

There from the start: Men and pregnancy



Matthew Roberts



Background

The author's clinical experience with fathers-to-be during pregnancy has highlighted the importance of paternal presence in family and clinical settings. This has motivated the steady development of his clinical practice towards whole-family care by reaching out to fathers and fathers-to-be.

Objectives

This article summarises the clinical experience of a perinatal psychiatrist and clinical specialist in fathers' mental health, around men's lives during pregnancy. The article also presents commonly observed clinical patterns and makes suggestions for clinicians seeking to enhance the care of these men and their families.

Discussion

Three key ideas gleaned from working with men in pregnancy are: occult perinatal mental health issues in men that have an impact on family wellbeing; seeking gender equity in co-parenting by acknowledging mothers' and fathers' '50–50' responsibility for the 'psychological birth' of a child; and strengths-based engagement of men as a men's health opportunity. Further resources are provided.

Learning of a partner's pregnancy and the prospect of fatherhood is a significant life event.¹ The relatively young field of perinatal psychiatry provides growing evidence that positive engagement of men around pregnancy enhances health outcomes for all family members: families thrive when men take up an active role during pregnancy.^{2,3} Healthy engagement with fatherhood is linked with improved health in the man and his children;⁴ this continues as children grow, even as they become parents themselves.^{5–7}

The important clinical emphasis given to sound perinatal care for pregnant women can unintentionally overshadow opportunities for preventive care or presentations of distress among men.⁸ Drawing on clinical experience, this article describes commonly encountered patterns and outcomes in men during the first and subsequent pregnancies of their partners, as well as key learnings from a growing specialist practice.

Normal patterns for men in pregnancy and illness prevention opportunities

Adjustment reactions in pregnancy

News of a pregnancy is usually a significant emotional and psychological landmark. A man's reaction to the news may indicate his degree of emotional readiness for his partner's pregnancy and parenthood.

One may enquire how present or absent the father-to-be feels in relation to his partner's pregnancy. Paternal absence may be an indication of additional risk factors for perinatal mental illness such as relationship tensions, socioeconomic stress or negative experiences of being parented.¹ Current ethical and legal factors that recognise a pregnancy as located in and belonging to a woman may reinforce such paternal absence.

In most pregnancies, transitional adjustment may be experienced as a degree of psychosocial stress that is significant but not overwhelming – a mix of good and bad news.⁹ Good news is generally much easier to process and share socially. Some men may experience bad news in the perinatal period (eg

fetal death, serious neonatal or partner illness) as unspeakable and overwhelming, and cope maladaptively through overwork, substance use, aggression or isolation.

Preparing for fatherhood

In this author's practice, the terms 'psychological nesting' and 'psychological birth' are used to describe parental reflective functioning¹⁰ perinatally. They refer to the processes by which women and men prepare an internal space to welcome a new child.

Psychological nesting in men includes developing an attachment to the pregnancy, anticipating changes to family relationships and conceptualising the self as 'father'.¹¹ Men who can talk with their partners, other men or more experienced fathers about fatherhood seem to be more comfortable with psychological nesting. Men with good relationships with their own fathers also approach parenthood with greater confidence.

In traditional family structures, men may feel conflicted between responsibilities to workplaces, financial provision and contribution to home life. A 'family balance sheet' of activities that give and take resources (Table 1) can be a helpful aid in decision-making, whatever the roles of the adults are in modern family life. The adults list the activities and resources of a week, indicating a minus sign for resources used up and plus sign for resources generated – multiple boxes may apply. In this example, the family had, on balance, a better week.

There may be a normal sense of stress and loss in men around their partner's first or subsequent births. This can include loss of a sense of control and mastery at work and home, loss of time for self-care and leisure, and loss of cherished aspects of the pre-parenthood dyad between the man and his partner.

Changing dynamics of a relationship

For first-time parents-to-be, a system of two must become a more complex system of three. For parents in subsequent pregnancies (including blended families), this huge adjustment repeats with variations, as the complexity of family life increases with each new member.

This author's practice uses the idea that each baby's psychological birth brings about changes to the couple's relationship that is analogous to the changes that physical birth makes in the mother's body: a normal and unavoidable injury occurs despite best efforts to minimise harm, and healing is essential.

