Assessing and managing paternal mental health issues

**Key points**

- The mental health of fathers is not as well researched as that of mothers.
- It is increasingly recognised that fathers can have postnatal depression or post-traumatic stress disorder.
- Paternal depression is under-diagnosed because it does not necessarily manifest through classic symptoms.
- Allowing men to explore their childhood experiences, anxieties and mental health issues can be cathartic.
- Fathers should be included in antenatal and postnatal care.

**Authors** Jane Hanley is honorary lecturer in perinatal mental health at Swansea University and course director at PMH Training; Mark Williams is an international campaigner and trainer in perinatal and paternal mental health.

**Abstract** How do men cope with pregnancy, childbirth and fatherhood? How do these events affect their mental wellbeing, their relationships with their partners and their attitudes towards their newborn child? Paternal mental health has long been neglected, but we now know that it is crucial to monitor it and recognise, assess and treat any mental health issues experienced by men in the perinatal period. This article offers an overview of this under-researched topic and provides guidance for health professionals in contact with future and young fathers.

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While maternal mental health is well researched, the mental health of men before, during and after the birth of their child is not (Ramirez and Badger, 2014). Investigations into the causes and consequences of paternal mental health issues is a relatively new field so data on this subject is limited. Two further reasons for the paucity of data is that high attrition rates compromise any statistical research findings (Woodall et al 2010; Sherr et al, 2006) and that men tend to self-manage their conditions rather than consult professionals (Wendt and Shafer, 2016). This article raises the awareness of paternal mental health issues, and provides guidance on how to recognise, assess and manage them.

**Antenatal period**

For many couples a pregnancy is welcome but for some, it may be a shock or a disappointment. An unplanned pregnancy can have a negative effect on both partners, but while there are numerous studies on the impact on women, the effect on men is not so well documented (Wellings et al, 2013). A few studies have explored the attitudes of potential fathers and found that most men had used contraception and had not contemplated the thought of their partner becoming pregnant (Kågesten et al, 2015). Approaching fatherhood triggered a range of emotions – some expressed anxiety, others anger and guilt. Some men felt it occurred at a difficult period because of competing demands on their time and resources. Their reactions were often dictated by their past experiences of dealing with difficult situations. Feelings of lack of control and freedom have been known to alter relationship dynamics and increase the risk of paternal anxiety and depression. What was evident in the studies was that most men were prepared to accept their parental responsibilities (Lindberg et al, 2017; Wilkes et al, 2012).

With limited evidence on a man’s psychological preparation for fatherhood, suppositions are often made about his suitability for the role, and it is often assumed that he has sound psychological health. However, he may have a mental health disorder – for example autism or...
Discussion

Asperger’s syndrome – that so far has gone unrecognised by health professionals. We suspect that many men have a history of anxiety, but this is difficult to quantify. Equally difficult to quantify is the number of future fathers who experience psychotic episodes, such as those seen in bipolar disorder, which they may successfully manage without external help until the ‘trauma’ of an impending birth.

There is a paucity of information on fathers’ insights into their own childhood experiences and how these influence their mental health. We know that children of depressed mothers are more at risk of having depression themselves, and that children of mothers who had high stress levels during pregnancy are more prone to attention deficit hyperactivity disorder and autism. It is entirely possible that a future father’s own mother had perinatal anxiety or depression. If such issues are disclosed and discussed, health professionals can help the future father understand how his own parental relationships may influence his relationships with his partner and child.

**Post-traumatic stress disorder**

Health professionals are increasingly aware that post-traumatic stress disorder (PTSD) can occur in men after the birth of a child, but there are few studies on its impact on fathers and families. When a traumatic delivery is witnessed, some fathers’ response is one of powerlessness, helplessness or even intense fear. If unresolved, these issues can manifest as intrusive memories, flashbacks and nightmares. The intensity of the distress may result in difficulties concentrating and sleeping, which can lead to frustration and hyper vigilance around the infant (Stramrood et al, 2013; Bradley and Slade, 2011).

There is an increased recognition that PTSD is not confined to war situations. Health professionals often assume they have prepared men for an impending birth, but in a minority of cases, men’s fears have not been addressed and PTSD can ensue. There is increasing evidence that the time around the delivery poses a risk to the mental health of the father (Stramrood et al, 2013).

Box 1 features the case of a man who developed PTSD after witnessing the birth of his child.

**Postnatal period**

Paternal postnatal depression is increasingly recognised but has not been extensively quantified. Current statistics show that around 10% of new fathers experience it (Paulson and Bazemore, 2012). Ramchandani et al (2011) found that men with a history of severe depression, and a propensity for anxiety and depression during the antenatal period, were more likely to have paternal depression in the postnatal period.

