Father Participation in Behavioral Parent Training for ADHD: Review and Recommendations for Increasing Inclusion and Engagement

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Research on parenting has generally focused on mothers, with fathers’ parenting approaches and interventions for fathers being relatively less studied. To investigate the involvement of fathers in behavioral parent training (BPT), the literature on BPT for attention-deficit/hyperactivity disorder (ADHD) was reviewed. A systematic review of this literature (N = 32) indicated that the majority of research studies are composed of mothers as participants in treatment and raters of outcome (87% of reviewed studies did not include information on father-related outcomes). Present barriers to father participation in BPT (e.g., content of classes, characteristics of fathers) are discussed. Strategies for increasing father participation are offered and include establishing the expectation that fathers will be involved in treatment at initial clinical contacts, collecting treatment-related information from both parents, conducting BPT classes that focus on issues of direct relevance to fathers, and integrating parent–child interactions in recreational settings into BPT programs.

Keywords: behavioral parent training, fathers, attention-deficit/hyperactivity disorder, parenting

Parents who are consistent, self-confident, and affectionate raise socially competent children (Reid, Webster-Stratton, & Hammond, 2003). Poor monitoring and inconsistent or punitive discipline strategies implemented by parents predict a number of negative adolescent and adult outcomes, including alcohol and substance abuse, delinquency, and academic failure (e.g., Lochman & Wells, 2002). In addition to predicting negative outcomes for children, noncontingent and inconsistent parental discipline predicts the development of future maladaptive parenting strategies (Granic & Patterson, 2006). Therefore, when treating childhood mental health disorders, parenting skills are an important target for intervention.

Behavioral parent training (BPT) approaches are a component of effective treatment across childhood mental health disorders (Chorpita et al., 2002). A typical BPT program teaches the child’s parent how to effectively mod- ify antecedents (e.g., rules, commands) and consequences (e.g., time-out, rewards) for target behaviors (e.g., noncompliance) in the child’s environment. Parents then implement these strategies in the home setting to target the reduction of problematic behaviors and increase appropriate behaviors.

Reports of positive BPT outcomes are tempered by poor adherence to BPT by participants, however. For example, a significant number of families who enroll in BPT programs never attend treatment or discontinue treatment prematurely (e.g., Barkley et al., 2000). Even those who regularly attend BPT sessions may arrive late for treatment, fail to complete homework assignments, and/or miss a significant number of sessions (Cunningham, Davis, Brenner, Dunn, & Rzasa, 1993). Given these problems with adherence, attention has turned to increasing the engagement of participants in BPT. For example, researchers have enhanced BPT with strategies to promote readiness for change and subsequent treatment adherence (Nock & Kazdin, 2005). Other researchers have identified specific groups of individuals who may experience barriers to participation in BPT and worked to tailor treatment to the needs of the targeted group (e.g., mothers with depression; Chronis, Gamble, Roberts, & Pelham, 2006). Fathers are an additional group that has been the target of researcher and clinician focus (Chronis, Chacko, Fabiano, Wymbis, & Pelham, 2004; Tiano & McNeil, 2005). The present article focuses on fathers of children with ADHD.

BPT has been used as a treatment for ADHD for over 40 years (Pelham & Fabiano, 2006). ADHD is characterized by developmentally inappropriate levels of inattention and/or hyperactivity/impulsivity (American Psychiatric Association, 2004), and these behaviors result in impairment in the affected...
child’s home, school, and in adult and peer relationships (Fabiano et al., 2006). Although there is accumulating evidence supporting the biological and genetic basis of ADHD (Swanson & Castellanos, 2002), the way that parents interact with a child can influence the problematic behaviors exhibited by a child with ADHD, and the interactions between the parent and child have reciprocal and recursive effects in families (Granic & Patterson, 2006). Indeed, family functioning is an area in which impairment may be most pronounced (e.g., Fabiano et al., 2006). In home settings, problem behaviors due to ADHD might include noncompliance to adult instructions and directions (e.g., the child does not complete chores, requires multiple commands/prompts before complying), disorganization, rule violations (e.g., misbehaves in public settings such as restaurants, stores), and difficulties in sibling and peer relationships (e.g., the child is bossy or teases other children).

