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Perspectives on supporting fathers affected by postnatal depression and a history of violence

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Title: Perspectives on supporting fathers affected by postnatal depression and a history of violence.

Abstract:

Intimate partner violence during the perinatal period is a significant public health problem that remains under-screened, under-diagnosed and under-treated. The establishment of evidence based guidelines to aid Health Visitors in providing support for couples experiencing violence has been hampered by the complex interplay between maternal and paternal mental health problems and violence.

Our study explored the experiences of UK fathers voluntarily engaged with services designed to reduce their exposure to violence.

The findings indicate that a tendency to violence was increased by stresses associated with the transition to parenthood. Men felt pressured by concerns for their partners' mental health, changes to their relationship with the mother, sleep disturbances and the burden of infant care they assumed when the mother could no longer cope.

Health Visitors are ideally situated to assess for factors linked to the emergence of violence and pre-empt the support needed to minimise its occurrence.

Key points

Transition to parenthood can be stressful with negative consequences for parent's mental health

Fathers supporting mothers with postpartum depression are themselves at risk of depression

Paternal depression and anxiety increase the risk of violence.

Health visitors are ideally situated to identify the support needs of fathers

Key words

Fathers

Depression

Postpartum

Violence

Men's health

Support needs

Background

Health visitors routinely perform psychosocial assessments of new mothers and fathers within the context of Family Centred Care (FCC) (Brook, 2015). Although FCC is inclusive of fathers, health visitors may focus primarily on mothers because they lack the knowledge and confidence to explore men's issues in the perinatal period (Whitelock, 2016). Unrecognised and unresolved issues held by fathers may ultimately have negative health consequences for mother and child (Garfield, 2015).

High levels of distress have been reported among expectant fathers and many fathers have mental health issues in the postpartum period (Boyce et al., 2007; Wynter et al., 2013). Students undertaking Health Visitor qualifications have reported that they felt underprepared for assessing and understanding paternal mental health issues (Oldfield and Carr, 2017). The evidence base required for the establishment of clinical guidelines for the assessment and support of at-risk fathers remains in the early stages of development (Garfield et al., 2014).

It is now widely recognised that a complex interplay exists between paternal and maternal mental health problems and the emergence / re-emergence of intimate partner violence (Kan et al., 2012). We were unable to locate any study that sought an understanding of the interplay from a father's perspective. The upcoming sections in this work highlight the literature exploring possible directional links; for example, violence may precede Maternal Post-partum Depression (MPPD) and maternal depression may trigger partner violence.

Maternal postpartum depression

Maternal depression is extensively explored in the literature; the incidence peaks between 6 weeks and 12 weeks following birth (Leahy-Warren and McCarthy, 2007). Nearly 13% of women experience depression during the first postnatal year (Gaynes et al., 2005; Leahy-Warren and McCarthy, 2007). Primary risk factors for the development of MPPD, consistently noted in research, include poor marital relationship and IPV (O'Hara, 2009).

Depression can be successfully treated prior to pregnancy, however the risk of a re-lapse into depressive symptoms is highest during a pregnancy and increases when pharmacological treatment has been curtailed for the safety of the foetus (Cohen, 2006).

Maternal depression and violence

Studies suggest that violence from several sources and time frames in a woman's life are predictive of MPPD and anxiety (Kendall-Tackett, 2007). Two studies identify a significant association between IPV committed during pregnancy and the onset of maternal depressive symptoms early in the postpartum period (Valentine et al., 2011; Tiwari et al., 2008).

The odds of having depression in the perinatal period, for women experiencing violence, are 3-5 times greater than for women in the community with no known history of violence (Howard et al., 2013). However the direction of associations is likely to be two –way in that ...

“depression may increase women’s vulnerability to domestic violence, and having experienced domestic violence can increase the odds of probable depression in the antenatal and postnatal period.” (Howard et al., 2013: 11).

