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Getting Help as Depressed Dad: A Lived Experience Narrative of Paternal Postnatal  
Depression, with Considerations for Healthcare Practice

Caroline Davenport<sup>1</sup> & Viren Swami<sup>1-2</sup>

<sup>1</sup>School of Psychology and Sport Science, Anglia Ruskin University, Cambridge, United  
Kingdom

<sup>2</sup>Centre for Psychological Medicine, Perdana University, Kuala Lumpur, Malaysia

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Address correspondence to: Caroline Davenport, School of Psychology and Sport Science,  
Anglia Ruskin University, Cambridge, Cambridgeshire CB1 1PT, United Kingdom. Email:  
[cje135@pgr.aru.ac.uk](mailto:cje135@pgr.aru.ac.uk).

## **Accessible Summary**

### **What is known about the subject?**

- A significant proportion of fathers report experiencing depression after their baby is born
- Fathers are not offered regular support for their psychological well-being in the transition to parenthood despite an acknowledged need for such support

### **What does the paper add to existing knowledge?**

- Lived experience provides new insight into how one father experienced postnatal depression, including the role of his partner in help-seeking
- It explains the delayed presentation in help-seeking as resulting from healthcare practitioner language and attitudes, and gendered expectations around mental health and help-seeking in the context of fatherhood

### **What are the implications for mental health nursing?**

- Mental health nurses should be aware that postnatal depression can affect fathers as well as mothers, and that it is necessary to support fathers in safe spaces and with appropriate language
- Planning care for depression in men should consider the recent birth of a child in order to provide effective care
- Clearer guidance is needed for supporting new fathers with postnatal depression

## **Abstract**

Lived experience is increasingly viewed as an important means of informing mental health practice. In this case, the lived experience narrative comes from a father who experienced postnatal depression (PND). Yet, whilst men are increasingly sharing their experiences of PND in the public sphere, there have been limited advances in their quality of care and support during the perinatal period. Services for perinatal mental health problems are targeted towards mothers, with fathers not traditionally being seen as experiencing perinatal mental health problems. Despite a recent growth of paternal mental health scholarship, this has not translated into universal practice, although NHS England (2018) have stipulated that, in England, partners (fathers) should be supported if the mother of their child is mentally unwell. This disparity is arguably due to numerous factors, which are discussed here.

**Keywords:** Postnatal depression; Fathers; Help-seeking; Narratives; Patient experience

## **1. Introduction**

My son has just turned four. As I write this, I can hear him – somewhere in our home – roaring like a dinosaur. He knows all their names, even the obscure ones, the ones that hardly anyone but palaeontologists know about, like *Gallimimus* and *Psittacosaurus*. I hear him roar and then laugh, and I love him immensely. But it hasn't always been thus: after my son's birth, I struggled with my mental health and, much later, was diagnosed with (paternal) postnatal depression. Saying that I "struggled with my mental health" feels a little like an under-sell: there were points in those first couple of years after my son was born when I didn't expect I'd be alive to see him turn four. Right now, I don't feel much like writing about that bleak period and, in any case, I've written about it elsewhere (Swami, 2019).

That I'm still here and able to tell you that my son is now four shouldn't be read as some inherent strength of character on my part. I didn't overcome postnatal depression on my own. And, in reflecting on my experiences, I feel that just as important as my experiences of struggling with postnatal depression is how I eventually received the help I desperately needed. The narrative of my seeking and receiving help is complex and, importantly, includes multiple points in which I came into contact with healthcare professionals. In writing about those points of contact, I hope that my narrative will be useful to mental health nurses, as well as other healthcare professionals who come in contact with fathers. I want, by explaining my experiences of contact with healthcare professionals, to help you understand how fathers experiencing psychological distress are sometimes let down by services, but also how those very same services can save a father's life – as they did for me.

### **1.1. Not Seeking Help**

My narrative of seeking help after the birth of my son actually begins with a reluctance to seek help, or really an active rejection of help. Even in my darkest moments, I didn't believe that I required professional help. I believed that everything I was experiencing

– the suicidal thoughts, the frequent bouts of anxiety and debilitating sadness, the anger at myself and others – were “normal” aspects of new fatherhood. Surely all new fathers experience something similar, I thought; the point was to get through as best I could until better days arrived. Waiting for those better days, however fleeting they were, became a sort of crutch. More than that, the fact that I was still alive – by which I mean that I hadn’t taken my life – became, in and of itself, evidence that everything was alright. If I was able to persevere in the face of what I would later, in therapy, describe as a blinding darkness, then what need did I have for professional help?

