Exploring the experiences of first time fatherhood and paternal postnatal depression:
A grounded theory analysis revealing the importance of the concept of 'coping'

KARINA BRIA
RN, RM, BN, Master of Midwifery

June 2013

Discipline of General Practice
School of Population Health & Clinical Practice
School of Psychology
Discipline of Gender, Work and Social Inquiry
The University of Adelaide

Thesis submitted in fulfilment of the requirements for the Degree of Doctor of Philosophy
NOTE: Pagination of the digital copy does not correspond with the pagination of the print copy
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIST OF TABLES</td>
<td>VII</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>VIII</td>
</tr>
<tr>
<td>LIST OF APPENDICES</td>
<td>IX</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>XII</td>
</tr>
<tr>
<td>PUBLICATIONS</td>
<td>XIII</td>
</tr>
<tr>
<td>DECLARATION</td>
<td>XIV</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>XV</td>
</tr>
<tr>
<td>CHAPTER 1 – FIRST TIME FATHERS AND PATERNAL POSTNATAL DEPRESSION</td>
<td>1</td>
</tr>
<tr>
<td>1.0 Introduction</td>
<td>1</td>
</tr>
<tr>
<td>1.1 Contemporary experiences of fatherhood</td>
<td>4</td>
</tr>
<tr>
<td>1.2 Depression</td>
<td>6</td>
</tr>
<tr>
<td>1.3 Masculinity, male depression and fatherhood</td>
<td>6</td>
</tr>
<tr>
<td>1.3.1 Men, depression and suicide</td>
<td>6</td>
</tr>
<tr>
<td>1.4 Postnatal depression</td>
<td>6</td>
</tr>
<tr>
<td>1.5 Scientific research and paternal depression</td>
<td>20</td>
</tr>
<tr>
<td>1.5.1 Predictors of paternal depression</td>
<td>21</td>
</tr>
<tr>
<td>1.5.2 Research methods to investigate paternal depression</td>
<td>22</td>
</tr>
<tr>
<td>1.5.3 Duration of paternal depression</td>
<td>23</td>
</tr>
<tr>
<td>1.5.4 Assessment of paternal depression</td>
<td>24</td>
</tr>
<tr>
<td>1.5.5 The need for a gender-specific questionnaire</td>
<td>25</td>
</tr>
<tr>
<td>1.6 What is unique to this research?</td>
<td>25</td>
</tr>
<tr>
<td>1.7 Theoretical framework for this research</td>
<td>26</td>
</tr>
<tr>
<td>1.8 Purpose and significance of this research</td>
<td>27</td>
</tr>
<tr>
<td>1.9 Initial research proposal</td>
<td>28</td>
</tr>
<tr>
<td>1.9.1 Final research proposal</td>
<td>29</td>
</tr>
<tr>
<td>1.10 Assumptions</td>
<td>30</td>
</tr>
<tr>
<td>1.11 Outline of this thesis</td>
<td>30</td>
</tr>
<tr>
<td>CHAPTER 2 – LITERATURE REVIEW</td>
<td>33</td>
</tr>
</tbody>
</table>
2.0 Introduction.......................................................................................................................... 33
2.1 A search of the research literature ..................................................................................... 34
2.2 Paternal postnatal depression ............................................................................................... 40
2.3 Prevalence of postnatal depression in fathers ........................................................................ 42
2.4 Predictors for paternal depression ......................................................................................... 45
2.5 Paternal mental health and its affect on the father-infant relationship ............................... 50
2.6 Assessment tools for perinatal depression .......................................................................... 52
2.6.1 Edinburgh Postnatal Depression Scale .......................................................................... 54
2.7 Gaps in the research on paternal depression ........................................................................ 55
2.8 Identifiable patterns in the research literature ..................................................................... 57
2.8.1 Other findings identified in the research literature ......................................................... 57
2.8.2 Convergence and agreement in the research literature ................................................... 58
2.9 Summary .............................................................................................................................. 59

CHAPTER 3 – THEORETICAL FRAMEWORK.............................................................................. 60
3.0 Introduction ........................................................................................................................ 60
3.1 Research question ................................................................................................................. 60
3.2 Research design .................................................................................................................. 62
3.3 Using two methods of inquiry ............................................................................................. 63
3.4 The discovery of grounded theory ....................................................................................... 65
3.5 Constructivist grounded theory ........................................................................................... 66
3.6 Using grounded theory methodology .................................................................................. 67
3.7 Data collection ....................................................................................................................... 68
3.7.1 In-depth interviewing ....................................................................................................... 68
3.7.2 Stages of the interview process .................................................................................... 69
3.7.3 Role of the interviewer ................................................................................................... 71
3.7.4 Probes and prompts ......................................................................................................... 73
3.8 Coding the data .................................................................................................................... 74
3.8.1 Memo writing and diagrams ......................................................................................... 75
3.8.2 Constant comparative analysis ...................................................................................... 76
3.8.3 Theoretical sampling ...................................................................................................... 76
3.9 Rigour in qualitative research ............................................................................................. 77
3.9.1 Discussion of emergent findings with advisory group
3.9.2 Peer debriefing
3.9.3 Presentations
3.9.4 Prolonged engagement
3.9.5 Recording the data objectively and comprehensively
3.10 Summary ........................................................................................................... 80

CHAPTER 4 - METHODS ......................................................................................... 81
4.0 Introduction ......................................................................................................... 81
4.1 Ethical considerations ......................................................................................... 88
4.2 Recruitment ......................................................................................................... 82
  4.2.1 Response to media exposure ......................................................................... 85
  4.2.2 Information for potential participants ............................................................ 85
  4.2.3 A need to broaden inclusion criteria ............................................................... 86
4.3 Selection of participants ..................................................................................... 87
4.4 The sample
4.5 Self-selected sampling
4.6 Commencement of interviews ............................................................................ 91
  4.6.1 Socio-demographic participant information ................................................. 92
4.7 Qualitative data collection .................................................................................. 95
4.8 Transcribing the data ......................................................................................... 97
4.9 Limitations to the qualitative method
4.10 Summary ........................................................................................................... 99

CHAPTER 5 – STAGE ONE - QUALITATIVE DATA ANALYSIS ..................... 100
5.0 Introduction ......................................................................................................... 100
5.1 Transcribing interviews ...................................................................................... 100
5.2 Coding the data using grounded theory analysis .............................................. 101
5.3 Theoretical sampling and saturation .................................................................. 101
5.4 Open coding ....................................................................................................... 102
5.5 Using a data management tool ........................................................................... 103
5.6 Developing themes and categories .................................................................... 104
5.7 Axial coding ....................................................................................................... 105
5.8 Selective coding .................................................................................................. 107
5.9 Major categories and sub-categories .................................................................. 107
5.10 Core category: **Coping** ................................................................................ 128
  5.10.1 The concept of coping ................................................................................ 130
  5.10.2 Coping strategies ......................................................................................... 131
  5.10.3 Coping with emotional distress and paternal depression ......................... 132
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.15 Further reduction of items</td>
<td>164</td>
</tr>
<tr>
<td>6.16 Summary</td>
<td>165</td>
</tr>
<tr>
<td>PHASE FOUR – CONSTRUCT OF A DRAFT QUESTIONNAIRE</td>
<td>167</td>
</tr>
<tr>
<td>6.17 Introduction</td>
<td>167</td>
</tr>
<tr>
<td>6.18 Questionnaire design</td>
<td>167</td>
</tr>
<tr>
<td>6.19 Face validity</td>
<td>168</td>
</tr>
<tr>
<td>6.20 Construct of the first draft questionnaire</td>
<td>169</td>
</tr>
<tr>
<td>6.20.1 Second draft questionnaire</td>
<td>171</td>
</tr>
<tr>
<td>6.20.2 Third draft questionnaire</td>
<td>174</td>
</tr>
<tr>
<td>6.21 Pilot the draft questionnaire</td>
<td>176</td>
</tr>
<tr>
<td>6.22 Results</td>
<td>177</td>
</tr>
<tr>
<td>6.23 Strengths and Limitations</td>
<td>179</td>
</tr>
<tr>
<td>6.24 Summary</td>
<td>179</td>
</tr>
<tr>
<td>CHAPTER 7– DISCUSSION</td>
<td>181</td>
</tr>
<tr>
<td>7.0 Introduction</td>
<td>181</td>
</tr>
<tr>
<td>7.1 Predictors of paternal depression</td>
<td>184</td>
</tr>
<tr>
<td>7.1.1 Changes to lifestyle</td>
<td></td>
</tr>
<tr>
<td>7.1.2 Change to the couple’s relationship</td>
<td></td>
</tr>
<tr>
<td>7.1.3 Responsibility of fatherhood</td>
<td></td>
</tr>
<tr>
<td>7.1.4 Unexpected feeding and health problems in the baby</td>
<td></td>
</tr>
<tr>
<td>7.1.5 Limited social support</td>
<td></td>
</tr>
<tr>
<td>7.2 Stage Two: Development of the Coping with New Fatherhood Questionnaire</td>
<td>194</td>
</tr>
<tr>
<td>7.3 Rigour and limitations of this research</td>
<td>195</td>
</tr>
<tr>
<td>7.4 Strengths of this research</td>
<td>197</td>
</tr>
<tr>
<td>7.5 Contributions of this research</td>
<td>198</td>
</tr>
<tr>
<td>7.6 Promotion and prevention in policy and practice</td>
<td>199</td>
</tr>
<tr>
<td>7.7 Directions for future research</td>
<td>201</td>
</tr>
<tr>
<td>7.8 Conclusion</td>
<td>202</td>
</tr>
<tr>
<td>APPENDICES</td>
<td>204</td>
</tr>
<tr>
<td>LIST OF ABBREVIATIONS</td>
<td>255</td>
</tr>
</tbody>
</table>
LIST OF TABLES

2.1 Studies included in the review of research literature in order of first author and in chronological order

4.6.1 Socio-demographic Participant Information

4.6.1 State, Metropolitan and Rural Demographic Information

4.6.1 Participants’ Experiences with Depression and Anxiety

6.14 Frequency Table

6.15 Themes and Items Table
LIST OF FIGURES

3.8 Coding Sequence for Data Analysis
5.4 Merged Codes with Similar Meaning
5.4 Codes to Create Preliminary Categories
5.7 Codes, Sub-categories and Preliminary Categories
5.10 Core Category
6.2 Flow Chart of Phases 1-4
6.12 Diagram of Example Q-sort
LIST OF APPENDICES

Appendix 1  Introduction Letter – Stage 1
Appendix 2  Information sheet for participants – Stage 1
Appendix 3  Consent form – Stage 1
Appendix 4  Socio-demographic questionnaire – Stage 1
Appendix 5  Socio-demographic data of interviewees – Stage 1
Appendix 6a Interview Guide 1
Appendix 6b Interview Guide 2
Appendix 6c Interview Guide 3
Appendix 7  Introduction letter for participants – Quantitative study – Stage 2
Appendix 8  Consent form – Stage 2
Appendix 9  Instruction sheet - Phase 2
Appendix 10 Survey of items – Phase 2
Appendix 11 Frequency table – Survey responses – Phase 2
Appendix 12a Histogram – Fairly Irrelevant
Appendix 12b Histogram – Entirely Irrelevant
Appendix 12c Histogram – Merged Fairly & Entirely Irrelevant
Appendix 13 Instruction sheet - Phase 3
Appendix 14 List of items – Q-sort exercise – Phase 3
Appendix 15 Table of items for Q-sort – Phase 3
Appendix 16 Frequency table for Q-sort results – Phase 3
Appendix 17 Information sheet – Pilot study – Phase 4
Appendix 18 Draft Coping with New Fatherhood Questionnaire (CNFQ)
Appendix 19 Feedback sheet – Phase 4
Appendix A  Advertisement – Stage 1 recruitment
Appendix B  Media release - *The Adelaigean* 2007
Appendix C  ABC News 2007 ‘Australian research to explore postnatal depression in dads’.
Appendix E  The Courier Mail 2007 ‘Dads miss out on postnatal support’.
Appendix F  Australian Associated Press General News 2007 ‘SA: Depression research on first time fathers’.
Appendix F  The Advertiser 2007 ‘Fathers get the ‘baby blues’.
Appendix G  Herald Sun 2007 ‘New dads get blues’.
Appendix H  ABC News 2007 ‘Australian research to explore postnatal depression in dads’.
Appendix I  Sun Herald 2008 ‘Daddy blues’.
ABSTRACT

This longitudinal exploratory research was conducted to explore the experiences of first time fathers who self-identified through in-depth interviews as having experienced depression and/or anxiety or depressed mood in the first six months after the birth of their baby as well as their experiences with first time fatherhood more generally.

The research was conducted in two distinct but interconnected stages with the results of the first method (qualitative) used to inform the second method (quantitative). Stage one involves a qualitative approach to explore in-depth the experiences of first time fathers as well as the phenomenon of paternal postnatal depression. The tenets of grounded theory analysis were used to analyse the data and identified the emergent theory of ‘coping’ comprised of all the emergent categories that provided an insight into the experiences of first time fathers in a specific context that provided a better understanding of the phenomenon from the participants’ perspective.

Stage two involves a quantitative approach in the collection of the data and was conducted in four phases. Each phase contributed to the development of the Coping with New Fatherhood Questionnaire (CNFQ), a gender-specific self-report questionnaire for application in future population-based research. In the fourth phase a small sub-set of participants from the qualitative research in stage one reviewed the questionnaire to provide feedback on the format, wording and purpose of the draft questionnaire to determine face validity. The author plans to continue as part of a post-doctoral research focus to further refine and pilot the CNFQ with a large population sample and assess the psychometric properties of the instrument.
PUBLICATIONS


ABSTRACTS


Bria K (Invited), Turnbull D, Ripper M, Barton C, Moulding N. Paternal Postnatal Depression in First Time Fathers. Preventing the Bough from Breaking: New Approaches To Postnatal Depression, Bonding And Attachment Conference, April 2008, Byron Bay, NSW.

Bria K, Turnbull D, Barton C. Paternal Postnatal Depression. 13th Annual Congress of the Perinatal Society of Australia & New Zealand (PSANZ) Conference April 2009, Darwin, NT.


DECLARATION

I certify that this work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. In addition, I certify that no part of this work will, in the future, be used in a submission for any other degree or diploma in any university or other tertiary institution without the prior approval of the University of Adelaide and where applicable, any partner institution responsible for the joint – award of this degree.

I give consent for this copy of my thesis, when deposited in the University Library, being made available for loan and photocopying, subject to the provisions of the Copyright Act 1968.

The author acknowledges that copyright of published works contained within this thesis resides with the copyright holder(s) of those works.

I also give permission for the digital version of my thesis to be made available on the web, via the University’s digital research repository, the Library catalogue, and also through web search engines, unless permission has been granted by the University to restrict access for a period of time.

Signed………………………………………………………………………..Date………………..
ACKNOWLEDGEMENTS

I sincerely thank the fathers who volunteered to generously share their experiences and committed their valuable time and interest to this research.

I would like to acknowledge my principle supervisor Professor Deborah Turnbull and co-supervisors Associate Professor Margie Ripper, Dr. Christopher Barton, Dr. Nicole Moulding and Professor Rhonda Small.

I would like to acknowledge Clear Words Australia Proofreading and Editing Services for professional editing assistance.
CHAPTER 1 – FIRST TIME FATHERS AND PATERNAL POSTNATAL DEPRESSION

1.0 Introduction

This research explored the experiences of first time fathers in the transition to fatherhood and the effect of paternal depression from the participant’s perspective. The decision to conduct this research was based on the author’s interest in family mental health problems encountered in clinical midwifery practice in particular how first time fathers are affected by the changes to their lifestyle after childbirth the contributing factors for fathers developing symptoms of depression after childbirth and how the father’s experiences with depression impacts his emotional wellbeing and his family.

In 2005, the author, as part of a Master of Midwifery conducted a review of research articles that investigated the incidence of postnatal depression in fathers. The outcome of the review, based on data available between 1980 and 2005, indicated that first time fathers in particular were at risk for developing symptoms of depression during the postnatal period due to a number of variables. The research literature included for the review employed mainly quantitative methods of investigation. The author was unable to locate any research that used a qualitative approach that investigated the experiences of fathers with depression during the postnatal period or research that reliably compares depression rates between first time fathers and other fathers.

A number of prevalence studies on paternal depression have been conducted in Australia and internationally in the last two decades. Research indicates that paternal depression develops more gradually over the first year after the baby’s birth
(Goodman, 2004). Fathers with paternal postnatal depression (PPND) may exhibit changes in social behaviour as the first indication of depressed mood (Condon, 2006). Other emotions may include heightened irritation, apathy and lethargy, indecisiveness and avoidance behaviour such as spending extensive time at work away from the family (Bria, Pincombe & Fedoruk, 2005; Kilmartin, 2005). Alcohol and drug use, fighting and partner violence can also reflect depressed mood but may be open to interpretations other than signs of depression (Melrose, 2010).

Researchers have used a range of terms such as depressive caseness, depressed mood, depressive mood disorder, depressive anxiety and paternal postnatal depression. However to date there is no formal definition for paternal depression. The primary variables identified in the literature as contributing to fathers developing postnatal depression included financial concerns, being unprepared for the role as a new father and feeling inadequate with the lack of knowledge and skills to take care of their newborn as well as having limited time to spend with their baby and partner after the birth.

The impact of paternal depression on family and child health has for some time been overlooked and the role of the father has not featured heavily in midwifery research about midwifery care. However the adverse effects of postnatal depression for both mothers and fathers on family relationships and child development have been documented (Garfield & Isacco, 2006: Ramchandani, Stein, Evans & O’Connor, 2005; Beck, 1996). According to Nystrom and Ohrling (2004) a child’s wellbeing and development is influenced by a positive and secure environment provided by able and competent parents. Left untreated, paternal depression limits men’s capacity to care...
for their partners and children (Melrose, 2010). A positive and caring home allows a 
woman to draw support to offer his partner (Melrose, 2010).

Midwives play a vital role in identifying and supporting women experiencing 
emotional difficulties before and after childbirth (Mauthner, 1997) and to provide 
appropriate interventions in helping vulnerable women (Williamson & McCutcheon, 
2004). For fathers however, there is a paucity in the research on the implication of 
paternal postnatal depression (PPND) to maternal and child health and the role of the 
midwife in identifying and providing support for fathers who become depressed 
(Melrose, 2010). Despite an emerging interest in the incidence and prevalence of 
PPND in the last decade, there is a need for evidence-based research that will 
influence midwifery practice in the education and support of fathers with postnatal 
depression.

In this first chapter the author discusses the contemporary experiences of fathers and 
how depression is conceptualized and thought to be caused as well as the major 
diagnostic systems and the intensity and duration of symptoms required to meet 
diagnostic criteria. Postnatal depression and how paternal postnatal depression has 
been identified in the research literature are discussed. The chapter concludes with a 
framework for the research and provides an outline of the significance and purpose of 
the research, the assumptions underlying the research and an outline for each chapter 
of this thesis.
'The birth of his first child marks one of the most profound changes a man may undergo, transforming his standing in the community, his most intimate relationships and his identity' (Fletcher, 2005 p. 461)

1.1 Contemporary experiences of fatherhood

There has been a significant shift in the way that family is organised and conceptualised in the 21st century. A father’s role within the family was, traditionally, the breadwinner and disciplinarian (Henwood & Proctor, 2003; Wall & Arnold, 2007) but as more women began to enter the labour force in the 1980’s (Australian Bureau of Statistics 2006a) there has been a cultural shift in gender roles and changes in social practices in Western societies (Draper, 2000). Parental roles have become less defined as couples contribute equally to the financial, social, emotional and physical wellbeing of their family (May & Strikwerder, 1992). This in turn has contributed to a shift in expectations of a father’s role in caring for his children, sharing domestic labour and acting as primary support to his partner (Henwood & Proctor, 2003; St. John, Cameron & McVeigh, 2004).

The early postnatal period causes great emotional and physical adjustment for parents (Jordan, 2004) and a valuable time to establish parental-infant bonding. It has been argued that fathers play an important role in supporting their partner in the early weeks after childbirth (Barclay, Donovan & Genovese, 1996) particularly as mothers are expected to leave hospital earlier (St. John, 2004) and many couples are distanced from their immediate families that impacts significantly on access to support and
childcare. When new parents are distanced from their family, the partner may be a new mother’s only source of physical and emotional support.

1.2 Depression

Depression encompasses a number of mental health disorders that are characterised by persistent low mood, low self-esteem and a loss of interest in daily life activities (Sadock & Sadock, 2003). Also referred to as depressive disorder or mood disorder depression encompasses a large group of signs and symptoms that may be expressed as a mild and transitory emotional state in response to a difficult life experience (Blatt & Maroudas, 1992) or a more profound chronic emotional disturbance that occurs over a number of weeks, months or years (Sadock & Sadock, 2003).

According to the national depression initiative (Beyondblue, accessed April 2011), depression affects 1:5 people in Australia at some stage in their lives. The World Health Organisation (WHO, accessed October 2013) reports that depression is the leading cause of disability worldwide and is a major contributor to the global burden of disease with more than 350 million people affected. Moreover women experience a higher prevalence of depression compared to men (Harris, 2001; Huang & Warner, 2005). Depression is associated with significant personal, social and economic morbidity, loss of functioning and productivity and adds considerable burden to the health provider industry (National Institute for Clinical Excellence (NICE), 2009).
The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, diagnostic criteria (DSM-IV p.349) classifies depressive disorders or mood disorders into primary subtypes that include major depressive disorder (MDD) minor depressive disorder and bipolar disorder or manic-depressive illness (characterised by episodes of excessive energy and activity as well as irritable mood) including bipolar I disorder (depressive and manic episodes) and bipolar II disorder (major depression and hypomania) and schizophrenia.

Additional mood disorders include dysthymic disorder or chronic depression (situated within the classification of MDD) characterised by unremitting depressed mood and feelings of guilt, inadequacy, anger, irritability, a lack of interest in participating in social activities, poor self-esteem and a sense of helplessness (Sadock & Sadock, 2003). Dysthymic disorder tends to develop in individuals before age 25 and may coexist with other mood disorders in particular major depressive disorder (Sadock & Sadock, 2003). Cyclothymic disorder (also situated within the classification of MDD) is characterised by episodes of mild depression and hypomania. According to Sadock and Sadock (2002) individuals may have a genetic predisposition to developing cyclothymic disorder. Clinical features include episodes of mania that are thought to contribute to difficulties for individuals in maintaining personal relationships.

**Signs and symptoms of depression**

Depression has an extensive range of symptoms that may be experienced as a mild state with feelings of sadness in response to life events such as losses or disappointments that usually resolve in time (Gross & Munoz, 1995) to major episodes that include feelings of worthlessness or guilt, difficulty concentrating or
making decisions, helplessness, hopelessness and self-hatred, poor self-esteem, changes in activity level, withdrawal from social situations, insomnia, fluctuations in weight and changes to appetite, decreased energy, loss of libido and recurrent thoughts of death or suicide that ultimately result in impaired interpersonal, social, and occupational functioning (Sadock & Sadock, 2003; Dennis & Hodnet, 2009).

**Causes**

A number of factors are thought to play a role in causing depression or mood disorder. Gross and Munoz (1995) postulate a biological factor of clinical depression is attributed to decreased levels of the neurotransmitters serotonin, norepinephrine and dopamine thought to influence the structures of the brain that regulate emotion, appetite, libido, sleep patterns and reactions to stress. Another biologic basis for depression is attributed to genetic inheritance where the risk for developing depression is two to three times more likely for persons directly related to a person with major depression (Gorman, 1997). Psychological influences such as anxiety (Tohotoa, Maycock, Hauck, Dhaliwal, Howat, Burns & Binns, 2012) psychosocial factors such as adverse life events in childhood (Chorpita & Barlow, 1998) and significant losses in adulthood increase the risk for developing depression (Harris, 2001) and low social support (Zelkowitz & Milet, 1997; Goodman, 2004) may increase risk for developing depression. Long-term alcohol and/or drug use has been linked to substance-abuse mood disorder (Gorman, 1997). Additionally physical illness, medical conditions such as cardiovascular disease, anaemia or thyroid dysfunction and certain medications can also cause depression (Suls & Bunde, 2005).
**Major depressive episode**

A major depressive episode manifests as a sense of hopelessness, a loss of interest in pleasurable activities, withdrawal from socialising with other people and depressed mood (not caused by grief or sadness) and thoughts of suicide (Sadock & Sadock, 2003).

**Subtypes of depression**

1. **Melancholic depression**
   Characterised by depressed mood and a loss of pleasure in most activities (Suls & Bunde, 2005)

2. **Atypical depression**
   Characterised by behaviours of hypersensitivity in response to perceived interpersonal rejection, excessive weight gain through comfort eating, excessive sleep or sleepiness (hypersomnia) (Sadock & Sadock, 2003).

3. **Catatonic depression**
   An uncommon and severe form of major depression that includes disturbances of motor function where the individual appears motionless (Sadock & Sadock, 2003).

4. **Postpartum depression**
   Postpartum depression (PPD) or postnatal depression (PND) can be experienced by women following childbirth with onset occurring between the first four weeks and twelve months postnatal (Mattey, Barnett, Howie & Kavanagh, 2003). PPD occurs in 10% - 20% of new mothers (Ballard, Davis, Cullen, Mohan & Dean, 1994). Further discussion on PPD is presented in section 1.4 of this chapter.
5. Seasonal affective disorder (SAD)
Episodes of depression that occurs in the autumn and/or winter seasons when individuals are exposed to less sunlight (Sadock & Sadock, 2003).

Diagnosis

1. Clinical interview and rating scales
A clinical interview is conducted by a suitably trained health professional with the aim of establishing the relevant biological, psychological and social factors that might be impacting on the individual’s mood (Pyszczynski & Greenberg, 1987). The mental health examination may include the use of a psychometric rating scale including but not limited to the Hamilton Rating Scale for Depression (HAM-D) (used as a clinical interview), the Raskin Depression Scale (measures the severity of depression symptoms) and the Zung Self-rating Depression Scale (measures the intensity of depression symptoms) (Sadock & Sadock, 2003). The rating scales do not diagnose depression but provide an indication of the severity of symptoms for a specified time period according to a specified cut-off score (McVeigh, Baafi & Williamson, 2002).

2. DSM-IV-TR criteria
The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) describes a major depressive episode as either a depressed mood or loss of interest and pleasure and at least four other symptoms that have been experienced most of the time on most days for at least two weeks.
3. ICD-10 criteria

The International Statistical Classification of Diseases and Related Health Problems (ICD-10) employed by the World Health Organisation (WHO) in the diagnosis of depression indicates that two out of three depressive symptoms identified as depressed mood, anhedonia (vulnerability) and reduced energy should be present to determine a diagnosis of depressive disorder (WHO, accessed October 2013).

Management

Common forms of treatment options for depression include psychotherapy, psychosocial support and antidepressant medication used alone or in combination (NICE, 2009). The World Health Organisation (WHO, accessed October 2013) recommends a combination of medication and psychotherapy such as cognitive behaviour therapy (CBT) or interpersonal therapy (IPT) for moderate to severe depression and psychosocial support for mild depression. According to Churchill, Moore, Davies, Caldwell, Jones, Lewis and Hunot (2012) psychotherapies provide an important alternative or adjunct in the treatment for depressive disorder and cite that outcomes from several surveys demonstrate that there is a consistent pattern in patients’ preference for psychological therapy compared to taking antidepressant medication.

Anxiety and Depression

Anxiety is a psychological and physiological state characterised by cognitive, somatic, behavioural and emotional factors (Tohotoa et al., 2012) and frequently presents with depression (Skari, Skreden, Malt, Dalholt, Ostensen, Egeland & Emblem, 2002). Anxiety disorder encompasses generalised anxiety disorder (GAD)
and acute adjustment disorder with anxiety, phobias, obsessive-compulsive disorder and posttraumatic stress. According to Matthey, Barnett, Howie & Kavanagh (2003) anxiety and depression occur simultaneously in up to fifty percent of patients in the primary care setting and distinguishing the two disorders for the purpose of assessment and treatment poses some difficulty for health clinicians. Matthey et al. (2003) conducted a study of first time parents for postnatal depression and anxiety and broadened diagnostic assessment to include phobia, panic disorder, acute adjustment disorder with anxiety and major and minor depression with the aim to increase the capture rate of caseness (depression and anxiety) in first time fathers and mothers who were assessed six weeks postnatal. The authors proposed that parents were more likely to develop symptoms consistent with anxiety and depression referred to as ‘postnatal mood disorder’ (PMD) rather than postnatal depression. Moreover that parents in the postnatal period should be screened for clinically significant symptoms of anxiety and depression.

1.2.1 Theories of depressive disorders or mood disorders

There are a number of theories of the development of depression and a wide array of cognitive, social and motivational dimensions on which depressed and non-depressed individuals differ from one another (Pyszczynski & Greenberg, 1987). Moreover there is a large number of different psychological theories from different theoretical frameworks that have evolved over the last two decades (Churchill, Moore, Davies, Caldwell, Jones, Lewis & Hunot, 2012) as clinical investigators from different theoretical perspectives have proposed differentiating causes of depression (Blatt & Maroudas, 1992). Based on behaviourist, cognitive, and biological foundations,
approaches to therapy and treatment also vary (Dennis & Hodnett, 2009).

The aetiology of depression or mood disorder appears to be multifactorial (WHO, 2000) rather than having a single causative factor. However psychosocial variables such as stressful life events (Bielawska-Batorowicz & Kossakowska-Petryka, 2006), difficulties establishing interpersonal relationships (Hangsleben, 1983) conflict within the marriage (Dudley, Roy, Kelk & Bernard, 2001) and lack of social support (Zelkowitz & Milet, 1997) appear to be common themes in the research literature.

There is a considerable diversity in the number of psychological theories of depression in the literature as well as different theories of aetiology and recommended treatments that are beyond the scope of this thesis. Therefore the author has limited the discussion to some of the cognitive and behavioural concepts of depression and how they pertain to men who are new fathers.

**Behavioural Theory of Depression**

Behavioural theory of depression proposed by Lewinsohn (1975) suggests that individuals develop depressive symptoms in response to a combination of environmental stressors that cause an individual to receive a low rate of positive reinforcement. According to Lewinsohn (1975) individuals who are depressed lack the coping skills to deal with low positive reinforcement. Moreover depressed individuals may receive positive reinforcement from family or friends who provide support for being depressed thus providing positive reinforcement for negative behaviour. According to Carvalho and Hodo (2011) low positive reinforcement can lead to avoidance behaviour where the individual becomes withdrawn and impassive.
and further inhibits the experience of positive environmental reward and positive reinforcement. Men’s responses to stressful life events and the development of depressive symptoms is consistent with the behavioural theory of depression. Becoming a parent for the first time is a seminal event that promotes intense emotions for both the mother and the father. The early weeks of new parenthood are considered to be predominantly stressful for new fathers (Zelkowitz & Milet, 1997) particularly when changes occur in the home and in the relationship with their partner as well as the fatigue engendered by infant care. Hangsleben (1983) purports that the impact of parenthood on new fathers may have a negative influence on men’s mental health ranging from mild symptoms to more severe symptoms of depression. Many new fathers are not prepared for the emotional struggle in response to the increase in responsibility and the changes to their personal relationship (Fletcher, Silberger & Galloway, 2004). Moreover men are often ill prepared to cope with unexpected situations such as difficult feeding or health problems with the baby (Greenhalgh, Slade & Spiby, 2000). Avoidance coping involves focusing attention away from the cause to manage, reduce or eliminate the stress and this can be either a behavioural or a cognitive process (Carvalho & Hopko, 2011). Men who experience negative emotions, distress, depression and/or anxiety as a new parent are more likely to work longer hours, withdraw from social events (Magovcevic & Addis, 2008) and indulge in risk taking behaviour such as alcohol and drug abuse (Condon, Boyce & Corkindale, 2004).

**Cognitive Theory of Depression**

In the early 1970s psychology experienced a shift towards a cognitive theory of depression with the most dominant being Beck’s Cognitive Model of Depression
Beck’s model is orientated to the behavioural and cognitive aspects of depression (Blatt & Maroudas, 1992). Cognitive theory proposes that individuals acquire a predisposition to depression and negative self-concept as a result of negative early life experiences (Calarco & Krone, 1991; McIntosh & Fischer, 2000) and that negative thoughts are generated by dysfunctional beliefs (McIntosh & Fischer, 2000) which in turn lead to the development of depression. Beck proposed a cognitive triad (McGinn, 2000) or negative schema (Calarco & Krone, 1991) of depression that consists of (a) negative views about the self (seeing the self as worthless and deficient), (b) a negative view about the environment (views the world as overwhelming, hostile and demanding) and, (c) negative views about the future (the expectation of suffering and failure) (McGinn, 2000). Individuals with negative thought processes are more likely to develop depression in response to stressful life experiences (Calarco & Krone, 1991). Oatley and Bolton (1985) also ascribe to the theory that depression may occur as the result of a stressful or threatening life experience. The authors postulate the importance of roles (described as a sense of self or identity) that is supported by personal goals, plans and expectations. When there is a disruption to the individual’s expectation of the role and the ability to fulfil the role the individual experiences a sense of emotional vulnerability that can lead to distress which in turn can lead to depression. According to Zelkowitz and Milet (1997) new fathers that feel less satisfied in their role within the family are prone to becoming depressed. Moreover, fathers who receive limited guidance or direction as a new parent are susceptible to becoming emotionally distressed. The process of adjusting to role changes can be psychologically challenging for new fathers and sufficient to precipitate depression (Lutz & Hock, 2002).
Other life events described by Oatley and Bolton (1985) as contributing factors to feelings of emotional vulnerability and depression include a lack of social support and unemployment. The emotional impact of low levels of social support and unemployment resonates with the outcomes of studies by Ballard et al. (1994) and Zelkowitz & Milet (1997) who identified elevated levels of stress and lowered self-esteem in new fathers who received less social support from family and friends in the postnatal period. Unemployment and financial burden experienced by single income families were also found to be predictors of mood disorders experienced by fathers (Bielawska-Batorowicz & Kossakowska-Petrycka, 2006; Areias, Kumar, Barros & Figueredo, 1996a).

1.3 Masculinity, male depression and fatherhood

The intense emotion experienced by new fathers has been seen as the most significant theme in the research literature on the transition to fatherhood (Henderson & Brouse, 1991; Pollock, Amankwaa & Amankwaa, 20005). Financial issues, increased responsibility for the new family, concerns about the health and safety of the baby, sleep deprivation, lack of support, reality of being a parent, changes to the couples’ relationship and adapting to the new role were reported by first time fathers to be major causes of stress (Pollock et al., 2005; Condon, Boyce & Corkindale, 2004) and predictors of men developing symptoms of postnatal depression (Lutz & Hock, 2002; Skari, Skreden, Malt, Dalholt, Ostensen, Egeland & Emblem, 2002; Condon et al, 2004; Madsen & Juhl, 2007). It has been argued that masculine socialisation shapes men to become adept at constructing psychological defences against their experiences and distorting the emotional experiences they induce (Healey, 2005). Magovcevic and
Addis (2008) postulate that men who have recently experienced a stressful life event might be at risk for experiencing negative affect (both anxiety and depression) and that their behaviour in response to this affect would be specifically associated with a masculine variant of depression that manifests as anger and aggression, avoidance behaviour such as over-involvement in work and/or sports, anxiety, irritability and risk taking behaviour such as binge drinking (Condon et al, 2004). According to Oliffe and Phillips (2008) and Lutz and Hock (2002) these behaviours are consistent with the norms of masculine socialisation.

Further, it has been posited that a taboo exists in Western society against men displaying emotions such as fear and sadness (Healy, 2005). In a recent review, Kilmartin (2005) argued that such suppression of emotions may lead to feelings of frustration, anger and powerlessness. Because men are socialised to disengage their feelings, they may fail to recognise symptoms of depressive illness or may resort to destructive behaviours like substance abuse in an attempt to deal with their depression (Kilmartin 2005; Healey 2005; Condon et al., 2004). Moreover fewer men than women seek help for psychological problems, therefore men who are depressed are at risk of being unidentified, undiagnosed and untreated (Cochran & Rabinowitz, 2003). This is potentially hazardous to the family’s emotional health and safety and may affect early paternal-infant bonding.

Further Condon et al.’s (2004) Australian research that included 204 first time fathers indicated that men exhibit gender-specific risk factors for perinatal psychological distress in relation to impending fatherhood. In light of this outcome, health
professionals, by identifying the risk factors and providing the right resources to address the problems may contribute to positive early parenting experiences for men. Moreover the use of gender-sensitive assessment strategies and interventions by health professionals within the community may identify more men who could be subsequently treated for depression (Cochran & Rabinowitz, 2003; Madsen & Juhl, 2007).

According to Healey (2005) men may believe that complaining of feeling ill and visiting the doctor is a threat to their masculinity. Furthermore Healy (2005) ascertained that males in Australia are less likely to seek professional help for problems of an emotional nature. This may be attributed to the risk men may fear of being stigmatised as having a mental health problem such as depression. Major and O’Brien (2005) suggest that people who are stigmatised may be devalued in the eyes of others in society as they are marked as different.

A study by Komiti, Judd and Jackson (2006) found that a variety of factors may contribute to men’s aversion to seeking help for mental health problems including attitudes and beliefs about mental illness, social stigma around mental illness, and the preference for self-reliance and seeing help-seeking as a sign of personal weakness. Further, the authors found that more men than women endorsed the notion that there was “something admirable about a person who was willing to cope by himself, without resorting to professional help” (p. 743) and that relying on informal help such as talking to a close friend or family member was preferred. This coincides with similar attitudes by several fathers in this research who preferred to talk to their partner about their emotional problems rather than talk to their GP. Conversely, an
article by Emslie, Ridge, Ziebland and Hunt (2006) on men’s account of depression found that some men want to talk about their experiences with depression and have challenged the notion that men prefer to remain silent.

A study by Gulliver, Griffiths and Christensen (2010) on perceived barriers and facilitators to mental health help-seeking in young people found that social support and positive encouragement by friends and family act as facilitators to help-seeking for mental health problems and this is comparable to the small number of fathers in this research who were encouraged by their partners to visit the GP when they became sad, irritable and withdrawn. With current research indicating that 1 in 6 men experience a depressive episode during their lifetime (Cummings, 2005) there is a need to focus on the issues surrounding gender as an important context of men’s responses to health care.

1.3.1 Men, depression and suicide

Suicide is the second most cause of death for men between the ages of 15 and 34 years (Oliffe & Phillips, 2008) and is considered a serious public health problem (WHO, 2000). Suicide is the result of a mental health disorder which results from ‘a complex interaction of biologic, genetic, psychological, sociological and environmental factors’ (WHO, 2000, p. 5). Mood disorders such as bipolar affective disorder, depressive episode, recurrent depressive disorder, anxiety disorder, and persistent mood disorders such as cyclothymia and dysthymia have been associated with suicide (Sadock & Sadock, 2003). Consequently, suicide is a significant risk for individuals with unrecognized and untreated depression (WHO, 2000). Men are less
likely to seek help for depression as this signals vulnerability, attracts stigma (O’Brien, 2005) and displays weakness that contradicts the strength and power synonymous with masculine ideals (Olliffe & Phillips, 2008).

1.4 Postnatal depression

Postnatal depression (PND) is defined as depression that develops between four weeks and twelve months after childbirth and affects approximately 1:6 women in Australia (Beyondblue, April 2011) the effects of which can have dire consequences for a woman’s emotional and physical health as well as her family. The postnatal or baby blues usually occurs within the first five days following childbirth and is a transient depressed mood where the mother experiences increased sensitivity, tearfulness, poor concentration and fatigue (Edhborg, Matthiesen, Lundh & Widstrom, 2005). Postpartum or puerperal psychosis occurs in 1% of women (Dennis & Hodnett, 2009) and has a serious debilitating effect that usually requires hospitalisation.

Mothers with PND may experience anxiety and negative feelings towards their baby, lethargy and fatigue, sleep disturbances, tearfulness, changes in appetite, irritability, and feelings of guilt and confusion (Cox, Holden & Sagovsky, 1987). According to Dennis and Hodnett (2009) a specific aetiology of PND is unclear however a number of psychosocial variables such as stressful life events, a lack of social support and problems within the marriage (Ballard et al., 1994; Matthey, Barnett, Ungerer & Waters, 2000) have been identified as significantly increasing the risk for women
becoming depressed. Moreover there are potential consequences for partners of women who experience PND because they have an increased risk of developing mental health problems (Lovestone & Kumar, 1993; Ballard et al., 1994). Notably, postnatal depression impacts on the social and cognitive development of babies and young children as a result of parental disharmony, poor interaction with the baby and failure to bond while providing maternal care (Ramchandani et al., 2005).

1.5 Scientific research and paternal depression

In the late 1980’s, an international research interest in men’s adjustment to fatherhood and depressive symptoms in fathers following the birth of their baby began to emerge (Hangsleben, 1983; Atkinson & Rickel, 1984). However there was little research interest in the phenomena of paternal depression in Australia until early 2000.

Between 2000 – 2007, a small number of Australian researchers investigated paternal and maternal depressed mood and anxiety, adjustments to fatherhood and the mental health and wellbeing of first time fathers in the transition to parenthood (Matthey, Barnett, Ungerer & Waters, 2000; Matthey, Barnett, Kavanagh & Howie, 2001; Matthey, Barnett, Howie & Kavanagh, 2003; Buist, Barnett, Milgrom, Pope, Condon, Elwood, Boyce, Austin & Hayes, 2002; Dudley, Roy, Kelk & Bernard, 2001; Condon et al., 2004). The outcomes of the Australian study coincided with findings from several international studies that indicated new fathers are at risk of experiencing postnatal depression (PND), depressed mood and depressive anxiety (Ballard, Davies, Cullen, Mohan & Dean, 1994; Deater-Deckard, Pickering, Dunn & Golding, 1998; Zelkowitz & Milet, 1997; Pinheiro, Magalhaes, Horta, Pinheiro, Da Silva & Pinto,
2006). As stated earlier, while these researchers have used a number of terms including depressed mood, depressive caseness, anxiety disorder, depressive disorder and paternal depression, there is no formal definition for paternal postnatal depression.

