

# Fatherhood and mental illness

## A review of key issues

**Rhys Price-Robertson**

Researchers have traditionally paid little attention to the intersections between men's mental illness and family life. Recently, however, this has been changing. This paper provides practitioners and policy-makers with a broad overview of some of the key issues identified in the growing literature on paternal mental illness.

### KEY MESSAGES

- Compared to many other life stages, the transition to fatherhood and the early years of childrearing are periods in which men are at a substantially increased risk of experiencing psychological distress.
- The children of men with a mental illness are more likely than other children to experience internalising (i.e., emotional) and externalising (i.e., behavioural) problems, as well as to be diagnosed with a mental illness themselves.
- Parenting behaviour is one of the mechanisms by which parental mental illness may translate into problem outcomes in children. Fathers with a mental illness are more likely than other fathers to show low levels of parental engagement, warmth and appropriate monitoring.
- The scarce qualitative literature exploring fathers' experiences of mental illness suggests that fatherhood is central to the image many men have of themselves—their experience of mental illness and their paternal identity are inextricably linked.
- Stigma is a significant source of suffering for many people with mental health concerns. Fathers with a mental illness can be subject to unique forms of stigma, which can influence their perceptions and experiences in a number of ways.
- Psychiatric and welfare service providers in Australia and internationally have often struggled to effectively engage fathers, either failing to see men as members of a family unit, or failing to offer services tailored to their specific needs.

It has been estimated that more than one million Australian children live in a family in which at least one parent has a mental illness (Maybery, Reupert, Patrick, Goodyear, & Crase, 2009). Furthermore, roughly 20% of mental health service users have reported that they live with dependent children (Howe, Batchelor, & Bochynska, 2012; Maybery et al., 2009). While mental illness does not preclude parents from providing appropriate care for their children (Beardslee, Gladstone, & O'Connor, 2011), it can potentially expose them and their families to a number of risks.

Parents experiencing mental health concerns are more likely than others to report parenting difficulties and strained parent-child relations (Kane & Garber, 2004; Wilson & Durbin, 2010), and their children are at increased risk of a range of emotional and behavioural problems, including psychiatric disorders (Connell & Goodman, 2002; Ramchandani & Psychogiou, 2009). Families in which a parent has a mental illness are at higher risk of experiencing socio-economic disadvantage (Eaton, Muntaner, & Sapag, 2010; Murali & Oyeboode, 2004), substance abuse problems (Reupert, Goodyear, & Maybery, 2012; Tiet & Mausbach, 2007), family violence (Howard et al., 2010; Oram, Trevillion, Feder, & Howard, 2013) and child maltreatment (Darlington, Feeney, & Rixon, 2005; Whitaker et al., 2008). They are also likely to be the subjects of stigma and discrimination (Angermeyer, Schulze, & Dietrich, 2003; Galasinski, 2013), and, if and when they seek professional help for their problems, to be met by service systems struggling to adequately acknowledge the interconnections between parental mental health, family functioning and children's wellbeing (Berlyn, Wise, & Soriano, 2008; Maxwell, Scourfield, Featherstone, Holland, & Tolman, 2012).

Most of the existent research on parental mental illness has focused on mothers (Ramchandani & Psychogiou, 2009; Styron, Pruett, McMahon, & Davidson, 2002). There are a number of reasons for this, including the well-known difficulties of recruiting men into research studies, mothers' greater involvement in daily childcare activities, and higher prevalence rates among women for the most commonly studied disorders (e.g., anxiety, depression) (Elgar, Mills, McGrath, Waschbusch, & Brownridge, 2007). However, there are also a number of reasons why it is important to separately study fathers' mental health.<sup>1</sup> Men tend to experience certain mental health concerns (e.g., depression) differently to women (Bronte-Tinkew, Moore, Matthews, & Carrano, 2007; Cochrane & Rabinowitz, 2000), to use different strategies to self-manage their health problems (Fletcher & StGeorge, 2010; Smith, Braunack-Mayer, Wittert, & Warin, 2008; Williams, 2007), and to be more reticent than women to seek professional help for health and welfare concerns (Addis & Mahalik, 2003; Galdas, Cheater, & Marshall, 2005). Also, mothers and fathers are subject to different gender and parenting norms and expectations, which can influence the ways in which mental illness impacts on parenting experiences and behaviours (Condon, 2006; Galasinski, 2013; Styron et al., 2002). For example, Galasinski (2013) found that a particular source of pain for fathers with severe mental illness was a sense of paternal inadequacy—the feeling that they had failed to fulfil the responsibilities expected of them as fathers, such as providing financially for their families.

It is an important time to be studying the connections between fatherhood and mental illness. As Smyth, Baxter, Fletcher, and Moloney (2013) have argued, “parenting roles, expectations and responsibilities are in transition, and the defining features of the father's role are expanding” (p. 377). Cultural images of what makes a “good father” have shifted significantly over recent generations: from the “moral teacher” of the early 20th century, to the “breadwinner” and “sex-role model” of the mid 20th century, to the “nurturant” and “involved” father that began to emerge in the 1970s and continues today (Flood, 2003; Lamb, 1987; 2010). Although changes in fathers' contributions to childcare and domestic labour have not kept pace with recent cultural ideals of gender equality in the home, many men are contributing to family life in ways that were comparatively rare in their grandfathers', or even their fathers', generation (Flood, 2003; Redshaw & Henderson, 2013; Smyth et al., 2013).

<sup>1</sup> Defining fatherhood is no easy task. For instance, Marsiglio, Day, and Lamb (2000) have distinguished between biological, economic, social, and legal forms of fatherhood. In this paper, the term “fatherhood” generally denotes what is called “social fatherhood”, which refers to “men's actual relationships, involvements and activities with respect to children, whether with children who are biologically 'theirs' or with children who are socially 'theirs' because of an intimate relationship with the child's mother (as stepfathers) or primary responsibility for parenting the child (as adoptive, gay or single fathers)” (Flood, 2003, p. 3)

Social scientists, too, are recognising fathers in new ways. The discipline of developmental psychology, for instance, has gradually moved from one “dominated by an attitude of mother-blaming”, to one in which both mothers’ and fathers’ contributions to children’s development are increasingly acknowledged (Connell & Goodman, 2002, p. 761). However, while some areas of scholarship on fathers’ mental health have developed quite substantial evidence bases (e.g., research on the effects of paternal mental illness on children), other areas remain seriously neglected (e.g., qualitative research on fathers’ experiences of mental illness) (Lefrançois, 2012). Indeed, very often fathers’ mental illness is considered solely through the lens of children’s wellbeing, meaning “the very *experience* of fathering with mental illness is nowhere to be found as a topic, issue or problem to be considered” (Galasinski, 2013, p. 21, emphasis added). Such gaps have obvious negative implications for understanding the service needs of fathers and their families. Mental health and welfare service providers in Australia and internationally have often struggled to effectively engage fathers, either failing to see men as members of a family unit, or failing to offer services tailored to the specific needs of fathers (Berlyn et al., 2008; Featherstone, 2009).

## The current paper

The purpose of this paper is to provide practitioners and policy-makers with an overview of some of the key issues identified in the growing literature on paternal mental illness. It is divided into six main sections:

1. Men’s mental health during the transition to parenthood;
2. Paternal mental illness and child development;
3. The effects of mental illness on men’s parenting behaviour;
4. Fathers’ experiences of mental illness;
5. Mental illness stigma and fatherhood; and
6. Fathers and the service sector.

The topics in sections 1–3 have attracted a moderate amount of research interest in recent years, and so, where possible, the focus is on the results of systematic reviews and meta-analyses. Section 4 focuses in some depth on the scant qualitative research on fathers’ experiences of mental illness. Sections 5 and 6 draw on literature other than that focused specifically on fathers’ mental health, and are intended to contextualise the research outlined in other sections. Where appropriate, Australian literature is emphasised throughout this review.

