The experiences of fathers with psychosis

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Abstract

Background: Fathers with psychosis have often been ignored by the research community. Aims: This project was designed to explore some of the potential issues concerning this group. Method: This study involves a qualitative investigation into the experiences of 10 white fathers who have a diagnosis of psychosis (schizophrenia, schizoaffective or other psychotic-type disorder). The collected data was analysed by means of Interpretative Phenomenological Analysis. Results: This study found that psychosis may directly and indirectly undermine the father-child relationship and the work of parenting. The fear of one's children inheriting psychosis is a concern amongst this group. In the process of fulfilling the role of fatherhood, men with psychosis benefit from a sense of pride in the father role, a sense of purpose to one's life, a feeling of pleasure in the creation and development of life, and motivation to change for the better. Conclusions: Treatment and care programmes need to be sensitive to the effects of fatherhood on psychosis and the effects of a father's psychosis on the mental health of his family. Extra support during the first months of fatherhood, parenting programmes and systemic approaches might help fathers with psychosis and their families.

Keywords: Fathers, psychosis, qualitative, IPA, experience

Introduction

In spite of the difficulties of having psychosis, it appears that many patients become fathers. However, in the research literature, little attention has been paid to what being a father with psychosis involves. For example, is it a welcome experience or a burden?

The change towards community care has been associated with an increase in the number of people with serious mental illness (SMI) who become parents (Miller, 1997; Oyserman, Mowbray, Meares, & Firminger, 2000). In the UK in the early 1990s, the prevalence of functional psychoses in couples with children was 0.4% while the prevalence of functional psychoses in single parents was 1.1% (Meltzer, Gill, Petticrew, & Hinds, 1995). While psychosis may lead to many men not becoming fathers, some studies have found that around
20% of men with chronic mental health problems are fathers (Caton, Courinos & Dominguez, 1999; Nicholson, Nason, Calabresi & Yando, 1999). Fathers with psychosis are therefore a substantial population, in need of further research (Styron, Pruett, McMahon & Davidson, 2002).

Mothers with psychosis

There is a great deal of research on mothers and motherhood and substantial research on mothers with serious mental illness (e.g., severe affective disorders or psychosis) which usually includes mothers with psychosis. However, studies specifically investigating mothers with psychosis are relatively rare.

Mothers with psychosis may be withdrawn and emotionally uninvolved with their children, which may adversely affect their children’s social functioning (Goodman & Brumley, 1990), and they may have increased levels of tension and uncertainty and diminished social contact with their children (Persson-Blennow, Naslund, McNeil & Kaij, 1986). There may be fatigue from anti-psychotic medication (Nicholson, Sweeney & Geller, 1998). Mothers with SMI may have difficulties establishing a social support network (Zemencuk, Rogosch & Mowbray, 1995) and their accommodation may be inappropriate and unsafe for raising children (Sands, 1995).

It is therefore unsurprising that mothers with SMI may fear losing custody of their children (Perkins, 1992) and feel the onus is on them to prove themselves competent parents (Cogan, 1998). Anxiety that any problems with the children could be blamed on one’s own mental illness can motivate one to try harder as a mother, but it can also discourage one from trying at all (Nicholson et al., 1998). In Ackerson’s (2003) investigation of 12 mothers and one father with SMI, the participants expressed reluctance in seeking treatment, based in part on the stigma of psychiatric disorder and related fears of losing custody. Mothers with SMI may choose not to take medication or refuse to go to hospital, placing their children’s needs before their own mental health. This can occur in spite of anxieties about experiencing a relapse, and then being hospitalized and separated from their family (Nicholson et al., 1998). Mothers with mental illness report anxiety that their children could also develop mental health problems, and single mothers with mental illness may find hospitalisation particularly distressing due to concern over childcare arrangements (Bassett, Lampe & Lloyd, 1999).

