core categories") and second order categories; (d) the judges came together, discussed the categories and their hierarchic ordering, reached a consensus regarding the name and range of each category, and listed the units of meaning or categories that still remained unclassified; (e) the judges were then asked to reconsider the unclassified units of meaning and those categories for which they had not reached a consensus and to try to organize them into new categories; and (f) a new list was prepared with all the categories that emerged in this second stage, and the process described under "c" and "d" was repeated until an agreement was achieved on the classification of all units of meaning, on the names of the categories, and on the hierarchic ordering among them, such that no unit of meaning remained unclassified.

The judges were two Bachelor level psychology students in their senior year who were trained by the second author about the treatment model and stages of treatment, as well as about the role of the treatment supporters in the process. The judges were also trained by the first author in Grounded Theory principles and coding procedures (Gevaton, 2001). As the judges' role changed at each analysis level, judges were provided with written instructions on the type of analysis they were asked to perform at each stage. To ensure comprehension of coding requirements and coding fidelity, judges sent the primary investigator the first transcript they analyzed before completing the remaining samples. Each of the transcripts was, therefore, analyzed by both judges separately and was reviewed for adherence and fidelity to coding procedures by the first author at the beginning and end of each analysis stage.

The reliability of the judges' analyses was assessed through the processes of consensus and repeated comparisons (Hill et al., 1997). Following their initial, independent classification of units of meaning to thematic categories, judges were

instructed to compare their categories and reach consensus regarding the final categories to be used. Reaching a consensus required the judges to form clear and easily applicable categories. Additionally, the process of repeated comparisons required the judges to test the agreed-upon categories again on the original data set and iteratively make revisions based on ease of application and fit to the data. The repeated nature of this process ensured that categories remained tied to the text, increasing the certainty that they could be used effectively by another person. This process also ensured that all the themes that emerged in the interviews were represented in the final categorical organization.

Prior to their involvement in this study, the two judges had received no prior academic training on issues related to fathers' involvement or engagement in psychotherapy. The study was presented to them as an "assessment of the process of fathers' engagement in therapy" and their task was described as "identifying and describing repeated themes in the interviews transcripts." The judges therefore were not aware of preexisting ways to cluster the data or of any hypotheses or potential biases of clinicians or researchers involved in the study. The analyses performed by the judges were therefore assumed to be independent of the investigators' hypotheses and of potential influence of prior research findings on this topic. Notwithstanding, the reliability of qualitative data analysis is considered a continuous process of evaluation that extends beyond the data analysis phase (Lincoln & Guba, 1985). This process involves the presentation of the results in a detailed format that delineates the path between the original data and the derived categories, as is provided in this article. This format enables the reader to judge the applicability of the categories to the content they describe, which itself provides an additional reliability assessment for the categories determined by the judges.

Findings

Systematic analysis of interviews led to the definition of three core categories: (1) Fathers' resistance to therapy; (2) Impact of fathers' limited presence in the home, and (3) Mothers' reaction to the fathers' attempted recruitment. A description of the main and sub-categories is presented in Table 1. In the following section, we will describe each of the categories with their respective sub-categories and provide example quotations from the interviews.

Category 1: The father's resistance to therapy

In all of the families involved in the study, the mothers initially contacted the center. The attitude of the fathers at the outset of treatment was initially skeptical or downright oppositional. Fathers' resistance was manifested at four levels:

Table 1. Final coding framework into thematic core categories and subcategories.

Core categories	Subcategories
1. The father's resistance to therapy	1.1. The father manifests doubts and apprehensions 1.2. The father's difficulty in forming a therapeutic alliance. 1.3. The father's difficulty with revealing the problem and involving supporters. The father's motivation to participate in therapy was external. 1.4. Attempts at handling the father's resistance.
2. The impact of limited presence of fathers in the home on treatment	2.1. Disconnection of fathers from their children. 2.2. Limited involvement of fathers as a cause of over-identification with the child. 2.3. Therapeutic attempts to achieve a gradual re-engagement of the fathers.
3. The mother's reactions to the attempted re-engagement of the father	3.1. Attempts to help the parents act together in spite of disagreements. 3.2. The mother's need for support and recognition. 3.3. Over-emphasis on the father may hamper the mother's ability to utilize therapy.