When parental functioning is considered, mothers of children with ADHD are more stressed, have greater rates of interparental discord, and parent–child interactions are impaired compared with typical families (Fischer, 1990; Hinshaw, 2002). Although not as well studied as mothers, fathers’ functioning in families with a child with ADHD has also been identified as impaired. For instance, fathers of children with ADHD reported impairment in their relationship with both the child and mother (Cunningham, Bemness, & Siegel, 1988). In terms of parenting daily hassles, fathers report rates comparable to those reported by mothers (Crnic & Booth, 1991). Compounding this impairment is the chronic nature of the disorder, which means children and families must learn to cope with the dysfunction throughout the child’s development (American Academy of Pediatrics, 2001). Therefore, based on these impairments, mothers and fathers of children with ADHD stand to benefit from BPT.

Review of Father Participation in BPT for ADHD

Because of the importance of parenting on developmental outcomes, a number of studies on the parenting behavior of mothers of both normal and deviant children has accrued. Although the pace has accelerated recently (Cassano, Adrian, Veits, & Zeman, 2006; Lamb, 1997), research on fathers and fathers’ parenting strategies has been conducted at a relatively slower pace. Fathers (defined broadly as any primary male caregiver—this includes biological, adoptive, stepfathers, boyfriends as well as male relatives such as grandfathers and uncles) are a group that is particularly underrepresented in studies of treatment outcome (Levine, 1993; Phares, 1996b). To investigate the extent to which fathers were included in ADHD BPT studies, a literature review was conducted using systematic literature review procedures (i.e., White, 1994).

Review of Father Participation in the ADHD Treatment Literature

Literature Search Procedures

The literature search procedures in the present article were adapted from a larger literature search conducted for a meta-analysis of ADHD treatments. First, searches using the computerized PsycINFO database were conducted. Descriptors entered into the database included father, behavior modification, contingency management, behavior therapy, parent training, attention deficit hyperactivity disorder, and attention deficit disorder. On the basis of the results of the computerized search, articles were identified that met the inclusion criteria described below. Second, each identified article’s reference section was then systematically reviewed, and additional studies not identified through the computerized search were added if inclusion criteria were met. Finally, serial searches of tables of contents in journals known to publish treatment studies were conducted (serial searches began at the year 1968). The literature search was terminated in September 2006.

Inclusion Criteria

Studies included in the review met the following criteria: (a) The participants must be diagnosed with ADHD or had well-described symptoms that suggested the characteristic behaviors of ADHD (e.g., “hyperactive,” “off-task”). In studies that focused on treatment for children with general externalizing behavior problems, at least 50% of the participants had to be diagnosed with ADHD. (Because no present evidence suggests BPT works differentially on the basis of ADHD subtypes or comorbidities, children with ADHD in general, rather than particular subtypes/comorbidities, are discussed in the present article.); (b) the participants had an IQ above 80; (c) the participants were under 18 years of age; (d) the participants’ symptoms were not better explained by a documented organic cause; (e) at least one treatment group used a BPT intervention; and (f) the report was primarily a treatment outcome study—laboratory investigations of parent–child interactions were not considered.

Results of the ADHD BPT Literature Search

In total, 32 studies meeting inclusion criteria were identified. Table 1 lists information on father inclusion. Notably, all of the studies included mothers, but the inclusion of fathers varied. Indeed, there are only four studies (13%) that explicitly reported the effectiveness of BPT for fathers (Anastopoulos & Farley, 2003; Barkley, Edwards, Laneri, Fletcher, & Metevia, 2001; Danforth, Harvey, Ulaszek, & McKee, 2006; Schuermann, Foote, Eyberg, Boggs, & Algina, 1998). Individual studies reported that father involvement in parent training for children with ADHD is specifically precluded by the study methods (e.g., Sonuga-Barke, Daley, Thompson, Laver-Bradbury, & Weeks, 2001) or minimized (e.g., Barkley, Guevremont, Anastopoulos, & Fletcher, 1992; Horn et al., 1991). In some cases, fathers were invited to attend treatment sessions (e.g., Pisterman et al., 1989), but no outcome measures were administered to fathers.

Summary of Studies of Father Participation in BPT

On the basis of the research of BPT for fathers, a few conclusions may be generated. First, there is little information on father involvement in BPT—only a minority of
studies specifically investigated the effectiveness of BPT programs for fathers. This finding is consistent with reviews of the child psychopathology (Phares & Compas, 1992) and pediatric psychology literature (Phares, Lopez, Fields, Kamboukos, & Duhig, 2005). Second, most of the studies have methodological limitations, low power to detect differences, or offer limited generalizability. Finally, no studies have explicitly addressed the independent effect of father involvement in BPT for children with ADHD. Given these findings, concluding that father involvement is unnecessary, or does not result in incremental benefit, is currently untenable because of a lack of data.

