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**The impact of maternal postnatal depression on men's experiences of fathering: A qualitative study of British fathers.**

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## **Abstract**

Evidence indicates that maternal postnatal depression can exert substantial effects on mothers, fathers and their children. There are conflicting findings about the extent to which fathers can buffer against the negative effects of maternal depression on children, and we understand relatively little about what shapes the way men father in the context of maternal postnatal depression. The present study explored men's accounts of fathering when their partner(s) was postnatally depressed. Narrative interviews were conducted with 14 British fathers and data were subjected to interpretative phenomenological analysis. An overarching theme of absence appeared to shape men's experiences of fathering, this was primarily felt as a perceived physical and/or psychological absence of their partner and co-parent. As a result, fathering in this context was a lonely and unexpectedly burdensome experience for some men. Other men felt that their ideal way of fathering had been thwarted by the perceived absence of a cohesive family unit, or by their own psychological/emotional absence as they became preoccupied with trying to understand the effects of the depression, particularly on their marital relationship. Some men, however, adapted to the situation by eventually accepting the loss of a shared parenting experience and by focusing on the father-child dyad, which they felt enabled them to emerge from the experience as better, more confident fathers. It is argued that professionals should consider the impact of postnatal depression on fathers, as well as mothers and their children, and that support should be made available to such men.

## **Introduction**

Postnatal depression affects between 10 and 15% of women in Western countries (e.g. Dennis & Hodnett, 2007; O'Hara & Swain, 1996; Robertson, Grace, Wallington, & Stewart, 2004). Onset typically occurs between one and three months postpartum, and for a high percentage of women, the depression persists beyond two years (American Psychiatric Association, 2000; Goodman, 2004). Postnatal depression is characterised by low mood, self-esteem, concentration and energy, increased tension, agitation, pessimism and guilt, as well as ideas of self-harm, disturbed sleep and weight change (Almond, 2009; Milgrom & McCloud, 1996). Although evidence regarding the biological/hormonal etiology is inconclusive (Cooper & Murray, 1998), documented risk factors for postnatal depression include antenatal depression or anxiety, recent life stressors, and a perceived or actual lack of practical and emotional support throughout pregnancy and the early postnatal period, especially from the infant's father (e.g. Akincigil, Munch, & Niemczyk, 2010; Milgrom, Gemmill, Bilszta, Hayes, Barnett et al., 2008). Antidepressant medication, psychological interventions and social support are the most common forms of treatment for postnatal depression (Hoffbrand, Howard, & Crawley, 2001).

Maternal postnatal depression can have a profound impact, not only on the mother, but also on children and the mother's partner. For example, compared to children of non-depressed mothers, children of postnatally depressed mothers are more likely to experience a range of poor cognitive (e.g. Cornish, McMahon, Ungerer, Barnett, Kowalenko et al., 2005) and psychosocial outcomes in early and middle childhood (e.g. Ramchandani, Stein, Evans, & O'Connor, 2005). However, the impact of postnatal depression on the male partners of women, and in particular on their fathering, is less well understood. Whilst there is some understanding of the factors mediating caregiver stress where a partner is depressed (e.g. Perlick, Gonzalez, Michael, Huth, Culver et al., 2012), the impact of this on parenting is less well documented. This is surprising given the emphasis in family research and UK policy on the importance of fathers to child and family wellbeing (e.g. Finn &

Henwood, 2009; Gold & Adeyemi, 2013; Loehlin, Horn, & Ernst, 2010; Ramchandani, Domoney, Sethna, Psychogios, Vlachos et al., 2012). As Asmussen and Weizel (2010) note, UK wide policies such as the National Service Framework for Children, Young People and Maternity Services (Department for Health, 2004), Every Parent Matters (Department for Education and Skills, 2007) and Support for All (Department of Children and Family Services, 2010) call for increased paternal responsibility and enhanced father involvement in order to improve children's wellbeing. Yet research consistently indicates that fathering is uniquely vulnerable to contextual influences (especially the relationship with their partner) in a way that mothering is not (Asmussen & Weizel, 2010). Thus, fathering in the context of maternal postnatal depression may generate distinct demands for men.

