

THE UNIVERSITY OF HULL

Paternal Postpartum Distress: A Discourse Analytic Study

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(DClinPsych)

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Summary

The portfolio thesis comprises of three parts: a systematic review paper, an empirical report and appendices.

Part one is a systematic review in which the literature relating to the empirical paper is reviewed. Literature concerning the prevalence of paternal distress within the first year postpartum is addressed. The review attempts to determine levels of severity and aims to stipulate when distress is more prevalent within the year. The usefulness of such epidemiological data is also considered.

Part two is an empirical paper examining the discourses around the postpartum father. The study aimed to conceptualise how the father's discursive position may limit the acceptability of distress in this period. The paper outlines popular competing constructions of postpartum fatherhood and paternal affect drawn from the accounts of first-time parents, midwives and health visitors. The impact of such discursive inconsistency on the recognition of this clinical issue is discussed. Clinical implications are then described.

Part three comprises the appendices. A reflective summary drawing on the overall research process is included.

Overview

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Part One: Systematic Literature Review

The Prevalence of Paternal Postpartum Distress: A Systematic Review

This paper is written ready for submission to the Journal of Social Science & Medicine. Please see appendix 2 for the Guideline for Authors.

1. Abstract

Aims: To establish the prevalence of paternal depression and other affective difficulties in the postpartum period.

Methods: Search terms were inputted into Blackwell-Synergy, Ingenta Connect, Medline & Web of Science. Studies were screened for quality using Scottish Intercollegiate Guidelines Network (SIGN, 2006) methodology checklists. Those that met with the inclusion criteria addressed both primiparous and subsequent biological parents 18 years and over in heterosexual relationships. Those having experienced significant obstetric complications or infant health difficulties were excluded. Further, mental health difficulties among parents who were recipients of intensive parenting support were excluded. Studies were required to assess paternal postpartum depressive, anxiety symptoms and or other affective difficulty as a primary objective, or to include their measurement as part of a wider study.

Findings: Twenty-six studies met the inclusion criteria. Prevalence for paternal depression ranged from 1.2% to 27.5% within the first year postpartum. Research has mainly considered the early postpartum period. However, a number of longitudinal studies suggest that paternal depression is more prevalent later in the postpartum year. There is also some indication that anxiety difficulties may be more prevalent among postpartum fathers.

Conclusions: The range of prevalence data shows that paternal postpartum distress is a clinical issue. It is discussed how prevalence rates vary dependant on measures employed. Further research is necessary to substantiate hypotheses about the course of

paternal postpartum depression. More longitudinal studies concerning paternal anxiety are also needed. It is asserted that neonatal services should increase their recognition of psychological difficulties in fathers in the postpartum year. Methodological issues are discussed.

Keywords: Paternal postpartum/natal depression/distress/mood; depressive disorder; depressed mood; anxiety; affective disorder; fathers.

2. Introduction

Aside from the many joys, the first year following the birth of a baby is also marked by significant role change, absence of routine, reduced sleep and other social and financial obstacles. Within certain contexts, the struggles associated with parenting an infant can culminate in mental health difficulties (Beck, 2001, Nicolson, 1998). Over the past decade or so maternal postpartum depression has received a great deal of empirical attention, making it the most frequently studied postnatal mental health difficulty (Ramchandi, Stein, Evans & O'Connor, 2005). Researchers now conceptualise postpartum depression as the product of psychosocial causes (Brockington, 2004), rather than endocrinology, as originally believed. It could be assumed that such factors would also impact on the mental health of the postpartum father. This is substantiated by epidemiological studies (Goodman, 2004). There is also indication of this in experiential research (Goodman, 2005, Premberg, Hellström & Berg, 2008). While there is evidence to support that fathers can experience clinical levels of distress, there is a paucity of research addressing it in terms of severity over the postpartum year.

Where research has attempted to pool understanding of paternal postpartum difficulties there is a tendency to focus solely on depression (e.g. Goodman, 2004). Other constructs need to be considered in order to further understanding of a postpartum father's emotional life, as it is believed that postpartum mental health is multifaceted.

This paper will review studies that have assessed paternal distress in the first year postpartum. The aim is to provide a clearer understanding of the prevalence of such difficulties. Further, as 'postpartum' refers to the year after birth, the term is unhelpful in

identifying when distress is more pronounced within this time. A secondary aim is therefore to examine data from different time points during the first year period.

3. Method

A search of the literature up to and including April 2008 was conducted using electronic resources Blackwell-Synergy, Ingenta Connect, Medline & Web of Science. A start date cut-off was not employed. Reference lists were also searched. Hand searches were carried out where referenced studies were not available in electronic form. Key search terms were fathers; paternal postpartum/natal; depression; distress; depressive disorder; depressed mood; affective and anxiety.

Studies that measured the prevalence of paternal depression, anxiety or any other affective difficulty within the first year postpartum were included in the review. The measurement of paternal mood could have been a primary focus or as part of a wider study. Papers that considered psychosis were excluded. Both primiparous and subsequent parents eighteen or over in a heterosexual relationship were included. Studies that addressed trauma associated with pregnancy and childbirth, and those assessing the emotional impact of serious obstetric complications did not meet with the criteria.

The studies were examined and critically appraised using combined elements from the Scottish Intercollegiate Guidelines Network (SIGN, 2004) methodology checklists for systematic reviews and diagnostic accuracy. Samples were considered in terms of their size, nationality, socio-economic diversity, representability and means of recruitment. Mood measures employed were assessed for their validity and reliability, and for the cut-off points used. Further, design was examined in terms of when mood was assessed postpartum, and whether measurement was longitudinal or cross-sectional. Reported paternal mood disturbances were categorised in terms of severity where possible.

4. Findings

Searches revealed 33 studies that addressed paternal affective difficulties within the postpartum year. The first identified study was conducted over three decades ago (Rees & Lutkins, 1971). Of those revealed, 25 met with the inclusion criteria. One paper did not specify the cut-off point used for the Edinburgh Postnatal Depression Scale (EPDS [Cox, Holden & Sagovsky 1987]) but was included for its assessment of anxiety (Matthey, Barnett, Howie & Kavanagh, 2003). A study by Dudley, Roy, Kelk & Bernard (2001) was excluded as it focused solely on the incidence of depression in individuals requiring parenting skills assistance. Despite strong qualitative designs, Zaslow, Pedersen, Cain & Suwalsky (1985) and Morgan, Matthey, Barnett & Richardson (1997) were excluded as no mood measure was administered. Six studies included measures which addressed the mental status of index couples whereby the mother had a diagnosis of postpartum depression. Three index studies measured and reported the incidence of depression in control fathers with non-depressed partners. These studies were included but were not incorporated in the range of prevalence reported since they report incidence, rather than prevalence data. A systematic review of 20 studies of paternal depression between 1980 and 2000 helped to identify prevalence studies (Goodman, 2004). Two prevalence studies (Aerias, Kumar, Barros & Figueirido, 1996a, Aerias, Kumar, Barros & Figueirido, 1996b) and two index studies (Zelkowitz & Milet, 1996 & Zelkowitz & Milet, 1997) employed the same sample and were therefore merged.

Table.1 summarises the studies that have addressed the prevalence and incidence of paternal mood difficulties in the postpartum period.