It must be noted that women with SMI may benefit from becoming mothers. Parenthood may provide mothers with a sense of identity which counteracts the loss of identity and self-efficacy which may accompany SMI (Deegan, 1993; Sands, 1995). The role of parent is likely to be central to one’s sense of self and is often a valued status, with parental success sometimes conveying a sense of self-worth and competence (Oyserman et al., 2000). Being responsible for children may motivate mothers to seek help for their SMI (Nicholson et al., 1998) and they can often benefit from their children’s support (Zemencuk et al., 1995).

Fathers with psychosis

No research has specifically investigated fathers with psychosis. However, one study of Australian parents with psychosis included 59 fathers (Hearle, Plant, Jenner, Barkla & McGrath, 1999). Thirteen parents reported a child care intervention had been made against their will, only 20 of the 48 parents with children under age 16 still lived with those children. Many parents said they wanted to manage child care on their own, many feared a loss of custody, some were too embarrassed to ask for help with childcare and some did not have
enough money for their ideal child care. However, the authors did not report the proportions of fathers versus mothers. Some studies of parents with SMI have included small numbers of fathers, finding that SMI may undermine the parental sensitivity of mothers and fathers (Thomas & Kalucy, 2002). Fathers and mothers with mental illness are often concerned about their children inheriting their illness (Aldridge & Becker, 2003).

The present study aimed to address the need for research into the experiences of fathers with psychosis (Nicholson et al., 1999; Silverstein, 2002). We hope that this exploratory research will provide researchers and clinicians and with a better understanding of the difficulties that fathers with psychosis undergo and how carers and staff may be better able to meet their needs. Given that so little is known about this area, we decided to adopt a qualitative approach. The overarching question we asked was: What is it like to be a father with psychosis? Our principle aim was to develop an accurate description of a small number of participants and their unique perceptions. This study did not aim to make statistical generalisations from this study group to a similar population. The strength of qualitative work such as this is to explore ideas and generate hypotheses.

Method

Recruitment

Two London ethics committees granted approval. The inclusion criteria for participants in this study were: (a) natural (biological) father of one’s children; (b) a diagnosis of psychosis – schizophrenia, schizoaffective or other psychotic disorder; (c) white ethnicity; (d) aged 18 years or older; (e) stable with regard to their mental state, i.e., a patient on remission or maintenance treatment; (f) contact with one’s children.

The participants were recruited from the patients of community mental health teams in West and North London. Of the 22 men identified as meeting the recruitment criteria, 6 did not have a stable mental state and/or they had very limited contact with their keyworker. Of the 16 men who were then approached for participation, 10 agreed to participate.

Procedure

The interview consisted of two parts: a brief demographic questionnaire aimed at collecting relevant information to the study and a semi-structured interview on fatherhood.

A semi-structured interview was given to each participant about the experience of fatherhood. The interview schedule was developed by reading the literature and reflecting on fatherhood and the literature on parents with serious mental illness. This was followed by a discussion between colleagues to consider what might be of interest. In line with the guidelines of Smith (Smith, 1995; Smith, Jarman & Osborn, 1999; Smith & Osborn, 2003), the interview was flexible, took into account participants’ understandings and included the possibility for questions on interesting areas that arose. The questions in this interview were aimed at collecting data on each participant’s subjective experience of being a father with psychosis. The interviews were audio-taped to facilitate their analysis.

Analysis

The interviews were analysed using Interpretative Phenomenological Analysis (IPA). The IPA approach acknowledges that direct access into someone’s internal world is impossible,
but one can obtain a measure of insight into phenomena as experienced by that person by
listening to their account and then making an interpretation of this (Smith, 1995;
Smith et al., 1999). Being concerned with the immediate psychological reality of each
participant, IPA was arguably the most useful qualitative method for the current study
(Willig, 2001).

