Fathers, Families, and Mental Health

Nydia Ntouda: On today's webinar, we have our presenters Dr. Sheehan Fisher and Dr. Craig Garfield. They will officially introduce themselves. You can get it from here.

Sheehan D. Fisher: Thank you. I'm Sheehan Fisher. I'm a Clinical Psychologist and Perinatal Clinical Psychologist at Northwestern University. I'm Associate Professor, and I focus on fathers' and mothers' mental health and how that impacts child health outcomes long term.

Craig Garfield: My name is Craig Garfield. I'm a Professor of Pediatrics and a practicing pediatrician at Northwestern University and Lurie Children's Hospital of Chicago. We're both really excited to be here and to be presenting this important topic to this group. We will be trading back and forth a little bit. You'll get to hear from both our perspectives on working with fathers and how fathers play an important role in families.

Our objectives today are for, one, is to describe how fathers are engaged in fathers in families. Then to discuss fathers' mental health and how it affects mothers and children. Then highlight how fathers can be engaged in programs and health care systems. Finally, because I think it may be of interest to this group in particular, to showcase one approach to the Fathers and Babies program that supports fathers' mental health.

It's always good to define who we're talking about and thinking about. Defining fathers in Head Start Programs, this comes from official documentation. The term father refers to fathers and other men who play a significant role in raising a child. This person may be a biological father, adoptive father, or a stepfather. He may be a grandfather, another adult male family member, a foster father, a guardian, or the mother's significant other. He may be the expectant partner of a pregnant woman or a pregnant person.

When we look at what fathers are like across the United States right now and all that variety, it's an extremely high number of people. 72 million men are fathers across the United States. 24 million fathers actually live in married couples with children less than 18 years old. 2 million single fathers live with children of less than 18 years old. And 20% of all single parents are men.

These numbers have actually been increasing over the years, and it may be something that you're seeing in the care that you're providing for families, is an increase in the number of men who are heading up households as single fathers. In general, webinars like this and other opportunities to learn about fathers come from a desire within the field and the work that you all are doing to understand better what roles fathers play in families. There are 250,000 stay at home fathers as of 2020. They are caring for about 400,000 children. This number has been steadily increasing. COVID and remote work has actually allowed some of this to change as well.

When we look at the variety of fathers in families, while 1 in 6 fathers may not live with their child, they are still involved. I'm sure this is something that you're coming across in your work too. 98% of fathers who do not live with their children, are involved with them to some degree. That may be anywhere from occasional visits to daily visits with that child.

40% of births in the United States are to non-married couples. Fathers who do not live with their children may be younger. They may be non-married. They may be of a lower socioeconomic status. They may be unemployed, have poor well-being, and have relationship instability. They may spend less time eating with, caring for, or playing with their children than resident fathers do.

Nonetheless, I think the first point is really important to remember, that fathers are overwhelmingly involved, regardless of their marital status, with their children. These next couple of slides actually are kind of getting at some of the opinions and thoughts of fathers across the country from a survey that's done by the Pew Charitable Trust.

This is, is fatherhood a positive experience for dads? This is what they asked mothers and fathers. You can see in the light green here the dads and the dark green and the moms, it's pretty equal in the percent saying parenting is extremely important to their identity. It's also nearly equal in the percent of parents mothers and fathers who say that it's rewarding all the time. Actually, dads are a little bit ahead of mothers saying that parenting is enjoyable all the time.

When you then look at who's doing the care at home, this has been pretty major shifts since 1965 to 2016. You can see on this particular image that paid work is in the dark green, housework is in the light green, and child care is in the more mustard colored here. You can say for mothers that that is all those numbers have increased both in the percent of time spent in paid work for moms and housework and in childcare.

From 1965 to 2016, it's really been a remarkable increase for dads in the child care realm. Almost three or four times more hours per week spent by dads in child directly in child care with their family. This is an important slide that also focuses on the fact that mothers still are doing the lion's share of work in the home. I think that's important to recognize. Yet, there still is a lot of opportunity for dads to be involved in the family in the care that they're providing.

Finally, when they asked dads were they spending enough time with their child, when you look at fathers, 63% said that they were not spending enough. There was too little time spent with their child. That was mostly due to work obligations. Again, you look at 62% of dad of fathers in this slide say that they aren't able to participate because of work obligations.

I think that data actually helps us counter some of the pre-assumptions and biases we might come to when we encounter fathers. Fathers are, in fact, interested and willing to participate in the care of their child. They want to learn, and particularly early on, they actually are most interested and receptive to different ideas around how to participate with their child. What

tends to happen, though, is that many dads end up going back to work, and then work becomes the primary thing, bringing home a paycheck, which is also important.