<i>Author(s)</i>	<i>Study aims & sample</i>	<i>Mood measure (and cut-off score)</i>	<i>Time of postpartum mood assessment</i>	<i>Prevalence of paternal mood disturbance diagnosis</i>	<i>Methodology rating (x, √, √√)</i>
eias et al. (1996a/1996b)	Longitudinal comparison of mood. Portuguese sample of 54 mothers & 42 husbands/partners, of mixed socioeconomic status	EPDS (Portuguese version [≥ 13]) SADS	3 months 12 months	4.8% depressed 23.8% depressed	√√
tkinson & Rickel (1984)	Cross-sectional comparison of depression US sample of 78 first time middle class married parents	BDI (≥ 10)	8 weeks	13% depressed	√
Ballard et al. (1994)	Longitudinal comparison of depression UK sample of 200 couples. Non postpartial control.	EPDS (≥ 13) PAS	6 weeks 6 months	9% depressed 5.4 % depressed 38% fathers depressed at 6 weeks were depressed at 6 months	√√
ielawska-Batorowicz & sakowska-Petrycka (2006)	Cross-sectional study of depression. Polish sample of 80 primiparous married couples, good socio-economic position	EPDS (Polish version [≥ 13]) BDI (Polish version)	3/4 months	27.5% depressed	√
Buist et al. (2003)	Longitudinal study of distress. Australian sample of 225 culturally & socio-economically mixed primiparous fathers	EPDS (≥ 10) PANAS BDI-II State anger & anxiety scales	1 month 4 months	6% depressed 8.3% depressed	√√
London et al. (2004)	Longitudinal study using Australian sample of 312 first-time fathers	EPDS (≥ 13), GHQ (> 5), MHI-5 (> 17), PANAS, AUDIT (> 7), HSCL-90	3 months 6 months	1.9% depressed; 25% drug/ alcohol misuse; 11.3% general psychological impairment 2.1% depressed; 25% drug/ alcohol misuse; 11.2% general psychological	√√

				impairment	
			12 months	2.3% depressed; 23.9% drug/ alcohol misuse; 10.4% general psychological impairment	
ater-Deckard et al. (1998)	Cohort sample of 7018 British fathers	EPDS (≥ 13)	2 months	3% depressed	√√
awcett & York (1986)	Cross-sectional sample of 70 couples. Solely Caucasian, largely middle class.	BDI (≥ 10)	6 weeks	13% depressed	√
eenhalgh et al. (2000)	Longitudinal study of depression using a British sample of 78 first-time fathers. Mixed social, occupational and ethnic sample.	EPDS (≥ 13)	1 week 6 weeks	3.9 % depressed 2.6 % depressed Significant correlation between negative experience of childbirth and depression scores at the first time point.	√√
Lane et al (1997)	Longitudinal study using Irish sample of 181 first-time fathers including measure of depression	EPDS (≥ 13)	3 days 6 weeks	3% depressed 1.2% depressed	√√
athers et al (1997)	US sample of 54 first-time couples. High Caucasian representation. Mixed socioeconomic status.	CES-D (≥ 16)	6 months	18% depressed	√
athers & Kelley (2000)	US sample of 124 cohabiting couples with unexpected pregnancy. All were first-time parents.	CES-D (≥ 16)	4 months	6.5% depressed	√√
adsen & Juhl (2007)	Cross-sectional study using 549 Danish fathers of varied socioeconomic positions. Most first-time parents.	EPDS (≥ 10) GMDS (≥ 13)	6 weeks	5% depressed 3.4% depressed 6.5% depressed [of 524] above cut-off on one or both scales	√√

Matthey et al (2000)	Longitudinal study using Australian sample of 157 fathers accessed through partners.	BDI-II (≥ 16)	6 weeks	2.8% depressed	√√
		GHQ (≥ 7)	4 months	3.2% depressed	
			12 months	4.7% depressed	
Matthey et al (2003)	Cross-sectional study using Australian sample of 356 fathers.	EPDS (unspecified)	6-8 weeks	9.7% anxiety	√√
		CES-D			
		DIS			
Morse et al (2001)	Longitudinal study of depression with sample of 327 Australian primiparous parents.	EPDS (≥ 10)	1 month	6% depressed	√√
			4 months	5.8% depressed	
Pinheiro et al (2005)	Cross-sectional study of 386 Brazilian first-time and subsequent fathers of mixed SES.	BDI (Portuguese version [$\geq 10/18$])	6-12 weeks	11.9% mild depression or above 4.1% moderate to severe depression	√
Raskin et al (1990)	Longitudinal comparison of pre&post -partum using a US sample of 86 married first-time parents. Culturally and socially mixed participants.	CES-D (≥ 16)	8 weeks	22% depressed	√
Rees & Lutkins (1971)	Cross-sectional study of 61 first-time and subsequent fathers. Unspecified cultural and socioeconomic representation.	BDI ($\geq 10/18$)	Within postpartum year	4.9% mild depression 3% moderate depression	√
Roberts et al (2006)	Study of mental health of index fathers (where mother had diagnosis of PPD) including 116 controls with non-depressed spouse. New Zealand sample of culturally and socially mixed participants.	BDI-II (>13) BAI (>7) GHQ-28 (>5) AUDIT	Within postpartum year	(Of controls) 6.9% depressed; 6.9% anxious; 14.7% general psychological impairment; 26.7% alcoholism;	√√
Skari et al (2002)	Longitudinal study including measurement of clinical distress in 122 Norwegian fathers. Both first-time and subsequent	GHQ-28	1 week	13% (clinically important psychological distress)	√√
		State Anxiety Scale	6 weeks	2% (clinically important psychological distress)	

	fathers.	Impact of Events Scale	6 months	11% (clinically important psychological distress) 1-2% clinical depression	
oliday et al (1999)	Cross-sectional study using a US sample of 51 first-time and subsequent parents. Culturally and socially mixed participants.	CES-D (≥ 16)	≈ 1 month	17.6% mild depression 7.9% moderate depression 25.5% overall	√
Zelkowitz & Milet (1996/1997)	Longitudinal study of 50 Canadian partners of women with postpartum depression Also 50 postpartal controls of partners of non-depressed women. First-time and subsequent parents.	EPDS (≥ 10) SCID SCL-90-R	6-9 weeks	(Of controls) 10% of controls reached caseness for depression 0% anxiety	√

AUDIT- Alcohol Use Disorders Identification Test (Saunders et al., 1993); BDI- Beck Depression Inventory (Beck & Steer 1987, Beck et al., 1996); CES-D- Center for Epidemiological Studies-Depression (Radloff, 1977); DIS- Diagnostic Interview Schedule (APA, 1994); GMDS-Gotland Male Depression Scale (Zierau et al., 2002); GHQ-30, General Health Questionnaire (Goldberg 1978); HSC- Hopkins Symptom Checklist (Mattson et al., 1969); MHI-5- Mental Health Inventory-Five Items (Berwick et al, 1991); PANAS- Positive & Negative Affect Schedule (Watson et al., 1988); PAS- Psychiatric Assessment (Dean et al., 1983); SADS- Schedule of Affective Disorders Scale/lifetime (Endicott & Spitzer, 1978); SCID- Structured Clinical Interview for DSM-III-R (Spitzer et al., 1990); SCL-90-R- Symptom Checklist 90-Revised (Derogatis 1983).

4.1. Paternal Postpartum Depression

Studies revealed a prevalence range of between 1.2% (Lane, Keville, Morris, Kinsella, Turner & Barry, 1997) and 27.5% (Bielawska-Batorowicz & Kossakowska-Petrycka, 2006) for paternal postpartum depression within the first year postpartum.

Considerable variance was found between studies in terms of prevalence and depression measures used. Further, of the studies that employed the EPDS, different cut-off scores were used across studies. The meaningfulness of pooled ‘prevalence’ data may therefore be compromised. For this reason, findings yielded from studies using different measures and cut-offs will be presented separately.

4.1.1. Paternal Depression Measured by the EPDS (≥ 13)

The EPDS was the only screening tool used in the studies for the specific detection of postpartum depression. The measure differs from conventional measures by deliberately excluding items relating to somatic symptoms (Cox & Holden, 2003). Seven studies measured paternal depression using the EPDS (≥ 13). Fathers exceeding cut-off ranged from 1.2% to 27.5% within the postpartum year. This is representative of variance overall.