These results replicate the BPT literature for disruptive behavior disorders other than ADHD. Although there are notable exceptions (e.g., Adesso & Lipson, 1981; Brestan, Eyberg, Boggs, & Algina, 1997; Connell, Sanders, & Markie-Dadds, 1997; Firestone, Kelly, & Fike, 1980; Gross, Fogg, & Tucker, 1995; Martin, 1977; Nixon, Sweeney, Erickson, & Touyz, 2003; Sanders, Markie-Dadds, Tully, & Bor, 2000; Webster-Stratton, 1990, 1992; Webster-Stratton & Hammond, 1990, 1997; see also Tiano & McNeil, 2005, for a detailed discussion of recent studies), fathers are also generally not included or assessed in BPT treatment outcome studies for other disruptive behavior disorders. Given the high rates of comorbidity between ADHD and other disruptive behavior disorders, fathers are underrepresented across parent intervention studies for children with externalizing behavior problems.

Table 1

Summary of Behavioral Parent Training Studies for Attention-Deficit/Hyperactivity Disorder and the Extent of Father Involvement in Each

<table>
<thead>
<tr>
<th>Study</th>
<th>Father involvement reported?</th>
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<tbody>
<tr>
<td>Anastopoulos et al., 1993</td>
<td>“Mothers and fathers were encouraged to attend PT, but for practical reasons this was not always possible. To remain eligible for the project, mothers were required to attend all treatment sessions;” (p. 587).</td>
</tr>
<tr>
<td>Anastopoulos &amp; Farley, 2003</td>
<td>Mothers and fathers participated in assessment at pre- and posttreatment as well as the intervention.</td>
</tr>
<tr>
<td>Barkley et al., 1992</td>
<td>For families assigned to the behavioral parent training group, 40% of fathers attended.</td>
</tr>
<tr>
<td>Barkley et al., 2000</td>
<td>Father involvement not reported, but 33% of parents assigned to a parent training group attended 0 sessions, and 54% of parents who did attend treatment sessions attended less than two thirds of the total number of sessions.</td>
</tr>
<tr>
<td>Barkley et al., 2001</td>
<td>78% of fathers in the Problem-solving Communication Training (PSCT) and 87% of fathers in the Behavioral Management Training/PSCT participated.</td>
</tr>
<tr>
<td>Bor et al., 2002</td>
<td>Involved in the initial intake, if present.</td>
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<tr>
<td>Danforth, 1998</td>
<td>“Participants were 8 mother/child dyads.”</td>
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<tr>
<td>Danforth, 1999</td>
<td>“Participants . . . 35-year-old single mother.”</td>
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<tr>
<td>Danforth et al. 2006</td>
<td>“Participants were 46 mothers and 26 fathers” (p. 190). “Data from mothers and fathers are presented separately” (p. 195).</td>
</tr>
<tr>
<td>Dubey et al., 1983</td>
<td>Not specified</td>
</tr>
<tr>
<td>Erhardt &amp; Baker, 1990</td>
<td>Case 1: The father “did not attend training” (p. 125); Case 2: The stepfather “attended only a few sessions. (p. 126).</td>
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<tr>
<td>Firestone et al., 1981</td>
<td>Not specified.</td>
</tr>
<tr>
<td>Frankel et al., 1997</td>
<td>Not specified.</td>
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<tr>
<td>Hoath &amp; Sanders, 2002</td>
<td>Not specified.</td>
</tr>
<tr>
<td>Horn et al., 1987</td>
<td>“Each parent training group consisted of the mothers of children. . . . If the father was currently living in the home, he was strongly encouraged to attend the parent groups” (p. 60).</td>
</tr>
<tr>
<td>Horn et al., 1990</td>
<td>Not specified.</td>
</tr>
<tr>
<td>Horn et al., 1991</td>
<td>“Because of poor participation on the fathers in both the assessments and the treatment groups, only mothers’ data are presented here. Two exceptions were divorced fathers who were the primary caregivers for their child” (p. 235).</td>
</tr>
<tr>
<td>Klein &amp; Abikoff, 1997</td>
<td>“The behavior therapist met with both parents for at least two extended sessions prior to the formal initiation of treatment” (p. 94).</td>
</tr>
<tr>
<td>McCleary &amp; Ridley, 1999</td>
<td>41% of parents in parent training group were fathers.</td>
</tr>
<tr>
<td>The MTA Cooperative Group, 1999</td>
<td>“If available, both parents were invited to attend all session” (cf. Wells et al., 2000, p. 488).</td>
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<tr>
<td>O’Leary et al., 1976</td>
<td>Not specified.</td>
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<tr>
<td>Pelham et al., 1980</td>
<td>Not specified.</td>
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<td>Pelham et al., 1988</td>
<td>Not specified.</td>
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<tr>
<td>Pfiffner &amp; McBurnett, 1997</td>
<td>Participation of non-targeted parents was strongly encouraged, and 33 of a possible 39 non-targeted parents attended an average of 70.5% of the group sessions” (p. 630).</td>
</tr>
<tr>
<td>Pisterman et al., 1989</td>
<td>“In all but two families, target parents were mothers. Non-target parents typically attended diagnosis interviews” (p. 400).</td>
</tr>
<tr>
<td>Pisterman et al., 1992</td>
<td>Fathers were included in the intervention and results were analyzed separately for fathers.</td>
</tr>
<tr>
<td>Schuhmann et al., 1998</td>
<td>“Mothers were the recipients of training in all cases” (p. 404).</td>
</tr>
<tr>
<td>Sonuga-Barke et al., 2001</td>
<td>Not specified.</td>
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<tr>
<td>Thurston, 1979</td>
<td>Not specified.</td>
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<tr>
<td>Tutty et al., 2003</td>
<td>Not specified.</td>
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<tr>
<td>Tynan et al., 1999</td>
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Rationale for Increased Father Participation in BPT

