

POSTNATAL DEPRESSION: STUDENT HEALTH VISITORS' PERCEPTIONS OF THEIR ROLE IN SUPPORTING FATHERS

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ABSTRACT

A qualitative, Interpretative Phenomenological Analysis (IPA) study was undertaken to explore student Health Visitors (HVs) perceptions' of their role in supporting fathers when their partner has had Postnatal Depression (PND).

Purposive sampling was used to ensure participants were chosen based on their ability to answer the research question. Data collection included one-to-one, semi-structured interviews with student HVs /newly qualified HVs, which were then transcribed and analysed by the researcher. Themes within the data were identified during analysis.

The findings demonstrate that student HVs felt that paternal mental health was not addressed in their training and they did not feel able to adequately support fathers in practice. Participants searched for a solution to how HVs can be more inclusive of fathers and how to support both parents in the postnatal period when the mother has got PND.

INTRODUCTION

The role of Health Visitors (HVs) within the United Kingdom (UK) is predominantly public-health focussed, including promoting health and well-being and reducing health inequalities for families and communities (Cowley et al. 2014). In order to meet the needs of a continually changing society, the HV's role is ever evolving. There have been significant changes in societal roles and responsibilities of parents in recent years following a national financial recession (Shirani et al. 2012 and Philpott, 2016). HVs are now having more contact with fathers, often due to unemployment, which has

led to the provision of 'family-centred' care, rather than focussing solely on women and children (Baldwin, 2015). Postnatal depression (PND) is a significant public health concern that HVs support families with within their sphere of practice. Whilst continuing to support women with PND, the 'family-centred' approach requires HVs to extend their scope of support towards fathers as well, to ensure a positive family dyad is maintained (Baldwin, 2015).

Taking this into consideration, the purpose of this research study is to explore student HVs perceptions' of their role in supporting fathers when their partner has had PND. Anecdotal evidence within the researcher's practice area highlighted a gap in practice in relation to HV service delivery, for fathers whose partner has had PND. The Healthy Child Programme (Department of Health (DH), 2009) identifies the significant role of the father and specifies that there should be adequate support for fathers. The researcher identified that, within their own practice area, newly qualified HVs are going into practice with little education in relation to supporting fathers at this crucial time for the family. Francis' (2013) recent report acknowledged that practitioners should be equipped with the knowledge base and subsequent application of this, to provide high quality care to clients. Similarly, Lord Willis' report 'Quality with Compassion: The future of nursing education' (Willis, 2013) recommended that there should be better evaluation of nursing education programmes to ensure that they prepare the students adequately to fulfil their future role.

BACKGROUND

Many women can experience emotional difficulties in the weeks following the birth of a baby and a strong correlation exists between maternal and paternal PND (Goodman, 2004; Bielawska-Batorowicz and Kossakowska-Petrycka, 2006; Spector 2006; Nishimura and Ohashi, 2010; Bradley and Slade, 2011 and Philpot 2016). Ramchandani et al. (2011), suggest that PND is now common in up to 10% of fathers, with symptoms manifesting similarly to PND in women.

Findings from Goodman's (2004), seminal integrative review surrounding paternal PND demonstrate that a prevalence of 24-50% of men, whose partner had PND, also experienced symptoms of depression. Similarly, onset of male depression was often following a diagnosis of PND in the woman (Goodman, 2004). Nishimura and Ohashi's (2010) more recent cohort study found that the most probable risk factor for paternal PND was PND in the mother. A previous history of depression and poor social functioning were also identified as risk factors.

Several authors suggest that if maternal PND is prolonged, support from the father can be withdrawn, posing a risk factor to the child if both parents are suffering with low mood (Goodman, 2004; Spector, 2006; Bradley and Slade, 2011). A robust, longitudinal study by Ramchandani et al. (2008) found 12% of children of fathers who had experienced PND had developed a psychiatric disorder by age seven. Similarly, Davé et al. (2008) found that 25% of fathers with depression, had a child with social, behavioural and conduct problems.

