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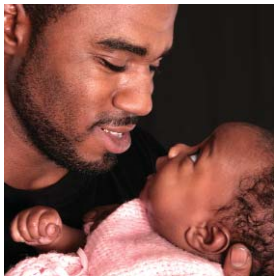
Fathers and family health in the perinatal period

A briefing on fathers' roles and impact



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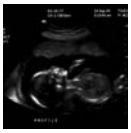

Introduction

Government policy and clinical guidelines are encouraging health and family services to engage proactively with fathers from pregnancy onwards.

The latest Teenage Pregnancy Guidance ('Getting Maternity Services Right for Teenage Mothers and Young Fathers', 2009) is clear about this; as is 'Healthy Lives, Brighter Futures – The Strategy for Children and Young People's Health' (2009).

The Department of Health has also recently produced an internet-based 'BabyLifeCheck' self-assessment tool for dads where previously this was only planned for mothers. This briefing summarises some of the evidence for engaging systematically with both parents.

Fathers, mothers and family health

Expectant and new fathers tend to re-evaluate their own health risk behaviours[1] (Blackburn et al, 2006b; Westmaas et al, 2002; Lupton & Barclay, 1997), make more healthy choices (Brenner & Mielck, 1993) and, when they receive emotional support, experience better physical and emotional health (Jones, 1988).

Their attitudes and health practices also influence mothers', and impact directly and indirectly on their babies' well being. Yet fathers tend to understand very little about the impact of their health behaviours on their families.[2]

Fathers at the birth

Teenage mothers are more likely to have a positive birth experience when they believe their baby's father is supportive of the pregnancy (Tarkka, 2000). Caesarean mothers' post-operative pain is strongly linked to their fear-experiences during labour, and these are mediated by the level of their birth partner's fear (Keogh et al, 2006). Gibbins & Thomson (2001) found that labouring women benefit when they feel 'in control' of the birth process – and a key component in this is experiencing support from their partner during the birth. Fathers who have been prepared well to participate in the labour process tend to be more active participants, and their partners' birth-experiences tend to be better (for review, see Diemer, 1997).

Fathers and smoking

More households with infants contain a smoking father than a smoking mother; when fathers smoke, tobacco consumption in the home is higher (Blackburn et al, 2005a); and smoking by a pregnant woman's partner is by far the biggest predictor of her smoking status (Bottorff et al, 2006; Lu et al, 2004; Penn & Owen, 2002). Heavy smoking by fathers is associated with sperm damage, reduced semen quality and reduced responsiveness to fertility treatment (British Medical Association, 2004); increased risk of early pregnancy loss (Venners et al, 2004) and, in infants, respiratory disease, low birth-weight and Sudden Infant Death (Health Education Authority, 1999). Fathers' smoking has also been identified as a risk factor for breastfeeding cessation at four months postpartum, independently of mother's smoking and other factors (McLeod et al, 2002). For society, there are productivity as well as health issues: children from smoking households miss an extra six days of school a year (Dake et al, 2006).

86% of couples are married or living together at the time of the birth AND **23%** who are living separately, move in together within nine months.

4.4% of parents are 'not in a relationship' at the time of the birth. But even among these, **10%** of fathers attend the birth, **25%** sign the birth certificate and **25%** are still in touch with mother and infant nine months later.

Source: Kiernan & Smith (2003), based on analysis of Millennium Cohort Data (which over-samples for low income and ethnic minority families and is therefore socially representative)

49% of mothers of 12-month-olds are now in the paid workforce and fathers undertake 25% of all parental childcare (more at weekends, and more when mothers work full-time).

Sources: ONS (2000), cited by Dunn et al (2006)[3]; and EOC (2003)[4].

Fathers and alcohol

With Fetal Alcohol Spectrum Disorder a substantial cause of cognitive and other disability in infants (NIAAA, 1987), the father's role in maternal drinking is attracting attention. Fathers' drinking is a risk factor for mothers' drinking (Loudenburg, 2003) and expectant mothers are almost four times more likely to have consumed alcohol, and over twice as likely to have used drugs, if the father has drug and alcohol related problems (Teitler, 2001). Up to 75% of children born with FASD have biological fathers who are heavy drinkers and alcoholics (Cicero, 1994); and heavy alcohol use by fathers is not only associated with poor bonding between father and infant, but also with poor bonding between mother and infant (Eiden & Leonard, 1996). Male partners who are opposed to the mother's intention to stop drinking inhibit her ability to reduce alcohol consumption (Astley et al, 2000).

Today's fathers undertake 800% more childcare than their own fathers did.

Source: Fisher et al (1999)

Fathers and perinatal depression

Partner factors, including a poor relationship with her baby's father and his providing insufficient emotional or practical support, are strongly associated with mothers' depression. By contrast, greater father involvement in infant care and other household tasks is correlated with lower parenting stress and depression in mothers (for review, see Fisher et al, 2006).

Engaging fathers in the support of depressed expectant and new mothers has been linked with significant decreases in the women's depressive symptoms and other psychiatric conditions (Grube, 2004; Matthey et al, 2004; Misri et al, 2000). Fathers' positive mental health when combined with high involvement in infant care can protect babies and children against the negative impact of mothers' depression (Mezulis et al, 2004; Edhborg et al, 2003; Field, 1998; Hossain et al, 1994; Fagot & Kavenagh, 1993).