The small amount of extant research on fathering in this context paints a complex picture. For example, some studies indicate that fathers can moderate the negative impact of maternal postnatal depression on children (Cabrera, Fitzgerald, Bradley, & Roggman, 2007; Chang, Halpern, & Kaufman, 2007), by adapting both the quantity (e.g. Hagen, 2002) and quality of their fathering (e.g. Albertsson-Karlgren, Graff, & Nettelbladt, 2001), and by parenting in ways that promote stronger father-child attachments (Edhborg, Lundh, Seimyr, & Widstrom, 2003). Other studies, though, fail to identify these positive effects. Many studies indicate that fathering does not buffer against the impact of the depression on children (e.g. Mezulis, Hyde, & Clark, 2004) with some suggesting that it has a negative impact on father-child interactions (Goodman, 2008).

Men's own accounts often highlight some of the difficulties they experience in this context. For instance, fathers have reported that their partner's postnatal depression had created a tense and hostile family environment, with unequal divisions of labour, wherein their contribution was unappreciated (e.g. Meighan, Davis, Thomas, & Droppleman, 1999; Webster, 2002) and their child care criticised or undermined (Morgan, Matthey, Barnett, & Richardson, 1997). Furthermore, Meighan et al. (1999) found that men fathering in this context perceived their own lives as

unpredictable and out of control, with irreparable damage to the partner relationship and a desire to avoid having more children in such a fragile context.

In addition, men's own mental health can be negatively affected in this context as they contend with the dual stressors of caring for a depressed partner and a young baby in unpredictable and tense circumstances (e.g. Roberts, Bushnell, Collings, & Purdie, 2006). International studies report that the partners of women with postnatal depression often develop depressive symptoms themselves (Areias, Kumar, Barros, & Figueiredo, 1996; Roberts et al., 2006; Roy, 2006).

Thus, much of the existing research indicates that maternal postnatal depression can create a complex context which negatively impacts fathers as well as children and mothers, and the interactions that take place between them. Yet relatively little is known about (i) what men perceive as the possibilities for 'good' fathering in this context and how they enact these; (ii) the routes by which effects on self, partner relationships and children are realized and (iii) the mechanisms by which some fathering becomes 'ecologically adaptive' (Asmussen & Weizel, 2010). We addressed these issues in the present study which adopted a cross-sectional, narrative based interview approach to elicit men's accounts of fathering where their partner had postnatal depression.

## **Methods**

The central tenet of a narrative approach is that events do not present themselves to the mind as stories, but often become so, with the narrator uniquely shaping the form and content of what is told (Bates, 2004). Highly suited to studying the impact of key life events (such as childbirth, e.g. Miller, Ryan, Keitner, Bishop, & Epstein, 2000) as well as the impact of illness (Hurwitz, Greenhalgh, & Skultans, 2004; Murray, 2003), narrative approaches reveal something of how we organise a life interrupted by illness (Hiles & Cermak, 2008; Murray, 2003) and in ways typically undefined by medicine (Frank, 1995). Data generated from narrative based interviews are suitable for diverse analyses (Murray, 2000; Riessman, 2003). We adopted an interpretative

phenomenological approach (Smith, Flowers, & Larkin, 2009), reflective of the personal (ontological) and interpersonal levels of narrative analysis described by Murray (2000).

### *Recruitment*

The study was approved by the University of Leeds Research Ethics Committee (07143-01). Given our commitment to a phenomenological approach, we were interested in soliciting accounts of fatherhood from men who perceived the mother of their child(ren) to have been postnatally depressed after the birth of at least one of their children. Men could participate regardless of their age, relationship status, time elapsed since the onset of postnatal depression, its duration or current status. A clinical diagnosis of postnatal depression was not an inclusion criterion, as many women choose not to seek medical intervention due to their concerns about being medicated or stigmatised.