We have a good opportunity in the beginning with a new baby or young children to encourage dads to be involved and let them know how important it is that they're involved. Fathers also are capable. There really is no evidence to suggest that dads aren't able to do everything short of breastfeeding their baby that mothers do as well. They are available. In that last slide I showed you, it shows that dads are also tied up with work. But generally speaking, if we can get across to fathers, the importance of their involvement, they will make opportunities available to participate with that baby or that child.

Then there are race, ethnicity, and cultural perspectives, which are important to bring to this, and biases that we may bring to the work and that society in general may have towards fathers. Some of that may be what's culturally acceptable in families for the dad to be doing and how involved are they with the child. There may be expectations around who does what in a family and what roles people play. Those are important things to explore as you work with families and as you work with fathers.

I think one of the things that you can really take home, though, is that when you start to think about the fathers that you know in the world that you work with, you can understand that it's very different than what might be appearing in the media as kind of like a bumbling dad who doesn't know how to even put on a diaper. Things like this Robert Wood Johnson Foundation Culture of Health Blog has really started to change the narrative and take back the story of what it means to be a caregiver, what it means to be a father in families today.

Some of these examples of these blog posts include Reclaiming The Narrative of Black Fatherhood. Other is Meeting Parents and Caregivers at Their Aspirations, how do dads want to be involved. Black Men Who Care Are the Role Models We Need. And finally, How Supporting Men as Caregivers Advances Gender Equity. It's really starting to take ownership of the narrative of fathers and families.

To look at this again, we know that fathers who are involved in their children's life they're competent caregivers of infants, they interact a little bit differently with their children than mothers do. For example, the two examples. One is fathers use different language when they're describing things as you're walking down the street compared to mothers. That language, actually, helps children develop more language exposure, and are actually beneficial when they're starting kindergarten and being in school too.

Dads might stereotypically describe something that's happening on the street. Moms might describe something that's happening in a store window. Just different language that comes into that mom. That's just kind of a stereotypical concept, but you get the idea. Fathers contribute to their child's development, including school readiness. They do that through reading, through talking with them, through singing with them, and being involved with them. Fathers also have an important role to play in the positive parenting of mothers and the support of mothers as they're going through that transition into motherhood and parenting.

Often the father is the first person that the mother's going to turn to for support and guidance in what's happening, and with questions. The more that we prepare fathers to be able to help in that capacity, the better the whole family is going to do, contributing to the well-being of the family. Then what more recent research has shown is the positive gains in fathers own development in life decisions. Even among fathers that we've interviewed in the past who are unemployed, lower socioeconomic status, dads who you would think that, oh, these guys don't want to be involved, no, that's not true.

They actually see having that child as an opportunity for change and a real lever towards making some improvements and making different life decisions for what they want to do, because they want to be there. That was what we heard from the dads we interviewed, they want to be there for their child. When that child goes to kindergarten, graduates high school, heads to college, they really want to be there.

Why is fathers' mental health so important? First of all, fathers who have mental health problems, like depression, are more likely to use corporal punishment or physical punishment. They're less likely to engage in positive parenting behaviors. They're less likely to actually to be reading to children, to play and engage with the child. Fathers with mental health disorders like depression also have lower-quality co-parenting relationships.

The way that they interact with their partner is not as positive and adds to stress on the partner's side of things as well. Children of depressed fathers report higher levels of emotional behavioral problems. That down the road, actually, when the children become tweens and teenagers, if they have had a depressed father, that actually impacts the child's well-being even as late as into adolescence and young adulthood.

Father involvement in child-related activities have positive including having positive father-child relationships and engaging in multiple forms of involvement is strongly related to child well-being. All the work and all the things that we're talking about today is trying to help improve fathers' involvement. In the more that dad is involved in child-related activities, the better the outcomes are for child well-being when these are positive activities. I'm going to hand this over now to Dr. Fisher.

Sheehan: Thank you, at least I want to highlight that when we're thinking about families and fathers, historically this is how we understood it. That we understood that when we looked at child outcomes in family environment, we're focused on mom to baby, and looking at the mother's mental health and health in general, and how that affects the fetus and then child. Fathers were many times viewed as, in the periphery, that they were kind of this outside thing that wasn't really focused on thought of as relevant to the family health.

We're trying to change that process by starting to think about how to integrate fathers more into this and think about this from a research experience. Understanding how the mother and

father influence one another for their mental health and also for their relationship if they're in a romantic or co-parenting relationship. Then seeing how that then in turn affects the child.

In addition, we want to think about the direct impact of each parent. We know a lot about the data around mother's impact on the child, but we also now want to think more about the father's direct impact on the child too. Understanding that they are experiencing their mental health can have an impact on this child. When we look at this, it's now looking at it as a more dynamic experience. Honestly, if we were to change those arrows, those arrows would be bidirectional where the child also can influence the parents, their mental health, their well-being, and even their relationship.

When we're thinking about this holistically, we're now looking at the whole family unit rather than simply thinking about this being a mother-child issue. When screening for mental health, we think about how to best approach this. Now, there's different measures out there that are utilized. The EPDS is commonly thought of utilizing it for post-natal depression. That has been validated for mothers and fathers now.