(1.1.) The father manifested doubts and apprehensions. The fathers' opposition was sometimes manifested by disparaging views of psychologists and psychotherapy. This opposition was often based on a view of therapy as "soft" and full of words. Some of the fathers said that psychologists weaken parents by supplying psychological justifications for the child's misbehavior. Some said that therapists always blame the parents for the child's problems.

The opposition of the fathers also took practical forms. One father refused to pay for sessions, one spoke on his cell phone during sessions, and one refused to speak with the treatment supporters between sessions. Other fathers expressed concerns that changing their response to the child's behaviors following treatment would destroy their relationship with the child or worsen the child's condition.

(1.2.) The father's difficulty in forming therapeutic alliance. With several fathers the therapists struggled to communicate directly, learn what was disturbing for them, or how they felt about the therapeutic recommendations. Lack of communication made it difficult for the therapists to attune therapeutic language and treatment goals to the father's needs. In some of the cases, the father seemed to agree in session to the prescribed recommendations, but later the therapists learned that the father dismissed the recommendation and was not willing to participate in the planned intervention at home.

In the absence of therapeutic alliance between father and therapist, the mother often took the role of an intermediary, communicating what the father thought but did not say, or conveying therapeutic messages to the father when he skipped sessions. This further contributed to the therapist's difficulty to assess the father's experience and perception of the therapeutic process and to the father's passive and uninvolved position even when he was physically present in sessions.

(1.3.) The father's difficulty revealing the problem with the child and involving supporters. Without exception, all the fathers in the study objected to the elements in the program that involved enlisting support and help from the community. The fathers were much more apprehensive than the mothers about the negative effects lifting the veil of secrecy might have on the child. Explanation to the objection involved concerns the child will feel humiliated, increase his aggressive behaviors, or that the child's reputation will be stained.

(1.4.) The father's motivation to participate in therapy was external. The fathers in this study did not seek therapy of their own accord. They came on the mother's demand, or because they thought that the mother was in need of help. Some of them were aware of the child's problematic behaviors, but stated they did not experience it directly. The problem was often described as a problem between the mother and the child or a result of the mother's ineffective management. Several fathers came to therapy hoping that it would teach the mother how to improve her behavior.

(1.5.) Attempts to handle the father's resistance. This subcategory consists of attitudes and steps on the therapist's part that were designed to diminish the father's resistance and increase his motivation. We identified three approaches:

(1.5.1.) Stressing matters that concern the father. The engagement of some fathers was achieved by the therapist's readiness to attend to what concerned them the most: the absence of positive contact with their child. Although the first priority of the counseling program was dealing with the child's violence, the therapist sometimes found that it was only possible to engage the father if he felt the therapy was helping him develop a better relationship with his child. In other cases, the engagement of fathers was furthered by supporting ancillary elements of the father's agenda, for instance, increasing religious observance, or getting the child to visit the paternal grandparents.

(1.5.2.) Adapting the treatment to the father's language. Therapists continuously paid special attention to the father in session, often by addressing direct questions to him in order to secure a higher degree of involvement. This was particularly important when the mother's presence was very dominant in sessions. A deliberate attempt was also made to modify the language of treatment and emphasize clear goals and practical action steps. This emphasis helped to enlist fathers' cooperation, particularly when they showed disinclination toward emotional or introspective language.

(1.5.3.) Coping non-judgmentally with the father's outbursts. In three of the families in which the father escalated conflicts with the child to the point of physical violence, therapists tried to recruit the father into treatment using a two-staged approach. In the first stage, they related to the father's difficulties non-judgmentally, trying to understand what made him lose control; in the second stage, they carefully challenged the father's

physical aggression, searching with him for alternative reactions. In this way, therapists addressed the father's angry outbursts without embarrassing and shaming him.

Category 2: The impact of limited presence of fathers in the home on treatment

The majority of fathers in the study were less involved with their children than were mothers, and in some cases fathers were completely cut-off from their children's lives. The meaning-units in this core-category were classified into three sub-categories:

(2.1.) Disconnection of fathers from their children. Most of the fathers in the study worked long hours and their contact with their children took place chiefly in the late evening or on weekends. Thus, they were less involved than mothers in positive interactions with the child and in implementation of discipline. Some of the fathers had no direct channel of communication with the child and all communication was mediated by the mother.

