



The impact of fathers on maltreated youths' mental health

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ABSTRACT

Men are increasingly the heads of single parent households, yet are often excluded from child welfare research and practice. To better serve all families in the child welfare system, it is necessary to understand the impact of primary caregiving men on children's wellbeing. In this study we investigated the longitudinal effects of primary caregiving fathers' mental health and substance use on child mental health, and examined possible differences by child age and gender. Regression analyses were conducted with the sample of 322 youth living with a male primary caregiver at the first wave of data collection from the National Survey of Child and Adolescent Wellbeing-II (NSCAW-II). We found that father depression at baseline consistently predicted child mental health outcomes three years later, even after accounting for demographics and baseline child mental health. Surprisingly, fathers' substance use did not predict child mental health, and interactions with child age and gender were not significant. Our findings are consistent with a small but growing literature suggesting that efforts to improve engagement of and attention to fathers within research, clinical and policy efforts are likely to be worthwhile.

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Men are increasingly the heads of single parent households. In fact, in 2011 single fathers headed 8% of households¹ – a nine-fold increase from 1960 (Livingston, 2013). Yet, fathers are often excluded from child welfare research and practice (Brown, Callahan, Strega, Walmsley, & Dominelli, 2009; Strega et al., 2008). While this gap is slowly decreasing, it still remains despite several national initiatives calling for improved efforts to engage fathers in parenting (e.g., National Fatherhood Initiative, Promoting Responsible Fatherhood and Strong Communities, and National Responsible Fatherhood Clearinghouse). Furthermore, fathers, who make up 8% of primary caregivers in the child welfare population, are especially understudied in the child welfare field (Bellamy, 2009). It is necessary to better understand the experiences of child welfare-involved children who are in the care of their father. The purpose of this study is to examine which father characteristics are most strongly associated with child mental health outcomes three years post-child protective services investigation.

Child welfare-involved children are at high risk for mental health problems such as depression and anxiety (Burns et al., 2004; Gewirtz & August, 2008) and caregivers influence these child outcomes (Lovejoy, Graczyk, O'Hare, & Neuman, 2000) through multiple potential pathways. One such pathway is their own psychopathology, which can shape their children's experiences and resulting mental health

outcomes throughout development. Parents of child welfare-involved children experience mental health problems at rates greater than that of the general population. The past year incidence of major depression among adult males in the general population is 5.1% (SAMHSA, 2014). The rate among fathers identified as primary caregivers in the child welfare population is three times this (17.9%) (Ayer, Woldetsadik, Malsberger, Burgette, & Kohl, under review). Additionally, nearly one in ten men in the child welfare population has a substance abuse or dependence disorder (Ayer et al., under review). These numbers signify further risk to the already vulnerable child welfare population.

It is well-established that children of depressed mothers are at increased risk of internalizing and externalizing problems (Bender, 2010; Downey & Coyne, 1990; Kim-Cohen, Moffitt, Taylor, Pawlby, & Caspi, 2005; Lyons-Ruth, Wolfe, & Lyubchik, 2000; Weissman et al., 2006). While much less attention has been given to the role of paternal depression and children's mental health, there is an emerging body of evidence demonstrating its contribution to child outcomes. In a large representative sample of US children living in two-parent households, researchers found that those living with depressed fathers were 70% more likely to have emotional or behavioral problems than those living with nondepressed fathers, after controlling for maternal depression (Weitzman, Rosenthal, & Liu, 2011). A meta-analysis found that overall, child externalizing problems were impacted similarly by mother and father psychopathology, but that child internalizing problems were most strongly related to mothers' psychopathology (Connell & Goodman, 2002). However, the body of work meta-analyzed mostly consisted of studies on two-parent households and those with a female primary caregiver, with no studies on fathers in the child welfare system. Contrary to findings in the general population where women are at greater

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¹ Although male primary caregivers can include relatives other than fathers (e.g., grandfathers, uncles, stepfathers), we will use the term "fathers" to refer to male primary caregivers in this study for simplicity, and to reflect that male primary caregivers are in fathering roles regardless of biological relations to the child.

risk for depression compared to men (Eaton et al., 2012), a recent study found that there were no significant differences in the prevalence of depression among male and female primary caregivers in the child welfare system (Ayer et al., under review). In addition, the same study found no differences in the use of mental health services between these groups, counter to findings in the general population suggesting that fathers are less likely than mothers to seek medical care for themselves or for their children (Moore & Kotelchuck, 2004). Thus, it is likely that paternal depression is as detrimental to child mental health as maternal depression; however, this issue has not yet been explored in a child welfare population. Given the complex problems encountered by child welfare-involved families, including those with fathers in the role of primary caregiver, it is essential to better understand the impact of paternal depression on children's mental health.

Even less is known about the role of paternal substance dependence and children's mental health. Despite a call to build out this research (McMahon & Rounsaville, 2002), this remains a major gap in the literature. Given the well-known association between maternal substance dependence and child outcomes (America, Child Welfare League of, 2001; Osborne & Berger, 2009), it is hypothesized here that a similar association will exist for paternal substance dependence.