It also didn’t help that, back then, I was almost entirely ignorant of postnatal depression. It was, I believed, a condition that only affected mothers – a belief that my colleagues and I have since found to be relatively widespread (Swami, Barron et al., 2020; Swami, Vintila et al., 2020). Understand my privilege: a psychologist with access to contemporary research; and yet, I was wilfully ignorant of the simple fact that fathers often do experience psychological distress after the birth of a child. That ignorance only strengthened my belief that everything I was experiencing was a “normal” part of fatherhood. It helped me to rationalise my experiences as typical, requiring not professional help but rather simply the passage of time: things would get better on their own and all I needed to do in the face of that blinding darkness was to persevere.

And yet, there was a part of me too that understood what I was experiencing was *not* “normal”, that it was detrimentally affecting my relationships with my son and partner, and that carrying on as normal was not truly a healthy option. Still, I refused opportunities to ask for help. To ask for help became for me an unparalleled admission of weakness: if I needed help with my mental health, what did that say about my ability to parent? In my mind, it said I was unable to do what I needed to do, unfit to be a father, and incapable as a parent. And so, I instead sought ways to both conceal the depths of my struggles from others and to manage

on my own, increasingly adrift and cut off from my own family. As my depression became more severe and increasingly debilitating, I became increasingly intransigent in my desire to not ask for help.

## **1.2. Missed Opportunities**

I did ask for help, once. It was during a routine visit with a health visitor. My partner, our son, and I sat in a roomful of other parents and their children, waiting for our turn to be seen. When it was finally our turn, our son was weighed and checked over, before the health visitor sat down with us to talk about how things were going. I remember feeling like an outsider in that conversation; really, it was a conversation between the health visitor and the mother of my child, and I was only there to laugh at the health visitor's jokes – a role I played admirably. And then the health visitor asked my partner how she was doing, if she was okay. I waited for my partner to answer, then – almost instinctively – I quietly said something like, “I'm not doing so well”. The health visitor asked me not to joke around, I was the dad after all and dads are the rock of the family. “You need to get on with being a dad”.

I've often reflected on that interaction. Feeble though it may have been and difficult as it was given the very public setting, it was a genuine attempt at asking for help. But the manner of our health visitor's response told me two important things. First, that dads don't get sad. I understood this both literally (fathers do not experience postnatal depression) and as an instruction (to be a good father, I must not struggle with my mental health). And second, that whatever I was experiencing, however bad my struggles, it was unimportant in the context of the well-being of my partner and son. I was made to feel separate to my own family or, if not quite separate, then certainly the least important component of it. What seemed to matter to the health visitor was that my son and partner were healthy; my own well-being, on the other hand, was not up for discussion.

At that moment, I felt utterly invisible and completely alone, and it strengthened my resolve to never ask for help. Because, to ask for help only to be told – implicitly, I suppose – that I didn't require help because I was a father, is shaming. There were many other points at which I interacted with health visitors and, on occasion, mental health nurses, but I never again brought up my own mental health. I allowed those conversations to become solely focused on my partner and, more than that, began to feel guilty that I'd ever asked for help in the first place. All of which only hastened ruptures that had been forming within my family unit: I was a separate part of that unit, required to function as a father but unable, but at the same time undeserving of care as a constituent part of that unit.

Sometime later, we were in our midwife's office for some reason I can't now remember – this time, no other parents around who might eaves-drop on our conversation. I remember the midwife being inquisitive: my partner was asked how she was doing and, then, I was asked the same question. I hadn't been expecting to be asked and found I couldn't give her an honest answer. I wanted to, I wanted someone to hear me, but not there. I think it would have shamed me to have had to admit I needed help in front of my partner and son. Maybe had I been asked the question individually, perhaps. But I also didn't have the words to articulate what I was experiencing: if it wasn't postnatal depression, then what was I really wanting to be helped with? Tiredness? Sleeplessness? And so, I brushed off her question: "I'm doing great!"

### **1.3. My Partner Saves My Life**

Of course, I wasn't doing great. No one knew that more than my partner. Early on, she'd tried suggesting politely that what I was experiencing was not a "normal" way of being, but I didn't want to hear it: "There's nothing wrong with me!". We were at a café one afternoon when she showed me a magazine she was reading. In it were some questions that she asked me to answer; I'd later learn that the questions were all taken from the Edinburgh

Postnatal Depression Scale (Cox et al., 1987). I scored high enough to be classified as probably depressed, but found ways to dismiss the evidence: it was only a magazine article, after all. Later, my partner's polite suggestions became more assertive demands that I seek professional help. But still I resisted: "I'm managing just fine!"