The fathers' reduced presence in the home led to systematic differences between theirs and the mothers' views of the children's problems. Most of the fathers viewed the child's problems as less severe than did mothers. Fathers were often unaware of the extent of the problems, and became familiar with them only during therapy. In families where the father was home more often or was responsible for part of the child's daily routine, he experienced the problems more frequently. In these families, the father's view of the problem was more similar to the mother's.

(2.2.) Limited involvement of fathers as a cause of over-protectiveness toward the child. Fathers' lower engagement contributed to feelings that their relationship with their child was vulnerable and should not be threatened by "harsh" disciplinary attempts. Many fathers in our study expressed concern about possible harm new disciplinary actions would cause to the child. In contrast, fear that the child would get hurt or the parent–child relationship would be harmed as a result of the disciplinary changes was never voiced by mothers. Instead, mothers that came to therapy in a state of despair were willing to do almost anything to change the child's behavior. Fathers, who were much less affected by daily conflicts, were afraid of losing the little positive contact they had with their child. These fathers consistently preferred strategies that would not "rock the boat."

(2.3.) Therapeutic attempts to achieve gradual re-engagement of fathers. Fathers in the study were more engaged with tasks that matched their initial level of involvement with their child. Fathers responded better when they were given concrete and structured tasks with good likelihood of success. For those fathers who had had virtually no relationship with their child prior to the therapy, the process of re-engagement began with positive gestures and attempts to develop

positive and potentially conflict-free interactions between father and child. It was only when fathers became somewhat closer to their child and displayed a greater interest in interacting with him or her, that his help was enlisted in helping to handle conflicts.

The therapeutic approach was different for those fathers who were used to spending time with their child. In these cases, therapists began directly with the task of recruiting the father to support the mother in dealing with the child's aggressive behaviors. When fathers already had a stable relationship with their child, they were recruited as full-fledged partners, being encouraged to assume independently some of the tasks that had previously been left to the mother.

Study interviews indicated that when fathers did become more present in the home, their therapeutic motivation grew. They became more aware of the problems and more interested in therapeutic tools to reduce escalation and parental helplessness. Moreover, increased presence of the father lifted some of the responsibility from the mother's shoulders. This often resulted in less escalations between mother and child. Nevertheless, fathers that were not involved with the child prior to therapy and were asked to join the mothers' disciplinary attempts at the beginning to therapy experienced their child's negative response as proof of the futility of their attempt to become more involved.

Category 3: The mother's reaction to the father's attempted recruitment

All the mothers in the current study were the primary caretakers of their children. With some families, this manifested in very high levels of maternal involvement: The mother felt responsible for all aspects of the child's life. These mothers had sometimes given up their careers, leisure activities, and social lives for the sake of their child. They were also the ones who bore most of the brunt of the child's negative and violent behaviors. The fathers in these families had little role in raising the child and were rarely exposed to the child's behavior problems. Instead, their interactions with their child were often limited to recreational activities. Meaning-units in this core-category were classified into three sub-categories:

(3.1.) Attempts to help parents act together in spite of disagreements. In six families, the parents were in significant disagreement about the child's problems and the best disciplinary approaches to handle them. Therapists attempted to help parents act in spite of their disagreements by identifying mutual goals and focusing on enhancing the parents' ability to execute these goals effectively. The parents' tendency to blame each other for the child's difficulties and attempts to "prove" the other parents' fault were discussed as further weakening their capacity to handle the child's aggression and as contradicting their own important goals. For example, when the mother accused the father of being absent and neglectful, the therapist tried to find

a way to address the mother's underlying need for support or wish that the child will spend more time with his father.

The therapists' attempts to help the parents engage in non escalating modes of communication worked well for families with mild level of parental dispute. In cases of severe dispute, where the parents were not able to refrain from criticism and offensive remarks, some therapists chose to treat the parents as two separate clients (even if they continued attending sessions together). Telephone conversations were held separately, independent therapeutic tasks were assigned to each parent, time was allotted in sessions for each parent to present his or her side while the other was required to listen in silence, and positive behaviors of each parent were reinforced by the therapist in the presence of the other parent.

In one of the families in which the parents were in severe conflict, the therapist's insistence that the parents reach a common ground regarding treatment goals resulted in intensification of the dispute during sessions and led to treatment termination.