Hormonal changes occur in men during the perinatal period, with variations in levels of oestrogen, cortisol, vasopressin and prolactin that may increase the risk of postnatal depression (Kim and Swain, 2007). Studies in animals have shown a decrease in paternal testosterone levels and increased prolactin levels: this made males more likely to respond to their offspring’s need for attention (Alexander, 2014; Fleming et al, 2002).

Maternal depression has been shown to have the most significant correlation to paternal depression (Dave et al, 2010; Wee et al, 2011). The reasons for this are unclear. One may be that the depressed mother is unable to support her partner because of her own illness. Another may be the father’s inability to understand or cope with his partner’s depression. Fathers may feel they are to blame because they are unable to fulfil the societal expectation that they should protect the family (Conde et al, 2011).

The couple may have similar experiences of mental health difficulties triggered by similar risk factors, and the arrival of a child may exacerbate the problems already present in the relationship (Demontigny et al, 2012). The father’s philosophy might be to avoid any upset and stay in an unhappy situation to remain with his child (Shorey et al, 2012).

**Symptoms and signs**

Depressed fathers describe symptoms of low mood and despondency, often occurring shortly after the birth. They find it difficult to concentrate on tasks and make decisions, feel lethargic and lack motivation. Summoning up the energy to engage with others is a challenge. They feel isolated and increasingly inadequate in their fathering skills, which often results in guilt. Life may seem ‘a long grey tunnel from which there [is] no escape’ (Williams, 2013; Chuick et al, 2009). If the father is severely depressed there is a risk of suicide (Oliffe et al, 2012).

The behaviours of depressed fathers tend to be different from those of depressed mothers. They may express their guilt through irritation or aggressive outbursts. To justify their own hostile behaviours, they may blame others for their own failings (Chuick et al, 2009). Although they may know that their conduct is unacceptable, they may find it difficult to admit it, either because they do not know how to express their emotions or because they think it is a sign of weakness to do so (Garfield et al, 2010; Wexler, 2009).

To combat feelings of inadequacy or fragility and emphasise their independence, some resort to escape in video games, surfing the web or overworking. Their resentment may degenerate into antisocial...
behaviour or self-medication with alcohol or illicit drugs, which may in turn precipitate domestic violence and abuse (Paulson and Bazemore, 2010; Wexler, 2009).

Many fathers’ mental health disorders remained undiagnosed because paternal depression often fails to manifest through the classic or overt symptoms described in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013).

Studies have noted a strong influence of the father on the infant, particularly if the father is depressed. Depressed fathers tend to be more hostile and passively aggressive, and are often less attentive to the infant’s needs. This threatens the infant’s secure attachment, which is associated, in turn, with an inability to interact socially and a lower cognitive development later in life. When both parents are depressed, the consequences for the wellbeing of the infant can be even more severe (Ramchandani et al, 2011).

Social media usually convey playful images of positive relationships between fathers and their newborn children. However, some fathers did not experience this in their own childhood, lacked a father role model or experienced an abusive relationship. Images of ‘good dads’ only compound their feelings of inadequacy, leading them to question whether they are the ‘good enough fathers’ that society expects.

Box 2 features the case of a man with postnatal depression.

Assessment tools

The perinatal period offers a prime opportunity for health professionals to assess the mental health of both parents, but fathers’ mental health is often neglected. Some professionals may enquire about their mood or attitude towards the birth, but there is little evidence of more robust enquiries. There are assessment tools that have been validated for use with fathers, but anecdotal evidence suggests they are not widely used, primarily because the father is either not present when the health professional visits or are reluctant to participate (Wendt and Shafer, 2016).

Since the National Institute for Health and Care Excellence published its clinical guideline 45 on antenatal and postnatal mental health in 2007 (which has since been replaced by clinical guideline 192 [NICE, 2014]), the Whooley questions (http://whooleyquestions.ucsf.edu/) have been widely used for assessing mothers’ mental health in the perinatal period. They have not been validated for fathers (Bosanquet et al, 2015), but there are no obvious reasons why they could not be used for them.

The Edinburgh Postnatal Depression Scale (EPDS) has been used globally for mothers and has been validated for fathers. Simple and user-friendly, it encourages the professionals to delve deeper into the reasons why a parent may have low mood (Edmondson et al, 2010; Cox et al, 1987).

Surrey Parenting Education and Support and the Fatherhood Institute have developed a tool for evaluating and supporting the mental health of new fathers (Bit.ly/FatherhoodTool).

Discussion and listening helps both mothers and fathers understand any mood disorder and can encourage them to express a need for further support. As with all assessment tools, health professionals need to be trained in listening and interpretation skills to ensure they use the tool correctly and to its full potential.

