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Future Directions in Father Inclusion, Engagement, Retention, and Positive Outcomes in Child and Adolescent Research

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Abstract

Fathers make important and unique contributions to positive child development. In spite of these findings the research literature has lagged in the study of the role and impact of fathers on child development and in the development of effective approaches and interventions for fathers. Parameters for additional study include the inclusion of fathers in treatment outcome studies, the engagement of fathers within studies once included, the retention of fathers in interventions and studies once engaged, and the appropriate measurement of father-related outcomes. A systematic review of 64 studies indicated that there is evidence fathers have been included within multiple studies aimed at improving parenting, but that there are relatively fewer studies of other targeted outcomes such as co-parenting. A set of recommendations for future directions in the next generation of father-focused studies in the child and adolescent psychology literature is presented, with an emphasis on improving study of the parameters of inclusion, engagement, retention, and measurement of outcomes.

Future Directions in Father Inclusion, Engagement, Retention, and Positive Outcomes in Child and Adolescent Research

Parenting by fathers includes a number of components including provision of support and resources, disciplining, encouraging and teaching adaptive behaviors, and co-parenting with the child's other parent. There is clear and consistent evidence that positive father involvement supports child development across a host of domains. For example, in early childhood, fathers' use of complex vocabulary words during informal interactions and shared book reading with young children uniquely contributes to language development and early literacy skills (Chacko et al., 2017; Pancsofar & Vernon-Feagans, 2006; Pancsofar, Vernon-Feagans, & The Family Life Project Investigators, 2010). Fathers also uniquely contribute to the development of appropriate socialization skills (Leidy, Schofield, & Parke, 2013). Increased positive father involvement is associated with improved academic grades and achievement (Forehand et al., 1986; Gordon, 2016; McBride et al., 2005; Nord et al., 1997). Fathers who are involved positively with their children have children with fewer mother-reported behavior problems (Amato & Rivera, 1999). In a meta-analysis, Amato and Gilbreth (1999) reported non-resident fathers who utilize effective parenting strategies had children with significantly fewer externalizing and internalizing problems. Research has suggested that over the past 50 years, fathers' roles in child care has increased almost three-fold (Parker & Livingston, 2017), underscoring that contemporary perspectives on father involvement, engagement, and intervention within clinical child and adolescent research must acknowledge and incorporate these demographic shifts. Indeed, due to their importance on a variety of outcomes, entire books have been written on the influence of fatherhood on child and family outcomes (e.g., Cabrera & Tamis-Lemonda, 2013).

Fathers themselves expect to be involved with their child – 92% of fathers report that disciplining the child is at least shared (U.S. Department of Health and Human Services, 2007). The majority of adults also expect fathers to share in the caretaking and raising of children at a level equal to mothers (Radcliffe Public Policy Center, 2000). A recent parenting survey using a best-worst scaling methodology illustrated that fathers from low-income families prioritize their child's outcomes (e.g., in academics, peer relationships, happiness) over other potential barriers such as transportation or associated costs (e.g., childcare) in their rating of attributes of helpful programming (Fabiano, Schatz, & Jerome, 2014), illustrating fathers' investment in their children's appropriate development rather than a focus on barriers to intervention. Clearly, there is an expectation that fathers will be involved via both their own self-reports and via public perception.

For children with mental health and behavioral challenges, fathers are an important target of intervention efforts. Recent calls for increasing father inclusion in research (Cassano et al., 2006; Chronis, Chacko, Fabiano et al., 2004; Fabiano, 2007; Parent et al., 2017; Panter-Brick, et al., 2014; Phares, Lopez, Fields, Kamboukos, & Duhig, 2005; Tiano & McNeil, 2005) largely echo similar calls from earlier periods (Budd & O'Brien, 1982; Coplin & Houts 1991; Levine, 1993; Miller & Prinz, 1990; Phares, 1992; Phares, 1996a; Phares, 1996b; Phares & Compas, 1992). It is clear researchers have identified the lack of father involvement and inclusion in the research literature to be a problem, but low levels of father involvement have persisted. Therefore, rather than another paper admiring the current problem, the goal of this paper is to identify potential reasons for lack of inclusion, review the existing literature to identify potential malleable factors in research design and interventions, and describe an initial agenda of future directions that will improve the state of the science on the study of fathers and fathering in

clinical child and adolescent psychology research. The focus of the review and recommendations will explore four key areas of father-based research: (1) Inclusion; (2) Engagement; (3) Retention; and (4) Measurement of outcomes. Each of these four parameters will be discussed in turn.

Brief Review of Child/Adolescent Studies with Father Involvement

To explore the range of intervention inclusion, engagement, retention, and outcomes measures in the clinical child and adolescent relevant literature, a systematic review of the literature was conducted in order to describe the current state of the literature and inform a discussion of future directions. This review included studies that used varied methodology, but all focused on fathers as the primary and direct targets of intervention. The rationale and approach for reviewing each of these four major parameters of father-focused research studies are described briefly within the description of methods.