The analysis was based on the guidelines of Smith et al. (1999) and Willig (2001). After
noting initial thoughts and observations, interesting or significant discourse and preliminary
interpretations, emerging theme titles were noted, summarising the tentative themes
identified thus far. Themes which were construed to be related, for example, those that
shared meanings, were clustered together under appropriate labels. These processes were
repeated many times until a final table of themes was generated.

During the analysis, steps were undertaken to evaluate the credibility of the results
(Elliott, Fischer, & Rennie, 1999). Credibility checks on the analysis were conducted, in
which a second researcher, an expert in IPA, conducted a data audit and an analysis audit, in
which codings were tested by returning to the original data. There was an examination of
how specific evidence was described in wider frames, and some categories were discussed
and changed in agreement between the two researchers (Elliott et al., 1999; Willig, 2001).
Following a detailed discussion between the two researchers, a final master thematic
framework was then created.

**Results**

**Participants**

For qualitative research Elliott et al. (1999) suggest that it is very important that one is able
to *situate the sample*. That is, to “aid the reader in judging the range of people and situations
to which the finding might be relevant”. The mean age of participants was 51 (range:
34 – 67). Seven participants had been diagnosed with schizophrenia, two had a diagnosis of
schizoaffective disorder and one had a diagnosis of delusional disorder (see Table I). Six
participants were living with their children at the time of interview. Five participants were
married, two were co-habiting, one was divorced and two were single. Four of the
participants were grandfathers and one of these men was a great-grandfather. Five were
educated up to the age of 15, four remained in education for one or more years after age 15.

**Themes given by the participants**

The findings of the interpretative phenomenological analysis are presented in this section,
illustrated by quotes from the transcripts which capture the essence of the participants’
experience.

*Psychosis undermines the father-child relationship and the work of parenting*

*Emotional disengagement from one’s children.* One important effect of psychosis appears to
be the way in which it undermines the relationship between the fathers and their children.
For example, one father said: “...something inconceivable took over me body and
I can’t sort of like be a father to him...I don’t feel fatherly to him at all...I feel isolated
from him” (F5).

With another participant this feeling of disengagement appeared to originate in his
paranoid delusions:
Table I. Participant characteristics.

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Diagnosis</th>
<th>Highest educational attainment</th>
<th>Occupation</th>
<th>Marital status and family living arrangements</th>
<th>Details of children</th>
<th>Frequency of contact with children</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
<td>58 Schizophrenia</td>
<td>Left school age 15</td>
<td>Retired skilled manual</td>
<td>Married, lives with wife</td>
<td>F(33)</td>
<td>'Regular'</td>
</tr>
<tr>
<td></td>
<td></td>
<td>GCE qualifications</td>
<td></td>
<td></td>
<td>M(28)</td>
<td>2 x week</td>
</tr>
<tr>
<td>F2</td>
<td>34 Schizophrenia</td>
<td>Left school age 14 without qualifications</td>
<td>Unskilled manual</td>
<td>Single, lives with own mother and child</td>
<td>M(10)</td>
<td>Lives with father</td>
</tr>
<tr>
<td>F3</td>
<td>37 Schizoaffective disorder</td>
<td>Left school age 16</td>
<td>Unemployed</td>
<td>Married, lives with wife and child</td>
<td>M(8)</td>
<td></td>
</tr>
<tr>
<td>F4</td>
<td>67 Schizophrenia</td>
<td>Left school age 15 without qualifications</td>
<td>Retired skilled manual</td>
<td>Divorced, lives alone</td>
<td>M(38)</td>
<td>1 x year</td>
</tr>
<tr>
<td>F5</td>
<td>54 Paranoid schizophrenia</td>
<td>Left school age 15 without qualifications</td>
<td>Unemployed</td>
<td>Single, lives alone</td>
<td>M(19)</td>
<td>1 - 2 x month</td>
</tr>
<tr>
<td>F6</td>
<td>64 Paranoid schizophrenia</td>
<td>Left school age 15 without qualifications</td>
<td>Skilled manual</td>
<td>Married, lives with wife</td>
<td>M(44)</td>
<td>1 x year</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M(42)</td>
<td>9 - 10 x year</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>F(35)</td>
<td>1 x week</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M(34)</td>
<td>1 x week</td>
</tr>
<tr>
<td>F7</td>
<td>66 Schizophrenia</td>
<td>Left school age 15.</td>
<td>Retired skilled manual</td>
<td>Married, lives with wife and son's family</td>
<td>M(36)</td>
<td>1 x week</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Scottish Highers</td>
<td></td>
<td></td>
<td>F(35)</td>
<td>2 x week</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M(33)</td>
<td>1 x week</td>
</tr>
<tr>
<td>F8</td>
<td>34 Schizophrenia</td>
<td>Left school age 17, Scottish Highers</td>
<td>Unemployed</td>
<td>Lives with partner and child</td>
<td>M(1)</td>
<td>Lives with father</td>
</tr>
<tr>
<td>F9</td>
<td>41 Delusional disorder</td>
<td>Left school age 16 without qualifications</td>
<td>Unemployed</td>
<td>Lives with partner and child (son)</td>
<td>F(16)</td>
<td>None</td>
</tr>
<tr>
<td>F10</td>
<td>53 Schizoaffective disorder</td>
<td>University Degree</td>
<td>Househusband</td>
<td>Married, lives with wife and children</td>
<td>M(12)</td>
<td>Live with father</td>
</tr>
</tbody>
</table>