Like expectant and new mothers, expectant and new fathers are prone to depression (Madsen et al, 2006; for review, see Huang & Warner, 2005). This can exacerbate mothers' depression; and impact negatively on children, particularly boys, in the short and longer term (Ramchandani et al, 2008; 2005). Factors linked to fathers' depression include their own neuroticism and substance abuse/ dependence and the mother's own difficulties (Huang & Warner, 2005). Couple-factors, including disagreement about the pregnancy and perceived lack of supportiveness from the mother are also significant (Huang & Warner, 2005; Dudley et al, 2001; Matthey et al, 2000). Low income fathers, including young fathers, are particularly vulnerable to depression, seemingly due to interacting factors (Anderson et al, 2005). By contrast, fathers who feel supported by their partners in finding their own ways of caring for their infants are unlikely to develop depression (Cowan & Cowan, 1988).

Fathers and breastfeeding

Fathers' influence on mothers' decisions to initiate and/or sustain breastfeeding can be substantial (for review, see Scott et al, 2001), possibly particularly in low-income families (Schmidt & Sigman-Grant, 2000). Fathers' beliefs that breastfeeding is bad for the breasts, makes breasts ugly and interferes with sex are associated with mothers' bottle-feeding intentions. Conversely, fathers' beliefs and knowledge about the positive benefits of breastfeeding and their active participation in the decision to breastfeed are positively associated with mothers' breastfeeding intentions, initiation and maintenance (Swanson & Power, 2005; Arora et al, 2000; Bromberg & Darby, 1997; Freed et al, 1993).

Barriers to fathers' support for breastfeeding include disapproval of women breastfeeding in public or in front of non-family members, and lack of knowledge about the health benefits and nutritional superiority of breastfeeding. These are far more common among fathers than mothers (Shaker et al, 2004; Pollock et al, 2002; Shepherd et al, 2000).

Teaching fathers how to prevent and manage the most common lactation difficulties and to advocate for breastfeeding and assist their partner have been found to have a marked, positive impact on breastfeeding initiation and continuation (Piscane et al, 2005; Wolfberg et al, 2004; Cohen et al, 2002).

Working with the couple and the couple relationship is likely to pay dividends. High couple relationship satisfaction is associated with fathers' support for breastfeeding (Falceto et al, 2004), while relationship distress is marginally predictive of early breastfeeding cessation (Sullivan et al, 2004); and a desire for the father to have opportunities to be close to the baby can be a factor in some mothers opting to cease breastfeeding (Jordan & Wall, 1993). Since high levels of maternal responsibility for household tasks and infant care are significant predictors of breastfeeding cessation, supporting fathers to take responsibility in these areas may contribute significantly to breastfeeding maintenance (Sullivan et al, 2004).

Conclusion

The discontinuities in everyday life associated with the perinatal period provide opportunities for establishing new routines (Bottorff et al, 2006), which makes this life transition a golden opportunity moment for supporting fathers to make healthier choices.

The more fathers understand the impact of their own negative health choices on their children, the more likely they are to address these behaviours (Moffatt & Stanton, 2005). Educating fathers as well as mothers about healthy behaviours during pregnancy, and encouraging joint decision making in this area, is likely to yield the greatest net positive impact on family health (Beenhakker, 2005).

Footnotes

1. In the US, 49.3% of expectant fathers smoke; 30.4% engaged recently in hazardous drinking; 27.5% have very low physical activity levels; 94.9% have an at-risk fruit/vegetable intake; and 42% a weight-related health risk (Everett et al, 2006).
2. For example, fathers have, at best, incomplete knowledge of the effects of passive smoking on infants: only 33% are aware that it contributes to SIDS; 24% that it contributes to ear infections; 65% that it is related to babies' developing asthma, bronchitis and pneumonia; and 75% that it contributes to coughing/sore throats in babies (Moffat & Stanton, 2005).
3. Dunn, J., Fergusson, E., & Maughan, B. (2006). Grandparents, grandchildren, and family change in contemporary Britain. In A. Clarke-Stewart & J. Dunn (eds.), *Families Count: Effects on Child and Adolescent Development*. New York: Cambridge University Press.
4. EOC (2003). *Time Use and Childcare*. Briefing paper based on analysis of the UK Time Use Survey (ONS, 2000/1).

The full references for the studies cited in this Briefing can be found in the relevant Fatherhood Institute research summaries, available free at: www.fatherhoodinstitute.org/index.php?id=3&cID=973

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The Institute (charity reg. no. 1075104):

- collates and publishes international research on fathers, fatherhood and different approaches to engaging with fathers
- helps shape national and local policies to ensure a father-inclusive approach to family policy
- injects research evidence on fathers and fatherhood into national debates about parenting and parental roles
- lobbies for changes in law, policy and practice to dismantle barriers to fathers' care of infants and children
- is the UK's leading provider of training, consultancy and publications on father-inclusive practice, for public and third sector agencies and employers

The Institute's vision is for a society that gives all children a strong and positive relationship with their father and any father-figures; supports both mothers and fathers as earners and carers; and prepares boys and girls for a future shared role in caring for children.

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