Why keep resisting when the offer of help came from someone I trusted? Lots of reasons, I suppose: my irrational thoughts convinced me that things would get better on their own, my fears scared me into believing I would lose my family if I were truly depressed, my shame told me that to ask for help would mean I'd failed as a parent, but most of all my depression spoke to me and said I was deserving of help. These were cycles of thinking that were constant and acted as a barrier to help-seeking. Even as all my fears came closer to reality, as my relationship with my partner broke down and whatever bonds I'd managed to create with my son began to wither away, I still steadfastly refused to seek help. Whatever it was I was experiencing, I would go through it alone and prove to everyone that I was capable. Except, I wasn't able to get better on my own.

Still, she persisted. But the walls that I'd built up around myself – partly as an act of self-preservation – were solid. The first time, I think, that she managed to break through was when she wrote me a letter, in which she told me how much I was missing out on having a healthy and meaningful relationship with my son because I was refusing help. I still have that letter and still read it from time to time. It helps keep me grounded when I feel myself slipping away. I slowly began to realise that, without help, things would never get better. That's the thing about depression: I'd convinced myself that it would all get better with time, but of course, everything was only getting worse. I was slipping ever closer toward suicide and yet I still naïvely believed that better days were approaching.

At one point, my partner – disappointed, fed up, unwilling to carry on any longer, and many other things besides – made me an appointment to see my GP, walked me there, sat



with me in the waiting room, and made sure I went in to actually talk to my GP. When I came out of the GP's office, my partner checked to see that I'd articulated what I'd been experiencing accurately and fully. It was an act that saved my life. Had she not done all of those things that day, and all the days that led up to it, I do not believe I would be here to write this. I would have no doubt succumbed to the spiral of depression that was pulling me ever close toward suicide. To put it differently, my partner did for me what I was unable or unwilling to do for myself, and in so doing she pulled me back from the abyss into which I'd fallen.

#### **1.4. A Conversation with My GP**

Sitting with my GP, I'm not sure I wanted to admit anything at first. But there was no way out: I was obviously there for a reason. And so, I told her what I'd been experiencing. Not in every detail – I only had ten minutes to explain, and I'd already used up several minutes wondering how to explain myself – but certainly the main points. It felt comforting to be able to speak with someone who listened and didn't attempt to dismiss what I was saying. When I'd finished, she said, "It sounds like you might be depressed". I remember feeling relieved: here was a health professional, someone who knew what they were talking about, giving me a label for what I'd been experiencing. That label was, in a funny way, life-altering for me. It gave me something to hang on to, it helped me to explain to myself that what I'd been experiencing was out-of-the-ordinary, and most of all it told me that there was a possibility of change for the better.

My GP explained to me the different care pathways available to me and suggested a combination of psychotherapy and medication. I really don't want to present this narrative as being one of instant realisation and a clear path to beating my depression. It wasn't remotely like that. I hesitated over being medicated, which set me back. I still believed that self-help would be more effective, which meant I didn't fully engage with healthcare practitioners.

One time, I had to see a different GP, who didn't seem to understand that fathers could experience postnatal depression, and I came away doubting everything I had been led to believe. And when, finally, I was referred to a family-centred psychotherapist, I initially didn't believe I needed that sort of help. I suppose asking for, and getting help, was only the first step. Actually receiving help, and persisting with that care over time, was just as difficult.

Even as I was in therapy, there were days when I didn't feel deserving of help, of my family, and any kind of support. There were setbacks and reluctance, dismissal and anger, missed appointments and reversals. But, in therapy, I also began to see where I was and where I wanted to be, who I wanted to become. In therapy, I found a safe space in which to say all the things I'd struggled to articulate previously. And, in therapy, I began to bond with my son. I learned to see past the blinding darkness, to put things in perspective, and to understand that my depression did not have to forever affect how I viewed myself as a parent. As my sessions came to end, I found myself wanting further help, like a scaffold, and my therapist suggested a parenting class for toddlers that they ran at their children's centre.

Parenting classes gave me the practical skills I needed to be able to more fully bond with my son – a complement to the psychological help I'd benefitted from in therapy. I was the only father in a group of about dozen parents, but that didn't matter. By that point, I'd begun to come to terms with my postnatal depression. During our first session, when we were introducing ourselves, I found myself openly saying that I was there because I was depressed and wanted help to be able to form a closer relationship with my son. I felt as though I had to make up for lost time, and the practical skills and knowledge to deal with a toddler helped me do just that. I learned a lot about myself in therapy, but in those parenting class I also learned how to be a better parent.