The National Society for the Prevention of Cruelty to Children facilitated study recruitment by allowing access to their support groups for women with postnatal depression. Twelve out of 25 women attending these support groups at the point of recruitment agreed to provide their partner's contact details so that they could be sent a study information pack. Three men agreed to participate via this route. An additional participant was recruited via a 'Dads' Group' run by the National Childbirth Trust. A further participant was recruited via a Sure Start family outreach worker who left a study information pack with families where postnatal depression had been identified. Nine further participants were recruited via snowballing.

### *Sample*

Participants were 14 fathers aged between 25 and 50 (mean age = 33.9 years). This sample size was sufficient for the intended interpretative phenomenological analysis (IPA) which prioritises the intensive analysis of a small sample (Smith, 1996; Smith, Jarman, & Osborn, 1999). Referent partners were aged between 21 and 48 (mean age = 29.6 years) at the point of interview.

Eight participants were in a partnership or cohabiting, five were married and one had recently separated. Relationship duration ranged from two to sixteen years (mean = 7.6 years). Participant and referent partner details are presented in Table 1. For most participants, it was their current or most recent partner who had experienced postnatal depression; however, for one participant it was his ex-partner. The number of children fathered by each participant ranged from one to five (mean = 2.5 children). At the point of interview, the participants' children were aged between 11 weeks and 17 years (mean = 5.6 years).

Table 2 details the participants' reports of their partner's postnatal depression in terms of its onset and status, as well as the nature of any contact with medical services. Five participants had only experienced fatherhood where their partner had postnatal depression and nine participants had also experienced fatherhood where maternal postnatal depression was not present. At the point of interview, seven participants reported that the referent partner had recovered from postnatal depression and seven reported that the depression was ongoing.

### *Data Collection*

Narrative interviews were conducted by the first author during 2008. Interviews began with the broad, history eliciting question: "Tell me about all of the significant events that have taken place from the time that fatherhood became important to you?" (Riessman, 2003; Wengraf, 2004). The account generated from this question was probed and participants were asked to provide more detail in places, still in a storied fashion (Flick, 2009). The interview then moved to discuss five 'nuclear episodes' (McAdams, 1993, p. 259) or key moments from their fathering experiences (a high point, a low point, a point of change, a challenge, and a time when support or advice was sought) which they felt were related to their partner's postnatal depression. Interviews concluded with McAdams' (1993) proposed final questions concerned with the participants' envisaged future and reflection on the overall theme of their narrative. Interviews were audio-recorded and



conducted in participants' homes, places of work or in a university building. Interviews ranged from 45 minutes to 3 hours, with a mean interview length of 90 minutes. Audio-recordings were transcribed verbatim by the first author following a 'lite' version of Jeffersonian standards of transcription notation, as has become commonplace in the transcription of data for IPA research (Smith et al., 2009).

### *Data analysis*

Data were analysed using IPA (Smith et al., 2009). Although narrative data are commonly analysed using narrative analysis, its' concern with narrative structure and/or identity (Christman, 2008; McAdams, Josselson, & Lieblich, 2006) were not appropriate for our interest. IPA argues that participants seek to interpret their experiences in a form that is understandable to themselves and this position is compatible with a particular conceptualisation of narrative as whatever emerges from the process of making sense of ourselves and our lives. We followed the procedures for IPA as outlined by Smith, Jarman and Osborn (1999) and Smith and Osborn (2003). The analysis involved: multiple readings by L.B. of transcripts; making descriptive (e.g. 'sometimes being excluded by mother from bedtime stories with child') and interpretive notes (e.g. 'inconsistent maternal gate-keeping'); developing conceptual themes (e.g. 'fathering as flexible or dispensable'); and exploring connections between them, firstly ideographically, and then at the group level (e.g. 'thwarted fathering'). L.B.'s emergent analyses were discussed by the research team on a case by case basis to guard against a narrow interpretation, use of selected extracts only or attention to particular accounts of fathering. Negative cases (n = 3) which were dissimilar to the broad analytic patterns are reported separately.

Yardley's (2000) four broad principles of quality in qualitative investigations guided the study, namely: sensitivity to context (e.g. the interview dialogic context; the ideological situating of fathering); commitment and rigour (e.g. recruitment of an appropriate sample; prolonged data

exploration to generate sophisticated theorising; involvement of other researchers to assess credibility of analysis); transparency and coherence (e.g. reflectivity; accounting of analytic process); and impact and importance (e.g. relevance to support services).