Methods

Inclusion Variables

A prerequisite for exploration of additional parameters of interest is that the father is initially included within the research study or intervention. It is not always clear from the research literature that this has been the case. For instance, in a review of parent training studies in the ADHD literature, Fabiano (2007) noted a few studies explicitly excluded fathers from participation, or if they did participate, did not include them in the evaluation of outcome. Tiano and McNeil (2005) identified fundamental problems in the feasibility of reviewing the literature on father inclusion in behavioral parent training studies as the participants' measures were not clearly separated in text and table (e.g., referred to as "parent" rather than mother/father; outcome data were aggregated across parents). In a recent global review of father inclusion in

interventions, Panter-Brick et al. (2014) concluded that many father-focused efforts in inclusion may be stymied by institutional or cultural barriers (e.g., staff attitudes toward fathers; intervention content not relevant to fathers), lack of clinician training on how to work with mothers, fathers, and co-parents, and inconsistent quality of program evaluation. Thus, there are barriers embedded in conventional approaches to conducting research with families, and reporting the results of the research, that maintain the lack of inclusion of fathers and father-specific outcomes. For the present review, the intervention target, participants (father alone, father plus collateral(s), and any dedicated attempts to promote father inclusion in the study were coded.

Intervention target. Studies were coded according to the target of the intervention. Intervention targets included the following five categories: 1) parenting; 2) co-parenting; 3) safety; 4) adult mental health; and 5) other. Parenting interventions were aimed at fathers specifically to improve their role as a caregiver or discipliner. Co-parenting interventions targeted fathers as well, but these interventions aimed to engage fathers in shared parenting initiatives and collaborative caregiver efforts. Interventions that targeted safety were minimal in this sample but included studies that promoted child wellbeing through protective actions taken by fathers participating in the intervention (i.e., tractor safety). Finally, the "Other" category captured studies that did not directly align with parenting, co-parenting, safety or adult mental health initiatives. Interrater reliability was assessed by the percent agreement for this category, and raters agreed on 95% of classifications.

Partner or child involvement. Studies were coded according to whether a partner participated, whether a child participated, or both participated.

Promotion of Father Inclusion. In addition to noting who participated in the study, whether any efforts were made to specifically promote father inclusion were coded. This might include defining "father" broadly to include a variety of male caregivers.

Engagement Variables

An effort must be made to engage fathers in the intervention, and it is important to underscore that this effort may need to be independent of an effort to engage the other parent, or the family as a whole. Indeed, one reason for a lack of engagement for fathers in parenting programs may be a misalignment between the need to actively engage in treatment and fathers', relative to mothers', motivation to begin treatment. Engagement in clinical settings includes the mechanisms in place to invite, enroll, and admit parents into treatments. This ranges from the advertising material distributed to generate referrals to practices used on the phone to speak with parents of children and adolescents.

Promotion of Father Engagement. The studies were coded to note whether any specific strategies were used to engage fathers in the intervention. These could be structural strategies such as modifying the location or time for the intervention or the individuals who administer it. These strategies could also include interventions or interactions to promote initial father engagement for promoting participation.

Retention Variables

There is a need to attend to the retention of the father in the programming. It is not uncommon to see fewer fathers available for endpoint assessments compared to mothers in studies of behavioral parent training (Tiano & McNeil, 2007). In a meta-analysis of 28 randomized, clinical trials that utilized the Triple P – Positive Parenting Program, the range of father drop out (0-100%) was significantly larger than that for mothers (0-28%) in studies that

reported participant attrition (Fletcher, Freeman, & Matthey, 2011). In contrast, Fabiano et al., (2009) illustrated improved retention as measured by father and child drop-out, father and child attendance, and father on-time arrival for the session, in a parenting program specifically designed to recruit and enroll fathers when compared to a typical group-based parent training class (see further description of this program in the Future Directions section below).

Attrition. Each study was coded for how attrition was reported in the study. Codes included attrition not reported; overall attrition reported; attrition reported by session; and attrition reported by assessment period.

Promotion of Father Retention. Studies were coded to note whether any specific strategies were used to retain fathers in the intervention. These could be structural strategies such as modifying the location or time for the intervention or the individuals who administer it. These strategies could also include interventions or interactions to promote initial father participation.

Assessment of Outcomes

There are many common constructs assessed following father-focused intervention, including the measurement of child functioning and psychosocial impairment, assessment of parenting skills, parental cognitions, parenting, or their family, and evaluation of satisfaction with treatment, to name a few. Ultimately, the field will only be informed on outcomes upon which assessments are collected. Thus, there will be gaps within the literature if fathers are not routinely included in treatment outcome assessments (e.g., Fabiano, 2007), or results are combined in such a way that individual parent ratings cannot be disentangled (e.g., Tiano & McNeil, 2005). Thus, it is important to investigate the range of outcomes represented within the current father-focused treatment literature, such that any areas of strength or limitation can be identified.

Study Outcome Measure. In the review of each study, the outcome measures included were also documented. Study outcome measures were coded as follows: child outcome; parenting behavior outcome; parenting cognitions outcome; father functioning outcome, co-parenting outcome; and treatment satisfaction outcome.