The preceding discussion enumerated the information available on fathers of children with ADHD in BPT programs. There are a number of theoretical and empirical reasons why this lack of father participation is problematic. For example, fathers contribute to many aspects of their child’s development, including the development of emotion regulation, social cognition, and focused attention, and, likely because of these factors, appropriate peer relationships (Parke et al., 2002). Fathers positively involved with their children have children with fewer mother-reported behavior problems (Amato & Rivera, 1999). Fathers also contribute uniquely to their child’s academic achievement and academic sense of competence (Amato & Gilbreth, 1999; Forehand, Long, Brody, & Fauber, 1986). In a meta-analysis of outcome studies, Amato and Gilbreth (1999) reported that nonresident fathers who use effective parenting strategies had children with significantly fewer externalizing and internalizing problems. More important, these are all aspects of functioning that are among the most pronounced areas of impairment in children with ADHD (Fabiano et al., 2006). Furthermore, fathers spend an average of 3–4.5 hr with or are available to their child each day, meaning that there is ample opportunity for positive interactions and the fostering of appropriate child development and behavior (Hofferth, Steuve, Pleck, Bianchi, & Sayer, 2002).

One specific area in which effective father involvement may result in beneficial outcomes is in recreational sports activities. Organized sports are a context for children to learn important life skills such as working with others on a team, being a good sport, and dealing appropriately with success and disappointment, and these activities are among the most common for children outside the home (U.S. Department of Education, 2001). Children with ADHD and other disruptive behavior disorders are characterized as having low frustration thresholds, problems with aggression and peer interactions, difficulties with sustaining attention, and following rules, and because of these behaviors, organized sports may present a real challenge to fathers parenting in this setting (e.g., Pelham et al., 1990). Several high-profile cases also demonstrate that some fathers may lack the skills necessary to effectively parent within the context of organized sports (e.g., “Hockey Dad’ Gets 6 to 10 Years for Fatal Beating”; CNN, 2002). Thus, fathers have the potential to contribute positively to child outcomes in these settings, yet they may struggle without a supportive intervention, such as BPT.

Increased father participation in BPT may also result in improved outcomes for the family’s functioning as a unit, and the father’s relationship with the child’s mother (Buhrmester, Camparo, Christensen, Gonzalez, & Hinshaw, 1992; Lee & Hunsley, 2006). For instance, Arnold, O’Leary, and Edwards (1997) investigated the impact of father involvement on mother and father discipline strategies in families of children with ADHD. Mothers reported that if childrearing views were dissimilar between parents, then father involvement resulted in less effective discipline practices. Thus, a father simply spending more time with his child is not sufficient for improving parenting—fathers and mothers must also be aligned in their approach to discipline strategies.