Management strategies

The transition to fatherhood can be complex and demanding, and take its toll on the most resilient of men. At no stage should health professionals assume that fathers are fully able to cope (Singleton and Edwards, 2015). Actively listening to identify a father’s mental health needs and signposting him to the appropriate services will help engage him. It is possible that he has not confronted his own anxieties, so allowing him to explore them can be cathartic. Explaining the possible link between feelings of distress and a drinking habit or a tendency to overwork can help him understand his avoidance behaviours. Exploring his diet and exercise patterns can determine his level of depression (Lobato et al, 2012). Exploring positive self-regard – a psychological prerequisite for a healthy mind – can help him achieve his full potential. Encouraging and supporting him to engage with his child can help expel the doubts he may have about his fathering skills.

There are therapeutic interventions that some find helpful. The most common, which is available as a web-based therapy, is cognitive behavioural therapy. This examines life situations and difficulties, explores the reasons for any negative thinking and behaviours, and attempts to replace them with more positive responses (Carter et al, 2015).

Mindfulness can also help. It is a thought process that allows individuals to focus their attention on their immediate thoughts, sensations, sights, sounds and smells, encouraging them to be in the present and not dwell on the past or worry about the future (Bajaj et al, 2016; Parent et al, 2016).

Referral to medical services should always be considered for psychopharmaceutical medications. Antidepressants may be prescribed for more severe forms of depression. A combination of medication and therapy can have positive results (Isaacs, 2017). Contact with support groups (Box 3) has also been found to be beneficial.

Whatever the choice of treatment, it will not be immediately effective. Fathers need to be patient and not expect too much too quickly but allow the treatment to take its course. This will help them understand their condition, recognise early warning signs and prevent reoccurrence.

Fathers may be reticent to engage with health professionals, whose input used to be reserved for mothers and who may be Box 2. Case study: postnatal depression

A young man was surprised when his partner told him she was pregnant, but gradually accepted the situation. As the pregnancy progressed he felt increasingly anxious, particularly about the financial implications and the lack of freedom. The relationship with his partner deteriorated significantly after his son was born. He tried to cope with his feelings of anger and despair, until a health professional noted his low mood, giving him an opportunity to confide in someone. He first described psychosomatic pain, but after further exploration agreed that he was probably experiencing paternal depression.

He commented: “It was only after speaking to you that I understood why I was drinking too much. I was getting more depressed after feeling out of place and thinking I was going to be a rubbish dad. I just found it easier to stay at work longer and then went to the pub. Doing that made me feel like a real man again.”

This opportunity to confront his thoughts and feelings enabled him to understand how they influenced his behaviour. His GP prescribed him an antidepressant and referred him for counselling. He was able to access useful websites and gained the confidence to seek out support services.
considered intrusive. A comprehensive knowledge of paternal mental health will help to break down barriers. Health professionals also need to recognize their own limitations and know when to refer patients. There is no ‘one size fits all’ and, if there is no significant progress, health professionals can feel impotent. A father’s condition may require a deeper or more intense therapeutic approach, particularly if there is a risk of suicide, and referral should never be seen as a failure, but as a skill.

The woman may be bearing the child, but it is the couple that are expecting the baby. During the perinatal period it would be helpful to engage the future father from the onset and involve him in education about the developmental stages of the foetus. Helping him understand not only the physical but also the psychological changes that he and his partner may experience can strengthen their relationship. Requesting his presence at home and during clinic visits will help him to focus on the family’s needs and become involved in infant feeding.

Conclusion
In the past, men’s mental health in the perinatal period has been ignored. Health professionals are now beginning to address the mental health needs of fathers, and fathers are starting to feel more included in the parenting role. There is growing interest in fathers’ mental health needs, and emotional and practical support is now available from recently created support groups and websites (Box 3).

There is still much to do and we need to:
- Include fathers in antenatal and postnatal care;
- Know how to respond to their emotional or psychological needs;
- Recognise and investigate paternal behaviours that may indicate depression;
- Better understand the risk factors for paternal anxiety and depression;
- Consider using a structured assessment tool, not only for future research but to enable fathers to monitor their progress;
- Establish pathways for paternal mental health similar to those for mothers.

As workloads increase, there is a risk of complacency and a danger that monitoring mental health may be not considered as important as monitoring physical health. It is crucial that health professionals address the mental health needs of new fathers. This will not only improve our understanding of mental illnesses, but possibly even halt their replication from one generation to the next.

References

For more on this topic go online...
- Meeting the mental health needs of new fathers
  Bit.ly/NTFathers
- The NHS Choices guide to stress, anxiety and depression
  Bit.ly/NHSChoicesAnxietyDepression
- Fathers Reaching Out: www.reachingoutpmh.co.uk
- The Samaritans: www.samaritans.org
- Rethink Mental Illness: www.rethink.org
- The Marché Society for Perinatal Mental Health: http://marcesociety.com

Box 3. Resources on paternal mental health
- The NHS Choices guide to stress, anxiety and depression: Bit.ly/NHSChoicesAnxietyDepression
- Fathers Reaching Out: www.reachingoutpmh.co.uk
- The Samaritans: www.samaritans.org
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