Study Review Procedures for Systematic Review

Using the PsycINFO database, the following key words or phrases were utilized: Father/paternal/male caregiver, involvement, engagement, interventions, training, education, prevention, empowerment, treatment, and clinical trial. This search was conducted in August of 2016 yielded 228 articles. Other articles were identified via bibliography review of the reference sections of screened studies. This yielded an additional 122 articles for a combined total of 350 abstracts to be screened. Book chapters and other formats that did not provide empirical data were excluded from review and left a sample of 150 studies to be reviewed using the inclusion checklist. The studies involved in this full text review met the following inclusion criteria: 1) includes an intervention to increase father engagement or promote father outcomes, 2) intervention does not target physical or sexual abusers, 3) intervention targets fathers of children 18 years of age or under. The final sample of studies meeting eligibility criteria was N=64 (see Figure 1). Studies were published between 1977 and 2016. The selected articles were then coded by the second author and the information was compiled in a database according to the variables described in the next section. Disagreements on inclusion criteria or coding results were resolved through discussion between the first and second author.

Results of the Systematic Review

Table 1 lists the results of the systematic review of papers that included father inclusion, engagement, retention, and reporting of father outcomes. As is clear from Table 1, the majority

of studies that have included father involvement focused on parenting, with a relatively smaller percentage focusing on co-parenting or alternative targets (e.g., adult mental health). In terms of collateral participants in the studies, 52% included the father's child(ren), 44% included the father's partner, and 22% reported that both the partner and child(ren) were included in the intervention. Thus, the current composition of father-focused research does not routinely include all family members. There was only a minority of studies ($N = 8$) that included a broad inclusion of male caretakers (note, other studies may have done so, but it is not clear from the description of participants whether this is the case).

Some studies included strategies to specifically attend to the needs of fathers, with the most common strategies relating to the use of a male therapist, maintaining groups of fathers only for all or some of the treatment, and tailoring the content to fathering concerns. For attrition, 38% of studies did not report on father attrition, meaning that for more than a third of studies, it is unclear the degree to which fathers were engaged with the intervention. Across the studies reporting attrition, there was variability in the approach to reporting father drop-out ranging from overall reports, to reports at each session or each assessment point. Notably, no studies were reviewed that specifically included strategies to promote father retention.

There was also variability in the type of measures included. The most common outcome measure was one focused on parenting behavior (72%). Across other measures there was less frequent use in studies with co-parenting measures occurring in about a quarter of the studies, and child outcomes (30%), assessment of father cognitions (38%), and measures of father functioning (38%) occurring in about a third of studies. Only 16% of studies included some measure of satisfaction with the intervention. Thus, there was a lack of continuity across measurement plans in these studies of father-focused intervention.

Summary. There are a significant number of studies that have focused on father-related outcomes ($N = 64$), but there is relatively little alignment among the targets of intervention, collaterals included in the studies (i.e., co-parent, child), methods for addressing and assessing attrition, and the outcome measures included. It can be noted that multiple studies have addressed parenting behaviors in fathers, representing a number of targeted areas of fathering (e.g., parenting during separation/divorce; parenting a child with a disruptive behavior disorder; parenting in fathers from low income groups). Three-quarters of the studies also utilized some measure of parenting behavior, however it is important to note that there was diversity in the type of measure included (e.g., behavioral observation, self-report).

The systematic review is perhaps more enlightening with respect to what was not included in the literature identified. Interestingly, given the importance of co-parenting noted in the research literature (e.g., Emery, Sbarra, & Grover, 2005), there are only six studies identified that explicitly investigated how to improve co-parenting in fathers. Increased study of co-parenting in parenting studies is important given some initial findings that families benefit to a greater extent in parenting interventions when fathers are involved with mothers (Bagner & Eyberg, 2003; Webster-Stratton, 1980). Further, though there is clear recognition that reasons for attrition may vary, and this is an important construct to study in father-focused intervention studies, the report of participant attrition in most studies was not at a level that would promote fine-grained analysis of alternative reasons. Finally, there is not uniformity in the measurement of father outcomes across studies. Although parenting and co-parenting outcomes are related, they are also distinct, and the lack of measurement of both constructs in studies of co-parenting and/or parenting presents as a missed opportunity in the research literature. It is also striking that so few studies assessed consumer satisfaction following intervention, as fathers may view

treatments and associated outcomes from participation in a manner distinct from mothers (e.g., Niec, et al., 2015), making it important to understand fathers' ratings of the palatability of approaches used within the field. Finally, the characteristics of the studies and participants in the 64 studies reviewed were quite diverse, including reason for referral, sample size, and intervention intensity and approach. These differences make synthesized conclusions across studies difficult, and suggest further targeted efforts to build knowledge within specific aspects of the literature are warranted.

It is important to also note that this systematic review has limitations. Like all reviews, it is possible that the search terms used in electronic searches and the serial searching of articles failed to uncover all relevant articles within the literature. Indeed, because of the focus in the electronic search on the term "father," studies that included fathers but characterized their sample as "families" or "parents" were not reliably identified, suggesting that this search is likely to be an under-representation of the entire literature on father involvement in intervention. Further, the systematic review did not include a quantitative synthesis of outcomes in a meta-analysis, though future work could address this limitation using the articles identified. However, this review does provide an indication of the current state of the literature, which has a number of unanswered questions and potential gaps, and it can serve as a springboard for the discussion of future directions. *Future Directions in Intervention Development, Evaluation, and Dissemination for Fathers*

