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Fathers' Perceived Reasons for Their Underrepresentation in Child Health Research and Strategies to Increase Their Involvement

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Abstract

Purpose—Examine fathers' perceived reasons for their lack of inclusion in pediatric research and strategies to increase their participation.

Description—We conducted expert interviews with researchers and practitioners (N = 13) working with fathers to inform the development of an online survey. The survey—which measured fathers' perceived reasons for their underrepresentation in pediatric research, recommended recruitment venues, and research personnel and study characteristics valued by fathers—was distributed online and in-person to fathers.

Assessment—Respondents included 303 fathers. Over 80 % of respondents reported that fathers are underrepresented in pediatric research because they have not been asked to participate. Frequently recommended recruitment venues included community sports events (52 %), social service programs (48 %) and the internet (60 %). Compared with white fathers, more non-white fathers recommended public transit (19 % vs. 10 %, $p = .02$), playgrounds (16 % vs. 6 %, $p = .007$) and barber shops (34 % vs. 14 %, $p < .0001$) and fewer recommended doctors' offices (31 % vs. 43 %, $p = .046$) as recruitment venues. Compared with residential fathers (100 % resident with the target child), more non-residential fathers recommended social services programs (45 % vs. 63 %, $p = .03$) and public transit (10 % vs. 27 %, $p = .001$) and fewer recommended the workplace (17 % vs. 40 %, $p = .002$) as recruitment venues. Study brevity, perceived benefits for fathers and their families, and the credibility of the lead organization were valued by fathers.

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Compliance With Ethical Standards

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Conclusion—Fathers' participation in pediatric research may increase if researchers explicitly invite father to participate, target father-focused recruitment venues, clearly communicate the benefits of the research for fathers and their families and adopt streamlined study procedures.

Keywords

Fathers; Underrepresentation; Recruitment strategies; Pediatric research

Introduction

Fathers have historically been underrepresented in pediatric research. In 2005 Phares and colleagues documented that 48 % of studies on parenting and child psychopathology included only mothers as research participants (Phares et al. 2005). In contrast, only 1 % of studies included only fathers. Moreover, only 25 % of eligible studies that included mothers and fathers analyzed the data separately by parent sex (Phares et al. 2005). Together these results indicate that only 26 % of all studies on parenting and child psychopathology included any results for fathers. Similarly, in a recent systematic review and content analysis of research on parenting and childhood obesity published since 2009, only 10 % of all studies included any results for fathers (Davison et al., in press). It has also been shown that fathers who participate in research are typically white, middle class, and married (Coley 2001). Low levels of father participation have been highlighted in child and family development (Panter-Brick et al. 2014; Phares and Compas 1992), pediatric psychology (Seiffge-Krenke 2002) healthcare (Garfield and Isacco 2012) and nutrition (Khandpur et al. 2014; Morgan et al. 2011).

The lack of fathers, particularly fathers from disadvantaged backgrounds, in pediatric research impedes our understanding of paternal effects on children's health and the development of effective family interventions. While this pattern may originate from traditional gender-based caregiving roles (Bianchi 2000), it may not reflect current caregiving practices. Alongside increases in maternal employment, father involvement in caregiving has almost tripled since 1965 (Parker and Wang 2013). Studies that have included fathers verify their important contributions to almost every aspect of child development (Carlson and McLanahan 2004; Lamb 2004; Sarkadi et al. 2008). As noted by Panter-Brick et al. (2014), the science and practice of pediatrics is impeded by the lack of information on fathers.

Contemporary explanations for fathers' relative absence from pediatric research focus on attributes of fathers such as their lack of time (Mitchell et al. 2007), lack of interest in research (Mitchell et al. 2007), and lack of availability and accessibility relative to mothers (Mitchell et al. 2007; Phares 1992). Additional explanations include mothers acting as "gatekeepers" (Mitchell et al. 2007) and fathers not being approached to participate (Hatchett et al. 2000), which reflect the roles of mothers and researchers respectively. Many of these explanations, however, are untested assumptions. As such, there is no clear explanation for the limited presence of fathers in contemporary pediatric research. Moreover, very little is known about factors that motivate fathers to participate in research which could be leveraged to increase their participation.

