Health visitors' experiences of supporting fathers with paternal postnatal depression

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Abstract

There is increasing recognition that fathers are susceptible to experiencing postnatal depression (PND). Despite health visitors being ideally placed to support fathers experiencing psychological distress, little is known about their experiences in supporting fathers as part of the family unit. The aim of this study, therefore, was to more fully understand the experiences of health visitors in the UK in supporting fathers with PND. The study used semi-structured interviews with six health visitors who were asked about their perceptions, experiences and understanding of working with fathers. Thematic analysis of the qualitative data produced four major themes: health visitors' understanding of fathers, the family and PND; systemic health visiting failures that prevent optimal care for fathers; barriers to working with fathers; and improvements to health visiting practice that would benefit fathers. Based on these findings, four recommendations for health visiting practice are made.

There is increasing recognition that new fathers are at elevated risk for experiencing postnatal depression (PND). Meta-analyses have placed the worldwide prevalence of paternal PND at about 9% during the first postpartum year (Rao et al, 2020), although it may be as high as 25% during the first 6 months postpartum (Paulson and Bazemore, 2010). Like maternal PND, the condition in fathers involves a loss of motivation or interest in experiences that would normally bring pleasure and joy. However for fathers, paternal PND may also include experiences of anger and resentment (Davenport et al, 2022). Untreated paternal PND places a heavy burden on the entire family unit, including impaired mental health in fathers themselves (e.g., Letourneau et al, 2011), increased risk of maternal mental health problems (Nishimura et al, 2015), and both short- and longer-term negative effects on child development (Ramchandani et al, 2008a; 2008b). As such, there is an urgent need for policies and guidelines to support the entry of distressed fathers into pathways of care (Goldstein et al, 2020). Health visitors have been identified as supporting fathers' mental health during the postnatal period given their contact with families (Baldwin, 2014; Vipham, 2023). However, existing evidence suggests that there are substantial barriers that affect health visitors' ability to engage and work with new fathers.

Background

There have been calls to 'think family' when delivering postnatal healthcare (Darwin et al, 2021) and health visitors are ideally placed to support fathers (Bateson et al, 2017; Davenport et al, 2022). However, there may be important barriers to effective engagement of fathers by health visitors, not least because of a lack of clear guidelines about how fathers should be supported. In the UK, national clinical guidelines, such as the National Institute for Health and Care Excellence (NICE) perinatal mental health guidelines (2014), continue to suggest PND as primarily maternal, providing no guidance on how healthcare practitioners should identify paternal PND or provide care for fathers. This means that symptoms of depression in new fathers often go undetected, forcing them to manage depressive episodes and symptoms on their own and leaving them frustrated when they are unable to do so (Swami, 2019).

Even if there was a change to clinical guidelines, the gendered culture of health visiting poses a significant impediment to optimal support for fathers. Menzies (2019) has suggested that health visiting services have traditionally focused on mothers and that these traditions often leave fathers sidelined or separate from their families. Indeed, contemporary health visiting continues to prioritise mothers and babies, with fathers often considered a low priority (Leonard et al, 2020). Most health visitors are women, which may be another barrier to supporting fathers (Humphries and Nolan, 2015) as they may feel uncomfortable speaking to a woman or engaging with services that are perceived as feminised.

Health visitors may also inadvertently reinforce gendered stereotypes of parenthood, such as notions that mothers are the primary or only caregivers (Bateson et al, 2017) and that fathers are invulnerable to psychological distress during the postnatal period, mirroring stereotypes in the general population (Swami et al, 2020).

There are also practical barriers to effective engagement of fathers. For example, health visiting offers a service during standard working hours (Ly, 2010), meaning many fathers who have returned to work will not be reachable (Oldfield and Carr, 2017). Additionally, health visitors report very heavy caseloads, meaning they may be reluctant to engage fathers, especially when they lack adequate resources, training and time to engage fathers (Bateson et al, 2020), issues that have all been amplified as a result of the Covid-19 pandemic (Menzies, 2021). Conversely, fathers themselves may be reluctant to disclose difficult psychological experiences to health visitors (Davenport et al, 2022), especially if health visitors are perceived as a ‘public authority’ who could potentially remove their child (Pedersen et al, 2021).