A further finding within the literature is that health professionals were often identified as not being inclusive of men when providing postnatal care (Goodman, 2004; Spector, 2006; Letourneau et al. 2010; Melrose, 2010; Eriksson and Salzman-

Eriksson, 2013 and Baldwin, 2015). Letourneau et al. (2010) report that within their qualitative study, the majority of men interviewed stated that they often felt 'ignored' by health professionals and the focus was on the mother and baby. A more recent study by Eriksson and Salzman-Eriksson (2013) found that fathers felt health professionals turned to the mother when offering support, which resulted in fathers feeling 'left out'. Baldwin (2015) suggests that, whilst efforts may be being made to be inclusive of fathers within perinatal care, men are often more reluctant than women to seek support or advice, particularly regarding mental health concerns. Reluctance to access support may also be due to an underlying concern regarding stigma attached to PND, stemming from a lack of education surrounding this subject (Letourneau et al. 2010; Melrose, 2010 and Philpot 2016). Philpot (2016) supports this and suggests that if fathers are made aware of PND in the antenatal period, they may feel more empowered to report low mood to a health professional.

Whilst support services for women with PND and general mental health services are widespread throughout the UK, several authors make a succinct argument that there is still a dearth of support services for men with PND (Letourneau et al. 2010; Melrose, 2010; Barlow, 2015 and Philpot 2016). Philpot (2016) suggests that a lack of support may have been as a consequence of the aforementioned under-reporting of the condition. Eriksson and Salzman-Eriksson (2013) suggest that online support forums for fathers are being utilised more frequently to overcome this lack of social and professional support. Whilst highlighting that HVs should signpost fathers to these forums, Eriksson and Salzman-Eriksson (2013) emphasise that such forums should only be used in addition to HV support, not to replace it.

A final predictive factor of significance for paternal PND that has been identified within the literature is socio-economic status (Spector, 2006; Nishimura and Ohashi, 2010; Bradley and Slade, 2011 and Philpot 2016). Bradley and Slade's (2010) literature review found that unemployment and age, notably men under 30 years old, were associated risk factors for PND. There has been a recent shift within families due to economic difficulties, as previously discussed, and, consequently, more men are now unemployed through redundancy or, in some cases, personal choice (Shirani, Henwood and Coltart, 2012 and Cowley et al. 2014). Unemployment and socio-economic status may both, therefore, be plausible contributory factors when considering barriers to accessing support.

The policy context in relation to this public health concern also recognises the need for change: 'Healthy Lives, Healthy People: Our strategy for Public Health in England' (DH, 2010) states that improved outcomes for children can occur by improving maternal health. This is supported by the more recent report from The Early Intervention Foundation (EIF), 'Getting it right for families' (EIF, 2014). The report stipulates that the early years are a vital time for brain development and highlights that when families are stressed and faced with adversities such as poor mental health, the child is at risk of social and emotional issues when they are older. Similarly, The 4 5 6 Model (DH, 2015) has identified 6 key public health high impact areas requiring attention by Health Visiting services, including the transition to parenthood and maternal mental health (DH, 2015).

METHODOLOGY

For the purpose of this study, Interpretative Phenomenological Analysis (IPA) was chosen specifically as it enables the researcher to gain a greater insight into student HVs' perceptions' of their role in relation to supporting fathers. Snelgrove (2014) suggests that the aim of IPA is to enable a more in-depth analysis of the lived experience.

Sampling

The sample chosen for this study was student HVs, due to qualify imminently, who have gained experience of supporting families both through observation of other HVs and also through their own practice. There is evidence to suggest that the use of students within research can reduce the credibility of the study, as students may provide inaccurate responses, giving responses they think the researcher may want to hear, rather than what they really believe or have experienced (Cleary, Walter and Jackson, 2014). The researcher, however, identified that student HVs will be delivering the service of the future and should, therefore, have involvement in shaping that service and contribute to evidence-based practice.

Purposive sampling was used to ensure participants were chosen based on their ability to answer the research question (Parahoo, 2014). An initial sample size of six was aimed for due to IPA samples being smaller (Smith et al. 2009). This allowed for potential withdrawal of participants, with an overall aim of achieving a sample of four participants. The final sample size was three, due to a lack of response from potential participants. Within this sample, there were newly qualified HVs as well due to a lack

of response from student HVs. This was approved through ethics prior to recruitment of HVs.

Ethical Considerations

For the purpose of this study, ethical approval was sought from University Ethics Committee and also the local Community Trust Research and Development Committee. Informed consent was gained prior to any data collection and a participant information sheet was given to all potential participants to ensure they were informed about the study and their role should they choose to participate.