Studies varied greatly in terms of sample size and representability. A British cohort study included 7018 primiparous and subsequent fathers representing a wide cultural and socioeconomic range (Deater-Deckard, Pickering, Dunn & Golding, 1998). Three percent of fathers exceeded scores of 12 at a two month postpartum time-point. Prevalence raised to 3.5% when postpartum stepfathers were included. Due to the strength of the research design, it is regrettable that Deater-Deckard et al. (1998) did not collect longitudinal data throughout the year.

Other studies using the EPDS (≥ 13) reported different prevalence at different time-points (Greenhalgh, Slade & Spiby, 2000, Lane et al. 1997, Ballard, Davies & Cullen, Mohan & Dean, 1994). Longitudinal studies that have measured depression in the early postpartum have shown a reduction in distress over time. Using a sample from the north of England, Greenhalgh et al. (2000) demonstrated a reduction from 3.9% to 2.6% between one and six weeks postpartum. At the same early postpartum time-points Lane et al. (1997)

showed a reduction from 3% to 1.2% depression over the first six weeks. Ballard and colleagues (1994) found a similar decrease in depressed mood at later time-points. Fathers assessed at six weeks and six months reported a prevalence of 9% and 5.4% respectively. It was also found that depressed men were more likely to report loss of libido and hopelessness than were depressed mothers and controls.

However, affective change over the first year was not found by Condon, Boyce & Corkindale (2004) who reported insignificant differences ranging from 1.9% at three months to 2.3% at 12 months postpartum. Despite statistical insignificance, however, Condon et al. (2004) observed a trend for depression to increase over the postpartum year. The researchers conceptualised the lack of significance as resulting from the large drop-out rate (54 fathers) observed. It could be argued that distressed participants would be more likely to drop-out, potentially resulting in an under-representation of affective difficulties at later time-points.

Higher prevalence was also identified at 12 months than at 3 months postpartum in a Portuguese longitudinal study (Aerías et al. 1996a, 1996b). Aerías and colleagues (1996a, 1996b) reported 19% increase in prevalence at 12 months using the Portuguese version of the EPDS (≥ 13). These findings support the argument that paternal depression is higher later in the postpartum year.

High prevalence data was yielded by Bielawska-Batorowicz & Kossakowska-Petrycha (2006), albeit at a different postpartum time-point. Using the Polish version of the EPDS

(≥ 13), prevalence of paternal depression at three/four months was 27.5%. Depressed fathers were significantly more likely to be younger, have less social support and feel disillusioned by the realities of parenting than their non-depressed counterparts.

Studies that have employed translated versions of the EPDS found the highest prevalence overall (Aerías et al. 1996a/1996b, Bielawska-Batorowicz & Kossakowska-Petrycha, 2006). This may suggest that these non-English forms may have implications for overrepresentation. Further, these studies used relatively small and non-representative samples. Also there was a reliance on volunteers through opportunistic sampling. Such limitations and cultural specificity of measures may account for the elevated prevalence identified.

Despite this, it is argued that the application of the EPDS (English version) to fathers has implications for under-representation, since men are less likely to endorse items suggestive of ‘female’ depression (Matthey, Barnett, Kavanagh & Howie, 2001, Kim & Swain, 2007). Receiver operating characteristics presented by Matthey et al. (2001) indicate improved validity with the revised cut-off of ≥ 10 , with 71.4% of depressed and 93.8% of non-depressed men being correctly classified against the CES-D¹. This compared to 42.9% and 97.9% using the higher cut-off. Hence, studies using the higher cut-off may provide under-inclusive prevalence data for paternal depression.

¹ Center (sic) for Epidemiological Studies-Depression (Radloff, 1977).

4.1.2. Paternal Depression Measured by the EPDS ≥ 10

Two prevalence studies employed the EPDS (≥ 10), with scores ranging from 5% to 6%.

Time-points for the assessment of paternal depression ranged between one to four months postpartum.

Madsen & Juhl (2007) applied the EPDS (≥ 10) to a large Danish sample. Fathers were mostly first-time parents and were assessed at six weeks postpartum. The prevalence of depression was reported as 5%. Such data is consistent with other rates of paternal depression measured in the early postpartum period. A longitudinal study by Buist, Morse & Durkin (2003) assessed paternal depression within a large representative sample of first-time fathers. Paternal depression was reported as 6% and 5.8% at one and four months respectively, using the revised cut-off. Buist et al (2003) argue their findings to suggest that paternal depression steadily reduces over the postpartum period. This is also supported in Ballard et al.'s (1994) study.

However, it is difficult to draw this conclusion when no identified studies have measured depression up to twelve months postpartum using the EPDS (≥ 10). Further, the above studies are inconsistent with those that have employed the conservative cut-off score.

This was not supported in an incidence study by Zelkowitz & Milet (1996/1997). The researchers employed the EPDS (≥ 10) to measure paternal depression in postpartum controls. Ten percent of 50 first-time and subsequent fathers reached criteria for depression between six and nine weeks postpartum.

4.1.3. Studies employing measures other than the EPDS

Eleven studies included in the review employed either the Beck Depression Inventory ([BDI Beck & Steer, 1987]), the Beck Depression Inventory-II (BDI-II [Beck, Steer & Brown, 1996]), Center (sic) for Epidemiological Studies-Depression ([CES-D] Radloff, 1977), the Structured Clinical Interview for the DSM (Spitzer, Williams, Gibbon & First, 1990) or a combination of the above. These studies are described below.

4.1.4. Paternal Depression Measured by the BDI

The BDI is a self report measure for depression consisting of cognitive affective and somatic items. Scores of between 10-18, 19-29, and 30-63 indicate mild, moderate and severe depression respectively. Prevalence of paternal depression as measured by the BDI ranged from 7.9 to 13% (mild and upwards).

Studies that have used the BDI have focused largely on relatively early postpartum time-points. Rees & Lutkins (1971) assessed paternal depression at no specified time-point within the postpartum year. A prevalence of 7.9% was reported amongst primiparous and subsequent parents. Also using the BDI, Atkinson & Rickel (1984) found that 13% of first-time fathers were depressed at eight weeks postpartum. Strikingly, the same high prevalence of 13% was found in a methodologically similar study at six weeks postpartum (Fawcett & York, 1986). Although the use of the BDI is a strength of these studies due to its high validity (Beck & Steer, 1984), their samples have limited representability due to their size and the sole recruitment of Caucasian middle class

married couples. Further, large sociological changes over the past decades may also render older studies less representative.

Nevertheless, a similar prevalence rate in the early postpartum was reported in a recent Brazilian study (Pinheiro, Magalhães, Horta, Pinheiro, daSilva & Pinto, 2005). Pinheiro et al. (2005) found that 11.9% of fathers were depressed according to the Portuguese version of the BDI between six and 12 weeks after birth. Whilst most studies have depended on opportunistic sampling, Pinheiro et al. (2005) randomly sampled fathers from a broad socio-economic cross-section. Despite this strength, the researchers own that their results are not representative of other populations. Results do suggest, however, that paternal postpartum depression would seem to transcend both developed and developing worlds (Pinheiro et al., 2005).

One longitudinal study was identified which used the BDI rather than the EPDS (Matthey, Barnett, Ungersen & Waters, 2000). Matthey et al. (2000) increased the cut-off (≥ 16) with the aim of improving its validity for postpartum difficulties. The researchers argued that items related to libido and sleep disturbance would be within the realms of normal postpartum experience, and not indicative of depression. Rates of depression from the early postpartum period are much lower than those reported above (2.8% at six weeks). Matthey and colleagues demonstrated that prevalence increased throughout the year, with the highest rate being at 12 months after birth (4.7%). Whilst mothers reported higher rates at other time-points, fathers were significantly more depressed than mothers at this later stage. Based on conservative measurement, Matthey et al. (2000)'s findings suggest that paternal depression is more prevalent in the late postpartum period. This

finding is reflected in the trend demonstrated by Condon et al. (2004) and Areias et al. (1996a, 1996b).