F4, F5, F6, Grandfathers; F7, Great-grandfather.
Well because you alienated them from your mind...they're my children but they're not my children...it's a horrible feeling. You know, it's to believe they weren't my children...I was...a bit offish with the kids, because I'm thinking they know what I'm going to say, and things like that...knowing that they can read me brain. Thinking that they can read me brain. (F6)

Hospital as a family disruption. Hospitalization due to an acute episode of psychosis was generally a negative experience for the participants, particularly because of the lengthy separations from the family. One father described how psychosis had removed him from his family and then kept him away in hospital. This prevented him from fulfilling his role as a father and family member, such as sharing in important family milestones: “...I haven’t been there for them sometimes because I’ve been in hospital...I was in there when my wife celebrated her fortieth birthday...the illness actually took me away from events that I should have been there” (F1).

A few of the fathers expressed a reluctance to be visited while hospitalized for psychosis. This was associated with a concern to protect the children from the possible distress of visiting a mental hospital, and may have taken precedence over the desire to renew contact them: “I’m a little cautious about having them in to see me, the ward, cause...some people are quite disturbed and it can be quite upsetting for them” (F10).

One father described how he never let his son visit him when he was in a mental hospital. He felt that this protected his son from the distress of seeing the other mentally ill patients and it kept him away from danger. However, it also appeared that he was protecting the father-child relationship by preventing his son from seeing him unwell and amongst the mentally ill. In addition, there may be issues of shame in allowing his son to see him when unwell, and a consequent avoidance of physical contact with his son:

...he’s never visited me. I’ve been admitted nearly every year since I’ve had him, you know, for at least a couple of months. I’ve never let him visit me. I can’t let him see what the kind of people that I’m living with, you know. I’m not well enough to see him. If I’m that unwell, I am sectioned, yeah? So I don’t want him to see me, like, that bad. Especially with the amount of people on the ward that have got really bad illnesses, and my son could be in...anything happens on them wards, fighting, anything... (F2)

Although this was a difficult separation, this father attempted to make up for the lack of physical contact by writing letters and telephoning:

I miss out, and my son misses out on my contact...not seeing me son when I’m on Section 3, maybe 4 months in hospital. And that really hurts, but I do keep phone contact and writing letters twice a week. (F2)

Another father reported that the decision not to visit him inside a mental hospital was his wife’s rather than his own, and they met outside in the hospital car park instead. There was a sense that she had a negative view of visiting her husband in the hospital: “They never came in, they was outside in the car park...my ex-wife never wanted to come into a mental hospital...” (F4).