There have been multiple calls to increase the research of fathers in clinical studies, increase the emphasis of fathers in developmental and developmental psychopathology research, and incorporate fathers into treatment plans. The systematic review above reveals a mixed conclusion has to be reached regarding the state of the father-focused, intervention research

literature. On the one hand, there are multiple studies that have investigated father-focused interventions and outcomes. However, on the other hand, these studies represent only a small portion of the child treatment literature, and they represent heterogenous targets of intervention, treatment approaches, and outcomes assessed, which make it difficult to draw broad conclusions. One key question that remains is how to best design treatment to be appropriate for the roles typically filled by fathers in families, while still acknowledging there are likely to be individual differences in family structures, roles, responsibilities, and interactions between all these parameters. Below are recommendations for the next generation of father-focused studies within the child and adolescent psychology research literature. A tension within the study of fathers is the creation of generalizable knowledge while at the same time ensuring the diversity within fathers and their families is well-represented in the study questions, research designs, and inclusion criteria. Another unresolved issue is the most appropriate way to classify the "participant" in a study – whether it is the father, the child with the father as a collateral, the co-parents, or the family unit. The decision of how to classify the participant will influence the outcome measures available for use, how the outcomes will generalize, and how the field will be informed. This will likely be driven by the study question as the positive impact of fathers is influenced by the father's behavior, the child's behavior, family functioning as a unit, and the transactions between all these parameters across time and settings (e.g., Jia, Kotila, & Schoppe-Sullivan, 2012; Wymbs, 2011). A final issue relates to an acknowledgement that the role of fathers may be dynamic across time, settings, and the child's developmental level. This will necessitate flexibility in the design of longitudinal studies and careful attention to the appropriate measurement and definition of outcomes. In spite of these issues, some general recommendations and future directions are offered below. As noted above in the Introduction,

there are four parameters of the study of fathers that require increased attention and study in the research literature. Namely, the inclusion, engagement, retention, and measurement of fathers are all areas in need of greater attention, and each will be discussed in turn.

Inclusion

In general, there is evidence that fathers have been included within the larger research literature, albeit to a lesser degree than mothers. Based on the systematic review of studies that have included fathers, it is a positive finding that the present review identified 64 studies focused on an intervention to improve the functioning of fathers. Panter-Brick et al. (2014) used a more liberal search criteria and identified 52 publications representing 34 exemplar programs that included fathers in an intervention. Thus, broad searches yield better rates of father inclusion in research relative to reviews of father inclusion in specific areas (e.g., Fabiano, 2007; Phares, et al., 2005; Tiano & McNeil, 2005). This inclusion within the literature is important given that there is evidence that the treatment effects illustrated overall, or for mothers specifically, are not necessarily consistent with the outcomes generated by fathers (Fletcher et al., 2011). Thus, this increased inclusion is necessary to generate reliable findings that apply to all family members.

To promote inclusion in child and adolescent psychology research, studies should routinely consent and enroll all parents/caregivers. If researchers establish an explicit expectation at the time of the informed consent meeting that all parents are present, there will be a greater likelihood that fathers will learn about the study and decide whether participation is desired. This provides a stronger alternative to relying on a single parent to consent to studies, which based on the larger parenting literature, appears to typically be the mother. Second, researchers can include fathers by addressing correspondence and sending materials to all parents. If the mother and father reside in different households, standard procedures would

include sending identical correspondence to both. Identical expectations should also be present for mothers and fathers for the completion of study ratings, behavioral observations, and participation in other aspects of the study procedures (e.g., completing measures of treatment satisfaction). In this manner, fathers are included as an active participant in research, rather than a passive or optional participant. Finally, the role of the other parent (e.g., the mother) in the inclusion of fathers is also an area of further study. Mothers may serve in a "gate-keeping" role for father involvement, and in cases where there are discipline disagreements, or misalignment in co-parenting expectations or roles, mothers may either encourage or discourage father engagement with the child (Arnold, O'Leary, & Edwards, 1997; Fagan & Cherson, 2017). Although contemporary approaches typically recruit the family as a whole, given that there are multiple decision-makers within the family, this approach may need to be modified to acknowledge and address the current goals, motivational level, and treatment preferences of each potential family member.

An additional note on inclusion relates to the description of the fathers within studies. Multiple individuals can serve in a fathering role, including biological parents, adoptive parents, step-parents, relatives (e.g., uncles, grandparents), older siblings, and romantic partners of the mother. It is possible that the characteristics of the individual in the fathering role will moderate outcomes, either due to some characteristic of that role itself (e.g., a step-parent may not have been present for a portion of the child's development) or a related factor (e.g., grandparents have already served in a parenting role; are of relatively advanced age to the biological parent). Specific descriptions of individuals within that father role within methods sections of scientific papers will assist with future systematic reviews and generalization of results, as the current

literature on this parameter of the study of fathers yields equivocal results (Sarkadi, Kristiansson, Oberklaid, & Bremberg, 2008).