To address these knowledge gaps, We recruited a diverse group of fathers for the *What about Dads?* study and solicited their feedback on issues related to the recruitment and retention of fathers in pediatric research. We were particularly interested in recruiting minority and non-residential fathers as they are particularly underrepresented in pediatric research (blinded, in press). This article presents fathers' perspectives on (1) their underrepresentation in pediatric research; (2) recommended recruitment venues; and (3) researcher and study characteristics that encourage enrollment and participation. We summarize results by fathers' ethnicity and residential status.

Methods

The *What About Dads?* study was implemented in Boston, MA in two phases. First, we conducted informal interviews with "fatherhood experts", including researchers who specialized in fathers and practitioners who worked in organizations implementing fatherhood programs (Phase 1). This phase informed the development and distribution of an online survey that captured recommended strategies to reach and engage fathers in pediatric research (Phase 2). The study was approved by the Office of Human Research Administration at the (blinded). No compensation was provided for the expert interviews. Fathers were compensated \$5 for completing the online survey.

Phase 1—Between August and October 2013, we conducted a total of 13 expert interviews with researchers (N = 5) and practitioners (N = 8). Fatherhood practitioners included family service providers (e.g., Department of Children and Families, Head Start) and staff from local health departments, child welfare agencies, and fatherhood initiatives. Interviews were conducted by two of the authors who had been trained in interview methods (KD, NK) and lasted approximately 30 min. Interview questions asked about the services offered through fatherhood programs, strategies for recruiting and engaging fathers, particularly low-income fathers, and associated challenges, recruitment venues, and compensation strategies. The interviews were not recorded as they were intended to be informal. The expert interviews highlighted key challenges to father engagement, helped establish partnerships with the individual researchers or practitioners and their organizations (Mitchell et al. 2007) (Weiss and Bailar 2002) that were crucial to our subsequent recruitment efforts and identified possible response options (e.g., recommended venues) for the online survey.

Phase 2—Between October and December 2013, we developed an online survey targeting fathers. Survey questions focused on possible reasons fathers participate less than mothers in pediatric research, recommended venues through which to reach and recruit fathers, demographic characteristics of research personnel that are important to fathers, and study characteristics that affect fathers' enrollment (e.g., length, compensation, format) (see Table 1). The survey also recorded demographic characteristics of fathers including marital status, age, highest level of education and race/ethnicity in addition to the number of children aged 10 years or younger, age of the youngest child (referent child) and residential (100 % resident with the child versus not) and relationship status (i.e., biological father, stepfather, and/or legal male guardian) with the referent child. In total, the survey included 29

questions, including demographic questions and questions not included in this study, and was written at approximately a 6th grade reading level.

A three step process was used to ensure that the survey addressed the research questions, was appropriate for the intended audience, and could be completed within 10 min. First, we developed an initial draft of the survey using results from the expert interviews. Second, using an open-ended response format, we administered the survey to a sample of ten fathers; fathers' responses were used to draft quantitative response options for the final survey. Third, we conducted cognitive testing of the revised survey with a separate sample of five fathers. Cognitive interviews focused on the phrasing of the items, the structure of the response options, survey length and the online format. Fathers interviewed during the survey development process met eligibility criteria for the main study (i.e., English speaking, a child 10 years old or younger) and had a similar demographic profile to fathers included in the main study.

Participant Recruitment and Survey Administration

We distributed the survey link to fathers through social media platforms (i.e., facebook), fatherhood listservs, and websites of the partner organizations between January and May 2014. We also utilized in-person recruitment strategies at fatherhood events or father-focused programs (e.g., Nurturing Fathers) to support the recruitment of a diverse sample of fathers. To complement these efforts, partner organizations distributed recruitment flyers at their local offices and research assistants distributed flyers at community meetings, conferences and informal local fatherhood meetings. The flyers provided a description of the study, listed study contact information and included the URL (Uniform Resource Locator) for the online survey. Eligible participants included English speaking adult men living in the US who self-identified as a father of a child age 10 years or younger. Fathers were not required to be living with their child(ren) or to be the biological father.