A recent meta-analysis by Alvarez-Segura et al., (2014) showed a positive correlation between IPV and MPPD. This association was also noted in a meta-analysis by Wu et al., (2012) with an additional finding that MPPD induced by violence could be prevented provided that the violence was identified early.

Paternal depression

Factors linked to the onset of depression differ by gender; a father’s risk of depression is influenced by encounters with challenging social circumstances and relationships (Underwood et al., 2017). Men’s risk of PPPD has been directly linked to their partners’ inability to resolve critical incidents in her life course, poor mental health status, personality issues and disharmony within the marital /de facto relationships (Dudley et al., 2001; Goodman, 2008).

The transition to fatherhood is stressful for many fathers and is associated with the onset or exacerbation of mental health issues (Parfitt and Ayers, 2014; Baldwin and Bick, 2017). Post-Partum Paternal Depression (PPPD) in men is a significant health problem that has flow-on effects, negatively influencing maternal well-being and child development (Goodman, 2004). Studies that robustly investigate the risk factors for PPPD are only just emerging (de Montigny, 2013).

Fathers experience distinctive challenges to their emotional well-being during the transition to fatherhood; these are manifested in three stages i) pregnancy brings on a reorganisation of ‘self’ identity ii) the birthing process becomes the most emotionally charged period in the transition and iii) the postpartum period ushers in profound interpersonal and intrapersonal challenges linked to assuming new responsibilities (Wee et al., 2011). These challenges require substantial personal adjustment; when adjustments are not realised or support is not provided, mental health issues may emerge. The most common mental disorder in men and women, within the first six months of birth, is Adjustment Disorder with anxiety symptoms (Wynter et al., 2013). Anxiety is highly comorbid with depression (Leach et al., 2016).

Growing evidence shows that fathers’ emotions are intrinsically influenced by their partner’s mood. First-time fathers may experience depressive symptoms in the immediate postpartum when they are most attuned to maternal mood changes (Cattaneo, 2015). A

strong predictor of PPPD is MPPD; between 24% and 50% of men, whose partners have MPPD, experience PPPD compared with 1.2% to 25.5% of men experiencing PPPD whose partners do not have depression (Goodman et al., 2004). The consequences of PPPD for men are not clear, "...even though up to 50% of men whose partners suffer from PPD also have depressive symptoms, little is known about the impact of maternal PPD on fathers." (Letourneau et al., 2012:69). Researchers are beginning to explore the idea that interventions specific to couple based depression may be beneficial (Anding et al., 2016).

Educating and skilling Health Visitors to assess women's wellbeing and identify symptoms of postnatal depression has been effective in mothers gaining timely and appropriate support (Morrell, 2009). However, screening fathers for PPPD is not routinely undertaken because of an assumed focus on mother and child (Whitelock, 2016). Should a Home Visitor identify a father in need of support they are likely to be concerned over the limited number supportive interventions available for fathers with depression and anxiety (O'Brien et al., 2016). Whilst Pilkington et al., (2016) provide some guidelines on how partners can support each other to prevent depression and reduce anxiety during the pregnancy these guidelines take no account of the influence of IPV; a complicating factor for the Health Visitor.

Paternal depression and violence

Fathers affected by anxiety and depression do not necessarily manifest the problem as sadness; they are mostly likely to "... express their depression under the guise of alcohol abuse, aggressive/violent outbursts, risk-taking behaviours, overworking," (Condon et al., 2004). There is scant research of good quality to assist Health Visitors in their targeting of fathers most in need of support and very few perinatal programs effectively address expectant and new fathers' mental health status (Rominov et al., 2016).

Method

A qualitative approach was taken to understand the men's experiences of early fatherhood and their perceived support needs around IPV. Face-to-face interviews were guided by seven broad questions with the objective of identifying a) challenges encountered in the transition to fatherhood, b) men's beliefs about precursors to violence, c) men's perceived support needs and the type of help they had sought and d) recommendations they would make for optimal timing of support. Questions pertaining to the nature and frequency of violence lay outside the aim of the study.

