The Impact of Fathers on Children With Obsessive-Compulsive Disorder

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A Master's Thesis
Submitted to the Faculty of Graduate Studies of
The University of Manitoba
In Partial Fulfillment of the Requirements for the Degree of

MASTER OF SOCIAL WORK

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ABSTRACT

The primary objective of this study is to increase knowledge about the inter-relationship between parenting and obsessive-compulsive disorder in children and adolescents. More specifically, this study sets out to understand the impact or influence of fathers on children and adolescents with obsessive-compulsive disorder. This study further examines the changing roles of fathers and the impact these have on their children with Obsessive-Compulsive Disorder.

In an attempt to gain new insights into the father-child relationship, I have placed an emphasis on both risk and protective factors. That is, the study examines the lived experience of these fathers encompassing their interpretation of their children's obsessions and compulsions as well as their response to same, which has further consequences for themselves and their children. It was also the intent of this study to move away from "blaming" the parent or the child and instead, to examine the transactional nature of the emergence and maintenance of obsessive-compulsive disorder.

This qualitative inquiry incorporates data drawn from a series of semi-structured, open-ended interviews with fathers of children diagnosed with obsessive-compulsive disorder. The interview guide presented questions that are framed in such a way to elicit responses related to meaning and feeling, so that I could apply a phenomenological approach to the inquiry. The participant selection or recruitment process involved fathers whose children were receiving treatment at the St. Boniface Hospital Anxiety Disorders Service for Children and Youth. The sample size identified prior to the commencement of this study was between eight and ten fathers although the actual number was nine.

Criteria did not discriminate between fathers who have also been diagnosed with a mental health disorder including obsessive-compulsive disorder as it was felt that a combination of clinical and non-clinical parents would enrich the data. The study further allowed for fathers whose children's primary diagnosis was obsessive-compulsive disorder but also possessed co-morbid features such as ADHD and Tourette Syndrome.

The data was examined through an inductive content analysis in order to uncover themes, patterns, and categories within the data. Using thematic inquiry which includes the fathers' verbatim quotations, the data was analyzed by transcribing all interviews from tape recordings to physical files and then comparing the themes, patterns, and categories to relevant literature.

The results derived from this study would be of interest to services such as the Anxiety Disorders Service for Children and Youth at the St. Boniface Hospital in their work with parents, particularly fathers. Furthermore, this data would likely be of benefit to any service within the child and adolescent mental health system which maintains a family focused approach as there appears much to gain from the insights offered by the participants in this study.

Chapter 1: Introduction

Obsessive-Compulsive Disorder as described in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) is characterized by recurrent obsessions and/or compulsions that cause marked distress and/or interference in one's life. As in the adult population, obsessive-compulsive disorder is much more common with children and adolescents than once thought. It is now known that obsessive-compulsive disorder affects as much as 3% of the North American general population with an incidence of approximately one (1) in three hundred and fifty (350) children and adolescents (Wand, Furer, & Shady, 1993). Among adults with obsessive-compulsive disorder, one-third to one-half of these develops the disorder during childhood (Morris & March, 2004).

In order to meet the criteria for obsessive-compulsive disorder, a child must meet the following key features:

- Obsessions which are recurrent and persistent thoughts, images, or impulses that are ego-dystonic, intrusive and, for the most part, acknowledged as senseless. Obsessions are generally accompanied by distressing negative affects, such as fear, disgust, doubt, or a feeling of incompleteness.
- The child attempts to ignore, suppress, or neutralize obsessive thoughts and associated feelings by performing compulsions. Compulsions are repetitive, purposeful behaviors that are often performed according to certain rules or in a stereotyped fashion in order to temporarily neutralize or alleviate obsessions and the dysphoric affects that accompany them.
- Since obsessive-compulsive disorder behaviors often occur in individuals without a disorder, the DSM-IV specifies that the obsessive-compulsive behavior

symptoms must be distressing, time-consuming (taking more than an hour per day), or must significantly interfere with school, social activities, or important relationships.

- The obsessions are not simply excessive worries about real problems and that affected individuals must recognize that the obsessions originate within the mind. Furthermore, at some point, an individual must recognize that the obsessions or compulsions are excessive and unreasonable. This insight can be waived for children and designated obsessive-compulsive disorder "with poor insight" as part of the diagnosis (March & Mulle, 1998, p. 5-6).

Obsessive-compulsive disorder may be unremitting, progressive or have a fluctuating course of remissions and exacerbations adversely affected by stress. There is usually a measure of voluntary control which may lead to the disorder being hidden from family members, educators, and physicians. Children are frequently ashamed of their rituals and perform them secretly. Another complicating factor, according to Wand, Furer, & Shady (1993), is that parents can "often become incorporated into the child's rituals where, in response to the child's demands, the parents allow themselves to become captive observers or participants. In some instances, the parent's presence becomes required in order for the child to complete the ritual to his or her satisfaction or to be able to leave the home to proceed to school or move on to another activity" (Wand, Furer, & Shady, 1993, p. 59).

The most common obsessions and compulsions seen in pediatric obsessive-compulsive disorder can be broken down into the following categories and associated obsessive concerns:

Contamination: Dirt; germs; animals/insects; illnesses; bodily fluids/waste; contaminants; household cleaners; "sticky" substances; spreading contamination, germs, illnesses, etc.

Harm to Self/Others: Even accidentally; causing harm to self or others due to thoughts or behaviors; acting upon aggressive impulses; blurting out inappropriate words/phrases; stealing or breaking things; causing something terrible to happen; frightening/violent images.

Sexual: Forbidden/perverse sexual thoughts; images; disturbing sexual impulses, desires; homosexuality; molestation; sexual acts toward others.

Hoarding/Saving: Losing things; throwing away objects that might be important.

Magical Thinking: Lucky or unlucky numbers, colors, names, etc.

Health/Body: Contracting illness (especially if fatal or rare); appearance; physical abnormalities (real or imagined).

Mortality/Religion: Dying and not going to Heaven; offending God; being sinful; morality/perfection; right/wrong.

Miscellaneous: Knowing or remembering certain things; saying things exactly right; not saying certain phrases or words; intrusive images, sounds, words, music, numbers, etc.

Along the same continuum, compulsions consist of the following categories and associated rituals:

Washing and Cleaning: Excessive/ritualized hand washing, showering, bathing, tooth brushing, grooming, toileting; cleaning clothing/personal items; avoiding "contaminated" objects/places.

Checking: Checking locks, alarms, school supplies, homework, toys, books, etc.; checking associated with washing, dressing, undressing, somatic concerns; checking that did/will not harm self or others; checking that nothing terrible did/will happen; checking for mistakes.

Repeating: Re-writing; re-reading; re-copying; re-tying (shoelaces); erasing; going in/out door or taking items in/out of school bag; getting up/down from seat; repeating words/phrases.

Counting: Counting objects; mental counting (especially up to a "magic number"); counting steps, chewing, hair brushing, etc.

Ordering/Arranging: Lining up objects in a certain way; arranging things in specific patterns; making objects/piles/groups "even"; making things symmetrical; "balancing" actions (e.g., doing things on the right and on the left).

Hoarding & Saving: Keeping seemingly unimportant/unnecessary items and/or trash; storing items of no particular value; having difficulty throwing things away; sorting through trash to ensure that nothing important has been thrown away.

Superstitions: Touching/tapping routines to prevent bad things from happening; avoiding stepping on cracks, lines, etc; avoiding "unlucky" objects/places.

Reassurance-seeking: Asking a parent to repeatedly answer the same questions; asking parents to describe what they are doing/planning to do; forcing family members to do things in a certain way or at a certain time; forcing family members to avoid certain things/activities.

Miscellaneous: Mental rituals; needing to tell/ask/confess; ritualized eating behaviors; excessive list-making; needing to touch/tap/rub; needing to do things until it feels "just right"; hair pulling; measures to prevent something bad from happening.

(Merlo and Storch, 2006, p. 218-219).

According to Castellanos and Hunter (1999), the most common reported obsessions in children and adolescents are fear of contamination (35%) and thoughts of harming oneself and familiar figures (30%). The most frequent compulsions are washing and cleaning rituals (75%), followed by checking behaviors (40%) and straightening (35%). They further contend that obsessions without rituals are generally rare. It is also important to note that certain obsessions and compulsions are present in the normal development of most children. In fact, most children go through phases in which they carry out certain rituals. Normal rituals, however, seem to vanish by the age of 8 years, whereas, childhood obsessive-compulsive disorder normally sets in after the age of 7 years. According to Thomsen (1998), "it is only when rituals interfere with day-to-day life, or cause distress, that an obsessive-compulsive disorder diagnosis should be considered" (p. 3).

Many studies have investigated the idea that there is an inherited vulnerability to obsessive-compulsive disorder, and the belief that obsessive-compulsive disorder is influenced by family genetics. According to Turner (2006), the majority of family studies

have supported the conclusion that first degree relatives of obsessive-compulsive disorder patients have significantly higher rates of obsessive-compulsive disorder (6.5-11.7%) in comparison to first degree relatives of controls (1.9-2.7%). Turner further indicates a need in finding a familial connection; one must carefully examine the contribution of genetics versus environmental factors (p. 919-920). Geller's (2006) study of familial influence revealed that genetic and non-genetic factors (parenting style, parent's management of obsessive-compulsive disorder, home environment) are about equally important.

One family characteristic that has been associated with obsessive-compulsive disorder is high expressed emotion. This refers to "a family environment characterized by hostility, criticism, or emotional over-involvement" (Turner, 2006, p. 920). Similarly, Barrett, Shortt, and Healey (2001) found that parents of children with obsessive-compulsive disorder were less confident in their child's ability, less rewarding of independence, and less likely to use positive problem solving in comparison with a control group of parents. Mancini and his associates viewed the problem as two-fold "whereby a constitutionally predisposed 'hypersensitivity' in the child is overlaid by parental over-concern and over-control" (Mancini et al., 2000, p.202). However, these researchers viewed parental rearing as only a moderate predictor of obsessive-compulsive behavior and thinking in children.

Derisley, Libby, Clark, and Reynolds (2005) have offered not so much a causal link between parents and their children with obsessive-compulsive disorder but strongly suggest that parents' responses to their children's anxiety and obsessive-compulsive behaviors play a large role in the maintenance of the problem. Stengler-Wenzke (2006)

and her fellow researchers also suggest that family members are often involved in "giving in to" or "assisting" in the child acting out obsessive-compulsive disorder symptoms. In one study, approximately 75% of relatives of patients with obsessive-compulsive disorder participated at least minimally in rituals, avoided them, or modified their behavior to accommodate the patients' symptoms. Not surprisingly, greater involvement of the family in the child's rituals was significantly related to distress in family members. Similar to the findings of Wand, Furer, and Shady (1993), Stengler-Wenzke (2006) noted that "patients with obsessive-compulsive disorder often provoke family members to participate in the illness and the related behaviors that can dominate family life and provoke intense disagreement among family members concerning responses to their symptoms" (p. 523).

Alonso et al. (2004) reported that many families become dysfunctional as a result of a family member's obsessive-compulsive disorder symptoms. They add that parents and siblings become involved in the sufferer's avoidance behaviors and compulsions in an effort to relieve the fear and anxiety that the patient is suffering. This sort of control which the child wields over the family leads to severe feelings of frustration, anger, guilt and loneliness in family members (Alonso et al, 2004).

Chapter Two: Literature Review

Attachment/Bonding

One of the potential etiological factors for child anxiety disorders is insecure attachment of the child to its caregivers. Attachment theory states that children have an evolutionary bias to behave in ways that enhances proximity to their caregivers. The sensitivity of the caregiver's response determines the security of the child in the relationship. According to Bogels and Brechman-Toussaint (2005), "insecure early attachment experiences lead individuals to form internal working models that, though adaptive to the primary caregiver, interfere with other relationships" (p. 835). In addition, Manassis et al. (1994) note that these individuals have difficulty providing to their own children the sensitive responsiveness necessary for security. In their study of attachment involving 36 mothers diagnosed with anxiety disorders, the researchers discovered that there was a prominent role of unresolved loss and trauma in their lives. Whether they experienced more losses or traumas than the general population or they simply had greater difficulty resolving them was not determined in this study, however. All children of these parents who had been diagnosed with anxiety disorders were insecurely attached supporting the researchers' contention that insecure attachment could be a risk for childhood anxiety disorders.

The results of Manassis' (1994) research also emphasized that children presenting with anxiety disorders cannot be diagnosed in isolation. The attachment relationships of such children must be examined to determine the most appropriate points of intervention. The parents' anxiety or an insecure parent-child relationship may require treatment in addition to the individual treatment of the child. It was further proposed that "when

treating adults with anxiety disorders, clinicians must be alert to the possibility of psychological difficulties in the children or in the parent-child relationship" (p.1111). From this perspective, "helping anxious adults resolve the losses and traumatic experiences of the past may indirectly benefit their children by improving the parent-child attachment relationship" (p.1111).

Manassis and Bradley (1994) have proposed an integrated model in which insecure attachment and inhibited temperament both contribute individually to the development of anxiety disorders, while the interaction between them is thought to play the greatest role. In a similar study on attachment, behavioral inhibition, and anxiety, Shamir-Essakow, Ungerer, and Rapee (2004) found that behaviorally inhibited children displayed higher levels of anxiety than their uninhibited counter-parts, while insecure children demonstrated higher levels of anxiety than secure children. The authors of this study did however concede that it remains unclear whether the link between maternal anxiety and child anxiety is due to genetic or environmental (i.e., parenting) influences. It was further determined that "behavioral inhibition was associated with child anxiety even after controlling for the effect of maternal anxiety" suggesting that although behavioral inhibition may be linked to a familial predisposition to anxiety, it is likely to act as an additional risk factor" (p.140).

Belsky (1999) had also found that insecure attachment still contributed to child anxiety over and above the contribution of maternal anxiety suggesting that attachment does not merely reflect a shared genetic vulnerability toward anxiety between mother and child. From this perspective, maternal failure to provide a predictable and secure base for the child may further increase the risk for anxiety.

Bogels and Brechman-Toussaint (2005), in their review of four clusters of family variables associated with anxious symptomology and anxiety disorders in children (bonding/attachment, broad family factors, parent child-rearing behaviors/styles, and parental beliefs about their child's anxious behavior), concluded that insecure attachment in parents and in children seems associated with anxiety. Whether insecure attachment is indeed a moderator in the transmission of anxiety disorders from parents to children, rather than just a by-product of parent anxiety and/or child temperament, remains to be investigated, according to these two researchers.

Parental Control/Protection

Parental over-control is a pattern of behavior involving excessive regulation of children's activities and/or routines, high levels of parental vigilance and intrusion, and discouragement of independent problem solving (Bogels & Brechman-Toussaint, 2006). In theory, parental over-control is believed to limit the development of children's autonomy, lead to perceptions of the environment as uncontrollable and a limited sense of personal competence and mastery and in turn, these factors will inevitably contribute to emergence of anxiety disorders in children.

The literature on parenting and anxiety disorders also differentiates two types of control: behavioral and psychological. Behavioral control consists of behaviors parents use to manage, regulate, and supervise their children. It is further broken down into two types: discipline and monitoring. Discipline refers to specific strategies that parents use to enforce rules and foster values in their children (Cummings et al., 2000). Monitoring is the level of awareness and supervision that parents maintain to track their child's

activities and whereabouts (Cummings et al., 2000). Psychological control is defined as the attempts parents make to impede their child's development of independence and autonomy (Ballash, Leyfer, Buckley, and Woodruff-Borden, 2006). In their study of the etiology of anxiety disorders in children, these researchers expanded further on parental control by distinguishing between parenting discipline styles consisting of dimensions of warmth as well as control. For example, an authoritarian style was associated with a lack of warmth and high control. An authoritative parenting style was associated with being controlling and demanding but also warm and receptive. Finally, a permissive parenting style was neither controlling nor demanding, but was warm. Children of authoritarian parents tended to be discontent, withdrawn, and distrustful. Children of authoritative parents were found to be content, self-reliant, explorative, and self-controlled while children of permissive parents tended to be the least self-reliant, explorative, and self-controlled.

Ginsburg and Schlossberg (2002), in their study of family-based treatment of childhood anxiety disorders discovered a total of five studies examining parental over-control. Two studies were based on an observational method (Dumas et al., 1995; Siqueland et al., 1996), one was based on child- and parent-report (Fristland & Crayton, 1991), and two were based on child-report only (Leib et al., 1991; McClure et al., 2001). Across these studies, parental over-control was defined as intrusive behavior, granting minimal autonomy to their child, constraining their child's individuality, use of excessive commands or instructions, and restriction of their child's behavior (p.145). Of the five, two found that higher levels of parental control were associated with higher levels of anxiety in children (Dumas et al. & Siqueland et al.), while one study (McClure et al.)

found mixed results (i.e. support for parental psychological control but no support for parental behavioral control.

Two comprehensive reviews of literature linking over-controlling parenting behavior and parental negativity to child anxiety have been published over the past 10 years (Rapee, 1997; Wood et al, 2003). Wood and his colleagues' review of observational studies of parental control revealed that behaviors during parent-child interactions were consistently linked with child anxiety disorders across studies. However, there was less consistency and validity in examining of parental control in child self-report studies and parent-report studies.

In a study by Dumas, LaFreniere, and Serketich (1995) involving transactional analysis of control in a total of 126 mother-child dyads, it was determined that mothers of anxious children were found to initiate more control exchanges and demonstrate more aversive affect in comparison to mothers of non-clinical children. They were further found to be more coercive and unresponsive to their children.

Mancini et al (2000) also support an integrated "over-control" model whereby a constitutionally predisposed 'hypersensitivity' in the child is overlaid by parental over-concern and over-control, with variable expressions of the latter leading to different types of obsessive-compulsive disorder (p.222). Rachman's (1976) research in the area of OCD specifically predicted that "cleaners" and "checkers" would both describe their parents as over-controlling, although cleaners would also report over-protection and checkers, over-criticism. The results of studies by Mancini et al. (2000) indicate that both higher obsession and rumination were significantly linked with low parental care and with

paternal over-protection. By contrast, higher compulsion scores were linked with higher maternal and paternal protection scores, but not with parental care scores.

Parental Psychopathology

High levels of anxiety in parents are thought to interfere with the development of their own adaptive coping skills and lead to specific anxiety-enhancing parenting behaviors that, in turn, increase their child's vulnerability to developing an anxiety disorder (Ginsburg, Siqueland, Masia-Warner, and Hedtke, 2004). They further observe that anxious parents tend to have strong beliefs about the nature of anxiety and its expression, the safety of the world, their child's ability to manage and cope with anxiety, and both their role and competence in handling anxiety. It is further proposed that anxious parents likely view anxiety as powerful and something to be avoided at all costs. Therefore, as a parent, they would view their role as one of protecting and saving their child and themselves from these experiences.

McClure, Brennan, Hammen, and Le Brocque (2000) also studied the mechanisms through which anxiety disorders may be transmitted from parent to child, including genetic factors. They cite Kendlar, Neale, Kessler, Heath and Eaves (1992) who conducted a study of twins of mothers with Generalized Anxiety Disorder and obtained estimates ranging from 19% to 30% for liability for the disorder (p.1-2). In their own study of parental anxiety disorders and its association with child anxiety disorders, involving a sample of 816 children, the results partially supported the hypothesis that children of anxiety disordered parents are at increased risk for anxiety disorders, even when other environmental stressors are co-varied. Risk increased significantly when the

parent had a lifetime history of an anxiety disorder. Specifically, maternal lifetime histories of an anxiety disorder "more than doubled the risk of anxiety disorders in both male and female offspring" (p.7). Risk for child anxiety disorders appeared to be greatest in the presence of co-morbid maternal anxiety and depressive disorders. In fact, children of co-morbidly affected mothers faced a triple risk for anxiety disorders relative to children of non-clinical mothers. It was also interesting to note from this study that children of mothers with depressive disorders alone were "not at significantly elevated risk for developing anxiety disorders" (p.7).