1.5.1 Predictors of paternal depression

A number of variables thought to contribute to men developing paternal depression have been reported in the research and are thought to be attributed to a lack of parenting experience, unexpected changes in lifestyle, changes to the couples’ relationship brought about by the birth of a baby, intimacy issues, increased financial responsibility, limited paternal leave and limited access to information specific to first time fatherhood through electronic or print media (Goodman, 2004; Zelkowitz & Milet, 1997; Dudley et al., 2001). Other risk factors for depression amongst fathers included being unemployed, having a partner with PND, being vulnerable to anxiety and depressed mood or a past history of depression (Goodman, 2004). Significantly, a small number of studies that investigated the correlates of maternal and paternal depression in couples indicated that fathers were at higher risk of becoming depressed when their partner experienced postnatal depression (Ballard et al., 1994; Areias, Kumar, Barros & Figueiredo, 1996a & 1996b; Matthey et al., 2000; Atkinson & Rickel, 1984; Zelkowitz & Milet, 1997; Pinheiro et al., 2006; Raskin, Richman & Gaines, 1990; Soliday, McClusky-Fawcett & O’Brien, 1999).
1.5.2 Research methods to investigate paternal depression

To date, quantitative methods of inquiry employing self-report questionnaires to determine prevalence rates of paternal depression have been the primary tools of investigation.

1 The term ‘intimacy issues’ has been used in this context as an informal term in relation to ‘a personal problem or emotional disorder’. 
Prevalence estimates have ranged from 1.2% (Lane, Keville, Kinsella, Turner & Barry, 1997) with a convenience sample size of 175 fathers and 11.9% (Pinheiro et al., 2006) with a population-based sample of 386 fathers.

While the prevalence of paternal depression is less than half of the prevalence rate of 10% – 15% reported for postnatal depression in mothers (Matthey et al., 2000), these figures are significant because they represent identified cases of paternal depression. A father and his family’s emotional wellbeing are at risk when depression is unidentified and untreated however, paternal depression and the potential consequences to the father’s long term emotional wellbeing and that of his family has been under-researched and in need of future research investigation.

1.5.3 Duration of paternal depression

Current research literature indicates paternal depression may manifest in men during their partners pregnancy (Condon et al, 2004) or may develop early in the postnatal period. Although the duration of paternal depression has not been clearly indicated in existing research, postnatal depression in mothers can last for several weeks or months (Richards, 1998) and is dependent on factors such as personality, marital harmony and social support (Bielawska-Batorowicz & Kossakowska-Petrycka, 2006).

Several studies with small convenience sample groups investigating the onset of paternal depression using only two timelines of investigation before the birth and within two months after childbirth do not provide an indication of duration. Longitudinal studies with large samples conducted over the first twelve months
postnatal provide a better indication of when symptoms first emerge and at what timeframes throughout the twelve months symptoms increase or subside. Arguably, longitudinal investigation is needed to explore patterns of consistency and change over time (Jordan, 2004).

1.5.4 Assessment of paternal depression

Investigators exploring the cause and effect of PND have used a number of assessment instruments. The Edinburgh Postnatal Depression Scale (EPDS) has been the most widely used measurement instrument to assess for PND in both women and men. This self-report questionnaire was developed by Cox, Holden & Sagovsky in 1987 to screen for depression in women following childbirth.

First developed as a 13-item scale, the EPDS was shortened to ten items following the removal of three items (“I have enjoyed being a mother” and two irritability items). According to Cox et al. (1987) converting the scale to ten items made it suitable for use with a wider population without impairing its effectiveness. Matthey et al. (2001) conducted the first study in Australia to validate the EPDS with fathers. EPDS scores were compared with the criterion measure of depression using the Diagnostic Statistics Manual of Mental Disorders (DSM-IV). Matthey et al. (2001) concluded that the EPDS was a reliable and valid measure of mood in fathers and suggested a two point lower cut-off score of 5/6 for men to detect depression and anxiety. This is discussed in more detail in chapter two.
1.5.5 The need for a gender-specific questionnaire

Although a variety of self-report measures have been used in primary research to determine the mental health and wellbeing of men on the transition to fatherhood, to date there is no questionnaire that indicates if a first time father is adjusting to the changes in his lifestyle and the demands of being a new parent. In light of this, a draft gender-specific self-report questionnaire for new fathers to indicate if they are coping with the experiences of early parenting has been developed. Unlike the EPDS that is designed to screen specifically for depression in women, the questionnaire for new fathers is not designed to identify symptoms of mental health problems such as depression, anxiety, phobias and personality disorders. Rather it is intended to indicate if a new father is coping with the experiences of new parenthood. Development of the questionnaire is discussed in more detail in chapter six.

1.6 What is unique to this research?

- This research was unique in that it used a qualitative approach to explore men’s lived experiences with paternal depression in the transition to first time fatherhood;
- This research was the first to include fathers that have provided a retrospective and prospective account of their experiences as first time fathers with depression and/or anxiety, depressed mood or distress during the postnatal period;
- This research was the first to recruit first time fathers who self-identified as having experienced depression, anxiety, depressed mood or distress in the
perinatal period;

- Expectant first time fathers were recruited during the last trimester of their partner’s pregnancy that self-identified as experiencing emotional distress, stress, depression and/or anxiety. Prospective interviews were conducted with new fathers at two, four and six months after the birth of their baby to identify in the analysis of the interview data if their symptoms intensified or abated during the postnatal period and, at what stage of the postnatal period their symptoms intensified or abated; and

- Ten men in the cohort of twenty-three men were diagnosed within the first twelve months postnatal (by a health professional) as having depression and/or anxiety. Only two of the ten men diagnosed with depression had a partner who had been diagnosed with PND.

1.7 Theoretical framework for this research

Grounded theory is used as the theoretical framework for this research to generate a rich supply of data about the lived experiences of men’s transition to first time fatherhood and paternal depression. This approach is used especially when researchers want to ascertain the participant’s perspective on a particular phenomenon.

The aim of this research was not to test an existing theory but to allow theories to emerge from the data obtained through the research. Therefore, the theory is grounded in the data.
Grounded theory analysis provided the author with a systematic approach to analysing the data that led to the emergent theory of ‘coping’.

1.8 Purpose and significance of this research

The purpose of this research is to follow on from the research conducted in the Master of Midwifery by exploring the experiences of first time fathers who self-identified as having experienced symptoms of paternal depression and to make a substantial contribution to the body of knowledge pertaining to this phenomenon. This research makes a unique contribution as a qualitative study conducted in Australia that explores the lived experiences of first time fathers during the transition to fatherhood and their experiences with depression, depressed mood, distress and/or anxiety after the birth of their baby and what effect this had on their emotional welfare and their family. Additionally, to date a qualitative exploratory study has not been conducted internationally.

The social construction of the experiences of first time fathers and paternal depression has been provided from the participants’ perspective.

The information generated from this thesis will contribute to current knowledge about how parenthood impacts on first time fathers and how paternal depression impacts the wellbeing of men and their families.

A four phase quantitative study was conducted with the aim of developing a draft gender-specific questionnaire for new fathers to determine if they are coping with the
experiences of parenthood.

1.9 Initial research proposal

In 2007, the initial research proposal was based on the desire to conduct a prevalence study of paternal depression in South Australia using the EPDS and to develop a gender-specific self-report questionnaire similar to the EPDS for new fathers. It was originally intended that items from the EPDS and the Beck Depression Inventory (BDI) (Beck, Ward, Mendelson, Mock & Erbaugh, 1961) would be used in the construct of the questionnaire. The questionnaire would be used as a screening tool to provide an indication of emotional wellbeing but would not be a direct measure of depression and anxiety. A pilot study to assess for face validity would be conducted with a large group of key informants. For postdoctoral work, a validation and prevalence study would be conducted using the draft questionnaire. Given the time constraints for a full-time PhD, the proposal was revised and discussed at length with the author’s advisory group.

Advisory group

Advisory group is the term of reference used throughout this thesis. The group comprised of four supervisors from different disciplines:

- Professor Deborah Turnbull (principal supervisor), Head of School, School of Psychology at The University of Adelaide.
- Associate Professor Margie Ripper (co-supervisor), School of Social Sciences, Gender, Work and Social Inquiry at The University of Adelaide.
- Dr. Christopher Barton (co-supervisor), Research Manager Military Arm,
Centre for Military and Veterans Health (CMVH) at The University of Adelaide.

- Dr. Nicole Moulding (external supervisor 2006-2008), School of Social Work and Social Policy, University of South Australia.

In 2009, the author moved to rural Victoria and became an external student. Associate Professor Rhonda Small, Director of Mother and Child Health, Faculty of Health Sciences at La Trobe University Victoria, was invited to join the advisory group as an external supervisor and assume the role formerly held by Dr. Nicole Moulding.

1.9.1 Final research proposal

In early 2008, the proposal for this research was developed based on a general consensus within the advisory group and the author that there was a need to conduct sound research that used a qualitative approach to the collection of data and the analysis of the data that would provide an insight to the experiences men encounter with paternal depression. The aim of conducting this research was twofold (a) to explore first time fathers’ experiences with new parenthood and their experiences with depression and (b) to develop a gender-specific self-report draft questionnaire that could be used as a research tool to indicate if a first time father is coping with the early parenthood experience. The author in future postdoctoral research intends to extensively pilot the questionnaire to further test its psychometric properties. This will include the development of scoring procedures.
1.10 Assumptions

The assumptions on which this research was based:

- First time fathers are potentially at risk of developing symptoms of depression before and/or after the birth of their baby. This is due to a number of variables;
- A qualitative method of inquiry will provide an in-depth exploration of this phenomenon and the outcomes will add to existing research on this phenomenon; and
- How fathers perceive and construct the social reality of paternal depression will influence how they experience the phenomenon.

1.11 Outline of this thesis

Chapter 1

This chapter provides an overview of the basis for conducting this research on the contemporary experiences of fathers in the 21st century and social implications for new families and it highlights the potential implications paternal depression may have to maternal and child health and wellbeing. It outlines development of a research framework and what contribution the outcomes of this research will provide and the overall structure of this thesis.
Chapter 2
The literature review provides a critical analysis of the research literature concerning paternal depression, psychological distress, dysphoria and men’s experiences in the transition to fatherhood. The author discusses what the research evidence indicates about paternal depression, methods employed to investigate the phenomenon and the gaps that have been identified in the research literature.

Chapter 3
This chapter presents an overview of the research design and the use of grounded theory and symbolic interactionism which is the theoretical framework that underpins this research. It demonstrates how constructivist grounded theory was used to address the research question and the use of qualitative and quantitative research methods to conduct this investigation.

Chapter 4
This chapter focuses on how the research was conducted and discusses recruitment strategies, the sample, ethical considerations and the collection of qualitative data.

Chapter 5
This chapter reports on stage one which is the analysis of qualitative data collected from interviews with twenty-three first time fathers. Constant comparative analysis was used to identify connections and links between codes and categories for similarities and differences leading to the development of the emergent theory - ‘coping’ (Strauss, 1987).
Chapter 6
This chapter describes in detail stage two which is the quantitative study that follows on from stage one (the qualitative study discussed in chapter five). The data from the qualitative study was used to inform the quantitative research in the development of a draft questionnaire to indicate if new fathers are coping with the experience of first time fatherhood. The research was conducted in a sequence of four phases. Each phase had a specific aim and employed a different method to create items, reduce items, rank and sort items and to refine items that would be used in the questionnaire. In the last phase of the quantitative research the draft questionnaire was piloted with a small group (n=6) of first time fathers to ascertain face validity.

Chapter 7
This chapter discusses the emergent theory of ‘coping’ as a result of using the tenets of grounded theory analysis, how the outcomes of this research fits within the existing body of knowledge about depression in new fathers after childbirth, and the concept of coping and coping strategies men engage with in relation to stressful life events. The strengths and limitations of this research and directions for future research are outlined.
CHAPTER 2 – LITERATURE REVIEW

2.0 Introduction

Paternal depression has been identified in the research literature as having considerable impact on the emotional and psychological wellbeing of fathers and their families. A small number of researchers in Australia have made valuable contributions to the research literature on paternal depression, anxiety and psychological distress in fathers as have a number of international studies. Depressive reactions related to fatherhood were reported in the research literature as early as 1931. Zilboorg (1931), from a psychoanalytic perspective, reported on the case of a father who developed acute depression, affective disorder and suicidal ideation during his wife’s second pregnancy attributed by emotional and financial burdens as a provider for his family. Ballard and Davies (1996) cited a small number of papers produced by Freeman (1951), Curtis (1955), Jarvis (1962) and Wainwright (1966) that had a specific focus on psychiatric morbidity in men in the postnatal period. Prominent symptoms were those of sexual difficulties, neurosis, anxiety and hypochondriasis (Ballard & Davies, 1996 p. 65). These reports indicate that men have experienced difficulties with the transition to fatherhood for several decades. This chapter provides a critical evaluation of the research literature pertaining to paternal depression in fathers.
The literature search focussed on published, peer-reviewed scientific literature from 1990 – 2008 related to paternal depression, depressed mood in fathers and depression and anxiety in men during the antenatal and postnatal period. However, as there has been a limited amount of research conducted on this topic, the timeline was extended to include one research article from 1971 and two articles from the mid 1980’s. Online journals that only provided an abstract of a potentially relevant study were located in the university library journal collections and hand searched to obtain the full text article. The search was not restricted to articles written in English. Translated copies of international studies were sought for inclusion in this review.

A search of electronic databases for published studies utilised the following sources: Web of Science, CINAHL (Cumulative Index of Nursing & Allied Health Literature), MEDLINE, AustHealth, ERIC, Cochrane Library, Academic OneFile, Academic Search Premier, Google Scholar, Web of Science, FAMILY, psycARTICLES, PsycINFO, PubMed and the Social Science Citation Index were all searched for reference lists of relevant studies.

Keywords used alone or in combination for the search included: paternal, paternal depression, paternal postnatal depression, paternal postpartum depression, postpartum depression, postnatal depression, depression, depressed mood, father, fatherhood, first-time fathers, new fathers, mental illness, men’s mental health and qualitative research.
A systematic search for literature captured international studies (n=20) from 1971 to 2009 and a small number of studies conducted in Australia (n=6) from 2000 to 2004. Themes investigated by researchers included the correlates of postnatal depression in mothers and fathers and comparative levels of psychological distress, paternal depressed mood during the antenatal and postnatal period, prevalence of paternal depression, effects of paternal mental health on child development, men’s adjustment to fatherhood and coping style, and the sensitivity of assessment tools for detecting depressive symptoms experienced by men.

All studies used a quantitative approach to the collection of data including self-report questionnaires and diagnostic interviews to obtain the data in relation to a number of variables that contributed to the emotional distress, depression, depressed mood and/or anxiety experienced by men in the transition to fatherhood. No qualitative research that explored men’s experiences with depression and the nature of paternal depression during the transition to fatherhood was located.

Quantitative research aims to collect the data drawn from a sample to compare the relationship between variables and express those relationships using ‘effect statistics, such as correlations, relative frequencies or differences between means’ (Hopkins, 2008, p. 12) and generalise the findings as representative of a population (Bartlett, Kotrlik & Higgins, 2001). Regardless of sample size, a well-planned study will include participants that are selected from the appropriate population and use reliable instruments ‘to obtain precise measurements and analysis of target concepts to test a hypothesis’ (Length, 2001 p. 1). According to Creswell (2003), the validity of an instrument is paramount to obtain information that is meaningful and accurately
measures what it is supposed to measure. Additionally, a high response rate is important when results will be generalised to the larger population regardless of sample size (Strauss & Corbin, 1990).

All aspects of the research design for each of the smaller studies were considered including the validity and reliability of the research, the representativeness of the sample to the population indicated by well-defined sampling frames, the inclusion criteria and whether power calculations had been undertaken to achieve statistically significant results in relation to the outcome measures of the research (Cohen, 1989).

 Twelve of the twenty-six studies that included a cohort of less than 100 participants were reviewed to establish if power calculations had been conducted by the researchers to ascertain if the sample size was adequate to answer the research question/hypothesis. Those studies are identified by * in table 1. Seven of the twelve studies with less than 100 participants used well-defined sampling frames and are identified by ** in table 1.

In the critique of the research literature, the author has included primary research divided into several categories according to certain assumptions and approaches by researchers. The categories include depressive symptoms in men in the transition to fatherhood, prevalence of paternal depression in fathers, paternal mental health and its effect on the father-infant relationship and assessment tools for perinatal depression.
Table 1: Studies included in the review of research literature in order of first author and in chronological order

AUSTRALIAN STUDIES (N=6) and INTERNATIONAL STUDIES (N=20)

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Design</th>
<th>Sample</th>
<th>Measures</th>
<th>Outcomes &amp; Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rees &amp; Lutkins 1971 UK</td>
<td>Comparative cohort research</td>
<td>77 Fathers &amp; 99 mothers</td>
<td>BDI Assessed 6 months AN &amp; 12, 27, 52 weeks PN</td>
<td>Depression lower in men than women. BDI cut-off of 17 – 23 (3%) fathers had moderate depression PN. BDI cut-off 10 – 7 (10%) fathers depressed AN &amp; 10 (13%)</td>
</tr>
<tr>
<td>*Hangsleben 1983 USA</td>
<td>Comparative cohort research</td>
<td>50 First time fathers</td>
<td>SMAT, DI, BCAI, FAIOF, FAIOC, LCI, High Scale – Hypomania based on SADS-L criteria assessed AN &amp; 3-5 weeks PN</td>
<td>Only one father was mildly depressed antenatally. Early fatherhood can be stressful &amp; disruptive to lifestyle</td>
</tr>
<tr>
<td>*Atkinson &amp; Rickel 1984 USA</td>
<td>2-Stage correlation research</td>
<td>78 First time fathers &amp; partners</td>
<td>BDI, ICB, NPI, DBI, PES-MR Assessed 2 months AN &amp; 2 months PN</td>
<td>10 (13%) fathers reported mild depression PN The strongest predictor of PND in both men &amp; women was AN depression</td>
</tr>
<tr>
<td>*Raskin et al. 1990 USA</td>
<td>2-Stage correlation research</td>
<td>86 First time fathers &amp; partners</td>
<td>CES-D Assessed 34 weeks gestation &amp; 2 months PN</td>
<td>4 (11.1%) couples depressed AN 12 (14%) fathers only depressed AN 14 (16%) fathers only depressed AN 4 (11.1%) couples depressed PN</td>
</tr>
<tr>
<td>Ballard et al. 1994 UK</td>
<td>2-Stage correlation design</td>
<td>178 Couples at 6 weeks PN 148 Couples at 6 months PN</td>
<td>EPDS (13 item), PAS semi-structured interview Assessed 6 weeks &amp; 6 months PN</td>
<td>16 (9%) fathers scores as cases using cut-off 13 at 6 weeks PN 8 (5.4%) fathers scored as cases using a cut-off 13 at 6 months PN</td>
</tr>
<tr>
<td>Areias et al. 1996(a) Portugal</td>
<td>Longitudinal research</td>
<td>54 Primigravida women, 42 Husbands, Sub-sample of women &amp; men (24 &amp; 12) @ 3 months PN</td>
<td>EPDS, SADS, SADS-L, Schedule, Sub-sample at 3 months PN with EPDS Assessed 3 &amp; 12 months PN</td>
<td>2 (4.8%) fathers were cases at 3 months PN 10 (23.8%) were cases at 12 months PN</td>
</tr>
<tr>
<td>Author/Year</td>
<td>Design</td>
<td>Sample</td>
<td>Measures</td>
<td>Outcomes &amp; Prevalence</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----------------</td>
<td>------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Areias et al. 1996(b)</td>
<td>Longitudinal research</td>
<td>54 Primigravida women, 42 Husbands, Sub-sample of women &amp; men (24 &amp; 12) @ 3 months PN</td>
<td>EPDS, SADS, EPI, SADS-L, LE, SAS, SSNI, ASQ Assessed then 3 &amp; 12 months PN</td>
<td>2 (4.8%) fathers had AN depression  2 (4.8%) at 3 months PN 15 (35.7%) at 12 months PN 4-12 months PN, 10 (23.8%) new cases &amp; 3 persisting cases</td>
</tr>
<tr>
<td>Lane et al. 1997</td>
<td>Comparative cohort research</td>
<td>175 Fathers &amp; 308 Mothers</td>
<td>EPDS, High Scale Assessed day 3 PN &amp; week 6 PN</td>
<td>EPDS scores for fathers on day 3 – 6 (3%) cut-off ≥13 &amp; 6 weeks 2 (1.2%) cut-off ≥13</td>
</tr>
<tr>
<td>*Leathers et al. 1997 USA</td>
<td>Correlation research</td>
<td>55 First time fathers &amp; partners</td>
<td>CES-D, PWS Assessed 6 months AN &amp; 6 months PN</td>
<td>Higher levels of depressive symptomatology in 17 (31%) women and 10 (18%) men PN</td>
</tr>
<tr>
<td>*Zelkowitz &amp; Milet 1997 Canada</td>
<td>2-Stage correlation research</td>
<td>Index group 50 men whose wives had PND &amp; Control group whose wives did not have PND</td>
<td>SCID-NP, DSM-III-R (structured clinical interview), SCL-90-R, TTP, NPI Assessed 6 – 8 weeks PN</td>
<td>12 (24%) men in index group and 5 (10%) men in control group had current psychiatric diagnosis determined by SCID&gt; Diagnoses included depressive disorders, anxious disorders, somatization disorders &amp; adjustment disorders</td>
</tr>
<tr>
<td>Deater-Deckard et al. 1998 UK</td>
<td>Longitudinal research</td>
<td>7,018 Women &amp; their male partners</td>
<td>EPDS (10-item) Assessed 18 weeks AN &amp; 2 months PN</td>
<td>Stepfathers had significantly increased levels depressive symptoms AN &amp; PN</td>
</tr>
<tr>
<td>*Soliday et al. 1999 USA</td>
<td>2-stage correlation research</td>
<td>51 Couples</td>
<td>CES-D, COPE, DAS-SF, PSI-SF, PANAS Assessed prior to birth &amp; 2 weeks PN</td>
<td>13 (25.5%) fathers were classified as depressed PN of this group – 9 (69.2%) were mildly depressed, 4 (30.8%) moderately depressed, 10 (19.6%) PN couples reported to have elevated depression scores</td>
</tr>
<tr>
<td>Matthey et al. 2000 Australia</td>
<td>Longitudinal research</td>
<td>157 Couples</td>
<td>DSQ, EPDS, BDI, GHQ-28 Assessed at 20 – 24 weeks gestation then 6 weeks, 4 &amp; 12 months PN</td>
<td>Fathers had lower rates of clinically significant distress or depression than mothers in the first year PN</td>
</tr>
<tr>
<td>Greenhalgh et al. 2000 UK</td>
<td>Comparative cohort research</td>
<td>78 First time fathers &amp;partners</td>
<td>ECQ, MBSS, DBQ, EPDS (10-item) Assessed 6 days &amp; 6 weeks PN</td>
<td>5 (6.4%) fathers scored above cut-off 12/13 at 6 days PN 4 (6.2%) fathers scored above cut-off 12/13 at 6 weeks PN A less fulfilling experience of childbirth for some fathers was associated with higher depressive symptomatology at 6 weeks PN</td>
</tr>
<tr>
<td>Author/Year</td>
<td>Design</td>
<td>Sample</td>
<td>Measure</td>
<td>Outcomes &amp; Prevalence</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------------------</td>
<td>---------------------------------</td>
<td>--------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Matthey et al. 2001</td>
<td>Longitudinal research</td>
<td>208 First time fathers</td>
<td>EPDS, CES-D, DIS, CES-D, DSM-IV</td>
<td>EPDS recommended cut-off 5/6 for depressive &amp; anxiety disorders 11 (5.2%) fathers had distress caseness 6 (2.9%) fathers had depression</td>
</tr>
<tr>
<td>Dudley et al. 2001</td>
<td>Cross-sectional design</td>
<td>92 Fathers &amp; 158 Mothers</td>
<td>EPDS (10-item), BDI, GHQ-30 for men, EPDS for women, EPI, DSQ, PBI, SDAC for both parents Assessed between 1 – 6 months PN</td>
<td>11 (11.9%) fathers scored above cut-off ≥12 on the EPDS 45 (49%) fathers exceeded the threshold of one or more of the 3 screening instruments</td>
</tr>
<tr>
<td>Lutz &amp; Hock 2002 USA</td>
<td>Comparative Cohort research</td>
<td>107 First time fathers &amp; partners</td>
<td>CES-D, VSS, DEQ, MCLI @ 22 – 25 months PN</td>
<td>CES-D scores indicated higher rates of depression for fathers compared to mothers. Fathers considered to be as vulnerable to depression phenomena as women</td>
</tr>
<tr>
<td>Buist et al. 2002</td>
<td>Longitudinal research</td>
<td>118 First time fathers</td>
<td>EPDS (&gt;10 threshold), DAS, IBQ, MGRSS, PANAS, BDI, STPI, PPA Assessed late pregnancy &amp; 4 months PN</td>
<td>14 (12%) fathers distressed AN 6 (5.8%) fathers at 4 months PN</td>
</tr>
<tr>
<td><strong>/</strong> Skari et al. 2002 Norway</td>
<td>Prospective, longitudinal population-based cohort research</td>
<td>122 Fathers &amp; 127 Mothers</td>
<td>GHQ-28, STAI, IES Assessed day 4, 6 weeks &amp; 6 months PN</td>
<td>Psychological distress reported in 16 (13%) fathers and 47 (37%) mothers soon after childbirth</td>
</tr>
<tr>
<td>Matthey et al. 2003</td>
<td>Comparative cohort research</td>
<td>2 groups first time fathers (n=196) and (n=160) &amp; first time mothers</td>
<td>EPDS, CES-D, PMS, DIS, DSM-IV Assessed 6 weeks PN</td>
<td>Some participants were part of a preventive intervention research. Many men &amp; women did not have clinical depression but did have anxiety disorders</td>
</tr>
<tr>
<td>Condon et al. 2004</td>
<td>Longitudinal cohort research</td>
<td>204 First time teenage fathers</td>
<td>EPDS, GHQ-28, MHI-5, PANAS, SAIS, HSCL-90, WHOQOL, DAS, SSQ, IBM, AUDIT Assessed 23 weeks AN &amp; 3, 6 &amp; 12 months PN</td>
<td>Pregnancy rather than the PN period considered most significant period for fathers</td>
</tr>
<tr>
<td>Edhborg et al. 2005 Sweden</td>
<td>Comparative cohort research</td>
<td>106 Couples</td>
<td>Blues questionnaire, PBQ, EPDS, ICQ Assessed 2 months PN</td>
<td>Fathers reported significantly higher scores for impaired father-infant bonding compared to mothers at 2 months PN</td>
</tr>
</tbody>
</table>
### 2.2 Paternal postnatal depression

A substantial research interest in psychiatric illness and childbirth emerged following studies in the UK by Paffenberger (1964) who reported the nature and course of psychosis following childbirth and Pitt (1968) who described an atypical depression observable in some women postnatal. In 1971, a research interest in depression before
and after childbirth began to evolve in the UK (Rees & Lutkins) and was later
developed by Hangsleben (1983) and Atkinson and Rickel (1984) in the USA.
Although the studies consisted of reasonably small samples the research provided an
indication of the incidence and predictors of parents’ experiences with depression
before and after childbirth. A research interest in perinatal depression in mothers and
fathers began to surge in the mid 1990’s and gained a stronger focus in the early
2000’s both internationally and in Australia.

Ballard et al. (1994) conducted the first study to examine postnatal depression (PND)
in fathers and mothers after childbirth and used the Edinburgh Postnatal Depression
Scale (EPDS) and subsequently a number of researchers have investigated various
psychological disorders in fathers and mothers during the transition to parenthood.
Psychological disorders have been referred to in the research literature as postnatal
mood disorder (Soliday et al., 1999) depressed mood (Matthey et al., 2000)
psychological distress and stress (Skari et al., 2002; Zelkowitz & Milet, 1997)
psychiatric morbidity (Ballard et al., 1994) depressive caseness (Matthey et al., 2003)
and distress caseness (Matthey et al., 2001). The largest research interest has focussed
on parental depression symptomatology (Ranchandani et al., 2005; Lutz & Hock,
2002; Raskin et al., 1990; Leathers, Kelley & Richman, 1997; Soliday et al., 1999;
Atkinson & Rickel, 1984; Rees & Lutkins, 1971; Edhborg et al., 2005; Deater-
Deckard et al., 1998; Dudley et al., 2001; Areias et al., 1996a & 1996b; Madsen &
Juhl, 2007). Postnatal depression has been described in the literature as being
generally similar to non-postnatal depression (Leathers et al., 1997).
2.3 Prevalence of postnatal depression in fathers

A number of studies determined the prevalence of paternal depression in the postnatal period however there was considerable variability in reported rates of depression and this appeared to be dependent on the timing of assessments, instruments used for assessments, sample size and socio-demographic variables. Fathers experienced the highest rates of depression between three and six months postnatal although this outcome needs cautious interpretation as most studies measured paternal depression in the time period before childbirth and up to six months postnatal. Only a small number of researchers conducted longitudinal investigation over the first twelve months or more after childbirth (Ramchandani et al., 2005; Areias et al., 1996a, 1996b; Condon et al., 2004; Matthey et al., 2000; Lutz & Hock, 2002; Rees & Lutkins, 1971; Deater-Deckard et al., 1998).

Three large population-based prevalence studies were conducted in the UK, Denmark and Brazil respectively. Ramchandani et al. (2005) included 8,431 fathers to determine the prevalence of depression in fathers at eight weeks and twenty-one months postnatal with the EPDS (cut-off score of 12). Prevalence was estimated to be 4% (303). Madsen & Juhl (2007) assessed fathers (n=549) at six weeks postnatal with the EPDS (cut-off score of 10) and the Gotland Male Depression Scale (GMDS). Prevalence with the EPDS was 5% (27) and 3.4% (18) with the GMDS. Pinheiro et al. (2006) included a population-based sample of couples (n=386). This was the first study to determine the prevalence of paternal depression in an underdeveloped country. A translated version of the Beck Depression Inventory (BDI) was used as the assessment tool. The researchers determined that 11.9% (46) of fathers were depressed and moderate to severe depression was identified in 4.1% (16) of the forty-
six fathers.

Matthey et al. (2000) in Australia and Ballard et al. (1994) in the UK investigated the prevalence of paternal depression in first time fathers. Matthey et al. (2000) used the EPDS (cut-off score of 12) to assess fathers (n=157) before the birth of their baby and at four months, six months and twelve months postnatal. Prevalence rates were estimated to be between 2.8% (4) and 5.3% (8) at all four time points. A second study by Matthey et al. (2001) found similar prevalence rates of 2.9% (4) and 5.3% (8) in a cohort of first time fathers (n=208) assessed at six weeks postnatal for depressive ‘caseness’ (depression and anxiety) with the EPDS (cut off score of 12). This compares to Ballard et al. (1994) who found a similar prevalence rate of 5.4% (8) in fathers at six months postnatal. The EPDS (cut-off score of 13) was used to assess men (n=178) at six weeks and six months postnatal. A greater percentage of men 9% (16) were depressed at six weeks postnatal. These outcomes contrast to Lane et al.’s. (1997) research in Ireland that concluded the prevalence of depression was 1.2% (2) in a cohort of fathers (n=175) who were assessed with the EPDS (cut-off score of 13) three days postnatal and six weeks postnatal. This was the lowest prevalence rate compared to all other prevalence studies. Prevalence rates were estimated using convenience samples that included mainly Caucasian, employed and educated participants therefore outcomes cannot be generalised to the population.

Research by Soliday et al. (1999) in the USA and Bielawska-Batorowicz & Kossakowska-Petryka (2006) in Poland found higher prevalence rates in fathers compared to other investigators. Soliday et al. (1999) used the Centre for Epidemiological Studies Depression Scale (CES-D) to assess fathers (n=51) in the last
trimester of their partner’s pregnancy and two weeks postnatal. Thirteen (25.5%) fathers were classified as depressed two weeks postnatal. Similarly, Bielawska-Batorowicz & Kossakowska-Petryka (2006) estimated a prevalence of 27.5% (22) in a sample of fathers (n=80) measured with the EPDS (cut-off score of 13) at three and four months postnatal. However, again the participants in both studies were predominately Caucasian, educated and employed.

Two smaller investigations conducted in the USA by Raskin et al. (1990) and Leathers et al. (1997) included first time fathers. Raskin et al. (1990) used the CES-D to assess fathers (n=86) before and after childbirth. Twelve (14%) men were depressed antenatal and fourteen (16%) men were found to be depressed two months postnatal. Leathers et al. (1997) found a slightly higher prevalence rate of 18% (10) in fathers (n=55) when assessed with the CES-D at six months postnatal. Time lines of assessment varied considerably between the two studies and this might explain the variation in prevalence rates.

Rees and Lutkins (1971) and Greenhalgh, Slade and Spiby (2000) in the UK found different prevalence rates in similar sample sizes. Rees et al. (1971) used the BDI (cut-off score of 17) with a sample of fathers (n=77). Men were assessed six months antenatal and three months, six months and twelve months postnatal. Prevalence was estimated between 2% (1) and 13% (10) at all four time points. Greenhalgh et al. (2000) determined a prevalence rate of 6.4% (4) in a sample of first time fathers (n=78) with the EPDS (cut-off score of 12/13) at six months postnatal. These prevalence rates compare to those identified in a study by Areias et al. (1996a) in Portugal. The researchers included a small convenience sample of fathers (n=42) who
were assessed with a translated version of the EPDS in Portuguese and the Semi-structured Clinical Interview (SADS). Assessments were conducted six months prior to the birth and twelve months postnatal. Two (4.8%) fathers were diagnosed with depression in the antenatal period, 2 (4.8%) fathers were depressed at three months postnatal and 10 (23.8%) new cases of depression in fathers were detected twelve months postnatal with three persisting cases. This finding was significant as it indicated that paternal depression in men was not limited to the early postnatal period. Unfortunately the outcomes came into question as men (n=9) in the study had a history of depression, drug dependence (n=1), alcohol dependence (n=2) and general anxiety disorder (n=2).

2.4 Predictors for paternal depression

The most commonly reported predictors of paternal depression - depressed mood, psychiatric morbidity and distress - in fathers were caused by several factors that have been summarised in the following paragraphs.

Financial pressures

Fathers experienced financial pressures brought about by the added responsibility of providing for a growing family, sustaining the family on a single income while the partner was on maternity leave and additional economic burdens such as rental or mortgage fees (Zelkowitz & Milet, 1997; Bielawska-Batorowicz & Kossakowska-Petryka, 2006; Lutz & Hock, 2002). Unemployment contributed to elevated levels of stress and lowered self-esteem in men under pressure to meet financial obligations and provide for the family (Deater-Deckard et al., 1998; Ballard et al., 1994). Men
who worked part-time and/or lacked job security were found to be at increased risk of becoming distressed by the lack of financial security. A small number of researchers determined that men who were employed in a working class or manual position were at higher risk for developing depressive symptoms (Areias et al., 1996a & 1996b; Lutz & Hock, 2002; Leathers et al., 1997; Ballard et al., 1994; Buist et al., 2002).

Quality of the relationship

Harmony and quality within a relationship were considered to influence men’s level of satisfaction, self-confidence and emotional security in the transition to fatherhood. Additionally a satisfactory relationship was reported to have a more positive effect on the father-infant relationship and the amount of involvement fathers invested in the care of their infants (Deater-Deckard et al., 1998; Matthey et al., 2000; Lutz & Hock, 2002; Bielawska-Batorowicz & Kossakowska-Petryka, 2006; Zelkowitz & Milet, 1997; Hangsleben, 1983; Condon et al., 2004). Zelkowitz and Milet (1997) found that an unstable relationship and a lack of intimacy were factors that caused fathers to become stressed. Atkinson & Rickel (1984) and Matthey et al. (2000) explored the quality of relationships and couple morbidity before and after childbirth. Outcomes for both investigations determined that antenatal depression was the strongest predictor of postnatal depression in both women and men. However parents who supported each other physically and emotionally after the birth of their baby were more likely to experience a more positive mood during the first postnatal year.

Less social support

A large study by Deater-Deckard et al. (1998) included 7,018 couples as part of the Avon Longitudinal Research of Pregnancy and Childbirth. The aim of the
investigation was to determine how men adjust to new parenthood in different family structures. Factors such as unemployment and less social support, violence in the relationship and life events contributed to men developing depression. Moreover, fathers living in stepfamilies had higher levels of depressive symptoms before and after childbirth than men in more traditional families.
Several smaller studies reported that fathers who received less social support by family and friends in the postnatal period felt less satisfied in their role within the family (Zelkowitz & Milet, 1997; Hangsleben, 1983; Lutz & Hock, 2002; Areias et al., 1996a & 1996b; Atkinson & Rickel, 1984). Furthermore changes to lifestyle and added responsibility of caring for a family significantly impacted on men’s emotional wellbeing. Bielawska-Batorowicz and Kossakowska-Petryka, (2006), Buist et al., (2002) and Leathers et al., (1997) found that fathers who had less emotional support from their partners after the birth of the baby were more likely to experience emotional distress. This was founded on the father’s need for closeness with the partner and a sense of loss men felt when their spouse directed her focus on the infant.

**Correlates of depression in fathers and mothers**

According to Ballard et al. (1994), fathers were significantly more likely to become depressed if their partner was depressed in the postnatal period. This outcome was observed by a number of researchers (Dudley et al., 2001; Areias et al., 1996a & 1996b; Matthey et al., 2000; Soliday et al., 1999; Pinheiro et al., 2006; Bielawska-Batorowicz & Kossakowska-Petryka, 2006; Raskin et al., 1990). Factors that contributed to men becoming depressed were considered to be emotional unavailability when a mother was depressed and the need for fathers to take on extra responsibility for infant care, partner support and management of the household.

Overall, mothers were found to have higher rates of perinatal depression than fathers (Areias et al., 1996a & 1996b; Skari et al., 2002; Lane et al., 1997; Pinheiro et al., 2006; Ballard et al., 1994). Conversely, Lutz and Hock (2002) found a greater
percentage of fathers than mothers were depressed after childbirth. Contributing factors were considered to be marital quality, employment status and personality characteristics. Similarly, Dudley et al. (2001) determined that personality traits and poor coping mechanisms contributed to couple morbidity.

**Other predictors for paternal depression**

As described earlier, a number of variables were found to influence the onset of depression in men after the birth of their baby. However Condon et al. (2004) determined that the antenatal period was the most stressful time for fathers with little change in psychological symptoms after childbirth. Higher rates of depression were detected in a convenience sample of expectant fathers (n=208) and this was attributed to lifestyle changes, less intimacy between couples during the pregnancy and the responsibility of impending fatherhood. Socio-demographic characteristics indicated the sample was mostly married, employed and most pregnancies were planned.

A small number of researchers considered depressed mood, anxiety or depression in the antenatal period to be the strongest predictor for men developing postnatal depression (Rees & Lutkins, 1971; Soliday et al., 1999). A history of depressive illness (Edhborg et al., 2005; Areias et al., 1996a & 1996b), single parenthood and first time parenthood were also considered to be contributing factors (Skari et al., 2002), as well as unplanned pregnancy (Buist et al., 2002; Lane et al., 1997). Conversely Hangsleben, (1983) found few fathers (n=50) were depressed before or after the birth of their baby. Disrupted sleep, fatigue and irritability did not cause fathers to become depressed. The authors reported that overall fathers were well adjusted with lifestyle changes and the demands of infant care. However further
investigation would be warranted as the sample size was small and participants were older (mean 27.1 years), educated, middle class, Caucasian and employed and this might explain the relatively low cases of depressive symptoms in fathers. Similarly Raskin et al. (1990) found in a cohort of expectant and new parents (n=86) when one parent had dysphoria, the other was unlikely to be similarly affected.

2.5 Paternal mental health and its effect on the father-infant relationship

Ramchandani et al. (2005) included 8,431 fathers and were the first to provide research evidence from a large population-based study of the potential negative impact on a child’s development when the father has postnatal depression. The study examined the effect of paternal depression on the cognitive and emotional development of children until they were 3.5 years old. Fathers were assessed for depression with the EPDS eight weeks after childbirth and again at twenty-one months postnatal. Disturbance of children’s emotional and behavioural development at 3.5 years were determined with maternal reports on the Rutter revised preschool scales (which measures emotional problems, conduct problems and hyperactivity - p. 2202). Findings indicated that children were at risk of behavioural problems if the father was depressed during the postnatal period. Arguably the most important outcome from this research was the potential impact a father’s depression could have on his child’s cognitive, emotional and social development. However results were based on maternal interpretations of their children’s behaviour and there was no direct observation of father-infant interaction by the researchers.

The association between distress, stress and depression experienced by new fathers and the effect on the father-infant relationship was measured by a small number of
studies. Edhborg et al. (2005) investigated blues, bonding (the tie between the parent and the infant), perception of the child’s temperament and depressive symptoms in new parents (n=106) two months postnatal. The Postpartum Bonding Questionnaire (PBQ) was used to assess the level of parental-infant bonding and the Infant Characteristic Questionnaire (ICQ) was used to measure the parent’s perception of their child’s temperament. Results indicated that fathers scored higher on the PBQ at two months postnatal than mothers and had more difficulties establishing an emotional relationship with their infant. As with the study by Ramchandani et al. (2005) there was no direct observation of father-infant interaction throughout the research period.