Reflexive accounting

Careful and deliberate preparation for interviewing this population was undertaken prior to data collection. The researchers were informed by the work of Marsiglio et al., (2013) as to the internal dialogues men were likely hold and their behaviours associated with

procreation and pregnancy. The researchers were reflexive in their engagement with this potentially vulnerable group; we were aware of the well documented association between personality disorders (PDs) and intimate partner violence (Howard, 2015). Consequently, the researchers sought to avoid sensitive issues and were aware of the need to withdraw questioning should the interviewees become distressed. Immediate support from qualified staff was made available to all participants prior to and following the interview.

Sampling

Strategies for accessing hard-to reach populations were employed in the recruitment process; recognising that the main barriers to participation were the sensitive nature of the topic under investigation and the social stigma attached perpetration of violence (Benoit et al., 2005; Magnani et al., 2005). As recommended by Muhib et al., (2001) we identified days and times when the target population gathered at a specific venue, allowing us to construct a sample with known properties. Fathers choosing to participate approached the support centre leader who then informed the research team; this process promoted participant's autonomy in giving consent. The men's consent was informed by a letter explaining the purpose of the study and an invitation to ask the researchers for additional information. Ethics approval was granted by second author's university ethics committee and administered as 002/03/JK/loM, prior to commencement of the study.

Analysis

A qualitative descriptive approach was used to comprehensively and accurately detail fathers' versions of their experiences and support needs (Sandelowski, 2000). Manual coding of content was used to create salient themes. Reliability was enhanced using a two stage analysis; separate analysis by each researcher was followed by a comparative analysis between researchers. Achieving a saturation of themes was not attempted because the researchers acknowledged, prior to the study, that the sensitive nature of the data (e.g. profound regret for past behaviours) and a diversity of life experiences between participants, would not support such an aim. It is now widely accepted that adopting saturation as a quality marker is inappropriate (O'Reilly and Parker, 2013).

Theme: mental health issues

The men were initially asked to provide brief comment on the quality of their childhood, this approach was designed to establish rapport between interviewer and interviewee. The following account echoes previous findings on the antecedents to male violence; where male children and young men have been victimized at shockingly high rates in their intimate relationships (Archer, 2002).

Q. What was your childhood like? *"Rubbish."* [Interviewer seeks to clarify statement] **Q. In what way?** *"Absolutely rubbish, in and out of care and God knows what else."*

[Interviewer seeks to clarify statement] **Q. In care from what age?** *"Yeah. From about five, six, seven, maybe that age."* [Interviewer seeks to clarify statement] **Q. Until?** *"Until I were 16, until I were about 16." ... "Yeah, me dad used to always beat us up and that."* [003] *"I've been in care myself you see, you know, from being a young lad, well from being a baby [003]... "I had to be moved from one home because the bloke who did it, he were always smacking me, ... you get whacked continuously," [003]...*

Both inductive and deductive research has set out the links between maltreatment in childhood and the development of mental health symptomatology in adulthood; often translating into disruptive and sometimes violent behaviour (Shorey et al., 2012).

Theme: Anxiety and depression

Almost all the men interviewed gave comment on unresolved anxieties; some related to attachment issues with their partner. Several fathers emphasised a fall in intimacy in the postpartum period as a sign of a weakening relationship with the mother.

"...well a few of us were saying the same thing, the lady or your partner...has to spend more time with the baby, feeding them, changing them, looking after them so they're not giving you their undivided attention, you're used to that 100%, before you had this baby; you're like number two now"

Pregnant women report concerns over their reduced physical and emotional availability during pregnancy as precursors to their partner's physical violence. Controlling behaviour, spurred on by their partners feeling of insecurity (sometimes over paternity), jealousy (suspicion of infidelity) and possessiveness (Bacchus et al., 2006; Jasinski, 2004).