Both sexes experience changes that are compounded by sleep deprivation, isolation, and a sense of fear and chaos as a new parent. One area where this can be a particular challenge is in sex and intimacy.¹² Compared with other normal parental losses, the loss of sexual closeness can be harder to acknowledge or share. Some parents may lay aside resulting difficulties to focus on the child's wellbeing. Others may move their attention to work, hobbies or other relationships.

However, children are deeply affected by the health of their parents' relationship.¹³ In this author's practice, the concept of an 'emotional roof' over a child's head has been useful. Whether or not the child's birth parents are together as a couple (ie including separated and blended families), that emotional roof is maintained when the child's main adult carers respect one another and honour the motherhood and fatherhood in the child's life. As an analogue of the 'secure base' from attachment theory,¹⁴ it follows that the emotional roof remains long after the child has grown and left the parents' physical roof behind.

Table 1. Example of 'family balance sheet' over one week

Family member	Finances	Time	Energy	Goodwill	Other resources	Net
Mother	(+) Parental leave pay (+) Loan from parents (-) Food shopping (-) Dispute with Human Resources over maternity leave	(-) Care of unwell baby	(+) Time with partner (+) Daily walks	(+) Seeing baby's wellbeing (-) Arguing over work hours (-) Partner's time at gym	(+) Friends' night out	(+)
Father	(+) Paid work – overtime (-) Rent (-) Gym membership	(-) Busy week at paid work (-) Elderly parents need help (-) Boss called on Sunday	(+) Time with partner and baby (+) Gym in evenings	(+) Parents supportive when visited (-) Arguing over work hours (-) Partner's night out with friends	(+) Attend a fathers' group	(-)
Baby	(-) Nappies, clothes and doctor's visit		(++) Feeling loved (-) Viral illness	(+) Getting plenty of play time with mother, father and grandparents	(+) Doctor's care at visit for viral illness	(+)
Net	(-)	(-)	(++)	(-)	(+)	(+)

Men's common mental health issues in pregnancy

Common psychiatric presentations in this practice among men in the perinatal period include panic attacks, symptoms of depression or anxiety interfering with work or home life, and obsessive-compulsive preoccupations around fear of mistreating partners or children. Angry outbursts, often accompanied by fears of hurting loved ones, may indicate the irritability of underlying generalised anxiety. Other unhelpful coping styles include addiction-pattern behaviour with alcohol and illicit drugs, gambling, exercise, work and sex.

This author's clinical experience suggests that paternal mental health can affect family wellbeing as deeply as maternal mental health. Perinatal mental illness may be more common in women than men,¹⁵ but women are also more likely to be screened or seek help perinatally. Distress and mental illness in fathers and fathers-to-be, as for men more broadly, is largely clinically silent.¹⁶

Consequently, general practitioners (GPs) are more likely to discover that a father is struggling with mental health issues via opportunistic questioning during a routine consultation, or via the mother of his child, especially if she is also suffering: men whose partners have depression or anxiety perinatally are more likely to have these illnesses themselves.¹ The above has given rise to a principal clinical rationale in this author's practice: in any nascent family, the health of each member deeply affects the health of the others.¹⁷ A distressed father predisposes the whole family to distress, and warrants clinical awareness and attention on par with what is now given to maternal and child mental health perinatally; they are all connected intimately. Positively, this practice has shown fatherhood to be an ideal window for engaging men around their health.

How clinicians can help Strengths-first engagement with men during the perinatal period

Many men seen clinically by this author seem to anticipate judgement, rejection or even ridicule (eg from partners, clinicians, colleagues) when showing vulnerability. Given that the perinatal period is a time of profound vulnerability for most fathers, a strengths-first¹⁸ approach has been found to be essential in this practice, creating a connection with men in a respectful and collaborative way.

A 'good-enough'¹⁹ therapeutic relationship can help a man understand what he feels and thinks during and after pregnancy, reduce isolation and engender appropriate help-seeking. This relationship can be built through interest and enquiry that recognises the importance of imminent fatherhood (Box 1). Improving a father's engagement this way may assist in setting up psychological or psychiatric care if needed.

It helps to start with the task of finding 'one good thing' about a man and his fatherhood: all but the most profoundly depressed men can usually at least endorse this author suggesting one firm strength

about their fatherhood. Exploring this strength and its probable aetiology (Box 2) with the same interest that clinicians would usually show in a presenting problem helps to create a connection through which a man may feel he can face his difficulties.