Last et al. (1991) found that first-degree relatives (especially males) of children with anxiety disorders were significantly more likely to have an anxiety disorder than children with ADHD or no psychopathology. Messer and Beidel (1994) examined both parental psychopathology and family environment in children with anxiety disorders. They found that fathers of anxious children showed more obsessive-compulsive, depressive, and global pathological symptoms than the fathers of children without anxiety. In their study, anxious children also tended to have more controlling parents who promoted less independence than comparisons, and family characteristics moderately predicted the presence of anxiety disorders over and above the child's characteristics alone. They hypothesized that family environment indirectly affects the acquisition of anxiety because parental psychopathology promotes more conflict and less cohesion in the home, which in turn contributes to the maintenance and/or enhancement of child anxiety.

Parental Sensitivity

Dadds and Roth (2001) and Manassis (2001) have emphasized that more sensitive parenting behaviors will decrease the risk for anxiety disorders in children as these behaviors have been associated with secure attachment relationships. Warren et al. (2003) have further observed in their work on maternal anxiety and child temperament that parents with anxiety disorders have been found to be less sensitive than non-clinical parents.

Unfortunately, little empirical research has examined the debate over the reciprocity between child temperament/behavioral inhibition and parental sensitivity. In light of this, Warren and Simmens (2005) elected to conduct an investigation to determine whether sensitive parenting early in childhood could reduce the risk for childhood anxiety symptoms, particularly for more temperamentally vulnerable children. This was part of a longitudinal study of early child care involving 1226 participants (631 boys, 595 girls) drawn from a larger ongoing study by the National Institute of Child Health and Human Development Early Child Care at George Washington University. The findings of the research generally supported the hypothesis that maternal sensitivity in early childhood was found to contribute to later reactions, manifested by symptoms of child anxiety and depression. Moreover, maternal sensitivity in early childhood significantly predicted decreased anxiety/depressive symptoms for children who had been more temperamentally difficult. Their results also revealed that there were differences between boys and girls. For one, higher levels of maternal sensitivity were found to reduce anxiety/depressive symptoms for more temperamentally difficult boys but not girls. It was speculated by Warren and Simmens from their own research and upon

review of other research comparing boys and girls (Osofsky and O'Connell, 1977; Weinberg et al, 1999) that boys tend to possess "more difficulties maintaining affective regulation, which could cause them to be more vulnerable to less sensitive parenting behaviors" (p.50). Interestingly, upon careful examination of these studies, it was noted that few, if any, of these researchers provided a clear definition of parental sensitivity. Given this omission, it would appear that these researchers have afforded themselves considerable leeway in their interpretation of the relationship between parental characteristics and their children's mental health.

Parent-Child Interaction

There is evidence presented in the research by Hummel and Gross (2001) to suggest that there are notable differences in the manner in which parents of anxious children and parents of non-anxious children interacted with their children. According to Hummel and Gross (2001), parents of anxious children engaged in fewer verbal exchanges with their children than parents of non-clinical children. The parents of anxious children differed in the quality of their exchanges as well, using fewer positive feedback verbalizations and more negative feedback than parents of non-clinical children. Similarly, experimental group children provided significantly fewer positive statements and significantly greater amount of negative feedback in their interactions with their parents, relative to the non-clinical children in this observational study of parent-child interaction.

One must also examine the parent-child relationship from the perspective of how the child's behaviors or global functioning elicits particular responses from the parent. As

noted earlier, many families become dysfunctional as a result of a family member's OCD symptoms. Frequently, parents and siblings become involved in the sufferer's avoidance behaviors and compulsions in an effort to relieve the fear and anxiety the child is experiencing.

While child-rearing patterns play a role in the development of OCD, one should also consider that the primary presence of obsessive-compulsive symptoms in a child may also elicit certain parental behaviors and attitudes, especially "a tendency towards greater rejection and/or protection towards the affected child" (Alonso et al., 2002, p.269). Given the likelihood of such a reciprocal relationship, research which frequently defines parents of anxiety disordered or, in this case, obsessive-compulsive children as over-protecting, over-controlling, or over-critical must take into consideration if these actions are unsolicited or in direct response to particular behaviors or traits presented by the child.

Affectionless Control

Parker (1983) was one of the earliest researchers to identify the combination of high parental over-protection (control) and low parental care (warmth) as a specific risk for childhood anxiety. Parker coined the phrase "affectionless control" to describe this pattern of parenting practices. In their review of theoretical models of affectionate versus affectionless control in anxious families, DiBartolo and Helt (2007), there appears to be considerable research which corroborates Parker's theories. For example, Hudson and Rapee (2001) observed mother-child interactions for 43 children diagnosed with and anxiety disorder, 20 children with Oppositional Defiant Disorder, and 32 non-clinical

children. Once again, mothers with anxious children displayed greater negativity (i.e. low warmth) and intrusive involvement (i.e. controlling behavior).

Bottom-up Studies

Dumas et al. (1995) examined the differences in interactions between parent-child dyads involving competent, aggressive, and anxious children. It was found that mothers of anxious children exhibited significantly more control and less positive affect during interactions than mothers in either competent or aggressive child groups. Connell and Goodman (2002) also emphasized the importance of considering the direction of influence in the associations between the presence of emotional and behavioral problems in children and parental psychopathology which they contend is often bi-directional, as the presence of internalizing and/or externalizing disorders in children may act as a stressor for mothers and fathers, which may affect the parents' mental health. They further indicate in their study that "mothers tended to be more distressed than fathers by the emotional and behavioral problems of younger children while fathers were more distressed by these problems during adolescence" (p.762).

Top-down Studies

These studies examine parenting style by observing interactions between parents diagnosed with an anxiety disorder and their children. In the first study of its kind, Whaley et al. (1999) examined interactions between anxious mothers and their children in order to determine whether maternal anxiety contributes to patterns of parental warmth and control observed during interactions. A total of 19 anxious mothers and 18 non-

clinical mothers and their children participated. Results revealed that anxious mothers were less warm and less granting of autonomy (more controlling) in their interactions with their children than non-clinical mothers across various tasks. These are findings consistent with the affectionless control models of anxiety development.

Top-down/Bottom-up Studies

Moore, Whaley, and Sigman (2004) integrated the two methodologies by recruiting half of their dyads on the basis of the anxiety status of the mother and the other half based on the anxiety status of the child. The researchers then divided their sample into four groups: anxious mothers with anxious children, non-anxious mothers with anxious children, anxious mothers with non-anxious children, and non-anxious mothers and non-anxious children. Maternal behavior during observations was coded for warmth and psychological granting of autonomy. Once again, the findings are consistent with Parker's (1983) affectionless control theory. Mothers of anxious children were more controlling than and less warm toward their children, regardless of their own anxiety status. Contrary to expectations, they found that child, not maternal anxiety status predicted low maternal warmth. Thus, anxious children elicited less warm behavior from their mothers, regardless of whether the mother was anxious or not. Furthermore, even non-anxious mothers were over-protective of their anxious child. According to DiBartolo and Helt (2007), these findings support a transactional understanding of the mutual influences of each person in the parent-child dyad in influencing the other.

Observational Studies versus Self-Report/Retrospective Studies:

According to Wood et al. (2003), the majority of the reviewed studies used self-report as the sole measure of parenting, and the validity of this type of data collection has been questioned. For one, a social desirability bias may limit the accuracy of parent-report data. By far, the bulk of research on parenting and anxiety disorders in children has been questionnaire based. The biases associated with the use of retrospective reporting can range from mood dependent memory bias to under-reporting of maladaptive parenting behavior.

Bogels et al. (2001) indicated a typically low agreement between parent and child report of parenting behavior such that children report less healthy parenting than their caregivers. Thus, sole reliance on maternal reporting may systematically underestimate maladaptive parenting within these families. Similarly, while relying on only child report may provide a valid measure of children's perception of parenting behavior, it may not accurately reflect actual parenting behavior within the family.

According to Bogels et al. (2001), there has been a recent trend towards using aggregate scores from multiple informants (mother, father, and child) which appear to "greatly enhance the internal consistency and generalizability of questionnaire-based indices" (p.842). While fewer studies have used observation, researchers such as Wood et al. (2003) contend that this data provides much stronger evidence for a relationship between child anxiety and parental control.

Paternal versus Maternal Role

Lamb (1975) emphasized a lack of research related to the father's role in child development. Since that time, there has been moderate progress in the area of research whereby a distinction is beginning to be made between the contributions fathers and mothers make with their children. This appears to suggest that researchers are beginning to acknowledge that fathers have a significant and unique influence on normative developmental processes (Earls, 1976; Lamb, 1997; Parke, 1995).

Although gains have been made in understanding fathers' role in normal child development, unfortunately the research on fathers' contribution to risk and protective factors for the development of psychopathology appears to be lagging behind the progress in normative studies (Phares and Compas 1992). Cassano, Adrian, Veits, and Zeman (2006) note that "this relative exclusion of fathers from the developmental psychopathology research leaves large gaps in the literature for understanding the development and maintenance of psychopathology in children" (p.584).

A number of meta-analyses have been conducted to determine if gains are being made in fathers' inclusion in clinical research. Two clinicians, Caplan and Hall-McCorquodale (1985) reviewed a total of 125 articles from nine journals from 1970 to 1982 and determined that 53% of the articles included some type of attribution to the mothers of children with mental health problems. Furthermore, these researchers did not discover any change within this time period to indicate that mothers were being blamed less for their children's psychopathology. Even more fascinating is that the authors found 72 forms of child psychopathology credited to mothers and yet, there was virtually no mention of fathers' influence.

Phares and Compas (1992) also elicited similar results in their examination of the role of fathers in child and adolescent psychopathology. They were particularly concerned with a possible sexist bias toward studying mothers' contribution to child and adolescent maladjustment while ignoring similar contributions by fathers. Caplan and Hall-McCorquodale (1985) refer to this phenomenon as "mother blaming" and relate that it has been occurring in research on child psychopathology for several decades. Phares and Compas (1992) discovered in their review of eight journals which included 577 articles published between 1984 and 1991, that 48% of child clinical research included mothers and not fathers, 1% of the research included fathers but not mothers, 25% included mothers and fathers but combined the data to represent a single parental variable, whereas only 26% of the studies included separate analyses of mothers and fathers.

More recently, Zimmerman, Salem, and Notaro (2000) conducted a review of 5 journals from 1993 to 1997 focusing on adolescent development. They found that approximately one third of the articles included information from mothers only, 2% of the articles relied on information from the father, and of the 65% of journals that did include both parents, 28% of the research did not analyze mother and father data separately. They concluded that "fathers are virtually absent in the child and adolescent literature unless they are a co-resident" (p.238).

Connell and Goodman (2002) analyzed 134 studies published since 1974 involving the association between internalizing and externalizing behavioral problems in children and the psychopathology in parents. Of significance in their findings is that externalizing problems in children were equally related to the presence of

psychopathology in mothers and fathers, whereas there were small differences in effect sizes for internalizing problems which would indicate mothers' influence may be more closely related to internalizing symptoms than fathers' influence. Nevertheless, Cassano, Adrian, Veits, and Zeman (2006), who make reference to this study, state that this study and those mentioned above revealed that research over the past 30 years "have illustrated the inaccuracy of the assumption that mothers are somehow to blame for all forms of psychopathology in their children" (p.584). Such findings should compel all future research into the study of internalizing and externalizing problems behavioral problems in children to account for the unique role each parent assumes in the development of same.

In a follow-up study to her 1992 report on the lack of attention given to the role of fathers in child and adolescent psychopathology, Phares et al. (2005) conducted an update to determine if there had been any changes in the representation of fathers in the developmental psychopathology literature between 1996 and 2003.This was a much more ambitious meta-analysis involving a review of 514 studies. Once again, the findings were quite discouraging as only 2% of the studies involved fathers only and only 25% included mothers and fathers in which they were assessed separately. A similar pattern was revealed by Phares, Lopez et al (2005) in their review of 179 studies involving pediatric health related journals. Their findings identified 57% studied mothers only, 9% included both mothers and fathers and analyzed them separately and 34 % included both parents but did not distinguish by gender. Only 1% of these studies included only fathers.

Following up on the longitudinal studies of Phares, the research group of Cassano, Adrian, Veits, and Zeman (2006) conducted a large scale review of 702 studies

encompassing a range of clinical psychology journals and developmental psychology journals. Overall, the results suggested that "clinical psychology journals were equally likely to include both parents with separate parent gender analysis, less likely to include parents without specifying gender, and less likely to publish a study including only mothers compared to developmental psychology journals" (p.587). A final analysis was conducted by this group of researchers which was to determine whether there had been any improvement in father research participation in recent history compared to previous efforts. Their findings did reveal a moderate improvement in the trend towards including fathers. Specifically, "the proportion of studies that examined parent gender as an independent variable increased from 25% between 1992 and 1998 to 32% between 1999 to 2004" (p.587).

Some encouraging signs in the research have been evidenced in studies of the role of fathers in relation to older children, where there appears to be some consensus that they assume a larger role. For example, in Cassano, Adrian, Veits, and Zeman's (2006) review, they determined that in the majority of studies which examined parental influences on adolescent psychopathology, fathers were included and more than 40% of these studies analyzed parent data separately by gender.

Chapter Three: Methodology

Research Design

According to Patton, "applied researchers are trying to understand how to deal with a significant societal problem" (p.217) as the nature of this phenomenon is already known. The design is essentially applied research in that the purpose is to contribute knowledge (the impact or contribution of fathers) to better understand the nature of the problem (obsessive-compulsive disorder in children and adolescents) in order to be more effective an intervening with this population (Patton, 2002). Selecting a qualitative inquiry using a phenomenological approach is based on a number of criteria. For example, Creswell (1998) indicated that a researcher would choose a qualitative study because "variables cannot be easily identified, theories are not available to explain behavior of participants or their population of study, and theories need to be developed" (p. 17). As had been made apparent from the literature review, little study has been devoted to fathers, not just in my specific topic area of obsessive-compulsive disorder in children but all psychopathologies involving children and adolescents.

This study set out to examine and understand the lived experience of these fathers encompassing their interpretation of their children's obsessions and compulsions as well as their response to same, which has further consequences for themselves and their children. The phenomenological approach is the most appropriate way of studying this population by extracting their perception of themselves in relation to their children rather than collecting anecdotal third person accounts of their thinking or behavior which would compromise the integrity, and more importantly, validity of the research.

Context

The St. Boniface Hospital currently operates an Anxiety Disorders Service for Children and Youth. This is an out-patient service which consists of an assessment/diagnostic component, individual and group therapy, education, as well as a family therapy and parent training component. The treatment team consists of a number disciplines including psychiatry, occupational therapy, nursing, and social work. Referrals are channeled through one primary source, Centralized Intake/Child and Adolescent Mental Health Program (Winnipeg Regional Health Authority). Referrals to the Centralized Intake program generally come from family physicians and pediatricians but can also be received directly from the parent and/or legal guardian. This service treats all forms of anxiety disorders including obsessive-compulsive disorder. The program espouses cognitive behavioral therapy as its primary intervention tool.

Sampling Strategy and Rationale

Fathers were recruited from families currently receiving treatment within the St. Boniface Hospital Child and Adolescent Mental Health Program's Anxiety Disorders Service for Children and Youth. More specifically, those selected were fathers whose children were diagnosed and being treated for obsessive-compulsive disorder. The initial part of this process involved the researcher submitting a formal written request to the service director of the Anxiety Disorders Service for Children and Youth outlining the purpose of the research, expectations, roles and responsibilities, maintenance of confidentiality, timelines and other logistical considerations (Appendix B).

It is important to note that prior to the commencement of this study, formal approval was sought through written submissions to the St. Boniface Hospital Research Review Committee, the University of Manitoba Main Campus Research Ethics Board, as well as the University of Manitoba Bannatyne Campus Research Ethics Board which oversees research at the St. Boniface Hospital. Approval was granted by all three boards well in advance of this study (Appendix E).

The researcher also furnished the administrator and the treatment team with a letter to parents which provides a similar summary regarding what is involved should they choose to participate (Appendix C). In order to further enhance confidentiality, letters sent out to the potential participants requesting their involvement were forwarded not by the researcher or by members of the treatment team but by the administrative staff of the Anxiety Disorders Service for Children and Youth. These letters were accompanied by a letter from Dr. Gary Altman, Program Director of the Anxiety Disorders Service for Children and Youth (Appendix F). In this letter, Dr. Altman stated that he was aware of the proposed research and further that he supported the endeavor. Participants were requested to contact the researcher directly rather than go through members of the treatment team or administrative staff, which further enhanced confidentiality for these parents.

It is also important to emphasize that while the treatment team was asked to assume an indirect role in the recruitment by identifying fathers of children with Obsessive-Compulsive Disorder from their respective caseloads and providing a list to the administrative staff, they assumed no further role (Appendix G). For example, at no time in the course of their involvement with the families of children with obsessive-

compulsive disorder did these clinicians openly solicit the participation of these fathers in this study. Furthermore, no staff from the Anxiety Disorders Service for Children and Youth was privy to the names of those fathers who chose to participate in this study. Their primary role as part of this study was to ensure that the proposed samples were narrowed down to fathers of children diagnosed with moderate to severe obsessive-compulsive disorder based on a combination of clinical interviews and the administration of the Children's Yale-Brown Obsessive-Compulsive Scale (CY-BOCS) administered and interpreted by the treatment team.

The CY-BOCS is a 10 item, clinician rated, semi-structured instrument designed to assess the symptom severity of obsessive-compulsive disorder in children. It is administered to both the child and parent (s), either separately or jointly. The CY-BOCS has five primary sections: (1) Instructions, (2) Obsessions Checklist, (3) Severity Items for Obsessions, (4) Compulsions Checklist, and (5) Severity Items for Obsessions. The measure also includes a set of investigational items concerning insight, avoidance, indecisiveness, pathological doubting, obsessive slowness, and over-valued ideation, which may be correlated with OCD (Scahill et al., 1997, p.844).

Data Collection Procedures

In performing a qualitative inquiry, I incorporated data drawn from semi-structured, open-ended interviews which have a number of advantages. For example, this approach is highly focused so that the participant's time is used efficiently. The interview schedule or interview guide presents questions that are framed in such a way to elicit responses related to meaning and feeling, so that I could apply a phenomenological

approach to the inquiry. The interviews themselves took place at a location mutually selected by the parent and the researcher.

It was important that each interview was structured in a consistent manner including an explanation of the purpose of the research, the parameters of the consent form, their rights and responsibilities, and the order of questioning. The interview guide was structured in such a way which allowed for some rapport building, and so those questions which presented as more provocative would be posed later within the interview. Furthermore, I attempted to maintain a degree of flexibility in using the interview format in anticipation that some participants might volunteer information outside of the context of the interview questions. Probing questions were also posed in instances which I felt require more clarification.