Anxiety disorders appear to be common for men during the perinatal period (Leach et al., 2016). However, little is known about the true prevalence and course of men's anxiety (Leach et al., 2015). The literature suggests the onset of depressive symptoms is pre-empted by the fathers increasing anxiety linked to parenting stress; the anxiety is heightened by the presence of maternal anxiety and MPPD (Vismara et al., 2016).

Theme: Co-occurrence of mental health issues

Several of the men spoke of their partners mental health problems in relation to factors that characterised their relationship; indicating that their mental health was in-part shaped by that of their partner.

“...she obviously had a problem which then I later found out she’d been abused by her father. If I’d have known that we could have dealt with it together.” [B075]

“Yeah, to be honest, she does like bottle a lot of things up because she’s told me she’s been abused in the past and things like that as well, you know, and a lot of things have happened to her, and she likes to keep [pause] keeps it to herself, this is the only reason why we didn’t get on half the time because we never spoke to each other about that stuff...”[ZOOM0003]

There are strong associations between child abuse and mental health problems for women in adult life, ranging from depression, PTSD, anxiety, self-harm, to sleep disorders (Dillon et al., 2013). The systematic review by Howard (2013:1) found that “high levels of depressive, anxiety, and PTSD symptoms in the antenatal and postnatal periods were consistently reported in cross-sectional studies”; these findings were significantly associated with life experiences of domestic violence and abuse.

Theme: unmet needs

All men interviewed outlined unmet needs in relation to their mental health symptoms and that of their partner; they subsequently responded to this situation with frustration and aggression. One man spoke of mounting anxieties related to changes in his relationship during the postpartum period and linked his worsening mental state to an inability to attract attention to his plight prior to being formally diagnosed with depression.

“blokes don’t really like opening up as rule, they’re(pauses) “I’m fine, if everything’s okay, I’m going to get on with it” and that was my big problem. I stressed out and wound up”... “ I did some very stupid things that I’m embarrassed and regret now but at the time I was depressed...I just hit rock bottom and thought - stuff it, I don’t care anymore! [B047].

The men clearly called for access to support services once aggression emerged and did not want events to progress to a point where punitive sanctions were enforced. In reference to the success of his current support programme one man stated...

“...But I wish I’d have come years ago to be honest, I just used to shout and swear and that and but I didn’t know these places existed [sic voluntary IPV service], I only ever thought it were through probation, police, Social Services ...”[0002].

Most men described symptoms of depression and an inability to have their plight recognised.

“They’re [the domestic violence team] all putting it down to depression, but I’d have preferred the help when I asked; begging for it, not after the events.” [B091]
[Interviewer seeks to clarify statement] So you couldn’t find anybody to help you?

“Nobody wanted to help me; they all thought I wasn’t serious enough”. [B091]

A recent meta-analysis of the literature estimated the prevalence of PPPD at 8.4% (Cameron et al., 2016). However, rates of paternal depression are likely to be much higher among perpetrators and survivors of IPV.

Most of the men revealed that they had depended on their partner for emotional support and direction; following the birth this support was not sufficient or forthcoming.

I cut off a lot of friends to focus myself on my wife and when the children came no focus was on me and I’d cut my friends off, and although it was my choice to do that, ... I’m just hurt. [B073]

I would be extremely patient at work because that’s the job; that really demanded of me, and then when I’d come home ...I couldn’t relax either at home, and I wasn’t able to relax somehow... because I’d cut off friends

I have no-one to talk to, and the nearest person to me is my wife, so when we have open conversation the things that hurt in me came out, and it’s quite caustic in our relationship, and coming here [sic. The support centre] helps me find ways to get rid of that, and then all that should be in my relationship are the right things. [B073]

The issue for this man and many of the fathers interviewed is that they reacted to their emotional stress with violence and would have liked to have been informed about the existence of the Leeds support centre before the violence erupted; the men felt that talking to staff about their experiences and concerns would have defused issues that were damaging to their relationship.