Data Screening and Analysis

A total of 471 responses from individuals who successfully completed the online screening and informed consent protocols were received and screened. Following the removal of duplicate responses which were identified by IP address, 364 eligible fathers were identified. Of these fathers, 61 initiated but did not complete the survey resulting in a final sample of 303 fathers. Fathers who did not complete the survey were disproportionately non-white and had less than a education compared with the final sample. Summary statistics (means, percentages) were developed for each research question. Differences in responses for white versus non-white fathers and residential versus non-residential fathers were examined using Chi square tests. In cases where a significant difference was identified, a logistic regression analysis was performed using the same variables (independent variable = race/ ethnicity or residential status) and including education, race/ethnicity (white, non-white), and residential status as covariates as appropriate.

Results

Characteristics of Participating Fathers

Of the 303 fathers included in the analyses, 266 fathers were recruited online (e.g., email, social media, websites) and 37 were recruited in person (e.g., fatherhood conferences, fatherhood parenting groups, head start centers). Fathers had a mean age of 37.3 (7.2) years and were from more over 30 states: 17 % (N = 51) were from Massachusetts (with 6 % from Boston), 10 % (N = 30) were from California, 6 % (N = 18) were from Ohio, 6 % (N = 18) were from Texas, and 5 % (N = 15) were from Maryland (Table 2). Nearly 32 % (N = 97) did not have a college degree, 40 % (N = 121) were not married, 16 % (N = 48) did not live full time in the same household as the referent child (i.e., youngest child aged 2–10 years), 33 % (N = 100) were non-white (including Hispanic, African American, Asian/Pacific Island and Native American) and 14 % (N = 42) were non-biological fathers.

Reasons for Fathers' Underrepresentation in Pediatric Research

When asked why fathers participate less than mothers in child health research, over 80 % (N = 248) of respondents indicated that *fathers have not been asked to participate* (Fig. 1). Nearly 25 % (N = 77) selected the responses *fathers are very busy* or *mothers do not encourage fathers to participate*. Few respondents indicated that low participation rates among fathers were due to a *lack of interest* (9 %, N = 28) or a *lack of trust in researchers* (6 %, N = 18) or that *mothers are more important than fathers in children's health* (8 %, N = 24). No differences in reported reasons for fathers' underrepresentation in research were observed for residential and non-residential fathers. When comparing responses by race/ethnicity, more non-white fathers than white fathers reported that *fathers are not interested in research* (14 % vs. 7 %; $\chi^2 = 4.03$, $p < .05$) and *fathers don't trust researchers* (11 % vs. 3 %; $\chi^2 = 6.84$, $p < .01$); differences remained significant after controlling for education and residential status in follow-up logistic regression analyses.

Recruitment Venues

The most frequently recommended venues for reaching and recruiting fathers included the internet (60 %), community sports events (51 %), social services programs (48 %), doctors' offices (39 %) health centers (38 %), and churches (38 %) (Table 3). Compared with white fathers, significantly more non-white fathers recommended public transit (19 vs. 10 %; $\chi^2 = 4.99$, $p < .05$) playgrounds (16 % vs. 6 %; $\chi^2 = 7.12$, $p < .01$) and barber shops (34 % vs. 14 %; $\chi^2 = 16.81$, $p < .001$) and significantly fewer recommended doctors' offices (31 % vs. 43 %; $\chi^2 = 3.96$, $p < .05$) as recruitment venues. Compared with residential fathers, significantly more non-residential fathers recommended social service programs (63 % vs. 45 %; $\chi^2 = 4.68$, $p < .05$) and public transit (27 % vs. 10 %; $\chi^2 = 10.27$, $p < .0$) and significantly fewer fathers recommended the workplace (17 % vs. 40 %; $\chi^2 = 9.23$, $p < .01$) as recruitment venues. In all cases, significant differences in recommended venues remained after accounting for covariates.