There's a more common measures that you might see in a hospital setting, like the PHQ-9, or even other measures you see more in research, like the Beck Depression Inventory or the Inventory of Depressive Symptomatology. Those are utilized, which have a lot more information especially for the IDS. It has more options rather than the PHQ-9 or the EPDS versus 9 or 10 items.

In addition, we want to understand the risk for or before we get to that is that with those screenings, we understand is that fathers have an increased risk of depression during the postpartum period. There approximately about 10% of fathers who experienced depression during that prenatal postpartum period, that first year, compared to moms whereas about 20%. That ratio stays the same as when you see in the general population of women versus men. About a two-to-one ratio of developing depression.

Even though it's commonly just within culture and even research we focus a lot on depression, we want to at least highlight that anxiety is also a high risk during the perinatal period. That this is something that is impacts both moms and fathers, and, therefore, there are some measures that can be utilized. The most common one is the GAD-7 which is generalized anxiety disorder seven, which is a seven-item measure of anxiety. Along with the Beck Anxiety Inventory is also common, especially if you're using the Beck Depression Inventory to measure depression.

Still even less research is focused on bipolar disorder, but there is enough data that says that fathers are at risk of those who are already predisposition or have a history of bipolar disorder are more likely to have hypomanic or manic episodes during the postpartum period. At increased risk thinking about the fact that their stress levels, their sleep habits, their social regulations are disrupted during this time, they're more likely to have a risk of developing symptoms during the postpartum period.

Some commonly used measures. The MDQ is really looking at, does this person meet criteria in lifetime? Does this person have bipolar disorder given that it is a chronic illness? Whereas the internal state scale is more focused on the day-to-day. Like, how are you feeling over this past week? What were the fluctuations of symptoms? Because you already have a diagnosis. These two measures can be quite useful for thinking about screening mood and anxiety disorders in fathers during the perinatal period.

Are the problem and this is gradually becoming less of a problem but still a major problem, is that fathers are not always accessible. That many times if the mother is coming to the prenatal visits, the father is not there. We're trying to find ways of circumventing some of the limitations of the maternal child health care system. One, that we need to make it more inclusive in general. But also if the father is not there, how do we screen for father depression? By asking the mother to complete forms that would rate her experience of his mood. If that is rated as high, then we can do a follow-up screening with the father directly.

This was developed as a way to ensure that we could get access to the files mental health given that we want to understand what the father is going through even if their father is not at the doctor's appointment. As I was going through this and doing this study, we saw that there were some things that were highlighted that realizing that fathers are less likely to report symptoms of feeling sad, or we'll call it softer emotional symptoms.

Part of it being on just how society encourages men to experience their health in mental health and what they're more likely to report. That called into question whether fathers and men in general manifest depression differently. We know this in other studies around even race and other ethnicity that people sometimes literally experience their symptoms differently than others based on their experience versus what is considered the key research in majority of participants, which tends to be more Caucasian.

We see that, for example, Black individuals might experience symptoms a little bit differently. The same thing we're concerned about when it comes to gender, that we're learning that fathers and men tend to under-report symptoms. That they might even have a masculine interpretation of their experience where they might experience it a certain way and may not view it as the word sadness, but might articulate it in a different form.

In addition, there's also the bias that can exist where clinicians are less likely to diagnose depression in men, and also men just are less likely to seek treatment. There's a concept that's called masculine depression. For that what we learn is that fathers and men might tend to experience and report depression more as externalizing symptoms. That they might be likely to engage in acting out type behaviors, and less emotionally phrased internalizing symptoms.

For example, the Masculine Depression Scale, which is one of many scales, you can see that for the internalizing symptoms, there's different options here that don't necessarily say I'm sad, but will focus on things that I just can't win or I feel a pit in my stomach or I feel odds are against me. I'm feeling numb, or even feeling like they're like hitting a wall. Or that I've been thinking about crying but can't cry.

Things that show that men are experiencing the similar type of distress is the underlying core of the construct, but they may not report it or even experience it in the same way as the traditional EPDS or PHQ-9. In addition, the measure includes externalizing symptoms. This gets into the idea that men are more likely to engage in either aggressive behaviors, whether verbal or physical. They might be more likely to engage in hypersexuality, whether it's about pornography or sex in general. Or substance use, like using alcohol or drugs as a way to manage their emotions.

This gets into the concept about how men tend to like to mask their depression by, well, I don't feel sad because I'm drinking every night. I don't actually get a chance to feel what I'm feeling, therefore, I don't feel sadness, but I am engaging in a change in my behavior that will fall under the umbrella of externalizing behaviors. This is important so that we are understanding that even though we know there's a heightened risk for fathers developing depression, this might actually be underreported not intentionally, but because of the measures that we're using to assess the level of distress that men are going through during this time.