## **Findings**

All but three of the participants felt that their (ex) partner's postnatal depression had significantly impacted their fathering. Our analysis identified a master theme of *absence* as the dominant lens through which the men recounted, and made sense of, their experience of fatherhood in this context. What was perceived as absent, as well as its' attributed cause and routes to impact varied and included a perception that: (a) partners were psychologically, emotionally or physically absent from parenting, necessitating compensatory fathering to *fill the void (theme 1)* and (b) they themselves, or anticipated family life, were absent in ways that *thwarted fathering (theme 2)*. Men's experience of *resilience (theme 3)* indicated something of how they understood themselves as adaptive and as striving to enact their version of good fathering.

### *Filling a void*

That postnatal depression had caused their partners' psychological and/or physical absence from mothering was reported by many fathers. Some perceived the absence or withdrawal as symptomatic of their partner's doubts about their capacity for mothering, whereas others understood the absence as a 'necessary evil' to the recovery of good mental health. Whatever its guise, maternal unavailability was overwhelmingly identified as the most toxic effect of the depression. Bill explained:

She got to the point where she wouldn't get out of bed, erm, she wouldn't eat, she wouldn't play with the kids. The kids would go in and give her a love and a kiss, and then she'd just turn over and go back to sleep, and that had an effect on all of us. The girls started to ask questions 'why won't mum get out of bed? Why doesn't mum wanna come

to the park with us? Why doesn't mum wanna come shopping with us? Why won't mum do my hair?

Maternal absence was seen as generating a void in the practical and psychological aspects of parenting. However, with only a few exceptions, participants did not gender parenting roles (e.g. as caretakers vs. bread-winners), nor did they suggest that, in response to their partners' absence, they were doing 'mothering' as opposed to 'fathering'. Rather, participants' emphasised the unexpected, and isolating, experience of taking on the duties of two parents. For example, Jasper stated that: 'It wasn't us doing this [parenting] and us sorting her head out, it was her sorting that out and me doing all of the baby stuff'. He recounted taking (unanticipated) responsibility for infant feeding when his partner had been too distressed to do it:

But behind closed doors, she [partner] was screaming, she was crying, she, she, she wouldn't, she couldn't even hold [baby]. She'd hold her and try to feed her and if she moved, or moved her head, 'oh she doesn't want it, she doesn't want it' and she'd be right aggressive. So I had to take over and do it and stuff and it just got, it was that, day-to-day, all the time.

An unshared parenting load rendered fathering an unexpectedly solitary experience for many participants. Rather than learning to parent alongside their partners, some participants felt they had no choice but to learn on their own. In addition, their normative parenting worries (e.g. infant sleeping, toddler tantrums) went unshared, and therefore often escalated. Even when partners were physically present, parenting was still experienced as disproportionately burdensome for many men, due to their partner's perceived psychological absence. For instance, the disengaged presence of Bill's wife was 'more of a hindrance than a help' and he 'nearly packed her bags' as her rejection of the children, and their misplaced guilt ('the kids would say 'is it something we've done?'), became an additional anxiety for him to carry.

Although the impact on day-to-day fathering differed from one participant to another, each reported feeling solely responsible for the family's functioning, and additionally, for protecting it

from external judgement. A sense of panic and urgency permeated Jasper's account (below) of how he worked to compensate for and conceal his partner's 'absence':

I'd come straight home and I'd be looking after [daughter], I'd change her, clean up the house, tidy whatever, and then I'd have to go back [to work], because she [partner] wouldn't, she wouldn't ever, she didn't do it (...) if I didn't come home and do it and people came in and saw that, then they'd know that something was wrong. So I had to come home from work and tidy up and do the house and make sure that [daughter] was alright and then go back to work.

Thus, for many men, maternal postnatal depression had contributed to a practical, psychological and emotional void in parenting and family life. Although the men did not seek to become substitute mothers to their children, their day-to-day fathering became an enactment of a dual parenting load and was typically a solitary experience with unshared parenting concerns.