4.1.5. Paternal Depression Measured by the BDI-II

The BDI-II (Beck et al. 1996) was constructed in order to conform more closely to diagnostic criteria for depression in the Diagnostic & Statistical Manual-IV (DSM-IV [APA, 1994]). The measure includes more items indicative of severe depression such as poor concentration, agitation and loss of energy. Items relating to somatic preoccupation and weight loss have been replaced. Scores of 14-19, 20-28 and 29-63 suggest mild, moderate and severe depression respectively. The BDI-II was employed in one study to measure depression in control fathers of non-depressed partners (Roberts, Bushnell, Collings & Purdie, 2006). Roberts et al. (2006) reported the incidence of depression amongst controls as 6.9% at unspecified time-points within the postpartum year.

4.1.6. Paternal Depression Measured by the CES-D

The CES-D is a 20 item self-report measure combining 10 cognitive and 10 somatic items. Scores of 16 and above indicate depression, with no established higher cut-offs to assess levels of severity. Three studies were identified that solely employed the CES-D to assess the incidence of paternal postpartum depression. High prevalence was found ranging between 18% and 25.5%, with a mean of 21.8%. A fourth study addressed the incidence of depression in fathers whose child was the result of an unwanted pregnancy.

Soliday, McCluskey-Fawcett & O'Brien (1999) reported that 25.5% of culturally mixed fathers were depressed at one month postpartum. Prevalence was based on a sample of 51 first-time and subsequent parents. Comparably high rates of paternal depression were found by Raskin, Richman & Gaines (1990). Raskin et al. (1990) used a sample of 86 US first-time fathers with good socio-economic and cultural representation. The researchers reported 22% prevalence at eight weeks postpartum.

A similar prevalence was established at six months postpartum (Leathers, Kelley & Richman, 1997). Fifty-four first-time fathers were screened at six months postpartum, with 18% reaching threshold for depression. Leathers et al. (1997) also assessed the impact of a father's sense of control and social and work gratification on paternal depression. They argue that psychosocial variables such as perceptions of social gratification are strongly related to maternal and paternal depression. There are certain limitations to the study however, in that despite socio-economic diversity, the sample is small and Caucasian parents are overrepresented.

Interestingly, the incidence of postpartum depression in parents following an unexpected pregnancy is considerably lower than other studies that have employed the CES-D. Using a larger sample than other studies using the CES-D, Leathers & Kelley (2000) found that 6.5% of fathers were depressed at four months postpartum.

4.1.7. Severity of Paternal Postnatal Depression

The usefulness of prevalence data is often compromised by the inability to infer levels of severity. Three aforementioned studies, however, grouped depressed fathers based on levels of distress. Mild paternal depression ranged from 4.9% to 11.9%. Depression rated moderate or above ranged from 3% to 7.9%.

Rees & Lutkins (1971) used the BDI to categorise mild and moderate depression, and reported 4.9% and 3% respectively. Using the same cut-offs, Pinheiro et al. (2005) reported 7.9% prevalence of mild, and 4.1% moderate to severe paternal depression. Further, Soliday et al. (1999) found rates of 17.6% for mild and 7.9% for moderate depression.

Skari, Skreden, Malt, Dalholt, Ostensen, Egeland et al. (2002) also considered the severity of emotional difficulties. Although Skari et al. (2002) report a low prevalence rate for paternal depression (1-2%) they observed a higher severity of distress in the few men who did reach caseness. Whilst no women reported suicidal ideation, three men endorsed such items at six weeks and one at six months. This suggests that an appreciation of severity may be lost in epidemiological research. By focusing solely on prevalence clinicians are at risk of losing sight of the seriousness of suicidality amongst this minority of fathers.

4.2. Clinically Important Distress

The terms clinically important distress and general psychological impairment, as distinct from mild depression, were used in three studies to report unspecified difficulties measured by the GHQ-28 (General Health Questionnaire, Goldberg, 1978) and the HSCL-90 (Hopkins Symptom Checklist, Mattson et al., 1969). Prevalence ranged from 2% to 13%.

Skari et al. (2002) reported prevalence of clinically important distress as 13% at one week and 11% at six months postpartum, using the GHQ-28. Significantly lower levels of paternal distress were found at six weeks (2%). Further, using the GHQ-28 & the HSCL-90, Condon et al. (2004) established a range of 10.4% to 11.3% over the postpartum year. Condon et al. (2004) found that paternal distress remained relatively constant throughout the year. The incidence of general psychological impairment in postpartum controls within the first year was 14.7% (Roberts et al. 2006).

4.3. Anxiety

There is some indication that anxiety disorders are commonly experienced by the postpartum father. The use of the DIS (Diagnostic Interview Schedule, [APA, 1994]) yielded a prevalence of anxiety as 9.7% at six-eight weeks postpartum (Matthey, Barnett, Howie & Kavanagh, 2003). Matthey et al. (2003) demonstrated that clinical caseness raised a low of 31% to a high of 130% for fathers when measures of anxiety were included. This compared to a range of 57% and 100% for mothers. This suggests that

focus on depression may result in psychological difficulties being underrepresented in men. Matthey and colleagues therefore recommend that the concept of postnatal mood disorder in both parents should be considered.

In a comparison of mothers' and fathers' item endorsement on the EPDS, Matthey et al. (2001) also indicate that fathers may experience anxiety, rather than depressive symptoms. Distressed fathers were significantly less likely to endorse items 'I have been so unhappy I have felt like crying' and 'I have felt sad or miserable' than their female counterparts.

Roberts et al. (2006) diagnosed 6.9% of control fathers with non-depressed spouses as clinically anxious within twelve months after birth. Interestingly, however, Zelkowitz & Milet (1996/1997) did not show support for anxiety symptoms in their comparison group when measured at six to nine weeks. This may suggest that difficulties are more likely to emerge later in the postpartum year, as shown with depression by Matthey et al. (2000).

4.4. Alcoholism

Studies that included a measure of alcoholism reported a high prevalence postpartum. One study reported a prevalence of between 23.9% and 25% over the postpartum year (Condon et al., 2004). Incidence of alcoholism in an index comparison group was reported as 26.7% (Roberts et al., 2003). Both studies measured alcoholism using the AUDIT (Alcohol Use Disorders Identification Test [Saunders, Aasland, Babor, de la Fuente, & Grant, 1993]) screening tool which is strong in detecting subjects who intake

hazardous amounts of alcohol (Piccinelli, Tessari, Bortolomasi, Piasere, Semenzin, Garzotto et al., 1997). However, Coulton, Drummond, James, Godfrey, Bland, Parrott et al. (2006) found that 24.9% of the general UK population meet this criteria. This suggests that the prevalence of alcoholism established by Condon et al. (2004) may not be necessarily related to the postpartum period.

5. Discussion

Over four decades, 33 identified studies have considered the prevalence of paternal distress in the first year after birth. It is demonstrated that paternal postpartum depression is a clinical issue. At present, however, there is a large degree of variability in prevalence rates between studies. Whilst the original aim was to provide prevalence data from different time-points over the postpartum year, this has not been possible as research has focused mostly on depression in the early months. There is some indication that paternal depression reduces within the first six months postpartum (Greenhalgh et al., 2000, Lane et al., 1997, Ballard et al., 1994). Studies have demonstrated that depression then increases by 12 months postpartum (Matthey et al., 2000, Aerias et al., 1996a, 1996b). Matthey et al. (2000) concluded that paternal depression may develop slowly over the protracted course of the postpartum year. A developing depression may therefore fall below cut-offs in the early postpartum period. This argument is also supported in Goodman's (2004) review. However, as few longitudinal studies have measured depression after six months postpartum, it is difficult to conclude this based on current research.