Fathers themselves report feeling excluded from health visiting services, considering it as a service for mothers and babies (Whitelock, 2016), and hesitating to seek help from health visitors. For example, a recent lived experience narrative highlighted the difficulty that a father experienced in requesting help from a health visitor (Davenport and Swami, 2022), which was denied, leaving the father feeling ignored. Moreover, many fathers report never having been asked about their own mental health by health visitors (Baldwin et al, 2021), reinforcing a perception that these services are ‘not for them’. Overall, the barriers to effective engagement of fathers are numerous, and range from personal to systemic factors (Baldwin et al, 2018).

While there is growing recognition that health visiting can do more to support fathers in the transition to parenthood (Black, 2023), much more can be done to better understand how health visitors understand paternal PND, their experiences of working (or not working) with fathers, their perceptions of barriers to effective engagement, and what they believe effective engagement would look like. To fill this gap, this qualitative study aimed to answer the question: how do health visiting services understand, respond to, and legitimise the experiences of fathers who experience paternal PND?

Methods

A qualitative study grounded in a pragmatic paradigm was conducted, which aligned with the practical aim of the study to actively understand health visitors’ perspectives of fathers with PND (Polit and Beck, 2012). Here, the emphasis was not on interpreting the individual experience, but rather in identifying relevant aspects of health visitor perceptions and practice experiences that offer potentially new and professionally focused knowledge that can be applied to future support and interventions for fathers.

Ethics

The study was conducted following ethics approval from the School Research Ethics Panel at the authors’ institution (approval code: EHPGR21_11). Each participant was provided with a participant information sheet. They gave written and verbal consent prior to the interviews. Participants were aware they could stop the interview at any time, without consequence. All participants were more senior than the primary researcher (the first author), which minimised the risk of coercion to participate. While two participants were professionally known to the primary researcher, they were both more senior and had not worked or studied in the same setting for over 2 years.

Participants

Health visitors were recruited through professional networking and social media dissemination, including via the Institute of Health Visiting. The sample comprised six registered health visitors in the UK, including four women and two men, aged between 33 and 60 years and holding between 6 and 22 years of registration. Five were working in roles in different settings across the UK, and one was retired. Further details are summarised in Table 1. The final sample size was justified through the concept of 'information power' in qualitative interview studies (Malterud et al, 2016). This work suggests that in studies focusing on rare or infrequent experiences, a small sample is appropriate.

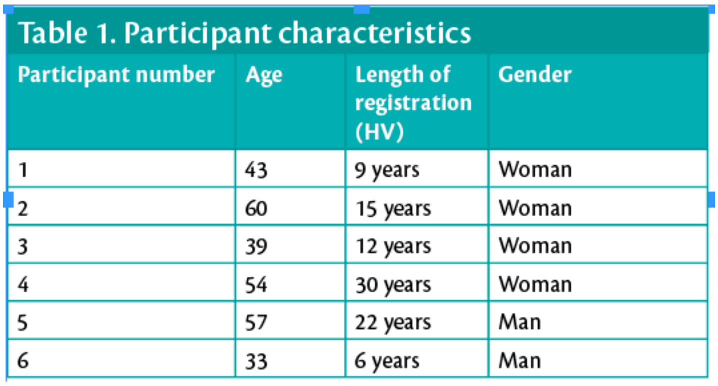

Table 1. Participant characteristics

Participant number	Age	Length of registration (HV)	Gender
1	43	9 years	Woman
2	60	15 years	Woman
3	39	12 years	Woman
4	54	30 years	Woman
5	57	22 years	Man
6	33	6 years	Man

Where participants may have diverse opinions, a sample of between six and 10 is acceptable (Malterud et al, 2016). Given that there was a time limit on data collection, recruitment was terminated after the sixth participant was interviewed.

Data collection

Data collection was conducted between November and December 2022 through the use of online, individual interviews using teleconferencing software (Microsoft Teams), with which all participants were professionally familiar. This approach was used in order to facilitate flexibility around participants' working schedules, particularly considering the busy schedules of health visitors and their high caseload demands.

Interviews were semi-structured around paternal PND and included questions about participants' personal perceptions and practices, as well as wider systems as illustrated in the interview schedule in Table 2. The schedule was based on the findings of previous studies on paternal PND, with questions designed to produce data that refutes or supports previous study findings and produce original knowledge from different perspectives overall.