### *Thwarted fathering*

As well as being directly affected by the responsibility of filling a void, men reported that the absence of co-operative parenting reflected, and further propelled, a disintegration of the adult relationship, which in turn impacted the family unit. Thus, how one is as a father, a partner and a member of a family appeared profoundly interrelated for many of the men. For example, Bill and Jasper reported that postnatal depression shifted their adult-adult relationship to carer-patient roles, which they felt thwarted their anticipated ways of fathering. David compared his experience of fathering without a backdrop of postnatal depression, in which 'everything is moving in the right direction', with that of 'all of a sudden' hitting 'a brick wall' when postnatal depression impacted their family. He felt that the destructive impact, which stemmed from the deterioration of the partner relationship and his subsequent desire to be away from the hostility, meant that they had no 'good times' as a family:

It [postnatal depression] just creates hostility between you, it creates, there's no cohesion between me and [partner]. We're not singing off the same hymn sheet as it were, we're

just, we're not, we are in the sense that we're both, undoubtedly she still loved the kids more than anything, so that wasn't in question, but as a family unit it's destructive, it's very destructive, very destructive. It's threatening on, it's fatal, fatal as in the relationship ending (...) it's very bad, it spirals out of control

Becoming preoccupied by the difficulties within the adult relationship meant that some men felt they were psychologically and physically absent as fathers. They felt this impoverished their interactions with their children, and described fathering as unfulfilling, disappointing and devoid of fun. Their accounts were tinged with resentment about being prevented (even through their own preoccupation with the depression) from being the father they wanted to be. George explained that it was his wife's emotional rejection of him, rather than her absence from mothering, which preoccupied him, leading to 'darker' times and 'switching off my feelings (...) to make like your own, kind of like your own postnatal depression pills'. George explained the mundane manifestation of this in relation to his fathering:

I have been really fed up and I just don't want anyone around me (...) I just don't wanna be around anyone and the kids will be like, saying like 'daddy's in a really bad mood, what's wrong with you daddy?' and I'm mumbling and being grumpy and whatever, but it's a case of it's just too much

In addition to the personal preoccupation with their partner's depression, some men felt that their fathering was thwarted by the constraints generated by their partner's mental health. Del felt that the pressure to solely maintain domestic life consumed his time and energy, and he felt 'guilty for not giving your kids the time you know they need - they want that time and they don't understand the situation'.

Del talked of feeling 'cheated' and 'robbed' of the opportunity to be a 'proper father' to his children and vividly contrasted his experiences of fatherhood with and without a backdrop of maternal postnatal depression:

It's like (...) having a picnic, on a meadow, in the sunshine, blue sky, birds flying by, birds

singing, and, and I would say [...] stuck, stuck in a tunnel on a wet, cold, rainy, miserable, dark day, big contrast (...) Where at the other stage you're just free as a bird (...) on the other hand you're like wading through, wading through thick mud, just to see if I can make it through the day, to go on to the next day. Surviving, you're not living, you're not enjoying your family, you're just surviving day after day, after day, after day. There's no enjoyment, no fun, there's no [sigh], you can't see a way out and all you can do is pitch in and try to stick it out and survive (...) no fun, no happiness, no smiles

For other participants, the thwarting of their anticipated ways of fathering came from more direct maternal gate-keeping which seemed particularly pertinent in that, for many men, spending time with one's child was an important aspect of the paternal role. For Matthew, his wife's oscillation between extreme absence and a dominant presence, dictated by her level of wellness, both afforded and restricted his opportunities for fathering. Whilst he expressed a willingness to be flexible, this left him feeling disappointed and frustrated at the lack of autonomy in fathering:

There were times when I'd see less of him [son] because there were times, there were times when [wife] was of the state of mind that she wasn't coping and had to prove to herself that she was doing things, and to do those things she had to do them. If that happened to be something that was involving [son], she would do that and exclude me from it, or take that task away from me (...) there were a lot of things that we kind of wanted to do as a family, wanted to do that didn't happen, and there was a feeling of disappointment there for me

Thus, there were multiple ways in which men experienced a re-railing or thwarting of their anticipated way of fathering. The strain of the depression on parenting and family cohesion unsettled, and sometimes entirely disrupted, the ways that men felt they could father, either because of maternal gate-keeping or because fathering was felt to be workable only within an integrated parenting system. Other men became psychologically absent fathers, preoccupied with making sense of their partner's withdrawal, bringing with it resentment as well as a direct impact on the father-child relationship.