(3.2.) The mother's need for support and recognition. In 9 of 10 cases in the present study, the mothers were the ones who bore the brunt of frequent hostile interactions with the child. Mothers' high investment and the constant pressure they lived under engendered a deep feeling of sacrifice and a strong need for recognition. In several families, mothers repeatedly expressed this need, telling the therapists how hard they have been working, how big their sacrifices were, and how much they felt that no one recognized or appreciated this.

In these families, mothers' need for acknowledgment seemed so intense that if therapists praised the father for his contribution, the mother felt slighted and betrayed. This was true even when, in the eyes of the therapist, the father was making positive steps that were potentially helpful for the mother. In two families, though the father successfully took on some of the difficult tasks with which the mother had previously struggled, such as putting the child to bed or driving the child to school, the mother felt it did not relieve her stress. On the contrary, in these families the mother expressed feeling undermined as a mother and left out. These mothers also criticized the father's attempts and tried to reclaim their previous roles back.

(3.3.) Over-emphasis on the father may impede the mother's ability to utilize therapy. Successful attempts to engage fathers in therapy depended considerably on mothers' attitudes toward the fathers' engagement. When the mother was willing to offer room for father's involvement, she supported therapist's attempts in this direction and reacted positively to signs of growing paternal involvement. However, where critical gaps existed between parents, or the father's ambivalence toward treatment did not subside in response to engagement attempts, investment of many therapeutic resources

in the father deprived the mother of the therapist's attention and support and eventually jeopardized the engagement of both parents.

In several cases, the assumption that higher involvement of an absent father in the house is crucial for change, resulted in a situation where the bulk of sessions focused on the father's engagement and treatment goals that the mother had set at the outset and was willing to work on independently were not executed. Alternative resources of support that could have been more available to the mother were not explored as well. Study interviews indicated that in cases of fathers with high objection to treatment and high criticism toward the mother that did not subside, the therapist's insistence to involve the father in sessions further weakened the mother and jeopardized her treatment motivation. In these cases, the therapist's decision to forego the father's presence and focus on supporting the mother in her steps, was found to improve the family's ability to benefit from therapy despite the father's absence.

Discussion

The current study sought to expand the literature on fathers' involvement in PT for child behavior problems by providing clinical insights into barriers to and strategies for working with fathers in PT. As little has been written on the process of engaging fathers in PT, we utilized a qualitative research design, interviewing the telephone treatment supporters and using a systematic data analysis strategy to identify the main categories and themes associated with paternal involvement in psychotherapy. By closely examining 10 different cases, we gained a preliminary understanding of the interpersonal processes that take place when a father arrives to treatment. The theoretical discussion and clinical suggestions that follow summarize key points in the results and link them back to the theoretical and clinical literature on fathers. As our study was qualitative in methodology, the links we suggest are discursive in nature; we aim to contribute to theoretical understanding of fathers' engagement, rather than providing quantitative findings about specific aspects of fathers' engagement.

Findings from the current study suggest that engagement of fathers in the therapeutic process influences the ability of both parents to benefit from therapy and implement behavioral recommendations to improve their child's behavior. Moreover, the study suggests that minimal or reluctant involvement of fathers is liable to undermine the course of therapy in one of several ways. It may prevent formation of the therapeutic alliance and development of clear treatment goals. It may also weaken the mother's attempts to resist her child's behavior problems and promote change. These observations are in line with Bagner and Eyberg's (2003) assertion that limited, half-hearted presence of fathers in therapy is likely to lead to treatment failure, and not to therapeutic gains.

Consistent with previous research on barriers to fathers' engagement, our qualitative data analysis supports the notion that engaging fathers in therapy

may require special attention and considerations from the therapist. Some of the approaches for engaging fathers in treatment, described in our sample, have been highlighted in prior research. Fathers tend to participate more when they are actively engaged and when their importance is emphasized (Dienhart & Avis, 1994; Duhig, 2002; Foote et al., 1998; Hecker, 1991; Walters et al., 2001). In addition, fathers are more engaged with a direct and task-oriented approach (Carr, 1998; Vetere, 1992), in line with a PT model. Our results also echo previous studies that emphasize the importance of the therapist's assuming a symmetric and non-judgmental position toward both parents (Bagner & Eyberg, 2003; Walters et al., 2001).