This review also includes three case studies, which were generously provided by families in contact with the national Children of Parents with a Mental Illness (COPMI) Initiative. It was considered important to highlight the voices of family members, as it can be easy to forget that people’s lived experiences rarely conform to the structures and categories of social-scientific research. Consider the host of complex and interrelated issues raised in the six short paragraphs in Box 1 (below): identity, race, ethnicity, place, abuse, trauma, repression, shame, cultural beliefs, work–life balance, marital relationships, men’s help-seeking behaviour, fathering, therapy, healing ... the list could go on. This is how mental illness manifests in the lives of individual fathers, and no single study in this review comes close to capturing such complexity. This is not meant as a disparagement of any particular form of research, but rather as a reminder that intellectual humility and an openness to diverse perspectives—including the perspectives of the subjects of the research themselves—are appropriate in the face of topics as complicated as fatherhood and mental illness.

## 1. Men’s mental health during the transition to parenthood

The transition to fatherhood—from conception, through pregnancy, and to the early months and years of parenting—can be a period of extremes. For many men, it is a time of happiness, excitement and love (Bradley & Slade, 2011; Johnson, 2002). Yet, it can also be a chapter of great upheaval and anxiety (Condon, Boyce, & Corkindale, 2004; Fenwick, Bayes, & Johansson, 2012; Hanson,

Hunter, Bormann, & Sobo, 2009). While the above statements could also be applied to women in the transition to motherhood, there is reason to believe that there are gender-specific factors that influence men's experience during this period. For example, in an ethnographic study of men's passage to fatherhood, Draper (2002; 2003) found that participants generally lacked the kind of clearly structured transition that tends to guide women's experiences of pregnancy, childbirth and early parenting. In the absence of such structure, expectant fathers in her study found themselves in a state of anxiety-provoking uncertainty; "in a kind of limbo ... between social statuses, neither one thing or the other" (Draper, 2003, p. 70). In a similar study of Australian fathers-to-be, Fenwick et al. (2012) found that "men struggled to come to terms with the reality of the pregnancy, their changing relationships and potential economic stability" (p. 7). These authors added that "adjusting to the news of a pregnancy and the subsequent anticipation of supporting their partner throughout the childbirth process can provoke a complex set of stress responses in expectant fathers" (p. 8).

While pre- and post-natal mental illness is a well-recognised health issue for women, researchers—along with society at large—have been slow to recognise it as an important issue for men (Condon, 2006; Solantaus & Salo, 2005). This is changing, however, and the last decade has seen "fathers emerge from the wings" (Solantaus & Salo, 2005, p. 2158). On the topic of men's pre- and post-natal mental health, there now exist numerous studies (e.g., Condon et al., 2004; Giallo et al., 2012; Ramchandani, Stein, Evans, & O'Connor, 2005), along with a number of reviews and meta-analyses (Ballard & Davies, 1996; Bradley & Slade, 2011; Goodman, 2004; Paulson & Bazemore, 2010; Schumacher, Zubaran, & White, 2008; Spector, 2006; Wee et al., 2013; Wee, Skouteris, Pier, Richardson, & Milgrom, 2011). The most common focus of this research has been depression. Best estimates for the prevalence rate of paternal pre- and post-natal depression have varied quite widely, depending on factors such as the sample size and constitution, as well as the measurement instruments used (Wee et al., 2011). However, a meta-analysis (Paulson & Bazemore, 2010), which included 43 studies and 28,004 participants from mostly high-income countries, found the "overall rate of paternal depression between the first trimester and one year postpartum was 10.4%" (p. 1966). The authors compared this figure to the 4.8% 12-month prevalence rate for depression in men in the US. Similarly, a recent Australian study (Giallo et al., 2012) found that 9.7% of fathers reported symptomatic or clinical psychological distress during the postnatal period, and that over the postnatal and early parenting years, fathers were at 1.38 increased odds of experiencing psychological distress compared to the general adult male population. Overall, these studies confirm that the transition to fatherhood is a time of heightened risk for paternal depression, and that "paternal prenatal and postpartum depression represents a significant public health concern" (Paulson & Bazemore, 2010, p. 1966). However, this risk is still less than that that applies to mothers, with best estimates suggesting that up to 19.2% of women have a major depressive episode during the first three months postpartum (Gavin et al., 2005).

Researchers have also investigated the risk factors associated with pre- and post-natal depression in fathers (for reviews, see: Ballard & Davies, 1996; Goodman, 2004; Schumacher et al., 2008; Wee et al., 2011). A large number of factors have been identified—from ethnicity, to parenting stress, to personality style. However, a smaller number of risk factors have occurred quite consistently in the literature. Maternal depression and poor couple (or marital) relationship quality are the most commonly cited factors, and have shown moderate to strong associations with paternal pre- and post-natal depression (Goodman, 2004; Paulson & Bazemore, 2010; Wee et al., 2011). Low social support is another regularly cited correlate of fathers' depression (Wee et al., 2011), and is a risk factor that can increase markedly for single, separated or divorced fathers (Giallo et al., 2012; Spector, 2006). For example, Giallo and colleagues (2012) found that when children were 2–3 years old, the prevalence rates of paternal psychological distress were 8.2% for resident fathers, and 17.5% for non-resident fathers. Men's psychological state before and during pregnancy also appears to have a strong bearing on their likelihood of developing post-natal depression. For instance, greater levels of pre-birth anger and anxiety have been found to be associated with depression in fathers' post-birth (Buist, Morse, & Durkin, 2003). Similarly, Ramchandani and colleagues (2008) found that the strongest predictors of paternal post-natal depression were high antenatal anxiety and depression, as well as a history of severe depression.

Far less research has investigated the prevalence or correlates of pre- and post-natal mental illnesses other than depression (e.g., anxiety, bipolar disorder, and schizophrenia) (Bradley & Slade, 2011). A small but growing body of literature indicates that fathers are more likely to experience anxiety disorders in the pre- and post-natal period (Ballard, Davis, Handy, & Mohan, 1993; Bradley, Slade, & Leviston, 2008; Condon et al., 2004; Field et al., 2006; Luoma et al., 2013; Matthey, Barnett, Howie, & Kavanagh, 2003). In one of the only attempts at estimating the community prevalence of paternal post-natal anxiety, Bradley and colleagues (2008) found that 6.6% of fathers in the UK reported clinically significant levels of anxiety 6 weeks after the birth of their child. In the same study, the authors also estimated men's levels of post-traumatic stress disorder (PTSD) following childbirth, and found the rates to be low (i.e., some men reported PTSD symptoms, but none reported fully symptomatic PTSD). Recent attempts at investigating bipolar and psychotic disorders in fathers in the pre- and post-natal period are extremely scarce, and many of the older studies that focused on this topic had very limited sample sizes or were based on clinical observations (for a review, see: Bradley & Slade, 2011).

### Box 1: Dad's story

#### Healing from trauma

I am a father of two children, aged 11 and 5, born in New Zealand of Samoan/ Maori heritage.

Growing up in Sydney with four siblings, I experienced trauma and sexual abuse from my mother and lived in fear every day. It was a very unstable childhood, but through my own determination I completed Year 12, went on to university, and tried to move on with my life.

My childhood abuse had given me an ingrained belief that sex equals love, and my early adult relationships reinforced this idea. In 2000, I married and my wife and I soon welcomed our first son. Becoming a father shifted the focus of our relationship to our child and I found my beliefs being challenged. How could my wife and child love me when they weren't showing me their love in the only way I knew? I loved my child and wanted the best for him, but my emotional state was regressing to that of my childhood. I felt redundant, lost, depressed and alone, and I couldn't acknowledge that what I was experiencing might be depression or the result of trauma.

Our second child was born and I continued to ignore my depression and the trauma of my childhood. I didn't talk about any of my feelings with my wife, believing instead that everything was fine. I had never told my wife about my childhood and didn't want her to know. Instead, I threw myself into my work, becoming so busy that I didn't need to think about it.

Looking back, I can see I was deeply affected by my childhood and my mental state was not good, but at the time I didn't want to see a doctor or counsellor. I was determined that my children would have a far better childhood than I had and that what happened to me would never happen to them. However, I was very disengaged, not present for them, and working too often and too hard. The shame I carried from my own childhood meant that I was very strict and angry with them, somehow believing this would mean they had a better life.

All these insights have only come to me in retrospect since I recognised I had depression and entered a 28 day rehab program in Sydney. I now have a therapist, see a GP, and have started medication, for the first time, for depression. My wife and I have recently separated, and it was through our marriage therapy that I recognised my depression. I see my boys several days a week and am focused on being a good father—I have learned to be present with my boys, doing things such as just kicking a ball around with them and giving them my full attention.