There is also suggestion that fathers are more likely to experience anxiety difficulties within the postpartum year (Matthey et al., 2003, Roberts et al., 2006). Matthey et al. (2003) demonstrated that caseness increased significantly for both parents when measures of anxiety were included. The effect of this was notably higher amongst postpartum fathers. This could suggest that the focus on depression may under-represent affective difficulties, especially in fathers. In a recent study demonstrating high anxiety amongst

mothers, Miller, Pallant & Negri (2006) stress the importance of screening for difficulties other than depression alone. This is supported by Clark & Watson's (1991) tripartite model which conceptualises symptoms of anxiety and depression along three spectrums of negative affect, physiological hyperarousal and lack of positive affect; thus accounting for overlap. Miller et al. (2006) suggest that the Depression Anxiety Stress Scales-21 (DASS-21 [Crawford & Henry 2003]) could therefore be used instead of unitary construct measures for postnatal difficulties.

Further, Joiner & Blalock (1995) argue that gender differences in general depression (i.e. not specifically postpartum) may be accounted for by an overlap of anxiety in men. This is consistent with studies that have addressed male distress in other clinical areas. Glover, Gannon, Sherr & Abel (1996), for example, demonstrated that distressed sub-fertile men were highly anxious, rather than depressed.

Limitations were identified within several studies relating to measurement of distress.

Firstly, as Lane et al. (1997) also argue, the use of self-report measures for depression has methodological limitations.

Secondly, the use of the CES-D yielded higher scores of paternal depression overall than the EPDS and the BDI. Despite some indication of its strong internal consistency (Lewinsohn, Hoberman & Rosenbaum, 1988), it has been argued to be less successful in differentiating between depression and other emotional responses such as fear (Roberts, Rhoades & Vernon, 1989). Therefore, its application may result in an under-representation of other difficulties such as anxiety.

Further, it was discussed how high prevalence scores were also found in studies where translated measures were used (Bielawska-Batorowicz, Kossakowska-Petrycha, 2006, Aérias et al., 1996a, 1996b). The Polish EPDS has been found to have satisfactory reliability and validity (Bielawska-Batorowicz, 1995, Kostwińska 2002, respectively). Additionally, the psychometric parameters of the Portuguese BDI are satisfactory (Aérias et al. 1996b, Gorestein & Andrade, 1996). Nevertheless, validity was established by comparing scores from other US forms, such as the CES-D, rather than on culturally specific measures.

The EPDS has been validated for men, although its psychometric properties have only been evaluated by one known study (Matthey et al., 2001). Also, despite the lowered cut-off score, items on the EPDS may not represent the male experience of depression (Madsen & Juhl, 2007, Brownhill, Wilhelm, Barclay & Schmied, 2005). Madsen & Juhl (2007) demonstrated that the inclusion of the Gotland Male Depression Scale (GMDS [Zierau, Bille, Rutz & Bech, 2002]) increased caseness of depression by 20.6%.

Most studies were dependent on parent volunteers rather than random sampling. Further, the researchers often accessed fathers through their partners (e.g. Buist, Morse & Durkin, 2003). This could result in sample biases as mothers may be more or less likely to pass on an invitation to a depressed spouse. Furthermore, high drop-out rates were observed in longitudinal studies (Lane et al., 1997, Condon et al., 2004). It has been discussed that depressed fathers may be more likely to discontinue with participation in research.

There is a great deal of methodological variation between studies. Whilst many studies have used repeated measures designs to control for the effects of parity by measuring

mood antenatally, few have employed non-postpartum controls. Although Ballard et al. (1994) report significantly higher levels of depression in postpartum fathers than in controls, the data itself is not presented in their paper. This is a limitation of such epidemiological research and therefore of the review itself.

In addition, there was little consistency in time-points used between studies. The selection of time points was not explicitly justified by authors in any of the studies identified. Also, in cross-sectional designs, selection was often opportunistic (e.g. Soliday et al., 1999). Further, although some studies have shown good representability (e.g. Deater-Deckard et al., 1998), others have focused mainly on first-time married Caucasian parents. In addition, no studies addressing the mental health of fathers who were younger or not in a relationship were identified during the search process. Whilst this could have been a product of limited search criteria, it could also be argued that cross-sections of populations are not fully represented by current research.

The literature strongly suggests that paternal postpartum depression is a clinical issue. It is also indicated that anxiety and generalised distress may be commonly experienced by postpartum fathers. To increase understanding of the nature and course of paternal difficulties, more longitudinal work measuring later postpartum time-points is necessary. Moreover, there is a need to employ samples that reflect today's parents, including more who are cohabiting, separated or single. This review has identified research over four decades that has considered paternal affect. Thus far the research does not seem to have been translated into clinical practice. For example, recent NICE guidelines for postnatal

care discuss the importance of supporting the father of a depressed spouse, but provide no guidance on how to identify paternal distress or how best to intervene (NICE, 2007).

Research has indicated that maternal depression can have a detrimental effect on the attachment and overall development of an infant, resulting from minimal stimulation and increased hostility (Murray & Cooper, 1996, Edhborg, 2001). There is some indication that paternal depression may have a similar effect (Ramchandani et al., 2005). Further, several studies included in the review demonstrated that maternal depression is a strong predictor of paternal depression (e.g. Raskin et al., 1990, Zelkowitz & Milet, 1996, Soliday et al., 1999). Distress in both parents may have serious implications for the family and the infant (Deater-Deckard et al., 1998, Goodman, 2004). Therefore, work aimed towards raising the profile of this important body of literature is necessary not only for fathers themselves, but to promote the wellbeing of the family.

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Part Two: Empirical Paper

Paternal Postpartum Distress: A Discourse Analytic Study

This paper is written ready for submission to the Journal of Social Science & Medicine. Please see appendix 2 for the Guideline for Authors.

1. Abstract

Epidemiological studies demonstrate that paternal postpartum depression is a clinical issue affecting between 1.2% and 25.5% of fathers in the first year after birth (Goodman, 2004). Further, there is some indication that gender specific risk factors predispose men to distress in this period, as well as the usual contextual difficulties associated with caring for a baby (Condon, Boyce & Corkindale, 2004). It seems, however, that the research has not been translated into clinical practice (e.g. NICE, 2007). It is suggested that prevailing discourses surrounding the postpartum father and paternal distress limit the utilisation of this body of research. This study examined the operation of such discourses. Semi-structured interviews were conducted with first-time parents, midwives and health visitors ($n=10$) concerning postpartum fatherhood. The data were analysed using Foucauldian Discourse Analysis (FDA [see Davies & Harré, 1990]). The analysis revealed competing constructions of the postpartum father's role. Whilst fathers were often described as equal contributors to child development, they were simultaneously represented as making absent or insignificant contributions. Discourses which limit the acceptability of paternal depression in the postpartum period were also identified. Within the context of hegemonic discourses, the construction of the postpartum father as having an ambiguous identity and an unimportant position may contribute to, and serve to maintain, depression in this period. The function of such discourses is explored. Implications for reflecting on the postpartum father's discursive position with health services are discussed.

2. Introduction

There is a perception that research has neglected men in terms of their emotional well-being in the postpartum period (Condon, Boyce & Corkindale, 2004, Goodman, 2004). To a degree this accurately reflects the status of research concerning paternal mental health in the first year after birth. There are however several studies that have assessed the prevalence of affective difficulties in postpartum fathers. These epidemiological studies consistently demonstrate that paternal postpartum depression is a significant clinical issue (Buist, Morse & Durkin, 2003, Deater-Deckard, Pickering, Dunn & Golding 2001, Areias, Kumar, Barros & Figueiredo, 1996). In a review by Goodman (2004) of 20 studies, a prevalence range of depression in fathers was established as between 1.2% and 25.5% within the first year postpartum.