Another thing then to look at is, OK, why does it matter? If fathers are dealing with depression, how does that relate to the rest of the family? One, it matters in itself that fathers are going through the stress. But we're also learning that fathers during the postpartum period experience depression that can have an impact on their child's internalizing and externalizing behaviors.

That the child now the father's depression at postpartum period can predict that three years later, the child can start to develop sadness themselves or anxiety or start to engage in misbehavior or oppositional type of behaviors that children who don't have a parent or mother and father with depression are less likely to experience.

I meant to highlight sorry is that what we one of the key findings about this, and especially one of the key clinical findings, is that when we account for mothers' depression in a model that predicts child health outcomes for internalizing and externalizing behaviors, after we account for the mom's impact on the child, the father's mental health during the postpartum period and subsequent depression has a direct impact on the child's mental health.

Which means that if we spend our energies on treating the mother's mental health and depression alone and do not address the father, the father's impact on the child is still there. Which means the child is still at risk even if we only focus on the mom. In looking at that model I was showing earlier with the mom, dad, and child, if we only focus on the mom, child relationship, we actually are still putting that child at risk for long term mental health and physical health issues because we're neglecting to see that the father's mental health does have importance within the family unit.

What do we do? How do we engage fathers in the health care system, in the community programs? How can we make sure that they are involved in the work that we're doing given that we understand that they do are at risk for developing depression and other mental health symptoms and have a direct impact on the family?

For one, when we're thinking about health care systems and community programs, we need to make sure that there's imagery that reflects the father. That the father's in the pamphlets and the materials, the handouts that we're utilizing. Letting them know that we are actually thinking about their experience and view them as an inherent part of the family. Also, encouraging that for just the family unit to understand how the father might apply to the family.

In addition, we need to consider what we call the clinic. I mentioned, the mother baby unit or the women's hospital, which are important things to have, but is there a space when we think about the family broadly to have inclusive language that also includes the father in that? Because we need to get away from some of the gender bias that is the mom's problem, put all the burden on the mom versus this should be a united effort of both the mother and father within heterosexual couples to support the child.

When the parent comes, like for example, even from OB/GYN visits and other pediatrician visits, is, are we making eye contact? Do we actually look at the other partner? If we're only looking at the mom when we're talking about at the pediatrician visit about what needs to be done for the child, that's signaling we're perpetuating that the mother is the one who has to do all the work. Versus inclusion of the father allows space for both of them to be engaged in the family unit.

Try to make sure that we're inclusive at all points of contact, not just the main visit for working with the doctor. It's also the staff and the nurses and the front desk. Everyone needs to be thinking about what they're doing to contribute to this issue or to undermine it in a way that would be supportive to equality in the home.

We need to make sure we're conscientious about exclusionary policies where men are not permitted, for example, or that they're many hospitals automatically put the mom as the emergency contact person versus asking the family who is going to be responsible for the child's medical care. Once again, we don't want to keep creating these gendered divides.

Then even something that needs to be done on a statewide level, like in Illinois for example, we do screening for mothers' mental health. That's a state law that ensures that mothers are screened for depression during the postpartum period. We need to now start thinking about making sure that we include fathers in this screening, given that we understand there's a heightened risk and that they impact the family.

We need to think about broadly how these are ways that we can engage the father. This is not only this is not an exhaustive list, but it's a start. Part of it is just getting the fathers engaged. Like buy-in is a big part of getting them engaged. The foot-in-the-door process can help.

For example, we can invite the fathers to the mother clinical visits during the perinatal period. Asking if the mother is OK with it for her own visits, OK, can you bring the father in the next time we make sure they're a part of the support system?

We need to help fathers to even be more aware of their own experiences. Like I said, when they're talking about masculine depression or that way that masculine depression exists, it doesn't mean the fathers' is doing that necessarily intentionally, but they may not be fully aware that they're feeling sad. They might feel like, what? Like, one of the items on it said I'm not sad, I'm mad. They may not even be aware that they're feeling sadness or vulnerability because of how they're being genderized throughout their life.

Need to make sure we provide psychoeducation on the impact of the paternal mental health on the family. One of the things that I've focused on when trying to do recruitment and also even engaging fathers in a clinical setting is that if fathers understand that their experience actually matters for their own health and you see this across medical health is that men many times don't always take care of their own health.

If you let them know, well, if you don't take care of yourself, your child's going to be at more risk for depression or your child will have certain developmental outcomes, then actually gets them more likely to want to be engaged in the support of their family.

This also creates buy-in for why they want to take care of their own mental health. Then you also have to address the biases and the questions the father might have about mental health. Try to make sure that they know that this is the science behind it and answer their questions. Even if they have a bias that might be gendered, help them understand where this bias might become a pitfall for their general values and goals.