It would appear that the meaning of hospitalization for fathers with psychosis is that it is a family disruptor, a painful experience which threatens their relationships with their children and partners. Hospital is an inappropriate environment for their children as it
may be dangerous and distressing, and fathers with psychosis may try to protect their children and the father-child relationship by limiting physical contact, even though they miss their children a great deal. We infer that the period of hospitalization may be a shameful, perhaps stigmatizing time for fathers with psychosis, and avoidance of physical contact with the children might also be associated with feelings of shame in letting their children see them when they are mentally ill and hospitalized amongst mentally ill individuals.

**Medication as a straitjacket.** There was a sense that the participants experienced the medication for their psychosis as having both beneficial and detrimental effects. The side effects of this medication were reported to affect one’s energy level: “...the tablets make me very tired. And if I don’t get enough sleep I get niggly” (F9). Medication also affects one’s concentration: “I find it affects my concentration, the injection” (F1).

Two of the participants described how medication had affected their ability to father their children. For one participant, medication felt like a straitjacket, constraining his ability to display emotions to his son: “...Largactil didn’t permit me to have conversations with him or be a father to him...it’s like a straitjacket, a mental straitjacket you see, emotional straitjacket. So difficult to show feelings with that stuff inside ya” (F5). The other participant said that he had lost consciousness while caring for his young son and attributed this to his medication: “...one time, my wife left the house. I had my son there...and I blacked out for 3 hours...to do with the medication...” (F3).

**A negative impact on one’s memory.** One participant described how he had had problems with his memory, which he attributed to his psychosis. He had forgotten important parental responsibilities, such as picking up his child from school. This led to a feeling of shame at having failed as a father:

...when I have those slips of memory, which are part of my illness, something major will get lost...and when it relates to the kids, that makes it hard to be a dad. I feel ashamed of having fallen short of my standards...in what I should be doing. (F10)

**Pre-fatherhood aspirations**

The participants recalled what they had thought of fatherhood before their first child was born. The most prominent theme was: Not to repeat history/to do it differently. Several of the fathers said they had decided to raise their own children in a different manner from their own upbringing. There was a sense that they perceived their own fathers as “anti-role-models” and there was a determination not to allow history to repeat itself:

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. (F2)

This father reported that he had experienced a high level of physical and emotional abuse. It is interesting that many of the fathers had terrible histories and were intent on not repeating them.
Fears for the children

Fears of passing on psychosis. Concern about passing on psychosis to one’s children was a widespread theme for the participants. There was an anxiety associated with the education they had received about genetic factors in the development of psychosis. Many participants were waiting to see whether or not their children would develop psychosis, fearing that history would repeat itself, and that their children would have to suffer the same negative experiences that they themselves had:

That they’ll be able to get through life without having to suffer the sort of illness I’ve had . . . I know there’s an increased likelihood that they will have a psychotic illness because I have one. I hope that the dice will come up their way and they won’t have it. (F10)

One father described how the fear of passing on his psychosis had been his first thought when he learned that his partner was pregnant: “. . . the first thing that came into my head, is cause like, I was told by my psychiatrist that my illness is hereditary, you know from my father. He had schizophrenia, my real father” (F2). He talked of his anxiety over history repeating itself: “It was like, just don’t get the schizophrenia like I got, cause you know, I wouldn’t like to bring another person into the world to have to go through what I’ve been through” (F2). Another father feared his child inheriting the stigma associated with psychosis: “Being diagnosed, having a label that lasts for a lifetime, is not very nice. And I don’t want that for my son” (F3).