Showing and fostering respect for fatherhood

As clinicians involved in the care of families during pregnancy, our responses and attitudes can help bring the men involved into the picture, or unintentionally nudge them away. Clinicians can be deliberate and direct in acting for gender-equitable parenting, in which fatherhood is celebrated, watched over and nurtured as much as are motherhood and childhood.

Valuing both parents' experiences equally can be supported on the ethical premise of distributive justice²¹ alone. However, this author's experience shows that babies and children also benefit when the adults around them value motherhood and fatherhood equally – they are quantitatively equal if qualitatively quite different. This can be honoured clinically via the aforementioned concepts of psychological nesting and a child's psychological birth being divided equitably between mothers and fathers.

GPs may support this through practice improvements (Box 3), direct enquiry about and advocacy for each man's fatherhood, and special interest networking and further education.

Connecting men to resources

Good information can greatly assist men struggling with fatherhood, but the most important resources are people. This includes capable and well-resourced clinicians and organisations that are able to respond to queries, take referrals, broker services,

Box 1. Five questions for a father-to-be that may assist with engagement²⁰

- What's best for you about this pregnancy/fatherhood?
- What's hardest for you about this pregnancy/fatherhood?
- What do you think your baby will be like?
- How do you think your life is changing and will change?
- What do you think will help you be the best dad you can be?

Box 2. Questions that may help to identify and explore strengths in a man's fatherhood*

- Direct approach: 'What do you think you're doing well as a father/father-to-be?'
- Aetiology: 'Why is it going well?'
- Values: 'Why does it matter to you?'
- Pleasure-based: 'What do you look forward to about fatherhood? Why?'
- Relational: 'What does your baby's mum say you do well? Why?'
- By subtraction: 'How would life for your baby and their mum be without you in it? Why?'

**Often, a strength is picked up in a man's narrative (eg describing partner's relief when he gets home and the child's clear joy at his arrival).*

Box 3. Father-inclusive practice improvements²²

- Training of all staff around father-inclusive practice
- Employing male clinic staff
- Opening after-hours, attending workplaces, or other efforts to reach men in situ
- Limited phone and email contact of doctors by men who work during regular opening hours
- Neutral colour schemes
- Posters and other reading material in the clinic

and advocate for the men who may be feeling unheard and marginalised (refer to 'Resources').

Once sufficient connection to resources is there, most men seen in this author's practice can tolerate difficult psychological work when they are able to frame it as helping them be better fathers. Some men may have limited language for their feelings, but they can usually articulate that they want something better for their child, and so we have somewhere to start. This strong value can also form the basis for change to the most important relationship a man has in becoming a father – the relationship with himself. What is it going to take for him to look in the mirror and see a good-enough father? It will surely help if we as clinicians go looking for that man too.

Key points

- Undetected paternal mental health issues may rank alongside more prevalent maternal mental illness regarding impact on family wellbeing.
- Paternal presence correlates positively with child and family health.
- Engaging men in each pregnancy via a strengths-first approach is a men's health opportunity.

Author

Matthew Roberts MBBS, MP, FRANZCP, Psychiatrist and Fatherhood Clinical Specialist, Mercy Health O'Connell Family Centre, Canterbury, Vic; Mount Street Medical Centre, Heidelberg, Vic. matthew.roberts@mercy.com.au

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Resources

- PANDA (Perinatal Anxiety and Depression Association), www.howisdadgoing.org.au, has referral networks for men in perinatal distress.
- beyondblue endeavours to engage with men through positive and humorous means through their website, www.mantherapy.org.au, and public health campaign.
- Maternity hospitals – many run antenatal programs for men.
- Maternal and child health/child and family health services – universal early family nursing care is becoming increasingly whole-family based, and many municipalities are working hard to improve their engagement with fathers.

Enhanced home-visiting programs that may have initially developed to address maternal mental illness may be able to help with families with paternal mental illness.

- SMS4Dads program is an innovative program using ground-breaking technology and reaches out to fathers-to-be and new fathers via their phones (www.sms4dads.com).
- Books and websites – some great local authors are active online²³ and in print,²⁴ with accessible language and graphics to appeal to the time-poor.

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