Then even making possible connections for treatment if needed. That we don't want them to think that just because they talk about their mental health, automatically they need to go see a doctor. When appropriate, making sure that they are getting that support they need. Even understanding how their masculine identity might impact how they engage and interact with the health care system providers that they can help them navigate it have the information needed to help navigate those systems properly.

One thing we want to, of course, highlight is that we want to engage fathers in early childhood programs. For example, to find out different Head Start and Early Head Start Programs you can do with the partner and engage fathers. That there are things out there.

This is a pinnacle and premier program to support fathers' adjustment. We also need more of these types of programs to really be geared toward the fathers' experience and support them so that they engage in the family and understand what the research says, what programs are available, and how they can grow within this new role in their life.

Finally, I want to highlight also how fathers can support mothers' mental health. Engaging fathers can help moms too. Even if you are focused on mom's health outcomes in general, utilizing the father within your goals can actually be a strength to your clinical intervention.

Why do that? As a clinical psychologist, even though I work with moms and dads, most of my patients are moms. What I've noticed is that as a field, we do a lot to put to support the moms.

A mom is dealing with depression, there's research and there's a lot of studies on the medication side that then we say to the mom, OK, you know what? This is what you need to take for supporting your mental health while pregnant or postpartum.

The mom has to think through that and has concerns about it because she's worried about breastfeeding. Those questions are answered. Then we say, go to your therapist. Therapist gives her behavioral interventions that when you go home, I want you to do these exercises every week. I want you to engage in these types of activities. These are things you can do for mindfulness, and other skills they want you to learn.

We put so much on the mom that the mom has to do all of it while also be a mom, and as Craig highlighted, still doing the majority of the household work and still many times working full time jobs. What we need to get away from is putting all this pressure on the mom to do everything, including now take care of her mental health, without utilizing the father, the person in the home that can help support her well-being.

There's different ways that we can do that fathers can do that. For, one, fathers can be advocates. I highlight this picture is actually of a father who I did a couple of talks with who lost his partner to suicide because he was advocating for her. He was trying to tell the doctors that she was in danger and trying to make sure they understood. Unfortunately, the doctors didn't always listen.

Many times fathers are the key advocate for their partner. They're the one who sees the mom day to day and knows what she's going through. We need to be sure that we listen to them when they're coming in and saying, hey, she's not OK, or I'm seeing her different than she normally is. To take that seriously, but also encourage fathers that they have the right to be an advocate for their partner.

In addition, we want followers to get engaged not only postpartum or when the child is older, but prenatally. We know that prenatal involvement predicts postpartum involvement. We need the fathers to attend the obstetric visits. We need the fathers to think about preparation for the postpartum period. Not just that they're going to build the crib or some of those things.

Really, about the planning for who's the doctor going to be for the pediatrician going to be for the child and starting to create ideas about how they want to approach parenting. Like really ingrained and invested into that preparation for the postpartum period. Even thinking about how do they want to have time with the child because they might have to go through extra steps, unfortunately, to make sure they can have parental leave after the child is born to be able to have time with the infant and with the mother. Then also rather than just assume, even asking what are the needs of the mom during pregnancy.

During the postpartum period, the fathers can then get involved with the infant soothing, the skin to skin contact, even assisting with breastfeeding. Breastfeeding is the only thing that they many times if it's a cisgender father can't personally do, but they can also support the mom during because that is one of the most stressful parts of having a newborn.

Then just even increasing their competencies from holding a baby to changing a diaper to cooking and cleaning, for whatever it is to make sure that they can be an equal partner in the home during the postpartum period, and not for it to be an out that they don't know how to do something. They can be learning, once again, prenatally how to develop these skills so that they're ready for the postpartum period.

Then, like I said, for the periphery family responsibilities, there's a lot of things that take the support the home broadly, and for the father to take serious consideration about what are those things and how could they get engaged. To be sure, though, we want to acknowledge that we do want to respect the mother's confidentiality and boundaries. If you're working with a mom, you need to ask her does she want her partner to be engaged in the treatment.

Also thinking about making sure that we are being inclusive about that there is risk for domestic violence, but that's not always what we need to jump to. We need to make sure we ask, but not make sure — create broad exclusionary policies, but make sure that we do ask the father the mother about is there a risk of domestic violence. Even acknowledging that sometimes there are absent fathers and uninvolved fathers. But as it says, psychoeducation should help support that goal.

There are also for us, for all of us in this webinar, thinking about future education on perinatal non-birthing parents. For example, the International Marce Society is a society focused on perinatal mental health. We have a fathers special interest group. I'm the chair of that group. actually, Craig's also a member of it. We do a lot of work in workshops, opposing papers, trying to provide education to anyone who works with fathers to make sure that they receive information that will be useful for them to apply.