Two of the older participants had adult children who had developed psychosis, and this had led to feelings of sadness:

. . .my son had a breakdown when he was 24, and you can imagine the effect on me when he went the same way as me . . . his paranoia, his illness was exactly the same as mine when I was that age, and yet I was always told that schizophrenia wasn’t hereditary. (F1)

One father wondered if his poor relationship with his son was linked to his son blaming him for passing on his psychosis:

Well they diagnosed him as a paranoid schizophrenic . . . he might be blaming me . . . for him being like the way he is . . . (I feel) . . . a little bit like a pariah or something like, not a pariah but a bit like a leper I expect or something like that. (F5)

For a few of the fathers, there was a concern that psychosis was a negative family legacy that would be passed down the generations: “I feel as it goes from son to son this thing you know? . . . this thing in the . . . family . . . this illness sort of thing” (F5).

The impact of parenting on the fathers themselves

Pride in the father role. The sense of pride in being a father was a common theme for the participants. This was associated with a sense of accomplishment and achievement, in having fathered a child and in successfully raising a child:

Yeah, it made me feel proud that I have actually had a son. Acknowledge that I have got a son and that I’m not just going to be the bloke who’s wandering around the age of 35 looking for a girl and never had children. (F2)
There was a sense that by becoming a parent, they had made a transition to a higher level of status, the status of “father” or “family man”: “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” (F7).

**Sense of purpose and meaning.** Many of the fathers described the sense of purpose and meaning that fatherhood brought to their lives. This was associated with taking on the responsibility for providing for one’s children: “...I think I’m a good dad. Cause I’m there for him, I make sure he’s got clothes, I make sure he’s got food...” (F9).

A common sub-theme was a sense of pleasure in the creation and development of a new human being. One father talked of his role in creating new life: “...I felt him being conceived...a very peaceful feeling came over me...I felt life being created” (F5). There was also a pleasure derived from watching one’s child develop into a self-sufficient person: “To see them grow up and keep well and that, you know, that’s what helps me to be a father...see that they’re helping their selves...” (F4).

**Support and understanding from children.** Several participants described the support and understanding that their children had given them in helping them to cope with their psychosis. This included comforting words and reassurance. The theme of support and understanding also incorporated a sense that the children felt empathy for their fathers, that they had acknowledged their father’s mental illness, accepted it, understood it, and tried to help them cope with it: “I don’t cope. I go to bed. The only thing I can do is lay in bed. Even then, [daughter] tells the kids that I’m no well, they’re so quiet it’s untrue” (F6).

**Motivation to make positive changes to one’s life.** A few of the fathers described how having children had given them the impetus to make positive changes to their lives. For one father, this meant an end to his 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... (F2)

Another father said that having a child gave him extra motivation to overcome his psychosis and the depression associated with it: “...she’s such a happy child, sort of quite life affirming. It jogs me out of the depression that used to sort of get me down...” (F8).

**Fatherhood can exacerbate one’s psychosis.** For some of the fathers, parenting was described as being accompanied by certain anxieties, such as concern for their children’s well-being: “There’s just big general worries...a lot of parents have about...about children...their physical safety...they can be happy...well-balanced people really” (F8).

Parental anxieties can be viewed as a burden of stress which compounds the other pressures which the participants experience. For example, one father said: “...I’m under more stress than if I wasn’t a parent...it’s just more stressful being a parent than not I think” (F8).

A few of the fathers described how having children around can be stressful in itself, and this stress can trigger deteriorations in one’s mental state. For one father, the lack of sleep through caring for his young baby was associated with an increase in his psychotic symptoms: “...I did struggle...I had to increase my medication after...I was telling the
signs that I was getting . . . a bit ill through lack of sleep . . .” (F8). Another father described how he had returned home after a hospitalization for psychosis and the noise and activity of his children had caused him to return to the ward, because he could not handle the associated stress:

... four young children . . . all under 5 and that, and they’re flying about, large as life all the time. You know, as soon as I got home, after coming out of a quiet hospital, you know it was too much for me. I had to go back in. (F7)

Discussion

Overview

This study has examined the experiences of fathers with psychosis in detail, finding that psychosis may directly and indirectly affect the father-child relationship and the work of parenting in both negative and positive ways.