One final point important to the discussion of inclusion is that the increased emphasis on the inclusion of fathers in treatment outcome studies may have unintended consequences that may be viewed as a negative side effect. For example, although a clinician may want to be as inclusive as possible and include the father in a treatment effort, mothers may not always want to include the father in the same manner. For example, when surveyed about participation in early intervention programs, fathers wanted to participate in groups with the mother, but mothers indicated that their preference was to participate in some or all groups without the father (Fabiano et al., 2014). This is similar to findings from Arnold, O'Leary, and Edwards (1997) wherein mothers and fathers who had dissimilar views of child discipline did not benefit from increased father involvement. It is also possible that increased father involvement will increase the time needed for assessment, interviewing, and measurement of outcome, which will also increase clinician burden and cost. Further, increased effort to include and retain fathers may result in less attention provided to others in the family, and have unanticipated, negative effects on their retention and engagement. Researchers exploring how to best retain fathers in treatment must therefore be mindful of potential consequences of these efforts, and future studies should actively assess for any positive or negative side effects of these efforts.

Engagement

Different perspectives on the child's behavior, developmental norms, levels of conflict and frequencies of conflict, and self-evaluations of roles and contributions to problem situations all interact to promote or decrease engagement. It is clear from the larger literature that engagement is a key construct in need of further study for fathers as the few studies that have

investigated motivation to change illustrate fathers are less likely to be action-oriented (Cunningham et al., 2008; Niec et al., 2015). These findings are not surprising to clinicians who typically engage with and work with mothers of referred children, with fathers attending sessions and intervention programs to a lesser extent.

An additional aspect of engagement may include stating plainly to the parents that differences between parents in views of child behavior, parenting, and the seriousness of particular behavioral concerns is normal (Yogman, Garfield, & Committee on Psychosocial Aspects of Child and Family Health, 2016). This may serve to reduce a barrier to engagement wherein parents are in disagreement regarding their own perspective on the child's need for treatment because it shifts the focus from which parent's perspective is right to a focus on validating each parents' point of view. Given some evidence of differences in parental attributions for child behavior and need for treatment (Sawrikar & Dadds, 2017), as well as treatment preferences (Waschbusch et al., 2011), additional investigation of these possible differences between parents and the impact how they approach and judge interventions may illuminate additional targets for engagement efforts.

For example, Niec, Barnett, Gering, Triemstra, and Solomon (2015) examined mother and father ratings of readiness for change at the initiation of parent management training. The potential stages of readiness for change were pre-contemplation (i.e., not ready to change), contemplation (i.e., considering change), and action (i.e., ready) to start changing. Interestingly, mothers were significantly more likely to rate themselves as in the contemplation or action stage – prepared to begin parent training and start treatment. In contrast, fathers were significantly more likely to rate themselves as being in the pre-contemplation stage – not considering treatment or changing their current behavior. These findings are in spite of both mothers and

fathers in the sample rating their child as having clinically elevated behavioral concerns and significant levels of parental stress. Cunningham et al. (2008) in a study of parental readiness to change also reported that significantly more mothers than fathers were classified as in the category of ready for action, relative to the interested in information or overwhelmed groups. Further, Waschbusch et al. (2011), in another experimental study of preferences, illustrated that mothers and fathers disagreed on the preferences for treatment for their young child, who had attention-deficit/hyperactivity disorder. In this study, fathers were significantly more likely to respond to questions in a manner that indicated medication avoidance, whereas mothers were more open to medication as they appeared to emphasize obtaining positive behavioral outcomes in their ratings, regardless of the treatment approach that obtained those outcomes. These studies illustrate an important point – that motivation for treatment and treatment preferences should not be presumed to be aligned within families and information on treatment and engagement efforts are likely to need to address multiple concerns, even within a family.

Engagement efforts should also consider alternative strategies than those used in traditional clinical practice. The model of service delivery in clinical child psychology has not appreciably changed in nearly 150 years with the predominant model still emphasizing a visit to a psychologist's office to sit and talk about problem behaviors. Kazdin and Blasé (2011) outline that the cost and impact of child and adolescent mental health concerns currently dwarfs treatment implementation and utilization, and one reason for this may be an insufficient range of service delivery models. Father engagement may increase with alternative service delivery models beyond a standing office appointment with a clinician, and this includes telehealth, self-help, therapy through smartphone applications, or service delivery in novel settings (e.g., sports little leagues, Fabiano et al., 2009; Fabiano et al., 2012; preschool academic reading enrichment

programs, Chacko et al., 2017), as well as innovations yet to be developed and evaluated. Indeed, recent innovations in both telehealth capability and behavioral intervention technologies (see Doss, Feinberg, Rothman, Roddy, & Comer, 2017 for a review) may be particularly important to include in the armamentarium of intervention approaches for fathers, given that they may reduce barriers related to scheduling, stigma, and engagement (e.g., Doss, Atkins, & Christensen, 2003; Niec et al., 2015). Although the current literature is inclusive of predominantly mothers (Comer et al., 2017; Jones et al., 2014), this is an area that should be explored to determine the efficacy of the approach for fathers. For example, work schedules and/or a need for a parent to provide child care may result in a barrier to father participation. If the parents can access the clinician through a camera linked to their computer, tablet, or smartphone, both could participate in an interview or treatment session from their home as barriers to co-participation are removed. As initial research has suggested that technology-supported intervention can improve parent training outcomes (e.g., Jones et al., 2014), future studies should begin to focus on the impact of these approaches on improving engagement and outcomes specifically for fathers.