Zelkowitz and Milet (1997) examined the relationship of stress and social support to perceptions of infant behaviour in a sample of fathers (n=50) whose partners had PND. Parental perceptions of infant behaviour were measured with the Neonatal Perception Inventory (NPI). The authors determined that paternal stress and less support from a depressed partner placed the father-infant relationship at risk. Gender role stress and men’s adjustment to fatherhood (Buist et al., 2002) was found to affect the father-infant bonding experience. However the assessment of the father-infant relationship relied on self-report measures without direct observation of father-infant interaction.

Dudley et al. (2001) examined the bonding experience between depressed parents and their infant in the first year after childbirth. The mother’s negative perception of her infant’s temperament was associated with maternal and paternal depression and this was thought to influence parent’s attachment with the infant. Correspondingly Atkinson & Rickel (1984) proposed that fathers who were depressed had a negative
perception of their infant’s behaviour. This compares to Hangsleben et al.’s. (1983) study of men’s transition to fatherhood and their involvement in infant care assessed with the 12-item Baby Care Activities Inventory (BCAI). Fathers who felt important in providing care for their infant performed more baby activities. Interestingly the researchers found that bottle-feeding appeared to increase fathers’ participation in baby care. The majority of respondents believed their role to be equally as important as the mothers both before and after childbirth. Also, there were very few symptoms of depression detected in the sample. The outcomes of these studies need to be regarded with caution as sample sizes were small and participants were educated, employed and predominately Caucasian.

2.6 Assessment tools for perinatal depression

A large number of assessment tools (n=66) were used to investigate paternal and maternal depression and there were too many to compare in this review. The BDI (Beck et al., 1961) to measure depression and anxiety, was used in seven studies and the Centre for Epidemiological Studies Depression Scale (CES-D) (Radloff, 1977) to identify the presence and severity of depressive symptomatology was used in six studies. The EPDS was used in sixteen of the twenty-six studies included in this review. Significantly, the BDI and the CES-D are not specific to the postnatal period and include items such as weight changes, loss of libido, sleep disturbance, difficulty in concentration and fatigue. According to Dudley et al. (2001) the frequency of mental disorders in fathers and mothers may by overestimated when these items are included as they cannot be distinguished from the changes that occur in the postnatal period.
Assessment with the EPDS

An Australian study (Matthey et al., 2001) included a convenience sample of fathers (n=208) and mothers (n=230) who were assessed six weeks postnatal. The Diagnostic Interview Schedule (DIS) (Robins, Heltzer, Croughan & Ratcliff, 1981) was used to determine scores for the EPDS (not known for fathers) and distress caseness (depression or anxiety disorders). The researchers specified that fathers experienced anxiety more than depression. Therefore fathers were assessed with the EPDS using distress caseness as the criterion. Results indicated a lower cut-off score of 5/6 was optimum as a screening value for anxiety and depression in men and a cut-off score of 7/8 for women. The authors concluded that the EPDS was a reliable and valid assessment tool to screen for depression and anxiety in men and can discriminate between distressed and non-distressed fathers. Moreover they suggested that the EPDS could be used to assess for depression in the general community. Matthey et al. (2003) broadened diagnostic assessment to include phobia, panic disorder, acute adjustment disorder with anxiety and major and minor depression. This aimed to increase the capture rate of caseness in first time fathers (n=356) and mothers (n=408) who were assessed six weeks postnatal. Matthey et al. (2003) indicated that both parents should be assessed for anxiety and depression referred to by the authors as ‘postnatal mood disorder’ (PMD) rather than postnatal depression.

The EPDS and the Gotland Male Depression Scale (GMDS) were compared for their sensitivity in the detection of depression in males (n=549) at six weeks postnatal (Madsen & Juhl, 2007). Five percent (n=27) of men were found to be depressed with the EPDS (cut-off score of 10) compared to 3.4% (n=18) with a GMDS (cut-off score of 13). Significantly, 20.6% (113) men had a score above the cut-off value of 13 on
the GMDS and a score that was under the cut-off value on the EPDS therefore the GMDS was found to be more sensitive to male depressive symptoms. The authors concluded that the EPDS was more sensitive in the detection of postnatal depression in men however the GMDS was more sensitive to male depressive symptoms.

2.6.1 Edinburgh Postnatal Depression Scale

As discussed in chapter one the EPDS was first designed by Cox, Holden and Sagovsky in 1987 to assess childbearing women for postnatal depression and was validated for use in the early postnatal period. The assessment tool has been used extensively in screening for depression in women in English and non-English communities and the translated version has been validated in several countries to assess for depressive symptoms in women using a cut-off score of 12/13 to indicate ‘probable depression’ and a cut-off score of 9/10, for ‘possible depression’ (Cox et al., 1997). The authors concluded that a cut-off score of 9/10 on the EPDS has 100% specificity and 76% sensitivity. The specificity of a test for depression is defined as the ‘proportion of people who are correctly classified as not depressed’ (Boyd, Lee & Somberg, 2005 p.145). The sensitivity of a test for depression is defined as the “proportion of people who are correctly classified as depressed” (Boyd et al., 2005 p.145). Matthey et al. (2001) validated the EPDS with new fathers and determined that the tool was a reliable and valid measure of mood in men. However the authors suggested a lower cut-off score of 5/6 was indicated to determine depression or anxiety disorders (distress caseness). Health professionals can administer the EPDS questionnaire without having specialist knowledge in psychiatry to measure symptoms such as depression, stress and anxiety in individuals.
Conversely, Areias et al. (1996a) sought to validate the EPDS with Portuguese mothers and to examine the incidence of perinatal depression in women (n=58) and men (n=42) before and after childbirth. The authors concluded that EPDS scores showed high values in both specificity and sensitivity in the women but did not appear to be sensitive with fathers. Moreover the authors concluded that the EPDS could discriminate major from minor depressive disorders in women but not in men. Language and cultural differences may potentially affect outcomes and it has been recommended that care should be taken so that the adapted tool is equivalent in both cultures (Guillemin, Bombardier & Beaton, 1993). Small, Lumley, Yelland & Brown (2006) support the use of the EPDS in cross-cultural research with postnatal women with the recommendation in future research that translation of the tool and extensive piloting of translations are implemented.

2.7 Gaps in the research on paternal depression

Research concerning men’s psychological distress and depression in the perinatal period has been investigated using predominately quantitative methods of inquiry. A variety of assessment instruments have been employed to determine the incidence, prevalence and predictors of paternal depression. Sample sizes varied considerably and most studies used convenience samples with little socio-demographic variation. Only five longitudinal population-based studies were conducted over a twelve to twenty-four month period (Ramchandani et al., 2005; Pinheiro et al., 2006; Deater-Deckard et al., 1998; Madsen & Juhl, 2007; Matthey et al., 2003).
Convenience samples (also referred to as non-probability sampling) involves the selection of participants based on their availability (Creswell, 2003) and are useful for obtaining information that a particular phenomenon or characteristic occurs within a given group (Miles & Huberman, 1994). According to Silverstein and Auerbach (2006, p. 353) this sampling technique is considered well suited to ‘studying groups about whom little is known’. However because some members of the population have no chance of being included in the sample the extent to which the sample represents the population cannot be known (Creswell, 2003).

The EPDS was the most widely used instrument in the detection of perinatal depression in fathers in the studies included in this review. Although the tool was considered to have 100% specificity and 76% sensitivity (Cox et al., 1987) in the detection of postnatal depressive symptoms and deemed to be a reliable and valid measure of mood in fathers (Matthey et al., 2001) it was purported by Areias et al. (1996a) to be less sensitive when used with men.

Additionally there is no gender-specific questionnaire that comprises items that are specific to the experiences of a new father after childbirth. According to Matthey et al. (2001, p. 176), an instrument that reflects the experiences, attitudes and beliefs of a specific group is ‘likely to have greater face validity for the respondents than some other measure of affect’.

Significantly no study to date has used a qualitative approach to explore men’s experiences with depression, anxiety and distress in the transition to parenthood as well as the nature and characteristics of those experiences. Therefore qualitative
inquiry would be the appropriate method for such exploration.

2.8 Identifiable patterns in the research literature

- Men were at increased risk of developing depression if their partner had PND;
- A prior history of depression/depressive illness, first time parenthood, life events, socio-economic hardship, unemployment, limited social networks and poor relationships the with partner contributed to fathers developing depression;
- First time fathers who were unsupported in the postnatal period were more likely to become distressed, anxious and depressed; and
- A lack of social support and social gratification contribute to father’s psychological distress.

2.8.1 Other findings identified in the research literature

- Antenatal depression experienced by expectant fathers was found to be more significant than postnatal depression (Condon, 2004);
- Distress caseness (depression and anxiety) rather than postnatal depression needs to be included in future investigation of paternal depression (Matthey et al., 2001);
- Personality and parental relationships place parents at risk for developing depressive symptoms;
- A large number (n=66) of self-report questionnaires were used to assess men’s adjustment to fatherhood, satisfaction with the parenting experience, father-
infant bonding and perinatal psychological distress;

- Time points for assessment, the type of measurement tool, sample size and interpretation of the data have contributed to the variations in prevalence rates of paternal depression in existing research;
- Postnatal couples are more likely to experience anxiety than depression (Matthey et al., 2003);
- Men have specific depressive symptoms compared to women and a gender-specific screening tool to detect male symptoms of depression needs to be developed (Madsen & Juhl, 2007); and
- The EPDS was not sensitive in the detection of depression in men (Areias et al., 1996a).

2.8.2 Convergence and agreement in the research literature

- Predictor variables of depression in fathers included a prior history of depressive illness, economic pressure, work pressure, lack of social support and social networking and a poor relationship with the partner;
- Fathers were at increased risk of becoming depressed if their partner had PND;
- A lower incidence of postnatal depression was detected in fathers compared to mothers;
- The EPDS was considered to be a valid measurement tool to assess men for paternal depression; and
- Paternal depression can have a negative impact on the father-infant relationship.
2.9 Summary

First time parenthood is a life changing experience and first time expectant and new parents are vulnerable to distress or depressive symptoms. The research literature does not dispute that some men are at risk for developing postnatal depression however this phenomenon remains, to date, under-researched. Despite an emerging literature about the changing roles of fathers, the incidence, prevalence and correlates of psychological disorders in fathers remains unclear. Existing research on depression has provided empirical data on the correlates of depression, dysphoria and psychological distress in couples during the perinatal period with only a small number of studies focussed specifically on fathers. The wide disparity in the prevalence of depression in men identified in international studies may be attributed to the use of different timelines after childbirth with different sample sizes such as small convenience sample groups or large population-based samples. Future prospective longitudinal research that employs a qualitative approach to investigation to explore the causal nature, onset and duration of postnatal depression in fathers is warranted.
CHAPTER 3 – THEORETICAL FRAMEWORK

3.0 Introduction

This chapter provides a discussion of the theoretical underpinning of this research using grounded theory analysis and symbolic interactionism. The code and category formation using constant comparative analysis have been discussed in detail. The memo writing and theoretical sampling techniques used to conceptualise and determine relationships between coded data are discussed. The principle guiding the interview process, the collection of qualitative data and the strategies used to ensure the rigour of the qualitative study are discussed in detail. The structure of this chapter includes a discussion on the principle of constructivist grounded theory followed by the methodology of Strauss.

3.1 Research question

An extensive review of the research literature concerning paternal depression in men before and after childbirth identified several themes:

- Paternal depression was associated with maternal depression;
- A number of terms have been used to describe depression in men before and after childbirth including paternal depression, depressed mood, anxiety disorder, depressive disorder and depressive caseness (depression and anxiety);
- Paternal depression is caused by a number of stressors;
- The father-infant bonding experience may be affected when men became depressed;
• Fathers had lower rates of clinically significant distress or depression than mothers; and

• An in-depth exploration of fathers’ experiences with paternal depression using a qualitative method of inquiry was warranted.

According to Kadam, Croft, McLeod & Hutchinson (2001), anxiety and depression are considered to be two of the most common disorders encountered by general practitioners and often co-exist. The aim of this research was to explore the experiences that first time fathers encounter with paternal depression, depressed mood and/or anxiety as well as their adjustment to fatherhood in the first twelve months following the birth of their baby.

Based on the outcomes of the literature review, a primary question was formulated as well as several key questions. Additionally the primary and key questions focus on postnatal depression because a greater proportion (n=19) of the cohort of twenty-three fathers has self-identified as having experienced symptoms of postnatal depression, depressed mood, distress and/or anxiety after the birth of their baby.

Primary question

If first-time fathers experience depression following the birth of their newborn, how does this impact their life in relation to parenting and their role as a father?

Key questions:

• Do their experiences vary at different points of time during the first twelve months of the postnatal period?
• Do their symptoms improve or worsen over the first twelve months of the postnatal period?
• How does paternal depression impact on a first-time father’s perception of the bonding experience with his newborn?
• What do men understand about their experiences of parenting, fatherhood and living with paternal depression?
• Is there a perceived gap in gender specific parenting education during the antenatal and postnatal period that may contribute to first-time fathers developing paternal depression?
• How does paternal depression affect the mental health and wellbeing of the father and his family?
• Are there other variables not identified in the research literature that will add to current knowledge about this phenomenon?

3.2 Research design

The nature and design of this research was based on a gap in the existing literature concerning the gender specific experiences of new fathers who recognise symptoms associated with PND, depressed mood and/or anxiety. As discussed in chapter two, paternal depression in first time fathers has not been explored using a qualitative approach to data collection and analysis. Also, there is no gender specific self-report questionnaire to determine if new fathers are coping with the experiences of parenthood.
This research used an exploratory, mixed methods approach and was divided into two distinct but interconnected stages. Stage one of the study involved a qualitative research approach to data collection and analysis using the tenets of grounded theory (GT) according to Strauss & Corbin (1998). Stage two of the study involved a quantitative study that was conducted in four phases and contributed to the development of a draft questionnaire. Both methods will now be discussed in detail.

3.3 Using two methods of inquiry

A longitudinal exploratory design was employed using both qualitative and quantitative methods of data collection and analysis. The aim of using both methods was to generate different forms of data providing a greater insight and a better understanding of the research questions (Ritchie & Lewis, 2003). Outcomes of the qualitative study were used to inform the quantitative study leading to the development of a questionnaire for new fathers.

Participants were interviewed at different time lines over a six-month period. A small group (n=4) of first time fathers were interviewed at two months, four months and six months after the birth of their baby. Interviews were conducted over a six-month period to determine the pattern of change in relation to time and to collect factual information on a continuing basis using the same participants (Jordan, 2004). Retrospective interviews were conducted with a second group of fathers (n=19) on two occasions approximately three months apart. The second interview was more focussed as the author sought specific information to extend theoretical categories and identify new codes.
A qualitative approach to data collection was used to explore men’s experiences in the transition to parenthood and paternal depression in-depth and identify important variables. Qualitative research allows the detail or understanding that is required of a phenomenon that may be too complex to be captured fully in quantitative statistical enquiry (Ritchie & Lewis, 2003). The author employed a qualitative method of inquiry in order to gain some insight into the participants’ thoughts and feelings as well as descriptions of their experiences Berg (2007, p. 3) posits that qualitative research refers to the meanings, concepts, characteristics, metaphors, symbols and descriptions of things; certain experiences cannot be meaningfully expressed by numbers and measures.

Grounded theory was used to systematically code interview data and develop theoretical categories which led to the development of an emergent theory (Strauss & Corbin, 1990). Several major themes were identified in the qualitative data that would be used to inform the quantitative study.

The quantitative study involved a sequence of four phases. Each phase served to rank, sort and refine a list of items obtained from the qualitative data that would be used in the construct of the coping questionnaire. The questionnaire was not designed as a measurement tool but to provide an indication to the health professional if a new father is coping with the early parenthood experience based on his responses. The questionnaire could be used as guide for further discussion between the father and the health professional and to encourage the father to debrief about his experiences, seek information or obtain advice. The fourth phase of the quantitative study involved a pilot study and included a sub-set of fathers (n=6) from the qualitative study.
Participants were asked to provide feedback on the format, wording and purpose of the draft questionnaire in order to determine face validity.

3.4 The discovery of grounded theory

Grounded theory (GT) was developed in the 1960’s by two sociologists Barney G. Glacer and Anselm L. Strauss (Polit & Beck, 2004). Glaser’s early academic training embraced the positivist paradigm and quantitative methods in research while Strauss followed a pragmatist philosophical tradition (Charmaz, 2006). In 1967, the two sociologists collaborated on a project that explored analytic ideas leading to the development of a systematic methodological strategy that social scientists could use to research a variety of topics (Charmaz, 2006).

Glaser and Strauss defined GT as a method of discovery theory that emerges from the data. Rather than deducing testable hypotheses from existing theories, Glaser and Strauss focused on developing theories ‘grounded’ in the data (Chenitz & Swanson, 1986). This method challenged the quantitative model on social science research (Mills, Bonner & Francis, 2006) and gained acceptance from quantitative researchers as a method that was known for its rigor and for its positivist assumptions (Charmaz, 2006).

Strauss and Corbin’s (1990, 1998) approach to GT departed from the traditional method devised by Glaser because the researcher asks questions of the data, makes connections between relationships and constructs theories based on interpretation. A paradigm model is used to make connections between categories and assists to provide an understanding of the conditions that surround events (Corbin & Strauss,
Paradigm model

The basic components of the paradigm model according to Strauss & Corbin (1998) include:

*Conditions* – the researcher asks why, where, how, and what of the data. In this process circumstances or conditions are revealed leading to the response.

*Actions/interactions and emotions* are responses by individuals to situations or events or problems and provide the reason or condition that caused their response.

*Consequences* are the outcomes of action/interaction or response to the situation, event or problem. This provides an answer to the question of what the individual did in response to the action/interaction or emotional responses. The use of the paradigm model throughout the coding and categorising of the qualitative data is discussed in detail in chapter five.

3.5 Constructivist grounded theory

This research follows the constructivist GT tradition because the primary purpose of the research is to explore the lived experiences of first time fathers through in-depth interviews and to collect rich, detailed data. Constructivists view reality as a social construction of individuals (Guba & Lincoln, 1989) through the theoretical concept of symbolic interactionism. Interaction occurs in the social world when people interpret and give meaning to the action of another person, reflect on the action and then react to it (Blumer, 1969).
According to Mills et al. (2006, p.2) ‘the researcher must choose a research paradigm that is congruent with their beliefs about the nature of reality’ in order to ensure a strong research design. However Mills et al. (2006) purport that Strauss and Corbin do not support the notion of a pre-existing reality rather that truth is enacted thereby supporting a relativist ontological position. Epistemologically, constructivism embraces the subjective relationships and experiences between the researcher and the participants and therefore fits within the interpretive tradition (Charmaz, 2006).

3.6 Using grounded theory methodology

GT is a systematic process that applies general principles and methods to the collection of data, the analysis of data and theory building (Howitt & Cramer, 2005) where the researcher constructs theory about issues of importance to people (Strauss & Corbin, 1998). Data analysis commences soon after the initial collection of the data. The researcher makes a constant comparison of the data by comparing incidents and events for similarities and differences.

Incidents and events that are conceptually similar and have been previously coded are put under the same conceptual label (Corbin & Strauss, 2008) and leads to the formation of categories. Categories offer a theoretical description of the data (Strauss & Corbin, 1998). As more data is collected and coded, conceptually similar codes are added to existing categories to further refine them. This method continues until categories become saturated and no new theories emerge from the data.
Grounded theory analysis uses inductive logic to generate the data and then deductive logic is used to compare the data against itself in order to produce theoretical frameworks (Kumar, Guite & Thornicroft, 2001). In-depth interviews with first time fathers enabled the author to explore the experiences of men when they become fathers as well as their experiences with paternal depression, depressed mood and anxiety. Theory building was continuous as the data was collected, transcribed and analysed. The author gained insight to the negative impact paternal depression can have on the emotional wellbeing of the father and his family and provided the data that added to the developing theory (Howitt & Cramer, 2005). This is discussed in more detail in chapter five.

3.7 Data collection

Unstructured interviews were used to collect rich textual data in the early stages of the research. As data analysis moved forward and the research became more focussed, structured interviews were designed to collect more data that would further refine categories and build on theories. Structured interview guides were used for the second and third interviews, as specific data was needed to expand and refine the information collected during early interviews. The collection of data stopped when categories became theoretically saturated and added nothing new (Strauss & Corbin, 1990).

3.7.1 In-depth interviewing

Interviews are one of the main methods used in the collection of data in qualitative research (Sproull, 1995). In-depth, semi-structured interview guides were used for the
first interview (Appendix 6a) and then structured interview guides were used for subsequent interviews as more specific information needed to be obtained. It was important for the author to establish a relationship of trust with the participant to facilitate disclosure and gain information that was relative but also meaningful to the purpose of the research (Schatzman & Strauss, 1973). This process will now be discussed in more detail.

3.7.2 Stages of the interview process

There are several stages to the interview process that Seale (2004, p.144-145) recommends as a systematic method of obtaining information that the author used to guide the interview process:

- Stage one - initial meeting and putting the participant at ease.

The author greeted the participant with an open smile and made light conversation. It was important to approach the participant in a relaxed manner and not appear rushed or disorganised.

- Stage two - introducing the research topic, explaining the purpose of the research and gaining permission to record the interview.

At this time the participant was assured of confidentiality. The author, for each interview, provided a brief overview of the content of the interview guide so the participant had some idea of what the conversation was going to focus on. Confidentiality was reinforced prior to commencing any interview.
Stage three - open the interview by obtaining background information first as that subject matter is familiar to the participant allowing him/her to begin to open up with information.

The first round of interviews commenced with a short demographic questionnaire and then proceeded with questions about the participant’s family to establish background information. Questions of a sensitive nature were asked later in the conversation once the author had established how comfortable the participant appeared with the interview. The participant’s body language and facial expressions gave an indication of how relaxed he was with the interview.

The flow of the conversation was also an indicator of the participant’s comfort level. If the participant showed signs of being uncomfortable with a particular question the author assured him of confidentiality and then approached the question in a different way. Alternatively, the question was left until later in the interview.

Stage four - key themes were explored and probes were used to elicit more information.

Probes were used to encourage the participant to provide more detail or to further explore a response that was potentially relevant to the data. For example: ‘I'd like you to tell me a little more about that’.

Stage five - as the interview drew to a close, the interviewer cued the participant by inviting him to discuss any topic covered in the interview in more depth.

The author cued the second to last question so the participant became aware that the
interview was drawing to an end. The participant was informed when the interview had concluded and was invited to make comments or suggestions about what had been discussed during the interview.

Stage six - once the tape recorder was switched off the interviewer thanked the participant and commented on how his contribution would help the research.

The author thanked the participant for attending the interview and commented that his contribution to the research was highly valued. The participant was informed when the author would contact him to attend the next interview and asked if he preferred to be contacted by phone or by email to arrange a day, time and location for the next interview.

### 3.7.3 Role of the interviewer

The role of the interviewer is to act as a facilitator to prompt the interviewee to open up during the interview and talk about experiences, feelings, thoughts and views (Douglas, 1985). The author made an effort not to interrupt the participant during his response to a question. It was important throughout the interview process to listen to responses and to pursue further any moment in the interview when additional clarification of a response was needed (Douglas, 1985).

The author demonstrated interest, respect, understanding and empathy towards the participant by maintaining eye contact when asking questions, by keeping the tone of voice at a relaxed but audible level, by staying focussed on the participant’s responses and not asking him to repeat himself. The author avoided forcing the conversation if the participant became visibly (face-to-face interview) uncomfortable.
The potential for role conflict

The potential for overlap as a midwife and researcher was an element that was considered thoroughly by the author prior to and throughout the duration of the research. The author’s role as a midwife may have shaped the types of questions used for interviews as well as how the research was presented and interpreted. The author was mindful of her professional role and prior experiences to avoid the possibility of introducing bias when conducting the interview and in the interpretation of the data. Consequently the author endeavoured to remain impartial at all stages of the research and discussed this process at periodic intervals with the supervisory panel in an informal manner.

The environment for conducting interviews

The environment hosting the interview was private, quiet and comfortable. The author, in preparation for the interview, prepared audio-recording equipment in advance, had a copy of the topic guide and placed a ‘do not disturb’ sign on any doors leading into the room hosting the interview. Staff in the surrounding area was advised in advance when and where the interview was going to be conducted. Bottled water and a glass were placed in proximity to the participant’s seat. The interview did not commence until the author had established if the participant felt comfortable and was ready to begin.

If at any time during the interview a participant demonstrated emotional responses such as anger, distress or embarrassment identified through body language and facial expressions (Minichiello, Aroni & Hays, 2008) the author did not interrupt his
response but demonstrated empathy through facial expressions and body language. If the participant stopped talking, the author offered reassurance and asked the participant if he felt comfortable to continue. According to Minichiello et al. (2008) unless the participant becomes very upset and distressed the interviewer is advised not to interrupt the interviewee but to allow him/her to articulate meanings and explore emotions in a supportive environment.

3.7.4 Probes and prompts

The author used probes to clarify a response or to further explore experiences described by the participant to gain a better understanding of them (Keats, 2000). When responses were brief, the author used probes to elicit more description and explanation from the participant. For example, one question asks the participant: ‘What community resources did you use to gain information about new parenting?’ Following the response, a probe was used to extend the participant’s response: ‘How useful were those services to you?’

The author, to encourage the participant to provide greater detail of his ideas, thoughts or feelings about a particular topic, used prompts (Fylan cited in Cronbach, 1990). At times, the responses were similar response to other participants’ and the author, in an effort to gain further perspective on the topic, used prompts to elicit more information to compare those responses for similarity (Keats, 2000).

For example, several participants gave a similar response to the question, ‘How do you see your role primarily within the relationship with your partner and baby?’ in that participants saw their role primarily to be a support role. The author then used a
prompt to expand on the response by asking, ‘How important do you consider a support role?’ Or, ‘I’d like you tell me a little more about what providing support to your family means to you?’

3.8 Coding the data

Grounded theory analysis involves the use of a three stage coding process using open coding, axial coding and selective coding (Strauss & Corbin, 1998). Coding of the data and development of an emergent theory has been explained in detail in chapter five.

Figure 1: Coding sequence for data analysis

In the initial stages of the coding process, open coding is used to identify and label conceptual codes in the data (Strauss & Corbin, 1998). Words or expressions that were used by the participant that held a specific meaning or stood alone were not given a conceptual label. This is referred to as an in vivo code (Strauss & Corbin, 1998).

The second stage involved axial coding. This was used to ask questions of the data to determine its meaning. Codes with similar relationships were grouped together to create categories and then sub-categories.

Selective coding required the author to combine categories with similar concepts with the aim of creating a core category. This process begins to refine a developing theory.
Throughout the coding process, the author wrote memos about thoughts and ideas of what was happening in the data, where the data appeared similar and what was a new development. Memo writing was a way of putting the author’s thoughts into writing. Diagrams were created to provide a visual perspective of the codes, categories and sub-categories. This assisted the author to make sense of the coding and categorising of the data.

3.8.1 Memo writing and diagrams

Memo writing is a fundamental process in GT analysis as it provides written accounts of analysis that relate to the formation of a theory (Strauss & Corbin, 1990). The author used memo writing to document thoughts and ideas about themes that were emerging from the data as well as codes and preliminary categories. Memo writing was a constructive way for the author to put thoughts down on paper at a particular point in time and provided a source of information that could be cross-referenced in the later stages of the coding process. Memos were written for each transcript as the interview data was compared with other interview data and led to the creation of an audit trail (Strauss & Corbin, 1990). Memo writing assisted the author to move from creating descriptive codes to creating more conceptual codes and categories as the skill with coding developed. By keeping the memos conceptual, the researcher will move the analysis beyond description to theory (Strauss, 1987).

Diagrams

Diagrams are used as visual concepts created by the researcher to explore the data, make links between key concepts and, to identify relationships between categories (Strauss & Corbin, 1998). The author used diagrams to create a visual picture of the
codes and preliminary categories in the early stages of the data analysis that represented maps of the author’s ideas and concepts. This helped to make sense of the data, especially in the early stages of the coding process when there were numerous codes and categories.

3.8.2 Constant comparative analysis

Constant comparative analysis was used to compare elements present in one data source with another i.e. one interview with another interview. This process was continued until the content of all the interview data had been compared to identify all commonalities (Polit & Beck, 2004). Comparative analysis assisted the author to identify connections and links between the data, codes and categories for similarities and differences. Incidents that were similar were placed under the same code adding to the properties and dimensions of that code (Corbin & Strauss, 2008). Codes and preliminary categories with similar concepts were merged in order to refine the codes. This process was continued until the codes became saturated and no new theories were being developed.

3.8.3 Theoretical sampling

Grounded theory analysis involves a number of key components one of which is theoretical sampling. This method of sampling differs to the initial sampling used at the beginning of the study as it involved collecting the data of theoretical relevance based on evolving concepts in order to elaborate and refine categories Strauss (1987). The aim of theoretical sampling is to obtain the data that will assist to develop the properties of a category and continues until it becomes saturated with the data and no
new properties emerge (Strauss & Corbin, 1990).

The author commenced the data analysis after the second interview and continued this throughout the first stage of the interview process. While coding the data, theoretical concepts or categories were created and these were noted in the memo journal. The author was able to establish several patterns emerging in the data that would lead to the development of an initial theory. Gaps identified in the developing theory that needed more detailed investigation prompted the author to develop an interview guide for the second round of interviews that contained structured questions (Appendix 6b). These questions were formed to gain specific detail from participants that would be used to elaborate and refine major themes in the data.

3.9 Rigour in qualitative research

A number of verification strategies can be employed to establish validity and reliability in logical-positivist quantitative methodology thus establishing rigour (Long & Johnson, 2000). However these methods of assessment are difficult in qualitative research. Seale and Silverman (1997) purport that the quality of qualitative research cannot be determined by prescribed formulas which are used in quantitative research. To ensure soundness of method, accuracy of the research’s findings and the integrity of assumptions made and the conclusions reached, the author employed several strategies that will now be discussed in detail.
3.9.1 Discussion of emergent findings with the advisory group

The advisory group were involved in a periodic review of each stage of the study including the data collection techniques and outcomes of the data analysis. The role of the supervisors here was to ensure that questions were comprehensive, fitting to the research topic and worded correctly, and this process was followed for each interview guide. To ensure a systematic approach to data collection and analysis had been undertaken and that the author remained true to the GT process of analysis, the supervisors, who were experienced in GT methodology, reviewed samples of the author’s coded data at each stage of the coding process. The feedback provided expert opinion to ensure that appropriate methods were implemented and data obtained was salient to the research topic.

3.9.2 Peer debriefing

Findings were discussed at regular intervals with knowledgeable colleagues in order to gain additional perspectives at various stages of the data analysis process. Short chapter drafts were presented at qualitative writing groups within the discipline of General Practice to gain constructive feedback and suggestions for making amendments. This activity provided comprehensive feedback from peers and served as a valuable guide to the authors writing style.
3.9.3 Presentations (Rice & Ezzy, 1999)

The author attended several national and local conferences throughout the duration of her candidature. Presenting at various interdisciplinary conferences as well as interested local groups allowed the author the opportunity to address the relevance of the study and to expose the research methods and findings to other researchers of varying levels of expertise. This served to attract valuable critical comment and/or suggestions from the audience that the author used to review and revise her work.

3.9.4 Prolonged engagement (Guba & Lincoln, 1989)

Interviews with participants were conducted at two or three intervals over a period of six to eight months. Interviews lasted for approximately 60-90 minutes. Conducting interviews with participants at various timeframes allowed the author to establish a rapport with each participant and to facilitate a level of trust in the interviewer/interviewee relationship. This process served to provide rich, quality interview data that was relative to the research topic.

3.9.5 Recording data objectively and comprehensively (Seale & Silverman, 1997)

Each participant in the study was provided with a copy of the transcribed interview and invited to give feedback about the authenticity of the information recorded and to validate if their responses were transcribed accurately. Participants could elect to have responses removed from the transcript or to make amendments if there was a perceived gap in the information prior to the author commencing the data analysis.
This chapter provided an overview of the discovery and development of grounded theory analysis and compared the traditional and evolved GT methods. The principle aim of GT analysis is to develop a theory ‘grounded’ in the data. A fundamental feature of grounded theory analysis is that data collection, data analysis and sampling occur simultaneously. Major themes in the data are identified and categories are created using a systematic coding process. Constant comparison of the data is used to develop and refine theoretically relevant categories. In-depth interviews and observation are the common form of data collection. Collecting sound interview data provides a foundation to capturing data that is relevant to the phenomenon being studied. The strategy for recruitment, ethical considerations, the sampling process and the means by which the qualitative data was collected is discussed in detail in chapter four.
CHAPTER 4 – METHODS

4.0 Introduction

This chapter provides a detailed description of ethical considerations, recruitment strategies and the sampling process used for the qualitative study. The study was promoted using several types of media and was successful in the recruitment of twenty-three men who volunteered to reflect on first time fatherhood and their experiences with distress, stress, paternal depression, depressed mood and/or anxiety.

4.1 Ethical considerations

Ethics approval to undertake this study was sought from The University of Adelaide Human Research Ethics Committee prior to the recruitment activity and was obtained July 20th 2007.

Ethical considerations:

- This study obtained information of a sensitive nature and the author ensured that the identity of all participants remained anonymous at all times;
- All digital recordings were erased once transcribed and transcripts remain in a locked filing cabinet in the Discipline of General Practice at The University of Adelaide;
- Access to all the research data was restricted to the author and her supervisors;
- Files will be stored at the University of Adelaide for a period of seven years;
- No identifying information has been used in any study artefacts, that is, in the thesis, published material or conference papers; and
- In case of participants becoming distressed or demonstrating a need for
assistance with depression or anxiety, counselling services were suggested including the local GP, the social work department of a local hospital, a local Community Health Centre or the Beyond blue website. A trained counsellor at The University of Adelaide Discipline of General Practice was available if required.

In gaining consent all participants received:

- A letter of introduction outlining the aims and objectives of the study project;
- The names, titles and contact details (work and after hours phone numbers) of the author and her supervisors;
- An information sheet outlining the details of each stage of the study and a consent form (Appendix 1) to conduct one-to-one interviews, audio tape the interviews and transcribe the interviews verbatim; and
- A copy of the Independent Complaints Procedure Form.

4.2 Recruitment

The study was first advertised in Adelaide’s Child magazine in August 2007 (Appendix A). This magazine was chosen because of its uniquely targeted publication to the Adelaide family market with children aged 0-14 years. Adelaide’s Child magazine is a free monthly publication and provides the latest information on a wide range of parenting topics, reviews of movies, videos and books for parents of infants, pre-school and school age children. It is distributed to the greater Adelaide metropolitan area including educational locations, retail, health locations and recreation venues. It was envisaged that the wide distribution area and the targeted readership would increase the capture rate of potential participants for the qualitative
As a recruitment strategy, the advertisement failed to generate inquiries from first time fathers in the community. The costs incurred for advertising were high and the author determined a new strategy that was both affordable and reached a wide-ranging audience within the community. The media centre for The University of Adelaide was consulted and a media release (Appendix B) was composed and released in The Adelaidean magazine, the free magazine of the University, on October 18th 2007.

The media release provided a brief description of the aims of the study and the need to recruit suitable participants who identified with specific criteria related to the symptoms of postnatal depression and anxiety. First time fathers from both metropolitan and rural communities in South Australia were invited to contact the study team via email or phone for further information.

The recruitment strategy was successful in promoting the study and attracted interest from journalists in Adelaide, interstate and New Zealand. Print media including the Sydney Morning Herald, The Herald Sun and Adelaide Advertiser, included a brief report about the study. Several local metropolitan, rural and interstate radio stations contacted the author to talk about the research topic. A popular radio station in New Zealand also contacted the author to participate in a talk back show.
Radio stations and print media

Radio stations:

New Zealand radio talkback show with Jim Moora

5AA talkback show with Amanda Blair

Perth Radio 6PR Bob Maumill

FOX MMM Melbourne

ABC radio national October 2007

Adelaide, Brisbane, Sydney, Melbourne, Port Pirie, Perth

Adelaide radio October 2007

- ABC FM, Fresh FM, FOX MMM, SAFM

Print media (Appendix C):

- Practical Parenting magazine February edition 2008
- Coles Baby magazine autumn edition 2008
- Sunday Life magazine Melbourne Age April 2008
- Sun-Herald Sydney May 2008
- Sydney Morning Herald 2007
- Sunday Life magazine – Sun Herald
- Melbourne Times
- Melbourne Age
- Article in Independent Weekly October 2007
- Adelaide Advertiser
- INTOUCH magazine (Mental Health SA)
4.2.1 Response to media exposure

Thirty-four men from several states of Australia contacted the author via email or by telephone expressing an interest in participating in the study. Email was a convenient and fast way to communicate with potential participants and provided a good forum to answer questions and exchange information. Several women made contact to express support of the study topic and/or to discuss their partners’ experiences with depressed mood, paternal depression and/or anxiety. Unfortunately, their partners were reluctant to participate in the study. All interested parties said they became aware of the study through their local radio station, print media or via the Internet.

4.2.2 Information for potential participants

Recruitment of a participant was not subject to a formal diagnosis of paternal depression by a health care professional.

Originally, potential participants included men whose partners were in the last trimester of pregnancy or who had just become a first time father within the last two weeks of a single infant not less than 36 completed weeks gestation with no physical or physiological impairment and/or disability. Men from both rural and urban South Australia were invited to participate at this stage.
In order to be eligible, men had to:

- Be aged 20 years or older (no upper limit). This age range was selected in an effort to prevent the introduction of potential bias to the research project. According to Condon et al. (2004) teenage fathers are potentially an at-risk subgroup of the population in terms of experiencing psychological symptomatology. Additionally, Burgess (2011) purports that fathers aged 18 years or younger experience unusually high stressors;
- Be able to read and write in English (from any ethnic group); and
- Be willing to share information through discourse about their experiences with first time fatherhood, paternal depression, depressed mood, anxiety and/or distress.

4.2.3 A need to broaden inclusion criteria

Two weeks following the media release, the criteria for recruitment needed to be broadened as men from other states of Australia with different levels of parenting experiences were interested in taking part in the research. These included first time fathers of infants older than four months and expectant fathers whose partner was in the last trimester of the pregnancy as well as fathers with older children who wanted to reflect on their experiences of first time fatherhood. The inclusion criteria was reviewed by the advisory group and broadened to include men from other states of Australia as follows:
Men who had experienced feeling distressed, anxious or depressed at some stage during the last three months of their partner’s pregnancy;

Men who had become a first time father in the last two to three weeks;

First time fathers who had experienced feeling depressed and/or anxious at some stage in the first three to twelve months since the birth of their baby;

Men with older families who expressed an interest in talking about their experiences with paternal depression and first time fatherhood; and

Men who were able to read and write in English (from any ethnic group) (retained from the original criteria).

A copy of the revised inclusion criteria was provided for The University of Adelaide Human Research Ethics Committee for their record.

4.3 Selection of participants

Thirty four (n=34) men contacted the author with an interest in taking part in the study. Of these, twenty eight (n=28) men were eligible and were sent an information sheet (Appendix 2) detailing the study’s purpose and a consent form (Appendix 3). Twenty three (n=23) fathers consented to participate. When the author had received a signed consent form, the person was contacted via email to acknowledge receipt of the consent form and to verify his inclusion as a participant in the study. All participants were supplied with a copy of the consent form for their personal record prior to conducting interviews.
Five men did not return a signed consent form despite two follow-up reminders. The author followed up reasons for men withdrawing their interest. One father planned to move overseas due to a job promotion. Three fathers determined that they did not have the time to participate in the study due to work and family commitments. Another father decided not to talk about his experiences.

4.4 The sample

The final cohort comprised twenty-three (n=23) fathers recruited from several states of Australia. Four (n=4) men were expecting their first baby and their partner was in the last trimester of pregnancy at the time of recruitment. Thirteen (n=13) men had one infant aged between 4 and 22 months. Six (n=6) fathers had children aged between 2 and 19 years.

The cohort was divided into two groups:

**Group 1:** Prospective interviews were conducted with four fathers (n=4) after the birth of their first baby. These fathers had experienced some degree of emotional stress or anxiety in relation to their partner’s impending birth and wanted to share their experiences as novice fathers during the first few months postnatal. The primary aim was to identify in the interview data obtained in the discourse with this small cohort of men if their level of stress or anxiety changed once they became a father, at what stage of the postnatal period this occurred and to determine the contributing factors.

**Group 2:** Retrospective interviews were conducted with fathers (n=19) of infants aged 4 months to 3 years and children aged 10 years to 19 years. The majority of participants had one infant and six fathers had more than one child. Fathers in this
group wanted to share their experiences of first time parenthood and reflect on their experiences with paternal depression, anxiety and emotional distress.

4.5 Self-selected sampling

Self-selected sampling is one method of investigation that allows potential participants to choose to take part in a study on their own accord. According to Walter (2006) people with an interest in the topic being researched are most likely to self-select. This form of sampling also allows participants the opportunity to share their experiences with researchers who have a vested interest in the phenomenon being studied.

Advantages of self-selection:

- Potential participants who meet the criteria for inclusion in a research project may save the researcher a significant amount of time and energy searching for appropriate candidates; and
- Potential participants who self-identify with the criteria are more likely to be committed to take part in the research and may have greater willingness to spend time attending interviews and to stay for the duration of the project (Walter, 2006).

Disadvantages of self-selection:

- There is likely to be a degree of self-selection bias (Babbie, 2007). For example the decision to participate in a research project may reflect some inherent bias in the characteristics or traits of the participant. This may lead to
the exaggeration of a particular finding from the research or the sample not being representative of the general population (Babbie, 2007).

