

Sad Dads: A Challenge for Pediatrics

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Opinions expressed in these commentaries are those of the author and not necessarily those of the American Academy of Pediatrics or its Committees.

www.pediatrics.org/cgi/doi/10.1542/peds.2011-0097

doi:10.1542/peds.2011-0097

Accepted for publication Jan 21, 2011

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PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

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FINANCIAL DISCLOSURE: The authors have indicated they have no financial relationships relevant to this article to disclose.

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A standout feature of the current generation of 67.8 million US fathers¹ is their involvement with their children. Time-diary studies have revealed that US fathers increased time spent on child care duties from 2.5 hours/week in 1965 to 7 hours/week in 2000, an amount greater than fathers in Australia, Canada, France, Britain, and Holland.² In 2006, 24% of 11.2 million preschool-aged children whose mothers work are cared for by their fathers during their mother's working hours.³ The notion of "family pediatrics," as well as the American Academy of Pediatrics report on fathers and pediatrics, encourages clinicians' active support of fathers, especially in light of today's changing families and the positive outcomes associated with father involvement.^{4,5} However, operationalizing provider support for fathers is not always straightforward.

In this issue of *Pediatrics*, Davis et al⁶ draw attention to the way that paternal depression affects fathers' parenting behaviors of their 1-year-old children. In their study, Davis et al focused on 4 behaviors typically discussed by pediatric providers during well-child visits: 3 positive behaviors (playing games, singing songs, and reading) and 1 negative behavior (spanking). The sample came from the Fragile Families and Child Wellbeing Study, a nationally representative, longitudinal birth cohort study of US children, born from 1998 to 2000, and their parents. Of the 1746 fathers in the sample, 7% reported a major depressive episode in the previous year. These depressed fathers were only half as likely to read to their children but 4 times more likely to spank their 1-year-old as nondepressed dads. For pediatricians committed to children's well-being, this is strong evidence for supporting fathers by addressing their parenting behaviors and possible depression in clinical encounters. Confirming earlier research,⁷ 82% of the fathers in the Davis et al study had attended a well-child visit in the previous year, which afforded an opportunity for engaging fathers in pediatrics.

As evidence mounts on the role that fathers play in families and the affect of paternal depression on child outcomes, how can pediatrics embrace paternal perinatal depression screening with the same vigor as is typical for maternal perinatal depression screening? Most pediatricians agree that identifying and referring mothers with symptoms of depression are within the scope of pediatric practice.^{8,9} Those providers who are convinced of the serious consequences of maternal depression for children and who use multiple methods for assessing mothers' moods have higher rates of identification and referral.^{8,9} Similarly, these factors are likely to be important for pediatricians' willingness to assess new fathers' mental health. Thus, there are 3 important elements that pediatric practitioners must recognize to respond effectively to paternal depression. First, the incidence of depression for fathers (and for mothers) seems to be highest in the first postnatal year,^{10,11} which provides a distinct time period within which practitioners can focus their energies. Second, practitioners must be aware that effective de-

pression screening tools, such as the Edinburgh Postnatal Depression Scale (EPDS), a widely used 10-question screen for maternal depression, have been validated for fathers, though often with small changes, such as a lower recommended cut point with an EPDS of ≥ 6 .¹² Third, as found in this

and other studies,⁷ fathers are indeed attending their child's acute and well-child care visits, which affords an opportunity for practitioners to discuss mental health and adjustment to parenting with fathers.

Fathers' active roles in families and their mental health clearly influence

child development and well-being. The field of pediatrics is now faced with finding ways to support fathers in their parenting role much in the same way we support mothers. In doing so, we may take one more important step forward in optimizing child health and development.

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Pediatrics; originally published online March 14, 2011;
DOI: 10.1542/peds.2011-0097

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DOI: 10.1542/peds.2011-0097

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