Research Personnel Characteristics

Over 85 % (N = 258) of fathers indicated that the racial or cultural background of the person interviewing them was not important (data not shown). Of the 42 fathers who indicated it was important, 39 (or 14 % of the sample) indicated they would be more comfortable being interviewed by someone of a similar racial or cultural background to themselves. Regarding interviewer gender, 73 % (N = 221) of fathers indicated that interviewer gender did not matter to them. Of the 82 fathers who indicated it was important, 61 (or 20 % of the sample) indicated they would be more comfortable with a male interviewer and 21 (7 % of the sample) preferred a female interviewer.

Study Characteristics

Study characteristics that fathers most frequently reported would affect their enrollment included the time commitment (57 %), potential benefits of the research for their family (56 %), the reputation of the leading organization (51 %), and the study topic (45 %) (Table 4). Only one group difference was identified; compared with non-residential fathers, significantly more residential fathers reported that the time commitment was important to them (61 % vs 35 %, $\chi^2 = 10.9$, $p < .001$). This effect was maintained after adjusting for covariates.

Among fathers who indicated that time commitment was important to them (N = 173), the mean minutes they were willing to participate was 44.6 min (median = 30 min). Fathers who valued the benefits of the research (N = 171) reported desired benefits such as improved recognition of fathers, improved access among fathers to their children, improving their own relationship with their children (“something to help me be the best dad I can”) and providing tangible tools dads can use. Among fathers who indicated that study topic was important to them (N = 137), topics of interest included the role of fathers in children’s lives, the physical and mental health of their children, co-parenting, divorce and visitation rights, effective parenting and obesity-related topics such as healthy child nutrition. Only a third of fathers (N = 102) indicated that compensation was important to them; on average, these fathers recommended \$20 compensation for a 30 min protocol and \$40 for a 60 min protocol.

Discussion

While researchers have postulated numerous reasons for the lack of inclusion of fathers in pediatric research, few studies have tested them directly. In this study of over 300 fathers, the vast majority (~80 %) reported that fathers are underrepresented in research because they have not been asked to participate. Thus, while most explanations for father underrepresentation have focused on attributes of fathers (e.g., lack of time, lack of interest), it may be that researchers have fallen prey to traditionally held beliefs of parental roles. Regarding possible recruitment venues, fathers recommended community sports events, social service programs and the internet in addition to the more commonly used recruitment venues of churches, schools and doctors’ offices. Results from this study also suggest that fathers are more likely to participate in studies when the expected time commitment is small, recruitment materials clearly state the benefits for fathers and their families and when they learn about the study through father-sensitive organizations.

A number of conclusions can be drawn from the differences observed in recommended recruitment venues by race/ethnicity and residential status. Our findings suggest that public transit may be a more fruitful venue for recruiting non-white and non-residential fathers than residential or white fathers. Barbershops may also be an effective recruitment venue for non-white fathers. In contrast, doctors' offices may be more effective for recruiting white fathers. While social service programs were frequently recommended by all groups of fathers, non-residential fathers suggested social service programs most often. Overall, the differences observed illustrate that recruitment venues should be selected based on the specific fathers of interest and that a broad cross section of venues may be necessary to reach a diverse sample of fathers.

Beyond the results, we learned a number of important lessons which may inform future research with fathers. First, we found that community partners were crucial to our ability to reach fathers. Their motivation facilitated fathers' participation in the study. In some cases, a representative from a partner organization called on behalf of a father to initiate the process and reassure him of the legitimacy of the study and then introduced the father to a study representative. While the groundwork to develop such relationships was time consuming, the upshot is that the actual process of recruitment was relatively straightforward and was completed within 3–4 months. Second, we learned the importance of carefully considering the operational definition of "father", or the dimensions of fatherhood you would like to measure, prior to study implementation. For example, after compiling the results we realized that we wanted to describe the custodial status of fathers (i.e., whether fathers had sole, joint or no custody of their child). This was not possible, however, as we did not measure custodial status. We recommend that fathers' biological, residential and custodial status are measured and reported in all studies with fathers. In addition to ensuring appropriate description of the sample it may also encourage researchers to recruit a diverse group of fathers to promote the generalizability of the study.