Interview guide 1 (Appendix 6a) was used to conduct the first retrospective interviews and the first prospective interviews (fathers two months postnatal).

**Characteristics of the participants**

Men were aged 20 years or older and had self-identified as having experienced symptoms of postnatal depression, depressed mood, distress and/or anxiety before (expectant fathers only) or after the birth of their baby. The members of this purposive sample were selected for recruitment to the study because they had particular characteristics that would enable a detailed exploration of the central themes in relation to first time fathers and their experiences with paternal depression. Moreover, when utilising a GT approach, the sample must have knowledge of the phenomenon that is being studied in order to establish a dialogue between the interviewer and participant and will generate rich, dense data (Creswell, 2003).

Most fathers were educated at a tertiary level and employed full-time. Twenty fathers were married. Two fathers were cohabiting with their partner and one father did not live with the mother but was involved in all aspects of the pregnancy, birth and infant care.

All pregnancies were planned however seven pregnancies occurred a little sooner than expected. Most couples attended a public hospital for the birth. Two couples planned a home birth with a private midwife. One couple birthed at home and the other couple needed to be transferred to the local hospital when complications developed during
the labour. Within twenty-four hours of the birth, the couple went home under the care of their midwife. The majority of mothers had a vaginal birth although four mothers had emergency caesarean sections. Most women breastfed their baby and four women experienced breastfeeding difficulties within the first six months postnatal.

Approximately one third of the fathers did not have paid paternal leave due to work related policies and used their annual leave or took unpaid leave. The majority of fathers took one to two weeks paternal leave.

A table of the characteristic data of participants is provided in Appendix 5.

4.6 Commencement of interviews

Interviews commenced within two weeks of receiving the signed consent forms. Prospective interviews were conducted at two, four and six months postnatal with the smaller cohort of four (n=4) fathers. Retrospective interviews were conducted on two occasions approximately three months apart with the thirteen (n=13) fathers whose baby was aged four months or older at the commencement of the research and six (n=6) fathers with older children. This larger group of nineteen fathers (n=19) reflected on their experiences as a first time father over a twelve-month period or more.

The first six months of the postnatal period was selected based on the following considerations:
• Higher rates of depression were reported during the first three to six months postnatal according to outcomes of a meta-analysis of depression in expecting and new fathers (Paulson & Bazemore, 2010);

• Notwithstanding the limitations of using this follow-up period, the time line for the PhD precluded longer term follow-up.

4.6.1 Socio-demographic participant information

A questionnaire was used to obtain information in relation to marital status, education, employment status and ethnicity and was completed by participants at the first interview. This information is contained in Appendix 4. Table 1 and Table 2 provide information pertaining to participants’ age and the state and region they reside in.

Table 1: Participants’ age

<table>
<thead>
<tr>
<th>AGE</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 - 25</td>
<td>2</td>
</tr>
<tr>
<td>26 - 30</td>
<td>6</td>
</tr>
<tr>
<td>31 - 40</td>
<td>9</td>
</tr>
<tr>
<td>41 - 50</td>
<td>6</td>
</tr>
<tr>
<td>Over 50</td>
<td>0</td>
</tr>
</tbody>
</table>
Table 2: State, metropolitan or rural demographic information

<table>
<thead>
<tr>
<th>STATE</th>
<th>METROPOLITAN (N=19)</th>
<th>RURAL (N=4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SA</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>NSW</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>VIC</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>QLD</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>ACT</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

The final cohort of fathers was aged between 23 and 47 years (mean 35.02; SD 7.43). All participants were heterosexual and employed full-time or part-time with one father working on a casual basis. All participants were Caucasian with English being their first language.

Additional information pertaining to the background data, including previous experiences with depression, partners with PND, type of birth and breastfeeding problems in the first six months has been tabled (Appendix 5). Information is provided in numbers and percentages. Participants who identified as having experienced symptoms of paternal depression and/or anxiety or were formally diagnosed with paternal depression are represented in Table 3.
Table 3: Participants’ experiences with depression or depressed mood or anxiety or stress

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men who self-identified with symptoms of paternal depression or depressed mood or anxiety after the birth of the baby</td>
<td>9</td>
</tr>
<tr>
<td>Men diagnosed by a health professional with depression after the birth of the baby</td>
<td>8</td>
</tr>
<tr>
<td>Men diagnosed by a health professional with anxiety after the birth of the baby</td>
<td>2</td>
</tr>
<tr>
<td>Men (prospective fathers) who self-identified as experiencing anxiety or stress before the birth</td>
<td>4</td>
</tr>
</tbody>
</table>

The fathers (n=9) who self-identified with symptoms of depression or depressed mood or anxiety or stress after the birth of their baby reported that their negative emotional experiences commenced between two weeks and twelve months postnatal.

The fathers (n=8) who had been diagnosed as being depressed by a health professional developed symptoms of depression between two months and eighteen months after the birth of their baby.

The fathers (n=2) who had been diagnosed as having anxiety by a health professional reported that their symptoms commenced immediately following the birth of their baby or within the first three months postnatal.
At the time of recruitment four (n=4) prospective fathers self-identified as having felt some anxiety or stress in the last trimester of their partner’s pregnancy. They were recruited to the study so the author could ascertain in the analysis of the interview data if their level of anxiety increased, remained the same or improved after the birth expressed by the participants in the discourse during the interview process. None of these participants experienced symptoms of anxiety or depression when interviewed at two, four and six months after the birth of their baby. They did, however experience stress or distress in the first two to three months postnatal. This is discussed in more detail in chapter five.

4.7 Qualitative data collection

Interviews

Interviews with participants were conducted face-to-face or by telephone according to the participants’ preference. Five (n=5) fathers elected to have face-to-face interviews. Eighteen (n=18) men elected to be interviewed by telephone. Participants who elected to have face-to-face interviews were offered the choice to have the interview conducted in their home, at work in their office or in a private office at The University of Adelaide, Discipline of General Practice.

Two (n=2) fathers who lived interstate requested a face-to-face interview for the first interview and elected to be interviewed by telephone for the second interview. Interviews were conducted at a time that was convenient to the interviewees. Due to participants’ work commitments and availability, the majority of interviews were conducted in the evening during weekdays or on a Saturday.
Interview guide

A semi-structured interview guide was created with the purpose of exploring the research topic and to fit with the participants’ experiences. The guide (Appendix 6a) was developed based on information obtained from the research literature on first time fatherhood and paternal depression. The guide included the following eight themes:

- The antenatal and birth experience;
- Preparation for parenthood;
- The experiences of first time parenting and the role of being a father;
- The experiences of caring for the baby and the emotional connection;
- Changes to lifestyle;
- Relationships with friends and colleagues;
- Experiences with paternal depression and emotional wellbeing; and
- Local community support services, information and resources available for new fathers

Questions were purposefully open and broad to encourage the participant to talk about his experiences in as much detail as he felt comfortable providing. Probes, such as ‘Can you tell me a little bit more about how you were feeling?’ were used when the author wanted the participant to further explain his response, to define a meaning or to explore unexpected responses (Drennan, 2003). Prompts such as ‘Just getting back to the point you made earlier...’ were used if the discussion drifted from the topic or the interviewer required more information.
The interview guide was designed so that questions regarding emotional experiences and experiences with paternal depression were left until the later stage of the interview as they were of a sensitive nature. This allowed the author time to build a rapport with the interviewee and gain his confidence with the interview process. This was deemed by the advisory group to be particularly important when conducting the first interview.

Interviews conducted by phone or face-to-face were relaxed and informal and invited the participant to talk openly and freely. The environment in which the interview was conducted was private, quiet and comfortable. Each interview lasted approximately 60 – 90 minutes. At the conclusion of each interview, the participant was asked if there was anything further that he would like to add or if he had any questions. All interviews were digitally audio-recorded and transcribed verbatim by the author within twenty-four hours of the interview. The data analysis commenced after the second interview to develop an extensive list of codes and categories. These were extended using constant comparative analysis with consecutive interviews (Strauss & Corbin, 1998).

4.8 Transcribing the data

Full transcripts included all pauses, ums, repetitions and errors in grammar in order to remain true to the conversation as possible, to assist in the interpretation of the data and to improve rigour in the transcribed data. Non-verbal behaviour such as facial expressions, body language and laughter were included in the transcribed data to improve the level of detail provided during the interview experience and to assist in the interpretation of the meaning as it was intended. Any significant digression from
the topic was not included in the transcript if there was no meaning to the topic.

Once an interview had been transcribed a copy was sent to the participant to make comment on prior to commencing the data analysis. This added to the validity of the information contained and provided an opportunity for the participant to elaborate or delete information if desired. No participants suggested any corrections or amendments to a transcript throughout the course of the study.

Microsoft Word was used to transcribe the interview data that was then stored in a locked filing cabinet in the Discipline of General Practice at The University of Adelaide. All interview recordings were erased after being transcribed. Each participant received a copy of the transcript for his personal record.

4.9 Limitations to the qualitative method

A qualitative approach aims to identify and develop an underlying theory through detailed description and analysis of words to answer a question of fulfil an aim (Charmaz, 2006). Unlike the quantitative approach that uses precise measurements to test variables and seek evidence of cause and effect, a qualitative method requires an inductive and subjective approach to interpret the language and attribute meaning to events and the relationship between them (Cluett & Bluff, 2000). Therefore bias is possible in the observation, interaction and interpretation of the data and this ‘has the potential to skew results of the research, intentionally or accidentally’ (Cluett & Bluff, 2000. p 209). Moreover participants who provide a retrospective account of their experiences may be affected by memory bias. This is discussed in more detail in chapter seven.
4.10 Summary

Twenty-three fathers from several states of Australia were recruited to participate in the first time fathers and paternal depression study. The members of this sample all had characteristics that allowed the author to conduct a detailed exploration of the central theme of this study. A small number of fathers had been formerly diagnosed as having paternal depression and/or anxiety after the birth of their baby. Other fathers self-identified in the discourse as having experienced stress, distress, anxiety or symptoms of depression. Qualitative data analysis using the tenets of grounded theory was employed to create conceptual categories and develop theories from interview data using inductive analysis and has been described in detail in chapter five.
CHAPTER 5 – STAGE ONE - QUALITATIVE DATA ANALYSIS

5.0 Introduction

This chapter discusses the analysis of the qualitative data collected in stage one of this study. The tenets of grounded theory were employed to code and analyse the data, which were done simultaneously. Constant comparative analysis was used to identify connections and links between codes and categories for similarities and differences leading to the development of an emergent theory (Strauss, 1987). Memo writing assisted with data analysis as thoughts and ideas about codes, categories and emerging themes were analysed. Each stage of the data analysis process is discussed in detail. The chapter concludes with a discussion about the emergent grounded theory of ‘Coping’.

5.1 Transcribing interviews

While transcribing the interviews, the author made note of all the descriptive words used by participants in regards to their experiences as a first time father. Participants reported a range of emotions from elation and joy at the birth of their baby to feelings of frustration, anger and sadness in the first few weeks after the birth when they were trying to adjust to the changes in their lifestyle, the demands of caring for a newborn and coping with sleep deprivation. As the author continued to transcribe the interview data, common themes started to emerge and these were noted in the study journal for future reference.
5.2 Coding the data using grounded theory analysis

The interview data was coded using a three-step process. Open coding created many descriptive codes and categories. Axial coding then merged codes with similar meanings, expanded categories and created sub-categories. Finally selective coding allowed theoretical interpretations of the data that eventually led to the development of an emergent theory (Strauss & Corbin, 1990). Theoretical sampling was used to collect specific data to expand categories. Constant comparisons were made between the emergent findings in the data. In an effort to ensure theoretical sensitivity, the author read the transcripts two or three times and made notes each time about her interpretations of the data and then compared this with the research literature to compare relevant concepts (Strauss & Corbin, 1990).

5.3 Theoretical sampling and saturation

Throughout the coding process the author used theoretical sampling to collect more focussed data that would fill gaps in the theory and expand initial ideas (Strauss & Corbin, 1990). This was achieved with the development of interview guides two and three (Appendix 6b & 6c). The guides included more structured questions in order to obtain specific information from the participants during the second and third interviews. New data was used to elaborate and refine major themes until there was nothing new emerging from the data and the themes became saturated. The three stages of the coding process will now be discussed in detail.
5.4 Open coding

Open coding aimed to create conceptual codes and categories (Strauss, 1987). In the early stages of the data analysis, the author began coding transcripts by hand line-by-line and sentence-by-sentence. Throughout this process, the author remained open to the data while thinking about concepts and their relationship (Strauss & Corbin, 1990). The coding paradigm was used to ask questions of the data such as who, how, where and what was going on in the data (Strauss, 1987). As a novice to the coding process, line-by-line coding was a slow and time-consuming process. Many codes were created from the data and most were descriptive.

Codes that were similar in meaning were merged to form a single code. An example is provided in Figure 1. Similar codes were merged to create the code labelled identifying with symptoms.

Figure 1: Merging codes with similar meaning

<table>
<thead>
<tr>
<th>SIMILAR CODES</th>
<th>CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear, Anger &amp; Sadness, Negativity, Guilt, Denial, Uncertainty, Frustration Anxiety, Lethargy, Apathy, Emotionally overwhelmed</td>
<td>Identifying with symptoms</td>
</tr>
</tbody>
</table>
In vivo codes, words used by study participants that were explicit in their meaning, were not given a conceptual label for example *emotionally overwhelmed, frustration* and *fear*.

Codes with similar concepts were grouped to form a preliminary category. Formation of the preliminary category *experiences with paternal depression* is provided in Figure 2.

Figure 2: Codes used to create the preliminary category ‘experiences with paternal depression’.

<table>
<thead>
<tr>
<th>CODES</th>
<th>PRELIMINARY CATEGORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty accepting PPND</td>
<td>EXPERIENCES WITH</td>
</tr>
<tr>
<td>Screening for PPND</td>
<td>PATERNAL DEPRESSION</td>
</tr>
<tr>
<td>Physical symptoms</td>
<td></td>
</tr>
<tr>
<td>Identifying with symptoms</td>
<td></td>
</tr>
</tbody>
</table>

5.5 Using a data management tool

As the amount of data increased, it became more difficult to manage so information was transferred to a data management software program NVivo 7, so that further coding of the data was more manageable. The software program NVivo (QSR International Pty Ltd, 2008) supports qualitative data analysis. This programme also assisted the author to manage the amount of data that was coded, to store files containing interview data and to store memos and create diagrams using coded data (Bazeley, 2007). NVivo 7 was employed specifically to assist the author to work with
the large amounts of data and to provide quick access to stored information in a password protected format.

5.6 Developing themes and categories

An outline of the coding sequence was presented in chapter three however the creation of codes and categories is discussed in detail in the following paragraphs. Growing confidence with the coding experience allowed the author to continue coding paragraph-by-paragraph. As coding continued the author became more interpretive of the data and used in vivo codes less and less unless there was a specific term used by a participant that captured the essence of the meaning. More intensive analysis and merging of codes and categories contributed to more conceptual thinking and theorising about the data. The author returned to the first few transcripts that were coded to compare the data coded earlier with the data coded later and compared them for similarities and differences making note of emergent ideas.

After several interview transcripts the author identified several major themes in the data. These included experiences with paternal depression, changes in personal relationships, preparing for parenthood, how the role impacts the father, changes in lifestyle, bonding with the baby, defining the role as a father, emotional experiences of fatherhood and adjusting to added responsibility.

As analysis of the transcripts continued, categories continued to be extended as codes with similar concepts were added. At this stage of the coding process, six preliminary categories were created: Experiences with paternal depression, Bonding with baby, Learning to cope, Preparing for fatherhood, Dealing with emotions and Defining the
role. The author returned to previously coded transcripts and reviewed the codes and categories. Three more categories were created - *Support structures*, *Work-Life balance* and *Relationships*. Codes within each category were grouped to form a sub-category as part of the next coding phase.

### 5.7 Axial coding

The aim of axial coding was to extend theoretical categories and create sub-categories. Codes with similar concepts were merged to create a sub-category and this surrounds the central preliminary category (Strauss & Corbin, 1990).

The author endeavoured to make connections between preliminary categories and their sub-categories. The coding paradigm model was used when comparing coded data with participants’ experiences, context, actions/interactions, interpretations and consequences (Strauss, 1987). The constant comparative method of data analysis was employed to compare data, codes and categories.

At this stage of coding the data, nine preliminary categories were created with nine sub-categories. These are represented in Figure 3.
Figure 3: Codes, Sub-categories and Preliminary categories (bold type).

- Negative and positive emotions, taboo to disclose
  - Avoiding disclosure
  - DEALING WITH EMOTIONS

- Focus on birth, Wanting to be a dad, Understanding the role
  - Need to know
  - PREPARING FOR FATHERHOOD

- Changes to lifestyle, Expect the unexpected, Need for affirmation
  - Facing challenges
  - LEARNING TO COPE

- Struggling to connect, Making a connection
  - Emotional connection
  - BONDING WITH BABY

- Closer emotionally, Sharing experiences
  - Being involved
  - RELATIONSHIPS

- Finding what works, Establishing friendships, Establishing routine
  - Prioritising
  - WORK-LIFE BALANCE

- Accepting change, Becoming self-reliant, Valuing support
  - Developing networks
  - SUPPORT STRUCTURES

- Understanding the role, Support role, Provider, Traditional role
  - Functional role
  - DEFINING THE ROLE

- Difficulty accepting paternal depression, Screening for paternal depression
  - Identifying symptoms
  - EXPERIENCES WITH PATERNAL DEPRESSION
5.8 Selective coding

Selective coding was used to make comparisons between categories, sub-categories and codes to develop a core category (Strauss, 1987). The author looked at previously coded incidents that appeared to be conceptually similar. Incidents that were similar were placed under the same category, adding to the general properties and dimensions (characteristics and variations) of the category and helped to refine the developing theory (Strauss & Corbin, 1998).

5.9 Major categories and sub-categories

The following paragraphs describe in detail each of the nine categories and associated sub-category together with supporting statements by participants (P). To ensure participants’ confidentiality names have not been used.

Categories and sub-categories are represented in bold type. Codes are represented in italics.

**Major category 1: Preparing for fatherhood**

**Preparing for fatherhood** is the category that relates to the expectant couple’s preparation for childbirth. Couples attended antenatal education classes and sought information related to pregnancy and childbirth via print or Internet media. Expectant fathers *needed to understand the role* as a new father as they found antenatal education had a *focus on the birth* and provided limited discussion about what the father’s role should be once the couple went home from hospital. Conversely, two fathers thought it was better not to have too much information, only what was relevant
to the labour and birth experience.

(P 1) “I think there’s an element of getting too much information and that can be sometimes daunting and confusing and so I specifically did not want too much information”.

(P 5) “I just wanted to learn myself. I just wanted to learn from experience”.

(P 13) “It’s really, really important from my experiences. More education about or awareness about just what the initial stages are like after the birth would be really good”.

(P 4) “Education that involves the dad would be of help once the couple are on their own”.

(P 8) “I think the classes were excellent but they really didn’t capture the reality of it all”.

(P 9) “I wasn’t prepared. All of a sudden I’m a father now with responsibilities. Then when I come home I like order. There is all this crap around the house now we’re getting woken every one or two hours and I thought OK, we weren’t prepared for that”.
Sub-category 1: Need to know

The amount of information expectant fathers sought varied depending on their need to know. This sub-category relates to how expectant fathers wanted realistic information to help prepare them for fatherhood. Respondents expressed that the education format of the classes was interesting but did not provide the practical skills that fathers realised they lacked once the baby had arrived. This was particularly pertinent once the couple went home after the birth. Fathers reflected on how unprepared they were for the demands of caring for a newborn, that the baby could develop reflux or feeding problems, or be a poor sleeper and how this would impact the family. Moreover fathers relied on their partners to teach them about baby care and felt this was a burden to their partner at times because as a mother, there was enough demand on her emotional and physical time.

(P 21) “I think to even introduce the thought of things not going well would have given me something to have as a crutch, to have relate to, rather than finding out for the first time”.

(P 12) “I think it was a vulnerable time and I think with better education and with greater knowledge I’m sure it would have made a wealth of difference”.

(P 6) “He had a fair dose of reflux. We didn’t really expect that. It was like living with a flock of seagulls”.

(P 9) “They don’t tell you about the colic problems, the reflux problems, up and down all night and you still have to perform at work….the drain”.
Major category 2: Bonding with baby

The category Bonding with baby relates to the father-infant relationship. Several fathers reported feeling an instant love for their baby and described the bonding experience as immediate because they made a connection with their baby.

(P 17) “Immediate love, it was just an immediate love”.

(P 19) “I don’t know how to describe it but wow, so here’s our baby I guess that’s where you start to get that love of the baby and then it starts to build up. It starts straight away that sort of attachment”.

Breastfeeding was considered by fathers to be important for the health of the baby and contributed to maternal-infant bonding. Fathers also considered their support and encouragement of their partner to breastfeed was an important role. Significantly, several fathers commented that not being able to breastfeed the baby hindered the bonding experience for them, as they did not have the skin-to-skin contact with the baby that the mother had while breastfeeding. During this time, they described their role as being a passive observer as their contribution was limited to changing the nappy and supporting the mother in her efforts to breastfeed. Two fathers who were able to bottle feed their baby reported the opportunity to cuddle the baby and sit quietly with their baby during the feed had positively impacted on the father-infant bond. For a small number of fathers it took several months before they felt a bond with their baby as they struggled to connect.
(P 14) “I felt useless for quite a long time and I would say that I don’t think that we had particularly bonded per say for maybe six months or so. I actually felt a bit disjointed and disassociated in the process, just struggling yeah”.

(P 3) “I just didn’t get that contact like the skin-to-skin and the feeling”.

(P 16) “Obviously that was quite a strong bonding time for mum and baby but from a father’s point of view how do I bond with the baby when I don’t breastfeed?”

(P 23) “I struggled to bond with her. I loved her to death but as a bonding thing I think it’s still increasing and I guess it took about ten months before I could say there was a really good bond there”.

Sub-category 2: Emotional connection

Making a connection and struggling to connect were conceptually similar and labelled as the sub-category Emotional connection. At around six weeks postnatal when the baby started smiling or became excited at the sound of the father’s voice or the sight of his face was the time for several fathers when they felt a strong sense of connection with their baby. Fathers also reported that being able to play with their baby and take the baby for walks in the pusher facilitated the bonding experience.

(P 9) “A few weeks later I actually felt some deep sense of being a father. Bonding with a child is something that happens subsequent to birth. It’s not automatic but when it happens it’s very deep”.

111
“What really cemented the bonding between me and the baby was at about the five to six week mark. She started focusing more and looking at me and knowing when I walked past and that was a big thing like she actually noticed me. Also, a big thing psychologically was when she started smiling at me”.

“I don’t have any problem with the baby care habits. What is scary is having to constantly readjust because it’s clear that her attention, her awareness, her interests are actually growing. It’s now a case of sleep time is just 45 minutes and while she’s awake you’ve got to interact with her so in a way it’s another curve for me and I’ve got to readjust my expectations especially at the end of a working day”.

**Major category 3: Defining the role**

The category **Defining the role** related to participants’ early postnatal experiences as a first time father. The majority of fathers in this study did not understand what their role should be after the birth but participated in caring for their newborn, providing physical and emotional support for their partner, providing financially for their family and assuming various responsibilities within the family home. Fathers discussed their steep learning curve in newborn care and indicated they often relied on their partner for information and guidance. Some fathers described feeling a sense of failure or inadequacy at times when they could not settle the baby, especially when it was crying. Fathers provided physical support to their partners in the early postnatal period by changing the baby’s nappy, bathing the baby, settling the baby and sharing the housework. A small number of fathers described their role as a burden of responsibility in the early weeks after the birth of their baby however their outlook became more positive once their level of confidence improved and they were more
familiar with their infant and the routines associated with parenting. Affirmation from their partner that they were making a definitive contribution to the care of their baby was considered important to their self-esteem.

(P 19) “I had to really adjust to what my role exactly was over those first few weeks. It was a tremendous period of change, also adjustment”.

(P 18) “I didn’t know what my role was. I had absolutely no idea”.

(P 10) “I was concerned about how I was going to cope and wasn’t too sure I really wanted to be a father”.

(P 5) “I guess my role was in supporting my wife in terms of doing the dishes and washing and whatever needed to be done so she could focus on the baby. There was a lot of support on the periphery that allowed my wife to focus on her role”.

(P 23) “I always thought that I wanted to do more but I struggled with coping and coping with a lot of crying. She wasn’t a good sleeper and I really struggled with my patience because it wore thin very quickly and I wasn’t overly confident as well”.

Sub-category 3: Functional role

The codes traditional role, support role and provider are conceptually similar and have been labelled as the sub-category Functional role. This sub-category pertains to the role that men assumed once the baby was born. The traditional role was something that some fathers stated they tried to avoid but found it difficult because of the
dynamics of the family. The mother was the primary caregiver and stayed home with the baby for the first few months after birth. The father was in the workforce and provided the finances and helped with bathing and changing and feeding the baby at the end of the day and contributed more time to infant care on the weekend. Several fathers commented that they strove to be a better father than their own had been as the memories of their own fathers involvement within the family dynamic influenced how they wanted to parent. The majority of fathers strove to be more involved with their child both physically and emotionally.

(P 4) “It’s more a traditional relationship. I am the breadwinner and go to work while my wife stays home and looks after the baby. We didn’t plan it that way it’s just the reality of the situation”.

(P 6) “After the birth the practicalities started to set in and it was like well mum’s doing more traditional mums work and dad is going to go to work to earn the dollars. That was a bit unexpected. I sort of hoped to be there and share the jobs 50/50 but you just can’t”.

(P 12) “I’d go to work and then from the time I got home I fed the baby and then I’d give her a bottle and then put her to bed”.

(P 7) “On the weekends I needed to share the responsibility and take a little bit off my wife”.

114
Whenever I get the chance I feed the baby, I change the baby. When I get home from work I look after the baby and play with the baby”.

Major category 4: Work-life balance

The category Work-life balance pertains to the changes fathers experienced in relation to their work and home life. Fathers discussed the need to establish a routine in order to balance work commitments as well as meeting the needs of their family. Coping with various demands at work and at home was a major concern to most fathers as well as learning to prioritise so they could use their time effectively. As the primary financial provider for the family, they discussed feeling guilty at times spending long hours away from home and not having enough quality time with their family at the end of a work day. Most fathers compensated by spending more time with their baby on the weekends. Prioritising has been labelled as the sub-category.

On the weekends I probably take a more predominant role in doing a bit more with the baby to give my wife a break”.

My wife plays a bit of sport now and she does other activities so I’ll have him for a few hours on the weekend”.

I cut my hours down to four days a week which is the same as the mother. It’s great on a personal level. It’s about work-life balance”.

I’m gone up to 12 hours a day during the week and I was concerned that I wasn’t contributing enough”.
Sub-category 4: Prioritising

This sub-category relates to fathers prioritising what they considered to be a need within their relationship. Fathers generally agreed that spending time with their family, protecting their family and providing financially were major priorities. Providing emotional support for their partner as a new mother in the first few months after the birth was also considered a priority, especially when their partner was breastfeeding.

(P 11) “To be here, to provide, to help, to assist, and be there as needed. I’m responsible for their safety and protection and their wellbeing”.

(P 15) “We always have dinner as a family together every night. Unless there are some unforeseen circumstances and on weekends that’s the time I spend with them”.

(P 2) “My wife didn’t find it easy to breastfeed at first. I believed it was a good thing to breastfeed and I did my best to support her in that”.

(P 8) “I guess the way I was able to view my support was to give lots of encouragement and support. Making sure meals were cooked and looking after my wife as she was looking after our daughter”.

Major category 5: Relationships

The category **Relationships** refers to the couple’s personal relationship as well as their relationship with family and friends. Fathers commented that once the baby arrived the mother’s focus of attention was primarily on the newborn and they discussed the difficulty they felt coming to terms with taking second place in the relationship as well as having less time to spend with their partner. Most fathers were not prepared for the change in their personal relationship specifically being able to spend quality time alone with the partner as well as sharing less intimacy.

During the interview process the topic of domestic violence with the intimate partner was not addressed by the interviewer. Furthermore there was no indication by any of the participants to suggest there were feelings of jealousy or rage towards their partner or their baby during their partner’s pregnancy and/or the postnatal period. If, at any time, a participant had provided an indication throughout the discourse that physical or verbal violence has occurred at any time throughout the perinatal period, this would have been pursued by the interviewer.

(P 18) “There’s someone else. All of a sudden you’re sharing your time and you’re not getting any time”.

(P 22) “Emotionally we are closer because we are a family although physically and intimately we are a little further apart than before”.

117
“I knew life was going to change but I didn’t realise it was going to change that much. Our time together definitely diminished, it just dried up. There is something else in the house that needs lots of attention. It was competition I guess. I still craved her attention”.

In the early postnatal period some couples experienced tension in their relationship and this was attributed to sleep deprivation, having a baby with reflux or feeding problems, or the baby being a poor sleeper. Personal relationships improved for the majority of couples once the baby started sleeping through the night and became more interactive with the parents. Several fathers responded that the couple became closer emotionally as they shared experiences and worked together for a common goal. By three to four months postnatal, couples had more opportunity to socialise with friends and family. New friendships were formed with other young families. Participants commented that being close to their family was important as they were a source of support and helped with child minding. Four couples lived in a different state to their family and relied on each other and their friends for support.

“I think I’m better with dealing with the lack of sleep for one thing above and beyond coping with how we deal with our sleeplessness and the baby’s poor sleeping patterns”.

“Family support is really important especially in the early months after the baby”.

“A lot of people well and truly by now have their parents or their grandparents
playing a role in spending time with them which gives the parent’s time. That’s something we definitely lacked from the word go”.

**Sub-category 5: Being involved**

The codes *shared experiences* and *working together* formed the sub-category **Being involved**. This pertained to fathers learning to share the responsibility of caring for their infant and gradually becoming autonomous in their care. As fathers’ confidence in their role developed, they were able to look after their infant independent of the mother. Couples also developed a partnership in caring for their family.

(P 2) “Most things are pretty much shared amongst the two of us. Changing the nappies and getting up in the night and going into him when he’s crying and all that sort of stuff”.

(P 16) “I’ll stay home at nights so my wife can go out and she does the same so I’m more confident there that I can do the whole lot by myself”.

(P 20) “We work as a team now and get everything done we need to”.

**Major category 6: Experiences with paternal depression**

The category **Experiences with paternal depression** pertained to the negative emotions described by fathers. Several men realised early in the postnatal period that they were depressed. Three responded that they felt anger and disappointment when their partner needed to have an emergency caesarean section as they were given little information or support from staff during the event and no opportunity to debrief
afterwards. Another couple experienced a failed home birth that resulted in an emergency caesarean section at a local hospital. The private midwife that cared for the couple during labour was not allowed to stay and support the couple during the birth and this caused them considerable distress. A small number of fathers indicated that they thought their character might predispose them to becoming depressed.

How fathers identified with the symptoms of depression, anxiety or emotional distress varied. Some men learnt about depression by talking to friends or family who had knowledge of depression. Others sought information about depressive illness on the Internet. Two fathers whose partners were diagnosed with postnatal depression identified with the symptoms experienced by their partners. When they were asked what they understood about postnatal depression, the majority responded that they understood women can develop PND after childbirth but had not considered that men also could become depressed during the postnatal period.

Fathers used different strategies to cope with how they felt emotionally. A small number of them immersed themselves in work. Some men talked to their partner and others gave themselves time to recover. A small number of fathers sought treatment from a health professional and were medicated or counselled. Few fathers played sport regularly or had a hobby or interest that gave them time out from their usual routine, especially in the first six months after the birth of their baby. However they remarked that they were not particularly concerned with the lack of time out for themselves because they believed that the situation would change in time.
(P 18) “I think it was a very vulnerable time and I was overwhelmed. I felt very disoriented. I was always under a black cloud”.

(P 15) “I was very confused and upset by what was going on and what I was feeling and I didn’t really know what was happening. I was crying some of the time and feeling very panicky”.

(R 17) “I went on the Internet to Beyondblue and I emailed a father’s group”.

(R 20) “We had some female friends that had gone through PND. Then I read this article in the paper and that just hit the nail on the head. I reckon I read it three or four times going ‘oh’ every time I read it”.

Sub-category 6: Identifying with symptoms

Symptoms described by participants included fear, anger, fatigue, sadness, apathy, anxiety, feeling irritable, feeling useless and being withdrawn. These properties formed the sub-category Identifying with symptoms. Although several respondents acknowledged that they identified with the symptoms of depression and/or anxiety or emotional distress, not all of them actively sought advice from a health professional as they preferred not to disclose how they were feeling to someone else.

The general perception within the cohort was that there was a stigma attached to mental health problem such as depression especially for men and this caused them to be reluctant to seek professional help. In one instance, a father was encouraged by his partner to visit the GP because she was concerned with his excessive tiredness, apathy
and withdrawn behaviour. He did not have a past history of depression was diagnosed by the GP as being depressed but not with postnatal depression. The GP explained that he didn’t believe fathers became depressed after childbirth, only mothers.

(P 5) “Things didn’t change until I was medicated. I was more available physically and emotionally and able to give a lot more”.

(P 10) “I had a lot of difficulty talking about it. A lot of difficulty admitting to myself and to my partner that there was anything wrong or that there was anything in particular I needed to do about that”.

(P 4) “I had gone with my wife to the GP who listed off the symptoms of PND and I identified with every one of them”.

(P 9) “I just wasn’t able to cope and my wife was the one who encouraged me to seek treatment because I was the one feeling the physical symptoms and just assumed I was feeling tired and run down all the time and she said no, you need to go and see someone”.

(P 19) “There is a stigma attached to mental health full stop. For men I think it’s also compounded because we are not open enough and we don’t talk to enough people, we don’t have enough bonding”.

122
Major category 7: Dealing with emotions

The category **Dealing with emotions** pertained to the fluctuation of *negative and positive emotions* fathers experienced in the early weeks as a new parent. Participants could openly disclose *positive emotions* such as feeling joy at the birth of their baby, a sense of pride in being a dad and feeling overwhelming love for their baby. However most fathers admitted that they found it difficult to talk about *negative emotions* as it was considered a cultural **taboo to disclose** their emotions, especially to other males. Fathers discussed feeling a sense of failure when they could not settle their crying baby. Anger and sadness were expressed when a baby developed reflux and/or feeding difficulties as this was not expected and something for which the father had no control. Feelings of resentment and grief related to the loss of identity and the loss of ‘time to self’. While a few men could talk to their partner or a close friend or relative, however most men preferred not to disclose to anyone. This became the sub-category **Avoiding disclosure**.

(P 7) “I was pretty much overwhelmed. There was a degree of difficulty in understanding the level of emotions involved”.

(P 18) “There is a taboo with men. They just do not like talking about things and I have to say I’ve been like that a bit”.

(P 1) “I just kept it to myself. I didn’t feel right but I didn’t feel as though I needed to talk”.

123
Sub-category 7: Avoiding disclosure

Most fathers in this study preferred not to talk about the negative emotions they felt in the first few months after the birth of their baby. This was attributed to the fear of appearing emotionally weak and unable to cope as a man and a father. It also related to the cultural perception that men do not talk about their emotional feelings, especially with their ‘mates’. The majority of respondents expressed this view. One father had close friends with whom he could talk openly about his problems. Another father thought that Australian culture was more accepting of men being open about their emotions. Several fathers could talk to their partner but this was restricted at times because they thought their partner had enough to cope with emotionally in her role as a new mother.

(P 22) “The sort of stereotype of having to be the man and having to be resilient and strong. It stops a lot of males talking because it’s seen as a weakness. It’s not manly”.

(P 19) “In society we are supposed to be the strong pillars that never buckle under pressure. The stereotypical strong Aussie male. I’d say there’s a general perception that men’s emotional needs are nowhere near as great as a woman’s”.

(P 11) “It’s the cultural impression. Men don’t admit weakness. There are certain topics that you just don’t discuss”.
“I guess to a certain degree it’s the cultural impression of you know men don’t admit weakness. There are just certain topics you don’t discuss. I guess there have been times when I’d like to burst into tears and enjoy the idea that I could just fall apart but I also feel that I don’t have that luxury”.

**Major category 8: Support structures**

The category **Support structures** refers to fathers learning to *accept change, becoming self-reliant* in caring for their infant and establishing their own routine. Fathers discussed the value of having family and friends for *support* and advice. In the second interview, they were asked if they had a mentor with whom they could talk to about their experiences as a new father. Four men considered their father or brother to be a mentor with whom they could discuss their experiences as a parent. Although most of them did not have a mentor, they commented that the idea of having someone with experience to provide support and advice to be of value especially as a first time father. Additionally there was no indication within the context of the discussion to indicate that the relationship some of the participants had with their own fathers might have rendered them more vulnerable to developing depression when they became fathers for the first time. On reflection, a discussion around the lack of a mentor and how this might contribute to fathers’ vulnerability to depression would have been worth some exploration.

“Probably the biggest reason for first time fathers having a mentor is so they don’t get as worried and upset as I did because you’ve got someone who has been there before and can say hey, it’s all going to be ok”.

125
“I think family are extremely important. They do a fair bit for us and my wife’s mother looks after the baby a couple of days a week and my step-mother looks after him one day a week”.

“Priceless. We are really lucky we have a very good family group. All our parents are still alive and still together and have beautiful relationships and our brothers are great”.

“I’ve made heaps of changes in my life over the last six to twelve months and I’m very content with my place in the world now and what I’m contributing as a father”.

Sub-category 8: Developing networks

Networking with other fathers and new parents provided valuable resources to share information and ideas. This created the sub-category Developing networks. This sub-category pertains to fathers developing social networks with other new fathers and sharing information about parenting and infant care. Friendships between new parents developed through their partners’ involvement in local infant playgroups. When participants were asked if they would attend a playgroup for fathers and their infants there was a mixed response. Not having access to playgroup during the week because of work commitments appeared to be the major reason.

“We gained a couple of friends through the mum’s group. One family in particular we’ve become quite good friends”.
“A support network like relatives or friends that can be back up if you need them. Especially for your partner when you are just not able to be there”.

“I’d consider going to a father-infant playgroup”.

“Oh, probably not. I probably wouldn’t want to use a fathers’ only playgroup”.

“An inherent thing with guys is that we don’t talk enough and we don’t have the opportunity to talk enough and I literally say to you that if ironically if they could encourage fathers to have fathers groups or if the women could encourage the men to get together and go out and allow them to talk about their situation it would make a huge difference”.

**Major category 9: Learning to cope**

**Learning to cope** is a major category and coping appears to be central to most categories. Participants described a number of emotional stresses in relation to their experiences with new parenthood. These included coping with less sleep, maintaining an income, learning to be a parent, coping with the change to routine and lifestyle, coping with the change to their personal relationship with their partner, having less time to themselves, providing physical and emotional support for their partner, coping with the loss of identity, establishing a bond with their baby, living up to peer expectations and feeling responsible for their family’s safety as well as coping with the symptoms of stress, distress, anxiety and depression. Therefore **coping** is considered by the author to be the core category.
(P 6) “I thought to myself that at times you have a good day and other times you’re struggling to cope with it”.

(P 23) “Overwhelming is a good word for first time fatherhood. Things can be way too much to cope with. Certain things get pushed aside and you don’t deal with them”.

(P 3) “I realised that I just can’t do what I want anymore. I can’t sit down and read the paper. I can’t just watch a movie. I just can’t do what I want around the house. I’ve got a baby and the really big thing that hit me is I felt I’ve lost my life. I lost me”.

(P 15) “I’m coping better now but at the start I didn’t really cope with the broken blocks of sleep and I was getting pretty worn down pretty quickly”.

5.10 Core category: Coping

Nine major categories emerged from the data and related to the physical, psychological and social experiences of men’s transition to parenthood. Coping appeared as a category early in the coding of data and remained as one of the main categories. Several categories identified that fathers struggled to cope at the outset with the changes to their lifestyle, the changes to their relationship, meeting financial demands, bonding with their baby, determining their role, dealing with their emotions and finding a work-life balance.
Figure 4: The **CORE CATEGORY** of coping is represented in this diagram.

The nine major categories and sub-categories are also represented.
5.10.1 The concept of coping

Coping is defined as ‘the constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person’ (Lazarus & Folkman, 1984 p. 117). The contemporary view of coping is viewed as an active process influenced by different variables such as personal characteristics, the type of encounter and the length of exposure to a particular event (Lazarus, 1993) and compares to the traditional concepts of coping where traits or manner (Lazarus, 1993) influence an individual’s ability to cope with external stressors (Folkman & Lazarus, 1980; Lazarus & Folkman, 1984). Additionally Folkman, Lazarus, Gruen & DeLongis (1986) signify that coping is a psychological construct that pertains to a struggle with perceived demands and conflict and the emotional distress that is generated by these. The individual attempts to gain control over an external social event and maintain some degree of emotional and psychological balance in order to achieve effective actions and decision-making.

The model of coping posited here has similarities to that of Lazarus and Folkman in that it identifies cognitive and behavioural efforts. Cognitive efforts in the current model include the major categories of Defining the role and Preparing for fatherhood. Behavioural efforts include the major categories of Work-life balance and Support structures. Influencing variables in the proposed model include the major category of Experiences with postnatal depression. At the same time, the posited model is quite distinct in that it applies to coping in a specific context, that of the postnatal period, and to a specific group, new fathers. In contrast, the model by Folkman and Lazarus (1980), is intended to be more of a general model and has been applied to how coping
mediates that relationship between the stressors of daily living and psychological, physical and social wellbeing (p. 219) through problem-focussed, emotion-focussed and appraisal-focussed coping strategies.