It is now widely assumed that maternal postpartum low mood is a reactive depression triggered by the large psychosocial changes of parenting a new child, rather than endocrinology (Lawrie, Herxheimer & Dalton, 2002, Nicolson, 1998). Further, the importance of psychosocial factors is stressed by the National Institute of Health & Clinical Excellence (NICE, 2007). Nicolson (1998) discusses the inevitability of postnatal difficulties due to reduced sleep and social contact, new and revised roles, financial implications and increased stress at work and home. One could reasonably assume that fathers would meet with similar contextual triggers as the potential difficulties associated with this transition will impact on both parents. Further, the 'new dad' movement stresses the importance of a father's increased involvement within the

family, suggesting that his role is now more concerned with active baby care (Zoja, 2001). It has also been suggested that gender specific risk factors such as a man's tendency to idealise pregnancy, birth and fatherhood (Condon, Donovan & Corkindale, 2000), their sparse social networks and dependence on their partners for social support (Cronenwett & Kunst-Wilson, 1981) and their increased financial and work stress (Westwood, 1996) within the context of short paternity leave, may predispose men to distress in the postpartum period. Further, it is claimed that many men may lack what would now be considered good role models for fathering themselves, due to cohort effects of being brought up in times when men were less involved in birth and child rearing (Condon et al. 2004). Existing research has not only demonstrated the presence of an unrecognised clinical phenomenon, but has also assisted in our understanding of how such difficulties can arise.

Despite the evidence that men can experience clinical levels of distress in this period, there is little indication of the translation of this knowledge into clinical practice. One of the reasons for this might be the ambiguous and unimportant positioning of the postpartum father as shaped by discourses around masculinity and paternity (see Lupton & Barclay, 1997). As Ramchandani, Stein, Evans & O'Connor (2005) suggest, a postpartum father is often portrayed as a welcomed playmate, with no other obvious role. This is supported by Raphael-Leff (2005) who asserts that due to recent social change fathers of today have few reference points for role clarification. Such ambiguity may limit the meaningfulness of existing epidemiological data, as it is difficult to argue that fathers are clinically neglected, when the identity of fathers as a group is unclear. With

little sense of identity it is difficult to stipulate how fathers contribute to early child development or how the transition to fatherhood can impact on their lives.

There is also some indication that the elusiveness of the postpartum father's role may predispose men to distress. In a meta-synthesis of ten studies on postpartum fatherhood by Goodman (2005) it is reported that fathers often experience a sense of guilt, helplessness, inadequacy and frustration in their attempts to fulfil their role as an involved father. Goodman also discusses how a father's role development is constrained by a sense of not being recognised as a contributor to infant development. Further, fathers were found to experience this as a barrier to bonding with the baby, which was described as hurtful (Nyström & Öhrling, 2004). Ahlborg & Strandmark (2001) reported that fathers experienced feelings of emotional rejection and emptiness in this period resulting partly from health professionals focusing solely on the mother. Further, Quinton, Pollock & Golding (2002) found that health visitors felt they lacked engagement skills with younger fathers in this period, due to the lack of clarity of paternal roles. Clinical case information shared by Fisher (2002) suggests that fathers' mental health difficulties are often maintained by a perception of unimportance and ambiguity which is generated antenatally through interaction with health professionals. This absence of a paternal postpartum role may therefore be entrenched by the time of birth.

Academic representations of fatherhood also communicate a sense of absence. Both classical and more contemporary psychoanalytic discourses describe a symbiotic fusion between mother and neonate, with no sense of a second parent until after the postnatal

year (e.g. Klein, 1945, Mahler, 1972). Although there is mention of the importance of a father's presence for babies (e.g. Winnicott, 1960), no systematic attempts have been made to ground this in theory (Lamb, 1981). Further, the eventual introduction of the father is often conceptualised as a time of conflict. When discussed, he is often described as on the outside of this relationship representing a threat to the mother-infant merger. Mahler (1972) mirrors Freud's Oedipal dilemma with the Rapprochement Crisis; a depressing time whereby the infant recognises their mother's love for another. It is interesting that psychoanalytic discourses sculpt the postpartum father as either absent or as someone who will later represent conflict and destabilisation.

Such theories were mostly developed without reference to gender politics and before the large sociological changes in parenting and gender roles (e.g. Draper 2003). However, despite increased paternal involvement and shared roles, representations of absence, ambiguity and instability would still seem prevalent. This can be identified in mainstream developmental research over recent decades, which has focused closely on the father's contribution to child development (e.g. Juby & Farrington, 2001, Brook, Whitman & Gordan, 1985). Whilst these researchers value the importance of a father in their conclusions, they appraise his contribution by considering the damaging effects of his absence. It would therefore seem that representations of absence and failure are more accessible than those of how fathers successfully fulfil their role. Discourses simultaneously sculpt a postpartum father as having a minimal role, and as not fulfilling a role that is expected. Such discursive inconsistencies may shape double binds for fathers that not only limit the usefulness of prevalence studies, but also contribute to distress.

Dominant constructions of masculinity may also assist in understanding why, despite contextual and gender specific risk factors, the recurrent finding that men experience depression in this period does not seem widely acknowledged. Hegemonic masculinity can be defined as the overarching masculinism which pervades all aspects of society including the state, education, health service and family systems which embodies the idealised logic of dominance, rational order and control (Courteney, 2000, Carrigan, Connell & Lee, 1985). This idealisation of rationality is in direct contrast to the apparent chaos and unpredictability of an emotionally driven disorder (Frosh, 1997). When men embody emotional disorders that are typically associated with women, such as postpartum depression, this may represent a challenge to hegemony. Hegemony may therefore limit the voice of distress in men (Courteney, 2000, Wetherell & Edley, 1999).

It is often difficult to recognise distress in men when it is hidden behind a guise of masculinity and expressed through numbing, avoidant and risky escape-type behaviours. (Brownhill, Wilhelm, Barclay & Schmied, 2005). Such behaviours include alcoholism, impulsivity and an increase in actions which reflect a disregard for personal well-being and one's own safety. Brownhill et al. (2005) suggest that emotional distress constrained by the tradition of masculinity may help to explain how depression may be generally overlooked in men. Hegemonic masculine discourses are therefore considered influential because of their role in silencing distress in men, and in doing so serving to maintain it. It is argued that hegemony not only restricts the recognition of such difficulties and limits the clinical utility of research, but also reduces the recognition of the experience for those who embody it.

The ambiguous positioning of men in this period, within the context of the transition and gender specific risk factors, may culminate in distress. Further, prevailing discourses may thwart attempts to voice this distress. This study aims to examine the operation of discourses around postpartum fatherhood in order to understand how the discursive position contributes to, and may limit the acceptability of, paternal postpartum difficulties. It is proposed that discursive research has implications for bringing about change in how professionals conceptualise and intervene with mental health phenomena. Encouraging reflection within services on the discourses we draw upon could assist health staff to utilise what is already known about this important clinical issue.

3. Methodology

3.1. Sample & Recruitment

Ten participants living or working within a city in the north east of England with a population of approximately 250,000 were recruited for the study. The sample consisted of three postpartum fathers; two postpartum mothers; three community midwives and two health visitors.

It was decided to recruit postpartum fathers as discourse analysis can demonstrate how groups position themselves through accepting or resisting representations of experience. Further, discourses drawn upon by postpartum mothers may be influential in shaping the father's position.

There is some suggestion that the postpartum father's positioning is shaped in the antenatal period (Fisher, 2002). Midwives have regular contact with expectant parents throughout pregnancy and have a four week postpartum remit to care for new families. Furthermore, midwives have a responsibility to conduct routine assessments of maternal affective difficulties in antenatal and postpartum periods. Their inclusion was justified based on the assumption that discourses available to midwives could be influential in positioning the postpartum father. The role of a health visitor includes the identification

of mental health difficulties and the implementation of individual and group interventions and initiatives as informed by current parenting policy. Representations drawn upon by health visitors could be influential due to their contact with families throughout the postpartum year.