The interview guide highlighted specific topics and themes which have been drawn from the literature review. Please refer to the interview guide (Appendix A). Questions were posed as open-ended in order to allow for some narrative on behalf of the participants. While the goal was to conduct a single structured interview with each parent, each was advised in advance of the option of a second interview if time had not allowed collecting all the necessary information outlined within the first interview. All participants were notified in advance that the interview may take approximately sixty (60) to ninety (90) minutes. The interviews were recorded on audiotape and later transcribed for the purpose of data analysis.

Data Management and Analysis

The data was examined through an inductive content analysis in order to uncover themes, patterns, and categories within the data. Using thematic inquiry which included the fathers' verbatim quotations, I analyzed the data by transcribing all interviews from tape recordings to a physical file. Following this task, I compared the themes, patterns, and categories to relevant literature. This comparison is outlined in greater detail in Chapter 5. The interview schedule itself acted as the central framework of the study by which I applied content and inductive analysis.

Creswell (1998) offers a number of strategies to analyze data based on the work of Bogdan and Biklen (1992), Miles and Huberman (1994), and Wolcott (1994). The first approach involves a general review of the data once it is transcribed and to begin writing findings in memo form or in reflection notes as one begins to discern patterns in the information. The researcher utilized reflection notes following each interview. It was also necessary to reduce the data by breaking it into codes or categories. In advance of the study, I had factored in potential categories or themes while in the process of designing the interview format. A number of the questions were inspired by the previous research to include themes such bonding and attachment, affection and control, hostility, and parenting style.

The themes or patterns and categories which evolved out of this coding process would represent the first round of coding. This process was initially done on an individual basis with each participant and once this was completed, I began to compare these meaning units between all of the participants in the study in the hope of eliciting more universal or core themes in the data. Miles and Huberman (1994) recommend that

the researcher should "make preliminary counts of data and determine how frequently codes appear in the database" (Creswell, 1998, p. 142). It was determined that this approach actually helped further narrow down the number of categories in the coding process which in turn made the analysis less formidable.

While the application of existing themes was utilized in the first round of coding, second level coding was utilized to not only to elicit more universal or core themes, but also to unveil any emerging themes, not already established in the current body of research. Comparisons made between the established patterns from the literature and the fathers' responses acted as a catalyst in the development of new patterns as there was considerable incongruence between the two.

Another important task involved in analyzing the data which Creswell (1998) proposed is to take note of any discrepancies between the clusters of data. This included apparent contradictions to the patterns which were beginning to form as well as those themes which stand alone.

Ethical Considerations

In accordance with the Social Work Code of Ethics and the University of Manitoba Ethics Protocol, I conducted this research in a manner which respected the individual rights of each participant and resulted in no harm coming to them in the course of my involvement with them. It was imperative that the participants were made well aware of the purposes of the research prior to consenting and that no deception was facilitated by the researcher either intentionally or by some form of negligence on my part.

The principle of consent includes an assumption of voluntary participation. I am not the practitioner and refusal to participate had no bearing on the participants' current or future treatment within the program from which I have drawn upon for recruitment. On that note, Shaw (2003) observed that there are often problems with dual roles of practitioner-researcher and could result in the participant exercising more discretion in self-disclosure in contemplation of how their responses might impact on their treatment or in this case, their child's treatment.

It must also be kept in mind that ethical issues emerged at various stages of the research process and while I endeavored to guarantee informed consent consisting of information of how I intended to utilize the information as well as resolve issues pertaining to privacy and confidentiality, I also engaged in ongoing process of reflection regarding the ethics of my research throughout the interview process. For example, while I had established an interview format consisting of a number of open-ended questions, I did not rule out the possibility that some of these questions could be determined to be offensive to some or that attempting to elicit a response may have come across as coercive and induce some level of discomfort on the part of these individuals. With that in mind, I considered the possibility of modifications in subsequent interviews should I have encountered such difficulties. In the final analysis, there were few modifications in the format.

In conducting ethical research, it was critical to try and avoid treating the participants' personal adversity in dealing with their OCD children as an opportunity for research. Peled and Leichtentritt (2002) suggest assuming a more empowering approach. I share this view that "being a research participant may constitute a meaningful social

role through which a person contributes to the development of new knowledge and may even experience personal learning and growth" (p. 149). Just as other researchers have been critical of the pattern of "mother blaming" in the literature, I am emphatic about avoiding "father blaming" and remained hopeful that in uncovering fathers' impact on their children that I would also elicit many strengths which would lead to positive outcomes. I also wanted the participants to get something out of the interviews as well, perhaps something as simple of feeling "heard" or through the process of self-exploration, they may have gained further insights into how to more effectively manage their child with obsessive-compulsive disorder. I share this premise with Peled and Leichtentrait (2003) who state that "ethical research should drive towards maximizing the *direct* benefits of research participation for participants" (p. 149).

As per the prevention of harm, there are a number of safeguards which I needed to exercise, beginning with the decision about who would participate in this study. While I had to depend on members of the Anxiety Disorders Service for Children and Youth treatment team for recruitment, I needed to advise these participants that they were free to withdraw their participation in the study at any point in the process and they were not obliged to provide an explanation for this decision. Furthermore, in the event that participants reported or presented as uncomfortable or distressed during the course of the interviews, I was able to furnish them with a number of options to put the interview on hold, de-brief about what is occurring for them, or provide them with a list of resources such as counseling should they feel that this would be beneficial.

It was also necessary to take into account the risk for involved others, including their child with OCD as well as other family members. For example, children with OCD

can evoke a number of strong emotions with parents including thoughts about harm to the child. In the event that one of the participants was to disclose thoughts about harm to the child, himself or to others, I would have been legally and ethically obligated to intervene, whether that is to report this information to the child welfare authorities or to recommend and/or advocate for this participant to actively seek therapeutic assistance for this individual in order to reduce the risk. I would not have attempted to directly assume a therapeutic role but simply act as a facilitator of these services as per their request. Fortunately, no extreme measures were warranted as the feedback I received from each participant suggested that no such issues emerged from these interviews.

Another ethical consideration involves dissemination of information as the participants were not provided with access to the research materials following the interview. However, I did prepare a brief written summary of the data and my analysis which was forwarded to each of the participants upon their request. Given that the thesis will eventually be made available as a public record, I will also provide the participants information about how to access this document should they wish to do so in the future. It should also be noted that an honorarium was offered to all of the participants.

Validity and Rigor

According to Creswell (1998), enhancing validity and rigor in qualitative analysis can be attained through a number of methods which include triangulation, peer review or debriefing, conducting member checks, clarifying researcher bias, rich, thick description, and external audits. For the purposes of this study, several of these techniques were employed. For one, in the process of coding the data, two additional coders were utilized

to offer interpretations of the participants' responses. It was imperative that these two (2) coders had no previous direct involvement in the study. For example, it would not have been appropriate to utilize a representative from the Anxiety Disorders Service for Children and Youth for this purpose. I recruited two former graduate students from the University Of Manitoba Faculty Of Social Work, Ms. Diva Faria, M.S.W., Program Specialist with Family Services and Housing and Mr. Ron Oberlin, M.S.W., Policy Analyst with Manitoba Health.

In addition to peer de-briefing or coding, the practice of member checking was utilized. All nine fathers participating in the study were forwarded a written summary of my findings and were asked to provide feedback regarding same to verify the researcher's interpretations and coding of their responses. Their feedback is documented in Chapter 5 (Conclusions and Recommendations).

Chapter 4: Presentation of the Data

Recruitment and Participation in the Research Process:

A total of thirty three letters were sent out from the St. Boniface Hospital's Anxiety Disorders Service for Children and Youth inviting fathers' participation in the study. The letters were posted between March and June of 2009. Ten fathers responded during this period with only one individual electing not to participate, citing a lack of available time as a rationale. The interviews took place between May 18, 2009 and July 22, 2009 with those remaining respondents. Although a $25 Honorarium was offered to all nine participants, two outright refused to accept, asserting that they felt the research was important on its own and expressed that they would have wanted to contribute to the study either way. In fact, the remaining seven participants also expressed some apprehension about the Honorarium but eventually were convinced to accept same. Three participants were interviewed at their residences; one participant was interviewed as his place of business, while the remaining five were interviewed at the researcher's office after hours. All of the participants signed the consent forms prior to the interview and each requested a copy of a summary of the researcher's findings upon completion of the study. The length of time for each interview ranged between 45 minutes and 90 minutes.

Demographics:

The ages of the participants in the study ranged between 30 and 53 with an average age of 43 years. All nine participants are currently employed and are working in a number of fields including the skilled trades, information technology, engineering, civil service, law, human resources, and social service. Two of the nine participants disclosed

experiencing some financial constraints which has affected their ability to access private psychology or other "fee for service" programming for their child on their children's behalf. It is interesting to note, that this factor did not deter them and each had in fact accessed these types of services prior to their child's admission to the St. Boniface Hospital program. The length of time in which these families had been accessing treatment at the St. Boniface Hospital Anxiety Disorders Services for Children and Youth ranged from two months to three years.

Makeup of the Families:

Participant A:	2 parent family, both parents are professionals, mom at home, 7 year old male with OCD, no siblings.
Participant B:	2 parent family, both parents working (professionals), 18 year old male with OCD, 11 year old female sibling.
Participant C:	2 parent family, both parents work (professionals), 16 year old male with OCD, 14 year old female sibling.
Participant D:	2 parent family, bio-mom at home, 18 and 15 year old males with OCD, 21 year old female sibling, bio-mom diagnosed with depression and anxiety disorder.
Participant E:	2 parent family, both parents working (professionals), 17 year old female with OCD, 21 year old male half-sibling and 11 year old male sibling.
Participant F:	2 parent family, both parents working (professionals), 10 year old male with OCD, 13 year old female sibling.
Participant G:	2 parent family, mom at home, dad is professional, 7 year old female with OCD, 9 year old female sibling, mom diagnosed with anxiety disorder and OCD.
Participant H:	2 parent family, mom at home, dad is skilled tradesperson (self-employed), 10 year old male with OCD, 7 years old twins (male and female).
Participant I:	2 parent family, both parents working (professionals), 12 year old son with OCD, 10 year old female sibling.

DATA ANALYSIS

Introduction

The interview schedule was loosely based on the available research into parenting and children with anxiety disorders and obsessive-compulsive disorder. Given these circumstances, it was inevitable that comparisons between these fathers' responses and the current literature on this topic would need to be made. However, what became evident early on in the analysis was that the application of these established themes to the information elicited from these interviews revealed many inconsistencies and contradictions. This was particularly the case with Attachment/Bonding and Parental Control/Protection. The established themes are as follows:

Attachment/Bonding

Upon careful examination of the categories or themes outlined in the literature review, it was felt that the two separate themes of attachment/bonding and parental sensitivity were far too difficult to distinguish from one another and so for this study, they have been combined to form one theme characterized by attachment.

It would appear from the participants' responses that attachment was not compromised in a significant manner notwithstanding the fact that most agree that their son or daughter's obsessive-compulsive disorder had tested their resolve. Some of the fathers spoke of how their attachment to their son or daughter was significantly enhanced by virtue of their ability to identify with their child given their own personal histories. One father remarked, "It is hard to be detached as somehow I feel responsible for it like

he got it from me". Another parent commented "I think my son and I are much closer" as a result of the obsessive-compulsive disorder. He added:

> "I don't think it has affected our relationship especially when it was the ocd and not my son we were battling. We try to forget about words and if there *was* anger, I have attempted to apologize for saying anything which may have hurt him but he hasn't said anything that was still bothering him".

It was observed that the gender of the child did not appear to have any bearing on attachment based on the responses of these nine individuals. It was observed that fathers who acknowledged their own struggle with anxiety or similar psychopathology maintained a particularly strong connection with their child. From their perspective, there is a perception that somehow they had genetically pre-disposed their child to developing obsessive-compulsive disorder. Whether or not these fathers could better identify with their child than the other participants in the study given their own experience of anxiety, none expressed any doubt about the parent-child bond. When questioned about the impact his son's obsessive-compulsive disorder had on the relationship, one father insisted that there had been no negative effect:

> "I don't really think so. I hope it hasn't. To me, it may have but I don't think to him that anything's changed. I feel it. I feel how unfortunate it is for him but you know everyone's got problems. He still comes to me for advice or an opinion. There is nothing that I don't think that I can handle and whatever else there is, I'm just ignoring it as it is blending in with the other ocd behaviors".

Similarly, another father indicated that his two sons' diagnoses with obsessive-compulsive disorder had "no impact". He further stated that "It's not like I want to avoid them or that I'm angry with them for it or I don't like them. I'm comfortable with them no matter what." One of the fathers is actually the adoptive father of an adolescent female with obsessive-compulsive disorder. He came into her life around age 5 and it was his contention that an attachment between he and his adoptive daughter evolved over a period of years. In his opinion, his adoptive daughter's obsessive-compulsive disorder was more incidental and not particularly influential in the bond he eventually forged with her. He shared the following:

> "Initially, she questioned whether I was going to last and be in her life but look what happened in her life with her real dad. I mean, she's always been close with my wife, much closer than me. But again, she had her first 5 years as well. She still shares more with my wife and she'll never share certain things with me, female stuff. She's very sensitive about that and will always go to my wife and that's o.k. She sort of chooses roles for me to help her with and knows that I'm a logical, practical thinker. I've learned that I need to make myself available for the kids to come to me but not to force it, particularly with my daughter."

This same father also speculated that any impasse in the bond he had with his daughter that was even remotely related to her obsessive-compulsive disorder was his own doing:

> "I think I made it difficult to bond for awhile, partly because of me and that I didn't totally understand at the time. I would say that the problem solving part of me and my attempting to narrow down or target the problem and solve it right away wasn't helpful".

Feedback from the other fathers was quite similar:

- "I don't think it (obsessive-compulsive disorder) has driven a wedge between us at all. The father-son or father-child relationship is solid, yet there will always be things about one that bugs the other and vice-versa. We have a close relationship and hopefully always will. I am not angry or resentful towards him for what he has gone through and what he has perhaps subjected others to. But no, to answer your question about our relationship being affected, I think not."
- "I don't think that there's anything permanently wrong with our relationship. We are very loving and affectionate people. She (the daughter) will come over and lay on my lap and in no way has the battle over her ocd affected how we feel about each other."

This perception of how the obsessive-compulsive disorder tended to draw parent and child together rather than pull them apart presents as the rule and not the exception amongst these nine individuals. Yet another example comes from a father of a 10 year old male whose obsessive-compulsive disorder centered on fears of contamination: "I am

there for any of my kids but with him and what's happened over the past 4 months, he had needed me and his mother more than ever." Certainly, there were fathers who acknowledged that obsessive-compulsive disorder presented a challenge to the foundation of the parent-child bond:

- "There's nothing about his convictions, his obsessions that enhance our relationship, if that's what you mean. But, I don't feel that he's damaged and therefore I don't feel that I should ever stop trying to reach him. He's also a bit of a different kid as well and I see a lot of similarities between myself and him when I was a kid".
- I don't see him as damaged at all. I don't believe that I have ever given him any reason to believe that I thought less of him or that I wished that he could different. I don't think we've lost anything due to his ocd. I think he and I are pretty close, I would say".

Parental Control/Protection

As indicated from the review of the current literature, there appears to be a correlation between parental over-control, both psychologically and behaviorally, and anxiety disorders, specifically obsessive-compulsive disorder in children. For example, it has been observed by researchers such as Bogels and Brechman-Toussaint (2006), Rapee (1997), Ginsburg and Schlossberg (2002), and Ballash, Leyfer, Buckley and Woodruff (2006) that a pattern of parental over-control of children's activities and routines as well as over-vigilance in other areas such as the problem solving process has the potential to stifle children's autonomy and induce a sense that the outside world is a threatening place

which is beyond their control. The tendency by some parents to interfere with the child's efforts to individuate compromises and even prevents the child from developing a mastery of their immediate environment. Obsessive-compulsive traits emerge as a means of over-compensating for these perceived environmental threats or simply act to "protect" the child from this hostile world.

The responses of the nine fathers in this study would suggest that their attempts at control or over-control were, for the most part, in response to actions by their children, and not necessarily a parenting strategy intended to protect or prevent their children from navigating the world around them. In general, none of the fathers considered their parenting approach as controlling or over-zealous except under extreme circumstances and that these tended to be more isolated incidents than everyday occurrences. Furthermore, it was disclosed by several of the fathers that they recognized when they were being controlling with their child with obsessive-compulsive disorder.

One father, whose child had also been diagnosed with Asperger's Disorder confided that the approach he has to take as a parent of an autistic child is in some ways, contrary to the literature in addressing obsessive-compulsive disorder: "It is interesting that with ocd, you try to teach him that it's o.k. to change whereas with Asperger's, you have to maintain these strict routines or rituals or he can't function".

This same father further disclosed that his child's idiosyncratic behavior, which, depending on the circumstances, could be interpreted as either related to his Asperger's or obsessive-compulsive disorder, inevitably compels him to over-control:

> "If he goes to the playground…which is not too frequent, I'll see him interacting with another kid and yet I know he sucks at it so I'll say "Oh

> ‘child’s name’, don’t do that!” yet if I’m with another parent, they’ll say, “Oh, they’re just being kids”. I know that’s ocd itself and yet I’m guilty of it but I just want my kid to succeed so I’m a bit controlling. Sometimes, I don’t know where to draw the line.”

Another parent indicated that prior to developing an understanding into obsessive-compulsive disorder; he leaned heavily on parenting that was quite controlling in nature:

> “I am more of a disciplinarian-type of parent while my wife is more laid back. So, sometimes, I have over-compensated for her style of parenting. She would let it go. This would make me really mad and really stressed out and I would take it out on the kids. Part of the problem too was that she was not willing to help out around the house for whatever reason so when her ocd behaviors (checking rituals) were also interfering with her getting things done, the approach I used was to treat it all as bad behavior. I tried that approach initially but it backfired. Eventually, I learned to ignore her looking and she would check just once and be fine.”

Parental Psychopathology

It was revealed from these interviews that while not all fathers possessed emotional or mental health struggles which would be considered pathologic or diagnostic, each acknowledged that there were aspects of their own personality which may have affected or continues to affect their son or daughter. All of the participants indicated that they also shared common personality characteristics as their children upon reflection on their respective childhoods. Some examples of this self-reflection are the following:

- "I had a lot of social problems growing up and a lot of worries but it went undiagnosed. I had a lot of anxiety and had a lot of nightmarish years during junior high and high school so that is the kind of thing that I was trying to keep him from."
- "I remember when I was quite young that I went through a phase in which I was quite scared that I'd told a lie. I would be uncertain about any response I gave for fear that it wasn't the truth. I used to think that something bad would happen to me if I lied."

Seven of the nine fathers reported that they were probably more "sensitive" or as two put it, "thin skinned" than their peers during childhood and adolescence. When asked, six of the nine indicated that they still felt that some of these fears and inadequacies continued to linger and conceded that it may affect their child's obsessive-compulsive disorder. One father made the following observation:

> "He definitely feeds on my anxieties. When I'm anxious about something, I have a shorter tempter I'm a lot less tolerant and I know he feeds off that. He becomes even more anxious". Another father shared "I possessed a rather fertile imagination, similar to my son and this didn't help in allaying my fears as a child. I'm always wondering if this is something I handed down".

The responses suggest to this writer that not only do the parents' own psychopathology or perceived psychopathology present as influential with their children with obsessive-compulsive disorder but when it is accompanied by a sense of identification or common ground with their son or daughter, a number of the fathers

noted that this factor has fostered a better sense of understanding and/or empathy for what their child was going through. At the same time, this empathy did not translate into parenting behaviors that interfered with the children's course of treatment. In fact, all nine fathers spoke of efforts on their behalf to challenge their child's irrational thoughts and further, prevent them from engaging in patterns of avoidant or compulsive behaviors which might perpetuate the child's obsessions. Examples of these approaches are outlined within Parenting Techniques.