5.10.2 Coping strategies

Coping strategies will influence how men adapt to fatherhood and what they do to reduce the effect of stress (Terry, 1991). Two prominent strategies identified in the literature include problem-focused coping where the individual aims to reduce stressors through a constructive approach to problem solving and emotion-focused coping that involves seeking emotional support or avoidance (Lazarus & Folkman, 1984). While it has been reported that women are more likely than men to use emotion-focused coping by seeking social support (Felsten, 1998), social networking and social support have been identified as factors that assist fathers to cope with the stressors of new parenthood (Zelkowitz & Milet, 1997; Diemer, 1997). Poor social functioning within a personal relationship may also influence poor coping strategies. Social resources and supports provide vital resources that individuals can draw upon to cope with their situation (Lazarus & Folkman, 1984). “The basic assumption is that people will better adapt to a given situation if they receive or believe they will receive social support when it is needed” (Lazarus & Folkman, 1984 p. 259). Avoidance also needs to be considered in this context as it can lead to depression (Felsten, 1998).

Fathers conceded that there were limited support systems available for them in the local community. For example, one father in rural South Australia felt let down by the local maternal/child health service after he and his partner sought advice on feeding.
problems and reflux in their baby. The parents were provided with outdated information and given a video about infant feeding that failed to address their concerns. Both parents endured their baby’s problems for a number of weeks and became increasingly distressed. They managed to obtain a referral to a dietician at the Women’s and Children’s Hospital in Adelaide who provided appropriate resources to improve their baby’s feeding and reflux problems.

On the other hand, some fathers found other avenues to gain support that were less confronting by establishing networks with other new parents with whom they shared a commonality. This provided them with the opportunity to exchange information and discuss some of the changes they encountered as a new parent and to obtain some comfort in the knowledge that they were not alone in their experiences. Family support was considered by fathers to be paramount as they offered advice, unconditional support and provided much needed time out for the couple through child minding.

5.10.3 Coping with emotional distress and paternal depression

In relation to men’s mental health, the notion of coping was the dominant category. With time, fathers came to recognise the extremes of emotions in relation to their experiences. Fathers who experienced symptoms of depression and/or anxiety after the birth of their baby identified their symptoms by sourcing information through the media or through family and friends who could relate similar experiences. Some men sought professional help with the encouragement of their partner because their depression continued up to and beyond the end of the first twelve months postnatal. Fathers who sought medical advice were treated for their depression and/or anxiety
with medication or with counselling. However a number of fathers elected to give themselves time to adjust to the changes they encountered and learnt to deal with their symptoms. For a small number of fathers, their experiences with stress and/or distress early in the postnatal period was self-limiting. Social norms of traditional masculinity and men’s inhibition of emotional expressiveness hinder men in seeking help for psychosocial problems (Möller-Leimkühler, 2002).

According to Williams (2005,) men in Western society tend not to perceive anxiety and emotional burdens as a potential health problem. Ill health is regarded as a sign of weakness and a threat to their masculinity. Men also will avoid seeking help for depressive symptoms because of the social stigma associated with having a mental health problem (Williams, 2005). Olliffe and Phillips (2008) posit that men’s self-disclosure and help-seeking for depressive illness was considered especially taboo when compared to sub-cohorts of men who experienced chronic diseases such as coronary health disease or prostate cancer. However in the discourse with the fathers in this study about stigma and social taboo, only two fathers believed the stigma of disclosure about depression existed in the community, which appears to challenge this notion. Investigation by Emslie et al. (2006) on men’s accounts of depression found that some men want to talk about their experiences with depression and have challenged the notion that men prefer to remain silent. The authors conducted a qualitative research comparing men’s and women’s accounts of their experiences with depression and reported that men who were willing to talk about their feelings and experiences with depression ‘consciously distanced themselves from culturally dominant forms of masculinity’ (p. 2249).
According to Courtenay (2000), hegemonic masculinity represents power and authority and health-related demonstrations of power and gender include ‘the denial of weakness or vulnerability, emotional and physical control, the appearance of being strong and robust and dismissal of any need for help’ (p. 1389). Addis and Mahalik (2003) suggest that men’s avoidance of help-seeking for physical and mental health problems is a product of masculine gender-role socialisation which has direct clinical reference for men’s help-seeking. In contrast, Emslie et al. (2006) identified in their analysis of in-depth interviews with men and their experiences with depression that a small number of their participants rejected the health practices associated with hegemonic masculinity and did not appear to find help-seeking as a challenge to their male identity (p. 2247).

Throughout the last few decades, fathers’ roles have evolved from the traditional role of an authoritarian figure and bread-winner to one that involves greater participation in the care of his children and engaging with household activities that offer more support to his partner (Day & Lamb, 2004). Wall and Arnold (2007) posit that although the culture of fatherhood in the 21st century indicates that fathers are more involved in their children’s activities and show more commitment to shared parenting, ‘cultural expectations surrounding this commitment are very different for fathers than they are for mothers’ (p. 522). According to Barclay and Lupton (1999), for some men undertaking their role and meeting social expectations in the early months of parenthood caused them to feel challenged by their expectations rather than rewarded. Moreover Jordan (2004) purports that some emotional distress is likely to occur as a reaction to significant role transitions as becoming a parent involves fundamental changes in interpersonal relationships, learning new skills and adapting to change as
well as readjustment of priorities.

Felsten (1998) asserts that men need to overcome that barriers in order to deal with the psychological and physical demands of the changes inherent in new fatherhood and to seek help through social support. Social network support and social support, particularly from the partner, friends and family (Barclay & Lupton, 1999), may assist men in their coping efforts and relieve psychological stress (Diemer, 1997).

According to Lazarus (1993, p. 237) ‘coping consists of cognitive and behavioural efforts to manage psychological stress’. Fathers in this study expressed that they found it difficult to cope with the range of emotions that felt foreign to them and even more difficult to disclose how they were feeling. The majority of men in this study chose not to disclose their emotions to friends for fear of appearing less masculine and being seen as ‘unable to cope’ as a father. Most fathers reported that they remained stoic and learned to cope with their emotional burdens rather than seek professional advice or talk to someone else as they considered the disclosure of personal feelings especially to other males, to be culturally unacceptable. However, several men relied on their partner as a confidante at times although not necessarily disclosing the extremes of their emotions as they felt that their partner was also dealing with the emotional burdens of new parenthood.

5.10.4 Coping and defining the role

The majority of men reported that they did not know what their role entailed once they became a father particularly in the early postnatal period. Fathers participated in
the care of their newborn and were often guided by their partner on the practical aspects of infant care such as bathing, changing and settling their baby. As discussed earlier in this chapter, participants considered their primary function as one of providing physical and emotional support for their partner, providing an income and protecting their family. Being involved in the practical aspects of parenting allowed fathers to develop the skills they needed to cope with the demands of caring for their newborn, to develop their role within the new family and to develop their confidence with the responsibilities of being a new father.

5.10.5 Coping with changes to the relationship

Participants disclosed that they were unprepared for the change that occurred within the dynamics of the relationship with their partner once the couple became a family. They often reported that the new baby became the mother’s focus of attention and fathers felt they had to learn to cope with their partner’s change of focus. Tension between the couples occurred in the first few weeks as parents were learning about their baby and adjusting to the changes in lifestyle. The lack of spontaneity to go out to do the shopping or visit friends or family was compounded by careful planning and preparation and this was considered to be time consuming. The lack of intimacy was an issue for some but not all fathers. Most men missed the emotional attention from their partner and being able to spend quality time as a couple. This was significant in the first few weeks after the birth of their baby but in time as the baby became older and the routine of feeding and sleeping started to change, the relationship gained momentum again as parents started to regain time together as a couple. Most fathers commented that the relationship with their partner strengthened as they shared a commonality as new parents.
5.10.6 Coping and the father-infant relationship

As stated earlier, some fathers commented that the bonding experience was instant and continued to develop as the baby became older while others found it difficult to feel any attachment to their baby and it took a number of weeks, even months, before they felt a bond with their baby. Fathers identified that the time of bonding occurred when the baby was older and the father was able to interact with the baby more. Fathers also commented that the bonding experience was easier once they became more confident in their role in caring for the baby. Some fathers commented that they found it difficult to cope with the guilt of not feeling an emotional bond with their baby until much later in the father-infant relationship.

5.10.7 Coping with limited social support

The majority of fathers commented that ‘there is nothing out there’ in reference to current information specific for males involved in infant care. Many fathers reported that when they could network with other new parents they learned more about childcare because new families shared a commonality and provided an avenue to share information. Interestingly, only a small number of men had someone who they considered a mentor and this was in most instances a brother or father. A mentor who was an experienced parent was considered by the majority of participants to be an asset, especially for a first time father as they could provide advice and information. Family support was highly valued as they offered emotional support and social support to the couple.
Paternal leave was considered to be important by all the fathers in this study because it gave them the opportunity to be at home with their new family in the early weeks after the birth of their baby. Paternal leave was also important to fathers because most men continued to work while their partner was in hospital and they did not have the opportunity to spend quality time with their partner and new baby.

Approximately one third of the participants in this study did not have paid paternal leave. This was attributed to having commenced a new job or not being eligible for leave because they had not worked with the company long enough to accrue leave time. Some fathers took annual leave to ensure they had some form of finance. Fathers who did manage to obtain paid leave took one week or two weeks at the most.

The short period of leave was considered by most fathers as not enough time to establish some semblance of a routine or to invest time in developing a relationship with their infant. This coincides with the findings by O’Brien et al. (2007). A few fathers commented that they felt guilty going back to work and leaving their partner at home alone to care for their baby. This was particularly relevant for couples that lived interstate and did not have the support of their family.

Several fathers suggested that paternal leave should be staggered so that men can spend time home with their families for one week of every month for the first four to six months. Five fathers were afforded the opportunity to work four days a week so that they could care for their child for three days of the week but this occurred after the first year postnatal.
One father became a full-time carer when his infant was six months old so that his partner could work full-time. This arrangement suited the couple and gave the father the opportunity to be a stay-at-home dad\(^1\). Two fathers worked from home so that they could spend more time with their child. Paternal leave was regarded by participants in this study as a topic that needs to be reviewed and improved by the government and society.

\(^1\)The term 'stay-at-home' dad was used by the participant and does not imply the expression of any opinion of the author.
5.10.8 Coping and work-life balance

In an effort to cope with the demands of work and home, most fathers discussed the need to establish a routine and to prioritise their time between family and work. In the early weeks after the birth of their baby, the focus for the majority of fathers was to provide an income to support their family. As time progressed, they commented that spending time with their family became a priority and they needed to find a balance between the two. A small number of fathers job shared with their partner and worked four days a week so that they could spend more time at home and participate in child care.

Working from home was another option that allowed fathers more time to spend with their family while procuring an income. The flexibility allowed them to take a greater role in the care of their infant and assisted to develop a closer bond between the father and his child. Fathers who cut back their work hours reported to be more satisfied with their work-life balance. However not all fathers had the option to be flexible in this way and had opted to spend more quality time with their family on the weekends rather than going to work or doing work around the home.

5.11 Comparisons with existing research

The author returned to the original literature review and then extended it to check if there were any existing qualitative studies that pertained to the experiences of new fatherhood and paternal depression with the emergent theme of coping. The two qualitative studies that concerned father’s experiences with postnatal depression (Meighan, Davis, Thomas & Droppleman, 1999) and the experiences of first time
fatherhood (Barclay & Lupton, 1999) found similar themes and patterns as those identified in this study and have been discussed in the following paragraphs.

Meighan et al. (1999) conducted a phenomenological study (‘description of the meaning of an experience from the world-view of those who have had that experience’ Cohen & Omery, 1994 cited in Meighan et al., p. 203) with eight fathers to gain a deeper understanding of the lived experiences of men when their partners suffered postnatal depression. Thematic analysis was used to identify common themes in the interview data. Barclay and Lupton (1999) conducted longitudinal qualitative research to investigate the experiences of fifteen first time fathers during the first six months postnatal. Discourse analysis (representation and creation of meaning through language and visual imagery p. 1014) was used to analyse the interview data to identify words, phrases, concepts and beliefs in the language participants used to describe their experiences.

Barclay and Lupton (1999) identified the following themes that correlate with several themes depicted in this study - changing relationship with partner, expectations and symbolic meanings of fatherhood and renegotiating paid employment and household work. The authors reported that first time fathers were challenged in meeting social expectations and defining their role within the new family. Furthermore work commitments influenced the amount of quality time fathers could spend with their baby and this affected the father-infant bonding experience. Fathers also felt excluded when their partner was breastfeeding and those that had the opportunity to bottle-feed their baby expressed a sense of engagement and bonding that was not achieved in other interactions.
Meighan et al. (1999) found that fathers were overwhelmed, frustrated, angry, lonely and anxious in relation to a sense of loss when the relationship with their partner changed and they received little emotional or physical support. Men described the need to be stoic regardless of their stress and fatigue with the increased demands of parenthood and living with a partner who was severely depressed. Additionally men reported that they had no outlet and limited time-out from responsibilities to the family and little social support from family and friends. Similar to the responses from the fathers in this research, Meighan et al. (1999) found that fathers needed additional support in order to cope with the changes to their lifestyle and personal relationships. Fathers also stressed the need for expectant couples to receive information about postnatal depression in antenatal classes and the steps parents need to take if one or the other parent becomes depressed. Barclay and Lupton (1999) and Meighan et al. (1999) found similarly that most fathers underestimated the level of disruption a new baby would cause to their lifestyle and relationship and while some fathers adapted and readjusted to the changes in their situation, others struggled to move forward for a long period of time.

5.12 Summary

The tenets of grounded theory were used to analyse qualitative data obtained in stage one of this study and led to the emergent theory of ‘Coping’. As the core category, ‘Coping’ was grounded in the data and emerged as the theory interwoven within most of the categories including experiences with paternal depression, defining the role, bonding with baby, changes in the relationship, limited social support and work-life
balance. The concept of coping and the strategies fathers used to cope with their experiences has been discussed. The emergent theory of coping was not identified in other qualitative research concerned with the experiences of men in the transition to fatherhood although two qualitative studies reported several similar themes and patterns to those found in this study. Major categories identified during data analysis were used in stage two of this study. This involved a four phase quantitative study in the development of the ‘Coping with new fatherhood questionnaire’ (CNFQ). Each phase of the quantitative study has been described in detail in chapter six.
CHAPTER 6 – STAGE TWO – A FOUR PHASE QUANTITATIVE STUDY

6.0 Introduction

This chapter discusses the four phase quantitative study which forms stage two of this study. Data from the qualitative study was used to inform this quantitative study. Each phase had a specific aim and employed a different method to create items, reduce items and refine items that would be used in the construct of a self-report questionnaire for new fathers. As discussed in chapter one, the aim of the questionnaire is to indicate if a new father is coping with the experiences of parenthood in the first twelve months postnatal and will be used as a research tool in a future population-based research. The author wanted to produce a tool that would be time effective for fathers to complete at any time during the postnatal period. To ascertain face validity of the draft questionnaire, the draft questionnaire was piloted with a small group (n=6) of first time fathers who had previously participated in the qualitative study.

6.1 Ethics approval

Ethics approval for phase one was not required. Ethics approval for phase two to four of the quantitative study was obtained from The University of Adelaide Human Research Ethics Committee in August 2008.
6.2 Flow chart of process

A linear process was conducted whereby data from one phase was used to inform the next phase. A flow chart (Figure 1) illustrates each phase.

Figure 1: Flow chart of phases 1 – 4

- **Study Aim**: Construct of a questionnaire to provide an indication if first time fathers COPE with their new role

- **Phase 1**: Items drafted following interviews with 23 first time fathers. Total items reduced 50% by experts according to the overall aim of the questionnaire, wording of items and replication

- **Phase 2**: Participants rank items on a 5-point Likert response scale according to how relevant each item appears in relation to their experiences of first time fatherhood

- **Phase 3**: Participants sort items into categories according to intuitive alignment and relevance

- **Phase 4**: Develop instructions and lead in Finalise the response format i.e. Likert scale Pilot the form with a small group of participants from the subset of the qualitative study to determine Face Validity
PHASE ONE – ITEM CREATION AND REDUCTION

6.3 Item creation

The author reviewed all the interview transcripts (n=50) from the qualitative study to generate a large pool of items (n=189) for the first phase of the quantitative study. Themes identified in the interview data were used to create items that included short statements about attitude or belief pertaining to the experiences of first time fathers during the transition to fatherhood. A combination of positive statements such as ‘I felt positive about being a father’ and negative statements such as ‘There were times when I felt I was not coping’ were included in the item pool. The author’s goal was to use the participants’ own language rather than using her own subjective interpretations to ensure the questionnaire appeared to have suitable face validity.

6.4 Criteria for item reduction

Three members of the advisory group were asked to appraise the list of items (n=189) with the aim of reducing the total number by 50%. In order to be retained, statements had to be

- Relevant to the aim of the questionnaire;
- Able to be understood by participants from a range of educational backgrounds;
- Straightforward and not open to misinterpretation;
- Non-repetitive; and
- Clear and concise in their wording.
Similar items were merged and any that were repetitive were removed. Ninety four (n=94) items were excluded creating a final pool of ninety-five (n=95).

The final pool of items pertained to a range of experiences including positive and negative emotions experienced by fathers in response to caring for their baby, father-infant bonding, changes to lifestyle, adjusting to added responsibility, being a father, relationship with the partner and social support from family and friends.

Negative emotions expressed by fathers included sadness, anxiety, anger, guilt, frustration, apathy, disillusionment and fear. Some fathers struggled to cope with the role as they were emotionally overwhelmed by their experiences as a first time parent. Other fathers expressed feeling a degree of difficulty coming to terms with the changes to their personal relationship as well as learning to adjust to the responsibility of fatherhood and the changes in lifestyle.

Positive emotions expressed by fathers included joy, overwhelming love for their baby, immediate attachment to the baby, feeling protective of the new family, reconnecting with their partner, valuing support from family and friends, a sense of pride in being a father, growing confidence with the role and enjoying the day-to-day interaction with their baby.
PHASE TWO – RANKING OF ITEMS FOR FURTHER REDUCTION

6.5 Introduction

The aim of phase two was to further reduce the pool of items (n=95) by at least 50% to create a pool of approximately 55 items that would be used in the draft questionnaire. Items were placed into a survey format with a Likert type response scale. The survey would be administered to a group of participants who would rank each item on the scale according to how relevant each item appeared in relation to their experiences of first time fatherhood. The development, implementation and outcome of the survey are discussed.

6.6 Design of the survey

The Likert Scale

The Likert scale was developed by sociologist Rensis Likert who was concerned with measuring psychological attitudes and wanted to do this in a scientific way (Uebersax, 2006). Likert scales may include a set of items that are rated on a 1-5 or 1-7 Disagree or Agree response scale where the respondent rates each item according to his/her subjective viewpoint (Trochim, 2006).

The author selected a five-point response scale for use in the questionnaire because it offered more variability in responses as compared to a forced choice three-point or four-point scale. It has been confirmed by Uebersax (PhD, Statistician) (2010, pers. comm. 24 April), the respondent burden should be considered when deciding on a five-point scale or a seven-point scale. According to Uebersax (2010) there might be
less encumbrance to the participant when responding to five options as opposed to seven options on a scale and this can be an advantage or a liability depending on the application. Additionally when considering statistical power, there is no difference between a five-point and a seven-point scale.

Rensis Likert’s sample scale (1932) had a traditional five-point alternative that included a Neutral or Undecided middle value that provides another choice for participants who feel they do not want to be forced into choosing a category (Dawes, 2008). The sample scale was considered by the author to be sufficient for the purpose of this survey.

6.6.1 Likert response scale

A Likert-type response scale was considered suitable for this survey because it was not the author’s intention to use a Likert scale where each item would attract a value that would be added or averaged to produce an overall score. In light of this, the response scale was designed according to the following criteria suggested by Uebersax (2006):

- The response scale is used to collect the response for an item. The participant will use his subjective viewpoint, attitude or opinion when providing a response as being Entirely relevant (higher agreement) or Entirely irrelevant (lowest agreement) to each item in the survey;
- The item is not associated with a scale value as mentioned earlier. Responses may be summed to create a score for a group of items and this is referred to as
a summative scale (Uebersax, 2006). The response scale for this survey is not intended as a summative scale; and

- The response is used for a single item so the participant treats each item separately.

6.6.2 Advantages of the survey

A survey design was used for this phase of the study because:

- Participants could remain anonymous;
- The survey could be completed at the participants’ convenience;
- The potential for interviewer bias is eliminated;
- A survey is time effective compared to conducting one-to-one interviews; and
- The survey would be cost effective (no travel or parking costs, copies can be printed off quickly and can be emailed or posted).

6.7 Recruitment of participants

The participants (n=23) who had taken part in the qualitative study in stage one were contacted by email and informed about the aim of the quantitative study and invited to complete the survey. A subset of participants (n=13) volunteered to participate. Each participant was sent an information package that included an introduction letter (Appendix 7), a consent form (Appendix 8), instructions to compete the survey (Appendix 9) and, a postage paid envelope in which to return the completed survey.

In order to ensure confidentiality and anonymity of participants:
- A cover letter detailed the aim of the exercise and how the results of the survey would contribute to the development of a self-report questionnaire for new fathers. The potential participant was assured in writing that responses were confidential. Each survey distributed would not contain any identifying features that would link the author to the participant.

- Participants were assured that there were no right or wrong responses and the objective of the survey was for the respondent to determine the degree of relevance for each item in relation to his experiences with new fatherhood.

6.7.1 Considerations

The disadvantage of using a self-report survey is the possibility of a low response rate. In order to encourage participants to complete and return the survey, the author ensured the following according to Edwards, Roberts, Clarke, Diguiseppi, Pratap, Wentz and Kwan (2002)

- The recruited participants that were interested in the topic;
- Included in the information sheet that items in the survey came from interview data and it was desirable that participants have knowledge pertaining to the topic being surveyed as they had a better understanding of the content;
- Included a due date for the return of completed surveys and included a prepaid envelope for the return of surveys; and
- Provided at least one reminder to non-participants and sent another copy of the survey in case the first one was lost or misplaced.
6.8 Ranking items in the survey

To facilitate a high response rate to the survey the author sent a reminder email to participants who had not returned the completed survey by the due date. According to Cluett & Bluff (2000) this method may increase response rates by 20%.

Method

Respondents were invited to rate each item on a five-point response scale according to the degree of ‘relevance’ he felt as being most characteristic of the statement according to his experiences as a first time father.

Participants were invited:

- To treat each item separately from every other item;
- That responses should indicate the participant’s own point of view based on his own experiences rather than what others might do or most people would do; and
- That there are no wrong or right answers.

The five-point Likert response scale options included Very Relevant, Somewhat Relevant, Neither Relevant nor Not Relevant, Fairly Irrelevant, Entirely Irrelevant (Appendix 10). It is necessary at this stage to emphasise that there was no score allocated to each response option. Total responses to each item were summed and this will now be discussed in more detail.
6.9 Survey responses

The author created a frequency table consisting of the sum of the responses to each item (Appendix 11) and met with the advisory group to discuss the results. A frequency histogram was created to provide a graphic representation of the summed responses to each item (Cross, 2005). Excel was used to create a graphical summary of the shape of the data’s distribution (Appendix 12a & 12b).

Higher item scores indicated a more favourable attitude by respondents (Capelleri, Gerber, Kourides & Gelfand, 2000). Entirely Irrelevant and Fairly Irrelevant received relatively low response rates therefore the author was advised to combine the responses to both (Appendix 11a & 12c) and to remove items that received a combined response of three or more. Therefore thirty-six (n=36) items were removed leaving a final pool of fifty-nine (n=59) items that would be used in the modified Q-sort exercise.

1 During the re-check of the data the candidate discovered that thirty-nine (n=39) items received three or four responses therefore thirty-nine items (n=39) should have been removed leaving a pool of fifty-six (n=56) items. However, items 69, 71 & 88 (with scores of three or more) were missed and thus were excluded in the final pool of fifty-nine (n=59) items.
6.9.1 Results

Total responses for each of the five categories on the Likert response scale are summarised as follows:

- Ninety-five (n=95) (100%) items were rated as being Very Relevant by at least one participant;
- Ninety-four (n=94) (98.9%) items were rated as being Somewhat Relevant by at least one participant;
- Eighty-three (n=83) (87.3%) items were rated as being Neither Relevant nor Not Relevant by at least one participant;
- Seventy-three (n=73) (76.8%) items were rated as being Fairly Irrelevant by at least one participant; and
- Fifty-two (n=52) (54.7%) items were rated as being Entirely Irrelevant by at least one participant.

The majority of participants (9 out of 13) rated the following items as being Very Relevant.

1. I enjoyed being with my baby
14. I felt positive about being a father
20. I felt joy at the birth of my baby
37. I felt it was my responsibility to protect my family

\(^1\)Total responses for each of the five categories reflects the data listed in the frequency table (Appendix 11).
The following items were rated by 8 out of 13 respondents as being *Somewhat Relevant.*

5. I could prioritise needs for the family
61. I felt confident that I was going to manage as a new parent
69. I relied on my partner for guidance in the first few months

One item received 7 out of 13 responses as being *Neither Relevant nor Not Relevant.*
45. I felt comfortable talking to my GP when I felt depressed

A minority of respondents (4 out of 13) indicated that the following items were *Fairly Irrelevant.*

56. I avoided talking to others about negative feelings as a parent
60. I felt the information I learned before the birth prepared me as a new parent
67. I felt I was competing with the baby for attention within my relationship
70. I felt I was in a rut
72. I needed more time for my own interests and hobbies

Finally, 5 out of 13 participants indicated that the following statement was * Entirely Irrelevant.*
76. My confidence as a father has never improved.
6.9.2 Interpretation of the results

The items that received the highest scores as being Very Relevant were related to positive experiences of being a father. The items rated as being Fairly Irrelevant may suggest that this cohort of fathers did not consider their needs to be particularly relevant. Items rated as being Somewhat Relevant may suggest that fathers’ negative emotions were considered as being less relevant within the broader context of the parenting experience.

6.10 Summary

Items in phase two were reduced to fifty-nine items (n=59) for use in phase three as part of a modified Q-sort activity. The design, implementation and outcomes for each stage of phase three are discussed in detail.
PHASE THREE – SORT ITEMS

6.11 Introduction

Phase three involved a modified ‘Q-sort’ technique (Brown, 1996) to sort items into themes. The fathers (n=23) who participated in the qualitative study were invited to participate in the Q-sort exercise. A subset of participants (n=6) from the qualitative study volunteered to participate and was invited to sort a list containing the 59 items identified in phase two into a table consisting of nine themes. Themes were identified during the analysis of interview data in the qualitative study in stage one.

6.12 Q-Methodology

Q methodology was developed by physicist-psychologist William Stephenson and is widely associated with quantitative analysis and its use in factor analysis (Brown, 1996). According to Brown (cited in van Excel & de Graaf 2005, p. 2) ‘the rankings are subject to factor analysis, and the resulting factors, in as much as they have arisen from individual subjectivities, indicate segments of subjectivity which exist’. Brown (1996) purports that qualitative researchers can use Q methodology to reveal subjective standpoints, attitudes and perceptions from the stance of the person or persons being observed. Q methodology has been used in the fields of academic psychology, communication, political science and more recently in the fields of behavioural and health sciences (Cross, 2005).
Q methodology is a self-directed process where participants are required to rank-order a set of statements from the most to least agreement (Cross, 2005). Statements are usually taken from the interview data thus, ‘grounded in concrete existence’ (Brown, 1996, p. 561). There may be 10 to 100 statements provided on cards referred to as the ‘Q set’. Each card is numbered and the participant is instructed to place each statement within a category on a grid according to his or her subjective preference (Cross, 2005).

Figure 2 provides an example Q-sort grid. Participants are invited to place each item within a category along a continuum. This forced distribution of items is referred to as ‘Q sorting’ and allows the respondent to model his/her view or account by sorting items into categories (Cross, 2005). Forced distribution encourages the sorter to compare items and determine which are more or less characteristic of a particular category in the placement of items (Young, 2005).

The aim of Q methodology is to obtain a range of different subjective points of view and allow respondents to apply their own meanings and understandings of the items (Cross, 2005). There is no right or wrong way to sorting (Young, 2005).
Figure 2: Diagram of an example Q-sort

O = neutral, 3 = stronger agreement, –3 = less agreement

6.12.1 Modified Q-sort method

A modified Q-sort exercise was used for this component of the study based on the need to simplify the exercise so that it was less complicated and less time consuming for the participant. The modified Q-sort design’s purpose was for respondents to sort items into themes according to his subjective interpretation. The participant’s personal experiences and beliefs would play a pivotal role in the placement of items (Young, 2005). Participants would be familiar with the items and themes based on their personal experiences and their prior involvement in the qualitative study in stage one. This gave meaning to the process of sorting data. The proposal to use a modified Q-
sort was taken from a study by Turnbull, Reid, McGinley and Shields (1995) who used a similar method when developing a questionnaire to measure midwife attitudes to the professional role.

6.12.2 Themes for the Q-sort exercise

Nine major themes were identified during the coding and categorising of interview data from the qualitative study and include the following:

1. Experiences with paternal postnatal depression
   This theme pertains to a number of negative emotional responses reported by fathers during the early parenting experience. Emotions included fear, anxiety, stress, distress, frustration, guilt, anger, apathy, sadness and apprehension.

2. Bonding with baby
   This theme pertains to the fathers’ experiences of early or delayed feelings of attachment to the baby.

3. Learning to cope
   This theme relates to several facets of fathers’ experiences with first time parenting including dealing with an unsettled or crying baby, adjusting to the demands of caring for a newborn, coping with broken sleep, coping with less hours of sleep, finding a balance between commitments at work and home, living on one income and having less relaxation time as well as adjusting to the changes in his personal relationship.
4. Preparing for fatherhood

This theme pertains to the experiences of fathers attending childbirth classes, talking to other fathers and seeking information about childbirth and early parenting.

5. Dealing with emotions

This theme pertains to a myriad of positive and negative emotions experienced by fathers during the first few months of parenting. For some fathers it was a burden of responsibility, while others expressed an overwhelming fear of failure in their efforts to be a good father.

6. Defining the role

This theme pertains to how most fathers defined their role which was generally being the support person to his partner, the financial provider and the protector of his family.

7. Relationships

This theme relates to the changes experienced by couples in their personal relationship after the birth. It also relates to changes in relationships with friends and family.

8. Work-Life balance

This theme pertains to fathers prioritising time spent at work, home and leisure.
9. Support structures
This theme involves fathers seeking guidance from their partners and support from family and friends.

6.13 The modified Q-sort exercise

Aim
Participants used intuitive alignment and relevance to sort items into themes.

Setting
The exercise was conducted face-to-face in the participant’s home, work office or coffee shop during lunch hour. The aim of conducting the exercise face-to-face was to provide enough detail about the exercise as needed to ensure that the participant understood what was required and to answer any questions the participant may have that pertained to completing the exercise.

Participants
The cohort of fathers (n=23) who participated in the qualitative study were contacted by email or telephone and invited to participate in the Q-sort exercise. Six (n=6) men volunteered and were sent an information sheet explaining the purpose of the exercise and the approximate time it would take to complete. The participants included four (n=4) fathers who had one child and two (n=2) fathers with more than one child. A consent form was supplied unless the respondent had participated in phase two. The author contacted participants to arrange a time and place to conduct the exercise.

Method
Participants were given a list of items numbered 1 to 59 (Appendix 14) and a table containing nine themes (Appendix 15) and were invited to allocate each item to one of the nine themes according to what he thought the item most reflected. The aim was to get approximately five to six items per theme. Participants completed the exercise in approximately 25 minutes. Throughout this time the author remained impartial so as not to influence the participant’s responses.

6.14 Results

The author created a frequency table for each theme containing the item number allocated by each participant (Appendix 16). For example, items numbered 4, 9, 11-15, 19, 20, 28, 32, 37, 40 and 52-54 were added to the theme Relationships. One participant placed item number 4 under the theme of relationships while five participants placed item number 40 under the theme of relationships.

Table 1: This frequency table includes the item number allocated to the theme relationships and the number of participants who allocated the item to this theme.

Original item numbers from phase one are represented in bold text.

**Relationships**

| Item No. | 4   | 9   | 11  | 12  | 13  | 14  | 15  | 16  | 18  | 20  | 21  | 22  | 23  | 24  | 25  | 26  | 28  | 32  | 37  | 39  | 40  | 41  | 42  | 43  | 44  | 45  | 46  | 47  | 48  | 49  | 50  | 51  | 52  | 53  | 54  |
|----------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| No. of responses | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 1   | 2   | 1   | 4   | 1   | 1   | 2   | 1   | 4   | 5   | 4   | 4   | 3   |
6.15 Further reduction of items

In order to further reduce the number of items that would be used in the first draft questionnaire, statements with similar wording were removed. Eleven (n=11) items were removed reducing the final component of items to forty-eight (n=48)\(^1\)

Themes (n=9) and Items (n=48) are represented in Table 2.

Table 2: Final quota of items allocated to each theme following the Q-sort exercise

<table>
<thead>
<tr>
<th>THEMES</th>
<th>ITEMS (Original item numbers from phase one in bold text)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relationships</strong></td>
<td>19. I felt supported by my partner (25)</td>
</tr>
<tr>
<td></td>
<td>39. The relationship with my partner strengthened in time after birth (51)</td>
</tr>
<tr>
<td></td>
<td>40. I felt there was a loss of spontaneity in the relationship becoming a parent (52)</td>
</tr>
<tr>
<td></td>
<td>52. I found it difficult to cope with the changes to my personal relationship with my partner (68)</td>
</tr>
<tr>
<td></td>
<td>53. I relied on my partner for guidance in the first few months (69)</td>
</tr>
<tr>
<td></td>
<td>54. I had limited opportunities to socialise with friends (71)</td>
</tr>
<tr>
<td><strong>Support structures</strong></td>
<td>10. I sought information and advice about parenting (13)</td>
</tr>
<tr>
<td></td>
<td>12. I welcomed support from family and friends (16)</td>
</tr>
<tr>
<td></td>
<td>20. I felt prepared to support my partner with breastfeeding (26)</td>
</tr>
<tr>
<td></td>
<td>31. I felt supported by friends and family (41)</td>
</tr>
<tr>
<td></td>
<td>43. I needed positive reassurance about my parenting skills (57)</td>
</tr>
<tr>
<td></td>
<td>45. I would accept support from others if I wasn’t coping with parenting (59)</td>
</tr>
<tr>
<td></td>
<td>50. Talking to other new parents was useful to my parenting experience (65)</td>
</tr>
<tr>
<td><strong>Experiences with paternal depression</strong></td>
<td>18. I felt easily frustrated and angry (24)</td>
</tr>
<tr>
<td></td>
<td>23. There were times when I felt I was not coping (30)</td>
</tr>
<tr>
<td></td>
<td>34. I felt comfortable talking to my GP when I felt depressed (45)</td>
</tr>
<tr>
<td></td>
<td>42. I felt emotionally overwhelmed with the demands of a newborn (55)</td>
</tr>
<tr>
<td></td>
<td>56. I needed to get away from the demands sometimes (88)</td>
</tr>
<tr>
<td></td>
<td>58. I felt overwhelmed with the experience as a new father (91)</td>
</tr>
<tr>
<td><strong>Learning to cope</strong></td>
<td>25. I felt anxious at times in the first few months of fatherhood (33)</td>
</tr>
<tr>
<td></td>
<td>38. I found it difficult to cope with the baby’s crying at times (50)</td>
</tr>
<tr>
<td></td>
<td>57. Things got better in time and I felt my confidence improve (89)</td>
</tr>
</tbody>
</table>
| Bonding with baby | 1. I enjoyed being with my baby (1)  
|                   | 4. I tried to be an involved father (4)  
|                   | 21. I felt attachment to my baby soon after the birth (28)  
|                   | 22. I didn’t feel a connection to my baby for several weeks (29) |
| Preparing for fatherhood | 7. I felt prepared for the new baby (8)  
|                         | 16. I didn’t really know what to expect as a new father (22)  
|                         | 36. Being a new father was less positive than I expected (47)  
|                         | 41. First time parenting was more difficult than anticipated (54)  
|                         | 44. I needed more realistic information to help prepare me as a parent (58)  
|                         | 46. I felt confident that I was going to manage as a new parent (61)  
|                         | 48. I felt ready for the commitment of being a parent (63)  |
| Work-life balance | 2. It was difficult to accept the changes to life style (2)  
|                   | 5. I could prioritise needs for the family (5)  
|                   | 6. I found a flexible work-life balance (6)  
|                   | 32. I tried to find a balance with work and family (42)  |
| Dealing with emotions | 14. I felt joy at the birth of my baby (20)  
|                         | 17. I felt positive emotions (23)³  
|                         | 26. I felt sad at times (35)  
|                         | 27. I felt a sense of loss sometimes (36)  
|                         | 29. I felt anxious at times (38)⁴  
|                         | 33. I could recognise negative changes to my emotion (44)  
|                         | 51. I felt angry at times (66)  |
| Defining the role | 13. I felt protective of my new family (18)  
|                   | 28. I felt it was my responsibility to protect my family (37)  
|                   | 37. I felt a protective role towards my partner and baby (49)  
|                   | 47. I felt responsible as the financial provider for my family (62)  |

---

³ Following a re-check of the data the final list of items was n=48 not n=50 as first recorded and this has been corrected.

² Item 13(18) was repeated by mistake in ‘Relationships’. It should have been Item 40(52) therefore it has been replaced with Item 40. Item 13(18) remains under ‘Defining the role’.

³Item 17(23) was repeated by mistake under ‘Bonding with baby’ and has been removed. It remains under ‘Dealing with emotions’.

⁴Item 29(38) was repeated under ‘Experiences with paternal depression’ and has been removed. It remains under ‘Dealing with emotions’.
6.16 Summary

A modified Q-sort exercise was employed because it was a simplified method of allocating items to themes and took less time for the participant to complete than a standard Q-sort. The aim of using a Q-sort method was to obtain the subjective viewpoints of participants who had knowledge of the topic through their experiences as first time fathers and their familiarity with the topic having participated in the qualitative study therefore adding relevance to the data. A final list of fort-eight (n=48) items would be used in the construct of a draft questionnaire and would be piloted in phase four with a small group of first time fathers as a subset of the qualitative study to determine face validity.
PHASE FOUR – CONSTRUCT OF A DRAFT QUESTIONNAIRE

6.17 Introduction

Phase four of this quantitative study involved the construct of the self-report ‘Coping with new fatherhood questionnaire’ (CNFQ). A pilot study was conducted with a subset of participants (n=6) from the qualitative study who were asked to provide feedback pertaining to the content, wording and readability of the items contained in the draft questionnaire.

6.18 Questionnaire design

When planning the design of the questionnaire the author considered the following issues

Presentation
The layout of the questionnaire should be easy to read, the sequence of questions should be easy to follow and the questions should be developed in an interactive style so the participants feel as though someone is talking to them. Questions need to be arranged so that there is a flow that fits with the participants’ thought processes. If the structure of the questionnaire makes sense, the participants are more likely to complete it (Cluett & Bluff, 2000).

Language and terminology
The language and terminology needs to be appropriate for the anticipated participants.
If the question is difficult to understand, the participants may not answer or their response will be a guess. This has the potential to affect the response rate as well as reliability and validity of the data collected (Jackson & Furnham, 2000; Cluett & Bluff, 2000).

The instrument is simple and brief

Each theme in the questionnaire needs to contain three or four short concise questions. If the questionnaire is too long respondents may lose interest and may not complete all questions (Jackson & Furnham, 2000).

Face validity

Items in the questionnaire need to appear to measure the right thing.

6.19 Face validity

According to Anastasi (1997) face validity is not what the test actually measures, but to what it appears superficially to measure. Face validity was considered an important component of the questionnaire design because it needed to look valid to the participants that will complete it as well as the professional personnel who will administer it (Anastasi, 1997). If the content of the questionnaire appears to be irrelevant or inappropriate there may be a poor response rate (Anastasi, 1997). The author included statements taken from the interview data that pertained to the experiences of first time fathers to ensure the items in the questionnaire were relevant to the representative sample.
6.20 Construct of the first draft questionnaire

As mentioned in phase three, forty-eight items (n=48) and nine themes would be used in the draft questionnaire. The themes included Relationships, Support structures, Preparing for fatherhood, Bonding with baby, Learning to cope, Experiences with paternal depression, Dealing with emotions, Defining the role and Work-life balance. Each section included several statements for example, ‘I felt prepared for the baby’. Items were placed into a questionnaire format and the author needed to consider the following:

1. Develop a lead in;
2. Add instructions that are clear and concise;
3. Decide on a response format (yes/no or Likert style) and;
4. Pilot the questionnaire with a small group of participants to determine face validity.

A response format

It was decided the response format would be a Likert style scale. In order to determine a response format the author reviewed what type of response format had been used in self-report questionnaires such as the Beck Depression Inventory (BDI) (Beck et al., 1961), the General Health Questionnaire (GHQ) (Goldberg, 1972), the Edinburgh Postnatal Depression Scale (EPDS) (Cox et al., 1987) and The Experience of Motherhood Questionnaire (EMQ) (Astbury, 1994).

Initially, the author considered a three-point Likert type response including not at all, somewhat and very much. This is a forced-choice response scale with no middle
neutral or undecided choice. The respondent is forced to decide whether he leans more towards the ‘agree’ or the ‘disagree’ end of the scale for each item (Trochim, 2006). The scoring rules were more difficult to determine than the author had anticipated.

The lead in
A lead in for the questionnaire was drafted and the author decided at this stage to confer with the advisory group to gain suggestions for a point scale and feedback on the lead in.

First draft lead in for the questionnaire:

‘First time fatherhood is a life changing experience that creates demands on fathers not previously envisaged before the birth of your baby. This questionnaire helps to determine how well you are coping with the demands as a new parent. There are nine topics each containing several questions relating to the topic’.