## *Resilience*

Narratives of personal resilience were also prominent in the men's accounts. Some men adapted to, and even encouraged, their partners' psychological and/or physical absence as a way to manifest their care for their partner and/or because they felt it liberated opportunities for, and autonomy in, fathering. For example, although Charlie felt incompetent with their infant, he reported that his partner's irritability with their children gave him an opportunity to be 'good cop' and to build an emotional connection with his son. In addition, Bill felt that, although his partner's emotional absence had necessitated 'mental toughness' on his part, he had benefited from a more holistic and rounded fathering experience compared to fathers who had experienced only the 'good times'. Their partner's depression was seen by many fathers as the trigger to 'do their damndest to be as actively involved as possible' (Matthew). Involvement was typically conceptualised as time invested, and was conveyed as being the active ingredient in becoming better, more confident fathers. Most frequently men adapted by accepting their partner's absence and the loss of joint parenting, and by shifting their priorities to the father-child relationship. Participants described how they 'protected' time alone with their child (e.g. bath time, night wakings) and Bill explained how he felt this strengthened his bond with his daughter:

I'd come home and as soon as I came home I'd let her [wife] go to bed, and it would just be me and [daughter]. And I think that's why I'm more chilled out with her to be honest with you, 'cos I did spend, it felt as though it was just me and her (...) in our own little world

Leighton similarly reported a happy father-son relationship disconnected from mothering or family life:

[H]e won't go nowhere without his dad, and vice versa you know what I mean? [...] I love spending time with him, I love doing, so for that reason alone and er with what I get back off him now er you know cuddles and wanting to come with his dad and the smiles and you know we're just happy with each other.

Although Sean's narrative predominantly centered around the regretted demise of the family unit, he too hoped for, and could envisage, a 'perfect' father-child relationship, disconnected from the mother-child relationship, in which all had recovered from the impact of the postnatal depression.

Thus, resilience in this context appears to be typified by the pursuance of a segregated father-child relationship, divorced from joint parenting. Although this individual approach to parenting was not their initial preference, it ultimately had a positive impact on the men's fathering and on the father-child relationship.

## **Discussion**

A number of studies chronicle the extent to which fathers ameliorate or exacerbate parenting, partner and family difficulties where the mother has postnatal depression, yet few illustrate men's own accounts of their fathering behaviours in this context. Our study indicates that, when their partner is depressed, fathers' experience is often one of solitary responsibility, family fracturing and a thwarting of ideal fathering. Where adaptation did emerge, it was characterized by the cultivating of exclusive father-child relationships.

For those men who felt their fathering was affected by their partner's depression, an overarching theme of absence shaped their experience. Differences were evident in who or what was absent, how this absence was perceived and how it impacted on the men's fathering. A significant absence was that of the mother, who was perceived as withdrawing entirely from mothering, rather than from discrete aspects of it, as has been reported in other, notably observational, studies (e.g. early breastfeeding cessation and reduced sensitivity and responsiveness, Field, 2010; expression of warmth, Lovejoy, Graczyk, O'Hare, & Neuman, 2000). However, Meighan et al. (1999), in their qualitative study exploring men's experiences of living with a postnatally depressed partner, also reported fathers' sense of loss of their partner, a loss of intimacy



and a loss of control over their lives. In our study, partner withdrawal from family life compelled many men to assume sole responsibility for the family's functioning, a finding consistently reported (e.g. Barclay & Lupton, 1999; Boath, Pryce, & Cox, 1998; Meighan et al., 1999). Day-to-day enactment of fathering was described as psychologically and practically lonely, unexpectedly burdensome and fluctuating according to their partner's needs. Furthermore, that their way of fathering was obligated rather than chosen triggered frustration and resentment for some, and diminished many men's enjoyment of fathering. Such lack of agency in ways of fathering is in contrast to the greater levels of negotiation over parenting responsibilities common in low-risk contexts, which confers greater satisfaction in parenting (St John, Cameron, & McVeigh, 2005).