The primary strength of this study is its focus on an important topic, namely fathers' future representation in pediatric research, and makes clear contributions to our knowledge of strategies to reach and engage fathers in research. We successfully recruited a relatively large sample of fathers, utilized multiple methods of recruitment, and did not rely on mothers as proxy reporters, which has been the predominant approach to date. This study also has a number of limitations. As a result of the online format utilized and the topic addressed, fathers who participated in the study may have been more internet savvy and more engaged caregivers than fathers in general. Additionally, non-English speaking fathers were excluded due to resource limitations, fathers who partially completed the survey (and whose data were not included in the analyses) were disproportionately non-white and non-college educated, and relatedly, the final sample included low percentages (i.e., ~30 %) of non-white, non-college educated and non-residential fathers. While we acknowledge that fathers in this study may not represent the population of fathers in the United States with young children, we recruited a sufficient number of fathers from underserved backgrounds (e.g., non-white, non-college educated, non-residential) to permit stratified analyses for white and non-white fathers. Due to the high degree of overlap between race/ethnicity and education, we did not run a second comparison for college and non-college educated fathers although we did control for education in the multivariate analyses. We also included

stratified analyses by fathers' residential status to address the limited inclusion of non-residential fathers in pediatric research (blinded, in press). Future studies can build on this research by including non-English speaking fathers, using multiple recruitment platforms (beyond the internet) and including a larger number of non-residential fathers. Despite these limitations, the sample of fathers included in this study was larger and more diverse than fathers historically included in research on parenting and child physical and mental health (blinded, in press; Phares et al. 2005).

Based on the results of this study, we have formulated a number of recommended practices to facilitate the future recruitment, engagement and retention of fathers in pediatric research. First, we recommend that researchers build a supportive network of clinicians and practitioners who work with and are trusted by fathers. Second, recruitment materials and messaging should explicitly solicit fathers' involvement. Directly ask fathers, rather than "parents", to participate. Third, in advertising the study, information on the potential benefits of the research to fathers and their families should be included. Finally, research staff should engage potential participants at father-friendly recruitment venues and through father-specific social support services, fatherhood groups, list serves, websites and social media sites.

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Significance

What is already known on this subject?

Fathers make important contributions to almost every aspect of child development. However fathers are rarely included as research participants in pediatric, or child health, studies. This limits our understanding of the role of fathers in children's health, an important aspect of development.

What this study adds?

This study presents fathers' perceived reasons for their lack of inclusion in pediatric research along with suggested recruitment venues and research and study characteristics that may motivate enrollment.

Fig. 1.
Percentage of respondents endorsing each reason for fathers' underrepresentation in child health research

Table 1Survey questions for the *What About Dads?* online survey

Survey question	Response options
1. Why do fathers participate less than mothers in child health research? (select up to 3 options)	Fathers are very busy and have little time for research, mothers generally do not encourage fathers to participate, mothers are more important than fathers for child health, fathers do not trust researchers, fathers have not been asked to participate, fathers are not interested in research on child health, other
2. What are good places to reach fathers and introduce studies on child health? (select up to 5 options)	Community sports events for children, child care centers, supermarkets, on public transport, doctors' offices or health care centers, churches, the internet, barber shops, social support services like fatherhood programs and family development programs, playgrounds, gyms, schools, my place of work, none of these places
3. If a study involves a 60 min interview about your role as a father, who would you be more comfortable with?	<p>a. With regards to race or culture? (select one)</p> <p>An interviewer from my ethnic or cultural group, an interviewer from another ethnic or cultural group, the ethnic or cultural group of the interviewer doesn't matter to me</p> <p>b. With regards to gender? (select one)</p> <p>A female interviewer, a male interviewer, the gender of the interviewer is not important to me</p>
4. What features of a study would affect your interest in enrolling? (select up to 3 options)	<p>a. Reputation of the organization leading the research</p> <p>b. Study topic</p> <p>What topics are most interesting to you?</p> <p>c. Potential benefits of the research for you and your family</p> <p>What benefits are important to you?</p> <p>d. Compensation provided</p> <p>How much (in dollars) would you expect for a 30 min interview?</p> <p>How much (in dollars) would you expect for a 60 min interview?</p> <p>e. Time commitment</p> <p>How many minutes for any one study session would you be willing to participate?</p> <p>f. Process used to collect the information</p> <p>What process would work best for you? (face-to-face interview, online interview, online survey, phone interview or survey, in person survey)</p> <p>g. Can you suggest other factors that are important to you?</p>