Instructions: Circle the response that you feel most applies to how you are feeling in your experience as a first time father. There are no right or wrong answers.

One member of the advisory group from The University of Adelaide Centre for Military and Veterans’ Health reviewed the draft questionnaire and made the following recommendations:

1. Change the three-point Likert response scale to include more response options;
2. Re-word the responses options;
3. Reword the lead in so it is more neutral and not so leading;
4. Merge statements with similar meanings to create a single statement in order to reduce repetition; and

5. Avoid dichotomous response categories as they do not encourage people to be critical.

6.20.1 Second draft questionnaire

A four-point Likert type response was created and included strongly disagree, somewhat disagree, somewhat agree, strongly agree. This is a forced-choice response scale with an even number of responses and no middle neutral or undecided choice.

Revise items

In order to further eliminate repetition of statements nine (n=9) items were removed.

- Item 12 (16) ‘I welcomed support from family and friends’ and item 45 (59) ‘I would accept support from others if I weren’t coping with parenting’ were removed as they were too familiar to item 31 (41) ‘I felt supported by friends and family’ which was retained in the questionnaire.

- Item 58 (91) ‘I felt overwhelmed with the experience as a new father’ was removed as it was similar to item 42 (55) ‘I felt emotionally overwhelmed with the demands of a newborn’.

- Items 13 (18) ‘I felt protective of my new family’ and 37 (49) ‘I felt a protective role towards my partner and baby’ were replaced with item 28 (37) ‘I felt it was my responsibility to protect my family’.

- Item 25 (33) ‘I felt anxious at times in the first few months of fatherhood’ was replaced with item 29 (38) ‘I felt anxious at times’.
• Item 32 (42) ‘I tried to find a balance with work and family’ was replaced with item 6 (6) ‘I found a flexible work-life balance’.

• Item 5 (5) ‘I could prioritise needs for my family’ and item 40 (52) ‘I felt there was a loss of spontaneity in the relationship becoming a parent’ were removed as they appeared to be ambiguous.

In this way the total number of items was reduced to thirty-nine (n=39).

Additionally a small number of statements were re-worded to be more succinct, for example

• Item 53 (69) ‘I relied on my partner for guidance in the first few months’ was changed to read ‘I relied on my partner for guidance’.

• Item 57 (89) ‘Things got better in time and I felt my confidence was improving’ was changed to read ‘Things got better and I felt my confidence improved’.

• Item 22 (29) ‘I didn’t feel a connection to my baby for several weeks’ was changed to read ‘I didn’t feel as connected to my baby as I would have liked’.

• Item 54 (71) ‘I had limited opportunities to socialise with friends’ was extended to read ‘I have less opportunity to socialise with friends that I did before the baby was born’.

A review of the data revealed a number of typographical errors and these were amended to reflect the item numbers that were intended. Items 53, 57 & 22 have been added as replacements for original typographical errors. The corrections have not affected the final construct of the CNPQ.
The themes entitled ‘Experiences with paternal postnatal depression’ and ‘Dealing with Emotions’ contained statements that reflected various emotions experienced by participants therefore both titles were combined and given the title ‘Feelings and Emotions’. The theme titled ‘Learning to cope’ was changed to ‘Coping’.

- Item 23 (30) ‘There were times when I felt I was not coping’ was placed under the theme Coping.
- Item 52 (68) ‘I found it difficult to cope with the changes to my personal relationship with my partner’ was placed under Coping.
- Item 36 (47) ‘Being a new fathers was less positive than I expected’ was placed under Feelings and Emotions.
- Item 27 (36) ‘I felt a sense of loss sometimes’ was placed under the title Work-life Balance.

Second draft lead in:

‘For some people first time fatherhood has been a life changing experience, which creates demands on fathers they had not envisaged before the birth. This questionnaire explores the ways you are coping with the demands as a new parent. There are several categories each containing several statements’.

Instructions: Circle the response that you feel most applies to how you are feeling at this point in time. There are no right or wrong answers.

The two members of the advisory group from La Trobe University Maternal & Child Health Services and The University of Adelaide Discipline of Psychology were asked
to determine if the questionnaire appeared easy to read, the lead in appropriate, the wording was appropriate or questions were repetitive. They reviewed the draft questionnaire. The following recommendations were made:

1. Change the four-point Likert to a five-point Likert scale;
2. The lead in could be made more neutral again;
3. Change all items to read in the present tense; and
4. Determine how the responses will be calculated.

6.20.2 Third draft questionnaire

The items were changed to read in the present tense so that the participant could respond according to how he was feeling at that point in time.

The response format

A five-point Likert type response of not at all; not much; neither one way or the other; somewhat; very much replaced Strongly disagree; Somewhat disagree; Somewhat agree; Strongly agree on the draft questionnaire (Appendix 18). The aim of changing the scale from a four-point Likert response format to a five-point Likert response was to increase overall variability in responses.

The lead in

The author decided to gain feedback from participants on the lead in when the questionnaire was piloted for face validity.
The scale

A scale was changed to a five-point response scale with a Neutral or Undecided middle value. A neutral category has been included with the aim of minimising participants missing the question or effectively not answering the question if they feel it is not relevant to them. This was confirmed by M Lorimer (Statistician, The University of Adelaide) (2010, pers. comm. 26 May).

Not at all Not much Neither one way or the other Somewhat Very much
1 2 3 4 5

Proposal for scoring:

- Positive statements will be scored 1 – 5 along the continuum;
- Negative statements will be reverse scored 5 – 1 along the continuum so that both negative and positive items are scored in the same direction (Astbury, 1994);
- Each of the 35 items in the questionnaire can be scored from 1 – 5 therefore an individual’s total score can range from a minimum of 35 to a maximum of 175.

The CNFQ is still in its draft form and will require extensive piloting in future population-based studies to refine the tool and determine a reliable cut-off. According to Edmonson, Psychogiou, Vlachos, Netsi and Ramchandani (2010) in their research on the assessment of the EPDS as a screening measure, a reliable cut-off can only be determined and established in population-based studies and perhaps will differ with different populations.
6.21 Pilot the draft questionnaire

Participants

The participants (n=23) who had taken part in the qualitative study in stage one were contacted via email and informed about the aim of the questionnaire and invited to participate in the pilot study. Six men volunteered to participate as they regarded the aim of the questionnaire to be important to determine if new fathers are coping with the parenting experience as well as helping them to receive assistance and/or advice from a health professional if required. Four (n=4) of the volunteers who had participated in phase three volunteered to participate in this activity and were fathers with one child. Two (n=2) participants had not taken part in phase three and had more than one child.

Setting

The participants could complete the exercise at a time convenient to them. Each participant was sent an information sheet (Appendix 17), a copy of the draft questionnaire (Appendix 18), a feedback sheet (Appendix 19) and a consent form if he had not participated in phase two or phase three of the quantitative study. A copy of the signed consent form was sent to participants for their own record.

Method

Participants were asked to provide feedback on the design and content of the questionnaire. The feedback sheet included five questions with a yes or no response and a space for the participant to provide a comment. The questions included:

1. Are the instructions for completing the questionnaire adequate?
2. Is it easy to read?

3. Are the questions easy to understand?

4. Does the questionnaire cover the important issues about the experiences of a first time father and coping with new parenthood?

5. Are there any questions that you would not include in this questionnaire?

Outcome

When the feedback sheets were returned, the author would need to:

1. Remove items that were reported to be ambiguous, difficult to understand or unnecessary;

2. Re-word or remove items that were deemed by participants as not applicable to the overall aim of the questionnaire; and

3. Consider amendments and/or additions according to participants’ suggestions.

6.22 Results

All participants (n=6) in the pilot study returned a completed feedback sheet and responded positively to the content of the draft questionnaire. Although the author did not specifically seek the participants’ opinions on the notion of coping or not coping and the cohort was small, there appeared to be no objection to the idea of coping or not coping.
**Feedback by participants:**

One participant suggested: “possibly to cover more the differential between prior expectation and reality after” adding “maybe some recognition that it is okay to have negative responses to questions, that’s life and it is all too common. It does not imply failure or bad parenting in any way”.

Another participant commented: “Yes, found it very easy to read and it flows very well” and “Simple but very straight forward and very effective” and “The survey is a very good tool as long as the participants are honest with themselves and this is in my opinion the first step in seeking professional help or just general assistance. As this is new ground breaking stuff, the survey can’t be too long and/or involved as no one would really complete it, and I believe this survey covers all the basic’s to make a good start on an assessment of the person’s wellbeing and to determine what “HELP” they get or where they go from here”.

Another comment: “It is a good eye opener and makes you really think that I am not alone” and “On page Two (2), question 15, I would strongly recommend that this is worded to include “and being honest about your thoughts and views to the other new parents and especially to yourself”.

Another participant added: “Well done, I feel all questions are easy to understand, and all the important and relevant questions are asked. Simply filling out the questionnaire would have helped me a lot when I was a first time father- whether it lead to any other support or not!”
6.23 Strengths and Limitations

Strengths

There was a high compliance (100%) of completion rates by participants for phases two, three and four.

- Phase two: Participants (n=13) volunteered to complete the survey. All completed surveys were returned.
- Phase three: Participants (n=6) volunteered to complete the Q-sort exercise and this was completed by all six participants.
- Phase four: Participants (n=6) volunteered to review the draft questionnaire and complete the feedback form with a 100% return of completed forms.

All participants were a sub-group of the cohort interviewed in phase one and therefore were representative of the population under research.

Limitations

Phase three and phase four had a relatively small number of participants (n=6). The questionnaire needs further refinement that can only be achieved with extensive pilot studies.
6.24 Summary

The coping with new fatherhood questionnaire (CNFQ) was designed to identify the positive and negative dimensions of fatherhood in regards to his relationship, support structures, father-infant bonding experience, emotional wellbeing and his role within the family. The draft questionnaire is in the early stage of its design. The author plans to continue at a post-doctoral level to further refine and develop the questionnaire and determine a reliable cut-off with extensive pilot studies. Moreover a pilot study to assess for construct validity, reliability and psychometric properties will need to be conducted with a large population sample.
CHAPTER 7 – DISCUSSION

7.0 Introduction

There were two primary objectives of this thesis. The first was to develop an emergent theory to explain the experiences of first time fathers in the transition to fatherhood and the effect of paternal postnatal depression from the participants’ perspective. The core social psychological problem identified by the constant comparative method of grounded theory was ‘Coping’. The emergent theory of coping is comprised of all the emergent categories that provided an insight into the experiences of first time fathers in a specific context that provided a better understanding of the phenomenon from the participants' perspective. Analysis of interview data discerned that participants’ conceptualised their language around the notion of coping rather than depression and anxiety. According to Lazarus and Folkman (1984) subjective self-report is the primary source of data about stress, appraisal, emotion and coping. The relationship between stress and coping is reciprocal: actions taken by a person to cope with a problem also affected the appraisal of the problem and subsequent coping (Stone, Greenberg, Kennedy-Moore & Newman, 1991). Moreover coping is regarded as a dynamic process which changes over time in response to objective demands and subjective appraisals of the situation (Stone et al., 1991).

The fathers in this research had limited coping strategies to deal with the difficulties they experienced during the transition to fatherhood. A few fathers worked longer hours and others engaged in some form of physical exercise such as walking, cycling or sport.
The qualitative study (chapter five) provided prospective and retrospective data from fathers and their experiences with the transition to parenthood and their emotional experiences with paternal depression, anxiety and distress. Analysis of the interview data revealed a number of factors that contributed to fathers’ experiences and these were consistent with the current research literature pertaining to fatherhood and paternal depression. Men’s experiences in the transition to fatherhood were complex, demanding and emotionally challenging. The major themes in the data will now be discussed.

*Depression and anxiety experienced by fathers*

As discussed in chapter four men self-identified as having experienced distress, stress, depression and/or anxiety before (prospective participants) and/or after (retrospective participants) the birth of their first child. Few men in this study reported that they were aware that fathers could become depressed during the postnatal period in relation to the changes associated with becoming a new parent. Most fathers commented that they recognised how they were feeling although they found it difficult to acknowledge their emotions because according to their understanding, women became depressed after childbirth, not men. Therefore most men chose not to seek the advice of a health professional. As suggested by Addis and Cohane (2005, p. 11), men may experience barriers to seeking help from health professionals when they perceive other men in their social networks as disparaging of the process. Additionally several fathers acknowledged that their reluctance to seek medical help was attributed to the perceived stigma as a male of having a mental health illness such as depression.
Experiences with stress and distress for a small number of men were self-limiting in the first three months postnatal and this coincides with the findings by Buist et al., (2002). For other fathers, their emotional distress or depression developed after the first three months postnatal and continued for some time after the first twelve months postnatal. These findings were similar to those depicted in the research by Areias et al. (1996a). Fathers who sought medical advice for their depression and/or anxiety were medicated or referred for counselling. Matthey et al. (2001) suggests that anxiety in new fathers may be a more common reaction to new parenthood than depression and although this might have been the case for a small number of fathers in this study, the actual number of men who were diagnosed by a health professional with depression exceeded those diagnosed with anxiety by two to one.

A majority of fathers commented that they received little antenatal education about the possibility of becoming distressed, anxious or depressed as a new parent in response to the changes of lifestyle as well as the changes to their personal relationship. These comments were consistent with the outcomes of studies by Greenhalgh et al. (2000) and Fletcher, Silberger and Galloway (2004) when describing the experiences of novice fathers. Further fathers were not prepared for the emotional struggle in their efforts to cope when the baby developed feeding or health problems and this compares to the experiences of new fathers in the research by Hangsleben et al. (1983).

An unexpected but significant finding in this study was that only two fathers diagnosed with paternal depression had a partner with postnatal depression. Moreover a further six fathers were diagnosed with depression within the first twelve months after the birth of their baby and their partners did not have depression. This finding is
in contrast with existing research that suggests if the mother is depressed, the father is at increased risk for developing depression (Dudley et al., 2001; Deater-Deckard et al., 1998; Matthey et al., 2003).

It was difficult for the author to ascertain directly why these fathers became depressed and their partners did not develop any symptoms of depression, however major themes identified in the data as having potentially contributed to fathers developing depression are discussed in more detail in the following sections of this chapter. Matthey et al. (2003) suggested that a history of depressive disorders appeared to be a greater risk factor for the development of postnatal mood disorder and this suggestion was consistent with a small number of fathers in this study who stated that they had experienced an episode of stress or depressed mood at some time before they became fathers. In addition, a small number of men determined that their character might have predisposed them to becoming depressed in response to the stressors experienced with first time parenthood and this compares with similar findings by Areias et al. (1996b), Dudley et al. (2001) and Matthey et al. (2003).

7.1 Predictors of paternal depression

A number of stressors were identified as potentially having contributed to men’s emotional distress, depression and/or anxiety and these have been discussed in chapter five. Five major factors concerned with men’s emotional distress and depression have been summarised in the following paragraphs and have been supported with similar outcomes depicted in existing professional literature concerned with paternal depression and men’s transition to fatherhood.
7.1.1 Changes to lifestyle

The early weeks of new parenthood were considered to be stressful for men particularly because of the changes that occurred within the home and in the relationship with their partner. First time parents were more vulnerable because of the changes to lifestyle and the increased demands of caring for a baby – a finding also consistent with Hangsleben (1983). Limited social support resources, as depicted in this study (chapter five), contributed to men experiencing difficulty in coping with the demands encountered as a father for the first time.

Fathers considered the time spent with their family to be a priority and several men commented that they gave up playing sport or spending time in a recreational activity because they felt they needed to be home with their partner and baby. This correlates to the outcomes of a research by Fletcher et al. (2004). However they acknowledged that they planned to return to former activities once the baby was older and they had more opportunity to socialise.

7.1.2 Change to the couple’s relationship

Dudley et al. (2001) and Bielowska-Batorowicz and Kasakowska-Petrycka, (2006) purport that men tend to rely on their partner for emotional support. A change in the centre of focus in the mother to the baby and the lack of emotional attention to the father caused some fathers to feel left out (Dudley et al., 2001). Most fathers reported that they were unprepared for the lack of quality time and the lack of intimacy within the relationship in the first few months postnatal and that it took a long time for them to adjust. These concerns were also described in the research by Fletcher et al. (2004)
One father in particular talked about how fearful he was of losing the companionship he once shared with his wife. This compares to the outcomes of study by Lutz and Hock (2002) who found that men expressed fear of abandonment, loneliness and change within the relationship that was linked with feeling excluded after the birth of their first child. Similarly the men in this research disclosed feeling a sense of loss when their partner’s focus of attention was predominately on the baby.

All the fathers in this research supported the benefits of breastfeeding from a nutritional and maternal-infant bonding perspective. However several men described having felt excluded and on the periphery of the family relationship because their partner was breastfeeding. Moreover the father-infant bonding experience was considered by several fathers to be hampered because there was less opportunity for skin-to-skin contact and the baby was dependent on the mother for feeding and not the father. Lane et al. (1997) and Barclay and Lupton (1999) reported similar concerns expressed by fathers in their research. Bonding was more difficult for some fathers to establish in the early weeks after the birth because they felt displaced. According to Edhborg et al. (2005) mothers and fathers might have gender specific understandings and responses to the baby. Early bonding problems may well be caused by circumstances surrounding the birth (Edhborg et al., 2005) and how men experience childbirth may have some influence on their subsequent emotional wellbeing. These suggestions correspond with the experiences that three fathers encountered when their partners required emergency caesareans due to complications during labour. Fathers reported that they received very little support from staff and had no opportunity to
debrief after such a stressful event and that the memory of those experiences had impacted on the early father-infant bonding experience.

7.1.3 Responsibility of fatherhood

Men reported that their primary function as a father was to provide financial security and to protect the wellbeing of their family. Several men reflected on the lack of information in antenatal classes that provided realistic and meaningful education in preparing them for the experiences of early parenthood. Moreover, men as first-time fathers wanted the opportunity to speak with experienced fathers about the prospect of new parenthood and this is similar to the outcomes in the research by Hangsleben (1983).

Education for expectant fathers

Antenatal education plays an important role in preparing expectant couples for childbirth and the transition to parenthood. In the 1990’s, childbirth education began to take on a family focus (Premberg & Lundgren, 2006) as more fathers attended antenatal classes and took an active role in supporting their partners during labour and childbirth. However, classes focused predominately on preparing the couple for labour and childbirth (Barclay et al., 1996) and support of the mother-infant relationship (Henderson & Brouse, 1991). There was little gender-specific information for fathers and little practical discussion on what their role involves in the early postnatal weeks (Cabrera, Tamis-Lemonda, Bradley, Hofferth & Lamb, 2000).
Although existing research acknowledges the unique needs and experiences of contemporary fathers in relation to their role as a parent the inclusion of father-specific classes to provide knowledge, skills and support for the father’s impending role is not universal (Cabrera et al., 2000). Contemporary research on parenting education programmes report that on the whole, men felt prepared for the labour and birth experience (Premberg & Ludgren, 2006; Petersson, Petersson & Hakansson, 2004) but lacked knowledge, skills and support to help prepare them for their role and function within the family after childbirth (Henderson & Brouse, 1991). Moreover men were not prepared for the reality of parenthood and the changes that would affect their lifestyle and the couple’s relationship (Fletcher et al., 2004).

The outcomes of a research on fathers’ attitudes to parent-infant classes (Matthey & Barnett, 1999) found a large proportion of the respondents would have liked more information concerning practical care of the baby after discharge from hospital. Opportunities to share information and network with other men in discussion groups were more important to expectant fathers (Premberg & Lundgren, 2006) than the education content of antenatal classes. It is argued that when men’s experiences are valued and validated by other men they develop the courage to be open to things that they would never have considered before (Sheehy, 2004). As men comprise an essential support for new mothers and infants, antenatal education in determining and meeting the needs of expectant fathers will better prepare them for the early parenthood experience.

Fathers in this research commented that they needed time to develop the role and often floundered with the role because of limited guidance or direction. Furthermore
most fathers did not have a mentor who could offer advice. Fathers discussed how they tried to define their role within the new relationship with their partner and baby and they felt less efficient as a carer compared to their partner.

As mentioned in chapter five, paternal leave was considered by the majority of the fathers in this research to be an important time to share in the care of their new baby and to spend time as a family. According to Buist, Morse and Durkin (2003) and Hangsleben (1983,) the early weeks of new fatherhood can be stressful as most men are not prepared for the wave of changes that come with having a new baby. Although this is considered to be a normal process for most first time parents (Buist et al., 2003), fathers need time, support and encouragement to adjust and to be an involved parent.

Paid paternal leave in the early weeks after the birth provides a father with the unique opportunity to spend time with his partner and be involved in the care of his baby (Tamentie, Tarkka, Astedt-Kurki, Paavilainen & Laippala, 2004) without an extra financial burden. The fathers in this research were the major contributors to finances and felt that providing financial security for their family was their greatest responsibility. Financial difficulties caused major stress when couples were renting, had high mortgages, fathers did not have permanent work or they incurred added medical costs if the baby experienced health problems. In Australia, the option for men to take paid leave is often limited or non-existent leading the author to question how society values the role of new fathers within the family context.
Social policy and parental leave in Australia

Provisions for paternal leave in Australia have been in place since 1990 (Whitehouse, Diamond & Baird, 2007). However the type of policy framework in place for entitlements to paid or unpaid leave will influence a father’s decision to take leave. This decision is also dependent on the nature of his employment as being permanent full-time, part-time or contract. Maternal leave entitlements will also influence how, when and for what length of time a father will consider taking paternal leave as maternal and paternal leave are not separate entitlements (Whitehouse et al., 2007).

The annual birth rate in Australia has continued to rise with 296,600 births registered in Australia in 2008 (Australian Bureau of Statistics (ABS) accessed March 6 2010) indicating an increase of 11,400 (4.0%) births since 2007. The number of births for 2008 signified the highest number of births registered in a calendar year in Australia and contrasts to 1971 with 276,400 births registered (ABS). Now more than ever, society needs to consider the value of parental leave to the new family.

The advantages of having time off for fathers, particularly in the early weeks after the birth are twofold. The father is present for his partner as she recovers physically and emotionally from childbirth and fathers can engage with their baby and develop paternal-infant bonding. Less than a third of the twenty-three fathers in this research took paternal leave. Seven fathers had one week of leave and nine fathers had two weeks leave. Twenty-two out of twenty-three fathers (95.6%) commented that two weeks was not enough time to adjust to the changes in the home environment, to establish some sort of routine and to spend time bonding with their baby and partner with the majority suggesting four weeks paternal leave would be most beneficial.
The Australian Government is currently considering a Paid Parental Leave (PPL) scheme that offers new parents 18 weeks paid parental leave (Comino, 2009). The PPL scheme will alleviate the financial burden of a single income that often causes new fathers considerable stress (Zelkowitz & Milet, 1997) and has been identified in the literature as a significant contributor to new parents developing depressive symptoms (Soliday et al., 1999). A leave entitlement for the first six months after childbirth would allow a parent to spend more time at home with the baby and ease the burden of utilising childcare services. The downside to the PPL initiative is that paid leave is based on an income test where payments would be limited to primary carers (Comino, 2009). As the mother is considered within a social context to be the primary carer, the father’s role once again fails to be acknowledged and the issue of having paid leave remains unaddressed.

How Australian society values the contribution that fathers make to a new family contrast to that of several Nordic countries including Sweden, Norway and Iceland. Work-family policy developments have expanded since the late 1990’s supporting longer leave time and flexible work provisions targeted at fathers who are encouraged to spend time caring for their family (O’Brien, Brandth & Kvande, 2007).

Norway provides a compulsory six-week paid quota for fathers to be at home with their new family (O’Brien et al., 2007) while Sweden offers new fathers ten days paid paternal leave after childbirth with a total of 480 days offered to one or the other parent in the first 18 months postnatal and is subsidised with 80% of the parent’s salary (Fagerskiold, 2008). To clarify the difference between paternal and parental leave, paternal leave is defined as ‘a statutory entitlement to enable a father to be
absent from work for a period of time when a child is born’ (O’Brien et al., 2007 p. 377) and parental leave is ‘a statutory entitlement to be absent from work after initial maternal or paternal leave’ (O’Brien et al., 2007 p. 377).

The government in Iceland introduced a paternal leave scheme in 2008 that entitled new parents to take nine months paid leave in the first eighteen months postnatal. Leave is divided into three months paid leave for mothers, three months paid leave for fathers and three months paid leave for both parents (O’Brien et al., 2007).

Longer leave time, flexible working provisions and the entitlement to paid paternal leave sends a clear message of how the societies in Nordic countries recognise the significant role fathers play in providing support for their partners and infant after childbirth and the importance of social support for new families. This contrasts to the entitlements for new fathers in Australia and needs to be addressed if families are considered important.

7.1.4 Unexpected feeding and health problems in the baby

A small number of fathers disclosed that they had certain expectations of how their baby was going to be after the birth and commented that they felt let down when their baby developed feeding problems, reflux or was a poor sleeper. Further men expressed feeling helpless and frustrated by their baby’s problems and felt this contributed to their depression. Matthey et al. (2003) and Dudley et al. (2001) reported similar accounts of anxiety and depression in fathers as a reaction to the baby’s ill health, problems with feeding or sleeping difficulties.
Limited social support from family, friends and partners contributed to fathers becoming emotionally distressed and this was also found to be a predictor of mood disorders experienced by men in the research by Bielawska-Batorowicz and Kossakowska-Petrycka (2006), Zelkowitz and Milet, (1997), Madsen and Juhl, (2007) and Atkinson and Rickel, (1984). Women at the time of pregnancy and the first six weeks postnatal have the most contact with health services and therefore have greater access to information and education in relation to infant care (Lane et al., 1997). Men however are not afforded the same opportunities and therefore must rely on their partner for advice and information or seek information via other forums.

Several families lived in another state or lived a significant distance from their family therefore access to support was limited. However, it must be stressed at this time that most of these families established friendships with other new families in their local community and this proved to be a good social network for them. The Internet was reported to be the most popular forum to access information about parenting issues and newborn care for fathers and this compares to a similar finding by Hudson, Campbell-Grossman, Fleck Elek and Shipman (2003). However a majority of men commented that there was limited father-specific information on early parenting and this caused a degree of frustration and disappointment.

Community Health Services were reported by the fathers in this research to be geared towards the mother and baby rather than the father and baby. For example, one couple went to the local Child, Adolescent and Family Health Centre to have their baby
vaccinated. Throughout the duration of the visit, the health nurse directed her conversation to the mother and not both parents who were present at the time. As a consequence, the father did not ask the nurse any questions directly but directed his wife to seek the answers because he perceived the nurse would be more receptive to his wife. This is not an uncommon event but it needs some consideration given that more fathers today are choosing to stay home to care for their children on a full-time basis or to job share with their partners and take a more active role in childcare.

7.2 Stage Two: Development of the Coping with New Fatherhood Questionnaire

As stated earlier, ‘coping’ was identified as the emergent theory grounded in the data that related to the experiences of first time fathers. As discussed in chapter two, a number of self-report questionnaires have been used in existing research to investigate paternal depression, dysphoria and men’s experiences in the transition to fatherhood. However the author was not able to locate a questionnaire that aimed to identify if a new father is coping with parenthood and contained gender-specific items relative to the experiences of fathers. This facilitated the development of the Coping with New Fatherhood Questionnaire (CNFQ). It is necessary to stress at this point that the CNFQ is not designed to detect fathers with depression, anxiety, phobias or personality disorder. Therefore the statements contained in the questionnaire do not include reference to symptoms such as insomnia, fatigue, thoughts of suicide or pessimism about the future (Zigmond & Snaith, 1983).

The CNFQ is a gender-specific self-report questionnaire consisting of thirty-five items that were taken directly from interview data and were specific to the socio-
psychological experiences of first time fathers who participated in this research. During a re-check of the data a small number of corrections were required to the original data set documented in chapter six, section 6.9 and section 6.9.1 and this is also reflected in the draft CNFQ. The author would like to stress that although anomalies were identified in four items were removed, this has not affected the overall aim of the questionnaire.

The CNFQ was developed for future population-based research with men to identify the level of coping and satisfaction associated with the experiences of new fatherhood. As discussed in Chapter one the initial proposal was to create a gender-specific self-report questionnaire to screen new fathers for depression and anxiety. However, given the time constraints for a full-time PhD the decision was made to construct the CNFQ and continue with its development as a postdoctoral endeavor. Moreover fathers are not the recipients of hospital maternity care and with few exceptions do not participate in community-based postnatal care. Therefore the questionnaire will have more usefulness for population-based research.

7.3 Rigour and limitations of this research

There were several methodological limitations to this research. First, a small sample size with limited socio-demographic variability minimised the extent to which the experiences of the fathers in this research can be generalised to the population and will need to be determined with a larger study. Second, there was limited representation of diverse ethnic and cultural backgrounds. Participants were educated (the majority at a tertiary level), skilled and all were employed in some capacity at the time of the interviews. Third, participants in this research were not screened for
depression and/or anxiety but self-identified as having experienced depression and/or anxiety or distress according to clearly specified criteria for inclusion. The author has acknowledged in chapter one that the well-established risks for depression in adults include a past history of psychiatric illness, substance dependence and exposure to violence including childhood abuse however these topics were not touched upon by the interviewer or the interviewees and as a consequence this was not discussed within the context of this thesis. Fourth, the majority of participants provided a retrospective account of their experiences and the recall of events may have been affected by memory bias. Furthermore the data was not independently coded, even for a subset, by another researcher.

According to Hassan (2006) the accuracy of recall by respondents significantly depends on the time interval between the event and the time of its assessment therefore the longer the interval, the higher the probability of incorrect recalls. The author acknowledges that recall bias was problematic in that it had the potential to influence the information provided by the participants whose experiences as novice fathers occurred several years prior to their interviews however much of the information was consistent with all the men from the cohort who provided a retrospective account of their experiences and also compared strongly with the experiences of fathers identified in existing research.

Although not all bias can be controlled or eliminated (Sica, 2006) the potential bias was addressed in the research and strategies to minimize bias were undertaken by the author as stated below:

- The process of participant selection was described;
• Potential participants who were excluded from the study were described;
• The study sample included participants that most closely reflected the characteristics of the population of interest;
• Inclusion and exclusion criteria were included;
• There was a high compliance of participants (100%) in the study;
• The data was collected from both cohorts at similar intervals using the same data collection tools;
• During the planning stage of the study the questions are well defined and articulated, the kind of information being sought was specified and the method of collecting the data was appropriate to answer the research questions. The interview techniques, quality of the questionnaires and the personal characteristics of the interviewer were considered in-depth prior to commencement of data collection;
• The interviewer did not disclose that she was a midwife and remained impartial throughout all interviews to avoid introducing bias in responses from the participants; and
• The author discussed the data in an on-going fashion with the supervisory team who were multidisciplinary and who were not involved in data collection.

7.4 Strengths of this research

The findings of this study are consistent with the outcomes of previous research conducted internationally and in Australia concerned with paternal depression and emotional distress experienced by new fathers after the birth of their baby.
The research design best suited this study because qualitative interviews provided in-depth information that pertained to the lived experiences of first time fathers therefore the information was first hand.

As rigour is built into the grounded theory method through the inductive-deductive cycle of theory generation, the author was mindful of engaging the process of grounded theory methodology as concisely as possible. As discussed in chapter three, several strategies were employed to ensure soundness of method, accuracy of the study’s findings and the integrity of assumptions made as well as conclusions reached.

The quantitative component of the study contributed to the development of the ‘Coping with New Fatherhood Questionnaire’ that included items taken directly from statements made from participants during their interviews. Therefore items were based on the subjective viewpoints of the participants and not the assumptions of the author.

7.5 Contributions of this research

This research makes several key contributions. First, the outcomes of this research complements existing research that investigated the experiences of fathers in the transition to first time parenthood and the psychological impact this life changing event can have on men. Second, it makes a unique contribution to existing research literature as it is the first research conducted in Australia that systematically explores
the lived experiences of first time fathers and their experiences with paternal depression, anxiety and emotional distress using a qualitative approach to data collection and analysis. Third, this research has provided a voice for a small cohort of fathers in Australia who volunteered to share their experiences as a first time parent. Major themes identified in the interview data have provided a benchmark for future qualitative research that is needed in order to strengthen the evidence-base on this topic. Fourth, the ‘Coping with New Fatherhood Questionnaire’ (CNFQ) was developed based on the outcomes of the qualitative component of this research. At this point in time, this is the first gender-specific self-report questionnaire designed to determine if a new father is coping with the experiences of parenting in the first twelve months postnatal. The questionnaire will be used for the purpose of future population-based research to identify the level of coping and satisfaction men experience when they become a new father.

7.6 Promotion and prevention in policy and practice

Antenatal education provides a unique opportunity for educators to provide information to expectant fathers on a number of key areas including:

- The changes men can expect to their lifestyle and their personal relationship with their partner;
- The importance of paternal leave as a time to help settle into the new role and share time with their partner and new baby;
- The need to have a forum conducive to engaging men in discussion about their doubts and anxieties in relation to impending fatherhood;
• The opportunity for fathers to learn about the resources available within the community that provides information and support with parenting. Women at the time of pregnancy and in the first six weeks postnatal have the most contact with health services and therefore have greater access to information and education in relation to infant care (Lane et al., 1997). Men however are not afforded the same opportunities and therefore rely on their partner for advice and information or seek information via other fora;

• The need for information that informs expectant fathers of the risk factors for depression and/or anxiety and emotional distress in the transition to parenthood. Educators have the opportunity to draw the topic of postnatal depression out of the shadows and discuss the implications that depression can have on a family’s emotional wellbeing if left undiagnosed and untreated. As men underutilise health services relative to women (Addis & Cohane, 2005), this is a prime opportunity to promote professional help-seeking by fathers as an important step towards highlighting the importance to family wellbeing when the father is emotionally well to support his partner and care for his children; and

• Evidence-based information concerned with paternal depression needs to be disseminated through the media in order to improve public awareness of the possibility that men become depressed after the birth of their baby. The more information the population receives in relation to mental health issues, the less stigmatised this health problem may become.
7.7 Directions for future research

Replication of this research design in similar environments is needed to compare the reliability of the findings of this research.

Additional longitudinal research should be conducted with a larger sample of first time fathers from a variety of geographic locations and socio-economic and ethnic backgrounds. Also discussion focus groups with first time fathers may provide a wider range of experiences with which to compare individually collected data from interviews.

7.7.1 Coping with New Fatherhood Questionnaire (CNFQ)

The author intends at a post-doctoral level to further refine and develop the draft Coping with New Fatherhood Questionnaire (CNFQ) in a longitudinal prospective study of new fathers to establish reliability and validity and to determine a reliable cut-off score. Cronbach’s alpha will be used to assess for internal consistency reliability and to assess the summative measure of the CNFQ (Tavakol & Dennick, 2011). Test-retest reliability will be conducted to obtain a correlation coefficient to provide an indication of the stability of test scores (Phelan & Wren, 2005). Known Groups Validity will be employed to support construct validity to evaluate the tool’s ability to discriminate between two groups based on each group demonstrating different mean scores on the questionnaire thus to determine if it can discriminate between a group known to have a particular trait and a group who do not have the trait. Similarly, known groups may be studied using groups of individuals with differing levels or severities of a trait. For example, a cohort of fathers who are coping with new parenthood should have lower scores on the test than the group known to be
7.8 Conclusion

Historically, fathers and their mental health have not been a topic of major research. Moreover there has been limited evidence-based midwifery research about paternal depression. This research has highlighted the potential negative impact on family wellbeing and child development when the father’s emotional state is compromised as well as the importance of fathers seeking help from health professionals to diagnose and treat their depression.

Midwives and maternal child health nurses are at the coalface in the provision of maternal-infant care and play a pivotal role in the early detection, education, support and referral of mothers and fathers who experience symptoms of depression or depressed mood. Women generally have regular contact with a midwife during visits to the antenatal clinic during pregnancy, and the postnatal clinic and maternal child health nurse after childbirth. The role of the midwife and maternal child health nurse includes the referral of clients for counselling or further assessment and treatment when the signs and symptoms of emotional distress are present. Clinic visits provide a prime opportunity for the health professional to gain information about how a woman and her partner are coping as new patents. This is particularly relevant for new parents in rural and remote regions who may be isolated from family and do not have adequate social support. If the mother’s emotional health is affected, there is a reasonable chance that the father’s emotional health also will be affected (Goodman, 2004).
As discussed in chapter one, paternal leave enables a father to be absent from work for a period of time after the birth of an infant and assists to recognise the significant role fathers play in providing support for their partners and infant after childbirth.

An unexpected but significant finding in this research was that only two fathers diagnosed with paternal depression had a partner with postnatal depression. This finding contrasts with existing research that suggests that paternal mood is correlated to maternal mood. Several fathers acknowledged that they realised early in the postnatal period that they were depressed and recalled the fluctuation of negative and positive emotions as a new parent, experiencing a sense of failure when they could not settle their crying baby and feeling emotions such as anger and sadness when the baby developed reflux or feeding difficulties.

This research is unique in its approach to explore the subject of paternal postnatal depression from the perspective of the father. The research makes an original contribution to the literature by extending the theoretical knowledge about this subject through the identification of the underlying concept of ‘coping’. While the general findings of this research are in line with many existing studies, this finding suggests that the notion of coping may have more salience in this context than the traditional conceptualisation of depression. Following from this, this research has made an attempt to develop a gender-specific questionnaire for application in population-based research. After further refinement of this tool, it may be possible to obtain robust estimates of the notion of coping in new fathers as a first step in developing novel health interventions.
Introduction Letter
Thank you for volunteering to participate in a study concerning paternal postnatal depression in first-time fathers. Karina Bria is a PhD student researcher at The University of Adelaide and in collaboration with her supervisors at The University of Adelaide is conducting the study entitled:

Exploring the experiences of first-time fathers with paternal postnatal depression during fatherhood: A grounded theory analysis.

The purpose of the study is to explore the experiences of first-time fathers who may feel depressed or anxious in the first few weeks after the birth of their baby as well as their experiences with first-time fatherhood more generally. The information gained from this study will provide specific information related to the experiences of first-time fathers in South Australia that may be used to inform the practice of health professionals in providing family health care.

During the study you will be asked to participate in 3 individual interviews in the first 6 months after the birth of your baby. The time and location for each interview will be convenient to you. Each interview will take approximately 1 hour.

You will also be asked to complete a short questionnaire at the first interview that includes questions such as the following: age, relationship to the person you live with, educational and economic status, language, and ethnicity. An envelope with return postage paid is included with this letter of introduction so that the written consent (attached) can be returned to Karina Bria. The signed consent form will be kept in a
password-protected file in order to maintain confidentiality and anonymity.

Please read the Information Sheet provided and sign the consent if you agree to participate in this study. Please return your signed consent in the return postage paid envelope within the next 3 weeks of receiving this information.

In approximately two weeks following the receipt of your consent you will be contacted to participate in the first interview.

You may withdraw from the study at any time.
Data generated from all interviews will be securely stored on a password-protected file at The University of Adelaide for seven years. All data stored on computer is password protected.

No individual will be identified in any report of the results. The results of the interviews will be included with other information obtained from the study in an article that will be prepared for publication in 2008/2009.
If you have any questions or concerns about this study, please do not hesitate to contact me at Ph (08) 8303 **** or email karina.bria@adelaide.edu.au. You may also contact the University of Adelaide Human Research Ethics Committee at Ph (08) 8303 **** Fax (08) 8303 ****

Sincerely,

Karina Bria
Department of General Practice Postgraduate Program
School of Population Health & Clinical Practice
The University of Adelaide
Information Sheet

Research on first-time fathers with postnatal depression

Thank-you for taking the time to read this information. The information below explains why this research is being carried out and how your participation may be useful to the future practice of health care professionals and future first-time fathers.

Purpose of the research
The aim of this study is to explore first-time fathers’ experiences with depression after the birth of their baby.

What are we asking you to do and how much time will it take?
Stage 1 of the study involves you attending 3 one-to-one interviews with the student researcher. The interview will be conducted at 2 months, 4 months and 6 months after the birth of your baby.

Interviews can be conducted at a time and place that is the most convenient to you. You will be asked several open-ended questions about your experiences as a first-time father with depression. The student researcher is interested in your experiences so you can discuss them freely and in as much detail as you feel comfortable. The interview will take approximately 1 hour and will be audio taped so that the student researcher can write what you have discussed word for word. You will be given a copy of the transcribed interview a short time after so that you can verify that all the information is correct. You may withdraw from participating in the study at any time.
How will the student researcher ensure that the information you provide will be confidential?
All information is confidential and you will not be identified at any time. All data will be stored at The University of Adelaide on a file that will be password protected. Only the student researcher and her supervisors will have access to information related to the study. This is stated on the consent form.

What measures will be taken in the event of an adverse event?
You have been provided with the contact numbers of the student researcher and her supervisors (see below) so that you may ask questions about the study, seek further information in relation to the study or to make a complaint about your participation.

Who can you contact if any problems arise?
Karina Bria – PhD candidate, The University of Adelaide, Postgraduate Program
Ph: (08) 8303 ****

Professor Deborah Turnbull – Supervisor, School of Psychology, Faculty of Health Sciences, The University of Adelaide Ph: 8303 ****

Associate Professor Margie Ripper – Co-supervisor, Gender, Work and Social Inquiry, School of Social Science, The University of Adelaide Ph: 8303 ****

Dr Christopher Barton – Co-supervisor, Discipline of General Practice, School of Population Health and Clinical Practice, The University of Adelaide Ph: 8303****

Dr Nicole Moulding – External supervisor, School of Social Work & Social Policy, University of South Australia, Magill Campus Ph: 8302 ****

Human Research Ethics Committee, Research Ethics and Compliance Unit, Research Branch, Level 7, 115 Grenfell Street, The University of Adelaide SA 5005 Ph (08) 8303 **** Fax (08) 8303 **** Email sabine.schreiber@adelaide.edu.au
NOTE:
This appendix is included on page 207 of the print copy of the thesis held in the University of Adelaide Library.
APPENDIX 4

Demographic Questionnaire

The purpose of this questionnaire is to obtain some general information about you. Please place a tick in the box that applies to the appropriate category. All information is confidential and will be used to obtain general demographic data on all participants in this research project.