THEME Prevention better than cure

Many of the men saw an association between disrupted sleep and change in sleeping arrangement and the onset of violence.

“Sleep deprivation can change you as a person...I tell you something right, that, if you’ve already got violence in a family and the child comes in, I can only imagine it would amplify the situation” [B073].

Several men explained how moving to separate rooms so that both parents were not awake for one child proved to be a solution to a better night’s sleep and a better relationship; provided that the father committed helping out at night when the mother requested respite.

Recent literature reviews identify strong correlations between poor sleep quality and the emergence of irritability, hostility and aggression; suggesting that screening for sleep

disturbance and poor quality sleep could aid in the identification of those at risk of emerging violence (Kamphuis et al., 2012).

The men interviewed wanted more information on what to expect as fathers. Antenatal classes were seen as not addressing fathers concerns; information and guidance was needed prior to any antenatal classes, with points specifically addressing the most likely challenges they would encounter.

" you need more clarification, you know, ...something like that 'cos they [sic. antenatal classes] only seem to work with the women.

There was a need to understand the mechanisms leading to relationship adjustments and maternal anxiety; a booklet specific to that topic was suggested.

[Interviewer seeks to clarify statement] What should be in that booklet for the dads? *"Giving them [fathers] step-by-step, this is going to happen so if there's any changes in your partner, or your wife, don't be thinking she don't love you"*

These comments suggest a gap between FCC theory and father inclusive practice; Health Visitors are now acknowledging the gaps in evidence and barriers to effecting inclusivity (Bateson, et al., 2017).

Discussion

This study provides insight into the mental health issues faced by men who had perpetrated violence in the perinatal period; the fathers had found solace in a supportive environment and were now in a position to make informed comment and recommendations.

The men in our study recounted interplay between their partners anxiety, partners depression and the co-occurrence of depression and linked these factors to the emergence of violence. These findings are similar to those of Kan et al., (2012) who describes a medley of psychological factors linked to violence a) the decline in quality of the couple's intimate relationship may be linked to the onset of violence, b) undiagnosed or undertreated mental health problems in either partner results in acts of abuse/violence or can be a result of experiencing violence, c) low levels of co-parenting lead to frustration over a lack of equitable workloads (compounded by sleep deprivation) resulting in frustration, failure to cope and depression.

Our findings concur with those of Mizukoshi et al., (2013) in that the fathers take the key role as essential supporter of partners with mental illness; the adoption of this burden of care subsequently impacts men's resilience and ultimately their mental wellbeing. The support needs of men in this study do not appear to differ greatly from those of first time fathers (Carlson et al., 2014). However, our data suggests that men with emotional issues prior to pregnancy, anxiety and depression, and a partner with a similar profile require assessment earlier than is currently practiced. In such a context, Leach et al., (2010)

recommends the use of a mixed measure to account for anxiety and depression as an overall burden of mental illness; identification of these risks to violence could lead to tailored support for those most likely to benefit.

Men with high levels of violence and psychopathology or long history of violence will have difficulty in achieving the necessary behavioural changes and will require formal mental health assessments and a long term treatment plan. However, Walker et al., (2015) contends that individuals with minimal violence and psychopathology will benefit from basic intervention. Health Visitors already deliver psychologically informed sessions to mothers; these are shown to be clinically effective at six and 12 months postnatally when compared with usual care (Whitelock, 2016). It may be possible to deliver similar sessions to fathers, thereby reducing the risk of IPV. For engagement with fathers to be effective, at a time when their existing relationship needs reaffirming or realigning, health visitors may need to increase efforts to validate their role and build trust (Tveter and Karlsson, 2017).

Conclusion

Little is known about the support needs of men who have a history of violence or who may hold an ideation to violence in response to the stress and anxiety encountered in the transition to fatherhood. Our research helps fill the gap in Health Visitors knowledge as well as promoting a wider debate on how to improve inclusivity of at-risk fathers, for the benefit of the entire family.