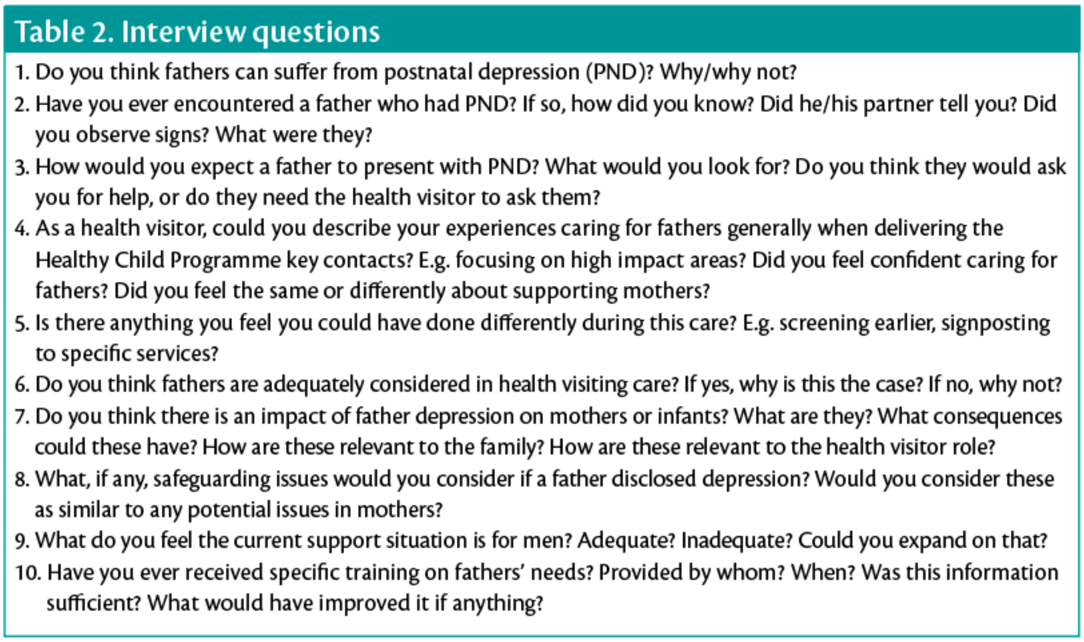

Table 2. Interview questions

1. Do you think fathers can suffer from postnatal depression (PND)? Why/why not?
2. Have you ever encountered a father who had PND? If so, how did you know? Did he/his partner tell you? Did you observe signs? What were they?
3. How would you expect a father to present with PND? What would you look for? Do you think they would ask you for help, or do they need the health visitor to ask them?
4. As a health visitor, could you describe your experiences caring for fathers generally when delivering the Healthy Child Programme key contacts? E.g. focusing on high impact areas? Did you feel confident caring for fathers? Did you feel the same or differently about supporting mothers?
5. Is there anything you feel you could have done differently during this care? E.g. screening earlier, signposting to specific services?
6. Do you think fathers are adequately considered in health visiting care? If yes, why is this the case? If no, why not?
7. Do you think there is an impact of father depression on mothers or infants? What are they? What consequences could these have? How are these relevant to the family? How are these relevant to the health visitor role?
8. What, if any, safeguarding issues would you consider if a father disclosed depression? Would you consider these as similar to any potential issues in mothers?
9. What do you feel the current support situation is for men? Adequate? Inadequate? Could you expand on that?
10. Have you ever received specific training on fathers' needs? Provided by whom? When? Was this information sufficient? What would have improved it if anything?

Interviews lasted between 12 and 46 minutes, with the average being 31 minutes. These times were sufficient to allow participants to recall their experiences and understanding of paternal PND. They do, however, reflect differences in participants' experiences, with the shortest interview participant recalling the least experiences working with fathers, and the short time overall perhaps reflecting that health visitors do not work with fathers routinely as they do with mothers. Transcription was completed using the Teams transcription function, but checked manually by the first author for accuracy.

Analysis

The first author is a health visitor and the second is a professor of psychology. Reflexive thematic analysis was chosen to analyse the study, because the research position of the first author was used to determine the relevance of the data to the research question. Following the recommendations of Braun and Clarke (2022), the transcripts were read numerous times to facilitate familiarisation with the data.

Following this, the first author coded the anonymised transcripts manually. The codes were assigned to passages that were considered relevant to health visiting practice towards fathers, both generally and with PND. Based on the aim to represent the participants as a group, codes were grouped by shared concepts to create themes.