Data Collection

Semi-structured interviews were chosen as the data collection method, as they enable the participant and researcher to engage in a conversation, whilst having a structure to work around, to ensure the research question is being answered (Brocki and Wearden, 2006). Field notes were taken during the interview, to support the audio data collected and included notes on the participants' body language and any key phrases which may have been used. This process enabled the researcher to reflect on the individual interviews and start the process of data analysis from an early stage (Smith et al. 2009).

Data Analysis

An IPA data analysis process was followed, as produced by Smith et al. (2009), to ensure robust and systematic analysis. This process is shown in Table 1.2 below.

FINDINGS

Lack of Experience

The most prominent theme to emerge from data analysis was a lack of experience both with supporting fathers in general and more specifically in relation to PND. This was highlighted early on in the interviews and was re-iterated throughout. The recurrent issue that appeared to be filtering through was that the majority of fathers return to work following a short paternity leave and, therefore, future contacts are predominantly with the mother and child only. Participants also recognised that another contributing factor to why they felt they had a lack of experience was that fathers would not always stay in the room for the visit.

There was a continued use of negative connotations within the interviews, in relation to lack of experience, which signifies a subtext of frustration and possible anxiety. This was emphasised when discussing HVs general contact with fathers:

Generally no....I don't think we do, no. No, no, I think erm because either they've gone back to work after their two weeks paternity leave and then after you don't see them unless they work shifts and things... (Participant (P) 1)

Probably as well areas that you work in, dads are at work and so you're not going to see them...(P2)

The repetition of 'no' from Participant 1 in this instance highlights the importance of this issue to the individual and is later supported by a personal admission of blame towards the situation:

But I do feel as if I should be supporting....I feel bad in a way really....you know when I go..... I think.....I can see that he needs some sort of support as well but.....it's difficult.... (P1)

Similar thoughts were also presented within the subsequent interviews, indicating that within this particular caring profession, there is a lot of internalisation, in relation to both personal and universal practice:

Yeah, you'd always like to do a little bit more, erm... but it depends on the family's circumstances.... (P2)

I do feel that we don't do enough for dads but it's difficult isn't it.... When you're trying to support both of them.... (P3)

Whilst participants voiced their wish to be able to support both parents equally, they did acknowledge that this may not have always been feasible and could lead to a conflict of interest for the practitioner:

I just find it difficult.... You know... when he phoned me for advice about his wife but I could tell he needed some support too but she was the priority so it was hard to try to help them both....(P3)

The repetition of the word 'difficult' was identified as highlighting a personal area of conflict for the participant, as they tried to rationalise their thoughts on the experience and search for a way forward from this.

Participants identified that their lack of experience in supporting fathers also stemmed from their academic training, as well as practical experience. It was highlighted across all interviews that there was a distinct lack of coverage of paternal support throughout the HV education programme at University.

Gap in Practice for Support for Fathers

Similarly to a lack of experience, participants also voiced that there is currently a gap in practice for support for fathers when their partner has PND. This appeared to be

linked again to fathers returning to work shortly after the birth, as they are not always present during visits:

I think erm because either they've gone back to work after their two weeks paternity leave and then after you don't see them unless they work shifts and things. Erm... sometimes you see them in clinic, but again, it is more....more mums I think come to clinic... (P1).

Participants did, however, also identify that an underlying cause for this may also be due to fathers' perceptions of the role of the HV and the purpose of health visiting visits:

You do reach the stage where, if a dad wants to excuse himself, you're not going to stop him doing that and it's sometimes having the confidence to say 'why don't you stay, you know... (P2).

Participant 2's comment highlights a lack of confidence in supporting fathers, which stems from the previous theme of not having enough experience during training. Participants discussed the experiences they have had in supporting fathers and from this it was interpreted by the researcher that there is a sense of self-doubt at individual capability within practice:

I think he just feels that....it's more....more for her really and it's difficult to.....I think 'cause I'm there supporting her and listening to her.....erm.....yeah, it's difficult really to help him. (P1).

... I think, I don't know about listening visits, I'd offer them but I don't know whether I'd.... put them across as listening visits. I don't know whether that would put them off a little bit.... (P2).