I have also learned that you can't do it all yourself, and that it's ok to ask for help. I think it can be very alien to a male to ask for help but I took that step when I asked my GP for anti-depressants. It was a big change, and made me nervous to do it, but I wanted to be there for my children and not pass on the shame that I experienced. I haven't talked to them yet about my depression but I am planning to soon. I want them to know that I'm fully there for them. I want to be a father that my children are proud of, regardless of all my failings and imperfections. My children are my life and I am proud of them both.

Provided by Children of Parents with a Mental Illness (COPMI).

## 2. Paternal mental illness and child development

Much of the research on fathers' mental illness has investigated the effects of fathers' mental health problems on children. Paternal depression is the most comprehensively studied disorder in this regard and has been found to be associated with internalising (i.e., emotional) and externalising (i.e., behavioural) problems in infancy and childhood (for reviews, see: Connell & Goodman, 2002; Kane & Garber, 2004; Ramchandani & Psychogiou, 2009), as well as increased risk of experiencing various psychiatric disorders in adolescence and young adulthood (Klein, Lewinsohn, Rohde, Seeley, & Olino, 2005; Lewinsohn, Olino, & Klein, 2005; Ramchandani & Psychogiou, 2009). Some of these associations appear to hold even in circumstances where paternal depression is relatively short-lived. For example, recent research has demonstrated that fathers' depression during pregnancy and the perinatal period can have detrimental effects on children's psychosocial wellbeing until at least 7 years of age—effects that remain when controlling for both maternal and later paternal depression (Kvalevaag et al., 2013; Ramchandani et al., 2005; Ramchandani, O'Connor, et al., 2008; Ramchandani, Stein et al., 2008). Two meta-analysis studies (Connell & Goodman, 2002; Kane & Garber, 2004) have indicated that although the effect sizes for the associations between fathers' depression and children's internalising and externalising behaviour problems are generally small in magnitude (e.g., Kane and Garber's (2004) analysis of 17 studies found mean effect sizes of  $r = 0.24$  and  $r = 0.19$  for externalising and internalising problems, respectively), they are broadly comparable to those identified in studies on maternal depression and children's outcomes. Effect sizes increase substantially, however, when both mothers and fathers concurrently experience mental health problems (Connell & Goodman, 2002; Kahn, Brandt, & Whitaker, 2004; Meadows, McLanahan, & Brooks-Gunn, 2007).

Less research has focused on associations between children's outcomes and fathers' psychiatric illnesses other than depression. A small number of studies have suggested that the children of men with anxiety disorders are more likely than others to themselves develop anxiety disorders and other psychosocial problems (Beidel & Turner, 1997; Bögels & Phares, 2008; Cooper, Fearn, Willetts, Seabrook, & Parkinson, 2006; Department of Veterans' Affairs, 2014; Kiliç, Özgüven, & Sayil, 2003; Last, Hersen, Kazdin, Orvaschel, & Perrin, 1991). In some situations, fathers' anxiety may affect children more than mothers' anxiety, perhaps because "children seem to put higher weight on fathers' responses than on mothers' responses in the face of possible threat, in order to decide whether the situation is dangerous and should be avoided, which is related to the development of subsequent anxiety or an anxiety disorder" (Bögels & Phares, 2008, p. 549). In support of this contention, one study measuring children's mental health following an earthquake in Bolu, Turkey, reported that the presence of paternal (but not maternal) PTSD was the most significant predictor of PTSD symptomatology in children (Kiliç et al., 2003).

The limited research on the effects of parents' severe and persistent mental illness (e.g., bipolar disorder, schizophrenia) on children indicates that children are at a substantially increased risk of developing psychiatric disorders, especially the same disorders as their parents (Henin et al., 2005; Hillegers et al., 2005; Rasic, Hajek, Alda, & Uher, 2014). A recent meta-analysis of studies quantifying such risk found that the offspring of parents with bipolar disorder and schizophrenia have around "a 1-in-3 risk of developing a psychotic or major mood disorder and 1-in-2 risk of developing any mental disorder" (Rasic et al., 2014, p. 35). However, little research has focused specifically on fathers, and it remains unclear whether these illnesses in fathers pose different or additional risks to children than the same illnesses in mothers (Ramchandani & Psychogiou, 2009). The children of parents with severe and persistent mental illness are also more likely to die of unnatural causes (Chen, Chiou, Tang, & Lin, 2010; Webb, Pickles, Appleby, Mortensen, & Abel, 2007). One study found that the young children of male psychiatric inpatients were up to ten times more likely than others to be the victims of homicide, and young adult offspring were up to three times more likely to commit suicide (Webb et al., 2007).

In recent years, researchers have turned their attention to the mechanisms by which fathers' mental illness affects children (Connell & Goodman, 2002; Ramchandani & Psychogiou, 2009).

Ramchandani and Psychogiou (2009) proposed that such mechanisms can be divided into three categories: “genetic, environmental and gene-environment interplay” (p. 648). Genetic pathways of risk transmission are complex, most often involving numerous genes each contributing to the overall level of risk (Rutter, Moffitt, & Caspi, 2006; Sullivan, Daly, & O’Donovan, 2012). It is clear, however, that genes have variable effects depending on the particular psychiatric disorder in question. For instance, schizophrenia and bipolar disorder are much more strongly heritable than depressive disorders (Sullivan et al., 2012). Beyond genetics, there are a number of environmental mechanisms by which paternal mental illness affects children. Such illnesses can directly undermine men’s ability to provide appropriate care for their children, and expose children to maladaptive affects, cognitions and behaviours (for further detail, see the next section of this paper). Paternal mental illness may negatively influence maternal psychological wellbeing, and so can compromise mothers’ health and parenting capacity (Field et al., 2006; Ramchandani & Psychogiou, 2009). It may be linked to increased marital or co-parenting conflict, which can have a strong negative impact on children (Hanington, Heron, Stein, & Ramchandani, 2012; Kane & Garber, 2009; Leinonen, Solantaus, & Punamäki, 2003). And it can have the indirect effect of leading to stressful or impoverished familial contexts (e.g., by compromising men’s ability to secure and maintain employment, fathers’ mental illness can negatively impact on families’ socioeconomic, employment and housing status) (Manning & Gregoire, 2006; Ramchandani & Psychogiou, 2009). Finally, “gene-environment interplay” refers to the fact that children’s risk is rarely all genetic or all environmental. Parental genetic factors are

## Box 2: Child’s story

### Growing up with parental mental illness

Growing up my family consisted of Mum, my Dad and my two younger brothers. Mum suffered from bipolar disorder and Dad was clinically depressed for my entire life. It all began in their teens before I was born.

I went to 13 different primary schools and my family constantly struggled for stability. My parents were one of the first in NSW to voluntarily place my brothers and me into permanent foster care. They wanted better for us, as we did not receive the extra support we needed as a family struggling with mental illness. It was a struggle for my parents to stay well and stable, and support and provide stability to their young family. So they made this extremely difficult decision, based on the fact that they wanted their kids to have the best the world had to offer and they realised that it might not be to stay with them. As a kid this was a very confusing and scary time because we didn’t understand what was going on. I was 11 at the time.

Dad’s illness stemmed from childhood traumas, and later in his life he self-medicated with drugs and alcohol, only to take his life when I was 19 years old. He was on and off medications throughout my life and had some hospital stays for his mental health and also from overdoses and suicide attempts, some of which I had discovered as a child, which was very traumatic for me. The grieving process, I tend to think, is different when it comes down to that person’s choice. It is almost six years since he passed away. Not a day goes by that I don’t miss him.

It took me making a lot of mistakes in my teenage years experimenting with drugs and alcohol, going out and partying and being irresponsible to learn about life and exactly where I didn’t want to be, and also to get me to the point where I am now. I have travelled and worked around Australia, been on a few overseas trips and seen some of the world, experienced new things and now have a stable government job as a Correctional Officer and see a psychologist regularly. We think I suffer from mild PTSD as a result of my childhood experiences, along with anxiety and depression. I managed this previously with medication, and now with regular appointments with my psychologist; to check in, touch base and have a better understanding in dealing with my emotions, situations and reactions to things.

I consider myself lucky. Very lucky. I’ve managed to do and see things my parents could have only dreamed of, and I’m grateful for that. I believe my morals, values and resilience come from them and I’m grateful for that. I look at the inmates I work with every day, and hear their stories, some that are so similar to my own, and I’m thankful that I’ve managed to assemble somewhat of a “normal” life, whatever that means.