As another example, the Coaching our Acting-Out Children: Heightening Essential Skills (COACHES) program is a service delivery model tailored for fathers that integrates behavioral parent training and child sports skills training into a community little league setting. Specifically, COACHES is a two-hour program that integrates sports activities into a parent training and child sports skills training program. For the first hour, children practice soccer skills while the fathers meet in a large group and review effective parenting strategies with other fathers. During the second hour, the fathers coach the children in a soccer little league game, and they are asked to practice the parenting strategies (e.g., praise) within the context of the sport.

The COACHES parent training approach is modeled after the seminal work of Charles Cunningham's Community Parent Education program (Cunningham, Bremner, Secord, & Harrison, 2009), which uses a coping-modeling-problem-solving approach that is designed to be used in school and other community settings rather than clinical settings to help parents recognize ineffective and effective parenting strategies and generate their own solutions to their parenting challenges (Cunningham, 1996; Cunningham et al., 1993). The COACHES child-based interventions are based on over 30 years of research and development from William E. Pelham Jr.'s summer treatment program (STP) for children with ADHD (Pelham, Greiner, & Gnagy, 1998). The STP has well-operationalized procedures for teaching children sports skills, clearly defines game rules and strategies, and integrates behavioral interventions (e.g., daily report card, liberal use of contingent praise, corrective feedback) into sports activities (O'Connor et al., 2014; Pelham et al., 2010; Pelham & Hoza, 1996). For the COACHES program children learn soccer skills, the rules of the game, and appropriate positioning on the field/in the gym, and their behavior is managed using a daily report card approach targeting skill drill and game behaviors. Then, the fathers and child join for a soccer game. The game is modeled after typical little league programs – there is a referee, a scoreboard, and the children are assigned to teams and have jerseys they wear each week. The fathers help coach the children in the game, and are assigned parenting skills to practice during each quarter. For example, when the topic of labeled praise is discussed, fathers are assigned a task of providing five labeled praise statements to their child each quarter. At the end of each quarter, when the children are at a water break, the parent training meets briefly with the fathers to review use of the strategy, and plan for how to best implement the strategy during the next quarter. Following the game, the fathers are asked to

continue to practice the strategy during everyday activities in the home and share information on the strategy with their partner/the child's other parent.

The program has been systematically evaluated (Fabiano et al., 2012; Fabiano et al., 2009). Fabiano et al. (2012) illustrated that the COACHES program resulted in improved outcomes, relative to a waitlist control, by increasing fathers' use of praise and reducing fathers' use of negative talk in laboratory observations. Fathers also rated child behavior problems as less intense at post-treatment in the COACHES group. Fabiano, Chacko, et al. (2009) reported results from a comparison of business as usual BPT and the COACHES program. Results indicated that fathers who attended the COACHES program attended more sessions, were more likely to complete homework, they and their children were less likely to drop out, fathers were more satisfied with treatment process, and at post-treatment they rated their children as improved relative to a traditional parent training approach. Additional studies have illustrated that COACHES can be deployed as a preventative approach for preschoolers in Head Start (Caserta, et al., 2018; Chacko et al., 2017). For example, Chacko et al. (2017) used shared book reading, rather than soccer, as the joint father-child activity in a sample of father-child dyads in Head Start preschools. The results of this study indicated that fathers improved in their parenting and rated children as having less intense behavioral challenges. Interestingly, children in the COACHES program evidenced improved early literacy skill development relative to those on the waitlist. Given that reading with the child is an activity that is commonly employed by fathers (Jones & Mosher, 2013), this appears to be a viable and useful extension of the COACHES program beyond sports activities.

The next generation of studies of father engagement should investigate parameters of intervention that help fathers move from a pre-contemplative stage to an action-oriented stage of

change. This may mean some re-imagining of typical clinical recruitment and intake procedures to address the hesitancy related to treatment initiation that appears more likely to be present in fathers (Cunningham et al., 2008). For example, rather than asking a father to enroll in a treatment program that lasts for three months and has a number of demands, researchers may study the impact of small "nudges" to promote initial participation at a modest level, which can be followed later by a discussion of increased involvement (Richburg-Hayes, et al., 2014). Further, as fathers appear to be effectively engaged in activity-oriented interventions with the child, additional research should be directed toward determining the best mechanisms for infusing reinforcing activities into treatment approaches. Finally, considerable research is needed to determine the most effective approach for engaging families – all parents and the child/adolescent. This may require studying whether there is a single approach that effectively engages all family members, or whether tailored messaging and contact is needed to ensure all family members are invested in the treatment program that follows. For instance, Piotrowska et al. (2017) present a theoretical model of engagement that incorporates both parents singly and as a family, and though this approach is one that requires additional empirical study to inform future practice, it is one with merit. In addition, the effect of father engagement on child and other parent engagement as an enabler or reducer, also needs study.

Retention

A clinician who worked hard to include fathers, and then initially engage fathers in clinical intervention, must still attend to the retention of fathers in treatment, given the greater drop-out rates and variability in engagement within clinical intervention (Fletcher et al., 2011). Retention is a construct that needs to be considered as both a summative indicator (i.e., did the father drop out, or not) and a formative indicator (i.e., when and to what degree did the father

drop-out). For instance, fathers could never initiate treatment at all, could drop out after the first session, or drop out later in the program. Explanatory reasons for all three of these timepoints are likely to represent different mechanisms of disengagement (Chacko et al., 2017). A father who never shows up for treatment at all may not have been motivated to engage in treatment, or made a decision that the treatment was not a good fit following the intake process. A father who drops out after one session may have experienced the intervention and decided there was a misalignment between his expectations for treatment and what was offered. A father who drops out toward the end of treatment may do so because the presenting concerns have been resolved and he made a determination additional treatment was not needed.