Compulsorily undertaking traditionally female tasks has been linked to rumination and depressive symptoms in men (Perlick et al., 2012). However, although men in the present study reported significant effects of the extra responsibility, they did not seem to view their fathering as compensatory mothering. This is in contrast to Finn and Henwood's (2009) UK study with 30 first-time fathers (from normative contexts) who framed their highly involved and nurturing fathering as motherly-like paternity. Our participants rarely gendered roles but instead oriented to a shared parenting discourse (Vuori, 2009) wherein both genders are, in principle, equally capable of and responsible for, all aspects of parenting.

Also in contrast to studies of fathering in normative contexts (e.g. Barclay & Lupton, 1999; St John et al., 2005), the men in the present study typically felt involved, rather than marginalised, in family life as a consequence of taking on additional responsibilities. However, in conjunction with the findings reported by Morgan et al. (1997), men's involvement in parenting was often vulnerable to their partner's fluctuating state of mental health, whereby feelings of anxiety and guilt over mothering sometimes led women to undermine men's fathering or to control access to the children. In such instances, men experienced being re-positioned as incompetent fathers in contrast to women's 'natural' ability to parent (also noted by Trinder, 2008 amongst non-depressed

partners). Such oscillation between the (compelled) involved and marginalised father was hard-hitting for some participants who reported extreme powerlessness and resentment. Although maternal gate-keeping is reported in normative contexts (e.g. Barclay & Lupton, 1999; Jordan, 1990; Trinder, 2008), where men feel assigned to supportive roles, the accounts provided here suggest that attempts at involved fathering may be additionally complex in the context of maternal postnatal depression where the mother's fragility or volatility mean that her needs are prioritised.

As well as being affected directly by their partner's gate-keeping, some men felt preoccupied with making sense of their partner's altered mental health, a finding also reported by Morgan et al. (1997). Although men have been described as poor communicators, and as failing to understand postnatal depression as a crisis of the self (Everingham, Heading, & Connor, 2006; Webster, 2002), our findings suggest that men were rarely given accounts by their partners which might have helped them to understand the changes in them, and their families. For some men in our study, their preoccupation with making sense of things rendered them (and not just their partner) psychologically and emotionally absent from parenting. Making sense of their altered partner and relationship was infused with a significant felt loss of their friend and partner. As spouses (or partners) are the main source of social support for men (Harvey & McGrath, 1988), the psychological and emotional withdrawal of the depressed mother is often felt acutely by them (Meighan et al., 1999). Our findings show that for some men, this has a direct impact on their perceived availability for fathering.

However, the role of the adult partnership in the experience of fathering in this context is complex. Our study supports the well documented association between postnatal depression and the state of the partner relationship (Milgrom & McCloud, 1996; Zelkowitz & Milet, 1996), and resonates with consistent studies which identify associations between relationship difficulties and low father involvement (even in low risk contexts) (Asmussen & Weizel, 2010; Doherty, Kouneski, & Erickson, 1998). Effects on fathering for the men in our study appeared to be mediated by the

adult partnership, but also by the lack of a secure and cohesive family unit. Although time spent with their children often increased due to greater domestic responsibilities, some men felt that their capacity to father was compromised without a stable, functioning family unit. Postnatal depression had limited both the quantity and quality of time spent together as a family, prohibiting the ‘package deal’, in which partnership and parenting are closely intertwined (Tach, Mincy, & Edin, 2010).

Asmussen and Weizel (2010) note that research consistently suggests that fathering is uniquely vulnerable to contextual factors, and postnatal depression appears to create a vulnerable context. Responding to Rodrigues et al.’s (2003) question of why so many fathers seem unable to support their postnatally depressed partner, our findings indicate multiple and shifting stressors that create a fragile, unexpected and often rejecting context for men whereby their fathering involvement is compelled, frustrated and shrouded in loss of the ideal.