The thing I always say is that we don't expect everyone to be an expert in fathers. That's not the goal. We provide information so you know enough to know how to utilize fathers in your research and/or clinical practice in a way that will support your personal goals by being informed. I also want to highlight that we have I'm the chair of the special interest groups in general, and recently we started the sexual and gender minority special interest group that's focused on both birthing and non-birthing parents. Think about we talked a lot about fathers, but that is technically not necessarily really capturing the full spectrum of the family unit.

When you think about non-birthing parents in general and Dr. Leiszle Lapping-Carr is the chair of that group to really make sure she provides education and information and tools that can make sure that we're providing an inclusive environment around non-birthing parents. I wanted to highlight also a model that includes father involvement to address mother mental health. This is a study that is ongoing we're wrapping it up, actually from NIMHD that I lead that's focused on African American fathers supporting mothers' mental health.

The idea was similar to, as I mentioned, for the ways that files can be utilized. I package that into an intervention that provided training to fathers where they were trained on how to support mom's mental health. So the whole intervention, the mothers not involved with the

intervention at all. We provide the information to the father that he can go home and support the mom in a healthy manner that helps to support her mental health.

He's trained on different things, these four categories for prenatal and postnatal involvement. They're trained on mental health, about what is the mom going through and how he can support her mental health. Learn communication relationship skills to help the mom feel supported and loved within the relationship, which can be under a strain during the postpartum period.

Then also a discussion about a balanced division of labor within the family task to ensure that the father is doing his equitable amount of work within the home for, like I said, changing diapers, but also like shopping for the food or making sure that there's supplies in the home. That they're dividing up the labor in a way that is not based on gender but based on what's best for their family and equitable split.

This is one model of how this can look of using this information to support fathers to engage in the family in a healthy way, but also even address their mental health. This is just a model of as I highlighted. What we did was also targeted the highest effect sizes for what actually affected mom's mental health as the way we develop this study. Now I turn it back over to Craig.

Craig: Thanks, Sheehan. And maybe this is a good place to mention as Sheehan kind of touched on too that what we're presenting today is information that is fairly cis gendered for male-female couples. I think that's an important piece of the parenting situation across America, it's the most families are cis gendered in America.

However, there's a lot of work to be done. Sheehan and his group are leading a lot of that work as well, as well as just raising awareness. There, ideally, will be future webinars on those sort of topics as in addition. I'll just pause for a second here and mention, we've worked with the CDC now to update what's called their pregnancy risk assessment monitoring system or PRAMS.

That is a 35-year-plus survey that's been in the field looking at mothers in the perinatal period and their needs. They approached us a number of years ago after moms were writing in the margins, why is the only question you ask about my partner was, did he hit, kick, beat, or slap me during pregnancy? They continued to write, the only way that I made it through the pregnancy was with the support of my partner.

We've developed a PRAMS for dads now that's live in five different states, trying to get a lot of this information and trying to really elevate what's happening in families today that have fathers who do want to be involved, and how we can do a better job of understanding what their needs are. One of the first questions that comes after we present that information is, what about same-sex couples or what about other issues in trans families and things like that?

Those are great questions. We're very early in understanding that and need people to advocate to actually present that data as well too. With that, Sheehan was wrapping up his section, talking about different models of ways to get involved and help and support fathers and

families, and how to conceptualize that. I want to give you one very practical approach that we've come up with. It's called Fathers and Babies. It's specifically been piloted in the home visiting environment which some of you may be coming from or may be familiar with. What we realized is that — the slides are not advancing for me. If someone can move that. Back one. Next slide.

Fathers and Babies really was an acknowledgment that there's increased attention to paternal perinatal health. That the paternal perinatal depression prevalence is about 10%, as Sheehan had mentioned too. There were no really good existing interventions that focused specifically on paternal mental health. That was the study that we had done looking at what was available for fathers.

We did some focus group with home visitors, with home visitor clients which were traditionally always women and their male partners. We got two recommendations that guided the development of FAB, Fathers and Babies. One was to focus on fathers' mental health and help fathers support their partner's mental health. There's this idea that, well, no, we're only going to help the mother, and we'll help the father to help the mother.

But we recognize that fathers actually also needed help as well, and that we needed to make this intervention flexible to accommodate fathers' schedule. Without really good family leave available in this country, most fathers are back at work at least by two weeks, if not earlier. We developed this for the use by Early Head Start home visitors and other MCH providers.

There's a link there at the bottom of the slide that you can go to for more information. I still can't control the slide. Next slide. What the intervention was, if you hit it again, FAB sessions are for male partners that are delivered concurrently with mothers and babies sessions, and that are received by mothers' home visiting clients.

We basically took mother baby, MB, and combined it with FAB. The first FAB session was delivered at request by the fathers either in-person or by phone. Then the subsequent sessions can be either in-person at the same time that the female client is being given a service at home, or via text messaging with embedded links in the FAB content.

What's really kind of cool is that the FAB content mirrors the mother-baby content. For example, mother-baby session number three encourages identification of different types of pleasant activities that improve mother's mood. The FAB session number three encourages identification of pleasant activities that improves father's mood and highlights the importance of the female partner also engaging in pleasant activities. It's a way to actually bring couples together as well. Next slide.