Father involvement may also sustain positive outcomes for the family following intervention programs. In an extensive review of the literature on father involvement, Pleck (1997) concluded that meaningful father involvement, though it may be stressful in the short run (e.g., learning and practicing new parenting techniques, revising family roles), might have positive effects on long-term career outcome and marital satisfaction for the parent as well as positive effects on child behavior and outcome. Indeed, McCord (1991) followed up boys assessed 50 years earlier and found that fathers who had low levels of conflicts with the child’s mother were most likely to raise children who were well adjusted in adulthood. Webster-Stratton (1980) and Bagnar and Eyberg (2003) compared father-involved families with father-absent families with children with conduct disorder after the completion of a parent training program. In both studies, no differences were found between groups at post-treatment, but at follow-up evaluations, only the families with father involvement in treatment maintained treatment gains at posttreatment levels. These studies suggest that father involvement may moderate treatment outcome, though one obvious limitation is that families were not randomly assigned to groups.

Therefore, when increasing father involvement, it may be important to target and enhance the quality of the father’s parenting strategies and discipline procedures. Although fathers report their own parenting skills to be effective (Hoza et al., 2000), when observed, fathers clearly struggle with parenting a child with ADHD and experience stress and emotional reactivity when interacting with a child behaving negatively. For example, Pelham et al. (1997, 1998) reported the effects of deviant child behavior on father stress and subsequent alcohol consumption. In these studies, fathers interacted with a child actor trained to behave like a child with ADHD and comorbid oppositional defiant/conduct disorder or a child actor trained to behave compliantly. After the interaction, fathers who interacted with the deviant child rated the experience as extremely stressful, and they rated their moods as more depressed, anxious, and hostile relative to those who interacted with a well-behaved child actor. Fathers who interacted with the child actor trained to behave negatively also reported their own child management strategies to be ineffective and less successful than those of fathers who interacted with a well-behaved child. Schuhmann et al. (1998) described a sample of fathers of preschool-age children with ADHD and/or conduct disorder observed in play activities, and the fathers at baseline were reported to make over two critical statements for every instance of praise. These studies all highlight potential targets of intervention for fathers who participate in BPT programs.

Barriers to Father Inclusion in BPT Studies

Despite the call by many researchers for increased father participation in BPT (Chronis et al., 2004; Levine, 1993; Miller & Prinz, 1990; Phares, 1992, 1996a; Phares, 1996b;
Phares & Compas, 1992; Tiano & McNeil, 2005), and the rationale described above, there has not been an increase in the study of fathers in BPT. Several reasons may be responsible for this, including characteristics of the fathers targeted for intervention, present clinical approaches to involving fathers in treatment, and the structure and content of BPT programs.

In a typical BPT program, behavioral principles are presented through a mixture of didactic presentations and group discussions (Barkley, 1987). Given that parents of children with ADHD have an increased likelihood to have ADHD themselves (Biederman, Faraone, & Monuteaux, 2002), and it is documented that maternal ADHD impedes parenting and BPT outcomes (Evans, Vallano, & Pelham, 1994; Sonuga-Barke, Daley, & Thompson, 2002), classroom-based instruction may also limit the progress made by fathers in BPT, and the classroom format may discourage father participation. Furthermore, clinical correspondence or interactions that only addresses the child’s mother, lack of flexible scheduling (i.e., no appointments available during evenings or weekends), and requiring only mothers to complete intake forms/clinical interviews all likely contribute to poor father participation, as the father’s involvement is marginalized from the first clinical interaction (Duhig, Phares, & Birkeland, 2002; Levine, 1993; Phares, 1996b; Schock, Gavazzi, Fristad, & Goldberg-Arnold, 2002).

The content of typical BPT classes may also fail to meet the needs of fathers because fathers serve in different roles in many families than mothers, and the topics discussed in typical BPT classes more often focus on the roles mothers are likely to hold (e.g., communicating with the child’s school; caregiving). In general, fathers and mothers share some parenting responsibilities (e.g., Russell & Russell, 1987), but mothers generally have substantially more interactions with children than fathers and are generally responsible for most of the child’s caregiving (Child Trends, 2002; Russell & Russell, 1987). In fact, Pleck (1997) stated “Research has yet to identify any child-care task for which fathers have primary responsibility” ([italics added] p. 73). According to Russell and Russell’s descriptive work, based on home observations of families, the only activities for which fathers are more likely to interact with children than mothers were those related to unstructured recreational activities or yardwork. These results were recently replicated in a United States sample, and again the only activities fathers were more likely to engage in than mothers were playing sports or participating in outdoor activities (Child Trends, 2002). Characteristics of the mother (e.g., work schedule, gender role attitudes) are unrelated to fathers’ engagement in recreational and unstructured activities with their children, suggesting that fathers in most two-parent families serve in this role, independent from the mother’s involvement (Marsiglio, 1991). On the basis of these studies, programs that work to increase positive child behavior in activities associated with caregiving (e.g., communicating with the school) may be of less direct relevance to many fathers.