A future research agenda focused on retention must attend to the multiple areas within an intervention program where a father could possibly to drop-out. A further consideration is whether one member of the family dropped out, both dropped out, or whether they alternated at attending sessions singly (i.e., the "family" attended all sessions but each parent attended only a subset of the total sessions) – each of these approaches to attendance could yield differing outcomes. Thus, although overall levels of retention are important, it is also necessary to explore the timing and extent of retention across the course of intervention. Although it is not possible to disentangle mothers and fathers in the family-focused intervention they studied, Prinz and Miller (1994) outline a number of parameters of retention to assess including initial drop-out prior to treatment, punctuality for sessions, between session homework completion, quality of interaction within sessions, number of appointments kept and number of "no-shows" for meetings. Additional research on strategies that maintain engagement (e.g., review of progress monitoring data; inclusion of father-child activities during treatment) should be emphasized as the research agenda on father-focused intervention progresses. There does seem to be evidence that programs

where fathers engaged in parent-child interactions yielded better retention, suggesting that either engaging in the treatment along with the child or the "hands-on" practice may be important components for promoting the retention of fathers (e.g., Fabiano, et al., 2009; Schuhmann et al., 1998). This aligns with research illustrating parents prefer interventions that also include their child as a participant (Miller, & Prinz, 2003) and that parenting interventions that include parent-child interactions yield stronger effects (Kaminski, Valle, Filene, & Boyle, 2008).

Measurement of Outcomes

Given the different roles that mothers and fathers may play within a family, careful attention to outcome measures is needed, particularly since most measures have been developed, validated, normed, and routinely used with mothers (see Johnston & Mash, 1989 for an example of an exception to this point). Take for example an evaluation of ADHD symptoms using a typical symptom-based rating scale. If the mother of the child is primarily responsible for situations that place attentional demands on the child (e.g., getting ready for school or bed, completing homework and chores), and the father typically interacts with the child during weekend activities when the mother is at her job, social learning theory would predict that the mother would observe and experience greater symptom presentation due to more frequent antecedent demands on attention. Thus, it would not be surprising to see misalignment between the two ratings, with father ratings yielding less endorsement of behavioral concerns and impairment in functioning than the mother ratings. Indeed, it has been long understood in the child psychology assessment literature that mother and father ratings, even of the same child in the same household, only moderately correlate (Achenbach, McConaughy, & Howell, 1987; De Los Reyes, et al., 2015; Duhig, Renk, Epstein, & Phares, 2000). A remaining challenge in the field is therefore how to best integrate mother and father ratings in clinical settings.

A related need in the this area is the development of a suite of measures that can be administered to fathers, other parents, other collaterals (e.g., teachers, coaches), and children that may be integrated across sources. The integration must facilitate diagnostic decision-making, treatment planning, progress monitoring, and treatment outcome evaluation. Currently, there are no clear professional guidelines that assist clinicians with managing discrepancies across ratings, determining which ratings to weight or emphasize in particular situations, and how to effectively deal with missing or incomplete data (e.g., how does a father complete a rating scale on functional behaviors if he only has supervised visitation). There is therefore a need to determine the best approach to integrating the multi-informant data for multiple purposes including diagnosis, treatment planning, and treatment evaluation (Martel, Markon, & Smith, 2017). Assessments also need to include norms for fathers, that are representative of diverse parenting roles of fathers (residential, non-residential), and that are appropriate for the diversity present within father samples across age, race, ethnicity, and role.

An additional question in the measurement of outcomes is whether the content of typical measures of parenting, parenting stress, parenting efficacy, and treatment satisfaction are representative of the range of items appropriate for both mothers and fathers. Discrepancies between mother and father ratings could represent true differences in ratings, or they could reflect that the items rated were more relevant for one parent rather than the other. It is also possible that fathers may be more reactive to observations in laboratory settings as they indicate a significantly poorer view of observations behind one-way windows (Tiano, Grate, & McNeil, 2013), and they are more likely to drop out of clinical trials all together (Fletcher et al., 2011), and this may mean that novel approaches to assessing parenting behaviors need to be developed.

A final consideration is that treatment satisfaction measures should be collected from both mothers and fathers. As noted above, parents may have varied expectations of treatment, which may influence their likelihood of engagement. Fathers may also have different perspectives on the relevance, effectiveness, and palatability of treatment procedures and processes (e.g., Tiano, Grate, & McNeil, 2013; Waschbusch et al., 2011). Further, fathers rate behavioral parent training programs that include parent-child activities as more satisfying relative to classroom-based, group intervention (Fabiano et al., 2009). These initial differences reported in the literature are signals that more acute analysis of father preferences and evaluations of treatment (both initially and summarily) are needed to better understand the approaches that will be palatable to fathers. Extending past that, integrating preference and palatability assessments across parents in a manner that informs clinicians on the best approach for engaging family members singly and as a unit is also a needed future direction.