A. Indicate your age by placing a tick in the appropriate circle.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>20 – 25</td>
<td>O</td>
</tr>
<tr>
<td>O</td>
<td>41 – 50</td>
<td>O</td>
</tr>
</tbody>
</table>

B. How would you describe your current marital status?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>Married</td>
</tr>
</tbody>
</table>

C. What is the highest level of education you have completed? Tick only one.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>Less than high school</td>
<td>O</td>
</tr>
<tr>
<td>O</td>
<td>Tafe College</td>
<td>O</td>
</tr>
<tr>
<td>O</td>
<td>University – Masters or Doctoral</td>
<td></td>
</tr>
</tbody>
</table>

D. What is your current employment status?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>Full-time</td>
<td>O</td>
</tr>
</tbody>
</table>
APPENDIX 5

Characteristic Information of Participants

Cohort of fathers (n=23)

**Age range**

23 – 47

**Parity**

Primiparous 17 (73.9%)
Multiparous 6 (26%)

Marital status

Married 20 (86.9%)
Cohabiting 2 (8.6%)
Living apart 1 (4.3%)

**Education**

University/College/ TAFE 19 (3.6%)
Secondary school 4 (17.4%)

**Employment**

Full time 21 (91.3%)
Part time 1 (4.3%)
Casual 1 (4.3%)

**Unplanned pregnancies**

7 (30.4%)

Mode of birth

Vaginal 19 (82.6%)
Emergency Caesarean 4 (17.4%)

**Place of birth**

Public hospital 16 (69.5%)
Private hospital 6 (26.0%)
Home birth 1 (4.3%)

**Paternal leave**

None 7 (30.4%)
1 week 9 (39.0%)
2 weeks 7 (30.4%)

**Partner breastfeeding first 6 months**

No 6 (26.0%)
Yes 17 (73.9%)

**Breastfeeding problems first 6 months**

Yes – initially 4 (17.3%)
Yes – more than 3 months None
Participants diagnosed with paternal postnatal depression 8 (34.7%)
Participants diagnosed with anxiety 4 (17.3%)
Participants self-identified with symptoms of paternal depression 11 (47.8%)
Participants self-identified with symptoms of paternal depression and anxiety 6 (26.0%)
Participants who did not experience paternal depression or anxiety 5 (21.7%)

Partners diagnosed with PND 2 (8.6%)
Partners with history of clinical depression 3 (13.0%)

**Bonding experience**

<table>
<thead>
<tr>
<th>Duration</th>
<th>Number (% of total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instant</td>
<td>3 (13.0%)</td>
</tr>
<tr>
<td>6 weeks – 12 weeks</td>
<td>5 (21.7%)</td>
</tr>
<tr>
<td>2 months – 6 months</td>
<td>8 (34.7%)</td>
</tr>
<tr>
<td>6 months – 12 months</td>
<td>3 (13.0%)</td>
</tr>
<tr>
<td>Longer</td>
<td>4 (17.4%)</td>
</tr>
</tbody>
</table>

**Babies ages at time of first interview**

<table>
<thead>
<tr>
<th>Interview Type</th>
<th>Babies Ages</th>
<th>Children Ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prospective interviews</td>
<td>Babies 4 months – 22 months</td>
<td>Children 2 – 5 years &amp; 10 – 19 years</td>
</tr>
<tr>
<td>Retrospective interviews</td>
<td>Babies 4 months – 22 months</td>
<td>Children 2 – 5 years &amp; 10 – 19 years</td>
</tr>
</tbody>
</table>
APPENDIX 6a

Interview Guide 1: Prospective Interview @ 2 Months Postnatal & Retrospective

Introductory questions

Q1. I’d like you to tell me a little about yourself and your immediate family.
Q2. If your relatives / friends had/have children, in what way has/did the exposure to babies and children helped when you had your baby?

Experiences during the pregnancy

Q3. I’d like you to tell me about/recall some of the things you were thinking about in the last few weeks of your partner’s pregnancy.
Probe - What were some of the concerns you had about becoming a dad for the first time?

About the birth

Q4. If you were at the birth of your baby, please tell me what you were/recall feeling when you witnessed your baby being born.
If not at the birth
(a) How did you feel about missing the birth?
Probe - I’d like you to tell me some of the things that were going through your mind when you held your baby for the first time.

Antenatal education

Q5. If you participated in preparation for parenthood classes, how useful were the classes in preparing you for caring for your newborn?
(a) If no – What information did you seek about early parenting?
(b) How many classes were specifically for fathers?
Probe - What sort of information would have been most helpful to you as a new father?
Q6. I’d like you to recall what information the midwives or educators gave you about postnatal depression.
(a) If there was no information about PND – what do you understand about PND?

Q7. Can you tell me what discussions you had with the midwife about breastfeeding?

Probe - How useful was the information on breastfeeding especially after you and your partner went home from hospital?

About fatherhood

Q8. How different are/do you recall your experiences (were) as a new father compared to what you thought it was going to be like before the baby arrived?

Q9. What have been/were the worst experiences you have had since the baby was born?

Changes to lifestyle

Q10. I’d like you to tell me about the changes that have occurred to your lifestyle since the birth of your baby?

Retrospective question – I’d like you to recall some of the changes that occurred to your lifestyle in the first few weeks after the birth.

How significant do you think these/those changes have been/were?

Relationship with partner

Q11. I’d like you to tell me how the relationship with your partner has changed since the birth of your baby?

Q12. How does your partner know about how you are feeling?

Retrospective question – How did your partner know about how you were feeling at the time?

Probe - What sorts of things have/did you discussed/discuss with your partner about the way you are/were feeling?

Friendships

Q13. Since the arrival of your baby, how has your relationship with friends changed?

Retrospective question – How did the relationship with friends change after the baby?

Work

Q14. How has/did being a new father impacted/impact on your work?
If you had paternal leave after the birth of your baby, how much time did you have? How much time would you have preferred?

**About paternal depression**

**Q15.** Please tell me about your understanding of paternal postnatal depression.

**Q16.** If you felt depressed after the birth, how soon after the birth did you start to feel depressed?

(a) If you didn’t feel depressed – I’d like you to tell me about how you are/were feeling emotionally.

**Probe** - What do you think caused the way you are/were feeling?

I’d like you to tell me what you do (if unresolved)/did (if resolved) to deal with the way you are/were feeling.

**Speaks with others**

**Q17.** If you discussed the way you have been/were feeling with anyone else in what way has/did that helped/help you?

**Q18.** What do you think first-time fathers need to know about paternal postnatal depression?

**Q19.** When do you feel is the best time for health professionals to talk to couples about postnatal depression?

*We are now coming to the end of the interview*

**Resources**

**Q20.** If you know/knew of any services in your local community that provides/provided information to new fathers about parenting I’d like you to tell me about the sort of information that is/was available.

Probe - What resources would you/ did you use to get information about parenting?

**Q21.** If you had an opportunity to provide advice to an expectant first time father, what are some of the things you would say?

This is the final question

**Q21.** Is there anything that you would like to add or discuss that I have not included in this interview today?

*Thank you this concludes our interview today*
APPENDIX 6b

Interview Guide 2 – Prospective Interview @ 4 Months Postnatal & Retrospective

About fatherhood
Q1. How different are your experiences as a father now compared to the last time you were interviewed?
Q2. If you have gained more confidence as a father, what has made you feel more confident?
Q3. Have you used any local community services or resources such as the Internet in the last two months to obtain information as a parent?
   Probe - (a) If so, what were they and how useful were they to you?
Q4. Have you used any community services or resources such as the Internet to obtain information in relation to your own health?
   (a) If so, what were they and how useful were they to you?

During our last interview I mentioned briefly about speaking with others about your emotional experiences as a new parent

Q5. How important do you think it is for a first-time father to have a mentor?
   Probe - I’d like you to tell me why a mentor would benefit a first time father.

Specific to fathers who’s partners breastfed their baby
Q6. How important did / do you feel your role is / was in supporting your partner with breastfeeding?
Q7. If there were some difficulties initially, what did / do you believe was the most difficult aspect of the breastfeeding experience?
   Probe - (a) If you had the opportunity to make a decision to continue or stop the breastfeeding, what would you decide/ have decided?

Bonding and attachment
Q8. I’d like you to tell me about your role now with respect to caring for your baby.
**Probe** - How comfortable are you/were you with this role?

**Changes to lifestyle**

**Q9.** I’d like you to tell me how the routine at home has changed in the last few months? (Established daily routine, more sleep, more personal time, etc)

**Q10.** If you get the chance to take some time out for yourself, do you have a hobby or play sport?

**Probe** - If not, I’d like you to tell me what you do to have some quality time for yourself.

**Friendships**

*You mentioned in our last interview that some friendships had changed in the first few months after the birth of your baby*

**Q11.** How have relationships with friends changed since the last interview?

**Psychological and Emotional wellbeing**

*You mentioned in our last interview that you experienced symptoms of...*(specific to each participant based on the information obtained in the first interview)*

**Q12.** If these feelings have changed in the last 2 months, how have they changed?

**Q13.** Do you believe there is a stigma attached to men and mental health?

**Probe** - If yes/no, why do you believe there is/is not a stigma?

*There is a short questionnaire that is offered to mothers in the first few weeks after birth that may detect symptoms of postnatal depression. It only takes 5 minutes to complete.*

**Q14.** How important do you believe it is for fathers to be screened for paternal depression after the birth of their baby?

**Q15.** Do you believe that you may have experienced/ are experiencing symptoms of paternal depression?

(a) I’d like you to describe what you are/were feeling.

(b) Have you/did you talked/talk to a GP about how you are/were feeling?
Relationship with partner
If the relationship with your partner has changed in the last two months
Q16. In what way have things changed?
   (a) How do you feel about the changes?

Focus on self
Q17. I’d like you to describe how you are feeling within yourself overall now?

If the symptoms have changed
Q18. What do you think has influenced the changes to how you are feeling?

If the symptoms have not changed
   (a) Why do you think you feel the same way?

We are coming to the end of the interview
Q19. I’d like you to give me a brief summation of your experience overall as a first
time father from the time of your baby’s birth until now.

Final question
Q20. Is there anything that you would like to add or comment on that has not been
covered in this interview today?

Thank you this concludes our interview today
APPENDIX 6c

Interview Guide 3: Prospective Interview @ 6 Months Postnatal & Retrospective

Fatherhood
Q1. I’d like you to tell me what you believe to be the greatest change for you personally since becoming a father?
Retrospective - I’d like you to tell me what you recall to be the greatest change for you in the first 12 months after becoming a father?
Probe question - (a) If you had that time again what would you do differently?
(Retrospective)
Q2. On a scale of 0 – 10 how would you rate your confidence level as a father right now?
(a) What has made you feel this level of confidence?
Retrospective – I’d like you to recall when you felt more confident with your role.
Q3. I’d like you to tell me how you have changed emotionally since becoming a father (Retrospective)

Bonding
Q4. On a scale of 0 – 10 how do you rate the strength of your bonding experience with your baby at this point in time?

Retrospective – I’d like you to recall when you thought the bonding experience with your baby was at its strongest.
Probe question - (a) I’d like you to tell me a little more about how the bonding experience is strong / not very strong / non-existent?

Q5. Do you believe that you are/were able to manage difficult situations with your baby such as constant crying / screaming / not sleeping / not settling? (Retrospective)
Probe question
(a) If yes or no, can you tell me a little more about that?
Relationships
Q6. Based on your experiences with first time parenthood what steps do you think men could take to improve their confidence as a new father? *(Retrospective)*
Q7. How important do you think it is for a new father to communicate his needs to his partner or someone close to him? *(Retrospective)*
Q8. How do/did you see your role primarily within the family? *(Retrospective)*
**Probe question** - (a) How important is your role?

Emotional perspectives
Q9. I’d like you to tell me how you are feeling emotionally at this point in time.
**Probe question**
(a) If feeling negative emotionally – who can/did you talk to about how you are feeling? *(Retrospective)*
Q10. Do/did you feel that your partner supports your emotional needs within the relationship? *(Retrospective)*
**Probe question** (a) If yes/no/not sure, can you explain this a little more? *(Retrospective)*
Q11. What do you/did you feel is/was the most important aspect of your relationship with your partner at this time? *(Retrospective)*
Q12. If you have/had experienced any symptoms of paternal depression since the birth of your baby, I’d like you to tell me about those experiences *(Retrospective)*

Final question
Q13. Is there anything that you would like to add or comment on that has not been discussed in this interview today?

Thank you this concludes our final interview
Introduction letter

Dear

I would like to invite you to take part in developing a questionnaire for first time fathers. The questionnaire aims to determine how well a new father is coping with the parenting experience in the first 12 months following the birth of his baby.

If you are interested in taking part in this phase of the study, please read the information sheet and instruction sheet contained in this package prior to completing the exercise. The items contained in the exercise are based on information obtained from interview data during the first stage of this study.

Your responses to this project are strictly confidential and you will remain anonymous. If you require further clarification about this exercise or you have any questions please contact me via email karina.bria@adelaide.edu.au or on my mobile.

I thank you in anticipation of your participation in this exercise.

Sincerely,

Karina Bria
PhD candidate
School of Population Health & Clinical Practice
Discipline of General Practice
The University of Adelaide
NOTE:
This appendix is included on page 220 of the print copy of the thesis held in the University of Adelaide Library.
APPENDIX 9

Instruction sheet for completing the survey

Materials for this exercise include:

- A table containing **95 Items** and a **5-Point Response Scale**
- A reply paid envelope

What you need to do:

- Place an ‘X’ in the box to indicate how relevant this item is to your experience as a first time father
- Only one response is required for each item
- There are no right or wrong answers

How long will it take?

This exercise will take approximately 20 minutes to complete and can be conducted independently by you at a time that is convenient to you

Return of completed material:

Once you have completed the exercise please return the documents in the reply paid envelope.

Please return your completed table **within 1 week** of receiving the materials.

Thank you for your participation in this exercise
### APPENDIX 10

**LIKERT RESPONSE SURVEY**

<table>
<thead>
<tr>
<th>SCALE</th>
<th>Entirely irrelevant</th>
<th>Fairly irrelevant</th>
<th>Neither relevant nor not relevant</th>
<th>Somewhat relevant</th>
<th>Very relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ITEMS</strong>&lt;br&gt;Place an ‘X’ in the box according to the relevance of each item</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I enjoyed being with my baby</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It was difficult to accept the changes to life style</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I could cope with added responsibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I tried to be an involved father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I could prioritise needs for the family</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I found a flexible work-life balance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I received enough information about caring for a newborn</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt prepared for the new baby</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I didn’t know what my role was as a new father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt frustrated by the baby’s constant crying</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt an immediate attachment with the baby</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I thought about walking away from the responsibility sometimes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I sought information and advice about parenting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt positive about being a father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I avoided talking to others about negative feelings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I welcomed support from family and friends</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt fear of rejection from my partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt protective of my new family</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I avoided talking to others about negative feelings or emotions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt joy at the birth of my baby</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I could talk to my partner about negative feelings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I didn’t really know what to expect as a new father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt positive emotions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt easily frustrated and angry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt supported by my partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt prepared to support my partner with breastfeeding</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt that I wasn’t meeting my partner’s expectations as a dad</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt attachment to my baby soon after the birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I didn’t feel a connection to my baby for several weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There were times when I felt I was not coping</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caring for a newborn was just what I expected</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt that I needed more time off after the birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt anxious at times in the first few months of fatherhood</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt trapped by the responsibility of fatherhood at times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt sad at times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt a sense of loss sometimes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt it was my responsibility to protect my family</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt anxious at times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I found the role of fatherhood was too challenging at times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt anxious about the responsibility of fatherhood at times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt supported by friends and family</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I tried to find a balance with work and family commitments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt I was struggling with my role in the family</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I could recognise negative changes to my emotions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt comfortable talking to my GP when I felt depressed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt selfish when I took time out for myself</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being a new father was less positive than I expected</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt some resentment towards the baby in the first few weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt a protective role towards my partner and baby</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I found it difficult to cope with the baby’s crying at Times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The relationship with my partner strengthened in time after the birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt there was a loss of spontaneity in the relationship becoming a parent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting advice from other parents was useful to me as a new parent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First time parenting was more difficult than anticipated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt emotionally overwhelmed with the demands of a newborn</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I avoided talking to others about negative feelings as a parent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I needed positive reassurance about my parenting skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I needed more realistic information to help prepare me as a parent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would accept support from others if I wasn’t coping with parenting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt the information I learned before the birth prepared me as a new parent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt confident that I was going to manage as a new parent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt responsible as the financial provider for my family</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt ready for the commitment of being a parent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I questioned my ability to be a good dad</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talking to other new parents was useful to my parenting experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt angry at times</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt I was competing with the baby for attention within my relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I found it difficult to cope with the changes to my personal relationship with my partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I relied on my partner for guidance in the first few months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt I was in a rut</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I had limited opportunities to socialise with friends</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I needed more time for my own interests and hobbies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I needed more support to develop my skills as a new parent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I had support from my partner when I felt stressed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I could turn to friends or family when I needed support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My confidence as a father had never improved</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I had opportunities to discuss my fears after the birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I found it difficult to cope with the lack of intimacy in the relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
I found it difficult as a new father to adjust to the changes in lifestyle
I felt frustrated about not knowing what to do
I had the feeling like I wanted to be alone and get away from it all
I started to realise I’m not coping too well
The potential for feeling depressed was always there
I needed advice on how to cope with looking after a baby
I wanted advice on how to look after my baby
I didn’t feel an instant love when I first saw my baby
I feel like I’m struggling at times
I needed to get away from the demands sometimes
Things got better in time and I felt my confidence improve
I felt depressed at times
I felt overwhelmed with the experience as a new father
Sometimes it was pretty terrifying not knowing what to expect
I didn’t feel a strong emotional reaction to my baby for some time
I needed support and encouragement in my role as a father
I really struggled with the father role at times
## APPENDIX 11

**Frequency table of responses to the survey**

<table>
<thead>
<tr>
<th>Item / Statement</th>
<th>Entirely irrelevant</th>
<th>Fairly irrelevant</th>
<th>Neither relevant nor not relevant</th>
<th>Somewhat relevant</th>
<th>Very relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I enjoy being with my baby</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4 (30.7%)</td>
<td>9 (69.2%)</td>
</tr>
<tr>
<td>2. It was difficult to accept the changes to lifestyle</td>
<td>1 (7.7%)</td>
<td>1 (7.7%)</td>
<td>1 (7.7%)</td>
<td>5 (38.4%)</td>
<td>5 (38.4%)</td>
</tr>
<tr>
<td>3. I could cope with added responsibility</td>
<td>0</td>
<td>0</td>
<td>2 (15.3%)</td>
<td>4 (30.7%)</td>
<td>7 (53.8%)</td>
</tr>
<tr>
<td>4. I tried to be an involved father</td>
<td>0</td>
<td>1 (7.7%)</td>
<td>1 (7.7%)</td>
<td>4 (30.7%)</td>
<td>7 (53.8%)</td>
</tr>
<tr>
<td>5. I could prioritise needs for the family</td>
<td>0</td>
<td>0</td>
<td>1 (7.7%)</td>
<td>8 (61.5%)</td>
<td>4 (30.7%)</td>
</tr>
<tr>
<td>6. I found a flexible work-life balance</td>
<td>0</td>
<td>1 (7.7%)</td>
<td>3 (23.0%)</td>
<td>5 (38.4%)</td>
<td>4 (30.7%)</td>
</tr>
<tr>
<td>7. I received enough information about caring for a newborn</td>
<td>1 (7.7%)</td>
<td>2 (15.3%)</td>
<td>2 (15.3%)</td>
<td>3 (23.0%)</td>
<td>5 (38.4%)</td>
</tr>
<tr>
<td>8. I felt prepared for the new baby</td>
<td>0</td>
<td>2 (15.3%)</td>
<td>1 (7.7%)</td>
<td>5 (38.4%)</td>
<td>5 (38.4%)</td>
</tr>
<tr>
<td>9. I didn’t know what my role was as a new father</td>
<td>2 (15.3%)</td>
<td>1 (7.7%)</td>
<td>2 (15.3%)</td>
<td>2 (15.3%)</td>
<td>6 (46.1%)</td>
</tr>
<tr>
<td>10. I felt frustrated by the baby’s constant crying</td>
<td>1 (7.7%)</td>
<td>1 (7.7%)</td>
<td>2 (15.3%)</td>
<td>4 (30.7%)</td>
<td>5 (38.4%)</td>
</tr>
<tr>
<td>11. I felt an immediate attachment with the baby</td>
<td>1 (7.7%)</td>
<td>1 (7.7%)</td>
<td>3 (23.0%)</td>
<td>3 (23.0%)</td>
<td>5 (38.4%)</td>
</tr>
<tr>
<td>12. I felt like walking away from the responsibility sometimes</td>
<td>4 (30.7%)</td>
<td>1 (7.7%)</td>
<td>2 (15.3%)</td>
<td>2 (15.3%)</td>
<td>5 (38.4%)</td>
</tr>
<tr>
<td>13. I sought information and advice about parenting</td>
<td>0</td>
<td>2 (15.3%)</td>
<td>2 (15.3%)</td>
<td>5 (38.4%)</td>
<td>4 (30.7%)</td>
</tr>
<tr>
<td>14. I felt positive about being a father</td>
<td>0</td>
<td>2 (15.3%)</td>
<td>1 (7.7%)</td>
<td>3 (23.0%)</td>
<td>9 (69.2%)</td>
</tr>
<tr>
<td>15. I avoided taking to others about negative feelings</td>
<td>2 (15.3%)</td>
<td>2 (15.3%)</td>
<td>2 (15.3%)</td>
<td>2 (15.3%)</td>
<td>5 (38.4%)</td>
</tr>
<tr>
<td>16. I welcomed support from family and friends</td>
<td>0</td>
<td>1 (7.7%)</td>
<td>4 (30.7%)</td>
<td>3 (23.0%)</td>
<td>5 (38.3%)</td>
</tr>
<tr>
<td>17. I felt fear of rejection from my partner</td>
<td>3 (23.0%)</td>
<td>0</td>
<td>3 (23.0%)</td>
<td>2 (15.3%)</td>
<td>5 (38.4%)</td>
</tr>
<tr>
<td>18. I felt protective of my new family</td>
<td>0</td>
<td>1 (7.7%)</td>
<td>3 (23.0%)</td>
<td>3 (23.0%)</td>
<td>6 (46.1%)</td>
</tr>
<tr>
<td>19. I avoided talking to others about negative feeling or emotions</td>
<td>1 (7.7%)</td>
<td>3 (23.0%)</td>
<td>1 (7.7%)</td>
<td>1 (7.7%)</td>
<td>7 (53.8%)</td>
</tr>
<tr>
<td>20. I felt joy at the birth of my baby</td>
<td>0</td>
<td>0</td>
<td>1 (7.7%)</td>
<td>3 (23.0%)</td>
<td>9 (69.2%)</td>
</tr>
<tr>
<td>21. I could talk to my partner about negative feelings</td>
<td>0</td>
<td>2 (15.3%)</td>
<td>2 (15.3%)</td>
<td>2 (15.3%)</td>
<td>7 (53.8%)</td>
</tr>
<tr>
<td>22. I didn’t really know what to expect as a new father</td>
<td>0</td>
<td>2 (15.3%)</td>
<td>0</td>
<td>6 (46.1%)</td>
<td>5 (38.4%)</td>
</tr>
<tr>
<td>23. I felt positive emotions</td>
<td>0</td>
<td>0</td>
<td>2 (15.3%)</td>
<td>6 (46.1%)</td>
<td>5 (38.4%)</td>
</tr>
<tr>
<td>24. I felt easily frustrated and angry</td>
<td>1 (7.7%)</td>
<td>1 (7.7%)</td>
<td>1 (7.7%)</td>
<td>4 (30.7%)</td>
<td>6 (46.1%)</td>
</tr>
<tr>
<td>25. I felt supported by my partner</td>
<td>1 (7.7%)</td>
<td>1 (7.7%)</td>
<td>0</td>
<td>6 (46.1%)</td>
<td>5 (38.4%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>26. I felt prepared to support my partner with breastfeeding</td>
<td>0</td>
<td>0</td>
<td>1 (7.7%)</td>
<td>7 (53.8%)</td>
<td>5 (38.4%)</td>
</tr>
<tr>
<td>27. I felt that I wasn’t meeting my partner’s expectations as a dad</td>
<td>2 (15.3%)</td>
<td>2 (15.3%)</td>
<td>1 (7.7%)</td>
<td>4 (30.7%)</td>
<td>4 (30.7%)</td>
</tr>
<tr>
<td>28. I felt attachment to my baby soon after the birth</td>
<td>0</td>
<td>1 (7.7%)</td>
<td>4 (30.7%)</td>
<td>3 (23.0%)</td>
<td>5 (38.4%)</td>
</tr>
<tr>
<td>29. I didn’t feel a connection to my baby for several weeks</td>
<td>1 (7.7%)</td>
<td>1 (7.7%)</td>
<td>3 (23.0%)</td>
<td>2 (15.3%)</td>
<td>6 (46.1%)</td>
</tr>
<tr>
<td>30. There were times when I felt I was not coping</td>
<td>0</td>
<td>0</td>
<td>1 (7.7%)</td>
<td>4 (30.7%)</td>
<td>8 (61.5%)</td>
</tr>
<tr>
<td>31. Caring for a newborn was just what I expected</td>
<td>1 (7.7%)</td>
<td>3 (23.0%)</td>
<td>4 (30.7%)</td>
<td>3 (23.0%)</td>
<td>2 (15.3%)</td>
</tr>
<tr>
<td>32. I felt that I needed more time off after the birth</td>
<td>0</td>
<td>2 (15.3%)</td>
<td>0</td>
<td>4 (30.7%)</td>
<td>7 (53.8%)</td>
</tr>
<tr>
<td>33. I felt anxious at times in the first few months of fatherhood</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6 (46.1%)</td>
<td>7 (53.8%)</td>
</tr>
<tr>
<td>34. I felt trapped by the responsibility of fatherhood at times</td>
<td>1 (7.7%)</td>
<td>2 (15.3%)</td>
<td>1 (7.7%)</td>
<td>1 (7.7%)</td>
<td>8 (61.5%)</td>
</tr>
<tr>
<td>35. I felt sad at times</td>
<td>0</td>
<td>2 (15.3%)</td>
<td>2 (15.3%)</td>
<td>1 (7.7%)</td>
<td>8 (61.5%)</td>
</tr>
<tr>
<td>36. I felt a sense of loss at times</td>
<td>2 (15.3%)</td>
<td>0</td>
<td>5 (38.4%)</td>
<td>2 (15.3%)</td>
<td>4 (30.7%)</td>
</tr>
<tr>
<td>37. I felt it was my responsibility to protect my family</td>
<td>0</td>
<td>1 (7.7%)</td>
<td>2 (15.3%)</td>
<td>1 (7.7%)</td>
<td>9 (69.2%)</td>
</tr>
<tr>
<td>38. I felt anxious at times</td>
<td>0</td>
<td>1 (7.7%)</td>
<td>1 (7.7%)</td>
<td>3 (23.0%)</td>
<td>8 (61.5%)</td>
</tr>
<tr>
<td>39. I felt the role of fatherhood was too challenging at times</td>
<td>1 (7.7%)</td>
<td>2 (15.3%)</td>
<td>4 (30.7%)</td>
<td>4 (30.7%)</td>
<td>2 (15.3%)</td>
</tr>
<tr>
<td>40. I felt anxious about the responsibility of fatherhood at times</td>
<td>0</td>
<td>0</td>
<td>2 (15.3%)</td>
<td>7 (53.8%)</td>
<td>4 (30.7%)</td>
</tr>
<tr>
<td>41. I felt supported by my friends and family</td>
<td>0</td>
<td>1 (7.7%)</td>
<td>4 (30.7%)</td>
<td>4 (30.7%)</td>
<td>4 (30.7%)</td>
</tr>
<tr>
<td>42. I tried to find a balance with work and family commitments</td>
<td>0</td>
<td>1 (7.7%)</td>
<td>3 (23.0%)</td>
<td>4 (30.7%)</td>
<td>5 (38.4%)</td>
</tr>
<tr>
<td>43. I felt I was struggling with my role in the family</td>
<td>2 (15.3%)</td>
<td>1 (7.7%)</td>
<td>0</td>
<td>6 (46.1%)</td>
<td>4 (30.7%)</td>
</tr>
<tr>
<td>44. I could recognise negative changes to my emotions</td>
<td>0</td>
<td>1 (7.7%)</td>
<td>4 (30.7%)</td>
<td>4 (30.7%)</td>
<td>4 (30.7%)</td>
</tr>
<tr>
<td>45. I felt comfortable talking to my GP when I felt depressed</td>
<td>0</td>
<td>2 (15.3%)</td>
<td>7 (53.8%)</td>
<td>0</td>
<td>4 (30.7%)</td>
</tr>
<tr>
<td>46. I felt selfish when I took time out for myself</td>
<td>1 (7.7%)</td>
<td>1 (7.7%)</td>
<td>2 (15.3%)</td>
<td>3 (23.0%)</td>
<td>6 (46.1%)</td>
</tr>
<tr>
<td>47. Being a new father was less positive than I expected</td>
<td>0</td>
<td>1 (7.7%)</td>
<td>1 (7.7%)</td>
<td>7 (53.8%)</td>
<td>4 (30.7%)</td>
</tr>
<tr>
<td>48. I felt some resentment towards the baby in the first few weeks</td>
<td>4 (30.7%)</td>
<td>1 (7.7%)</td>
<td>2 (15.3%)</td>
<td>1 (7.7%)</td>
<td>5 (38.4%)</td>
</tr>
<tr>
<td>49. I felt a protective role towards my partner and baby</td>
<td>0</td>
<td>1 (7.7%)</td>
<td>2 (15.3%)</td>
<td>3 (23.0%)</td>
<td>7 (53.8%)</td>
</tr>
<tr>
<td>50. I found it difficult to cope with the baby’s crying at times</td>
<td>0</td>
<td>0</td>
<td>1 (7.7%)</td>
<td>4 (30.7%)</td>
<td>8 (61.5%)</td>
</tr>
<tr>
<td>51. The relationship with my partner strengthened in time after the birth</td>
<td>0</td>
<td>1 (7.7%)</td>
<td>5 (38.4%)</td>
<td>4 (30.7%)</td>
<td>3 (23.0%)</td>
</tr>
<tr>
<td>52. I felt there was a loss of spontaneity in the relationship becoming a parent</td>
<td>1 (7.7%)</td>
<td>0</td>
<td>2 (15.3%)</td>
<td>4 (30.7%)</td>
<td>6 (46.1%)</td>
</tr>
<tr>
<td>53. Getting advice from other parents was useful to me a new parent</td>
<td>3 (23.0%)</td>
<td>2 (15.3%)</td>
<td>2 (15.3%)</td>
<td>3 (23.0%)</td>
<td>3 (23.0%)</td>
</tr>
<tr>
<td>Question</td>
<td>Response Distribution</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>54. First time parenting was more difficult than anticipated</td>
<td>0 2 (15.3%) 0 5 (38.4%) 6 (46.1%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>55. I felt emotionally overwhelmed with the demands of a newborn</td>
<td>0 1 (7.7%) 3 (23.0%) 4 (30.7%) 5 (38.4%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>56. I avoided talking to others about negative feelings as a parent</td>
<td>1 (7.7%) 4 (30.7%) 1 (7.7%) 2 (15.3%) 5 (38.4%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>57. I needed positive reassurance about my parenting skills</td>
<td>0 1 (7.7%) 5 (38.4%) 4 (30.7%) 3 (23.0%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>58. I needed more realistic information to help prepare me as a parent</td>
<td>0 1 (7.7%) 2 (15.3%) 5 (38.4%) 5 (38.4%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>59. I would accept support from others if I wasn’t coping with parenting</td>
<td>0 2 (15.3%) 3 (23.0%) 5 (38.4%) 3 (23.0%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60. I felt the information I learned before the birth prepared me as a new parent</td>
<td>1 (7.7%) 4 (30.7%) 4 (30.7%) 1 (7.7%) 3 (23.0%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>61. I felt confident that I was going to manage as a new parent</td>
<td>1 (7.7%) 0 2 (15.3%) 8 (61.5%) 2 (15.3%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>62. I felt responsible as the financial provider for my family</td>
<td>1 (7.7%) 0 1 (7.7%) 4 (30.7%) 7 (53.8%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>63. I felt ready for the commitment of being a parent</td>
<td>1 (7.7%) 0 1 (7.7%) 6 (46.1%) 5 (38.4%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>64. I questioned my ability to be a good dad</td>
<td>0 1 (7.7%) 1 (7.7%) 5 (38.4%) 6 (46.1%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65. Talking to other new parents was useful to my parenting experience</td>
<td>1 (7.7%) 1 (7.7%) 6 (46.1%) 3 (23.0%) 2 (15.3%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>66. I felt angry at times</td>
<td>1 (7.7%) 0 4 (30.7%) 2 (15.3%) 6 (46.1%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>67. I felt I was competing with the baby for attention within my relationship</td>
<td>1 (7.7%) 4 (30.7%) 2 (15.3%) 2 (15.3%) 4 (30.7%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>68. I found it difficult to cope with the changes to my personal relationship with my partner</td>
<td>0 2 (15.3%) 2 (15.3%) 4 (30.7%) 5 (38.4%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>69. I relied on my partner for guidance in the first few months</td>
<td>2 (15.3%) 1 (7.7%) 1 (7.7%) 8 (61.5%) 1 (7.7%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>70. I felt I was in a rut</td>
<td>2 (15.3%) 4 (30.7%) 0 2 (15.3%) 5 (38.4%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>71. I had limited opportunities to socialise with friends</td>
<td>0 3 (23.0%) 0 6 (46.1%) 4 (30.7%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>72. I needed more time for my own interests and hobbies</td>
<td>2 (15.3%) 4 (30.7%) 1 (7.7%) 3 (23.0%) 3 (23.0%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>73. I needed more support from my partner when I felt stressed</td>
<td>2 (15.3%) 2 (15.3%) 4 (30.7%) 3 (23.0%) 2 (15.3%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>74. I had support from my partner when I felt stressed</td>
<td>1 (7.7%) 3 (23.0%) 0 5 (38.4%) 4 (30.7%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>75. I could turn to friends or family when I needed support</td>
<td>1 (7.7%) 3 (23.0%) 2 (15.3%) 3 (23.0%) 4 (30.7%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>76. My confidence as a father never improved</td>
<td>5 (38.4%) 2 (15.3%) 1 (7.7%) 3 (23.0%) 2 (15.3%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>77. I had opportunities to discuss my fears after the birth</td>
<td>3 (23.0%) 2 (15.3%) 2 (15.3%) 2 (15.3%) 4 (30.7%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>78. I found it difficult to cope with the lack of intimacy in the relationship</td>
<td>2 (15.3%) 2 (15.3%) 0 4 (30.7%) 5 (38.4%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>79. I found it difficult as a new father to adjust to the changes in lifestyle</td>
<td>2 (15.3%) 1 (7.7%) 1 (7.7%) 4 (30.7%) 5 (38.4%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>80. I felt frustrated about not knowing what to do</td>
<td>0</td>
<td>1 (7.7%)</td>
<td>3 (23.0%)</td>
<td>4 (30.7%)</td>
<td>5 (38.4%)</td>
</tr>
<tr>
<td>81. I had the feeling like I wanted to be alone and get away from it all</td>
<td>1 (7.7%)</td>
<td>2 (15.3%)</td>
<td>2 (15.3%)</td>
<td>3 (23.0%)</td>
<td>5 (38.4%)</td>
</tr>
<tr>
<td>82. I started to realise I'm not coping too well</td>
<td>2 (15.3%)</td>
<td>3 (23.0%)</td>
<td>1 (7.7%)</td>
<td>2 (15.3%)</td>
<td>5 (38.4%)</td>
</tr>
<tr>
<td>83. The potential for feeling depressed was always there</td>
<td>0</td>
<td>3 (23.0%)</td>
<td>1 (7.7%)</td>
<td>4 (30.7%)</td>
<td>5 (38.4%)</td>
</tr>
<tr>
<td>84. I needed advice on how to cope with looking after a baby</td>
<td>2 (15.3%)</td>
<td>2 (15.3%)</td>
<td>2 (15.3%)</td>
<td>5 (38.4%)</td>
<td>2 (15.3%)</td>
</tr>
<tr>
<td>85. I wanted advice on how to look after my baby</td>
<td>2 (15.3%)</td>
<td>1 (7.7%)</td>
<td>1 (7.7%)</td>
<td>4 (30.7%)</td>
<td>5 (38.4%)</td>
</tr>
<tr>
<td>86. I didn’t feel an instant love when I first saw my baby</td>
<td>2 (15.3%)</td>
<td>1 (7.7%)</td>
<td>1 (7.7%)</td>
<td>4 (30.7%)</td>
<td>5 (38.4%)</td>
</tr>
<tr>
<td>87. I feel like I’m struggling at times</td>
<td>2 (15.3%)</td>
<td>2 (15.3%)</td>
<td>1 (7.7%)</td>
<td>3 (23.0%)</td>
<td>5 (38.4%)</td>
</tr>
<tr>
<td>88. I needed to get away from the demands sometimes</td>
<td>3 (23.0%)</td>
<td>0</td>
<td>2 (15.3%)</td>
<td>3 (23.0%)</td>
<td>5 (38.4%)</td>
</tr>
<tr>
<td>89. Things got better in time and I felt my confidence improve</td>
<td>1 (7.7%)</td>
<td>0</td>
<td>2 (15.3%)</td>
<td>3 (23.0%)</td>
<td>7 (53.8%)</td>
</tr>
<tr>
<td>90. I felt depressed at times</td>
<td>4 (30.7%)</td>
<td>2 (15.3%)</td>
<td>0</td>
<td>2 (15.3%)</td>
<td>5 (38.4%)</td>
</tr>
<tr>
<td>91. I felt overwhelmed with the experience as a new father</td>
<td>1 (7.7%)</td>
<td>1 (7.7%)</td>
<td>1 (7.7%)</td>
<td>3 (23.0%)</td>
<td>7 (53.8%)</td>
</tr>
<tr>
<td>92. Sometimes it was pretty terrifying not knowing what to expect</td>
<td>0</td>
<td>0</td>
<td>4 (30.7%)</td>
<td>7 (53.8%)</td>
<td>2 (15.3%)</td>
</tr>
<tr>
<td>93. I didn’t feel a strong emotional reaction to my baby for some time</td>
<td>3 (23.0%)</td>
<td>0</td>
<td>2 (15.3%)</td>
<td>6 (46.1%)</td>
<td>2 (15.3%)</td>
</tr>
<tr>
<td>94. I needed support and encouragement in my role as a father</td>
<td>1 (7.7%)</td>
<td>3 (23.0%)</td>
<td>1 (7.7%)</td>
<td>5 (38.4%)</td>
<td>3 (23.0%)</td>
</tr>
<tr>
<td>95. I really struggled with the father role at times</td>
<td>0</td>
<td>3 (23.0%)</td>
<td>1 (7.7%)</td>
<td>3 (23.0%)</td>
<td>6 (46.1%)</td>
</tr>
</tbody>
</table>
### APPENDIX 11a