What, at the end of the day, we were able to develop was a home visitors manual and a father's manual. I'll show you an example of what the father's manual looks like. Next slide. You can take a look. It's very small, but you get a sense from here's worksheet 2.1. This would be delivered in a text that then parents then fathers are able to access through a link.

Gabe and Michael's day. It's a little bit hard to see on the slide, but on the left-hand side is Gabe waking up, really, just down already from the get-go. Not having a good day from the minute he woke up. Then there's Michael's day where he actually is engaging in and looking for opportunities for pleasant day activities. Then then there's a worksheet of what kind of pleasant activities might be, things that you want to engage in that you can check off that you've done or thought about. Next slide.

We did this in a pilot study where we looked at 30 mother and father dyads or couples this was predominantly African American and Hispanic dads in a variety of different relationship statuses. Some were married, some were on cohabiting, some were coupled consistently. What we found quantitatively is that there was a decrease in perceived stress among both the male and the female members of the couple at three months after completing the FAB. This remained, actually, at the six-month follow-up for both males and females.

There was a decrease, actually, in depressive symptoms and anxiety for both males and females. It was a small sample, so we don't have statistical significance for that like we do for the perceived stress, but we do get a very strong signal that depressive symptoms and anxieties improved if they had participated in this FAB study.

When we looked at it qualitatively in some of the comments that people had said if you can click the slide again. Yep, click again. One dad said, "It helped me with stress and helped with mental health." Another dad said, "FAB helps you think about a young baby's future, your own future, your partner's future, the kid's future. It helps you think, like, it's not only for babies and fathers or babies and mothers, it's broad. It's for everybody." That is really, was our goal, was to think about it from a holistic perspective. Next slide.

To give you some of the take-home messages from today's session, father's mental health is affected by becoming a new parent. This affects family health. As we said, there's been a shift in the field to think not only about how do we do this to help babies and mothers, but also what's the benefit for the father because, ultimately, it impacts the entire family.

Fathers and mothers and infants can each have an impact on the other's mental health. Engaging fathers in their children's lives is important and can be supported by Early Head Start staff as well and Head Start staff. When fathers are engaged and supported, they can then be a resource to support maternal mental health. I think that's one of the take-home messages here.

If you want to learn more and see some of the other resources that are available, two additional resources from Fathers Incorporated include status, code blue, addressing the mental health and resiliency of Black fathers. Another resource called mental health matters, why Black fathers' positive mental health is good for youth academic outcomes. Again, these are offering broader perspectives into just thinking of that maternal child health, or MCH, is just about the mother and the child. But it actually brings the F into MCH. I'll turn it back over to Nydia.

Nydia: Great. Did you want to take any of the questions or that we had come into the Q&A, or just the takeaways that you gave?

Sheehan: Happy to, one of the questions was from Jesse stating, is there a way or a recommendation for men to overcome not expressing their feelings, emotions? How can we approach fathers in regards to their mental health?

It depends on what point you're engaging with them. Like, for example, if I'm seeing a father who's actually coming to see me, that's already a head start. But it's still a lot of trying to normalize talking about emotions and even, honestly, a lot of it is about developing insight into their own experience, where they just maybe don't have the words or even awareness of what they're experiencing.

In other settings, if I'm working with a mom, one of the key things I've found is just bringing the father into the mom's visit for one time. Just talking about family health and things gives them an idea of, oh, this is not a dangerous place. It's not as odd to talk about feelings. It's almost like a nice introduction to it.

But, of course, if you're not seeing them in like a mental health setting, then it is part of it is just a lot of it about normalizing it in the different pamphlets, the different ways you talk about it. Like having diversity within your staff and in the clinic what your program is so that men and women are talking about mental health and health in a normal way, it really just creates a more relaxed environment.

I think that we've seen a lot of this even within culture, in general, like from media and other things that the more something becomes popularized, the more people feel comfortable admitting it. But it requires some of that modeling up front to make it a safe space to actually know that if I say this, it doesn't conflict with my identity as a male or about my strength or other things. And you see this across different cultures and backgrounds, but we're talking about it specifically around the male gender.

Craig: I would just add on to that too, Sheehan, to this particular question. I think normalizing it is a big step in the right direction. And even saying things like, I've talked to a lot of dads and they also feel like they don't know what they're doing when their child is born or they're feeling the stress of this time as well, helps the dad understand that they're not alone. That this isn't something that's just unique to them.

One example I'll give is that as part of my clinical work, I work in the neonatal intensive care unit where babies are born premature and stay in the hospital for weeks or months at a time. We started a NICU dads group there. We don't call it a support group because as Sheehan was saying, there's some language that dads automatically say, that's not me. I don't need support. I don't need therapy. There's that mental health stigma. We just call it NICU dad's group.