## **1.5. My Son**

I know I'm repeating myself, but my son has just turned four and I love him dearly. I'm glad I'm still alive to see him turn four and I'm glad I'm able to tell you about him. But I wouldn't be here were it not for my partner and her not giving up on me. I wouldn't be here were it not for the empathy of my GP, the compassion of my therapist, and the kindness of everyone in those parenting classes. My trajectory of seeking and receiving help hasn't always been easy, hasn't always been linear, and I am still discovering the joys of being a parent even today. And now, if you'll excuse me, I'd like to go give my son a hug.

## **2. Implications for Mental Health Practice**

### **2.1. Viewing fathers as equal family members is important for their mental health care**

Within the family context, fathers are important. The responsibilities of new fatherhood, including financial, can negatively affect fathers' emotional health (Baldwin et al., 2019). However, fathers underplay their struggles in comparison with the mothers (Darwin et al., 2017). They also worry what their family may think if they are identified as suffering a mental health difficulty (Baldwin et al., 2019). These feelings limit fathers' ability to share their emotions. As such, in nursing interactions, it would be of benefit to validate fathers as equal parents. This is because it is acknowledged that postnatal depression is prevalent in fathers (Cameron et al., 2016), and educating families that the evidence demonstrates fathers can suffer from the condition, may reduce these fears.

Another worry is identified by Edhborg et al. (2019), who found depressed new fathers experienced detrimental changes in their relationships. There is an established link between maternal PND and paternal PND (Goodman, 2008), so emphasising the importance of paternal mental health is especially important if a mother is struggling, because fathers are at increased risk. Furthermore, internalising symptoms in fathers are also associated with

negative infant affectivity (Spry et al., 2020) and paternal PND is linked to later problems in children, including conduct disorders (Ramchandani et al., 2008). As such, paternal PND has the potential to negatively impact the whole family, and supports a family centred approach to mental health care in the perinatal period. This should ideally include the option of family-centred therapy/intervention, as well as individual mental health support for dads.

## **2.2. Consideration of gender roles in parenthood would be beneficial**

Transition to fatherhood is a period where men's roles change. As a result, they experience unique barriers to initiating help-seeking and receiving support. Pedersen et al. (2021) found that fathers believe PND is a condition which affects mothers, so they may not identify with the illness despite feeling unwell. Their mental health literacy is lower than that of women's health literacy for the condition (Swami et al., 2020), meaning self-identification is limited. This means nurses and other healthcare practitioners need to be aware of paternal PND. In the case that men do identify their illness however, there are further gendered barriers.

Courtenay (2011) observes that health professionals are less likely to successfully identify depression in men. Currently, men in the UK are not routinely screened for postnatal depression, whereas this is recommended for women (National Institute for Health and Care Excellence, 2014). Such disparity may result in under-identification of paternal PND. A screening tool for PND has been validated for fathers (Matthey et al., 2001), but a change in local and national policy (and funding to allow the extra time and staffing required for routine assessment of depression in fathers) is necessary for this to be embedded into clinical practice. This is supported by literature which suggests that screening would assist in fathers' identification of the condition (Schuppan et al., 2019). Therefore, despite a current gap in care provision for dads, change is required in improving these care inequalities with regards to father mental health support (Williams, 2020).

### **2.3. Identify men at increased risk**

Although we have suggested that regular screening would be beneficial, in its absence it would be wise to consider the fathers who may be most at risk of depression. In studies into father mental health, participants have pre-existing mental health conditions (Ieradi et al., 2019; Hambidge et al., 2021). Thus, in the case a father has a history of mental health disorder, it would be advisable to offer increased support in his transition to fatherhood, as this is recommended in the mother (NICE, 2014). This may also require consideration of their individual social circumstances.

As in broader healthcare, marginalised groups of men may also be at increased risk, and knowledge around their needs is even more limited. For instance, Baldwin et al. (2019) noted a lack of research around young fathers, and those who are unemployed. Additionally, general depression prevalence in men is over fifty percent more likely if they live in a deprived area (Remes et al., 2019). Gay men are also more susceptible to depression (Lee et al., 2017). These men may be at increased risk when they become fathers. A lack of support and role model may also increase risk of paternal PND (Kim & Swain, 2007). Marginalisation has increased men's psychological distress in one study (O'Donnell & Richardson, 2018), so it is wise to keep in mind this may be true in the postnatal period also.

### **2.4. Language of healthcare practitioners influences help-seeking**

Broadly speaking, it is clear that healthcare professionals should be aware of the possibility of PND in fathers. In Allen et al. (2007, p. 49), it is suggested "through the characterisation of words that meaning and understanding is conveyed" in reference to nurses. Viren's experience demonstrates that both meaning and understanding by the health visitor was lacking. Clearly, supportive, rather than dismissive, language should be used with fathers. But in mental health nursing, "therapeutic interventions" delivered within the nurse-patient relationship is a unique skill (Browne et al., 2012, p. 842), so mental health nurses are

in an ideal position to changing the individual and wider societal perceptions of paternal PND through their skillset and role.