Provided by Children of Parents with a Mental Illness (COPMI).

associated with specific environmental factors, and many environmental risks only affect (or more seriously affect) children who have particular genetic propensities (Rutter et al., 2006).

A number of other factors moderate the association between fathers' mental illness and children's functioning (Connell & Goodman, 2002; Ramchandani & Psychogiou, 2009). First, children's age influences risk, with mental illness in fathers more closely related to emotional and behaviour problems in older (i.e., school aged) children. In a meta-analysis of the relative strength of mothers' and fathers' mental illness on children, a "striking difference" was found in the direction of age effects for mothers and fathers: mothers' mental health problems were more closely related to younger children's outcomes, while fathers' had stronger effects on older children (Connell & Goodman, 2002). This finding appears to reflect cultural norms, whereby mothers tend to act as primary caregivers during early development, and fathers become increasingly involved and salient to development as children mature. Second, children's sex influences the effects of paternal psychopathology, with boys generally more vulnerable than girls (Ramchandani & Psychogiou, 2009; Ramchandani et al., 2005). The exact reasons for this sex difference are unclear, though it has been proposed that fathers may spend more time with sons, seeing it as a man's role to impart skills and knowledge to boys, which in turn may expose boys to the maladaptive behaviours that can stem from psychopathology (Marsiglio, 1991). Third, children's qualities, especially temperamental features, can either expose them to or protect them from risk (Beardslee et al., 2011; Belsky, Hsieh, & Crnic, 1998; Ramchandani & Psychogiou, 2009). For example, the behaviours of children with "difficult temperaments" (e.g., problems with self-regulation, emotional expression and attention) may exacerbate negative interactions with mentally unwell parents (Connell & Goodman, 2002). Finally, family structure can influence children's risk of being negatively affected by paternal mental illness (Meadows et al., 2007). For example, although "father absence" is a much-discussed problem, a father's presence can actually exacerbate children's negative outcomes if both parents are ill.

### 3. The effects of mental illness on men's parenting behaviour

Parenting behaviour is one of the mechanisms by which parental mental illness may translate into problematic outcomes in children. Although parenting behaviour alone is insufficient for understanding the familial transmission of mental health problems (Wilson & Durbin, 2010), it occupies its own section in this review for three reasons. First, compared to most other mechanisms by which parental mental illness affects children, considerable research attention has been paid to parenting behaviour and parent-child relations (Elgar et al., 2007; Wilson & Durbin, 2010). Second, parenting behaviours play a central role in a number of the theoretical models used to understand child development and family relations (e.g., attachment, family systems, object relations) (Elgar et al., 2007). Third, parenting is perhaps the most readily modifiable risk factor, especially for professionals working in the field with families affected by mental illness (e.g., through psycho-educational programs) (Fletcher et al., 2012; Johnson, Cohen, Kasen, & Brook, 2004). Although previous research on the relationship between parental mental illness and parenting behaviour has overwhelmingly been conducted with mothers (O'Hara & Fisher, 2010; Wilson & Durbin, 2010), and although "[r]esearch on the parenting of mentally ill fathers is still in its infancy" (O'Hara & Fisher, 2010, p. 273), there are now enough research findings to draw some conclusions, if only for certain psychiatric illnesses.

As in other areas, research on the parenting practices of fathers with mental illness has tended to concentrate on fathers with depression (O'Hara & Fisher, 2010; Wilson & Durbin, 2010). In general, paternal depression has been found to be associated with suboptimal parenting behaviours and parent-child relations (Ackerson, 2003a; Bronte-Tinkew et al., 2007; Kane & Garber, 2009; Wilson & Durbin, 2010). As an array of adaptive and maladaptive paternal behaviours and states have been measured (including engagement, warmth, acceptance, disciplinary practices, disengagement, hostility, control, rejection, criticism and anger), this literature can be difficult to neatly summarise. However, in a recent meta-analytic review of the effects of paternal depression on fathers' parenting



behaviour, Wilson and Durbin (2010) suggested that parenting can “typically be classified within the two broad categories of positive and negative parenting behaviours” (p. 169); the former designating behaviours generally associated with or involving parental engagement, warmth and appropriate monitoring, and the latter involving disengagement, hostility, criticism and inappropriate monitoring. Using this simplified typology, Wilson and Durbin found that fathers with depression tended to display decreased positive and increased negative parenting behaviours. Although the effect sizes for these associations were small ( $r = -.19$  and  $r = .16$  for positive and negative parenting behaviours, respectively), the authors noted that the extant literature consists primarily of community samples, in which fathers typically experience milder symptoms, and so their findings may underestimate the strength of association in more severely affected cohorts, such as male psychiatric inpatients. While men’s depression may express itself differently than women’s, and so have different influences on parental behaviour (Cochrane & Rabinowitz, 2000; Field, Hossain, & Malphurs, 1999), several studies that included both mothers and fathers have indicated a comparable influence of depressive symptomatology on parenting behaviour (Cummings, Keller, & Davies, 2005; Papp, Cummings, & Goeke-Morey, 2005).

Only a few studies have quantitatively investigated the impact of other psychiatric disorders on fathers’ parenting behaviour (e.g., Bögels, Van Oosten, Muris, & Smulders, 2001; Bosco, Renk, Dinger, Epstein, & Phares, 2003; Harvey, Danforth, McKee, Ulaszek, & Friedman, 2003; Johnson, Cohen, Kasen, & Brook, 2004; Parfitt & Ayers, 2012; van der Bruggen, Bögels, & van Zeilst, 2010). Broadly, this research suggests that a variety of psychiatric illnesses are associated with parenting difficulties. For example, an observational study with fathers who displayed attention deficit hyperactivity disorder (ADHD) symptomatology found that they exhibited a “lax parenting” style and argued more frequently during parent–child interactions than fathers who did not display ADHD symptomatology (Harvey et al., 2003). Similarly, fathers’ anxiety has been associated with decreased warmth in father–child relationships (Bögels et al., 2001), controlling parental behaviours (van der Bruggen et al., 2010) and a lack of assistance provided to children’s mothers (Johnson et al., 2004). There is also some indication that different psychiatric illnesses may lead to unique parenting deficits. In a study measuring several psychiatric disorders and their associations with maladaptive paternal behaviour, Johnson, Cohen, Kasen, and Brook (2004) found that different disorders were independently associated with specific types of behaviour. For instance, while paternal antisocial personality disorder correlated with poor supervision of children, paternal anxiety disorders did not. However, there are still too few studies to draw any firm conclusions about the specificity of parenting behaviours across different forms of paternal mental illness (O’Hara & Fisher, 2010). Indeed, a number of authors have suggested that in many cases it may be more useful to think not in terms of specific diagnoses, but rather to consider how parenting behaviour is influenced by the states of low positive affect and high negative affect that cut across numerous diagnostic categories (Lovejoy, Graczyk, O’Hare, & Neuman, 2000; O’Hara & Fisher, 2010; Wilson & Durbin, 2010). In support of this approach, research with mothers has indicated that the severity and chronicity of mental illness may be a more important indicator of suboptimal parenting practices than a specific diagnosis (Ackerson, 2003b; Rogosch, Mowbray, & Bogat, 1992).

Finally, mental illness can impact on parenting capacity and behaviour, as well as parent-child relations, by contributing to discord or violence within families (Beardslee et al., 2011; Cummings et al., 2005). Numerous studies have indicated that various psychiatric illnesses can increase marital hostility or conflict (Du Rocher Schudlich & Cummings, 2007; Low & Stocker, 2005), which in turn can “spillover” into problematic parenting behaviours and parent-child relations (Krishnakumar & Buehler, 2000; Ponnet et al., 2013). Similarly, paternal mental illness has been associated with poorer co-parenting relations (i.e., “the ways that parents and/or parent figures relate to each other in the role of parent” (Feinberg, 2003, p. 96)). (Isacco, Garfield, & Rogers, 2010; Majdandžić, de Vente, Feinberg, Aktar, & Bögels, 2012; Price-Robertson, Baxter, & Mathews, in press). Researchers have also identified relationships between different forms of parental mental illness and both family violence (Howard et al., 2010; Oram et al., 2013) and child abuse and neglect (Darlington et al., 2005; Walsh, MacMillan, & Jamieson, 2002; Whitaker et al., 2008). For example, a Canadian study

with a large-scale representative community sample found that when compared to participants with no history of family mental illness, participants reporting a parental history of depression, schizophrenia, or mania were two to three times more likely to report they had been physically or sexually abused as children (Walsh, et al., 2002).