Making the content of BPT relevant to fathers is therefore an important clinical consideration. For example, most BPT programs ask parents to complete weekly assignments, for which they implement the parenting strategies learned in the classroom setting in the home environment. Homework completion is hypothesized to mediate BPT outcome—those who consistently implement the procedures at home obtain more positive outcomes (Kazantzis, Deane, & Ronan, 2000). Fathers who are disengaged from BPT, or find it lacking in meaningfulness for their own needs, may be less likely to attempt the parenting strategies and therefore improve their parenting behavior. In the few studies that have illustrated father benefit of BPT, fathers engaged in parent–child interactions, suggesting that this may be an important component for fathers (e.g., Schuhmann et al., 1998), and child involvement is a treatment component parents prefer (Miller & Prinz, 2003). Thus, treatments that include parent–child interactions in relevant settings may contribute to positive father-related outcomes in BPT (Chronis et al., 2004; Reitman, O’Callaghan, & Mitchell, 2005).

Another reason for a lack of father participation in BPT is that parent training may be presented in a way that frames the individual as lacking a skill—deficient in parenting skills and in need of training to obtain the skills. Addis and Mahalik (2003) concluded men are highly unlikely to seek help if doing so means admitting there is a problem with a central part of their self-concept, and therefore this way of presenting the intervention may be highly ineffective for men. A recent study by Hoza et al. (2000) highlights another possible limitation of this way of framing BPT. In that study, mothers and fathers of children with ADHD were administered a number of questionnaires to report on different aspects of their parenting. Mothers and fathers did not differ on measures of attributional style, cognitive errors, attributions for child effort, or use of dysfunctional discipline, but fathers were more likely to make more internal attributions for success, have higher self-esteem, and have a higher sense of parenting efficacy compared with mothers. Thus, although not differing from mothers in domains such as cognitive errors and dysfunctional discipline, fathers did not report a problem in parenting. On the basis of these results, one reason fathers may not seek out BPT services is that they do not view their parenting as an area in need of intervention.

Effective BPT programs for fathers will be those that specifically address the barriers described above to increase the palatability and usefulness of BPT for fathers. Suggestions for addressing these barriers are discussed below.

Recommendations for Including Fathers in Comprehensive ADHD Treatment

There is a clear rationale for father involvement in the treatment of childhood ADHD, but there is also evidence that fathers are not routinely included. The research literature also seems to suggest simply attempting to involve fathers by encouraging participation in standard treatment procedures is an unsophisticated approach—interventions need to be tailored to the specific needs and responsibilities of fathers.
Although in general increasing the involvement of fathers in BPT may be desirable, it is not always appropriate, and before a discussion of recommendations for including fathers in treatment can commence, certain situations in which father involvement may be undesirable must be noted. For example, not all fathers are willing to participate in research or clinical interventions (Costigan & Cox, 2001). If a treatment provider required both parents to participate, then some families would be unable to derive any benefits from treatment that might be obtained from the mother and child participating. Clinicians must also weigh the appropriateness of father participation in situations that involve child maltreatment or domestic violence. In cases of mild to moderate family abuse or maltreatment, supportive interventions should be implemented (Crooks, Scott, Francis, Kelly, & Reid, 2006; Emery & Laumann-Billings, 1998), which may include BPT, but clinical judgment and safety concerns might preclude father participation in treatment activities that include the other parent or child until these concerns are addressed. There are also some cases in which father involvement should not be encouraged. Jaffee, Moffitt, Caspi, and Taylor (2003) reported that children who lived in a two-parent home in which the father exhibited high rates of antisocial behavior had more behavior problems than if a father with similar behaviors had no contact with the child. Therefore, in situations in which the father is currently engaging in high levels of antisocial activity, including family violence or severe abuse, a goal of intervention should be to reduce or eliminate the father's participation in family activities rather than reduce it (Emery & Laumann-Billings, 1998).