Parents were aged between 20-39 years and had babies between eight to 12 months old. All parents were white British and either in professional employment or training. All were first-time biological parents in a heterosexual relationship with their baby's corresponding parent. Parents were recruited through health visitors based at a health centre serving a wide socioeconomic range. A letter outlining the key features of the research and contact information was provided to parents at their nine month visit by their health visitor (see appendices 3 & 4). Information was also provided to a mother-and-baby group. Fathers were not accessed through groups or services directed solely towards paternity because of potential biases in selection. Health visitors and community midwives were also white British. Ages ranged from 34 to 47 years. Health visitors working at the health centre were also provided with information and invited to take part (see appendix 5). Community midwives were recruited through a local maternity hospital. Interested participants approached the researchers using the contact information provided.

Discursive research does not make inferences concerning internal experiences but rather the discourses that are available to represent a subjective experience. Therefore a mixed

sample was employed as each group draw upon representations of subjective experiences that may limit and empower postpartum fathers.

3.2. Measures

The semi-structured interview schedule was constructed by drawing upon the literature on paternal and maternal postpartum depression, the transition to parenthood and research concerning roles of new fathers. Participants were first asked to draw and describe an image that for them depicted fatherhood in the first year. Interview items included what the role of a father is the in the first year after birth, the importance of this role and how one could tell if he was doing well or struggling. Participants were also asked to comment on paternal postnatal distress in both parents (see Appendix 6 for the interview schedule).

Parents were asked to complete the Positive & Negative Affect Schedule (PANAS [Watson, Clark & Tellegen, 1988]) for assessment of their current mood. The PANAS was used due to its brevity, its reliability and validity (Crawford & Henry, 2004), and its measurement of both positive and negative affect which has been argued to provide a more meaningful sense of emotionality (Clark & Watson, 1991; Jolly, Dyck, Kramer & Wherry, 1994). The scale served as a screening tool for mood difficulties. This provided an indication of risk and gave an emotional context to a participant's account. All parents endorsed more items relating to positive affect. No affective difficulties were identified.

3.3. Procedure

Approval was granted by the local NHS research ethics committee (see appendix 7 for the approval letter). All interviewees were given at least seven days to consider whether they wished to participate in the study. Parent participants were interviewed in their homes and health staff at their place of work. All interviews were conducted separately. Participants gave written consent (see appendix 8) and were asked to provide demographic information (see appendix 9). Interviews were digitally recorded and transcribed verbatim (see appendix 10 for transcription notation). Audio files were deleted on transcription. Names and major distinguishing features were anonymised and pseudonyms provided.

3.4. Data Analysis

Parker (1998) describes discourse analysis as an examination of taken-for-granted assumptions around a construct and the social function that is served by such language use. The study of discourse is used in mental health research when it is apparent that there are competing accounts regarding representations of experience that in effect reduce the usefulness of existing literature (Tonkiss, 1998). When it is argued that a research area lacks utility despite its importance, there is value in attempting to mobilise what is already known by assessing resistance and the underpinnings of its dormancy. As the study is concerned with how popular representations of postpartum fathers may limit the clinical utility of research on paternal depression, Foucauldian Discourse Analysis (FDA [Foucault, 1984]) was felt most appropriate. The use of FDA over discursive psychology

approaches was justified due to its concern with how language is embedded in power relations and how these are supported by governmental institutions (e.g. Davies & Harré, 1990, Willig, 1999). The focus on macro rather than micro levels of interaction was more applicable for this research in order to identify how discourses can limit or empower postpartum fathers.

The structured stages of FDA allow for rigorous analysis with a simultaneous subjective component. The analysis involves a systematic itemisation of the ways of speaking and the categories of person within the text. Contradictions in ways of speaking and the consequential positioning of subjects were then identified (see appendix 11 for an extract demonstrating stages of FDA). The analysis was then extended to consider how institutions are reinforced or subverted by discourses, and how they serve to empower or disadvantage subject groups (Bannister, Burman, Parker, Taylor & Tindall, 1995).

4. Results

4.1. Competing Discourses around Postpartum Fatherhood

A key finding of this research is that active paternal involvement and parental androgyny in the postpartum period are idealised. Analysis indicated that such idealisation results from an absent construction of successful postpartum fathering. Interviewees drew upon contrasting discourses of postpartum fatherhood. The polarity of representations meant that the identity of the postpartum father was difficult for interviewees to define. Whilst participants often discussed the nature of such contrasts, other competing accounts were used interchangeably as if subjects were disconnected from the disparity. The construct of the postpartum father as an equal contributor to baby care was commonly endorsed, and ideals of equal parenting were often commended. However, accounts of the postpartum father as unimportant, absent or peripheral seemed consistently prevalent.

The endorsement of parenting equality may serve the function of empowering fathers who are unable to draw upon a model of successful postpartum paternity. However, analysis indicates that it simultaneously threatens institutions of masculinity and maternity. This dual function of empowerment and threat accounts for such discursive conflict. The discourses relating to postpartum paternity that simultaneously endorse and

resist the idealisation of parental androgyny are discussed below. It is then reported how discourses around paternal emotionality are either undesirable or absent.

4.2. Idealisation of Parental Androgyny

4.2.1. Active involvement as empowering for men: a reaction to marginalisation

Interviewees often drew upon the idea that fathers have increased their involvement over recent decades in response to perceived marginalisation. An account by community midwife Maeve, for example, suggests that involvement reduces the marginalisation of the postpartum father. In response to a question relating to the father's identity, Maeve stated:

It's (postpartum fatherhood) changed from 20 years ago, then there would be a more sidelined image, of a dad on the periphery looking in. But these days he's much more in there in the mix with the mum.

The representation of marginalisation was acknowledged but then resisted or actively withdrawn by postpartum father interviewees. Toby, Earl and Peter seemed to be

struggling between embodiment and resistance of the concept. Toby discussed how some men report feeling ‘sidelined...and left on the margins’, but that he personally does not ‘get this’ idea. This was also seen in Earl’s account:

That’s the hardest thing, that’s the hardest thing for me, that is knowing what I have to do as a father is everything I can to support the family, but the best thing to do to support the family is unfortunately being on the sideline sometimes. And again that’s a dreadful word not meaning on the sidelines, but, I’m as involved as I want to be aren’t I.

Earl draws upon accounts that disown the difficult feelings associated with distance from his daughter, by stating that he is there as much as he wants to be. Whilst this ‘sidelined’ representation is readily available for fathers, it is not an attractive subject position. Thus resistance to the active involvement discourse may allow the father to distance themselves from the difficult feelings associated with marginalisation.

Analysis suggested that the active and equal involvement rhetoric may serve to empower men in a time whereby they are perceived as sidelined or peripheral. However, there was also resistance to marginalisation, suggesting its undesirability.

4.2.2. Resistance to Involved Postpartum Paternity: the Postpartum Father requires Education & Encouragement

Health workers often drew upon the discourse that services are needed to coax fathers into active involvement in the postpartum period, as if fathers are resistant to it. The construction that parenting is thrust upon fathers was also apparent. When asked what came to mind when she thought of a father in the first year Helen, a health visitor, described the image of a father being handed a baby in the door way as he gets home from work. Here paternity is portrayed as being administered by others, rather than approached by fathers themselves.

Helen's account also suggests that it is due to external influences that active involvement is valued, and not from within fathers themselves. This is implied in the following extracts from Helen & Holly:

Now we're getting more dads involved. At one time it wouldn't really have been that entertained I don't think whereas it is now.