While researchers such as Phares (1993) emphasized that by and large, "children of clinically referred or diagnosed fathers are at increased risk for a variety of types of psychopathology compared to children whose fathers have not been referred or diagnosed" (p.163), this sampling of fathers, a number of whom have been diagnosed, appear to be using their own psychopathology to their advantage. More importantly, their understanding of the impact of their own psychopathology and its potential impact on their children is being carefully tracked by these individuals in what could best be described as harm reduction.

While paternal characteristics and externalizing and internalizing child problems can be correlated, the connection must factor in the fathers' insight into their own psychopathology and the efforts they have made to limit its influence on their children. The current literature has tended to steer clear of this variable and focus most of its attention on the correlation between fathers' mental health status and their children's psychopathology.

Parent-Child Interaction

While all of the fathers indicated that they played an active role in interventions with their children, it was further observed that each presented with a good understanding of the most commonly utilized cognitive-behavioral therapy techniques for obsessive-compulsive disorder. Cognitive-Behavioral Therapy (CBT) is a well-validated psychotherapeutic technique, developed from experimental psychology principles as well as several clinical trials in adults and more recently in children and adolescents and it has established itself as an effective tool in the treatment of pediatric obsessive-compulsive disorders (OCD) which will be expanded upon in the course of this paper.

Cognitive-Behavioral Therapy teaches children cognitive strategies to challenge and detach themselves from obsessions and the propensity to engage in compulsive behavior. Although there are a number of other CBT techniques, Exposure/Response Prevention is considered the most effective approach in treating OCD. Essentially, the client is exposed to stimuli that trigger the obsessions or compulsions while resisting the urges to escape from or neutralize their anxiety by engaging in the compulsive behaviors (Bolton & Perrin, 2007). In other words, it follows the classic conditioning model in which the child approaches the anxiety-provoking situation in order to unlearn the fear response, thereby reducing anxiety. It is generally recommended that exposure be a graduated process beginning with situations which produce a minimal amount of anxiety so as to facilitate success early on in treatment (Morris & March, 2004).

According to March and Mulle (1998), exposure requires the child to confront triggers for their OCD such as touching a “contaminated” door knob and response prevention takes place when the child resists the temptation to perform the usual anxiety-

relieving compulsion such as washing hands or using a tissue or their sleeve to grasp a knob. The extinction process can also be expedited when parents also ignore the child's compulsive seeking of reassurance, refusal and/or avoidance of an activity which is anxiety inducing. The following are some examples of cognitive-behavioral therapy techniques which were initiated by the fathers:

- "At the beginning of the week, we would identify something bad which he thought might happen if he didn't do the ritual. We would get him not to do the ritual and check at the end of the week that when he didn't do it, nothing bad ever happened. That was the beginning of a big change for him. He is very clever and the exposure work made sense to him."
- "Well, currently the strategy we are using is not to give into it, not to allow it. We have really improved lately and particularly since Christmas and his second semester had began. We sort of push back and try to take his work away from him as he tries to do his work over and over again. His compulsivity is to copy and re-copy his work as he is never satisfied. We would actually ration the paper we give him. It sounds partly mean by the way we approach it and he gets quite upset with us. It's quite cyclic whereby he does go through periods where we don't have to step in."
- "I tend to question them what they're doing and sort of get them to pull themselves out of the pattern and get them to level off."
- "What I try to do is to get him to look at his belongings and have him determine whether he will actually use these things and whether they truly have a practical purpose. I also try to offer him two or three options such

as taking them to a thrift store so he will realize they go to good use. The fact that he won't see these things again is for him at the immediate time, a fear."

- "I would try to talk to him in a way where he still felt good about himself even though we were dealing with troubling behavior."
- "We try to use reasoning. We tell her "that is what your ocd wants you to do".
- "I limit the number of choices she is given so that if she does get stuck, there are fewer options for her to obsess over. I've managed to develop some techniques that are partly intended as distractions such as making a game out of a task such as getting up in the morning (at which time she begins to obsess over the bad things that might happen that day) so that she is less likely to think about why she doesn't want to do a particular activity. I make it fun but some days it works and some days, it doesn't."
- "What might happen is that perhaps I would indulge his behavior temporarily but then turn to problem solving it. Most of these things we just fell into, such as using a shopping cart to walk down the aisle (the child possessed irrational fears about walking down store aisles where other people had walked before him but using a shopping cart for protection, the child gradually became more comfortable walking around the store. Eventually, he no longer felt compelled to use the shopping cart as nothing bad ever happened when he walked down aisles) and this was

before he entered into this treatment. I can't honestly remember exactly how we began, perhaps serendipity, I don't know."

It has also been found to be quite useful for children to "externalize" OCD so that they develop a sense they can influence or even master something outside of themselves. Externalizing also prevents them from over-pathologizing their difficulties. Chansky (2000) described this process as "bossing back" obsessive-compulsive disorder and is considered the foundation of cognitive-behavioral therapy with younger children. Chansky reported that using the "brain trick" label helps children separate themselves from the problem and fight back. She adds, "the more they re-label OCD as a bossy brain bug giving them extra jobs for no reason, the faster the brain will learn to get unstuck and children will be back on track thinking and doing what they want" (p.57). Externalizing is also a core technique utilized in narrative therapy.

All of the fathers with younger children utilized this "bossing back" technique and each has found it effective. Some examples provide by the participants include the following:

- "We use this method where we try to externalize the problem. It's something we call "stupid head". You know, what is "stupid head" making you do or how is "stupid head" trying to control you? He knows he can talk to "stupid head" in order to get him to re-gain control. Both of us (parents) are on this program and on the same wave length.
- "We'll tell her that her ocd is telling her to go back to bed but you shouldn't let it push you around. She will say, I'd like to fight it but I can't do that today."

One of the fathers of a younger child related that he experienced a "breakthrough" with his son recently following an outburst related to the child's obsessive-compulsive disorder. He described the following exchange between father and son:

- "Is it you or is it the ocd that's making you act this way? He sat back and said it *was* the ocd and at this point on, be began to see himself separately from the ocd. Even better, he apologized to everyone for his behavior."
- "We also started helping our son separate himself from the ocd by giving it a name, "Old Cranky Bully". My son is a very shy guy and yet once he could start telling it (the ocd) where to go, the more successful he will be and overcoming the struggle."

Paternal versus Maternal Role

As has been stated throughout this study, in order to provide meaningful and accurate information regarding child development, research must become broader to allow for the quiet revolution involving the diversity in the roles of fathers and the changing conceptualization of the family. In 2002, Vanier Institute of the Family jointly funded a study, "Contemporary Family Trends – Portraits of Fathers" along with the University of Quebec at Hull in which the diverse and ever expanding role of fathers was examined. The lead researcher, Dr. Diane Dubeau observed that "for many years, men were providers and as such, had to spend most of their time outside of the family home in order to provide the family with a certain economic security. Now the pendulum has swung in the other direction, and men are no longer mere providers but are now affectionate and caring fathers, directly and emotionally involved in raising, caring for

and interacting with their children" (p.8). She goes on to state that "the greater number of women in the job market, the higher divorce rate and a less traditional division of roles and responsibilities for mothers and fathers are all factors that explain why fathers now play a more active role". (p.8). One particularly salient factor that this researcher points out is the simple fact that men want to be closer to their children.

There is increasing evidence that fathers are just as sensitive as mothers to different signals emitted by the child yet when observing parental behaviors on an everyday basis, researchers have noted that similar competencies do not necessarily translate into an equitable sharing of familial and educational tasks since mothers take on the primary role in raising children (Cote & Chamberland, 1991). However, notwithstanding perhaps the quantitative differences (the frequency of the parents' interaction with the child); there are greater similarities than differences between parental behaviors coinciding with the increased participation of fathers in parenting their children, according to Dr. Dubeau (2002).

For example, all of the participants in this study viewed their role in the life of their child with obsessive-compulsive disorder as "active" and in some cases on an equal basis to the mothers. Furthermore, there was a consensus amongst these fathers that the challenge presented by the child with obsessive-compulsive disorder and the "fall out" with other members of the household, is a task that is to be shared between both parents. It is interesting to note that all tended to defer to the mother for a final decision in cases in which there was some dispute over handling the child's obsessive-compulsive disorder. When asked about the extent of his role with his child with obsessive-compulsive disorder on a day to day basis, one father commented:

> "A lot. My wife and I have always shared the parenting. I drive them to most of their activities. Three days out of the week, I pick them up from school. As for his appointments for the counselor, she does more. I did go the first time but after that, my wife took over. I also ask him what happened at counseling each time he goes to keep apprised of what he's learning."

Another father's response to this question was quite similar. He described the extent of his role as a parent as follows:

> "I did a lot. I changed diapers and I was up for feedings. And, when my wife and I first got together, we shared duties equally. Whoever got home from work first would be responsible for getting dinner ready. Whoever got up from dinner first would do the dishes. It was 50/50 all the way. When our oldest was born, my wife didn't go back to work so she assumed more household duties but I have continued to try and do my part."

Similarly, another father stated:

> "I've always been a very active dad with not just him (the child with obsessive-compulsive disorder) but all of my kids. That has always been a priority for me; to one day have a family and operate my own business. And, the only reason why I own a business is so that I can spend more time with my family as I'm in charge. My work takes time away form them but the important things such as doctor's appointments are things that I will not miss. I would say that my wife and I are pretty equal in

terms of parenting. During the past few months, I began working about a half-hour later so that I could make sure I got my son and the other kids off to school. I would get up around 5 o'clock in the morning just so that I could get my son up by a quarter to 6 as this is what it would take to get him to school by 8:30 given his various rituals around clothing and washing. That was the least I could do given the stressful position my wife has been in for the other part of the time when I'm at work."

Two of the fathers spoke at some length about the synthesis between themselves and the mothers and a degree of insight in recognizing when it was most prudent to step in and assume a larger role or when to back off. The two commented:

- "No, I'm not a stereotypical guy who won't ask for directions. If I know that there is somebody better at something, then I will go to them for guidance. Like I said earlier, my wife is taking a leading role on this and I look for her for some direction".
- "I think I felt sympathetic, too soft and I know that my wife and I would have these discussions and she would remind me that I had to be firm with him (child with obsessive-compulsive disorder). I realize that we are not doing him any favors by giving in. I've never had to re-direct my wife as I think that we're more or less on the same page regarding his ocd; maybe not with certain other things but certainly on the same page with the ocd".

To get a sense of the degree to which these fathers will go to challenge their children's obsessive-compulsive disorder, there are some particularly remarkable examples of persistence on the part of these individuals. One father, whose son possessed

debilitating contamination obsessions, put a plan together to help the child overcome his fears by having him go to a movie at a local shopping mall. The father used a strong incentive based approach as his son really wanted to see a particular movie which was popular amongst his peers. According to this individual, the events unfolded in the following manner:

> "We tried one day, but he couldn't do it so we took his younger brother. But, he still desperately wants to see it. So, I get him in the truck on Tuesday and we arrive at the mall. He's all 'gung ho' and we get into the mall which was phenomenal. He makes it into the mall after barely being able to leave his bedroom for the past few weeks. Amazing! We get into the theatre and it's packed. He makes a '180' turn and walks out. I tell him we can go every night until you can get comfortable and physically get in to see that movie…whatever it takes. I think those are things my wife will do as well. We'll do anything to gradually get him to overcome these fears. That is something we have tried to do since day one. We were not about to allow for him to avoid opportunities when they come along even though we recognized over the past few months just how painful it has been for him. At times, the only way to get him out of a vehicle or out of the house is to physically remove him, which is not how we want to do things in the long run. Fortunately for now, he's only 55 pounds. He's not a big kid so it doesn't take much effort to move him. It can be hard in other ways as he will verbally abuse me and my wife. You know, 'I hate you' and that sort of thing."

Another father's parenting style appears to have been derived more from a cognitive-behavior therapy perspective in which he appealed more to his child's intellect. This individual emphasized that:

> "We're not really rewards based parents. I'm more of…you'll probably hear me say quite often, "Do you have any better decisions?" which I recognize is not necessarily the best way to go. When it comes to specifics of this sort of behavior, the ocd behavior, my initial thought and response is "If you tell me more about this, then maybe I can help you but if you're going to tell me that it's just hard, I can't really help because I don't understand what you're going through". It kind of becomes self-fulfilling and yeah, I probably won't be able to help you. I accept that it is difficult but at the end of the day, what is it that you would like me to do to help you? If you just want me to accept or simply acknowledge you're experiencing or feeling these things, that's o.k. I can do that. If you want more acknowledgement, you're going to have to give me more than that. I suppose that my approach for this last while sounds sort of self-serving, it probably is. However, before that, I was probably more dismissive."

Summary of Established Themes

There were a number of contradictions in the data collected from these fathers and the themes derived from the current literature. For example, in the case of Attachment Bonding, the fathers reported feeling closer to their child and in some instances, reported a sense of identification with what their child was enduring as a result of their own

histories. Furthermore, in the case of Parental Control/Protection, fathers did not view their parenting styles being over-controlling or manipulative and that it was only under certain circumstances in which they felt compelled to exert an excess in control. However, even then, these individuals indicated an awareness of when they were being over-zealous with their son or daughter. Parental Psychopathology appears to follow a similar path as attachment and bonding. That is, those fathers who reported a history of mental health issues indicated that it actually elicited from them a greater sensitivity to their child's struggle.

It was quite evident that under the theme of Parent-Child Interaction that these nine individuals assumed a significant role in their son and daughter's treatment and based on the language or terminology they used, it would also appear that they have spent a considerable amount of time studying the subject and effective treatment of same. As for the Paternal versus Maternal Role, the fathers' reported efforts would strongly suggest that there has emerged a healthy "blurring" of roles in these families whereby traditional male or female roles are no longer predetermined by gender.

Emerging Themes

Introduction

It was deemed necessary to uncover themes beyond the available literature following this initial coding, particularly given this researcher's contention that these themes do not provide a completely accurate or comprehensive portrayal of this sampling of fathers. On one level, this is actually quite encouraging as it might suggest that there are distinctions between fathers and mothers in the manner in which they interpret and manage their children with obsessive-compulsive disorder. The following six themes are intended to reflect these perceived differences between parents:

Fear and Despair

This presented as a recurring theme for most of the fathers, particularly when it came to contemplating their son or daughter's future. Part of the fear for some fathers was exacerbated by their struggle to access services for their children and the fact that even after participating in treatment, the obsessions and compulsions have persisted. This was by and large those fathers with children who had been in treatment for less than 6 months. Four of the nine fathers interviewed spoke of despair brought about by the lack of available information on resources for children and obsessive-compulsive disorder and that each of these individuals went through periods in which they were dealing with their family physician exclusively or pursuing services within the private sector.

Two of these individuals also appear to have been given misinformation about medications used to treat obsessive-compulsive disorder which, in retrospect, they conceded that they could have been more pro-active about accessing more fact-based

information rather than heed the warnings and cautionary tales of various well meaning friends and relatives. One father shared with this writer, his sense of hopelessness in his family's quest to access services for their adolescent son with obsessive-compulsive disorder:

> "We could do nothing. We couldn't take any steps to change his situation. My wife and I were willing to do anything. We even called the Mayo Clinic in the States and we told them we wanted to arrange or schedule an appointment. They told us send them a family record from his (my son) physician about his condition and they might see him for $10,000. We did not have any help to guide us in the bigger community. Nobody knew what to do. In the meantime, it was like looking after a much younger child but we know that it has to do with his ocd. And, with all of the shouting, again it was a feeling that we were helpless. Then I would think to myself, nobody cares about us and furthermore, nobody wants to help us."

While it was conceded by this father that they are fairly recent immigrants to Canada, he added that both he and his wife are professionals and generally quite resourceful. Yet, prior to accessing the Anxiety Disorders Service at St. Boniface Hospital, they began to fear that only a life threatening crisis for their son could have compelled their physician and other professionals to act.

On that same continuum, one of the other fathers, in light of his ongoing frustration with the system, shared with the researcher that it was actually suggested to

him by a friend to simply escort his son to the Children's Emergency at the Health Sciences Centre in order to force the system to act:

> "We didn't know what to do. We didn't know what was going on. These psychologists told our friend who told us to get him to the Emergency Room. They told us that the doctors are probably going to tell you that it's an "age" thing and get over it but don't leave until you talk to a psychiatrist. That would have been mid-April and we waited at Children's Hospital for 6 1/2 hours. A general doctor came and spoke to us and to Drew and right away got a psychiatrist to see him. After only 10 minutes, he confirmed that he had severe obsessive-compulsive disorder. So, we have an answer to what's going on. That got the ball rolling!"

However, the real fear for these nine individuals had to do with contemplating what the future would hold for their child with obsessive-compulsive disorder. One father made the following observation:

> "As he gets older, I get worried. I get more and more worried what will become of him. How will he cope in the future? I see him as vulnerable, absolutely and right now he is getting a lot of attention. I start to think about what happens after high school. Right now, he is getting lots of support from different people but that will end. I don't know what will happen when becomes an adult and we become less available."

Similarly, another father spoke of his fears stemming from an incident he had with his son in a movie theatre. At the time, the child, a compulsive hoarder, was

crawling around on all fours by his seat attempting to pick up food that had fallen onto the floor of the theatre:

> "I think this was a time when I was pretty disturbed by it (obsessive-compulsive disorder) and worried what the future might hold for him as I am watching him crawling around on the floor of the movie theatre. It was not like I was aware of the people around us or that he was making a scene and I was embarrassed. I was focused on him and how I could help him. In general, I would say that I'm happy with him. But, when I see this kind of behavior and obsessing, I worry about how much that will translate into the future. I feel so sad when I see his loss of control. I can see at times that he is reaching out, almost asking for help when he displays this sort of helplessness…powerlessness over these things. I am not sure what it means for people who have ocd and when it has been identified at his age. I've seen extreme examples of ocd and sometimes I think. Man, I hope it doesn't get that bad for him."

All of the fathers, notwithstanding their fears, spoke of their children's strengths of character and resilience which helped but did not completely alleviate these fears about the future. For example, when one father was asked about what the future might hold for his daughter, he responded:

> "There are times when I worry about that. I don't know if I see it so much as a character flaw. I worry more that this is going to shut a million doors for her in the future and that really saddens me that she'll never allow herself to do anything in life because this constant worrying and

> obsessing. That worries me! I don't want her to cheat herself out of her many gifts because of her ocd. I want so much to foster that as that's something she can be proud of. Yet, she keeps telling herself that she can't do things and she will stop trying. This is what worries me that she doesn't recognize her gifts or that her ocd won't allow it."

This argument about strength of character overcoming or over-riding the obsessive-compulsive disorder was shared by most of the fathers. One father was particularly philosophical in examining the conflict:

> "I think I'm more upset. No, that's not the right word. I'm more concerned and maudlin when I think about it now than I may have been in the past. I think I'm a little more…yeah, I think I am a little more concerned about to what extreme this could go. What if it manifests itself as much more anti-social? I mean, his behavior now is well within a reasonable level and his strengths are considerable, and are more than offsetting his ocd. I mean, he is the top student, literally, and very interested in things and a real joy to be around. And, I guess my thoughts are about projecting into the future and what if these so-called "voices" were to step in and take over? I've known very wonderful people over the years, whom, through no fault of their own, experience very unpleasant outcomes in their lives. So, I think I'm more conscious of that. It's more bothersome now than it was some time ago when this thing was just surfacing."