Throughout the process, and adhering to the reflexive approach, the codes were assigned based on the first author's judgement of their importance to health visiting practice. The second author reviewed the analysis during the creation of themes to ensure that themes remained centred around paternal PND, rather than health visiting as a general practice. This avoided the findings becoming blurred and irrelevant to the research question. If difference of opinion arose, these were resolved through consensual discussion.

Further, this 'balance' minimised the risk of personal biases influencing the analysis. The dataset, including codes and theme production, is available from the corresponding author on reasonable request.

Results

The analysis produced four major themes: health visitors' understanding of fathers, the family and PND; systemic health visiting failures that prevent optimal care for fathers; barriers to working with fathers; and improvements to health visiting practice that would benefit fathers.

Health visitors' understanding of fathers, the family and PND

Overall, participants believed fathers were highly interested in both their role as fathers and their infants' wellbeing. Despite this, participants also believed fathers experienced significant stigma around their mental health. One expressed how she believed fathers feel when they may have PND:

'They've got that self-imposed stigma and, you know, around, I'm the big burly man, I'm macho and society expects me to be strong.' [Participant 2]

All participants recognised PND as a condition that could affect men. This was based on professional experiences, such as seeing cases of paternal PND, as well as the logical possibility of paternal PND given the challenges that new fathers go through:

'It's obvious that they must do because of the change in life, the change in stress or the responsibilities, the change in their partners and their attentions to the baby, and so there's less attention on them, and they've got to deal with all of this.' [Participant 4]

Some participants believed fathers experienced PND in a similar way to mothers, saying it was 'similar' to the mother's experience.

There were also differences identified in the male presentation, where fathers felt 'disconnected' from their partners. One difference was fathers' feelings of anger:

'I noticed something … where they can come over angry and whether sometimes it depression is coming out as anger.' [Participant 5]

Participants roundly recognised PND as having an impact on both fathers and their family unit, affecting the father's emotional and physical wellbeing, limiting their ability to interact with their families:

'They're not emotionally available. They're not physically available when they're depressed, and they're not … interacting and being part of the family.' [Participant 2]

Paternal PND was also linked to work–home life challenges and partner relationships, where with 'postnatally depressed dads, often it is about their relationship' (Participant 3). It was also linked to resentment:

'I think there's a real risk of fractured relationships that will take a long time to mend if it's not supported because you'll have resentment. "I have the baby. Why weren't you there for me?" But, you know, and I think … that takes a long time to mend.' [Participant 3]

Systemic health visiting failures that prevent optimal care for fathers

Each participant described the current service structure for fathers as poor, in the context of a broader negative social reaction to fathers:

'We silence men, particularly around their children and their babies. We're very quick to silence a man.' [Participant 3]

This silence was maintained by a dearth of support for men, with father-centred care described as a 'false narrative' and not representative of the health visiting service in reality. Pressured health visiting resources were common limitations in the service, which were further identified as barriers to the support of fathers:

‘Most 0–19 services have been stripped, pared back so much.’ [Participant 1]

There were limited opportunities for emotional support. The concept of supporting even maternal mental health wellbeing was considered a rare professional indulgence:

‘I’ve even heard comments like, “You mean you’ve got time to do listening visits?” as if that’s, like, a terrible thing ... it’s seen as a bit of a luxury that we’re not afforded at the moment.’ [Participant 4]

A lack of father-focused training was identified, as well as an absence of policy or guidance, resulting in participants being unsure about how to proceed with support:

‘[We] don’t think we know what to do with them when they are postnatally depressed or when they are struggling. I don’t … there’s not a clear pathway.’ [Participant 3]

A lack of father-specific secondary support services was identified:

‘There’s services like your generic, kind of, GP services. Perinatal mental health teams are there to support, but I think, in my experience, the services that were available in terms of perinatal mental health would only support dad if mum had got an issue. And then there are other generic things, you know, your IAPT services and things that dads have … talking therapies, things like that, that they have to engage with [are] slightly removed from the health visiting service.’ [Participant 6]

There were identified challenges in implementing record-sharing:

‘We automatically … we want … that consent to link for health records of each key family member and to let them know … we will be sharing significant information routinely at that point. But there’s a lot of barriers and difficulties in doing that.’ [Participant 1]

Another issue was the lack of connection between the father and baby’s record:

‘Interestingly, when I go into a home, I always make a point of saying to dad, “You’re not linked to your baby’s records like mum is. I’d like to link you to your baby. Is that OK?” And they’re always like, “Well, why aren’t we linked?” ... They absolutely want to be … on their baby’s records as their father, and it upsets them that they’re not.’ [Participant 3]

A third issue was the inability to record any father mental health difficulties, including PND, which were identified during encounters with fathers:

‘Because … we only open mum and baby’s records in our organisation you’re thinking, “Do I ask dad these questions?” Because I don’t know where to put it, for one thing.’ [Participant 5]

In short, the participants suggested that sharing and connecting records was rare and inconsistent. Consistency of record sharing and integration of services is also a regular outcome of serious case reviews.

Barriers to working with fathers

Gender was one characteristic that shaped how participants worked with fathers. A male participant shared his view that most men do not consider health visiting as a service for them:

‘I always sense a little bit of embarrassment that I’m even talking to them about their mental health to begin with, but I definitely feel that they absolutely do not expect me to even ask them how they are.’ [Participant 3]

Another observation was that health visiting is a mostly female profession. One male participant described a scenario where his colleague commented that fathers were more open when he was present during joint visits:

‘When I’ve been out as a pair [with] another female health visitor, they have commented on how dads linger and engage more when I have been there.’ [Participant 6]
Further, health visitors’ perception of fathers as aggressive was described as a reason for them to avoid visiting the home alone:

‘ … because they feel they need to redirect or represent themselves in this… I care for my wife and kids, kind of thing, and then we get hold of that anger and which can impact … because there’ll be some members of staff because there’ll be things all over the records saying do not go alone.’ [Participant 5]

Fathers were also sometimes fearful of health visitors:

‘Really, really frightened, that asking for a higher level of support from both health visiting and social care is gonna lead to care proceedings and their child being removed.’ [Participant 1]

These risk-averse practices around fathers were also considered to reinforce fathers’ fears. Men’s help-seeking was experienced as limited, with mothers being one route through which a father’s mental health needs were recognised and communicated:

‘Dad I never actually managed to see … but mum had said that his behaviour had changed and she was concerned about his mental health.’ [Participant 6]

Participants considered the working hours of health visitors to limit working fathers’ ability to attend reviews. The antenatal review was most commonly attended by fathers, followed by the new birth visit:

‘The only time I would say you more likely took count of them is the birth visit because they’re often around, but certainly not always … probably 50–60% of the time at a birth visit a father may be there, but then that is often the only time you’d see them.’ [Participant 4]

Even when at home some fathers avoided health visitors:

‘To some extent they disappeared upstairs, ‘cause they don’t really see it as their role, or stating, “She’s in there. I’ll get her for you”.’ (Participant 5)

Father support was limited by working hours, the timing of reviews and, at times, a reaction where fathers automatically seek out the mother.

Possible improvements to the health visiting service
Participants considered early opportunities to encounter fathers with PND as positive, although they acknowledged this did not routinely occur at the time of interview. A need to ‘go where the fathers are’ was identified, particularly in the antenatal period:

‘An antenatal for dad, a specific, targeted core contact for dad because of the way … we can engage with them in that, regardless of where mum is before the child arrives to … do that health education, health promotion side of things. Emotional wellbeing as part of it as well and really get them to buy into the service before the baby’s there.’ [Participant 6]

Participants considered professional communication with fathers as different to that with mothers. In particular, they described rapport as harder to build with men. Some participants identified a need for careful language, suggesting that this should be respectful, and non-blaming language was considered most appropriate:

‘I think you have to be very careful because they will absolutely bat you back with jokes, and you’ve got to be careful that you’re not … going down that jokey line.’ [Participant 3]

The participants explained that communication with fathers should be direct and inclusive. When used, participants recalled fathers expressing tearfulness, gratitude at feeling involved and an openness about their mental health difficulties.

Despite a disparate system, participants described a need to include fathers as family members during their encounters with families. Group settings were also discussed as potential environments for fathers to share their PND, although only one male participant had attempted this:

‘It’s difficult with dads; like I say, we’ve set up a dads group. The one I did on a Saturday went really well. But to be fair it was in a children’s centre back in the day. We had a bit of a budget, bacon sarnies, brought the kids, interaction with kids brilliant …’ [Participant 5]

Another area of inequality was around social class. Of the fathers who did engage with the participants, most were educated and middle-class. Conversely, the language of deprived fathers; specifically, their use of swearing, was described as a tool used to avoid services.