The proposed study will identify father-related risk factors for child mental health using existing data from a longitudinal, national probability study of children and families investigated for CM (National Survey of Child and Adolescent Wellbeing-II; NSCAW-II). Specifically, this study answers the following research questions:

1. Among child welfare-involved families with fathers identified as primary caregivers, is father depression and substance dependence associated with poorer child mental health outcomes at 3-year follow-up?
2. Do these associations vary by child age and gender?

1. Methods

Secondary data analyses of the National Survey of Child and Adolescent Wellbeing-II (NSCAW-II) were conducted to determine whether baseline (i.e., wave 1) father depression and substance dependence predicted child mental health outcomes at 3-year (wave 3) follow up. Further, we assessed whether these associations differed by child age and gender. NSCAW-II is a longitudinal, national probability study of children and families investigated for CM (see (Dolan, Smith, Casanueva, & Ringeisen, 2011) for a detailed description of the study design). Demographic characteristics, as well as mental health and substance dependence needs of fathers have already been described using the NSCAW-II baseline data (Ayer et al., under review).

1.1. Sample

The NSCAW-II sample includes 5872 children aged birth to 17.5 years old whose investigations were closed during a 15-month period beginning February 2008. There were 322 (5.5%) youth who lived in their home with a male primary caregiver ("father") at baseline.

1.2. Measures

Demographic variables included caseworker report of number of days in out of home care between baseline and wave 3, whether the father was the perpetrator of the index maltreatment, severity of the index maltreatment, and type of maltreatment; child age, gender, and race (White, Black, Hispanic) based on combined child, father and caseworker reports; and father report on his age, education of high school or above, employment (employed vs. not employed), family income below the federal poverty level, and whether he is the child's biological parent.

1.2.1. Child mental health

The parent-report Child Behavior Checklist (CBCL) (T.M. Achenbach & Rescorla, 2001) internalizing (32 items; baseline $\alpha = .99$) and externalizing problems (35 items; baseline $\alpha = .99$) raw scores were used to measure child mental health at baseline and at 3-year follow up (wave 3). The CBCL preschool version was used for youth ages 1.5–5 and the school age version for ages 6–18. The CBCL is a widely used quantitative and empirically based measure of psychopathology in children and adolescents. The preschool version contains 100 items and the school age version contains 120 items (e.g., "there is very little that he/she enjoys") on which parents rate their child's behavior in the preceding 6 months on a three-point scale, where 0 = not true, 1 = somewhat or sometimes true, and 2 = very true or often true. The psychometric properties of the CBCL are strong and well established (T. M. Achenbach & Rescorla, 2000).

Primary caregiver depression was measured by the Composite International Diagnostic Interview-Short Form (CIDI-SF) depression module (Kessler, Andrews, Mroczek, Ustun, & Wittchen, 1998). The CIDI-SF is a diagnostic interview that screens for psychiatric disorders as per the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (Association, American Psychiatric, 2000). The CIDI-SF is valid and reliable, and classifies respondents as having major depressive disorder with 93% accuracy (Kessler et al., 1998). The CIDI-SF assessed past-year depression with stem-branch logic where fathers were first asked if there was a 2-week period during the past 12 months where they felt sad, blue or depressed. If the father answered "yes", they were then asked additional questions about the worst 2-week period. A "probably depression" diagnosis was assigned if the father reported three or more symptoms of depression (as defined by the DSM-IV) in addition to experiencing two or more weeks of dysphoric mood, two or more weeks of anhedonia, or using antidepressant medication.

Primary caregiver substance dependence was measured by the Alcohol Use Disorders Identification Test (AUDIT; total score 8 or higher indicates alcohol dependence) (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001) and Drug Abuse Screening Test (DAST-20; total score 6 or higher indicates drug dependence) (Skinner, 1982). These self-report measures have good psychometric properties (Yudko, Lozhkina, & Fouts, 2007). The AUDIT includes ten items, which ask respondents about alcohol use, alcohol dependence, and alcohol-related problems (e.g., "have you or someone else been injured as a result of your drinking?"). The DAST-20 contains 20 yes/no items, which measure problematic substance use (e.g., "are you always able to stop using drugs when you want to?"). Using the aforementioned clinical cutoffs, we created a dichotomous "any substance dependence" variable to encompass both drug and alcohol dependence.

1.3. Data analysis

We used *IVEware* version 0.2, imputation and variance estimation software developed by the Survey Research Center at the University of Michigan, to perform multiple imputation to replace missing values of covariates. Multiple imputation accounts for the uncertainty of the imputed values by creating multiple (in our case, 10) copies of the original dataset with missing variables replaced. Missing elements in one variable are imputed by estimating the distribution of the observed values of that variable, conditional on all other variables included in the analysis.

All analyses described below were then run in two steps: 1) Each of the 10 completed datasets were analyzed using the standard statistical procedures; 2) The 10 sets of parameter estimates and associated covariance matrices produced by the standard procedures were then analyzed using the MIANALYZE procedure. The MIANALYZE procedure combines these sets of results to calculate valid inferences for the parameters, accounting for both the within variance of each imputed value and between variance for each imputed dataset. All analyses were run with SAS version 9.4.

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