The repetition of 'I don't know' can be interpreted as a lack of experience in relation to this subject and, therefore, the participant does not have any prior knowledge to draw upon, to determine what would be an effective method of support.

Searching for a Solution

Participants were able to reflect upon their role in relation to supporting fathers and in doing so, were able to identify areas for improvement, including searching for a solution to the current lack of support for fathers. An area that was considered by participants was the use of current online counselling facilities already available. However, participants did acknowledge that this may equally present as a barrier to health professionals when trying to offer support to fathers:

. *I think with the websites and chat rooms, I think it's a good support erm.... but I don't think, say for instance something was... if it deteriorated in terms of dad's mood or coping mechanisms. What... who... who checks up that and who follows it through, if you know, things aren't going so well? (P2).*

A common proposal for future service delivery that did arise from the interviews was the possible benefits of a group setting:

I think maybe if we had erm....even a group or something for dads you know.....something where they could come and ask questions.....so that they know that they can access the health visiting service as well(P1).

I remember working in one area and I'm sure they had a football group.... it's addressing a need which is, you know, to be with other people who are going through the same thing, so maybe it doesn't have to be a one to one, it could be a group setting, erm... and that appeals. (P2).

Whilst group support was identified by participants as a possible way forward for supporting fathers, it was acknowledged that one-to-one support may also be effective. Participants did, however, voice concern over how they would deliver one-to-one support and if it should differ from the support offered to women:

I don't know whether it would be a different way.....you know to approach.....I'd like to think that I'd be able to but I think.....when we're taught, we're taught.....I suppose with mums in mind in a way aren't we.....so.....yeah.... (P1).

From this excerpt it has been identified that the participant is internalising how they would offer support to fathers. This is conveyed through the regular breaks within the sentence, demonstrating thought processing and the search for a solution.

Finally, participants also identified that a key starting point for supporting fathers, was to improve general contact and engagement with them:

I think....I think we maybe need to try harder to engage dads.....yeah.... (P1).

Yeah... I think I could make it more explicit, but I do kind of put myself across as a family health visitor ... but I don't think I make it explicit enough that I am here for dad in particular, if that's necessary, it's more of a 'I'm here for the family'... (P2).

DISCUSSION

'Lack of Experience' was highlighted as a theme early on in the study as participants voiced their concern at not having enough exposure to fathers during Universal HV

contacts. Despite The Healthy Child Programme (DH, 2009) stipulating that fathers should be included within core health visiting contacts, the findings from the study are suggestive of a lack of contact with fathers. Melrose (2010) suggests that many fathers may not discuss how they are feeling with anyone due to the presumed associated stigma and fear of appearing unable to cope. Whilst this may not be an explicit reason for lack of contact with fathers, it may be indirectly linked to why some fathers are not present during HV contacts, despite being at home at the time of contact. Similarly, Baldwin (2015) suggests that often fathers can feel that Health Professionals do not include them in pre and postnatal care. Evidence from the study suggests that both student HVs and newly qualified HVs did not feel they were always inclusive of fathers within their visits. Participants recognised this, stating that it as an area they felt they needed to improve on within their own personal practice.

Participants also discussed that they felt there had been a lack of coverage of paternal mental health within their training, both practically and theoretically. Coates and Gilroy's (2014) study on student HVs' perceptions of their role, found that mental health was an area which they considered to be a predominant part of their role. Whilst participants reported maternal mental health to be covered in detail, paternal mental health was not covered enough for participants to feel confident in addressing it within practice.

The second theme, 'Gap in Practice for Support for Fathers' is supported within the wider literature (Bielawska-Batorowicz and Kossakowska-Petrycka, 2006; Letourneau et al. 2010; Melrose, 2010). The authors suggest that fathers can feel isolated following the birth of a baby, as the majority of care is directed towards the

mother and child (Bielawska-Batorowicz and Kossakowska-Petrycka, 2006; Letourneau et al. 2010; Melrose, 2010). Participants within this current research study also commented that there was minimal support for fathers in their local area. This appeared to have a strong correlation with participants also stating that they did not have a lot of exposure to fathers in practice. Recent research indicates that whilst fathers may not always want to access support, they would still like to be informed of what support is available (Letourneau et al. 2010; Baldwin, 2015). This is significant as it suggests that support for fathers should be offered and discussed even if it is not then required, to enable fathers to make an informed choice about their own health and access support if required.