In instances in which increased father involvement is warranted, involving fathers in BPT treatments for ADHD should be addressed on multiple levels (i.e., Sanders, Markie-Dadds, & Turner, 2003). These levels include population-based efforts to normalize father involvement and emphasize the important role fathers have in families and in child development (e.g., National Fatherhood Initiative, 2006), psychoeducational efforts to improve and support effective fathering (McBride & McBride, 1993), and, as discussed below, efforts to include fathers in clinical interventions.

**Recommendations for Involving Fathers in ADHD Assessments**

Beginning with initial correspondence/contacts and including the intake, fathers should be explicitly invited to participate in treatment. This approach provides the clinician with an initial contact with the father and, through the intake process, may promote insight into the father's perspective on the child's functioning and behavior. Encouraging father involvement may also require additional modifications in clinical practice. For example, appointments might need to be scheduled during weekends/evenings to accommodate working parents. Because both parents are expected to attend, childcare should also be provided. An additional recommendation is that clinicians should broaden their conceptualization of father involvement to include any male caregiver who helps parent a child. This means assessments of father involvement must extend beyond merely asking about the child's contact with a biological father to specifically ask who helps parent and monitor the child other than the mother. Effort should also be directed toward engaging noncustodial fathers to participate in BPT. Initial assessments should also be independently completed by mothers and fathers to obtain both parents' perspectives.

In the case of ADHD, parents who report on child behavior and functioning might disagree on the nature and extent of ADHD-related behaviors, with each contributing unique variance to the assessment (i.e., $r = .62$ for correlations between mother and father report of externalizing behaviors; Achenbach, McGaughy, & Howell, 1987). For example, because fathers often have limited interactions with school, and may have many parent–child interactions in situations in which ADHD symptoms are not impairing (i.e., unstructured free play), it is imperative that clinicians acknowledge the differences between informants and explain that these differences are expected. Clinicians might do this by focusing less on the specific symptoms of ADHD (which may be related to school behaviors or situations handled by the mother) and instead focus on functionally impaired areas (e.g., peer relations), and targets of treatment may vary across informants (see Fabiano et al., 2006; Pelham, Fabiano, & Massetti, 2005).

A related practical point concerns the development and validation of standardized ADHD rating scales. Numerous well-validated and widely disseminated rating scales for ADHD exist (Pelham, Fabiano, Gnagy, Greiner, & Hoza, 2005), but the available research used mothers and teachers as informants. Research on appropriate questionnaire items and interview questions must be developed, piloted, and validated for use with fathers. It is possible that the present bank of ADHD symptoms may not be applicable or as important as other behaviors in the settings and situations in which fathers observe and manage their children's behavior. There are also limited rating scales available that include norms for fathers (e.g., Johnston & Mash, 1989). This presents a serious problem for researchers and clinicians interested in determining whether treatment “normalized” the child's functioning per father report (i.e., Kendall & Grove, 1988; Kendall & Sheldrick, 2000) and also confounds how a father's ratings should contribute to a child's diagnosis. Researchers need to begin to routinely collect normative data and validate measures using mothers, teachers, and fathers as raters.

**Recommendations for Involving Fathers in ADHD Treatments**

Recent publications include excellent recommendations for increasing father participation and engagement in treatment (Chronis et al., 2004; Lee & Hunsley, 2006; Phares, Fields, & Binitie, 2006). Below, recommendations and areas in need of future research in the study of father involvement, engagement, and participation in the child and family’s treatment are offered. A new approach to BPT that aims
to explicitly address the needs of fathers of children with ADHD is also briefly described.

One strategy clinicians and practitioners should use in treatment is to routinely presume fathers will be involved in the intervention and clearly project this expectation to the family. Clinicians can also work to reduce any stigma related to clinical services. Because fathers are unlikely to seek out treatment if doing so requires an acknowledgement of a skills deficit (Addis & Mahalik, 2003), calling an intervention “parent training” may discourage father participation because the title implies a skills deficit. Framing BPT as a means of enhancing existing skill areas and using a less pejorative label might be better received by fathers. Another strategy might be to include the child in treatment activities aimed at improving parenting (Miller & Prinz, 2003). Parents, in particular fathers, may view the ADHD-related difficulties as child focused and minimize the contribution of parenting to the behavior problems. Programs that incorporate practice of parenting strategies within the context of child activities could potentially make the program less threatening to the fathers’ self-concepts.