Another father attempted to put obsessive-compulsive disorder in terms that made sense for him: “It’s much easier for me to see it as “a glitch” so I try to liken it to being born with a peanut allergy or physical ailment.”

Normalizing

One challenge which all of the fathers reported experiencing was discriminating between what is “normal” childhood or adolescent behavior and obsessive-compulsive disorder. Most agreed that there was an inherent danger in “pathologizing” all of their child’s idiosyncrasies as this can have a profound impact on their parenting but also on their child’s psyche. Ironically, five of these fathers speculated on how their initial inclination to dismiss the early signs of obsessions and compulsions in their children resulted in more deeply entrenched rituals and fears that may not have reached such a chronic level had they intervened earlier. Another aspect to the normalizing is that most of the fathers provided examples of obsessions and compulsion which their son or daughter had been displaying that were quite innocuous. As such, the fathers shared that under these circumstances, they elected not to intervene with the child in any manner to eliminate this particular ritual or avoidant behavior. One father stated:

> “If he goes to a playground…which is not too frequent, I see him interacting with another kid and yet I know he sucks at it so I’ll say, “Don’t do that” yet if I’m with another parent, they’ll say, “oh they’re just being kids”. I know that’s ocd itself and I’m guilty of it but I just want my kid to succeed so I’m a bit controlling. I don’t know. Maybe I need to

> have another kid to see if this one is weird or not because I don't know who to compare him to."

Another father confided:

> "What I am feeling now is that I can't differentiate between a typical 16 year old boy and his obsessions and compulsions as, at this age, he would probably have some uncertainties or some lack of confidence in his work. 16 year old boys have their own set of characteristics. It makes it easier to think of things that way because then I feel less sorry for him or sympathetic as I see him struggle."

This same father also attempted to put his son's struggles in further perspective in making the following observations:

> "I try to talk to him about looking around you and recognize that you're not so different from anyone else. There are times when he feels so disadvantaged in comparison to others, especially last semester when he was doing homework 3 to 4 hours a night. You know, "I don't have a life" or "All I ever do is work" and so on. I feel how unfortunate it is for him, but you know, "everyone's got problems", some greater that what you have!"

In response to his two children, both of whom have been diagnosed with obsessive-compulsive disorder, one father stated that their irrational thinking and ritualistic behavior didn't arouse any sense of alarm. In fact, he shared the following:

> "You know, that didn't bother me. That's the weird thing. It doesn't bother me. You don't see it for one thing, as I may have gotten used to it

> but even if I did notice, it doesn't affect me. They're my kids and I love them. Anger or frustration doesn't come to mind."

One of the fathers, whose son struggled with hoarding, initially attributed the pattern to his son's personality. According to this father:

> "I mean, he's a sensitive guy and he easily becomes attached to things which have some sort of sentimental value to him. At first, I viewed the behavior as that was just the way he was and initially didn't see it as dysfunctional. I guess this notion of wanting to see things again. I guess his sentimental side has laid the groundwork for some of his ocd characteristics."

Six of the nine fathers interviewed also speculated that there was a degree of manipulation on their son or daughter's part whereby they discovered that they could use the diagnosis to their advantage under certain circumstances. One observed of his daughter:

> "Kids are smart. If we're not careful, she can use these excuses in order to manipulate us as parents to their advantage. I'd like to believe that my wife and I are on the same page but I am concerned that my daughter recognizes that if she kicks up enough fuss, we'll stop whatever we're doing and do things for her, a sort of attention-seeking ploy. I don't want to become so cynical to always suspect that she's conning me. I don't know where the line is and this is a dangerous thing for us."

Another father's experience was quite similar although his daughter was much older than the previous father. He noted the following:

> "What I have done is suggest to her that she makes too much out of situations and that at times I think that she was making up ocd stuff to avoid things so there was an element of manipulation in my mind with her. She seems to have stopped doing that as it may have worked about two years ago or so. Maybe, we called her enough on that she stopped."

Along the same continuum in distinguishing between the child's obsessive-compulsive disorder and manipulative behavior, one father indicated:

> "There is also the manipulation piece as he will convince himself at home that he can't do anything to change things and yet when he goes to see the therapist, Doris, he says that everything is fine which is not what he's telling us. You don't want to tell him that what he is experiencing isn't real but you can't help but question once in awhile that he is using it to get out of doing something he doesn't want to do. Interestingly, I hesitate to say this but there is comfort in believing that at least some of this is in fact a manipulation. If he isn't, well then, I'll have to deal with it as it comes."

One of the fathers berated himself for not picking up on the problem earlier although he conceded that in the beginning, he assumed that his son's irrational fears around germs and contamination were being fueled more by the media attention given to the H1N1 virus during this past year. In addition to what he saw on television, his school had also developed programming to educate the students about proper health care such as hand washing. Combined with his son's naivety and sensitivity to stress, this father characterized the pre-conditions to the development of his son's obsessive-compulsive

disorder as "the perfect storm" and that his deterioration was fairly rapid. According to this father:

> "Yeah, what he did when this first started, he wouldn't go near his brother. He was all grossed out by him. He is hitting early puberty so we figured that maybe part of it was a hormonal thing. We treated it as normally as possible. We treated it as a 'kid thing". We told him that "there is nothing wrong with your brother. Suck it up. Go play with him!" He would but he wouldn't touch him. We noticed this building where he would slowly move further and further away from his younger brother when they played. That's how we dealt with it for the first while. Sort of monitoring the situation but not getting too worked up about it and turning it into something it wasn't."

However, even after the diagnosis of obsessive-compulsive disorder was established for his son, this father indicated that he and his wife were emphatic about not allowing it to "define" him. He related that "We show compassion for him. We tell him that we know that he's going through a hard time but he is not to take his frustration over his ocd out on other family members. That is something we have tried to do from day one. We were also not about to allow for him to avoid opportunities when they came along even though we recognized over the past few months just how painful it has been for him."

One father was particularly concerned about the potential stigma attached to his son's diagnosis and in fact, he spoke quite eloquently about the perils of labeling children, particularly young children which he contended is done far too frequently

within schools and the child and adolescent mental health system. Even with their son's diagnosis, this father advised of the following:

> "It is up to us to do our best to really understand and ensure him as parents that there be no stigma attached to it and that it's just who he is. To the extent of which he can tell us what he is feeling and what he needs, we will do our part to try and overcome any barriers."

As for labeling in more general terms, he offered the following:

> "So, any behaviors he shows at school, no matter how common, are then seen in the context of this diagnosis. I would not take kindly to getting a call and being told that my son is going to be given Ritalin because it would be more convenient for the people around him. While I can't speak for my wife, I think for myself that going to see a professional and being in such a hurry to put a label on people is a dangerous thing, potentially. For example, I don't think that half of the kids in schools nowadays with ADHD actually have ADHD. In my opinion, it's a coping mechanism and it's not for the kids. I think that in life, you have to "fall off your bike" a few times before you learn that what you're doing are bad things to do. I do worry about him starting school and that the opinions of the school are coloured so early by labels like this because it can become a self-fulfilling prophecy. What I mean is that teachers and other school personnel may begin responding to him in a particular way early on knowing that he has obsessive-compulsive disorder or ADHD or pick any 3 letters at random!

> So, any behaviors he shows at school, no matter how common, are then seen in the context of this diagnosis."

When asked about how labeling specifically applied to his own son, this father replied:

> "Fortunately, our son, from what we hear from his teachers, is not disruptive and is actually seen as a very nice young man. He's won a couple of citizenship awards in light of his positive attitude and behavior. So, my concerns with the label and this is for any child, is to be placed into this box and treated differently than his or her peers by his teachers and the impact that this has on the child emotionally. But also, not to put too fine a point on this issue, we're getting to the point where the effects are further reaching where these individuals will have trouble getting insurance and as in the movie, "Gattaca", the legitimacy of future aspirations are denied by what happens so early in people's lives. I don't have to tell you that the whole spectrum of mental health, particularly when you are dealing with children, needs to exercise far greater discretion and sensitivity so that these kinds of things don't occur."

Influence/Impact of Faith/Spirituality

While this was not an area I had considered collecting information on as part of the interview format, I feel that it is important to note that faith or spirituality was brought up by four of the nine participants as relevant and that it did in fact impact on their son or daughter. Two of these individuals shared that their faith was strongly tested in their quest to help their child while another two spoke of how they turned to their

church or community for guidance in dealing with the challenges facing the family in light of the child's diagnosis. In retrospect, I would say that if given the chance to re-interview these 9 fathers, it appears that much richer data could have been collected in this particular topic area. In fact, it was not until I began reviewing the data that this theme really began to emerge. On the topic of faith and its impact on parenting, one father related:

> "I would say that our involvement with our church has definitely improved our ability in handling stress. We are very strong spiritually. My daughter sees that and while she, herself doesn't go out of her way to go to church right now, I can see that she finds strength and comfort in the fact that we go and that we are spiritual people. She does pray a lot but she is not comfortable with the surroundings of the church."

Another father spoke of how his faith or religion taught him and his son about the value in relationships and how to derive "strength" from fellowship and friendships "in both good and bad times. This father confided that their faith helped them overcome the disappointment they experienced with members of their community and the medical profession when they reached out for help. One father shared that he was able to utilize the concept of faith and spirituality to comfort his son even though he did not consider himself or his wife particular pious:

> "We're not a religious family but there are times he will turn to me and my wife and ask, "Why has God done this to me?". We tell him that God must know that you're a strong and brave person and he knows you're strong enough to beat it or else he wouldn't test you like this. You'll find

> out one day and it will be a benefit to you. We find that this kind of reassurance helps. We also continually tell him that one day he will do something really special with his life as we can see it in him. He is very much concerned about the well being of other people and coming into contact with the ocd might one day result in him actually helping other kids conquer this problem."

Impact on Other Family Members

The parents' response to their children's anxiety and obsessive-compulsive behaviors can play a significant role in reduction or elimination of the problem or conversely, help to perpetuate the maintenance of the problem. The greater the involvement of the family in the child's rituals was significantly related to distress in family members. To reiterate the work of Wand, Furer, and Shady (1993), Stengler-Wenzke (2006) emphasized that individuals with obsessive-compulsive disorder, inadvertently exploiting family members love and concern for them, compel these other individuals to participate in their rituals to such a degree that they provoke intense disagreement among family members concerning responses to their symptoms. Research has shown that many families become dysfunctional as a result of a family member's obsessive-compulsive disorder symptoms. According to Alonso et al (2004), this sort of indulgence creates a power differential of the child over other family members and can be extremely disruptive to individual members emotionally and to family dynamics as a whole.

Each of the participants in this study presented with considerable insight into the impact their son or daughter's obsessive-compulsive disorder had on other family members but also an acknowledgement of how their responses to their child affected other family members. One father described in considerable detail the profound impact his son's obsessive-compulsive disorder had on his sister:

> "I just want to mention that in terms of impact, his sister has been affected and she has felt the pain of his ocd. The amount of attention that we pay him does affect and she feels it. She feels sometimes that she's getting shortchanged in terms of attention and she blames ocd on a lot of the conflict which does occur in the house as in any family. She sees everyone screaming and probably perceives stress levels as being higher than we think as my son is struggling with his homework. Sometimes, she lashes out not just at him but us by saying mean things. She can be resentful of him because of his ocd and like the mean kid in the school yard, she will pick on that vulnerable side. Interestingly, I think that sometimes, she does get special consideration as a way of compensating for her stress that has been brought on by my son's ocd. But, we try to be consistent with both kids and not treat one differently than the other. We explain to her that if she had this problem that we'd be dealing with her and helping her, just as we do with her brother. So, we try not to over-compensate in light of her perception that things are unfair at home. She gets her share of attention."

Another father had a very similar experience with his daughter in her struggles dealing with her two brothers, both of whom were diagnosed with obsessive-compulsive

disorder. According to this father, his daughter experienced chronic "bitterness and resentment" and described the following scenario:

> "When she has friends over and their ocd issues come up, there's embarrassment. I don't think that she would be embarrassed otherwise. She may worry when she is with her friends that they (her brothers) will do something". This father was nevertheless impressed that his daughter did not allow her brothers' difficulties to "control her life: "At least she doesn't avoid having people over so it's not that bad."

One father disclosed that he has struggled with a considerable amount of guilt over the impact his youngest daughter's obsessive-compulsive disorder had on her older sister and furthermore, expressed fears about becoming disconnected with her due to the efforts he and his wife have had to put in with their younger child:

> "I'm also worried about how this affected my older daughter. She tends to spend a lot more time in her room and will more often than not prefer to spend time at a friend's place. That's part of her personality. I mean, she's quite an independent kid. I do try to spend some quality time with my oldest daughter as I think that's really important under the circumstances. But, I still notice that she will change (her clothing) upstairs or brush her hair and get ready in the upstairs bathroom which I know she's doing to avoid us when we deal with her younger sister. I mean, I'd get ready upstairs by myself, if I could, too! I still try to make sure that my oldest daughter does not get left out in terms of attention as the focus has been so much on my youngest daughter. I basically make sure that my oldest

daughter knows that she is still important and that's she is around. We're trying."

This father also indicated that his relationship with his wife has been compromised in dealing with their daughter's obsessive-compulsive disorder. He shared the following:

"No, I'm not a stereotypical guy who won't ask for directions. If I know that there is somebody is better at something, then I will go to them for guidance. Like I said earlier, my wife is taking a lead role on this and I look to her for some direction, yet when I step in and offer to help, she'll tell me that I'm not helping which is a little discouraging and a little frustrating. The dynamics get muddled and crappier as we try to help my daughter. I would say that my wife and I are certainly not at our closest. Her focus is our youngest daughter and I'm trying to hold the whole family together."

It is interesting to note that of the eight families with more than one child, in all but one family, it has been the female sibling who has been affected the most by the child with obsessive-compulsive disorder. In all of these families, the female sibling is generally quite high functioning both socially and academically. In some instances, the obsessive-compulsive child directs a considerable amount of anger and resentment to this sibling, particularly during those periods in which their obsessions and compulsions are the most debilitating. One father related:

"He blames everything on her including his ocd. There have been times when he as even gotten physical with her. It's hard as a parent to see this

> come from him as he is normally a gentle, loving, and caring child." It was further conceded by this father that "I'm probably spending a lot more time with him than the other kids and that is time taken away from them. I talked to my wife about doing things with the other kids. For example, I recently took my other son to the movies, just him and me, the other day. However, out of everyone, I think that it is my daughter who has been affected the most."

Another disclosed that due to his daughter's high level of functioning, he is perhaps less attached emotionally:

> "I would say with confidence that my daughter and I don't have the same kind of relationship as I have with my son. Perhaps, it has to do with his seizure when he was younger and I have somehow paid closer attention to him given how serious a situation it was. I think also that when she was young, she was so attached to her mom and so contented that I don't think that I went out of my way necessarily to interact with her. I think that there's a distance there as a result, but not something unhealthy. When I look back, you know, she wasn't demanding much attention from me so I was happy to go work on my computer, perhaps not the best choice, mind you."

The relationship between the siblings was not always wrought with animosity. In one case, the father advised that his daughter actually took on a care giving role with her brother as she came to recognize just how debilitating his obsessive-compulsive disorder had become for him. This individual remarked:

> "I wouldn't say she was neglected but we didn't have as much time for her as she is accustomed to. I think that she was also scared for her brother and that concerned me. She was used to him being her big brother and he was no longer acting that way and while most of their time they were fighting, I knew that she was worried about him."

According to this father, his daughter wanted to be part of her older brother's treatment and apparently, actively participated when the family met with Dr. Altman. One of the fathers described his daughter as a pseudo-parent:

> "I find that there are times when his older sister can be quite motherly with him and she is concerned. On other occasions, they're like any brother and sister and they're at each other."

Validation of the Child's Strengths and Attributes

While the ability to look past the diagnosis and examine the child's other qualities and achievements was not easy for all of the participants, each was able to come up with examples of accomplishments and distinctions their son or daughter has achieved notwithstanding obsessive-compulsive disorder. In some instances, fathers spoke of particular qualities in their children which may in fact have made them more vulnerable to develop obsessive-compulsive disorder and yet these could still be considered strengths or virtues depending on the circumstances:

- "I don't know if I read this somewhere in a psychology book but where it states that ocd is like a heightened sense of morality."

- "He got a part-time job at Christmas time which has been very helpful. He works at a personal care home in St. Boniface. There are only 3 hour shifts, they feed him, and they treat him respectfully. It's a terrific high school kid job. He's happy with it and I think it helps take his mind off other things. He felt quite proud of himself that he got it on his own and when other kids went there afterward and were refused, he felt even more valuable or special."
- "The younger one, we do quite a bit of stuff together. We bought a welder and we do that together. Also, going to his lacrosse games. They're into sports and stuff."
- "She's a very caring person, especially with her friends and she is very close and caring with her brother. She's always thinking of other people or kids. She would probably become a teacher one day as she thinks so much of others. If we're having trouble with our 12 year old, she will often try to intervene and while she used to take sides, she is now more of a mediator or negotiator. She has really grown up a lot in the past few years."
- "After awhile, he realized that he did have ocd and he was ready to take it on. Certainly now, we can talk openly about it and it is not something which he has to be embarrassed or uncomfortable about. We're all in it together to help him."
- "Well, it is his personality. I mean, he is a sensitive guy and he easily becomes attached to things which have some sort of sentimental value to him. At first, I just viewed the behavior as that was the way he was and

initially, I didn't see it as dysfunctional. I guess it is this notion of wanting to see things again. I guess his sentimental side has laid the groundwork for some of his ocd characteristics."

- "She is the first person to say, "Bye dad. I love you. Have a great day!" and I'll do the same for her. She's also smart and she has this incredible social ability. We had a garage sale recently, and it's incredible to watch her go. It's as if she's stopped thinking and she's in the zone, you know. She's there meeting with people and has no idea who they are but she has shown this incredible, innate skill in relating to people!"
- "I don't want her to cheat herself out of that because of her ocd. I want so much to foster that as that's something she can be proud of. Yet, she keeps telling herself that she can't do things and she will stop trying. This is what worries me that she doesn't recognize her gifts or that her ocd won't allow it."
- "We know it's worth it. My son has always been the kindest kid. He's very passionate and community minded about everything from homeless people to what's going on in other countries such as Ethiopia."
- It's gotten a lot better. He gets in the moment. We give him that moment and it's over and we can reason with him again. He's very bright and he can be reasoned with on an intellectual basis."
- "We weren't all that shocked with it when it surfaced as there is a bit of a family history of it. So, it wasn't one of those "oh my God" sort of responses but the hardest part for me was remembering this is a child with

ocd as he is a very bright, a very mature individual who is really kind beyond his years. Sometimes, he would be doing things where he was stuck and unable to stop. It took me a long time, many months to kind of internalize that this was something that I need to be thinking about."

Guilt and Regret

In the case of those nine fathers with children with obsessive-compulsive disorder, all but one expressed at least some degree of regret as well as self-blame in relation to emergence and maintenance of their child's disorder. It was speculated by two of the fathers that their child's struggle may be due in part to their own personal shortcomings and independent of their parenting. All eight fathers noted that they had made a number of decisions pertaining to their children which they regret. However, while these individuals expressed that their responses may have exacerbated the problem in the moment, not one advised of any enduring effects. Their observations are as follows:

- "It is hard to be detached as somehow I feel responsible for it like he got it from me."
- "In the beginning, I did not have the patience to deal with my son's ocd and there was a lot of yelling and it took almost a year from the time we first went to the doctor to when he got into St. Boniface Hospital. It was very difficult and I now feel badly how I reacted."
- "I think that my lack of patience with him not only had to do with the stress of his ocd and how it was affecting us as a family, but also the

stress and frustration I was experiencing when I felt that no one was helping us."