## 4. Fathers' experiences of mental illness

This section reviews the findings from qualitative research on men's experiences of mental health problems within the family context. It is notable that such research is “practically non-existent” (Galasinski, 2013, p. 21). Only three studies have focused exclusively on the experiences of fathers with mental illness (i.e., Evenson, Rhodes, Feigenbaum, & Solly, 2008; Galasinski, 2013; Reupert & Maybery, 2009). Additionally, a small number of studies have included both mothers and fathers, (i.e., Ackerson, 2003a; Ahlström, Skärsäter, & Danielson, 2010; Bournsnel, 2007; Thomas & Kalucy, 2002; 2003; Tjoflåt & Ramvi, 2013; Wilson & Crowe, 2009), although the relevance of these articles to the current discussion is limited by the fact that in all cases female participants substantially outnumbered males, and in most cases researchers did not distinguish gender differences. As the three studies that have concentrated on the experiences of fathers were exploratory, had different foci, and were conducted in different countries, it would perhaps be a contrivance to attempt to neatly synthesise their findings. This section therefore comprises separate outlines of these three primary studies.

### Study one: Fathers, fatherhood and mental illness

The most recent and detailed investigation of fathers' experiences of mental illness was conducted with Polish men suffering from severe and persistent mental illness and published in monograph form as *Fathers, Fatherhood and Mental Illness: A Discourse Analysis of Rejection* (Galasinski, 2013). A central thread running through this work is the “inherent contradiction between the dominant expectations of fatherhood and the dominant discourses and imagery of mental illness” (p. 1). As Galasinski explained, fathers are:

expected to be strong, providing, nurturing, a role model and this on top of the ‘normal’ expectations of what it means to be a man: active, enterprising, tough and powerful. But on the other hand, mental illness undermines all this. Social perceptions of mental illness are precisely the opposite of what it is to be a role model, while the illnesses often prevent men from being “manly”. (p. 1)

It is perhaps unsurprising, then, that an almost universal experience for the men in this study was a sense of inadequacy; of having failed to perform the activities and fulfil the responsibilities expected of them as fathers. As one participant put it, “In my consciousness it is that I did too little. At the time I had this awareness that I did too little, that I should do more, when I saw that others have more, and better. But the greatest pain for me was that I didn't earn enough for my family” (Galasinski, 2013, p. 34). Although many participants spoke of closeness with their children—of emotional engagement and a strong sense of love and devotion—they also believed that such closeness was inadequate if it was not supported by other behaviours. Summarising the beliefs of these men, Galasinski noted that, “a good father is one who loves, but the really good father is the one who does, who changes the love into doing” (p. 44). For a number of participants, a sense of paternal inadequacy was yet another source of suffering in their lives, compounding existing feelings of failure, rejection and exclusion.

Another central focus of this research was the way in which men communicated (or didn't communicate) their illness experiences with their families. The author of the study endeavoured to learn about how the fathers in his study spoke to their children about their illness, but was surprised to discover that such conversations were rare: men “either communicated the fact that they were ill in the barest possible terms, or denied that they communicated it at all” (Galasinski,

2013, p. 84). In some cases, men hid their illness not only from their children, but also from their wives and extended families. In one extraordinary case, a 72-year-old father, in psychiatric care, with diagnosed bipolar disorder for over 40 years, had never shared with his wife and children the fact that he was afflicted with a mental illness. Galasinski saw the men's reticence as clearly related to the stigma of mental illness; as attempts "to stave off a public incorporation of illness into their identities" (p. 64); and to spare their children and wives from the "stigma by association" that comes from having a father or partner with mental health problems.

A final, and particularly poignant, major theme in this study was men's sense of rejection by their children. Galasinski identified this as the "dominant motif in the fathers' construction of their relationship with their children" (p. 156). A number of men portrayed their offspring (many of whom were of an independent age) as disengaged from their lives—"absent, not in touch, not offering help, even when needed" (p. 156). Other fathers spoke of their children failing to accept the existence of their illness or their suffering. As one participant said, "They don't understand me. They think I am simply normal. They just don't understand me. I talk about a voice, hey what kind of voice, what kind of voice? They don't believe me" (p. 150). This rejection was often a source of deep and abiding pain.

Ultimately, Galasinski's study paints an "almost invariably negative" picture of what it is to be a father with serious and persistent mental illness (p. 165). However, as there can be profound differences in attitudes to parenting and mental health across cultures and ethnicities (Shwalb, Shwalb, & Lamb, 2013), it is unclear to what extent his findings reflect experiences common to fathers from diverse contexts, and to what extent they are more indicative of particular elements of Polish culture. The two remaining studies that have focused on fathers' experiences of mental illness suggest that for at least some men with mental illness in Australia and the United Kingdom, fatherhood is seen as a very positive aspect of their lives.

## Study two: Fathers' experience of parenting with a mental illness

The second qualitative study investigating fathers' experiences of mental illness was conducted in Australia (Reupert & Maybery, 2009). Although none of the participants lived full-time with their children at the time of the study, many still "reported fatherhood as central to the image they had of themselves" (p. 66). All participants reported broadly positive relationships with their children, even if they did not have regular contact, and even if at times the relationships went through difficult periods. As one father of adult children explained, "It has been rocky. Sometimes [name of daughter] has not wanted to talk to me, but now we get along pretty well ... We talk over the phone, and I see her and her family at Christmas, you know, all the family times" (p. 64). A number of men experienced anger and frustration regarding custody disputes with their former partners, and "strongly believed their mental illness was a significant negative factor when decisions were being made regarding access [to children]" (p. 64).

While the sense of paternal inadequacy identified by Galasinski (2013) was not as evident in Reupert and Maybery's findings, the "inherent contradiction" between the dominant discourses of masculinity and fatherhood, on the one hand, and mental illness, on the other, was articulated by many of the Australian fathers. One participant said, "Blokes—we are supposed to be strong aren't we? We don't do that really [get sick]" (Reupert & Maybery, 2009, p. 65). Another said, "Through this whole time my [now ex-] wife had friends to talk to because women support other women, but men don't ... Men are supposed to be tough and strong ... As a kid, I was taught by my brother to take pain and bear it, so that's what I did" (p. 65). This adherence to traditional masculine beliefs and behavioural norms reinforced a sense of isolation for a number of participants, who reported a reluctance to talk to their "mates", partners or families about their illness and its attendant problems (e.g., housing and employment issues).

While all of the fathers in this study acknowledged that they needed support managing their mental health problems, most expressed dissatisfaction with the professional assistance they had received. One man described his experiences in the pre- and post-natal period:

My [ex-]wife and I, we went to antenatal classes, and [were] given lots of handouts on breastfeeding and things like that, but nothing on fathering. It was a very stressful time with a new baby and having interrupted sleep, and little sex. This stress, I believe, made my depression worse ... I really wanted a job description on fathering ... it's not just mothers suffering from PND [post natal depression], but men, too, have a tough time. It's our own version of PND. (Reupert & Maybery, 2009, p. 65)

Additionally, many men believed that even when they were in contact with appropriate services (e.g., mental health, child protection, family courts), professionals tended to overemphasise their pathology, assuming, for example, that any grievances they raised stemmed from their illness rather than from legitimate concerns.

Although many of the narratives collected in this study involved hardship, there were also more positive stories, with some participants indicating that their children had improved their mental health. For instance, one man stated explicitly that his children provided him with a sense of purpose and meaning: "My kids keep me focused and directed ... Before I had kids, I didn't really have any goals, but when I had kids, I wanted to buy a house, settle down. Before my son was born, I had attempted suicide, but afterwards I felt that now I had something to live for, even when I was feeling bad" (p. 64). Another fathers' adult offspring assisted him by confronting him when his symptoms became particularly pronounced: "My [adult] kids came to me and basically told me that I need to do something ... that I couldn't go on like this" (p. 64).