However, some participants did talk in ways which indicated adaptation to their circumstances. In such instances, adaptation was not progressed by professional or local support (as men rarely seek it, George, 1996), but rather by an evolution in their perception of where they had agency. This typically meant prospering the father-child dyad independent of the adult relationship, a finding also noted by Easterbrooks, Barrett, Brady, and Davis (2007). Drives for agency and individuation emerged for men despite not having a clear understanding of why their relationship had become so difficult, suggesting that men’s adaptation to maternal postnatal depression may be less characterised by making sense of life events than finding opportunities for autonomy in them (see Adler, 2012; Lilgendahl & McAdams, 2011). That some fathers adapted by investing heavily in the father-child relationship presents an important contribution to the outcomes literature which typically posit poor trajectories for children of maternally depressed mothers. Our study shows the attempts by some men to buffer against the negative effects of maternal withdrawal by establishing a distinct father-child relationship, which men felt conferred some psychological protection to them

both. However, that this was the only reported form of adaptation perhaps points to the limited possibilities men perceive in living with a partner who is postnatally depressed.

A number of qualifications apply to our study. At the time of interview, some men remained with their partner whilst others were separated physically or emotionally and their recollection of their fathering experience is likely to have oriented to narrative consistency (Smorti, 2011). Our sample has limited diversity and the study may have only recruited men who had redemptive stories, perhaps missing those fathers who had become entirely disengaged from fathering.

The findings of the present study raise a number of issues for families experiencing postnatal depression. In line with the findings outlined here, Roberts et al. (2006) stressed that health care professionals must begin to consider the mental health of fathers. They suggested that routine assessments of men's postnatal health would encourage the detection of problems that might otherwise go unnoticed due to the overwhelming focus on mothers and children, and the reluctance of men to seek assistance for psychological difficulties. Asmussen and Weizel (2010) suggest that family-based services, rather than father-based services, are more likely to effectively engage fathers and improve fathering behaviours. While some fathers may prefer 'fathers' only' groups, evidence suggests that they are just as likely, if not more likely, to attend parenting groups that include fathers and mothers (Asmussen & Weizel, 2010). In addition, research suggests that fathering interventions are more likely to be effective if they contain an element that promotes good communication with the mother within the co-parenting system. It has been argued that supporting men would be cost effective and would, in turn, be beneficial for women and children, as well as the men themselves (Boath et al., 1998).

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Table 1: Participant and referent partners' details

Variable	Category	Participants ( <i>n</i> )	Referent partners ( <i>n</i> )
Age	20-24	0	3
	25-29	4	6
	30-34	4	3
	35-39	3	0
	40-44	2	1
	45 and over	1	1
Occupation	Banking and Finance	1	0
	Catering and Hospitality	1	1
	Education	2	2
	Engineering/Manufacturing	3	0
	Healthcare	1	1
	Househusband/Housewife	1	4
	IT	2	0
	Personal Services	1	2
	Recruitment	0	1
	Retail	0	1
	Social Services	0	1
	Self-employed	2	1
	Ethnicity	White-British	11
White-Irish		1	0
Black-Caribbean		2	1
Black-Caribbean and White-British		0	1
Marital Status	Cohabiting	8	
	Married	5	
	Separated	1	
Relationship Duration	2 -3 years	3	
	4 -5 years	2	
	6 -7 years	2	
	8 - 9 years	3	
	11 -12 years	3	
	16 years	1	

Table 2: Details of mother's postnatal depression as perceived by father participants

Features of postnatal depression	Details	Number of participants
Births followed by postnatal depression	All births	4
	Youngest child only	6
	Eldest child only	2
	Eldest and youngest child	1
	Only child	1
Medical intervention	No medical intervention sought	3
	Consulted GP	10 <sup>a</sup>

	Undisclosed	1
Status of depression at time of interview	Ongoing	7
	Recovered	7

<sup>a</sup> Of these, nine were prescribed anti-depressant medication, two were also referred to a mother and baby unit and the outcome of one is unknown.