The final theme identified from the data was 'Searching for a Solution'. Participants recognised and acknowledged that current services were not adequate for supporting fathers when their partner has had PND, and, several suggestions were brought forward on how to resolve this. Online counselling services and chat rooms were discussed, however, participants felt that this would not be effective as fathers may still feel isolated. Within the current literature available, Eriksson and Salzman-Eriksson (2013) suggest that online counselling facilities may serve as a more attractive option to some fathers as it can be anonymous, and support could be received at any time of the day. Participants voiced concern at such facilities, as some felt that there was not a formal process for follow-up and if a father's mood deteriorated there may not be adequate support for this online.

Letourneau et al. (2010) and Baldwin (2015) suggest that a group setting can be effective if individuals are prepared to attend, however, some may not want to admit that they are struggling or need support, due to fear of stigma. Participants did discuss that they would support fathers on a one-to-one basis if this was preferred, however, were unsure how it would be managed if they were supporting the mother as well.

CONCLUSION

PND is now a growing health concern for fathers as well as mothers, with up to 10% of men experiencing low mood following the birth of their baby (Baldwin, 2015). This figure can increase significantly, if the mother also has PND (Goodman 2004). An IPA research study was undertaken to explore both student and newly qualified HVs perceptions' of their role in supporting fathers when their partner has had PND. Following one-to-one interviews with both student and newly qualified HVs, data was analysed and emergent themes were identified. It has been highlighted from the study that participants did not feel confident supporting fathers in practice, which was predominantly due to both a lack of experience and exposure to fathers. Participants also highlighted that their Health Visiting education thus far had not had enough coverage of paternal mental health and support for fathers. This is indicative of the need for change to be implemented within HV education and practice, to ensure fathers' needs are being met and delivery of 'The Healthy Child Programme' (DH, 2009) is sufficient.

The study also acknowledged strategies that may be put in place to support fathers in the future, including offering one-to-one support from HVs and providing structured group activities for fathers to attend.

LIMITATIONS

This piece of research has been conducted using IPA, which, by its nature, requires a small sample size. Due to a lack of participants, however, the sample was smaller than anticipated and the results may not be generalizable to the wider Health Visiting community, as it explored individual perceptions which are more subjective. Further research into this area is required as family dynamics are ever-evolving and HV service delivery should advance in order to meet changing health needs. Similarly, the researcher was a novice, therefore, whilst the interviews generated adequate data, a larger-scale study may be required to further explore this subject area in greater detail.

KEY POINTS

- There is a strong correlation between maternal and paternal PND, with up to 50% of fathers experiencing low mood if their partner has PND.
- HVs are now having more contact with fathers during Universal contacts; however, there is still a lack of support services available for fathers.
- Fathers have identified that they feel 'left out' by health professionals in the postnatal period.
- Student and newly qualified HVs report that they do not feel adequately prepared to support fathers when their partner has PND and attribute this to lack of experience during their training.

- Options such as group support and online-counselling forums have been considered by HVs to support fathers.
- Further training in relation to paternal mental health has been identified within this study as an area for consideration by Specialist Community Public Health Nurse programmes in the UK.

Table 1.1

INCLUSION CRITERIA	EXCLUSION CRITERIA
Students on the Specialist Community Public Health Nurse Health Visitor Programme in one Higher Education Institution (HEI)	No experience of managing postnatal depression with a father present within the family home
Experience of managing/observing management of postnatal depression with a father present within the family home	

Table 1.2

STEP 1: Reading and re-reading	Repeated reading of the transcripts in order to immerse oneself in the data.
STEP 2: Initial noting	In-depth examination of semantic content and language, considering each line of transcript individually, including interpreting what the participant meant through words used and pace of speech.
STEP 3: Developing emergent themes	Analysing initial notes to search for themes within the data, considering what was important to the participant.
STEP 4: Searching for connections across emergent themes	Consideration of how the themes identified 'fit together', including identifying subordinate themes that link the main themes together.
Step 5: Moving to the next case	Consider the next transcript, bracketing previous emerging ideas (from previous transcripts) when possible to be able to treat each transcript on an individual basis.
Step 6: Looking for patterns across cases	Considering themes that are common across all transcripts and compiling them into a table of themes.

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