We get anywhere from five to 15 dads in that room. Where people think, oh, dads aren't going to talk, they're not going to share their experiences. It's actually the exact opposite. Once they start telling the story of what's been going on and it might not be about what they're feeling, but it's about what the mom and the baby are going through, and eventually we come through the back door to how is it for them and how are they feeling, honestly, they won't stop talking about it. We went on for hours.

People are in tears and they're hugging. It's the exact opposite of the stereotypes that we have around men and males and masculinity. That is in the clinical setting, for sure. You need to think about, OK, in my environment where I'm working and engaging with these dads, how can I break through to them to say, you know what you're experiencing is what many, many dads feel. I have yet to meet a dad again thinking about the baby experience who doesn't think they're going to break their baby. That they're just so big I just had a dad this week tell me, I'm big, my hands are big, and my baby's really small.

I was like, you know what? The more confidence and the more exposure you have now to your child, the more likely it is and the research backs this up that when your baby's nine or 12 months old, you're going to be more involved because you feel more comfortable. When you can go home and participate in the care and the help and the feeding of that baby, the more likely you are to feel comfortable as that baby gets older and you've built that relationship from the beginning.

Sheehan: I take back on that a little bit before we get to the next question is, yes, that's why it's emphasizing early involvement. A lot of times I tell fathers, do not let your own child be the first child you ever held. Get experience before the baby comes because the more they feel comfortable with it, like Craig said, that really predicts involvement long term and even sets the tone of how much there'll be a balance of parenting responsibilities between the mom and dad.

If it's already starting off with those first few months the father is disengaged, it starts to set this almost cements this dynamic between the mom and dad of whose role is the child or not, and we're trying to move away from that model. Another couple of questions were on the MDS. There isn't, from my understanding, any specific training or certification for the Mass and Depression Scale. You can look up the article that tells you how to measure it and to or to score it.

But outside of it there's no specific training that's needed for it. I think it's something that's useful, even just the item levels are useful, much less the sum score, to at least understand how much the stress is this person going through. I'm not saying it's a perfect measure, but it is a start to move in the direction of broadening beyond just simple depression measures that have been more popular. I'm not aware of it being in any other languages. I do some research for Spanish and English. I haven't used this measure yet in it, so I haven't translated it myself.

But I would say it would be important to consider utilizing it. But it is also not measured, or it hasn't been tested in other cultures to see, do each of the items actually reflect how this will be experienced in another background? But that's what we need, is like more work to broaden these measures in general, even some of the traditional measures.

Craig: I might jump in on Amanda's question here. Do you address the purple period after the baby is born? That's the purple period of crying, I believe, she's referring to which can be really stressful for both parents, but dads in particular who may not be oriented well to what that crying means or doesn't mean. That it may not mean anything. It's just literally a way that babies are kind of letting off steam, and there may not be anything wrong.

We actually have a study in the field right now thinking about dads in general and how they may not come into parenting really, like, they certainly haven't read what to expect when you're expecting, they may not be prepared. They may just show up and be like, oh my gosh, now the baby's here, what do I need to know?

We actually have created a series of very short videos, like what the basics are that you need to know. Which includes crying, bathing, car seat safety, mental health, breastfeeding, sleep, and there's one more that I can't remember that we're now testing. We're seeing, can you actually deliver these to the newborn nursery?

Right after the baby's born where dad's like, oh my gosh, what do I do now? Maybe mom's taking a nap, maybe the baby's sleeping, which could be a perfect time for dads to learn more about what they need to do that they didn't brush up on, cramming for the exam. And we're studying that to see if two weeks and 30 days afterwards, do they actually retain that information? And did it change their behaviors, especially around things like safe sleep? We're definitely looking at innovative ways to actually reach out to dads.

Nydia: Awesome! Thank you. You guys were able to squeeze in a couple of questions. We appreciate you doing that. I would like to remind folks that the recording and the handout will be sent out to everyone who attended as well as everyone who registered. Many of the resources that were listed in the webinar in the slides are listed in the handout as well. I saw a couple of questions that asked about some of the statistics that Dr. Garfield and Dr. Fisher shared, and that will be in your handout.

Thank you, again, to Dr. Craig Garfield, Dr. Sheehan Fisher for all of this very important information today. To our participants, if you have more questions, you can go to My Peers or write to health@ecetta.info. The evaluation URL has been placed in the chat. It will appear when you leave the Zoom platform. Just remember that after you submit the evaluation, you will see a new URL. This link will allow you to access, download, save, and print your certificates. You can subscribe to our monthly list of resources using this URL.

You can find our resources in the Health section of the ETLKC, or write us. Again, that address is health@ecetta.info. We thank you all very much for your participation today. Thanks, again, to

our presenters Dr. Garfield and Dr. Fisher. Kate, you can close the Zoom platform. Thank you so much.