### Study three: The experiences of fathers with psychosis

The third study investigating fathers' experiences of mental illness was conducted in the UK with fathers with psychotic disorders, including schizophrenia and schizoaffective disorder (Evenson et al., 2008). A central concern for many of these participants was the way in which "psychosis may directly or indirectly undermine the father-child relationship and the work of parenting" (p. 629). For some fathers, this manifested as an emotional disengagement from their children and feelings of alienation and isolation; as one man said, "something inconceivable took over me body and I can't sort of be like a father to him ... I don't feel fatherly to him at all ... I feel isolated from him" (p. 632). The effects of psychiatric medications appeared to play a role in such feelings, being seen by some men as a "straightjacket", undermining their energy levels, concentration, and ability to emotionally engage with their children. Hospitalisation due to acute episodes of psychosis was also very disruptive to the family lives and parenting practices of a number of participants. One father noted how hospitalisation had undermined his ability to fulfil the fathering role: "I haven't been there for them sometimes because I've been in hospital... I was in there when my wife celebrated her 40th birthday ... the illness actually took me away from events that I should have been there" (p. 634)

Evenson and colleagues asked participants to recall what they had thought about fatherhood before their first child was born. The dominant response was some variation of, "*Not to repeat history/to do it differently*" (p. 635). Many participants desired to raise their children differently to how they had been raised, which was unsurprising given that a number reported histories of significant trauma and maltreatment. Indeed, many of the men "viewed their own fathers as *anti-role-models*" (p. 369):

I had an idea, from a very early age, from the age of 16, I thought if I ever have a son, I'm going to treat him totally different to the way my (step) dad treats me. He's never going to be punched, kicked, beaten, sworn at, nothing. He's going to have it nice and easy and a better chance than I got started with in life ... like a paternal instinct. (p. 635)

Despite their intentions to behave in a manner different to their own caregivers, there was a widespread fear among participants that they would pass a psychotic illness on to their own

children; a fear that was associated with their knowledge that genetic factors played a role in the genesis of psychosis.

Finally, as also reported by Reupert and Maybery (2009), a number of participants believed that fatherhood had had a positive impact on their lives. Some men felt a sense of accomplishment, achievement and pride in the fathering role (e.g., “Well I feel proud like ... I feel that I’ve achieved something ... that’s worth achieving. To be a family man and have a family” [p. 637]). Many described the sense of purpose and meaning that their children had brought to their lives (“... I felt him being conceived ... a very peaceful feeling came over me ... I felt life being created” [p. 637]). Others indicated that having children had been the impetus to make positive changes in their lives. For example, for one participant, fatherhood signalled the end of a violent lifestyle: “I don’t want him to see me with broken knuckles, black eyes and all that, so I have stopped ... I’m changing, cause my son’s getting older. I don’t want him to see that I’m doing all this ... and now all he sees the last four years of me is the good side of me. Cause I’m not fighting no more” (p. 637). Thus, in contrast to Galasinski’s “almost invariably negative” picture of what it is to be a father with severe and persistent mental illness, Evenson and colleagues identified both positive and negative aspects to fatherhood for the participants in their study.

## 5. Mental illness stigma and fatherhood

Where there is mental illness, there is almost invariably an accompanying social disapproval. As suggested in the above review of qualitative research, individuals already afflicted by psychiatric disorders often face the additional burden of stigma; of being perceived as having a “spoiled identity”, to use Goffman’s (1963) term. Indeed, as Hinshaw (2005) argued, “the stigmatisation that surrounds mental illness is increasingly recognised as a central issue, if not *the* central issue, for the entire mental health field” (p. 714). According to Link and Phelan (2001), “stigma exists when elements of labelling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows these processes to unfold” (p. 367). Elaborating on this broad definition, Pryor and Reeder (2011) developed a conceptual model comprising four forms of stigma: *public stigma*, or the reactions of those who stigmatise to those they perceive as having a stigmatising condition; *self-stigma*, which can entail both apprehension of the possibility of being exposed to stigmatising interactions or circumstances, and the internalisation of stigmatising narratives; *stigma by association*, which sees stigma directed towards those associated with a discredited individual (e.g., family members, health workers); and, *structural stigma*, which involves the endorsement or perpetuation of a stigmatised status by society’s institutions and discourses. All of these forms of stigma have the capacity to profoundly undermine the employment chances, social networks and self-esteem of people with a mental illness, which can in turn expose them to greater risk of the prolongation or recurrence of their symptoms (Link & Phelan, 2010; Rüschi, Angermeyer, & Corrigan, 2005).

A small number of researchers have explored the connection between masculinity and stigma (e.g., Gannon, Glover, & Abel, 2004; Inhorn, 2004; Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011; Wyrod, 2011). Men who fall short of hegemonic masculine ideals—which in many contexts still include notions of strength, stoicism, control and self-sufficiency—tend to have access to comparatively less social power, risk being reproached for transgressing socially constructed gender boundaries, and are more likely to be the subjects of stigmatisation. For example, in many cultures men with infertility experience stigmatisation, as they are perceived to be deficient in virility and potency, which tend to be defining components of traditional forms of masculinity (Gannon et al., 2004; Inhorn, 2004). Mental illness, too, can easily expose men to situations, states and experiences that are starkly at odds with traditional masculinity (Addis & Mahalik, 2003; Galasinski, 2013). These may include feelings of vulnerability, dependence, emotionality, loss of control, the inability to financially provide for one’s dependants, and so on. Thus, although mental illness stigma is a common experience for both men and women, it is likely that this stigma at least in part manifests

along gendered lines, and that men with mental illness are discriminated against for their loss of masculine status or their transgression of masculine behaviour norms.

The few studies that have directly explored the relationship between fatherhood and stigma (though not necessarily in the context of mental health) (e.g., Francis, 2012; Galasinski, 2013; Greaves, Oliffe, Ponc, Kelly, & Bottorff, 2010; Reupert & Maybery, 2009; Rochlen, McKelley, & Whittaker, 2010) suggest that the fathering role may further transform men's gendered experiences of stigma. A notable example is the study by Greaves and colleagues (2010), which analysed the relationships between smoking stigma, masculinities and contemporary fathering in Canada. While smoking is increasingly stigmatised throughout Canada, this stigmatisation is significantly intensified for new fathers. As the authors explained,

Fathers, expectant and new, can also experience the focus of a disapproving and punitive gaze previously reserved solely for expectant and new mothers. However, this gaze appears to be gendered. Whereas women are often blamed for hurting or damaging the foetus or infant through smoking... men who smoke are viewed as threatening and undermining their masculine identities and responsibilities of protector and provider. (p. 531)

Another example is Rochlen, McKelley, and Whittaker's (2010) study of stay-at-home fathers, in which approximately half of the participants reported stigmatising incidents, such as ostracisation at playgrounds or childcare centres. Many believed that their stigma experiences were directly related to their violation of traditional parenting norms. Finally, and most pertinently for this review, is the qualitative research outlined in the previous section (Ackerson, 2003a; Bournell, 2007; Galasinski, 2013; Reupert & Maybery, 2009; Tjoflåt & Ramvi, 2013; Wilson & Crowe, 2009), which found that the stigma of mental illness can profoundly influence men's understanding of themselves as fathers, the ways in which they communicate with their children and others about the illness, their efforts at self-managing their illness, and their help-seeking behaviours. More research is needed in this area, and the current paper is drawing on gender and social theory that is not accepted by all researchers working in the areas of men's studies and family studies. However, it does not seem premature to at least suggest that fathers with a mental illness can be subject to unique forms of stigma, which can influence their perceptions and experiences in a number of ways.

In addition to fathers' personal experiences of stigma, the families of men with mental illness may be subjected to the harms of "stigma by association" (or "courtesy stigma", as Goffman [1963] called it). Although the literature on this form of stigma is limited compared to most other forms (Hinshaw, 2004; Larson & Corrigan, 2008), it is clear that stigma by association can negatively impact individual family members and the communicative and emotional dynamics of the family as a whole (e.g., Angermeyer et al., 2003; Francis, 2012; Karnieli-Miller et al., 2013). For example, family members of people with a mental illness often report strained or distant relationships with relatives and friends, as well as experiences of social exclusion (Corrigan & Miller, 2004; Karnieli-Miller et al., 2013). Perhaps unsurprisingly, then, Hinshaw (2004) noted that "the predominant coping mechanism for families in response to the mental disorder of a child, spouse, or other relative has been one of secrecy and concealment" (p. 720). Indeed, some studies have indicated that up to half of all family members believe they should hide their relationship with the individual affected by mental illness in order to avoid bringing shame on the family. This concealment, Hinshaw argued, "limits openness about mental illness, curtails access to needed assessments and treatments, and places funding efforts and legal rights as low priorities" (p. 724). Corrigan and Miller (2004) contended that families' shame and concealment is related to social stereotypes and prejudices directed towards families of individuals with a mental illness; specifically, *parents* are often held to blame for their children's mental illness, *siblings and spouses* are held to blame for their family member's perceived mismanagement of their symptoms, and *children* are perceived as damaged or contaminated by their parent's mental health problems.