Negative aspects

In line with the hospitalization and separation anxieties of mothers with SMI (Nicholson et al., 1998), some of the participants in this study experience hospitalization for psychosis as a disruption to their lives and the lives of their family members. Being away in hospital and separated from their families may prevent the fathers from “being there” for their partners and children. Fathers with psychosis may reluctantly enforce this separation in a desire to protect their children (and perhaps the father-child relationship) from the inappropriate environment of the mental hospital. It is possible that the avoidance of physical contact with the children is also associated with feelings of shame in being mentally ill and hospitalised amongst mentally ill persons. Similar to the anxieties of fathers and mothers with mental illness (Aldridge & Becker, 2003; Bassett et al., 1999), the participants were concerned that their children would inherit their mental illness and they too would have to experience psychosis.

The fathers in this study did not report that the responsibilities of parenting and a lack of childcare made it difficult to access treatment, unlike mothers with SMI (Nicholson et al., 1998). Nor did they have a fear of losing custody and then consequently avoid treatment, unlike mothers with SMI (Nicholson et al., 1998) or the mothers and one father with SMI in the study by Ackerson (2003). In fact, these fathers did not have any concerns about losing custody of their children, in contrast to previous research on Australian fathers and mothers with psychosis (Hearle et al., 1999). Further research is required to examine this issue, as perhaps this reflects situations for fathers with psychosis in the UK, or some other limitation of our research (see below). Maybe these fathers had fewer difficulties in their childcare arrangements as (although not reported in this paper’s results) only one father mentioned needing extra help with childcare, in contrast to the parents in the Hearle et al. (1999) study.

In a way similar to the mothers with psychosis in the study by Goodman and Brumley (1990), some of the participants in our study reported that psychosis is associated with a sense of emotional disengagement from one’s children and this undermines the parent-child relationship. The participants reported that medication may affect fathering by reducing energy levels, concentration and ability to display emotions, which is in line with what is known about the effects of medication amongst mothers with SMI (Nicholson et al., 1998).
Another theme, not reported in previous studies, is that psychosis may be attributed to be the cause of memory problems which interfere with the meeting of parental responsibilities, resulting in a feeling of shame and a sense of failure in the father role.

The fathers reported that psychosis impeded them from fulfilling their parenting role, which has implications for the well-being of their children with regard to their social functioning (Goodman & Brumley, 1990). Although not reported by the participants in this study, children can be victims of discrimination at school as a result of a parent’s mental illness (Ackerson, 2003). This “stigma by association” may occur in the form of bullying at school and the children of parents with mental illness may consequently seek to conceal their parent’s illness from others (Aldridge & Becker, 2003).

Research has found that parents with mental illness are more likely to demonstrate parenting deficits, and this is associated with mental illness in their children. This association may be substantially mediated via maladaptive parenting behaviour, indicating that it is less likely parental mental illness per se leads to the development of mental health problems in their children. This raises the possibility that helping fathers with psychosis to modify maladaptive parenting styles will reduce the likelihood that their children will also develop mental health problems (Johnson, Cohen, Kasen, Smailes, & Brook, 2001).

Some of the participants reported that concern for their children or simply having children around has been a source of anxiety, and a few of the participants said they thought that certain stresses associated with fatherhood may have exacerbated their psychosis. It is noted that Nicholson et al. (1998) found that mothers with SMI who become parents may experience role-strain issues accompanied by stress and guilt, and these might be additional pressures which can compromise the mothers’ mental health.

