How involved are men in 'involved fathering'?

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Over the past few decades fatherhood and fathering has received an increasing amount of attention from academics, practitioners, stakeholders, and in all forms of media and the public. Fathering types range from house-husbands, primary parent, social father to men who have limited or no contact with their children. In many societies the views of men's parenting roles has moved on from the traditional 'provider/disciplinarian' to an ideal of 'involved fatherhood'. In these societies, men are encouraged and expected to be both intimate and involved parents. The importance of paternal relationships on a child's mental, physical and emotional wellbeing has been thoroughly established.

Although there is a rise in the number of 'stay-at-home-dads' in the UK it is difficult to give an accurate figure on how many there are (Adams, 2015). However, there is growing recognition that the reality of 'involved fathering' is quite different from the ideal. Factors preventing father's accomplishing their desired level of involvement include '…societal attitudes, issues relating to the development of their baby, economic barriers, a lack of support from healthcare practitioners and government policies…' (Machin, 2015, p. 36). For example, the fathers' in Machin study reported receiving support only during their child's birth, suggesting a lack of support from NHS staff before and after the birth (Machin, 2015, p. 48).

Many men feel the government's current policies only 'paid lip service' to the involvement of fathers (Machin, 2015, p. 54). Similarly, a review found that men felt excluded and isolated from the processes of pregnancy and childbirth and the business of infant feeding, as demonstrated by the

paucity of health promotion material aimed at men, and the side-lining of men in antenatal classes (Earle and Hadley, 2018). It is interesting how the majority of those factors are socio-structural, and highlight the embeddedness of traditional masculine stereotypes within establishments such as the government and the NHS. For example, although paternal depression has a comparable effect as maternal depression – a decrease in positive and an increase in negative behaviours (Wilson and Durbin, 2010) – there is comparatively little support.

Men who challenge prescriptive stereotypes, for example, gay men, house-husbands, and male primary school teachers, are often subject to discrimination, exclusion, isolation, mistrust, and stigmatisation by men and women (Letherby, 2012; Hadley, 2017). The practice of 'hegemonic masculinities' has been much discussed in sociological and health research. Research has shown male patients that do not conform to masculine stereotypes can be viewed negatively by health professionals (Seymour-Smith et al., 2002; Robertson, 2007; Hadley, 2021). Healthcare practitioners have been recorded 'othering' male patients who do not conform to gender norms of invincibility and bravery (Watson, 2000; Gough and Robertson, 2010; Hugill, 2012; Hadley, 2021).

Men are typically seen to have an ambivalent attitude to health and to accessing health services (Williams, 2007; Robertson, 2007; Williams, 2010). Men's health behaviours have been strongly linked with the hegemonic masculine ideal of stoicism and risk taking. The stereotypical constructions surrounding men and masculinity entail men being independent, virile, assertive, strong, emotionally restricted and robust. Although the ideal of 'involved fathering' is promoted, it is undermined by ambivalent structural support and societal practices. This highlights the relationship between individual agency and the institutionalisation of ideal gender norms. The impact of stereotypical gender norms delivered through healthcare raises the question 'How much of the

reason for men not accessing healthcare is due to the healthcare providers?' Is it the case that it is healthcare that does not access men rather than men who do not access healthcare (Hadley, 2021)?