## 6. Fathers and the service sector

It is widely recognised as problematic that fathers with mental illness do not engage with health and welfare services in proportion to their need (Ackerson, 2003b; Featherstone, 2009; Fletcher et al., 2012; Maxwell et al., 2012). There are many social-cultural and service factors that act as barriers to fathers' engagement with services. A point emphasised in the literature is that men are less likely than women to seek professional help for a range of problems, including mental health concerns, physical illness and disability, and stressful life events (Addis & Mahalik, 2003; Galdas et al., 2005; Möller-Leimkühler, 2002). This reluctance to access services carries over to fathers, who "are much less likely than mothers to seek out health workers, community welfare professionals and parents' groups if they need support in their role as carer" (Berlyn et al., 2008, p. 5.; Williams, 2007, 2009). Gendered socialisation and men's enactments of masculinities play an important role in shaping men's health behaviours (Addis & Mahalik, 2003; Chapple, Ziebland, & McPherson, 2004; Price-Robertson, 2012; Richardson & Rabiee, 2001; Williams, 2007, 2009). The traditional masculine ideals of self-reliance, physical toughness, and emotional control can create powerful barriers to men disclosing their physical or psychological concerns and seeking appropriate care. However, the relationship between masculinities and men's help-seeking behaviours is by no means simple: multiple factors mediate this relationship (e.g., ethnicity, geography, class position, and the type of illness or difficulty in question) (Addis & Mahalik, 2003; Galdas et al., 2005; Williams, 2007, 2009), and individual men develop unique strategies for negotiating masculine discourses and norms, including a partial or complete rejection of the behaviours associated with traditional masculinity (Connell, 2005). Thus, although masculinity is sometimes treated as the sole determinant in men's underutilisation of services, it is important to consider other factors (Fletcher & StGeorge, 2010; Maxwell et al., 2012; Smith et al., 2008).

Even when fathers do access medical or psychiatric care, services often fail to adequately acknowledge the interconnections between paternal mental illness, family life and children's wellbeing (Fletcher et al., 2012; Maybery & Reupert, 2009). While there are a handful of clinical interventions designed specifically for parents with a mental illness (for reviews, see: COPMI, n.d.; Hinden, Biebel, Nicholson, Henry, & Katz-Leavy, 2006; Reupert & Maybery, 2011), they are comparatively rare, and most do not target or attract fathers (Reupert & Maybery, 2011). When it comes to mainstream services, one only has to look at the current state of advice to Australian health practitioners regarding fathers with mental health concerns to see that there is much ground to be covered before mainstream medicine and psychiatry can be called "father-inclusive". Few articles have explored the topic of how best to make mainstream Australian health services more responsive to the needs of fathers. Those that have focused on this topic have found it necessary to concentrate on the most rudimentary elements of father-inclusivity. For example, in Fletcher and colleagues' (2012) article in the *Medical Journal of Australia* advising clinicians on how best to assist fathers with a mental illness, much of the advice focused on the vital but most basic step of simply enquiring about male clients' family lives (e.g., sample questions for clinicians included "Do you have children?" and "What is your involvement in your children's lives?" [p. 35]). This article can be contrasted with those focused on the treatment of mothers with mental health concerns, which have recently considered more advanced or nuanced issues, such as the most effective methods of screening during the pre-natal period for early detection of psychopathology, and the treatment dilemmas confronting women with perinatal mental illness (e.g., Pearlstein, 2008; Sharma & Sharma, 2012; Van Der Ham, Berry, Hoehn, & Fraser, 2013).

In contrast to medical and psychiatric services, child and family services (e.g., statutory child protection, family relationship services) are better positioned to acknowledge the interconnections between parental psychopathology and family life as they often assist with problems that obviously involve multiple family members (e.g., family violence, relationship difficulties). However, they are often ill-equipped to effectively engage men, or even biased against them (Featherstone, 2009; Maxwell et al., 2012). A number of studies in Australia (e.g., Berlyn et al., 2008; Russell et al., 1999) and internationally (e.g., Featherstone, 2009; Scourfield, 2003; 2006) have found that negative or

ambivalent attitudes towards fathers are common in welfare settings. For instance, in an analysis of the child protection system in the UK, Scourfield (2003; 2006) identified two dominant discourses about male clients: they were seen as “a threat”, presumed to be violent and coercive; and, as being of “no use”, “said to spend little time on, and have few skills for, either child care or domestic work” (Scourfield, 2006, p. 81). It is unsurprising, then, that in Featherstone’s (2009) study exploring the experiences of fathers whose children were involved in social care services in the UK, participants tended to be very critical of social workers, routinely describing them as “on the woman’s side” (p. 163). This prejudice against fathers is thought to be related to the female-dominated child and family welfare workforce, the traditional societal assumption that childrearing is predominantly women’s responsibility, and worker’s fears of violent male clients (Featherstone, 2009; Maxwell et al., 2012). While a bias against fathers is clearly problematic, it must be acknowledged that this is a complex area of scholarship and practice, and that workers assumptions and fears often stem from very real concerns: family violence perpetrated by father figures is a feature of many child protection cases (Featherstone, 2009; Lamont, 2011), and, in at least some cases, “fathers involvement with their children can be linked to their desire to retain control and further undermine women” (Featherstone, 2009, p. 171; Flood, 2012).

Suggestions for increasing father engagement in health and welfare services have focused on policy, attitudinal, and service level changes. At the policy level, there are signs that the specific health issues faced by men and fathers are gaining increased attention. In 2010 the Australian Government released the *National Male Health Policy*, the first national framework to focus specifically on improving men’s health and achieving equal health outcomes for at-risk male populations (Department of Health, 2011). With regard to fathers, this policy committed \$6 million over 3 years to “promote the role of Aboriginal and Torres Strait Islander fathers and partners, grandfathers and uncles, and encourage them to participate in their children’s and families’ lives, especially in the antenatal period and early childhood years” (Department of Health, 2011). However, there are still a number of barriers to general father-inclusive service provision (Department of Families, Housing, Community Services and Indigenous Affairs, 2009), as well as to effective family-focused psychiatric practice (Maybery & Reupert, 2009), which can see the specific service needs of families affected by paternal mental illness doubly excluded. The Australian Government funded initiative *Children of Parents with a Mental Illness* (COPMI), which works towards strengthening the capacity of mental health services to meet the needs of families affected by parental mental illness, goes some way in addressing this exclusion, though its remit falls short of the transformative system-wide reform that would be necessary to ensure that all Australian health and welfare services were capable of effectively engaging with fathers with a mental illness (Scott, 2013).

A number of authors have also drawn attention to the need for more effective collaboration between mental health, child protection, and family relationship and welfare services (Ackerson, 2003b; Darlington et al., 2005; Hunter & Price-Robertson, 2014; Myers, Schmied, Johnson, & Cleary, 2013; Scott, 2009). As Ackerson (2003b) has argued, in the absence of such collaboration, parents with mental health concerns can be “caught in the gap between the child welfare and mental health systems. Their mental illness is viewed as an individual problem that is the responsibility of the local mental health service, whereas the safety and welfare of their children is the responsibility of the child welfare system” (p. 187). While there is still work to be done translating policy into effective and enduring collaborations on the ground (Darlington et al., 2005; Myers et al., 2013; Scott, 2009; 2013), a number of current Australian policy and practice initiatives emphasise interagency collaboration (e.g., *The National Framework for Protecting Australia’s Children 2009–2020* [National Framework], *Building Capacity Building Bridges*, *Fourth National Mental Health Plan*). Of particular note is the National Framework, which is a long-term collaborative agenda to improve the safety and wellbeing of Australia’s children, with the key message “protecting children is everyone’s business”. The National Framework promotes a public health model approach to protecting children, which not only promotes interagency collaboration, but also places a greater emphasis on assisting families early to prevent abuse and neglect occurring by having universal supports (e.g., mental health and education) available for all families and children.