- "I am his father and the difficulties with my son should be something that a father should be able to solve."
- "I'm probably inconsistent which is not really helpful and this approach may be disruptive to him. Part of that is that I let my guard down".
- "And, to be honest, I feel like a bit of a failure. I used to succeeding in whatever I do. You know? You start something and you finish it".
- "I do regret sometimes that I set lesser standards as he will pick up on this once in awhile."
- "As for my anger with her, it was more or less yelling and arguing but it never got us anywhere. I have a legal background and sometimes I don't realize it but I argue for the sake of arguing which is not good in this kind of situation. I've stopped that but I didn't see it as arguing but I have learned to be more sensitive."
- "I used to treat it all as bad behavior. I tried that approach initially but it backfired so I chose to back away from that."
- "I don't know of anything other than I could have been more patient but initially, I may have channeled that into not talking or not getting into it with him. I assume that when he picked up on my frustration which, in the beginning, wasn't hard to do, he would go around and *secretly* collect things."

- "I think that she feels bad and I am aware of that. I walked out one morning, slammed the door, got in my car and drove off. I thought about it for a little while and phoned my daughters and wife and apologized. It's like that saying about going to bed in a good mood and waking up in a good mood and going to work or school in a good mood. I didn't want all of us to start the day on a bad foot but I slip sometimes."
- "I don't want her feeling guilt. That is still the emotion I think that I'm giving her. I recognize that I have that knack for making her feel bad when I'm angry or frustrated and I need to be mindful of that. Whether I am successful at stopping her from feeling guilty or not is not clear but at least I'm trying. You look at her looking at you while you're freaking out and you think, "Yeah, I'm dad of the year!"
- "My wife has yelled at him. I have yelled at him as well when he became stuck with his ocd. I sit back 10 minutes later and nothing has changed. The yelling hasn't helped. In fact, it has made it worse."

Summary

What appear to figure prominently in this section are qualities such as insight and humility on the part of the fathers. Most, if not all, attempted to take some ownership of mistakes made along the way in responding to the challenges and some of these individuals displayed a certain vulnerability, particularly as they contemplated their child's future. On a more encouraging note, the capacity to separate their child from obsessive-compulsive disorder and further, the ability to resist the temptation of viewing

all of their child's idiosyncratic behavior in the context of a psychopathology were additional attributes from these six themes.

Their sensitivity was also not limited to the child with obsessive-compulsive disorder but also extended to other family members. Along with that understanding, a number of the fathers also conceded that, to their regret, relationships with other family members had been compromised or even damaged in some cases. While some sought ways of compensating for this imbalance, others rationalized that if the other child or children were to have been the one with the diagnosis, the same rules would have applied.

Underlying much of their efforts in this section and the previous one is a degree of faith or optimism that their child's circumstances will eventually turn around provided that they continue to work at it. This has acted as a catalyst for change for each father in spite of their fears about the future. It is this belief or faith in their child, in himself, in their family, and the system at large which appear to compel each of these individuals to take on challenge after challenge.

Case Scenarios:

In addition to the semi-structured interview, the nine participants were also asked to problem solve two case scenarios involving children with obsessive-compulsive disorder. The scenarios are based on a composite of obsessive-compulsive disorder cases derived from the literature and this writer's discussions with clinical staff at the Anxiety Disorders Service for Children and Youth. The case scenarios are as follows:

1. *Your son/daughter is a meticulous student. He/she often worries about getting every answer right on tests, so much so that he/she rarely finished them. Half-way through a test, she/she felt compelled to go back and check the answers he/she wasn't sure of. At home, he/she would stay up late doing homework, checking the answers over and over again. After going to bed, he/she would get up, turn on the light, check to make sure all of their books and papers were in their backpack, and then go back to bed. Next, he/she would get up again and turn off the light. Sometimes, the light switch didn't seem to "click" right so he/she would switch it on and off several times until it "felt right". He/she would often be found in their bedroom crying or agitated that they couldn't get things "just right".*
2. *Your son/daughter is worried about soiling his/her clothes with feces. He/she is becoming increasingly obsessive about being "dirty" and he/she has a number of compulsions related to insuring that no "poop" touches his/her body or an item of clothing they are wearing. Due to this fear, he/she refuses to wear underwear. During periods that he/she is feeling particularly "unclean", he/she will spend days at a time wearing nothing but a towel and will refuse to leave the house because they feel "too dirty to go out". He/she no longer feels safe using a bathroom anywhere other than at home.*

Case Scenario #1 Responses:

All of the participants conceded this was by far the easier case to problem solve in terms of complexity as well as their own comfort level in comparison to the second case

scenario. The majority of the fathers tackled the problem in a pragmatic way and certainly consistent with a cognitive-behavioral therapy model. For example, according to Chansky (2000) and her work using cognitive-behavioral therapy, "children with checking or repeating rituals are taught that their senses are giving them the wrong message. Instead of heeding the call to double- and quadruple check, they are coached to break the ritual by *doing it wrong* or not at all, by feeling the doubt and uncertainty of whether something is done or right, and then walking away" (p.253-254). Chansky further indicates that "by not checking, they will see their awful feeling pass" (p. 254). With respect to "just right" thinking in relation to obsessive-compulsive disorder, Chansky emphasizes a similar approach of discouraging or preventing repeated rituals or "doing the opposite of what the OCD commands" (p.266). As opposed to "just right", the child is directed to embrace "good enough" (p.267) as a mindset. Again, as with the checking rituals, the exposure needs to be long enough or frequent enough so the child comes to realize that when they accept "good enough", no disaster has befallen them. Some examples of how the fathers managed some of these challenges such as the checking rituals include the following:

- "In the case of this child checking things over and over, I'd probably get him to pause and I would check it and tell him that if I checked off his work, it's probably o.k."
- "I have to also convince him what is "good enough". For example, 80% is good enough and he must accept that he doesn't have to be perfect all the time. To also have the teacher communicate to him

that he still did a wonderful job and that B+ or A+ don't matter so long as he has learned something."

- "I think that if I were in the position of being this child's father, I would come in and try to determine exactly what he is worried about and assure him that those things had been done *well* as a means of encouraging him."
- "If you show them that if 9 plus 9 equals 18, there is no need to go back and check something that is not going to change. If you can get the kid to accept that they've done the answers right the first time and make them feel comfortable or confident in their choices."
- "I would probably go over the work once with him and maybe double check it but leave it at that. I would encourage him to trust himself. Have a little faith in himself."

The fathers responded along the same continuum regarding the issue of the light switch:

- "As for the light switch clicking, maybe I would pull it off and show him how it works and show him that it doesn't matter if it clicks or not as long as the light turn on or off. I would simply try to rationalize that the only thing that matters is that it is either light or dark."
- "As for the light switch ritual, I would show him other light switches and show him that they all click a little differently yet they all work essentially the same. There is no one right or wrong

way to turn a light off or on. When it's working, it's working. There's no mystery to it."

- "As for the light switch problem, they've got to learn that they can switch and leave it. It's kind of like the math question. Once it's off or on, that's it. There is no other state that the light is. They need to recognize that it is that simple. Maybe, step back and not touch it and you know, nothing happens when you don't take any action. It's not a person. It's not trying to outwit you."
- "As for the flicking of the lights, I would tell him that he's going to burn the light out and to stop doing it. I would be pragmatic. The light works or it doesn't. That's it."

Summary

Their approach appeared to suggest that they were able to detach themselves emotionally from the child in the scenario and their irrational thinking and re-direct the child in a manner in which there is little debate and where the problem solving is narrowed down to a few simple tasks. There was no inclination to indulge the child in their rituals nor was did there directions involve any degree of condescension or ridicule. Their responses might further suggest that these fathers have experienced similar situations with their own sons and daughters and they have already developed a repertoire of strategies to combat such rituals in their own children.

Case Scenario #2 Responses:

The second scenario, involving contamination fears, is actually the most common obsessive-compulsive disorder, according to the literature. Chansky (2000) indicates that in therapy, "overcoming contamination fears means two things: (1) learning to live with the thoughts and feelings of being unclean, and (2) not avoiding situations that are perceived as contaminated" (p.245). It was apparent from the fathers' responses that, notwithstanding the fact that many acknowledged a degree of personal discomfort dealing with a scenario as extreme as the one described, most were already familiar enough with behavioral strategies from their participation in their own children's therapy and provided remarkable insight:

- "I have heard that at St. Boniface Hospital with the group exercises, they get the children to touch something that is dirty and prevent them from washing right away just so they can understand that being dirty temporarily is not harmful. When you expose them to something unusual, they learn that nothing bad will happen. As a parent, I would try to sit her down and explain how it is not logic what they are worrying about and avoiding in terms of germs. The second thing is to find her someone who is around her age who has recovered from this kind of germ phobia and have them explain how they overcame fear. I think also to get her to be dirty once in awhile and prove to her that nothing will happen during those brief times when you are a little dirty."

- "I think that I would try to get her into some dirty environments and force the issue. She would obviously have to get dressed but try to get her outside playing in the dirt and encourage her to become involved in activities that would be less clean as a means of exposure. My son is actually quite particular in public washrooms about things he will or won't touch."
- "Maybe, use the exposure exercise with this child."
- "That would be very tough…very hard to deal with as a parent. This could be quite frustrating for any parent. I guess that I would try to talk to her about just what she was so worried about as it is a normal bodily function and if it gets on you it *can* be cleaned off. I would try to normalize it for her. I suppose that if she had to go to the bathroom in public that I would try to find somewhere sanitary where she could go as most public washrooms are not clean enough for the average person, let alone a child with these fears."
- "I assume that this is going to involve some kind of exposure exercise. I think it's all about normalizing it for the child. It is a normal human function. It's not like we all wipe it all over ourselves. There is a process when you go to the bathroom and afterward. That should be it. You tell them "have a poo, wipe your bum, and wash your hands after". If she has a tendency to over-wash following this, start with a number and work your way down until she is only washing once and not excessively after she goes."

- "How do your talk about it? I suppose you have to talk about it. That's probably part of the problem. You have to talk openly and when I say that, talk about it *within* the family. Use some humour if you can and try to make light of it. Goodness knows that boys find things like farting and bathroom talk funny. You've got to talk about it around the house and make it a more mundane subject to discuss so everyone doesn't get all emotional about it. Talk about the benefits of "two-ply and three-ply" toilet paper and joke around about it. I don't think that I would go as far as arrange group family time in the bathroom but certainly, the family *can* help."
- "You know, I'd make sure that she had clean clothes. Like my son, I would take the clothes right of the dryer and say to her, "There you go, perfectly clean!" With my son, if he was handed clothes that were still warm, that acted as a reassurance that they were clean. Just to reassure to them that they were clean would be something that I would start with and show them that after a day, they're still not really dirty and it's alright."
- "I would look for compromises. If you have to go out, at least wear a skirt. We can go out and come home and use the washroom. The next time, we go out to where there's a public washroom but not use it. Next time, go into a public washroom and walk out. Sometimes, there are really filthy public washrooms so I would understand her trepidation. I had some of that. I had this whole

> process about what stalls I would use. For example, I would only use the far stall as I thought it afforded me the most privacy. But, in this girl's case, I think that I would set up a series of exposures because even if you got into salaciously bad interactions, it's still got to be better than where this appears to be going."

Summary

It is interesting to note that only two (2) fathers recommended deferring to the clinician, psychiatrist or physician and even they expressed that the family must assume the primary role in this exposure and response process. It is the researcher's contention that these are fairly significant findings in that the participants have by and large elected to take a direct approach in dealing with obsessive-compulsive disorder. This is exemplified not only in the manner in which they have intervened with their own children but also when asked to problem solve in these two case scenarios. Even in circumstances where they find themselves quite uncomfortable such as in the second scenario, the father endeavored to find practical solutions and that accessing outside help is a direction taken after all other avenues have been exhausted.

Chapter 5: Discussion and Conclusion

Comparing Results with Other Studies/Current Literature:

Introduction

As indicated earlier, the data collected from these fathers appears to suggest there is a considerable degree of incongruence between the responses of the fathers in this study and the findings from other studies involving parents and children with anxiety disorders. Furthermore, this disparity was not isolated to a few categories but featured prominently in several themes including attachment and parental sensitivity, parental control and protection, parental psychopathology, and parent-child interaction. In addition to these differences, a number of other themes emerged in the course of this research which may have been overlooked in these other studies. I will concede that the majority of this other research focused on mothers exclusively, so a direct comparison cannot be made.

Attachment/Bonding

Manassis et al. (1994) spoke of all children in their study of mothers diagnosed with an anxiety disorder being "insecurely attached" (p.835) and that this places them at considerable risk to develop an anxiety disorder themselves. These findings that attachment is strongly correlated with anxiety disorders in children were shared by several other researchers including Belsky (1999), Bogels and Brechman-Toussaint (2005) although most of this research focused on mothers. Interestingly, Phares (1999) found that in studies on attachment between parents of infants and children, there was

very little difference between mothers and fathers. According to Phares, "this pattern seems related to the fact that most parental dyads tend to have similar parenting styles with their children, and these parenting styles seem to be most influential in determining the type of parent-child attachment" (p.23). This is supported by the works of Bronstein and Cowan (1988); Cath, Gurwitt and Ginsburg (1989); Lamb (1997), Lamb et al. (1985); Parke (1995); and Pruett (2000). For example, Pruett (1989; 2000) observed that "paternal warmth has been found similar to maternal warmth in its advantageous effects on child psychosocial development, achievement, and sex-role development" (p.219).

It is evident that there has been a limited amount of empirical research which has specifically examined the debate over the reciprocity between child temperament/behavioral inhibition and parental sensitivity. Of the few studies, Warren and Simmens' (2005) research generally supported the contention that parental sensitivity (maternal) in early childhood was found to contribute to later reactions in child anxiety/depressive symptoms. They found that this sensitivity significantly predicted decreased anxiety/depressive symptoms for children who had been more temperamentally difficult.

Parental sensitivity, as derived from this study appears to encompass a number of categories including attachment, fear and despair, normalizing, parenting techniques, as well as the impact on other family members. What has been a consistent theme within each of these categories is really the participants' sensitivity when it comes to their children. Each displayed the capacity to separate their child from their various obsessions and compulsions so as to treat the disorder as the "enemy". Not only did these individuals

recognize this distinction, but they were also able to communicate this to their child which was even more reassuring.

Furthermore, these fathers also demonstrated considerable sensitivity and understanding into how other members of the household were being affected and in some cases, characterized some of their response to their other children as negligent in light of the demands placed on them by their child with obsessive-compulsive disorder. The sensitivity appeared to result in an empathic rather than sympathetic response in that the fathers, for the most part, were pro-active in addressing their child's obsessive-compulsive disorder.

Attachment was a significant theme amongst all nine of the participants in this study and provided the researcher with some of the richest data in comparison to the other themes and patterns. The fathers' responses would strongly dispute the notion that their children's obsessive-compulsive disorder could be the consequence of a lack of warmth, sensitivity, or secure attachment. These individuals presented as profoundly concerned with their children's welfare and there is little evidence of wavering from this position.

Parental Control/Protection

It has been observed by researchers such as Bogels and Brechman-Toussaint (2006); Cummings et al (2000), Ginsburg and Schlossberg (2002) amongst others that parental over-control, both behaviorally and psychologically, interferes with or impairs the development of a child's sense of autonomy and leads them to view the outside world as uncontrollable. They further assert that a child's perception of personal competence

and mastery is compromised by excessive control and leads to compensatory emotions and behaviors, from which anxiety disorders are manifested.

In the case of the nine fathers in this study, their responses would suggest that their attempts at control or over-control were, for the most part, in response to actions by their children and not necessarily a parenting strategy intended to protect or prevent their children from navigating the world around them. In general, none of the fathers considered their parenting approach as controlling or over-zealous except under extreme circumstances and that these tended to be more isolated situations than an everyday occurrence. Furthermore, it was disclosed by several of the fathers that they recognized when they were being controlling with their child with obsessive-compulsive disorder.

Parental Psychopathology

There has been much debate regarding the impact of parents' own mental health issues may have on their children who present with, as in this case, obsessive-compulsive disorder. Coinciding with this debate is the whole "nature versus nurture" dilemma, which for the sake of this particular study will not be explored in any further detail. Certainly, the majority of the fathers in this study conceded that they shared certain personality traits with their son or daughter which they conceded could have laid the groundwork for the child to develop obsessive-compulsive disorder. However, only one of the nine participants indicated that he had a formally diagnosed anxiety disorder, while the remainder who did indicate a history of mood or anxiety problems were never identified or treated for same. However, two of the fathers disclosed that their spouses had been diagnosed with and treated for an anxiety disorder.

Unlike some of the literature such as Messer and Beidel (1994) who found that by and large, the parents of anxious children tended to be more controlling and who promote less independence, the fathers in this study appeared to go to great lengths to instill a sense of competence and independence in their children through their vigilance in exposing them to situations which were inducing the anxiety and obsessive-compulsive behaviors.

Parent-Child Interaction

There has been much speculation within the literature regarding the connection between child temperament and behavioral inhibition and parental sensitivity. As indicated within the literature review, it was stated that there is a need to examine the parent-child relationship from the perspective of how the child's behaviors or global functioning elicits particular responses from the parent. It has been further noted that a family can become dysfunctional as a result of a family member's obsessive-compulsive disorder when the other members get caught up in the child's obsessions and compulsions to the point of participating or indulging the sufferer.

The approaches taken by these fathers did not strongly suggest complicity or collusion in the rituals; instead, these individuals appeared to take a more directive approach with their children. In fact, what was particularly remarkable about the participants in this study is they came in with a working knowledge of obsessive-compulsive disorder and the cognitive-behavioral approaches commonly used to treat same. While each met with a degree of resistance and even hostility and aggression from their children, there was little evidence based on their responses that they might relent

and take the easier path of avoidance or indulgence of their child's obsessions and compulsions.

Paternal versus Maternal Role

Phares (1992) observed that "studies of fathers based on either mothers' reports or on the fathers' absence add to the under-representation of direct investigation of the father's role in child psychopathology" (p.657). She further speculated that "one possible explanation for the under-representation of fathers in child psychopathology research is the assumption of greater availability of mothers than fathers as research participants" (p.657). From this researcher's experience, this certainly would not appear to hold true when almost a third of those approached to participate in this study responded.

More importantly, for the purpose of this study, is the question of the degree of involvement fathers assume in the day-to-day lives of their children with obsessive-compulsive disorder and the impact of same. While the research appears to acknowledge that there has been an evolution in fathers' role in their children's lives, there has not been an extensive amount written about the specifics of their involvement. The participants in this study, while conceding some quantitative differences of involvement between themselves and the children's mothers, would all characterize themselves as active in their parenting judging by their responses and detailed descriptions in the earlier section on Paternal versus Maternal Roles.

Emerging Themes:

Introduction

The following section is intended to provide a more detailed analysis of these new or emerging themes drawn from this research. Each theme is examined for its relevance or significance to the study of fathers but just as important is the question of the practical application of these emerging themes. For example, prior to commencing this research, much consideration was given to selecting an area of mental health which I believe deserved further attention.