**Frequency table of combined responses to Entirely irrelevant and Fairly irrelevant**

<table>
<thead>
<tr>
<th>Item / Statement</th>
<th>Entirely irrelevant</th>
<th>Fairly irrelevant</th>
<th>Total for combined responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I enjoy being with my baby</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2. It was difficult to accept the changes to lifestyle</td>
<td>1 (7.7%)</td>
<td>1 (7.7%)</td>
<td>2</td>
</tr>
<tr>
<td>3. I could cope with added responsibility</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4. I tried to be an involved father</td>
<td>0</td>
<td>1 (7.7%)</td>
<td>1</td>
</tr>
<tr>
<td>5. I could prioritise needs for the family</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6. I found a flexible work-life balance</td>
<td>0</td>
<td>1 (7.7%)</td>
<td>1</td>
</tr>
<tr>
<td>7. I received enough information about caring for a newborn</td>
<td>1 (7.7%)</td>
<td>2 (15.3%)</td>
<td>3</td>
</tr>
<tr>
<td>8. I felt prepared for the new baby</td>
<td>0</td>
<td>2 (15.3%)</td>
<td>1</td>
</tr>
<tr>
<td>9. I didn’t know what my role was as a new father</td>
<td>2 (15.3%)</td>
<td>1 (7.7%)</td>
<td>3</td>
</tr>
<tr>
<td>10. I felt frustrated by the baby’s constant crying</td>
<td>1 (7.7%)</td>
<td>1 (7.7%)</td>
<td>2</td>
</tr>
<tr>
<td>11. I felt an immediate attachment with the baby</td>
<td>1 (7.7%)</td>
<td>1 (7.7%)</td>
<td>2</td>
</tr>
<tr>
<td>12. I felt like walking away from the responsibility sometimes</td>
<td>4 (30.7%)</td>
<td>1 (7.7%)</td>
<td>5</td>
</tr>
<tr>
<td>13. I sought information and advice about parenting</td>
<td>0</td>
<td>2 (15.3%)</td>
<td>2</td>
</tr>
<tr>
<td>14. I felt positive about being a father</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>15. I avoided taking to others about negative feelings</td>
<td>2 (15.3%)</td>
<td>2 (15.3%)</td>
<td>4</td>
</tr>
<tr>
<td>16. I welcomed support from family and friends</td>
<td>0</td>
<td>1 (7.7%)</td>
<td>1</td>
</tr>
<tr>
<td>17. I felt fear of rejection from my partner</td>
<td>3 (23.0%)</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>18. I felt protective of my new family</td>
<td>0</td>
<td>1 (7.7%)</td>
<td>1</td>
</tr>
<tr>
<td>19. I avoided talking to others about negative feeling or emotions</td>
<td>1 (7.7%)</td>
<td>3 (23.0%)</td>
<td>4</td>
</tr>
<tr>
<td>20. I felt joy at the birth of my baby</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
| Question                                                                 | Yes | No (%)  | No
|-------------------------------------------------------------------------|-----|---------|---
| 21. I could talk to my partner about negative feelings                  | 0   | 2 (15.3%) | 2
| 22. I didn’t really know what to expect as a new father                 | 0   | 2 (15.3%) | 2
| 23. I felt positive emotions                                            | 0   | 0        | 0
| 24. I felt easily frustrated and angry                                  | 1 (7.7%) | 1 (7.7%) | 2
| 25. I felt supported by my partner                                      | 1 (7.7%) | 1 (7.7%) | 2
| 26. I felt prepared to support my partner with breastfeeding            | 0   | 0        | 0
| 27. I felt that I wasn’t meeting my partner’s expectations as a dad     | 2 (15.3%) | 2 (15.3%) | 4
| 28. I felt attachment to my baby soon after the birth                   | 0   | 1 (7.7%) | 1
| 29. I didn’t feel a connection to my baby for several weeks            | 1 (7.7%) | 1 (7.7%) | 2
| 30. There were times when I felt I was not coping                       | 0   | 0        | 0
| 31. Caring for a newborn was just what I expected                       | 1 (7.7%) | 3 (23.0%) | 4
| 32. I felt that I needed more time off after the birth                  | 0   | 2 (15.3%) | 2
| 33. I felt anxious at times in the first few months of fatherhood       | 0   | 0        | 0
| 34. I felt trapped by the responsibility of fatherhood at times         | 1 (7.7%) | 2 (15.3%) | 3
| 35. I felt sad at times                                                 | 0   | 2 (15.3%) | 2
| 36. I felt a sense of loss sometimes                                    | 2 (15.3%) | 0        | 2
| 37. I felt it was my responsibility to protect my family                | 0   | 1 (7.7%) | 1
| 38. I felt anxious at times                                             | 0   | 1 (7.7%) | 1
| 39. I felt the role of fatherhood was too challenging at times          | 1 (7.7%) | 2 (15.3%) | 3
| 40. I felt anxious about the responsibility of fatherhood at times      | 0   | 0        | 0
| 41. I felt supported by my friends and family                           | 0   | 1 (7.7%) | 1
| 42. I tried to find a balance with work and family commitments         | 0   | 1 (7.7%) | 1
| 43. I felt I was struggling with my role in the family                  | 2 (15.3%) | 1 (7.7%) | 3
| 44. I could recognise negative changes to my emotions                   | 0   | 1 (7.7%) | 1
| 45. I felt comfortable talking to my GP when I felt depressed           | 0   | 2 (15.3%) | 2
| 46. I felt selfish when I took time out for myself                      | 1 (7.7%) | 1 (7.7%) | 2
<p>| 47. | Being a new father was less positive than I expected | 0 | 1 (7.7%) | 1 |
| 48. | I felt some resentment towards the baby in the first few weeks | 4 (30.7%) | 1 (7.7%) | 5 |
| 49. | I felt a protective role towards my partner and baby | 0 | 1 (7.7%) | 1 |
| 50. | I found it difficult to cope with the baby’s crying at times | 0 | 0 | 0 |
| 51. | The relationship with my partner strengthened in time after the birth | 0 | 1 (7.7%) | 1 |
| 52. | I felt there was a loss of spontaneity in the relationship becoming a parent | 1 (7.7%) | 0 | 1 |
| 53. | Getting advice from other parents was useful to me as a new parent | 3 (23.0%) | 2 (15.3%) | 5 |
| 54. | First time parenting was more difficult than anticipated | 0 | 2 (15.3%) | 2 |
| 55. | I felt emotionally overwhelmed with the demands of a newborn | 0 | 1 (7.7%) | 1 |
| 56. | I avoided talking to others about negative feelings as a parent | 1 (7.7%) | 4 (30.7%) | 5 |
| 57. | I needed positive reassurance about my parenting skills | 0 | 1 (7.7%) | 1 |
| 58. | I needed more realistic information to help prepare me as a parent | 0 | 1 (7.7%) | 1 |
| 59. | I would accept support from others if I wasn’t coping with parenting | 0 | 2 (15.3%) | 2 |
| 60. | I felt the information I learned before the birth prepared me as a new parent | 1 (7.7%) | 4 (30.7%) | 5 |
| 61. | I felt confident that I was going to manage as a new parent | 1 (7.7%) | 0 | 1 |
| 62. | I felt responsible as the financial provider for my family | 1 (7.7%) | 0 | 1 |
| 63. | I felt ready for the commitment of being a parent | 1 (7.7%) | 0 | 1 |
| 64. | I questioned my ability to be a good dad | 0 | 1 (7.7%) | 1 |
| 65. | Talking to other new parents was useful to my parenting experience | 1 (7.7%) | 1 (7.7%) | 2 |
| 66. | I felt angry at times | 1 (7.7%) | 0 | 1 |
| 67. | I felt I was competing with the baby for attention within my relationship | 1 (7.7%) | 4 (30.7%) | 5 |
| 68. | I found it difficult to cope with the changes to my personal relationship with my partner | 0 | 2 (15.3%) | 2 |
| 69. | I relied on my partner for guidance in the first few months | 2 (15.3%) | 1 (7.7%) | 3 |
| 70. | I felt I was in a rut | 2 (15.3%) | 4 (30.7%) | 6 |
| 71. | I had limited opportunities to socialise with friends | 0 | 3 (23.0%) | 3 |
| 72. | I needed more time for my own interests and hobbies | 2 (15.3%) | 4 (30.7%) | 6 |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>73. I needed more support from my partner when I felt stressed</td>
<td>2 (15.3%)</td>
<td>2 (15.3%)</td>
<td>4</td>
</tr>
<tr>
<td>74. I had support from my partner when I felt stressed</td>
<td>1 (7.7%)</td>
<td>3 (23.0%)</td>
<td>4</td>
</tr>
<tr>
<td>75. I could turn to friends or family when I needed support</td>
<td>1 (7.7%)</td>
<td>3 (23.0%)</td>
<td>4</td>
</tr>
<tr>
<td>76. My confidence as a father never improved</td>
<td>5 (38.4%)</td>
<td>2 (15.3%)</td>
<td>7</td>
</tr>
<tr>
<td>77. I had opportunities to discuss my fears after the birth</td>
<td>3 (23.0%)</td>
<td>2 (15.3%)</td>
<td>5</td>
</tr>
<tr>
<td>78. I found it difficult to cope with the lack of intimacy in the relationship</td>
<td>2 (15.3%)</td>
<td>2 (15.3%)</td>
<td>4</td>
</tr>
<tr>
<td>79. I found it difficult as a new father to adjust to the changes in lifestyle</td>
<td>2 (15.3%)</td>
<td>1 (7.7%)</td>
<td>3</td>
</tr>
<tr>
<td>80. I felt frustrated about not knowing what to do</td>
<td>0</td>
<td>1 (7.7%)</td>
<td>1</td>
</tr>
<tr>
<td>81. I had the feeling like I wanted to be alone and get away from it all</td>
<td>1 (7.7%)</td>
<td>2 (15.3%)</td>
<td>3</td>
</tr>
<tr>
<td>82. I started to realise I’m not coping too well</td>
<td>2 (15.3%)</td>
<td>3 (23.0%)</td>
<td>5</td>
</tr>
<tr>
<td>83. The potential for feeling depressed was always there</td>
<td>0</td>
<td>3 (23.0%)</td>
<td>3</td>
</tr>
<tr>
<td>84. I needed advice on how to cope with looking after a baby</td>
<td>2 (15.3%)</td>
<td>2 (15.3%)</td>
<td>4</td>
</tr>
<tr>
<td>85. I wanted advice on how to look after my baby</td>
<td>2 (15.3%)</td>
<td>1 (7.7%)</td>
<td>3</td>
</tr>
<tr>
<td>86. I didn’t feel an instant love when I first saw my baby</td>
<td>2 (15.3%)</td>
<td>1 (7.7%)</td>
<td>3</td>
</tr>
<tr>
<td>87. I feel like I’m struggling at times</td>
<td>2 (15.3%)</td>
<td>2 (15.3%)</td>
<td>4</td>
</tr>
<tr>
<td>88. I needed to get away from the demands sometimes</td>
<td>3 (23.0%)</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>89. Things got better in time and I felt my confidence improve</td>
<td>1 (7.7%)</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>90. I felt depressed at times</td>
<td>4 (30.7%)</td>
<td>2 (15.3%)</td>
<td>6</td>
</tr>
<tr>
<td>91. I felt overwhelmed with the experience as a new father</td>
<td>1 (7.7%)</td>
<td>1 (7.7%)</td>
<td>2</td>
</tr>
<tr>
<td>92. Sometimes it was pretty terrifying not knowing what to expect</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>93. I didn’t feel a strong emotional reaction to my baby for some time</td>
<td>3 (23.0%)</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>94. I needed support and encouragement in my role as a father</td>
<td>1 (7.7%)</td>
<td>3 (23.0%)</td>
<td>4</td>
</tr>
<tr>
<td>95. I really struggled with the father role at times</td>
<td>0</td>
<td>3 (23.0%)</td>
<td>3</td>
</tr>
</tbody>
</table>
APPENDIX 12a

APPENDIX 12b
APPENDIX 12c

Merged Data Entirely & Fairly Irrelevant

238
Instruction Sheet for Q-sort Exercise

Materials in this Pilot study include:

- A list of items numbered 1–59
- A table consisting of 9 themes

Exercise:

Match each item numbered 1-59 to each of the 9 themes.

Each item can be placed in any one of the 9 themes according to how you interpret the placement of items.

This exercise will contribute to the development of a questionnaire to assess if new fathers are coping with fatherhood in the first 12 months after the birth of their baby.

Your response in this exercise is strictly confidential and you will not be identified in any way.

You may withdraw your participation in this exercise at any time without explanation.

If you would like to participate in this exercise, please let me know by contacting me via email karina.bria@adealide.edu.au or on my mobile 0419 018 379 to arrange a time to complete the exercise at your convenience.

In appreciation for your participation,

Karina Bria
PhD candidate
School of Population Health & Clinical Practice
Discipline of General Practice
The University of Adelaide
APPENDIX 14

List of Items for Q-sort Exercise

<table>
<thead>
<tr>
<th>Items 1 – 59 (Original items numbered 1-95 from phase one (Appendix 10) in bold type)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I enjoyed being with my baby (1)</td>
</tr>
<tr>
<td>2. It was difficult to accept the changes to life style (2)</td>
</tr>
<tr>
<td>3. I could cope with added responsibility (3)</td>
</tr>
<tr>
<td>4. I tried to be an involved father (4)</td>
</tr>
<tr>
<td>5. I could prioritise needs for the family (5)</td>
</tr>
<tr>
<td>6. I found a flexible work-life balance (6)</td>
</tr>
<tr>
<td>7. I felt prepared for the new baby (8)</td>
</tr>
<tr>
<td>8. I felt frustrated by the baby’s constant crying (10)</td>
</tr>
<tr>
<td>9. I felt an immediate attachment with the baby (11)</td>
</tr>
<tr>
<td>10. I sought information and advice about parenting (13)</td>
</tr>
<tr>
<td>11. I felt positive about being a father (14)</td>
</tr>
<tr>
<td>12. I welcomed support from family and friends (16)</td>
</tr>
<tr>
<td>13. I felt protective of my new family (18)</td>
</tr>
<tr>
<td>14. I felt joy at the birth of my baby (20)</td>
</tr>
<tr>
<td>15. I could talk to my partner about negative feelings (21)</td>
</tr>
<tr>
<td>16. I didn’t really know what to expect as a new father (22)</td>
</tr>
<tr>
<td>17. I felt positive emotions (23)</td>
</tr>
<tr>
<td>18. I felt easily frustrated and angry (24)</td>
</tr>
<tr>
<td>19. I felt supported by my partner (25)</td>
</tr>
<tr>
<td>20. I felt prepared to support my partner with breastfeeding (26)</td>
</tr>
<tr>
<td>21. I felt attachment to my baby soon after the birth (28)</td>
</tr>
<tr>
<td>22. I didn’t feel a connection to my baby for several weeks (29)</td>
</tr>
<tr>
<td>23. There were times when I felt I was not coping (30)</td>
</tr>
<tr>
<td>24. I felt that I needed more time off after the birth (32)</td>
</tr>
<tr>
<td>25. I felt anxious at times in the first few months of fatherhood (33)</td>
</tr>
<tr>
<td>26. I felt sad at times (35)</td>
</tr>
<tr>
<td>27. I felt a sense of loss sometime (36)</td>
</tr>
<tr>
<td>28. I felt it was my responsibility to protect my family (37)</td>
</tr>
<tr>
<td>29. I felt anxious at times (38)</td>
</tr>
<tr>
<td>30. I felt anxious about the responsibility of fatherhood at times (40)</td>
</tr>
<tr>
<td>31. I felt supported by friends and family (41)</td>
</tr>
<tr>
<td>32. I tried to find a balance with work and family (42)</td>
</tr>
<tr>
<td>33. I could recognise negative changes to my emotion (44)</td>
</tr>
<tr>
<td>34. I felt comfortable talking to my GP when I felt depressed (45)</td>
</tr>
<tr>
<td>35. I felt selfish when I took time out for myself (46)</td>
</tr>
<tr>
<td>36. Being a new father was less positive than I expected (47)</td>
</tr>
<tr>
<td>37. I felt a protective role towards my partner and baby (49)</td>
</tr>
<tr>
<td>38. I found it difficult to cope with the baby’s crying at times (50)</td>
</tr>
<tr>
<td>39. The relationship with my partner strengthened in time after the birth (51)</td>
</tr>
<tr>
<td>40. I felt there was a loss of spontaneity in the relationship becoming a parent (52)</td>
</tr>
<tr>
<td>41. First time parenting was more difficult than anticipated (54)</td>
</tr>
<tr>
<td>42. I felt emotionally overwhelmed with the demands of a newborn (55)</td>
</tr>
<tr>
<td>43. I needed positive reassurance about my parenting skills (57)</td>
</tr>
<tr>
<td>44. I needed more realistic information to help prepare me as a parent (58)</td>
</tr>
<tr>
<td>45. I would accept support from others if I weren’t coping with parenting (59)</td>
</tr>
<tr>
<td>46. I felt confident that I was going to manage as a new parent (61)</td>
</tr>
</tbody>
</table>
47. I felt responsible as the financial provider for my family (62)
48. I felt ready for the commitment of being a parent (63)
49. I questioned my ability to be a good dad (64)
50. Talking to other new parents was useful to my parenting experience (65)
51. I felt angry at times (66)
52. I found it difficult to cope with the changes to my personal relationship with my partner (68)
53. I relied on my partner for guidance in the first few months (69)
54. I had limited opportunities to socialise with friends (71)
55. I felt frustrated about not knowing what to do (80)
56. I needed to get away from the demands sometimes (88)
57. Things got better in time and I felt my confidence improve (89)
58. I felt overwhelmed with the experience as a new father (91)
59. Sometimes it was pretty terrifying not knowing what to expect (92)
### TABLE OF 9 THEMES

**Q-SORT EXERCISE**

<table>
<thead>
<tr>
<th>Relationships</th>
<th>Support Structures</th>
<th>Experiences with Paternal Postnatal Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning to Cope</td>
<td>Bonding with Baby</td>
<td>Preparing for Fatherhood</td>
</tr>
<tr>
<td>Work-Life balance</td>
<td>Dealing with Emotions</td>
<td>Defining the Role</td>
</tr>
</tbody>
</table>
### APPENDIX 16

**Frequency table of responses to the modified Q-sort exercise**

(Original item numbers in bold type)

#### Relationships

<table>
<thead>
<tr>
<th>Item No.</th>
<th>4</th>
<th>9</th>
<th>11</th>
<th>14</th>
<th>16</th>
<th>18</th>
<th>20</th>
<th>21</th>
<th>25</th>
<th>26</th>
<th>37</th>
<th>42</th>
<th>49</th>
<th>51</th>
<th>52</th>
<th>54</th>
<th>68</th>
<th>69</th>
<th>71</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of responses</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Support Structures

<table>
<thead>
<tr>
<th>Item No.</th>
<th>10</th>
<th>13</th>
<th>15</th>
<th>21</th>
<th>25</th>
<th>26</th>
<th>23</th>
<th>24</th>
<th>32</th>
<th>35</th>
<th>30</th>
<th>24</th>
<th>26</th>
<th>23</th>
<th>30</th>
<th>26</th>
<th>35</th>
<th>31</th>
<th>41</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of responses</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Experiences with Paternal Postnatal Depression

<table>
<thead>
<tr>
<th>Item No.</th>
<th>2</th>
<th>4</th>
<th>8</th>
<th>10</th>
<th>14</th>
<th>15</th>
<th>18</th>
<th>21</th>
<th>23</th>
<th>24</th>
<th>30</th>
<th>29</th>
<th>31</th>
<th>34</th>
<th>35</th>
<th>36</th>
<th>38</th>
<th>40</th>
<th>44</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of responses</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

| Item No. | 50 | 65 | 51 | 66 | 52 | 68 | 54 | 71 | 55 | 80 | 56 | 88 | 57 | 89 | 58 | 91 | 59 | 92 |
|----------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| No. of responses | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 3 | 1 | 3 | 1 |

#### Learning to Cope

<table>
<thead>
<tr>
<th>Item No.</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>8</th>
<th>10</th>
<th>18</th>
<th>24</th>
<th>19</th>
<th>25</th>
<th>23</th>
<th>30</th>
<th>33</th>
<th>34</th>
<th>36</th>
<th>47</th>
<th>38</th>
<th>50</th>
<th>40</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of responses</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item No.</th>
<th>49</th>
<th>64</th>
<th>51</th>
<th>66</th>
<th>55</th>
<th>80</th>
<th>56</th>
<th>88</th>
<th>57</th>
<th>89</th>
<th>59</th>
<th>92</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of responses</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Bonding with Baby

<table>
<thead>
<tr>
<th>Item No.</th>
<th>1</th>
<th>3</th>
<th>4</th>
<th>8</th>
<th>9</th>
<th>14</th>
<th>17</th>
<th>21</th>
<th>22</th>
<th>28</th>
<th>29</th>
<th>35</th>
<th>49</th>
<th>57</th>
<th>89</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of responses</td>
<td>6</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Preparing for Fatherhood

<table>
<thead>
<tr>
<th>Item No.</th>
<th>2</th>
<th>3</th>
<th>5</th>
<th>7</th>
<th>10</th>
<th>11</th>
<th>14</th>
<th>16</th>
<th>20</th>
<th>21</th>
<th>22</th>
<th>28</th>
<th>29</th>
<th>46</th>
<th>64</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of responses</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>4</td>
</tr>
</tbody>
</table>

### Work-Life Balance

| Item No. | 2  | 3  | 5  | 6  | 9  | 11 | 13 | 14 | 18 | 22 | 24 | 30 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 40 | 42 | 43 | 44 | 46 | 47 | 48 | 49 | 57 | 89 |
|----------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| No. of responses | 3  | 3  | 6  | 1  | 1  | 4  | 2  | 2  | 1  | 1  | 1  | 3  | 4  | 3  | 4  | 1  | 1  | 1  | 1  | 1  | 3  | 1  | 2  | |

### Dealing with Emotions

| Item No. | 7  | 8  | 9  | 11 | 14 | 15 | 17 | 18 | 22 | 24 | 26 | 27 | 29 | 33 | 35 | 39 | 42 | 48 | 49 | 51 | 55 | 57 | 58 | 88 | 89 |
|----------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| No. of responses | 2  | 2  | 2  | 2  | 2  | 3  | 2  | 3  | 1  | 1  | 1  | 3  | 4  | 3  | 4  | 1  | 1  | 1  | 1  | 3  | 1  | 2  | |

### Defining the Role

| Item No. | 3  | 3  | 11 | 13 | 16 | 18 | 20 | 22 | 26 | 28 | 30 | 32 | 35 | 37 | 42 | 44 | 47 | 49 | 59 | 82 |
|----------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| No. of responses | 1  | 1  | 4  | 2  | 2  | 1  | 5  | 2  | 1  | 2  | 4  | 1  | 1  | 5  | 1  | 1  |    |    |    |    |    |    |    |
Information Sheet - First Time Fathers and Coping Questionnaire

Dear

Thanks to you and the group of fathers who participated in the First Time Fathers and Depression Study a questionnaire has been constructed based on the information that I gained through the interviews.

The questionnaire is still in its draft form and I would like to invite your feedback on what you think of the questionnaire with respect to:

- How it is worded
- If the statements appear relevant to assess how a new father is coping with parenthood
- If there are any statements that you would not include
- If the questionnaire is easy to follow
- Any changes that you would recommend

I welcome your feedback and any suggestions that you would recommend.

Please feel free to make corrections or amendments to the document before returning it to me.

I am available at any time to discuss suggestions or recommendations that you may have in regards to improving the content and quality of this questionnaire. I can be contacted on my Mobile *** or via email karina.bria@adelaide.edu.au.

Your feedback is highly valued and confidential.

Karina Bria
PhD candidate
Discipline of General Practice
The University of Adelaide
Coping with First Time Fatherhood Questionnaire (CFFQ)

This questionnaire explores men’s reactions to first time fatherhood. There are no right or wrong answers.

There are several sections each containing several questions.

**Instructions:** Please circle the response that *you* feel most applies to how *you are feeling* at this point in time.

*(Original item numbers from phase one in brackets)*

**Preparing for fatherhood**

1) I felt prepared for the new baby (8)
   Not at all  Not much  Neither one way or the other  Somewhat  Very much

2) I didn’t really know what to expect as a new father (22)
   Not at all  Not much  Neither one way or the other  Somewhat  Very much

3) First time parenting is more difficult than I anticipated (54)
   Not at all  Not much  Neither one way or the other  Somewhat  Very much

4) *I needed more realistic information to help prepare me as a parent (58)*
   Not at all  Not much  Neither one way or the other  Somewhat  Very much

5) I feel confident that I am going to manage as a new parent (61)
   Not at all  Not much  Neither one way or the other  Somewhat  Very much

6) I felt ready for the commitment of being a parent before the birth (63)
   Not at all  Not much  Neither one way or the other  Somewhat  Very much
Relationships

7) I feel supported by my partner (25)

Not at all    Not much    Neither one way or the other    Somewhat    Very much

8) The relationship with my partner has strengthened since the birth (51)

Not at all    Not much    Neither one way or the other    Somewhat    Very much

9) I rely on my partner for guidance

Phase 1 item 69 – Phase 3 item 53

10) I have less opportunity to socialise with friends than I did before the baby was born

Phase 1 item 71 – Phase 3 item 54

Both items should not have been included

Support structures

9) I seek information and advice about parenting (13)

Not at all    Not much    Neither one way or the other    Somewhat    Very much

10) I feel prepared to support my partner with feeding the baby (26)

Not at all    Not much    Neither one way or the other    Somewhat    Very much

11) I feel supported by friends and family (41)

Not at all    Not much    Neither one way or the other    Somewhat    Very much

12) I need positive reassurance about my parenting skills (57)

Not at all    Not much    Neither one way or the other    Somewhat    Very much

13) Talking to other new parents is useful to my parenting experience (65)

(if applicable)

Not at all    Not much    Neither one way or the other    Somewhat    Very much

Bonding with baby

14) I enjoy being with my baby (1)

Not at all    Not much    Neither one way or the other    Somewhat    Very much

15) I try to be an involved father (4)

Not at all    Not much    Neither one way or the other    Somewhat    Very much
16)  I felt attachment to my baby soon after the birth (28)
Not at all  Not much  Neither one way or the other  Somewhat  Very much

17)  *I didn’t feel a connection to my baby for several weeks (29)
Not at all  Not much  Neither one way the other  Somewhat  Very much

Removed 9/9/11

20)  I do not feel as connected as I would like to be with my baby as yet
Repeat of Phase 1 item 29 – should not be included

Coping

18)  *There are times when I feel I am not coping with being a father (30)
Not at all  Not much  Neither one way or the other  Somewhat  Very much

19)  *I find it difficult to cope with the baby’s crying at times (50)
Not at all  Not much  Neither one way or the other  Somewhat  Very much

20)  Things are getting better and I feel my confidence improving (89)
Not at all  Not much  Neither one way or the other  Somewhat  Very much

21)  *I find it difficult to cope with the changes to my personal relationship with my partner (68)

Feelings and Emotions

22)  *I feel anxious at times (38)
Not at all  Not much  Neither one way or the other  Somewhat  Very much

23)  I feel comfortable talking to my GP if I’m feeling low (45)
Not at all  Not much  Neither one way or the other  Somewhat  Very much

24)  *I feel emotionally overwhelmed with the demands of a newborn (55)
Not at all  Not much  Neither one way or the other  Somewhat  Very much

Removed 9/9/11

28) I need to get away from the demands of parenting sometimes
Phase 1 item 88 – Phase 3 item 56
This item should not have been included

25)  Being a new father is a less positive experience than I expected (47)
Not at all  Not much  Neither one way or the other  Somewhat  Very much
26) I felt joy at the birth of my baby (20)
Not at all Not much Neither one way or the other Somewhat Very much

27) I feel positive emotions (23)
Not at all Not much Neither one way or the other Somewhat Very much

28) *I feel sad sometimes (35)
Not at all Not much Neither one way or the other Somewhat Very much

29) I can recognise negative changes to my emotions (44)
Not at all Not much Neither one way or the other Somewhat Very much

30) *I feel angry at times (66)
Not at all Not much Neither one way or the other Somewhat Very much

**Defining the role**

31) I feel responsible as the financial provider for my family (62)
Not at all Not much Neither one way or the other Somewhat Very much

32) I feel it is my responsibility to protect my family (37)
Not at all Not much Neither one way or the other Somewhat Very much

**Work-Life balance**

33) *It is difficult to accept the changes to life style (2)
Not at all Not much Neither one way or the other Somewhat Very much

34) I have found a flexible work-life balance (6)
Not at all Not much Neither one way or the other Somewhat Very much

35) *I feel a sense of loss sometimes (36)
Not at all Not much Neither one way or the other Somewhat Very much
Proposal for scoring:

- Positive statements will be scored 1 – 5 along the continuum; and
- Negative statements (marked with an asterisk) are reverse scored 5 – 1 along the continuum so that both negative and positive items are scored in the same direction.

For example:

34) I have found a flexible work-life balance (6)

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Not much</th>
<th>Neither one way or the other</th>
<th>Somewhat</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

18) *There are times when I feel I am not coping with being a father (30)

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Not much</th>
<th>Neither one way or the other</th>
<th>Somewhat</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

- The total score is determined by adding together the scores for each of the 35 statements

- An individual’s total score can range from a minimum of 35 to a maximum of 175.
Feedback Sheet Coping With First Time Fatherhood Questionnaire

I would really appreciate your feedback on the design and content of the questionnaire. Please add comments for each question.

Please tick yes or no to the following questions

Is it easy to read?
Yes □ □ □ □
Comment………………………………………………………………………………………...
………………………………………………………………………………………………

Are the instructions for completing the questionnaire adequate?
Yes □ □ □ □
Comment………………………………………………………………………………………...
………………………………………………………………………………………………

Are the questions easy to understand?
Yes □ □ □ □
Comment………………………………………………………………………………………...
………………………………………………………………………………………………

Does the questionnaire cover the important issues about first time fathers and coping with early parenting?
Yes □ □ □ □
Comment………………………………………………………………………………………...
………………………………………………………………………………………………
Are there any questions that you would **not** include in this questionnaire?

Yes [ ] [ ]

Comment…………………………………………………………………………………………
…………………………………………………………………………………………

Please make suggestions if you find questions that are irrelevant, ambiguous, badly worded or confusing in any way.

Comment…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………

THANK YOU
APPENDIX 20

Edinburgh Postnatal Depression Scale (EPDS)

J.L Cox, J.M. Holden, R. Sagovsky
Department of Psychiatry, University of Edinburgh

As you have recently had a baby, we would like to know how you are feeling. Please UNDERLINE the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.
Here is an example, already completed.
I have felt happy:
Yes, all the time
Yes, most of the time
No, not very often
No, not at all
This would mean: “I have felt happy most of the time” during the past week. Please complete the other questions in the same way.

In the past 7 days:
I have been able to laugh and see the funny side of things.

As much as I always could
Not quite so much now
Definitely not so much now
Not at all
I have looked forward with enjoyment to things

As much as I ever did
Rather less than I used to
Definitely less that I used to
Hardly at all
*I have blamed myself unnecessarily when things went wrong.

Yes, most of the time
Yes, some of the time
Not very often
No, never
I have been anxious or worried for no good reason.

No, not at all
Hardly ever
Yes, sometimes
Yes, very often
*I have felt scared or panicky for not very good reason.

Yes, quite a lot
Yes, sometimes
No, not much
No, not at all
*Things have been getting on top of me.

Yes, most of the time I haven’t been able to cope at all
Yes, sometimes I haven’t been coping as well as usual
No, most of the time I have coped quite well
No, I have been coping as well as ever
*I have been so unhappy that I have had difficulty sleeping.

Yes, most of the time
Yes, sometimes
Not very often
No, not at all
*I have felt sad or miserable.

Yes, most of the time
Yes, quite often
Not very often
No, not at all
I have been so unhappy that I have been crying.

Yes, most of the time
Yes, quite often
Only occasionally
No, never
*The thought of harming myself has occurred to me.

Yes, quite often
Sometimes
Hardly ever
Never

Response categories are scored 0, 1, 2, and 3 according to increased severity of the symptoms. Items marked with an asterisk are reverse scored (i.e., 3, 2, 1, and 0). The total score is calculated by adding together the score for each of the ten items. Users may reproduce the scale without further permission providing they respect copyright by quoting names of the authors, the title and the source of the paper in all reproduced copies.
## APPENDIX 21

### LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AN</td>
<td>Antenatal</td>
</tr>
<tr>
<td>ASQ</td>
<td>Attribution Style Questionnaire</td>
</tr>
<tr>
<td>AUDIT</td>
<td>Alcohol Use Disorders Identification Test</td>
</tr>
<tr>
<td>BCAI</td>
<td>Baby Care Activities Inventory</td>
</tr>
<tr>
<td>BDI</td>
<td>Beck Depression Inventory</td>
</tr>
<tr>
<td>CES-D</td>
<td>Centre for Epidemiological Studies Depression Scale</td>
</tr>
<tr>
<td>CES-DIS</td>
<td>Centre for Epidemiological Studies - Diagnostic Interview Schedule</td>
</tr>
<tr>
<td>COPE</td>
<td>Coping subscales (Carver, Scheier &amp; Weintraub)</td>
</tr>
<tr>
<td>DAS</td>
<td>Dyadic Adjustment Scale</td>
</tr>
<tr>
<td>DAS-SF</td>
<td>Dyadic Adjustment Scale – Short Form</td>
</tr>
<tr>
<td>DBI</td>
<td>Degree of Bother Inventory</td>
</tr>
<tr>
<td>DBQ</td>
<td>Description of the Baby Questionnaire</td>
</tr>
<tr>
<td>DEQ</td>
<td>Depressive Experiences Questionnaire</td>
</tr>
<tr>
<td>DI</td>
<td>Depression Inventory</td>
</tr>
<tr>
<td>DIS</td>
<td>Diagnostic Interview Schedule</td>
</tr>
<tr>
<td>DSM-IV</td>
<td>Diagnostic &amp; Statistical Manual of Mental Disorders – Five Axes</td>
</tr>
<tr>
<td>DSM-111-R</td>
<td>Diagnostic &amp; Statistical Manual of Mental Disorders - Revised</td>
</tr>
<tr>
<td>DSQ</td>
<td>Defence Style Questionnaire</td>
</tr>
<tr>
<td>ECQ</td>
<td>Experience of Childbirth Questionnaire</td>
</tr>
<tr>
<td>EPDS</td>
<td>Edinburgh Postnatal Depression Scale</td>
</tr>
<tr>
<td>EPI</td>
<td>Eysenck Personality Inventory</td>
</tr>
<tr>
<td>EPQ-R</td>
<td>Eysenck Personality Questionnaire</td>
</tr>
<tr>
<td>ES</td>
<td>Expectations Scale</td>
</tr>
<tr>
<td>FAIOC</td>
<td>Fathering Activities Inventory with Own Child</td>
</tr>
<tr>
<td>FAIOF</td>
<td>Fathering Activities Inventory with Own Father</td>
</tr>
<tr>
<td>GESTATION</td>
<td>Pregnancy</td>
</tr>
<tr>
<td>GHQ</td>
<td>General Health Questionnaire</td>
</tr>
<tr>
<td>GMDS</td>
<td>Gotland Male Depression Scale</td>
</tr>
<tr>
<td>HCP</td>
<td>Heath care professional</td>
</tr>
<tr>
<td>HIGHS SCALE</td>
<td>Measures Hypomania – based on the SADS-L criteria</td>
</tr>
<tr>
<td>HSCL-90</td>
<td>Hopkins Symptom Checklist</td>
</tr>
<tr>
<td>IBM</td>
<td>Intimate Bond Measure</td>
</tr>
<tr>
<td>IBQ</td>
<td>Intimate Bonds Questionnaire</td>
</tr>
<tr>
<td>ICB</td>
<td>Inventory of Caregiving Behavior</td>
</tr>
<tr>
<td>ICQ</td>
<td>Infant Characteristic Questionnaire</td>
</tr>
<tr>
<td>IES</td>
<td>Impact of Event Scale</td>
</tr>
<tr>
<td>LE</td>
<td>Life Events</td>
</tr>
<tr>
<td>LCI</td>
<td>Lifestyle Changes Inventory</td>
</tr>
<tr>
<td>MBBS</td>
<td>Miller Behavioral Style Scale</td>
</tr>
<tr>
<td>MBS</td>
<td>Marital Bonds Scale</td>
</tr>
<tr>
<td>MBU</td>
<td>Mothers and Babies Unit</td>
</tr>
<tr>
<td>MCLI</td>
<td>Marital Comparison Level Index</td>
</tr>
<tr>
<td>MGRSS</td>
<td>Masculine Gender Role Stress Scale</td>
</tr>
<tr>
<td>MHI-5</td>
<td>Mental Health Scale</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>MULTIPARA</td>
<td>A woman who had borne more than one viable infant</td>
</tr>
<tr>
<td>NPI</td>
<td>Neonatal Perception Inventory</td>
</tr>
<tr>
<td>PANAS</td>
<td>Positive and Negative Affect Schedule</td>
</tr>
<tr>
<td>PAS</td>
<td>Psychiatric Assessment Schedule</td>
</tr>
<tr>
<td>PBI</td>
<td>Parental Bonding Instrument</td>
</tr>
<tr>
<td>PBQ</td>
<td>Postpartum Bonding Questionnaire</td>
</tr>
<tr>
<td>PES-MR</td>
<td>Pleasant Events Schedule – Mood Related scale</td>
</tr>
<tr>
<td>PMD</td>
<td>Postnatal Mood Disorder</td>
</tr>
<tr>
<td>PMS</td>
<td>Profile of Mood States</td>
</tr>
<tr>
<td>PN</td>
<td>Postnatal</td>
</tr>
<tr>
<td>PND</td>
<td>Postnatal depression</td>
</tr>
<tr>
<td>PP</td>
<td>Postpartum</td>
</tr>
<tr>
<td>PPA</td>
<td>Paternal Postnatal Attachment questionnaire</td>
</tr>
<tr>
<td>PPND</td>
<td>Paternal postnatal depression</td>
</tr>
<tr>
<td>PRIMIPAROUS</td>
<td>Having borne one child</td>
</tr>
<tr>
<td>PSI-SF</td>
<td>Parenting Stress Index – Short Form</td>
</tr>
<tr>
<td>PWS</td>
<td>Perception of Work Scale (modified Kandel scale)</td>
</tr>
<tr>
<td>RDC</td>
<td>Research Diagnostic Criteria</td>
</tr>
<tr>
<td>SADS</td>
<td>Schedule for Affective Disorders</td>
</tr>
<tr>
<td>SADS-L</td>
<td>Schedule for Affective Disorder and Schizophrenia – Lifetime Version</td>
</tr>
<tr>
<td>SAIS</td>
<td>Self-assessment Irritability Scale</td>
</tr>
<tr>
<td>SAS</td>
<td>Social Adjustment Scale</td>
</tr>
<tr>
<td>SCL-90-R</td>
<td>Symptom checklist 90-R</td>
</tr>
<tr>
<td>SCID-NP</td>
<td>Structured Clinical Interview for DSM-III-R - non-patient version</td>
</tr>
<tr>
<td>SDAC</td>
<td>Spanier Dyadic Adjustment Scale</td>
</tr>
<tr>
<td>SSNI</td>
<td>Social Support Network Inventory</td>
</tr>
<tr>
<td>SMAT</td>
<td>Short Marital Adjustment Test</td>
</tr>
<tr>
<td>SPQ</td>
<td>Standardised Psychiatric Questionnaire</td>
</tr>
<tr>
<td>SCI</td>
<td>Structured Clinical Interview</td>
</tr>
<tr>
<td>SSCI</td>
<td>Semi-structured Clinical Interviews</td>
</tr>
<tr>
<td>SSS</td>
<td>Social Support Scale</td>
</tr>
<tr>
<td>SSQ</td>
<td>Social Support Questionnaire</td>
</tr>
<tr>
<td>STAI-X1</td>
<td>State-Trait Anxiety Inventory</td>
</tr>
<tr>
<td>STPI</td>
<td>State-Trait Personality Inventory</td>
</tr>
<tr>
<td>TTP</td>
<td>Transition to Parenthood</td>
</tr>
<tr>
<td>VSS</td>
<td>Vocal Satisfaction Scale</td>
</tr>
<tr>
<td>WHOQOL</td>
<td>World Health Organization Quality of Life Instrument</td>
</tr>
</tbody>
</table>
APPENDIX A

ADVERTISEMENT STAGE 1

HAVE YOU BECOME A FATHER FOR THE FIRST-TIME?

WAS YOUR BABY BORN IN THE LAST 2 WEEKS?

ARE YOU AGED BETWEEN 20-55 YEARS?

DO YOU THINK YOU MAY HAVE DEPRESSION?

If you answer yes to all of the above then The University of Adelaide is looking for YOU to participate in a study evaluating the experiences of first-time fathers who may be experiencing postnatal depression.

Please contact us if you think you are eligible

To Find Out More Please Call **********
This study has been approved by the Human Research Ethics Committee
All information will be kept strictly confidential
FIRST-TIME FATHERS SOUGHT FOR RESEARCH

Up to 10% of first-time fathers experience postnatal depression but in most cases their symptoms are not treated, according to University of Adelaide researcher Karina Bria. The PhD student within the University’s Discipline of General Practice is recruiting new fathers for her field work into the area of postnatal depression in first-time fathers. Ms Bria says existing research in Australia reveals that many men experience anxiety and depression when they become fathers for the first time, but more support is given to new mothers and male postnatal symptoms often go untreated. “Men’s experiences of their transition to fatherhood have not been a major focus for investigation in Australia or overseas, despite between 5-10% of men experiencing depression, anxiety, stress and psychological distress,” she says. Men are reportedly at greater risk of their depression going unrecognised and untreated because more support and attention is focused on first-time mothers, many of whom are battling the same problems. In fact, postnatal depression among mothers is also the strongest predictor of depression in the father, according to existing research. Ms Bria is looking to recruit new fathers who are experiencing postnatal depression. The interviews will explore whether male postnatal depression improves or worsens in the first six months of their child’s birth, how depression impacts on a first-time father’s ability to bond with their child and the long term affects of postnatal depression on the father and his family. “I want to develop a gender specific screening questionnaire that primary health care professionals can use to detect symptoms of postnatal depression in fathers.”

This research will include interviews, the development of a gender specific screening questionnaire and pilot testing of the questionnaire.

Men interested in taking part in the research are asked to contact karina.bria@adelaide.edu.au.

Participants will be asked to attend a series of three one-on-one interviews over a six-month period. All information is confidential.

MEDIA CONTACT: Karina Bria, PhD student, Discipline of General Practice, University of Adelaide. Tel: +61 8 **** (w) ********
Candy Gibson, Media & Public Relations Officer, University of Adelaide. Tel: +61 8 8303 3173 (w), +61 0414 559 773 (mobile) or email candace.gibson@adelaide.edu.au
NOTE:
This appendix is included on page 258 of the print copy of the thesis held in the University of Adelaide Library.
NOTE:
This appendix is included on pages 259-260 of the print copy of the thesis held in the University of Adelaide Library.
NOTE:
This appendix is included on page 261 of the print copy of the thesis held in the University of Adelaide Library.
NOTE:
This appendix is included on pages 262-263 of the print copy of the thesis held in the University of Adelaide Library.
NOTE:
This appendix is included on page 264 of the print copy of the thesis held in the University of Adelaide Library.
NOTE:
This appendix is included on pages 265-266 of the print copy of the thesis held in the University of Adelaide Library.
NOTE:
This appendix is included on pages 267-269 of the print copy of the thesis held in the University of Adelaide Library.


FRIEDMAN, R. J., KATZ, M. M. (1974)


WORLD HEALTH ORGANISATION 2013, Depression, Viewed 2 October 2013, http://www.who.int/mediacentre/factsheet/fs369