Another recommendation concerns using treatment models that are palatable to fathers that are implemented in familiar settings. Thus, present interventions for ADHD might need to be adapted to address needs and treatment goals specific to fathers. As an example of one such treatment model, William E. Pelham, Jr. has spent the last 25 years developing and refining a summer treatment program (STP) for children with ADHD, with sports activities serving as a context to treat problems in peer relationships and build competencies in important functional domains (Pelham, Fabiano, Gnagy, et al., 2005). Given that both children with ADHD and their fathers may benefit from learning effective skills within the context of sports activities, that fathers typically interact with their children in these settings, and the critical role such activities play in the development of peer relationships, recreational activities are particularly appropriate for integration into father-focused BPT programs. Changing the treatment setting from a classroom/didactic setting to one that includes an activity-oriented setting might make regular attendance at treatment reinforcement and relevant, and promote the practice of parenting skills.

As an example of a program specifically tailored to address some of the limitations of existing treatment programs for fathers of children with ADHD is the Coaching our Acting-out Children: Heightening Essential Skills (COACHES) program. The COACHES program was conceptualized on the basis of the integration of two evidence-based treatments for ADHD—the STP (Pelham, Fabiano, Gnagy, et al., 2005) and group BPT (e.g., Cunningham, Bremner, & Secord, 1998). The COACHES program was created on the basis of the premise that including a sports activity within the context of BPT would increase the palatability of a BPT program and directly address an area of functioning relevant to fathers in their parenting.

During the first hour, fathers review how to implement effective parenting strategies in a group setting (e.g., using praise, using time out). Concurrently, children practice soccer skill drills with paraprofessional counselors to increase competencies in the sports domain (Hupp & Reitman, 1999; Pelham, Fabiano, Gnagy, et al., 2005; Pelham et al., 1990). Then, during the second hour, the parent and child groups join together for a soccer game. The soccer game provides a context for the fathers to interact with their children and practice the parenting strategies taught in the classroom (e.g., praise, using effective commands), and it also serves as an opportunity for clinicians to observe the fathers’ parenting and provide feedback as the game progresses. Fathers are assigned weekly homework assignments to practice the techniques with their child at home during the week. Preliminary results suggest that fathers are more engaged (i.e., attend more sessions, complete more homework) in the COACHES program relative to a traditional approach (Fabiano, 2005).

Recommendations for Future Directions in BPT Research With Fathers

As the study of BPT for fathers of children with ADHD continues, researchers should attend to a number of parameters that are underaddressed in the literature. Presently, the study of fathers in clinical studies is concentrated in Caucasian, relatively older samples (Cassano et al., 2006). Future studies that address BPT effectiveness across racial and ethnic groups, stages of development (i.e., birth to adolescence/young adulthood), and gender (i.e., fathers of boys vs. girls with ADHD) are needed to better understand the moderators of BPT treatment. In addition, little attention has been devoted to BPT interventions for noncustodial fathers, or fathers across diverse family structures (e.g., stepfathers, grandparents, gay fathers).

An approach that includes parent–child interactions is consistent with a long history of effective BPT interventions used with parents (e.g., Eyberg & Robinson, 1982; Forehand, Griest, & Wells, 1979). Sports activities are seen as a natural forum for BPT programs aimed at fathers, but presumably other activities might also be beneficial (e.g., artistic activities) for promoting a positive father–child relationship and offering opportunities to engage in and practice parenting behaviors. These activities need to be evaluated in carefully conducted research, and natural follow-up studies to this work might include investigating whether the activity should be different for mothers versus fathers, and parents of same- versus opposite-gender children.

Furthermore, mothers and fathers are responsible for different roles in families (Pleck, 1997). Present practice involves inviting fathers to attend BPT if available/interested along with the mother. More research is needed on whether it is advisable to include father-only groups in treatment. Grouping parents by gender might afford time for more discussions of parenting strategies that have direct relevance for each group. Perhaps a model of BPT that begins with parents attending together to learn basic parenting strategies and then separating by gender for more focused sessions is a promising model, but it is one that awaits empirical research.

Overall, improving family functioning, increasing parent-
ing competence, and ensuring the use of effective parenting strategies across settings are important reasons to increase father involvement in BPT. Improvement in these domains is particularly important for fathers of children with ADHD. Additional research on father involvement in treatments for ADHD is needed and should build on the pioneering research of promising studies (e.g., Anastopoulos & Farley, 2003; Barkley et al., 2001; Danforth et al., 2006; Schummann et al., 1998).

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