While previous studies have mostly focused on overcoming fathers' initial resistance to joining therapy and early formation of treatment alliance (a barrier that was represented in our first core category—the father's resistance to therapy), our data analysis revealed two additional components that appear to play an important role in the success or failure of attempts to engage fathers: the impact of fathers' limited presence in the home on treatment, and the reaction of mothers to fathers' attempted recruitment into therapy. Our qualitative analysis of treatment supporters' perception of family engagement in treatment showed that the degree of fathers' presence in the home more broadly seems to correspond to their capacity to be involved in therapy. Thus, when the father's involvement at home is extremely limited, his motivation for therapy may be superficial and not grounded in a personal need for assistance or even a thorough understanding of the problem. Increasing the father's presence at home may, therefore, be an important prerequisite for engaging a father successfully in therapy. Our findings suggest that the process of enhancing the father's presence at home may need to be accomplished gradually and according to the father's initial involvement and motivation. Based on our data, attempts to have fathers "dive in" to dealing with their child's aggression may reinforce the dynamic of inconsistent paternal engagement that vacillates between negative interactions and paternal withdrawal (DeKlyen et al., 1998). Engagement strategies that are not attuned to the father's initial level of involvement may, therefore, bare the risk of causing fathers to feel unequipped to deal with their child's difficulties. As a result, it may exacerbate paternal disengagement following the first sign of trouble with the child.

Based on our data, taking a gradual approach to increasing fathers' involvement at home may allow for subsequent inclusion of the father as an important partner in therapy, even when he engages in small or less "problem-focused" tasks (e.g., developing a positive relationship with the child or supporting the mother). In this manner, the experiences of the families in our study suggest that the father can increase his presence gradually as he first develops positive parenting experiences. To this end, therapists may focus on providing fathers with opportunities for building their sense of competency and comfort with the child. Taking such an approach may help address Lundahl et al.'s (2008)

concerning finding that fathers often experience therapy as less relevant in addressing their own parenting needs.

In the current study, mothers' attitudes toward fathers' involvement in therapy appeared to influence both fathers' overall engagement and the therapeutic effectiveness of fathers' involvement. In our sample, mothers who felt angry, often due to years of paternal disengagement, frequently had difficulty supporting the changes fathers made and did not easily "make room" for them to participate more actively at home. Often, these mothers were more judgmental and skeptical than their therapists in evaluating the sustainability of fathers' attempts to engage and participate both at home and in therapy. Moreover, the treatment supporters observed that these mothers experienced the fathers' successes in creating change as a threat to their own sense of competency rather than as an opportunity to share the parenting load.

Results of our analysis also suggest that it may be easier for fathers to help mothers by increasing their direct involvement with the child and by helping with concrete tasks that had previously been the mother's role (i.e., via the direct influence path), than by expressing their appreciation for or offering emotional support to the mother (i.e., via the indirect influence path). Qualitatively, it appears that fathers who agreed to help with their child and reduce some of the mother's responsibilities were most successful in improving both the child's behavior and father–child communication. However, even in these cases, the fathers' increased involvement did not always seem to help alleviate the mothers' sense of helplessness and isolation. In spite of improvement in their children's difficulties, these mothers, in our sample, ended treatment unsatisfied, feeling treatment did little for them.

The themes that emerged from our analysis seem to support prior studies that linked the quality of the relationship between parents with the fathers' level of involvement with the child (Katz & Gottman, 1993; McBride et al., 2005). These findings suggest that successful treatment programming may include helping mothers to accept and support fathers' involvement in new parenting tasks. As predicted by Heubeck, Watson, and Russell (1986), focusing only on the father's progress while overlooking the mother's perception of his help or her persistent efforts in caring for the child may leave the mother feeling unrecognized and unsupported, experiencing treatment as less helpful in addressing her own needs. This pattern was suggested by our data, and a previous outcome study in NVR provides additional support to this point: While involved fathers reported significant improvement in their own and the mother's parenting, mothers reported experiencing only minimal level of change (Lavi-Levavi et al., 2013).