Furthermore, a secondary agenda in completing this study from the start has been to conduct research that would make a significant contribution. I would hope that it would act as a catalyst for services such as the Anxiety Disorders Service for Children and Youth to engage fathers more actively in the treatment process given the evidence presented of their impact. This study also has the potential to stimulate other research involving fathers and certainly, based on the positive feedback from the nine participants, they are clearly an under-utilized resource when it comes to the treatment of children with mental heath problems.

Fear and Despair

What makes this category relevant is that their fears or sense of hopelessness has not only evolved out of their children's obsessive-compulsive disorder but has also stemmed from larger systemic issues. Notwithstanding the fact that all nine fathers report significant improvement in their children's functioning since initiating treatment at the St. Boniface Hospital, many of these individuals shared that there were considerable

challenges getting to this point. Some of these problems appear to rest with physicians who lack an awareness of resources; waitlists for services within the child and adolescent mental health system are climbing; and accessing private practice psychology/social work clinicians is expensive and even with insurance coverage, it tends to be time limited.

The fear and despair, as it applies to the children, has to do with speculation by these fathers about future outcomes should their son or daughter not overcome the limitations placed on them by their obsessive-compulsive disorder. However, these fears appeared to act as a catalyst for the fathers and from their responses throughout this study, it was apparent that they would not allow the disorder to control their child's destiny.

Influence of Faith/Spirituality

This theme surfaced without any solicitation and for all intents and purposes was not explored in great detail suggesting that it was under-represented in this study. It is conceded that the role that spirituality can have for people with mental health problems is getting more attention. For example, in the United Kingdom, the Royal College of Physicians has authorized research by the *Special Interest Group on Spirituality* (www.rcpsych.ac.uk/college/sig/spirit/index.asp) while the Mental Health Foundation and National Institute for Mental Health in England have funded projects such as *Inspiring Hope* (www.mentalhealth.org.uk/html/content/spirituality project.pdf). In simple and pragmatic terms, spirituality provides individuals and families with a sense of hope. The experience of a mental health problem for the individual and the family around them can be very isolating. Spirituality "places an emphasis of making use of personal,

internal, and external sources of strength and one's spiritual awareness that focus on inner peace and hope, helping to alleviate anxiety and distress for some people" (National Schizophrenic Fellowship 2009, Rethink Fact Sheet: *Spirituality & Mental Illness*: London). It would then appear prudent on the part of mental health professionals to be sensitive to attitudes and practices such as those related to one's sense of spirituality that have the potential to increase mental stability and emotional well-being. This might be interpreted as a holistic approach to mental health as it includes the health of mind, body and spirit (Richards & Bergin, 1997). It would appear that in this is a resource that we often fail to access or emphasize in our work with individuals and families.

Those individuals who brought up faith as an influence related to it as a source of strength and guidance in the face of the challenges their children presented with their obsessive-compulsive disorder. One father used his child's questions about God testing of his resolve as an opportunity to accomplish two tasks. The first was to communicate to his son that God viewed him as unique and more than capable of overcoming this burden; and secondly, place the locus of control back on the child by encouraging him to do battle with the disorder with the assurance than he is being watched over. According to this father this has apparently provided his son with a sense of a greater purpose in that he can be an example to others by overcoming this disorder.

The other parents have found that their place of worship afforded them a sanctuary to unburden themselves of the stress and frustration of coping with a child with obsessive-compulsive disorder on a daily basis. One of the fathers characterized the fellowship and support he gained from his church as "energy" with which he and the mother could take back home with them.

Normalizing

All of the participants in this study displayed an ability to avoid defining their child by virtue of his or her diagnosis and acknowledge other attributes which could garner praise and admiration. All of the fathers spoke of resilience in their son or daughter which they believed would help them overcome the challenges which obsessive-compulsive disorder presented. However, the perception or view of their children's strengths was not always intertwined with their diagnosis. That is, to most of these fathers, their child's obsessive-compulsive disorder is treated as almost incidental and in no way does it define them as people.

There also appeared to be a concerted effort on the part of these individuals to avoid treating all problem behaviors with their son and daughter as somehow connected to the diagnosis. In fact, a number of the fathers confided that their child became aware of how they could be granted some leeway for various improprieties within the household by attempting to attribute this behavior to their obsessive-compulsive behavior. Similarly, many of the fathers spoke of having to challenge their son or daughter at times when they became engrossed in self-pity without completely invalidating their child's feelings. Those fathers with adolescent children noted that there were a lot idiosyncrasies accompanied by mood dysregulation which they debated could just as easily have been attributed to typical adolescent self-doubt and insecurities.

One caveat to this theme is that in this field of mental health, clinicians often emphasize letting go of the idea of "normal". For example, according to Fitzgibbons (2003), "we are aware that there is a certain inconsistency in what we are saying. On the one hand, we say that the point of treatment is to help your child get within the normal

range of functioning. On the other hand, we say that everyone must let go of the idea of normal" (p.172). Fitzgibbons characterizes this as a "paradox" (p.172) of obsessive-compulsive disorder. She further observed that there is a trap in "comparing desired behavior (that which is not OCD) to other people's behavior to determine what is okay, misses the point of the problem" and that is "normal people's actions are not an accurate gauge of what are and are not okay behaviors because normal people don't have any OCD consequences linked to their activities" (p.172).

Given the possible confusion, normalizing, as it applies to this study, is not intended to determine some 'barometer" for acceptable behavior, but associated more with how these individuals were able to avoid over-scrutinizing or perhaps "pathologizing" their son's or daughter's behavior.

Validation of the Child's Strengths and Attributes

Along the same continuum as normalizing, another remarkable theme derived from these interviews is the propensity on the part of the fathers to extol the virtues of their children, in spite of their obsessive-compulsive behavior. This was also done so in an unsolicited manner. On that note, Fitzgibbons (2003) characterizes the role of the parent as a sort of "assistant coach" (p. 75) in the treatment process. She related that "remembering the starting point, and important victories along the way, can pump up a child's confidence so he or she can push on" (p.76). From Fitzgibbons' perspective, "to keep motivation high, it is necessary to celebrate and encourage every gain" (p.76). The fathers in this study impressed as very supportive and enthusiastic about their children's achievements and skills, some of which were directly utilized in their "battle" with

obsessive-compulsive disorder while others were simply remarkable qualities in and of themselves. While a number of these individuals conceded that some of the limitations placed on their son or daughter due to their obsessive-compulsive disorder interfered with the full realization of their full potential, the diagnosis was not so powerful that it rendered these other positive qualities inconsequential.

Guilt and Regret

Eight of the nine participants acknowledged that there were decisions and omissions which evidently contributed to their children's obsessive-compulsive disorder. This speaks volumes about accountability but what could best be described as co-ownership of the problem and of the solution. Their sense that they have an important role to play in the quest for their child to rise above their disorder is also commendable. There was also no propensity on their part to cast dispersions on the other parent and in general, there presented an inclination to turn to the mother for guidance as further to ensure that an alliance existed in their parenting. While many conceded errors in their approaches, the tendency was to learn from these and forge ahead rather than ruminate over the mistake or malign themselves in any way.

A lack of patience appeared to be the consensus when these individuals consider their parenting retrospectively. Underlying some of this insight appears to be what could best be described as stereotypical male pride based on traditional male socialization. A number of the fathers spoke about being accustomed to solving most problems which came along in different areas of their lives. One individual went as far as state

unequivocally, “I am his father and the difficulties with my son should be something that a father should be able to solve”.

Perhaps, some perspective taking might be in order for some of these individuals. For example, it is important for any parent to examine the whole issue of liability. As much as one might assume he or she can control their child’s destiny, they need to come to the realization that there are many more variables at work in their child’s development than the influence they wield. Furthermore, some parents need to begin to adopt a different attitude which involves embracing certain premises such as uncertainty and the capacity to let go of “normal” (Fitzgibbons, 2003, p. 92). Similarly, Phares (1999) discourages the inclination for parents to view the link between the parent and the child with a mental health problem as causal. Instead, she suggests that there can be an “association and correlation” between the parent and the child’s obsessive-compulsive disorder.

One proposition which has been posed by a number of researchers has been to examine the reciprocal nature of the child’s mental health problem and the parent’s emotional or behavioral response. For example, Phares questions if having a difficult child “causes” (p.46) psychological problems in the parent. There are various other factors which could be contributing to the father’s struggle including marital conflict, financial struggles, workplace stress or conflict, or health problems in immediate or extended family members. The bottom line is that it is a complex issue and that most mental health problems are the result of numerous internal and environmental factors. There appears to be a “compulsion” for some parents who feel a need to assign blame or

confirm a cause because it alleviates uncertainty and confusion, a state which is intolerable for some people.

Impact on Other Family Members

Again, this was an area in which the participants displayed considerable insight. The consensus amongst these individuals was that there was significantly less time and attention granted the other children in the home as a result of the resources allocated to treat the child with obsessive-compulsive disorder. One father actually brought up the subject unsolicited as he had been quite concerned about the effects his son's obsessive-compulsive disorder had on his daughter. All of the fathers with more than one child acknowledged that there was "collateral damage" from dealing with a family member with obsessive-compulsive disorder and they appeared sensitive to its effects on others. Although most of the focus was on siblings, the participants also factored their spouse into the list of members being affected.

Summary of Emerging Themes

Coming into the study, I did anticipate that new categories or themes would likely surface from the data collection. This expectation is driven by the fact that most of the established patterns such as attachment and parental control were derived from research which has primarily focused on mothers. As indicated earlier, there was a certain amount of difficulty "fitting" these fathers' responses into these categories which compelled me to question whether fathers or males do in fact have their own unique interpretation of their child's disorder and to coincide with this, a distinct approach to the problem. This is

not to suggest that none of these emerging themes would apply to mothers if I were to have completed a similar study on women. Nevertheless, I do consider it significant that a number of additional themes surfaced from this study.

Validity Checks

Findings of the Co-coders

Similar themes were derived from the co-coders, Ron Oberlin, M.S.W., and Diva Faria, M.S.W. (Appendix G) with one limitation involving the researcher's instructions. Prior to being provided with copies of the transcribed data, Mr. Oberlin and Ms. Faria were presented with an overview of the current themes drawn from the literature on parents and children with anxiety disorders. It would appear that this overview tended to bias their interpretation of data somewhat as both relied quite heavily on the most common patterns derived from the available research. For example, they focused almost exclusively on four primary themes: Parental Sensitivity/Attachment, Parental Control/Protection, Parental Psychopathology, and Parent/Child Interaction. In retrospect, it would have been helpful for me to have encouraged these two individuals to be open to other emerging themes should they have found the established patterns too constraining.

Notwithstanding some of these factors, their insight proved quite valuable and certainly enriched the interpretation of the data. For example, Mr. Oberlin noted that parental control and protection is not a significant issue where there is a heightened level of sensitivity and attachment. Both coders observed that there was a high level of insight amongst almost all of the fathers in terms of the disorder and its impact on the child and the family. Both noted that in those instances in which fathers appeared to exert more

control over their child's behavior, that the approach was not generally a part of their repertoire as a parent and that it was used in only the most extreme circumstances. The coders further acknowledged that these fathers recognized when they were being over-zealous with their children and furthermore, conceded that such an approach had its limitations.

A similar generative or strengths-based approach appeared to be taken by these two coders whereby they too credited a number of the fathers with being unwavering in their commitment to effect change in their son or daughter. Mr. Oberlin observed of one father, "A strong desire to address difficulties based on a wish to help his son. A high level of insight, overall" while Ms. Faria stated of the same father, "The parent demonstrates an understanding and acknowledgment that parent over control is not helpful". In fact, both coders indicated that the majority of the fathers presented as quite modest and candid about their poor decision making at times and yet were also resolute about taking more appropriate measures to enhance their child quality of living. Please refer to *Appendix H* for their respective interpretations of the data.

Member Checking

Following data collection, the researcher completed a brief written summary of the findings and forwarded copies of this document by mail. To ensure confidentiality, I excluded any direct quotations or any other identifying information in the summary. The participants were asked to provide critical feedback on the findings upon reviewing this document. Four of the nine fathers responded and have provided feedback on the

research. Overall, their responses would suggest that they endorse the researcher's findings.

To begin with, two of the participants noted that their wives had also read the document and while they did not challenge the findings, they questioned why mothers were not included in the study. One mother apparently questioned some sources of the researcher's data from the literature review as the summary did not include a list of references. Examples of feedback are as follows:

- "I was very impressed with how you captured my feelings about my son and was very interesting to read about the links and comparisons to relationships with mothers."
- "I appreciate the comments on faith and I agree that could have been explored in more detail. One has to be careful coming into any study with a set of predispositions. I encourage you to further investigate this area."
- "One other issue which could have been explored further as well is the impact on the other children in the home, both young and old. For example, the younger child saw OCD as normal behavior until we corrected him otherwise. He had often observed the behavior first hand when they slept together in the same room.
- "I read through the first few pages and it looked good. I think I recognized myself a few times too. Thanks for doing the research."
- "In general, I can say that spirituality did not play a role in coping with my son's OCD. As far as the Jewish community goes, we knocked on many doors but they literally prevented my son from getting proper help for over

a year (that's before we started seeing Dr. Altman). That included a Jewish pediatrician who refused to refer, a psychiatrist from Jewish Child and Family Services who collaborated with the pediatrician, and Jewish Child and Family Services who claimed their hands were tied. On the other hand, my son feels very comfortable with Dr. Altman because Dr. Altman is Jewish. I guess sharing the same background does help in stressful situations."

- "I would agree that guilt is a factor. Although I would get angry with my son, I think that part of my frustration was that as a father, I thought that I would be able to solve this problem. This was hard for me."
- "I like the section on separating ocd from normal behavior. I'd like to believe that not everything my son does or says is related to this problem."
- "I was relieved to see that a lot of fathers were like me in their thinking, particularly in their ability to identify with their child and what they were going through.

Discussion and Conclusion

Merits of the Study

Fathers clearly offer a unique contribution to a child's development and evidence has shown that while their methods differ from mothers in a number of ways, their influence is very similar. According to Pruett (2000), children show a similar pattern of attachment to their mothers and fathers which begins in infancy. Furthermore, "paternal warmth has been found similar to maternal warmth in its advantageous effects on child psychosocial development, achievement, and sex-role development" (p.219). Phares (1992), whom has been extensively referenced in this study, states that this evolution in the study of fathers and their influence on children could only be achieved by continuing research which questions early theories of child development and actually "empirically tests the assumed insignificance of fathers in this domain" (p.660).

Overview of Major Findings

There were a number of outcomes from this study which I would consider significant. To begin, the established themes from the available data such as Parental Psychopathology, Attachment/Bonding, Parental Control/Protection, and Parent-Child Interaction) failed to provide a truly accurate depiction of this group of fathers. This is not to say that these categories didn't provide some utility. In fact, what these groupings did was to compel me to explore other underlying themes within the data. The reason for this is that the responses of these individuals were often incongruent and at times, contrary to the current research.

One such example that could be considered would be the theme of Attachment/Bonding. It was determined that, contrary to the literature, many of the fathers actually spoke of being drawn closer to their child in managing the disorder and that the parent-child bond grew stronger. This was particularly the case with those fathers who acknowledged their own history of anxiety or similar psychopathology. These individuals identified quite strongly with their child's struggle and were highly motivated to prevent them from suffering as they had during their youth. Any setback or impasse in their relationship tended to be looked upon as a challenge which was their responsibility to restore. Notwithstanding themes which latter emerged involving fear, despair, and guilt, there did not appear to be any compelling evidence to suggest that the parent-child bond was ever in jeopardy.

Another significant finding from this study was derived from examining the parenting role. For all nine fathers, this was a responsibility which they took quite seriously and their contribution impressed as significant in as much that it was active and enduring. Furthermore, each viewed effective parenting as a partnership which required coordination, sensitivity, timing, and modesty. Furthermore, the fathers displayed remarkable composure and creativity in their efforts to have their child overcome specific obsessions and compulsions. Many reported that the exposure exercises utilized to allay their child's irrational fears were not learned from reading a manual or from their work with their child's therapist. These fathers indicated that, more often than not, their approaches involving exposure and response emerged out of an understanding or sensitivity to their child's specific interests and needs which also acted as a catalyst in motivating their children.

What was also revealed from this study, notwithstanding the challenges, that these fathers continued to maintain a high degree of optimism and faith that their children's circumstances would eventually change for the better. Many spoke of the qualities of their child's character and their own resolve as a means of overcoming obsessive-compulsive disorder. Their capacity to continue to assume such a generative approach also appeared to be enhanced by another significant theme involving "normalizing". Many of the fathers proved quite adept at discriminating between behaviors which are consistent with a particular developmental stage and obsessive-compulsive disorder. While this did result in some fathers underestimating the problem at times, psychologically, this approach also allowed them to separate their son or daughter from the disorder.

Although only four of the nine participants spoke of faith and spirituality and its impact on them and their child with obsessive-compulsive disorder, it is considered an important finding for the simple reason that there appears to be very little research on the utility and value of faith, particularly when families are faced with challenges such as mental illness. It is a resource for families that does not get acknowledged very often.

This is not to suggest that simple prayer or spiritual reflection is to be considered a primary intervention tool. However, as I observed from the interviews with these fathers, faith does have a place in the treatment process, particularly during those occasions when families experienced setbacks or relapses. Similarly, faith and spirituality helped provide some perspective for families. In the case of the father whose son asked "Why has God done this to me?" he was able to offer reassurance by suggesting the

"God" valued him and viewed him as a "strong" and "brave" person and the test he is being subjected to at that time would ultimately benefit him.

One outcome of this study which really didn't relate to the impact of the father but was considered noteworthy by several fathers with more than one child was a pervasive resentment and hostility by the child with obsessive-compulsive disorder towards the sibling who was functioning better than they were. While I do not know if gender is the significant factor, as this is a limited study, but the hostility was typically directed at a female sibling by a male child with obsessive-compulsive disorder. The profile of the female sibling is also fairly consistent. The sibling is generally bright and successful in both academic and social pursuits, or at least appear to be more successful. It should be noted that there does not appear to be any evidence that these siblings are in any way provocative with the child with obsessive-compulsive disorder. It is conceded that this scenario does get played out in many households independent of any accompanying mental health problem and may not be particularly remarkable and simply be attributed to common sibling rivalry.

I did not elicit any significant differences in fathers based on socio-economic background although there did not appear to be great disparity in incomes between these nine individuals. Notwithstanding the significance of faith and spirituality, neither culture nor race appeared to factor into this study. I also did not find significant differences between fathers with only one child and those with two or more children. The chronological age of the fathers was examined as well to determine if there were any differences in the responses of younger fathers versus older fathers. However, no remarkable differences were noted in this examination.

Limitations of the Study

This study involves the examination and/or measurement of only one member of the parent-child dyad and obviously, there would have been benefits to analyzing the sequence of interactions between the parents and child in order to understand how the obsessions and compulsions unfold. However, recording the antecedents and consequences of parenting behaviors would be a particularly time and labour-intensive task involving a combination of retrospective and observational research. A further critique of this self-report method is outlined in Ginsburg et al (2004). While they also concede that measuring family functioning as it pertains to anxiety disorders in children is time-effective and cost-effective, they still reflect perceptions (parent or child) rather than actual family functioning. Furthermore, they comment that this perception of family functioning is usually not the same for parents and children and self-report ratings are not always consistent with therapist ratings or observational ratings of family functioning (p. 35).