Summary

Fathers play a crucial role in child development, both singly and in collaboration with the child's other parent. Across a number of studies identified, there is clear evidence fathers can be engaged in efforts to improve parenting, and to a lesser degree, in effective co-parenting. The current research literature is still in the early stages of development, and there is an urgent need to increase our knowledge on the best ways to include, engage, retain, and assess fathers in clinical treatment outcome research. Due to the positive influence of father development on a host of outcomes (e.g., academic, social, family functioning), it is imperative that the field continues to study the best way to utilize and sustain positive, father contributions to the child and family.

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Table 1.

Summary of articles and reports included in systematic review.

Author (Year)	Inclusion criteria broadened	Child involvement (C)/Partner Involvement (P)	Engagement Effort	Attrition Reported	Outcome Measures
Coparenting					
Abbass-Dick et al. (2015)		C/P		1,3	2,5,6
Fagan (2008)		P	T	3	2,3,5
Cornille & Barlow (2006)		--	F	0	3
Feinberg and Kan (2008)		P	T	2,3	1,2,5
Hawkins (1994)		P	T	1	4,5,6
Rienks et al. (2011)		P	T	1	4,5
Parenting					
Adubato, Adams and Budd (1981)		C/P		0	2
Bendixen et al. (2011)		C/P		0	2,4
Caldwell et al. (2010)		--		3	3,2,4
Cookston et al. (2006)		P		1	5
Cowan et al. (2006)		P	T,F	0	2,4
Cowan et al. (2009)		P	F	3	1,2,3,4,5
Cowan et al. (2014)	*	P		3	2,5,6
Cruz (2009)	*	C		0	1,2
DeGarmo and Forgatch (2007)		P		1,3	1,2
Doherty, Farrell Erikson and LaRossa (2006)		C/P	T	1	2
Elder et al. (2003)		C/P		0	2
Elder et al. (2005)	*	C		1	1,2
Elder et al. (2011)		C/P		1	1,2
Epstein (2010)		--		1	3,4
Fabiano et al. (2009)		C	S,F	3	1,2,6
Fabiano et al. (2012)	*	C		2,3	1,2,6
Fagan and Iglesias (1999)	*	C	S	3	1,2
Fagan and Stevenson (1995)		--		0	2,3,4
Fagan and Stevenson (2002)	*	--	T	3	3

Frank et al. (2015)		P	C	3	1,2,5,6
Griswold et al. (2004)		C/P		0	2,4
Harrison (1997)		--		0	1,2,3
Helfenbaum-Kun and Ortiz (2008)		P	S	2,3	1,2,5
Kissman (2000)	*	P	C	0	2,4,5
Landreth and Lobaugh (1998)		C		0	1,3,4
Lawrence, Davies and Ramchandani (2012)		C	S	1	1,2,4,6
Levant and Doyle (1983)		--	T	0	2,3,5
Magill-Evans et al. (2016)		C		0	2,3
Mahoney, Wiggers and Lash (1996)		C		1	2
Martin (1977)		C/P		1	1,2
Martinson et al. (2007)		C/P		1	4
Mazza (2002)		--		0	3,4
McBride (1990)		C	C	0	2,3
McBride (1991)		C		0	2,3
Olhansky (2006)		--		0	3
Parra-Cardona, Wampler and Sharp (2006)		--		1	3
Pfannenstiel and Honig (1991)		C/P		0	2
Philliber Research Associates (2010)		--		1	2,3,6
Robbers (2005)		C	T	1	2,3,5
Robbers (2008)		P		1	2,3
Roggman et al. (2004)		C/P	C	1	1,2,4,5
Russell and Matson (1998)		C/P		0	2,4,6
Skarupski (2005)		C		1	2,3
Self-Brown et al. (2015)		C		1	2,6
Vadasy et al. (1985)		C		1	2,3,4
Wakabayashi et al. (2011)		C		1	2,3
Watson (1992)		--		0	4
Safety					
Jinnah, Stoneman and Rains (2014)		C/P		3	2,3
Adult Mental Health					

Lam, Fals-Stewart and Kelley (2009)		C/P		3	2,4,5
Other					
Bauman and Wasserman (2010)		--	T,S	0	3
Bloomer and Sipe (2003)		--		3	4
Dilorio et al. (2007)	*	C		1	1,2
Knox and Redcross (2000)		P		1	2,4,5
Kost (1997)		--		0	4
Morgan et al. (2014)		C		1,3	1,2
Morgan et al. (2011)		C	T	3	1,2
Schroeder, Looney and Schexnayder (2004)		--		0	4
Spaulding & Baldwin (2009)		--		0	2,4

Note. C=child participation; P=partner participation.
Items denoted with * under Inclusion specifically noted a broad spectrum of father figures could be included beyond the biological father.
Attrition labels are as follows: 0=attrition not reported;1=overall attrition reported; 2=attrition reported by session, 3=attrition reported by assessment period.
Engagement effort labels are as follows: C=Content tailored to fathering; T=Therapist (e.g., male therapist); S=Setting (e.g., location or time of treatment tailored for fathers); F=Father-only group.
Study outcome measures were coded as follows, 1=child outcome; 2=parenting behavior outcome; 3=parenting cognitions outcome; 4=father functioning outcome, 5=co-parenting outcome; 6=treatment satisfaction outcome.

Figure 1. Diagram of literature search results and reasons for exclusion.