### Box 3: Dad's story

#### Working towards recovery

For a long time, I didn't think I was making any progress and my symptoms and issues were multifaceted so it was a little like dealing with an octopus one leg at a time. The learning curve is about me and what works. I had to deal with ruminating. I needed to slow down, taking time, rest. Medication helped. Therapy worked wonders.

Recovery meant decoupling my identity from my performance and has changed me immensely. I have a more solid sense of self. I individuated from my wife, which was necessary. I'm still type A, but a very tempered one almost to the point of being covert. I had to discover what strengthened and energised me, and what didn't.

For example, I found that fishing alone and with others recharged me. I found the same at work in the greenhouse—working alone and with others was physically demanding but had enormous benefits. I had to make meaning of my illness to somehow redeem it. I blogged, I journalled, I read. I returned to work in a professional capacity—slowly.

Recovery is glacial and non-linear. It's more of an adventure than a trip from A to B. It's sometimes circular with the destination unclear. I often felt like a ship that had left the dock but unable to see my destination or to know if I would ever reach it.

While my capacity for productivity has not fully returned, nor my resilience, I've reached a point now where the person I am today, is much better than the person I used to be (you can ask my wife). Mental illness nearly killed me—but recovery from it made me into a better version of me.

The only criticism or disappointment I had in hindsight with my treatment is that at no stage did any clinician refer me to one of the many NGOs that operate in the mental health sector and they would have been an amazing resource and support for my family—my wife and children and myself.

Today I work with men experiencing mental illness and families who are caring for a loved one with symptoms. We didn't get much support as a family and I know that there are other poor bastards out there wanting to die just like me. I share my story wherever people find it useful so hopefully they and their families can go on a journey of recovery too and find life again.

Provided by Children of Parents with a mental illness (COPMI).

At the level of attitudinal change, researchers have focused on influencing the attitudes and behaviours of both fathers themselves and services providers. Carefully identifying and dissolving the barriers to men's help-seeking is likely to increase the willingness of fathers with mental health problems to seek and receive professional assistance (Addis & Mahalik, 2003; Thornicroft, 2006). Australian initiatives aimed at combating mental illness stigma and men's reticence to engage with health and welfare services (e.g., *beyondblue*, *Men's Sheds*, *The SANE Media Centre*), appear to have enjoyed some success (Jorm, Christensen, & Griffiths, 2005; Ormsby, Stanley, & Jaworski, 2010; Pirkis, Blood, Dare, & Holland, 2008), though significant mental illness stigma and differences in help-seeking behaviour between men and women still remain (Reavley & Jorm, 2011; Thornicroft, 2006). Recent efforts at educating medical practitioners about father-inclusive practice are promising (e.g., Fletcher et al., 2012), but it is unclear what impact they have had. Unfortunately, comparatively little attention has been dedicated to changing the negative or ambivalent attitudes towards fathers that have been identified in social work and child welfare environments, despite calls from a number of authors for such efforts to be made (e.g., Featherstone, 2009; Maxwell et al., 2012). Increasing the number of male workers is a common suggestion for achieving such attitudinal changes (Berlyn et al., 2008), though attracting male workers to such positions has proven difficult (Featherstone, 2009).

At the level of service provision, Berlyn, Wise and Soriano (2008) found that “programs for men have a tendency to be a sideline operation to main service activities”, and that services that were most effective at attracting fathers had “made an organisation-wide commitment to increasing father participation, providing staff with training on engaging fathers, and creating staff positions dedicated to involving fathers in the service's activities” (p.5). Maxwell and colleagues (2012) echoed this

finding in their recent review of the factors that have been found to facilitate father engagement with child welfare services. Such factors included: *early identification and involvement*, where fathers were invited to engage with services as early as possible; *a proactive approach to engaging fathers*, which involved practices such as visiting fathers at home, and ensuring that services' opening hours accommodated working fathers; and, *making services relevant to fathers*, especially by focusing on their self-identified needs (e.g., unemployment, mental health and substance abuse problems). These authors also emphasised the complexity involved in intervening when fathers are the perpetrators of family violence, and called for more research into the most effective methods for engaging such men. Similarly, a number of authors have explored strategies for overcoming the challenges that parental mental illness can present to child welfare service providers, which is a particularly pertinent issue given the comparatively high levels of parental mental illness among families referred to child protection services (for a review, see Jeffreys, Rogers & Hirte, 2011). Such challenges include parents withdrawing from services due to a lack of insight into their illness, long-term treatment goals being undermined by the episodic and unpredictable nature of mental illness, and parents' unrealistic expectations of children's behaviour, responsibility and levels of independence (Darlington et al., 2005; Jeffreys et al., 2011).

## Conclusion

The past decade has seen growing research interest on the issue of fathers' mental health. There are now quite substantial bodies of literature on topics such as men's pre- and post-natal depression, and the relationship between paternal mental illness and children's development. Indeed, research on the latter topic has progressed from basic exploration of the associations between fathers' illness and children's outcomes, to detailed empirical examination of the mechanisms by which fathers' illness affects children. This is timely work that has much to contribute to the practice of assisting families afflicted by paternal mental health problems.

However, this review has also demonstrated that there are substantial gaps in the literature. For example, the extant research has focused overwhelmingly on depressive disorders, with anxiety disorders coming in at a distant second. In most sections of this review, studies on illnesses such as bipolar disorder and schizophrenia were either scarce, or non-existent. This leaves a number of important questions unanswered: Do different psychopathologies have differential effects on parenting behaviours and children's outcomes? What effects does fatherhood have on men with pre-existing severe and persistent mental illness? In what ways might fatherhood support recovery from severe and persistent mental illness?

There is also a dearth of research that adequately contextualises the quantitative psychological research outlined in the earlier sections of this paper. Qualitative research on fathers' experiences of living with a mental illness is "practically non-existent" (Galasinski, 2013, p. 21). Such research has the potential to illuminate often-overlooked issues or perspectives. For example, two of the three qualitative studies outlined in detail in this review found that many men with mental illness saw very positive aspects to fatherhood (Evenson et al., 2008; Reupert & Maybery, 2009) (This finding was also supported by qualitative research with both mothers and fathers [e.g., Ackerson, 2003a; Ahlström et al., 2010; Tjoflåt & Ramvi, 2013]). Men spoke of hardship, stress and dysfunction, to be sure. But they also shared the sense of meaning and purpose that their children had brought to their lives, as well as how the expectations and structures associated with family life had been important factors in their efforts towards recovery. Such narratives have generally been missed by the existing research, which has almost invariably adopted a deficit-based approach, focusing exclusively on the failings of fathers and/or their children's increased risk of various psychosocial problems (Ackerson, 2003b; Lefrançois, 2011; Wilson & Crowe, 2009). Of course, the individual and familial suffering associated with mental illness should not be downplayed, but nor should the complexities of experience of those with psychopathology, or their strengths, capabilities and desires to be competent parents (Ackerson, 2003b). Similarly, although the impact of stigma on

fathers' lives was a consistent message in the qualitative literature, very few researchers have focused specifically on the role that stigma plays in fathers' lives, and even more generally on the ways in which stigma intersects with gender and parenting discourses.

It is hoped that this paper has provided readers with at least an overview of some of the key issues identified in the growing literature on paternal mental illness, and perhaps some inspiration to use the insights from this literature in their area of expertise, whether that be research, social policy-making, or frontline service provision. Clearly, there is much work to be done before Australian service systems routinely acknowledge men as fathers, and are equipped to respond to the many ways in which family life and mental illness can and do intersect.

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At the time of writing, **Rhys Price-Robertson** was a Senior Research Officer with the CFCA information exchange at the Australian Institute of Family Studies. He is currently a PhD candidate at Monash University, where he is investigating the experiences of families affected by paternal mental illness.

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Australian Institute of Family Studies  
Level 20, 485 La Trobe Street  
Melbourne VIC 3000 Australia  
Phone: (03) 9214 7888 Fax: (03) 9214 7839  
Internet: <[www.aifs.gov.au](http://www.aifs.gov.au)>

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