**Positive aspects**

Support, empathy and understanding from children had helped some participants to cope with their psychosis, just as children have been shown to help mothers with SMI (Zemencuk et al., 1995). Just as parental responsibility may motivate mothers with SMI to seek help (Nicholson et al., 1998), having children gave some of the fathers in this study the motivation to make positive changes to their lives. In one case this included extra motivation to overcome psychosis and depression. The participants reported on a sense of pride in having accomplished the transition to the status of father and in successfully raising a child. This is consistent with the literature on mothers with SMI (e.g., Oyserman et al., 2000) and research into the experience of the transition to fatherhood (Henwood & Procter, 2003; Lewis, 1986). Becoming a father had brought with it a sense of purpose and meaning to life and there was a pleasure in the creation and development of new life. This is similar to other fathers’ experience of heightened purpose and meaning (Lewis, 1986). In line with the research indicating that fathers may express their emotional attachment to the family via the role of provider (Warin, Solomon, Lewis & Langford, 1999), some of the participants expressed a sense of purpose and meaning associated with the responsibility of providing for one’s children.

Before becoming fathers, several of the men said they had decided to raise their own children differently from their fathers, and there was a determination not to allow history to repeat itself. There is clear evidence that trauma is a contributing factor in psychosis (Read, van Os, Morrison & Ross, 2005), and five of the fathers in this study had experienced some form of significant trauma during childhood. There was a sense that several participants viewed their own fathers as anti-role-models. Consistent with Pruett’s (2000) theory, many participants had undergone a process of reworking in which they decided
to compensate for early negative experiences by becoming better fathers to their own children.

One might infer from the results of this study that fatherhood can provide a "father" identity in a similar way to how being a mother provides a "mother" identity to women with SMI (Deegan, 1993; Sands, 1995). In spite of the mixed comments, with reports of both negative and positive experiences of being a father, our subjective impression is that the participants did not regret taking on this role.

**Limitations**

As discussed earlier, we employed credibility checks as suggested by Elliott et al. (1999). However, this research might have the following limitations: The study group of fathers was limited in number and may be biased by the self-selecting nature of the recruitment strategy. Those who participated may have had more positive fathering experiences and been more interested in reflecting on such experiences. They may have unusual characteristics, inherent in the fact that they had agreed to talk to a stranger about intimate details of their lives. Participants may have been more likely to have stable supportive families and fewer mental health problems, as they were able to spend several hours participating in this study.

It is acknowledged that this study examined fathers of one ethnicity and there are differences in attitudes to parenting (Townsend, 2002) and attitudes to mental illness (Warner, 2004) amongst different ethnic groups. Further research is needed into fathers with psychosis of other ethnic backgrounds as well as those who are not in contact with their children, and those who are step-fathers or foster fathers.

**Service implications**

While modern UK Care Programme Approach (CPA) planning takes paternal status into account, more is needed to address the needs of fathers with psychosis. Services ought to have more education on the direct and indirect effects of a father's psychosis on the mental health of their family. Inpatient units need to be made more child-friendly so that fathers who are admitted are able to meet their families in safe and comfortable surroundings. Psycho-education and relapse prevention work needs to be sensitive to the positive and negative effects of fatherhood on psychosis.

Services need to ask fathers with psychosis specific questions about what support they or their families may need and explore the provision of extra support in response to these needs. Male clients with psychosis may require extra support during the first months of fatherhood, as the stresses of parenting may have a negative impact on their mental health. There is also a need for parenting programmes like Integrated Family Treatment (IFT) to help fathers with psychosis over the longer term. IFT has been shown to be successful in improving the parenting skills of parents with SMI (Brunette, Richardson, White, Bemis, & Eelkema, 2004). Implementation of such assistance programmes might benefit the children of parents with psychosis by modifying maladaptive parenting styles and so lower the children's risk of developing mental health problems themselves (Johnson et al., 2001).

Individualist models of therapy may neglect the importance of family relationships, relationships with the wider community and the needs of the children of parents with psychosis. There is a need for more systemic approaches to address the needs of fathers with psychosis and their families. These might consider how adult and child mental health services and carers organizations work together to help children of psychotic parents, and perhaps help fathers with psychosis to develop and use social support networks.
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