The participants suggested a need for universality. However, the antenatal review in particular has become ‘targeted’, meaning that only families perceived as experiencing increased needs are eligible:

‘When services are stretched, the antenatal contact is the first one to be dropped. If it’s not dropped, it’s sort of prioritised to … vulnerable families, but actually all families making a transition to parenthood are vulnerable.’ [Participant 2]

One participant stated the importance of men knowing that services for them do not disadvantage mothers:

‘I think they could do with their own labelled … channel to go down. So that they feel it’s for them and it’s acceptable for them and they’re not … moving in on women’s services.’ [Participant 4]

Another recommended asking about fathers at the same time as the mother:

‘… obviously we had … the service delivery framework, we had to ask about maternal mental health, but I also at that point would always ask if Dad was available; say, “This is something that happens in men, is this something that you’ve noticed?” and approach the question that way’’ [Participant 6]

Discussion

This study has produced new insight into perceptions and experiences of health visitors working with fathers with PND in the UK. The available research, albeit limited, shows that health visitors do not regularly acknowledge fathers’ mental health in their professional practice, instead preferring to focus on mothers and babies (Whitelock, 2016). In the present study, however there was some evidence that the sample had greater experience of working with fathers.

While there were only six participants, five of them described having asked fathers about their wellbeing and all participants considered PND as a condition that could affect fathers, despite PND not currently being diagnosed in men (Bruno et al, 2020). Thus, it may be that the landscape of health visiting is changing in tandem with broader shifts in wider society, with men's mental healthcare needs more commonly acknowledged and recognised.

However, participants' understanding of how PND presents in fathers was mixed. Some health visitors expected that this was similar to how PND is experienced by mothers. Two health visitors considered fathers' depression or distress to manifest through anger or aggression, which supports the same finding elsewhere (Eddy et al, 2019; Macdonald et al, 2020; Pedersen et al, 2021). These mixed perceptions, in addition to the difference in experiences working with distressed fathers, highlight an inconsistency in the level of skill and experience in paternal mental health. This conflicts with concept of specialist community public health nursing as having consistent and specialist knowledge when managing public health (Nursing and Midwifery Council, 2022).

Health visitors have previously been considered as ideally positioned to assist fathers into healthcare pathways (Davenport et al, 2022; Vipham, 2023). However, the present study suggests there may be barriers to this. First, the limited resources and high workloads described by participants resulted in key contacts for 'universal' or low-risk families being dropped, with only targeted contacts being offered. This included the antenatal contact. This is particularly troublesome because the participants described the antenatal visit as the most common opportunity to encounter fathers; yet this contact is no longer being offered to all families within a stretched system. Additionally, there was recognition that fathers may be present at the new birth review, but after this point they had often returned to work and so the health visitor did not encounter them. In short, the working practices of UK fathers limited their opportunity to attend reviews. The current health visiting service offers a more limited opportunity to encounter fathers than previously.

Limitations

A sample of six participants is too small to generalise this study's findings, given that 5979 health visitors are currently registered in the UK (NHS Digital, 2022). This limits the transferability of the findings, although the work has produced some powerful, novel findings. Also, selection bias may indicate that these self-selecting participants were more invested in father support. However, the sample were mixed enough in their demographics to determine that their comments about system wide problems were accurate and trustworthy.

Recommendations

Four recommendations are made for health visiting practice:

Universal training on father's mental health needs, and the communication skills (e.g. language) necessary to support these, should be offered to all health visitors
Increased recruitment of male health visitors would encourage a workforce where fathers are more comfortable disclosing their difficulties, viewing the services as there for them as well as the mother
An evidence-based pathway for fathers would enable health visitors to offer appropriate support and signposting for fathers, including assessment of their mental health needs
Most importantly, investment in public health on a governmental level is vital if the health visiting service is to have the resources to support fathers within their family unit.

Conclusion

This study examined the perceptions and experiences of six health visitors towards fathers with PND. It found that, although health visitors are individually invested in fathers, viewing them as important, there are limitations to supporting fathers with PND. There was a mixed level of experience and confidence, as well as system limitations, including a lack of resources and funding, which acted as barriers to universal support for men. There is a need for clearer communication, acknowledgement of the mother and policy for health visitors working with paternal PND.

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