Table 2

Characteristics of participant fathers (N = 303)

Characteristic	N (%)
Highest completed education	
High school or less	70 (23.1)
Vocational school	27 (8.9)
College graduate	122 (40.3)
Postgraduate degree	84 (27.7)
Residential status with child (non-residential)	48 (15.8)
Marital status	
Married	190 (62.7)
Cohabiting	30 (9.9)
Single	61 (20.1)
None of the above	22 (7.2)
Race/ethnicity	
Non-Hispanic white	203 (67.0)
African American/Black	42 (13.9)
Hispanic	26 (8.9)
Asian/Pacific Island	15 (4.9)
Native American	2 (0.7)
Other/multiracial	15 (4.9)
Age distribution of children	
At least 1 child 5 years	133 (43.9)
At least 1 child 6–10 years	92 (30.4)
At least 1 child 5 years and 1 child 6–10 years	78 (25.7)
Fatherhood status	
Only biological father	262 (86)
Biological and non-biological father	28 (9)
Non-biological father only	13 (4)

Table 3

Number (and percentage) of fathers who selected a “venue” as a recommended recruitment venue for fathers

Recommended venue (N, %)	Full sample (N = 303)	Race/ethnicity		Residential status	
		Non-white (N = 100)	White (N = 203)	Non-residential (N = 48)	Residential (N = 255)
Community-focused venues (N, %)					
Community sports events	156 (52)	48 (48)	108 (53)	22 (46)	134 (53)
Social services	146 (48)	45 (45)	101 (50)	30 (63)*	116 (45)
Doctor's offices/health center	118 (39)	31 (31)*	87 (43)	15 (31)	103 (40)
Churches	116 (38)	39 (39)	77 (38)	17 (35)	99 (38)
Public transit	39 (13)	19 (19)*	20 (10)	13 (27)**	26 (10)
Playgrounds	29 (10)	16 (16)**	13 (6)	4 (8)	25 (10)
Supermarkets	21 (7)	7 (7)	14 (7)	5 (10)	16 (6)
Father-focused venues (N, %)					
Internet sites	181 (60)	57 (57)	124 (61)	25 (52)	156 (61)
Workplace	109 (36)	37 (37)	72 (35)	8 (17)**	101 (40)
Gym	107 (35)	38 (38)	69 (33)	17 (35)	90 (35)
Barber shops	62 (21)	34 (34)**	28 (14)	13 (27)	49 (19)
Child-focused venue (N, %)					
Schools	112 (37)	31 (31)	81 (39)	16 (33)	96 (38)
Child care centers	74 (24)	26 (26)	48 (23)	11 (22)	63 (25)

Chi square test of group differences is statistically significant at $p < .05$ (*) or $p < .01$ (**); chi-square values are reported in the text

Table 4

Number (and percentage) of fathers who reported that a study characteristic was important to them

Study Characteristic (N, %)	Full sample (N = 303)	Race/ethnicity		Residential status	
		Non-white (N = 100)	White (N = 203)	Non-residential (N = 48)	Residential (N = 255)
Time commitment	173 (57)	58 (58)	115 (57)	17 (35)**	156 (61)
Potential benefits to family	171 (56)	49 (49)	122 (60)	29 (60)	142 (56)
Reputation of organization	155 (51)	47 (47)	108 (53)	21 (43)	134 (53)
Study topic	137 (45)	43 (44)	94 (46)	20 (42)	117 (46)
Compensation	102 (34)	37 (37)	65 (32)	12 (25)	90 (35)
Data collection process	82 (27)	25 (25)	57 (28)	16 (33)	66 (26)

Chi square test of group differences is statistically significant at $p < .01$ (**)