For nurses, Melrose (2010) suggested that delivering screening, and providing information on paternal PND is possible, whilst Hammarlund et al.'s (2015) nurses observed that fathers were depressed. But opportunity and recognition are not enough. Gough et al. (2016) identified men's need to appear genuine when disclosing their depression. Fear of judgement may result in indirect disclosure, such as with Viren's 'joke'. Attention should be paid to this, and consider Darwin et al.'s (2017) findings that fathers minimise their struggles. Language of nursing staff, therefore, should be empathetic and validating whenever and however they communicate their struggle with PND.

## **2.5. Minimising stigma by providing sensitive care**

To destigmatise paternal PND it is important to provide non-judgmental care to fathers with depression, but the condition is considered 'taboo' (Pedersen et al, 2021; p6). Stigma around male mental health can be social or self in origin (Covello, 2020): with paternal PND it is likely both. There is a lack of support for the father's mental health (Mayers et al., 2020), which may reinforce this. Fathers are concerned that health professionals are not adequately trained to provide emotional support (Rowe et al., 2013), so the mental health nursing role may be of unique benefit here, when challenging these stigmas.

Schuppan et al (2019) identified screening as lessening stigma. However, social environment is also important in terms of real-life support: fathers often prefer face-to-face, one-to-one support around PND, and typically prefer to be visited at home (Letourneau et al., 2012). Early intervention is imperative (Parry et al., 2019), so pregnancy is an ideal opportunity to consider emerging paternal mental health problems. Thus challenging both

social and self-stigma (Covello, 2020), from the earliest point possible, is necessary to improve outcomes.

## **2.6. Recognise the role of partners, including in father help-seeking**

Viren cites his partner as responsible for saving his life. His suicidal feelings support Quevedo et al.'s (2011) findings that men affected by postpartum depression are at increased risk of suicide. Postnatally, fathers experience relationship changes (Baldwin et al., 2019), including feeling less intimate than before (Darwin et al., 2017). A key observation is that men's partners were the trigger for their help-seeking (Darwin et al., 2017) with fathers identifying that partners could have motivated them to seek help (Pedersen et al., 2019). This mirrors Norcross et al. (1996) who identify that women have a significant influence on men's health-seeking generally. However, fathers are also prevented from help-seeking if they feel their partners have more problems (Schuppan et al., 2019), so a confidential environment for fathers to seek help away from their partner, is likely needed.

One implication for healthcare would be to use routine contacts with the mother to ask them about their relationship, as a way of enquiring about the father's mental health. Information could be offered in terms of signposting to relative agencies, and providing information in written form (Darwin et al., 2017). It should also be noted that the GP is a favoured choice of professional (Baldwin et al., 2019) in fathers' help-seeking, but that men who visit the GP-as with Viren-have more severe symptoms (Darwin et al., 2017). Changing the delivery of support to include information around paternal PND, and where to access help, would be of benefit to men and their partners.

## **2.7. Offering hope of recovery no matter how dark the days**

Regardless of Viren's experience of depression, he has emphasised the positive place he is in now with his son. The highs and lows of paternal depression are also mirrored in the literature. Quevedo (2011) identifies the increased risk of suicide for fathers with postpartum

depression postnatally, whilst Darwin (2017) recognises that fathers find their parenting experience more fulfilling as the child grows and becomes more interactive. New parenthood is a challenging time for all parents, but particularly so in the case of perinatal mental illness. Increasing understanding and education around paternal PND can only help fathers who are unwell, but most importantly will offer them hope that things will eventually improve.

### **3. Conclusion**

This lived experience narrative around paternal PND demonstrates that nurses' attitudes are important, since men perceive poor support during the postnatal period. Relating back to Viren's experiences, challenging stigma around the condition, specifically through use of non-judgemental and compassionate language, is necessary. It is also important to consider the challenges fathers encounter when seeking help, and consider that in the instance of help-seeking, it may be the case that their suffering is severe. To help fathers, demonstrating an interest in their mental health across healthcare settings can challenge both poor experiences of care, and perceptions of PND as affecting the mother, subsequently encouraging help-seeking for paternal PND. That being said, fathers are not a homogenous group and marginalised fathers are likely to suffer increased barriers to identification and support for the condition. A consistent family-centred approach to this condition can only improve the experiences of new fathers, and in doing so, help their partners and children. However, in the longer term, and to benefit family health, clinical guidance and further research is needed.



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