Similarly, Rapee (1997) noted that agreement between respondents is usually poor, suggesting biases associated with each perspective. Typically, children tend to report less healthy patterns of family functioning than their parents (Sawyer et al, 1988) and view parents as more alike than they actually are, while parents tend to present their child-rearing behaviors as more favorable than they actually are (Schwarz, Barton-Henry, & Pruzinsky, 1985). It is possible that this could have circumvented the potential lack of agreement between informants by combining informant data which would include mother, father and child but this has not been done in most studies, according to Rapee (1997).

Prospective or observational studies of obsessive-compulsive disorder may be more objective than self-report or retrospective research, although the external validity of these assessment methods has not been well established. Specifically, it is not clear if the behavior of families in the so-called "laboratory" setting or during a given task generalize to other situations such as in the natural environment (Ginsburg, Grover, and Ialongo, 2004, p.37)

This would have the potential of validating whether children and their parents' respective perceptions of each other is distorted or accurate. According to McClure, Brennan, Hammen and LeBrocque (2001), observations of parent-child interaction could further provide data regarding parent modeling of anxious behaviors, which may factor into parent-child transmission of anxiety disorders. However, observational research can become quite complicated and require a range of strategies in order to verify reliability.

It should also be emphasized that for all intents and purposes, the outcomes derived from this study are based on a relatively small and select sample of fathers. For example, as it turned out, this was a study of nine middle class Caucasian males and while some presented as more affluent than others, I am really unable to offer any commentary on socioeconomic status and its impact on parenting children with obsessive-compulsive disorder. I will at least note that other researchers such as Levy-Shiff and Israelashvili (1988), Volling and Belsky (1991), and Easterbrooks and Goldberg (1984) have found that while fathers who are better off financially tended to spend less time with their children, they have also been found to be more positively involved with their young children than fathers of lower economic status.

It is also noted that the findings of this study were derived from intact or two-parent families. It is conceded that there certainly could be some insight gained from studying divorced/separated fathers as well as examining distinctions between those with and without custody of their children. Furthermore, another possible limitation of this study is that I elected not to gather comparable data from mothers and perhaps, as a result, I am not as able to evaluate the relative contributions of amount and quality of father-child interactions to child outcomes because I didn't compare fathers with mothers.

Research Bias

Questionnaire and structured interview-based studies appear to dominate research investigating the connection between parenting and child anxiety, the other design being direct observation of parenting behavior during structured parent-child interactions. According to Bogels and Brechman-Toussaint (2006), biases associated with the use of retrospective reporting, such as mood dependent memory bias, and a tendency to explain current problems from past experiences, together with biases related to the reporting of current parenting practices (i.e. under-reporting of maladaptive parenting practices) may misrepresent the true relationship between these parenting behaviors and child anxiety when data is collected with the approach that has been selected for this study. Sole reliance on paternal reporting may systematically under-estimate maladaptive parenting within these families. Alternatively, if I would have chosen to rely only on the child's report, I might elicit a valid measure of his or her *perception* of parenting behavior, but this still does not accurately reflect *actual* parenting behavior within the family (p.842).

Researcher Bias

Morse, Barrett, Mayan, Olson, and Spiers (2002) emphasize "research is only as good as the investigator" (p. 10) and that it is their creativity, sensitivity, flexibility and skill in using verification strategies as outlined earlier that more reliably determines the validity or rigor of a study. They further propose that "responsiveness of the investigator to whether or not the categorization scheme actually holds (and is kept), or appears thin and muddled (and the scheme is changed), influences the outcome" (p.11). These authors share Patton's (2002) viewpoint that it is imperative for the investigator to abandon any ideas that are poorly supported regardless of the potential they initially appear to provide.

Given the above, researcher reflexivity and social location will also need to be factored into my interpretation and analysis of the data. Some important factors to consider include gender and the risk of bias given that the researcher and the participants are all male. Secondly, I am employed within the child and adolescent mental health system as a mental health clinician with the Winnipeg Regional Health Authority's Centralized Intake Program. In this capacity, I am responsible for triage and referral of children and families to the Anxiety Disorders Service for Children and Youth. In fact, it is possible that I may have been the clinician directly responsible for referring some of these participants' children for treatment at this facility. Furthermore, I have a degree of experience and knowledge about obsessive-compulsive disorder which pre-dates this current study. The potential risk could be the emergence of certain pre-conceived expectations or interpretations of the data based on other experiences. Alternatively, the researcher's experience may also be an advantage as I should be less likely to misinterpret information being shared in light of my familiarity with the subject matter.

Relevance to Social Work Practice

Social work assumes an important role within the treatment and management of anxiety disorders, specifically obsessive-compulsive disorder in children and adolescents. The treatment modality commonly associated with social work intervention in the context of anxiety disorders in children and adolescents is family therapy.

The treatment of obsessive-compulsive disorder is most often best accomplished within the family environment and therefore this study on the interaction between parenting, specifically the role of fathers is not only relevant but essential for social work practice. In a study of father involvement in the treatment of behavioral disorders in children, Lundahl, Tollefson, Risser, and Lovejoy (2008) determined that "failing to include fathers, whatever the reason, tends to diminish outcomes and that including fathers results in more typical outcomes" (p. 102).

While father involvement may not dramatically improve outcomes, at least in comparison to mothers, these authors still emphasize that their inclusion in treatment leads to more positive outcomes for children. Strengthening men's involvement in fathering roles is crucial for social work practice given the evolving role of fathers during the latter part of the twentieth century and into the new millennium.

Fathering, according to Mahalik and Morrison (2006), is connected to a range of well-being issues for children, spouses/partners, and for fathers themselves. Their research and that of Lamb (1997) reveals that involved fathers "enhance their children's problem-solving skills and intellectual development, capacity for empathy, and promote an internal locus of control in their children" (p. 62). At the same time, fathers, like

mothers, utilizing a dysfunctional parenting style, place their children at risk for a variety of emotional and behavioral disorders.

Social work, like other disciplines has also largely ignored or at least under-estimated the important contribution fathers make to the health and welfare of their children. According to Lee and Hunsley (2006), the research on parenting continues to present a number of gaps, particularly as it relates to the role of fathers. They point out that there are important similarities and differences between mothers and fathers in their parenting styles, the relevance to practice being recognition of the differences and exploiting those which would be considered strengths to the benefit of the child but also the parent dyad.

It is anticipated that by developing a more accurate understanding of the impact of both fathers and mothers on children with obsessive-compulsive disorder, decisions regarding intervention strategies will be based on empirical data rather than generalizations derived from research on mothers exclusively or studies which have failed to make any distinction between fathers and mothers and their unique contribution.

The fact is that there has been considerable variability in the research to support the benefits of a family therapy component in the treatment of anxiety disorders, and begs the question of whether family-based interventions have been targeting areas with the most potential for change. For example, Nauta, Scholing, Emmelkamp, and Minderaa (2001), Barrett et al (1996), and Barrett, Duffy, Dadds and Rapee (2001) have all conducted long term follow-up studies of treatment programs which included a parental component with inconclusive results as to the beneficial effects.

It appears that the therapeutic strategies directed towards parents have tended to be more didactic in nature and most do not appear to pay attention to parental thoughts and feelings. Instead, they teach parents operant principles (for example, consistent praise of approach and coping behavior and ignorance of problem behavior of the child), "disregarding the parental thoughts and feelings that may provoke their current behavior or hinder them to perform recommended new behavior" (Nauta, Scholing, Emmelkamp, and Minderaa, 2001, p.339).

Phares (1992) noted that although the overall efficacy of a variety of therapeutic interventions for children and adolescents has been investigated, only behavioral parent training interventions have been investigated to establish directly the possible impact of paternal involvement in the therapeutic process. Another caveat that one must take into consideration is that "involvement" for fathers and mothers is often operationalized as attendance in therapy rather than as active participation or motivation within the therapeutic process. Nevertheless, in four studies completed in this area (Adesso & Lipson, 1981; Firestone, Kelly, and Fike, 1980; B. Martin, 1977; Webster-Stratton, 1985), father involvement, mother involvement, or both father and mother involvement in behavioral parent training resulted in therapeutic benefits for the child. Webster-Stratton (1985) found particularly superior maintenance of treatment gains in the father-involved families at one-year follow-up when compared to father-absent families. It should nevertheless be conceded that this could be misleading as increased stressors and economic hardship due to the mothers' status as single parents are variables which should not be ignored.

Further to the above, Lamb, Pleck, Charnov, and Levine (1985, 1987) conceptualized a model of paternal involvement as being comprised of three dimensions: (1) *Engagement* or the extent to which fathers experience direct contact and shared interactions with their children in the context of caretaking, play and leisure; (2) *Availability* or a father's presence or accessibility to the child; and (3) *Responsibility* or the extent to which a father arranges for resources to be available to the child, including organizing and planning children's lives. I would contend that based on the data collected from the fathers in this study that most, if not all, met or exceeded those criteria.

Given the growing evidence supporting the benefits of involving fathers in the treatment process, clinicians should begin contemplating more effective ways of engaging these individuals and perhaps participation for either parent no longer be considered as optional. Lazar, Sagi, and Fraser (1991) also found that therapist characteristics were significantly related to the inclusion of fathers in therapy. They observed that therapists who were more likely to include both mothers and fathers in treatment were male, newer to the profession, more educated in family therapy techniques, and more likely to espouse egalitarian beliefs about family responsibilities. In addition to these qualities, at a systemic level, when an organization, agency or practice within which these therapists worked was supportive of family involvement, offered child care, and flexible appointment times such as evening and weekend hours, therapists were more likely to engage fathers in treatment.

Social work tends to pride itself in starting where the client is rather than simply assuming that they know what is in the client's best interests. The lack of research regarding fathers is a case in point and is further evidence of antiquated assumptions of

their role in the family based on stereotyping which should have been considered redundant years ago.

For social work, according to Lukens and Prchal (in Bentley, K.J., 2002), a primary objective has been to move away from pathology of individuals with mental health problems and take a "strengths based approach" (p.127). That is, the client (s) is considered from the point of view that they possess a degree of resiliency and have the capacity to change with or without the aid of others. The nine participants in this study appear to have instinctively taken such a perspective which could, in turn, make the prognosis for change in their sons and daughters that much more likely.

On this continuum, the goal of clinical social work takes the perspective that improvement in social functioning factors into the equation, not only the individual and their capacity for change or adaptation but also affecting change outside of the individual. Saari (1986) makes such a point by defining the goal of clinical social work as "the improvement of social functioning through the enhancement of the meaningfulness of life experiences and an expansion of the range of choices for individual behavior in an environment capable of supporting a variety of adaptive patterns. Effectiveness of the interventions is presumed to rely upon the strengthening and reordering of the organizational structures in the client's life, including those structures that have been traditionally been seen as intra-psychic, interpersonal, institutional, and/or societal" (pp. 11-12).

Similarly, Johnson (in Bentley, K.J., 2002) proposes that each individual possesses particular risk and protective factors and that the role of the social worker is to "help diminish risk factors or lessen their effects, while developing protective factors or

enhancing their effects" (p. 366). Such an emphasis is in keeping with the social work profession's core set of values.

Implications for Education

Education, as it applies to this study involves those professionals who currently work with children, adolescents and their parents in the treatment of obsessive-compulsive disorder. Given that so little research has focused on fathers over the years, I anticipated at least some new insights. For example, there are a number of chronic problems in this field in the recruitment, engagement and maintenance of fathers in therapy. There was an expectation that the knowledge derived from this study will provide clinicians more insight into how fathers interpret and respond to their child's obsessive-compulsive disorder. Furthermore, education also applies to the fathers themselves as it was hoped that these individuals discovered that they possessed a more significant impact on their children than initially thought. From the researcher's perspective, there was an expectation that this study would unveil important data regarding the parent-child dynamic and the reciprocal impact as outlined in the literature review within "Top-down/Bottom-up Studies" (Moore, Whaley, and Sigman, 2004).

Implications for Future Research

What has been quite evident in this research on parenting and obsessive-compulsive disorder in children is the lack of attention given to the role of fathers in child development and child psychopathology. It is imperative that future research discontinues the practice of treating mother and father data as a single variable. As cited earlier,

Cassano, Adrian, Veits, and Zeman (2006) have found a moderately optimistic trend in that more fathers are appearing in research on child psychopathology and there are clearer distinctions of parental influence based on gender.

It is conceded that most of this research which takes into consideration the role of the father tends to be with older children and adolescents, which again speaks to outdated views of the role of men in early childhood development. It may be reasonable to conclude that researchers have taken steps to adjust theories and methodology that may have previously underemphasized the role of the father. Furthermore, there is much to be said about improving recruitment strategies which may increase paternal involvement in research.

According to Phares and Compas (1992), future research needs to go beyond simply affirming that fathers make a significant contribution to the occurrence of psychopathology in their children but clarify the mechanisms through which these effects are exerted (p.404). They further emphasize that it will not be sufficient to merely increase the amount of evidence that is accumulated concerning fathers and psychopathology in children but that there needs to be substantial changes in the types of evidence that are gathered as well.

This study failed to identify a "smoking gun" in terms of the negative impact of these fathers on their children. In fact, the study appeared to reveal a number of positive qualities in these individuals which impress more as protective factors than risk factors in relation to their children's obsessive-compulsive disorder. This study suggests that if this group of fathers were in any way representative of the larger population of parents that they assume an active and influential role in their children's lives. It would then imply

that there is a need by those working with children with obsessive-compulsive disorder to attempt to include fathers in the treatment process, directly or indirectly.

This is not to suggest therapy works better when fathers are involved but Phares (1999) maintains that "it is not important which parent is involved – it is important only that one of the parents be involved. In other words, whether the mother or the father takes part in the therapy does not matter as long as one of the parents or other primary caretakers is involved" (p.81). Phares noted that this lack of difference is the result of what is called "unprogrammed learning" (p.81) whereby the parent involved directly in the child's treatment disseminates what they have learned in therapy to the other parent. This enhances consistency in parenting and provides greater benefit for the child in the long run.

Further to the above, this study has also indicated to this writer that fathers are no more difficult to recruit than mothers in research, as exemplified in the ratio of responses to the total number of letters forwarded to parents. Also, there was no attrition whatsoever and all of the fathers expressed that they were quite interested in learning of the outcome of the study. Their participation and enthusiasm in this study also did not appear to be leveraged by the honorarium and in fact, most were reluctant to accept the money when offered. My impression from the time spent interviewing these nine individuals is that they view parenting as central to their sense of self and that it is not a responsibility which they prefer to defer to the mother as they maintain that it is to be shared.

For those who experienced even a moderate amount of success in parenting their child with obsessive-compulsive disorder, their responses indicate to this writer that it

provided them with a sense of competence and self-worth and any failures or setbacks along the way were treated as simply a challenge and not a call for a surrender. All appeared to take a great deal of pride in the connection or bond they have developed with their children.

In consideration of future research, I would also be less inclined to continue to depend on studies such as those referenced in my review of the literature which I found did not apply to a lot of my outcomes and I question whether these studies even considered fathers at the time their measurement tools or interview formats were designed. Historically, comparing maternal and paternal traits has tended to lead to rather negative images of fathers: the absent father, the incompetent father, the violent father, and the uninvolved father. Haas and Hwang (1995) emphasize that it is time that researchers studying fatherhood take more of a generative approach and place more emphasis on fathers' strengths and motivations in their paternal role. These observations are further shared by Pruett (1995) who noted that for many years studies were conducted exclusively on mothers which culminated in parental qualities being linked to feminine traits such as sensitivity, communication, and demonstration of emotion which, as has been elicited from this study, is clearly not an exclusive female domain.

Conclusions

Changes in societal trends need to be acknowledged as part of this study, particularly changes in the role of the father in families with children experiencing mental health problems. For example, it has been noted by Cassano, Adrian, and Veits (2006)

that there has been a marked increase in paternal involvement in child-rearing activities during the latter part of the twentieth century and carrying over into the new millennium.

In order to provide meaningful and accurate information regarding child development and psychopathology such as in this study of obsessive-compulsive disorder in children, theoretical assumptions and hypotheses that drive research must be broad enough to allow for the roles of fathers that are consistent with the evolving conceptualization of the family.

As outlined earlier, the current body of research suggests that little progress has been made over the past 3 decades to incorporate fathers into research that attempts to identify risk and protective factors in the development and maintenance of psychological maladjustment in their children. Cassano, Adrian, Veits, and Zeman (2006) suggest that there are several potential reasons for the under-representation of fathers in child psychopathology research. First of all, researchers may assume that fathers are more difficult to recruit than mothers, and that fathers would not have the time for research pursuits. According to these 4 authors, the research that has investigated participation rates of mothers and fathers does not support this assumption, particularly the work of Phares (1995). They further contend that researchers may be relying on "sexist theories that purport unexamined and unequal treatment of participants based on gender" (p.588).

In essence, there appears to be a considerably large body of research that has, for years, relied on antiquated societal norms and assumptions about the role of each parent in the care of children. These researchers have further emphasized that the inclusion of just one parent for understanding the development of child psychopathology is problematic and that it is becoming increasingly apparent that mothers and fathers each

make unique contributions. Thus, the inclusion of both parents in research efforts is not only warranted, it is essential. If research on the development and maintenance of psychopathology is based on the data from one half of the parental influence, "risks and protective factors that affect the developmental pathways of psychopathology may remain unexplained or misattributed" (Cassano, Adrian, Veits, & Zeman, 2006, p.584).

Today's fathers are much more active participants in the parenting process than they were in the previous generation. They are no longer simply the providers and their roles have become as diverse as mothers, although there remains a quantitative difference in involvement which none of these fathers would deny. Nevertheless, their time investment, degree of involvement, and availability (emotionally, intellectually, and behaviorally) has increased substantially over the years and so a more complex definition of paternal involvement must be acknowledged.

What also cannot be stressed enough from this study and what has also been outlined in some of the literature (Connell and Goodman, 2002), the direction of influence in the connection between the presence of emotional and behavioral problems in children and parental psychopathology may in fact be bi-directional. It is apparent from these interviews that most of the fathers found that their son or daughter's obsessive-compulsive disorder did act as a significant stressor for them, which may have affected their own mental health and that of other members of the family. Furthermore, while this term is often used to describe children under difficult circumstances, it cannot be stated enough that these nine fathers proved to be quite resilient in the manner they responded to the challenges posed by their children's obsessive-compulsive disorder.

Palkovitz (2007) noted, as I have in the course of my research, that the study of fathers within the past 30 years "has mostly adapted concepts from social sciences to fit their particular empirical research area" (p.190) which initially left me with a "square peg-round hole" quandary. That is, I spent a considerable amount of time and energy attempting to establish links between my findings and the existing literature in forming meaning units and themes. While similarities exist, there were also a number of emerging themes which I could not ignore.

Although I intended to take a "generative" (Haas & Hwang, 1995) approach to studying fathers, focusing as much as possible on strengths and motivations, I actually found myself rather surprised, if not inspired, by the display of dedication and concern these individuals had for their children. Furthermore, each presented as remarkably self-aware and willing to examine aspects of their character, both strengths and weaknesses, as well as their conduct and how it has impacted on their child and their obsessive-compulsive disorder. This insight also extended to their sensitivity to the impact this struggle has had on other family members including the child's siblings and the mothers.

In espousing such a strengths-based model, I acknowledge the challenges facing individuals and families with chronic mental health problems while at the same time, I have chosen to focus on enriching their personal strengths and emphasizing the uniqueness of fatherhood. I am very fortunate to have been permitted by these nine individuals to explore such an intimate part of their lives with them. I can only hope that the knowledge derived from this research will further empower them and perhaps other families in the future.

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