In summary, based on our qualitative data analysis of treatment supporters' impressions of paternal engagement in child psychotherapy, a tentative framework for engaging fathers in PT for child behavior problems may be suggested. Based on our findings, such a model would be two-pronged, and would involve both carefully and gradually re-involving the father, while also taking the

mother's reactions in consideration and supporting and reinforcing the mother in her parenting. We hypothesize, based on our qualitative findings in a small sample of families engaged in PT, that when these two aims happen concurrently, mothers may be more receptive to fathers' increased involvement and may, thus, be better able to support and recognize it. The model we suggest is consistent with the multi-dimensional model of fathers' involvement described earlier in the current article (e.g., the direct and indirect paths; Cummings et al., 2004). It may provide a template for understanding and improving fathers' involvement by setting realistic clinical goals that address both the direct and indirect paths of his contribution to the family. Further work to develop, test, and validate treatment protocols explicitly incorporating these aims will be needed to provide a scientific ground and further assessment of this proposed model.

Results of this study provide preliminary insight into the dynamics involved in engaging fathers in parent counseling programs for children with behavior problems. They help shed new light on the interpersonal process that working with both parents entails and point toward the need for a multi-level approach to engaging fathers in PT. The need to adopt a multi-level approach to engaging fathers may explain the difficulty many therapists have with engaging fathers effectively, as well as the inconsistent findings among studies on fathers' involvement in therapy. In many ways, our observations and resulting clinical suggestions are in line with Panter-Brick and colleagues' (2014) recommendations for improving engagement of fathers in treatment that stress the importance of adapting the intervention to fathers and improving therapists' competency in working within a co-parenting model. Results of our study suggest that without a commitment from the therapist to working effectively with both parents, the father may attend treatment, without engaging fully. Low paternal engagement in spite of attendance may reinforce fathers' sense of being marginalized in the family system or ineffective as a parent. It may also reinforce the mother's feelings of isolation.

The present study suffers from several limitations. First, the decision to interview the treatment supporters and not the parents may have impacted the data available for analysis, as it represented the perspective of the clinical team but not the direct perspective of the fathers and their experience of the therapeutic process. The unique position of the treatment supporters between the therapy room and the home enabled a broader reflection on fathers' engagement and from a family-system perspective. Moreover, it enabled us to include data regarding families where fathers were minimally engaged and ambivalent, whereas interviewing fathers directly would likely have resulted in a more limited, positively skewed sample. Nonetheless, the treatment supporters inevitably brought their own interpretations and biases to the study, and they may have not fully captured the experience of the fathers, mothers, and therapist. As the fathers' and mothers' direct points of views are also critical for understanding

the engagement process, there will be a need for future studies to expand on the current study to include parents' direct report on their experiences with therapy. Expanding future studies to capture the perspectives held by various members of the treatment process will enable to a richer understanding of the results of our study while ensuring that the unique perspectives of the fathers and the mothers are being captured.

An additional limitation of the study is related to our sample. The families discussed in the study were diverse in terms of their religiosity, cultural values, and level of involvement of fathers at home prior to treatment. However, while this sample of cases is representative of the larger population of families arriving for PT at our clinic, all the families were Israeli, were able to pay for treatment, were married as part of heterosexual couples, and had both parents cohabitating in the home. These characteristics, in addition to the small sample size, may limit the generalizability of the study results to other populations. Future research should replicate the study in other communities and with families with different couple constellations in order to establish the generalizability of study results.

Finally, the decision to use qualitative methodology for data analysis could be seen as a limitation. However, this approach enabled us to capture the complexity of the phenomenon we sought to explore and to study engagement as a process rather than an outcome. Nonetheless, in order to establish the findings and suggestions of the current study more robustly and to lay a stronger groundwork for developing an evidence-based approach to clinical work with fathers, additional steps are needed. These steps should involve studying engagement processes at a micro-level during therapy sessions, using, for example, quantitative, interactional coding methodologies to measure the father's engagement in relation to the mother's reaction to it. The development of quantitative measures of paternal engagement and predictors of successful paternal treatment involvement will also be helpful, and could be based on many of the observations and findings made here regarding facilitators and barriers toward fathers' engagement and successful PT outcomes. This line of work will enable scientific establishment of the benefits of fathers' engagement on treatment outcome, as well as begin to provide clearer guidelines for clinicians to work effectively with fathers in PT and child psychotherapy. Based on the results of this line of research, there will then be a need for randomized, controlled clinical trials to develop and validate a protocol for enhancing fathers' engagement in child psychotherapy. Such a protocol will ultimately contribute to dissemination of key strategies for involving fathers in the therapy process, in turn contributing to more positive mental health outcomes for children with externalizing behaviors.

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