The more knowledge they have, the more involved they are I think. We're really trying to encourage it. Some dads will just laugh when you say about attending

groups, it's just, you know, it's just not the image they want to be seen being involved with really.

It was also seen that participants drew upon the discourse that postpartum fathers require directions on how to parent. This was particularly endorsed by midwife interviewees. Maeve, for example, explained how there are many things a father can be doing in the early weeks, that midwives help them to identify. Milly also drew upon representations of fathers who are 'just not interested' in taking advice, and were subsequently positioned as disinterested in fatherhood.

The construction of a father resisting active involvement was also drawn upon. All health staff and parents drew upon the representation of a father who would struggle with such involvement, often owning it as a stereotype. This was suggested in health visitor Holly's account. In relation to a newly established baby massage class for fathers, she explained that those attending would be perceived as 'a bit funny' at their rugby club.

Conflicting discourses around what involved fathering means for maternity would seem to have the effect of creating uncertainty about what the father's role actually entails. The need to be educated and encouraged described above could also be the product of the view that fathers are naturally ill-equipped to be parents. Despite unanimous endorsement of an active postpartum father's role, interviewees also drew upon discourses that

discredit his contribution, creating a sense of absence or unimportance. A need to devalue a father's parenting may be reactive to the construction of active involvement posing threats to masculinity and maternity.

Accounts drawn upon by Amy, for example, demonstrate a need to protect the unique role of the mother. Amy begins by describing how the couple value shared parenting:

(My partner) has not got much time...he's either working or looking after the baby...(father's do) pretty much the same as mums do, we share everything equally, I don't think I do anything really different to what he would do.

This is later contradicted in Amy's response to a question about the struggles of early fatherhood:

I just don't think the father finds the transition hard, I mean obviously...I don't think that much has changed for (partner). I think it's (his life) quite as it used to be really (.) whereas mine is not.

Amy also asserts that having their baby 'has not really made a huge impact on his life...being with the father is to sup- they don't spend as much time with the baby'. She also explained that she would not 'expect a father to be (depressed) because, well in my opinion it's not had such an effect on his life in that he's still able to go to work and see his friends and do things. He's got a lot of freedom'. A stark contrast is seen here between the representation of an equally involved working father, and the representation of a father with an absent role, as suggested by the notion that his life remains unchanged. This discourse implies that although parents can do the same tasks, the father's contribution is not as valuable as the mothers'.

Holly also draws upon competing accounts, with similar effect. When asked to represent the postpartum father pictorially, Holly drew two identical adults forming a circle in which the baby was nurtured. In relation to this she explained how a postpartum father's role is:

The same as, as a parent, same as the mum really...you'll go through the same sort of major changes. It's such a major life changing event.

The representation that equal parenting does not impact on a fathers' life was then voiced after a short pause:

Their life doesn't change as much...they're soon back at work.

Whilst simultaneously endorsing an ideal of parenting equality, Holly's account also implies that a father's contribution is not 'parenting', and that the mother is the sole parent.

The rhetoric of the father as 'supporter' or 'helper' in the postpartum period, rather than an equal parent, was commonly used. This seemed to be embodied by the fathers who rated their partners' expertise over their own, and described themselves as awaiting permission or instructions on how to parent. Toby's account suggests this:

I would say it's (his role) erm, is one of support, erm, and (2) both physically, and emotionally. The full array really, yeh...support, being around, doing what you can do. You might know best but, you know (partner) she does the reading as well, does the general background reading and whatnot and the research...so she's clued up as well... I bow to that knowledge and I'm just there to do what I can do (.) yeh ...it's all about just yeh (1) sort of helping where I can.

This was also alluded to in the images drawn and described by midwife interviewees Mary and Milly. Both images portrayed an intimate bond between father and neonate, with the absence of a mother. Mary's drawing depicted a father as 'doing the mothering' whilst the mother rested. This suggests that the postpartum father is a part-time or substitute mother, who will withdraw when the mother is present. Such representations demonstrate the simultaneous enforcement and withdrawal of the idealisation of parental androgyny, due to the potential threat it may pose to maternity.

This was also seen in Siobhan's account, whereby fathers were described as 'equally important'. However, there was also a need to defend the essential maternal 'operations' role by explaining how it can be overshadowed by brief interactions with the father. stated:

I'm like chopped liver because I'm the one who does all the making the food and washing the clothes, buying the clothes, and he comes home and her face lights up, he does the short bursts of massively fun exciting throwing her around, his role is the excitement and the fun...I'm like old hat, you know...and I am the stability and the you know, I'm here twenty four hours with her

This extract suggests that postpartum fathers have responsibility for the more enjoyable sides of parenting, with the effect of taking away an appreciation of 'mothering'. There is

a need for Siobhan to explain how much her role entails and how important and ‘nutritious’ her contribution is for a baby. She describes her role as the ‘stability’ and discusses the permanence of her presence. This contrasts with the language used for the father’s contribution which suggests instability and brevity, such as ‘throwing’ and ‘short bursts’.

4.2.3. The Absent Representation of Successful Postpartum Fathering

It seemed difficult for interviewees to identify how a postpartum father would be doing well. This discursive position is conceptualised as the product of such contrasting endorsement of discourses surrounding involvement. For example, in response to how one could tell whether a postpartum father was fulfilling his role, community midwife Milly stated:

For a father I think that would be very difficult really, I suppose the best people to ask would be the children when they’ve grown up.

Further, postpartum father Toby found difficulty in explaining what doing well as a father would entail, and also explained how one would have to wait until the children were older. He also attempted to answer what he felt was important about the father’s

contribution by hypothesising the effects of his absence or death, and concluded that his daughter would grow up fine with just the mother.

In addition, Peter struggled to draw upon a representation of a father doing well in his role as the following extract suggests:

I don't think you can really explain it to be honest. I can see whether they are being happy about being a parent or not. It just happens really. I don't know how I'd describe how to be a good father.

Earl was able to embody the discourse that he was doing well. Although, this then seemed to be disowned as he described how his daughter's development would occur naturally regardless of his contribution.

I'm fairly satisfied that I am doing well, well I don't know if I'm doing the absolute best I can. But I look at the baby and see she's happy...and the fact she's progressing...must be doing something right, or the pair of us, but that is the nature of things that will happen automatically.

Earl also explained how he has little sense of what doing the ‘right thing’ would entail. He explained how neither being at work or being at home made him feel satisfied that he was doing the best for his baby, and that he should be doing both at the same time:

I feel I should be doing both and I know that it’s a physical impossibility for me to do both.

Further, Earl referenced the 1950s father having struggled to define a postpartum father’s role, suggesting uncertainty about the current model.

4.3. Emotionality as threatening to masculinity

The inevitable stresses of postpartum parenting were appreciated by all interviewees. However as described earlier in Amy’s account, this was discredited in response to a question concerning the emotional impact of fathering. Analysis revealed that representations of paternal emotionality seem to be products of a larger discourse that affective difficulties present a threat to masculinity.

4.3.1. Father as damaging or uncommitted to fatherhood

In response to how a father could struggle emotionally, Toby drew upon accounts that made it difficult to contemplate a depressed father. He also drew upon representations of such a father as 'bad' and even damaging, likening him to a drug addict.

I don't get the negatives, and so it's difficult to put myself into somebody that would live like that and that would have problems and be a bad father and bla bla bla, I just don't get it, you know, even if you're a crack-head, I just don't get it, I don't get how you can not do the right thing by a child you brought into the world.

Reference to drug addiction in response to the consideration of what might be difficult for fathers was also made by Peter. There is a sense from both extracts that more extreme negative reference points are the most accessible when one considers a father who is struggling. Peter also represented the experience of paternal distress to indicate poor parenting.

If he's going to get like that (depressed) then he shouldn't have been a father, should he.

Both accounts suggest that there is an element of choice to becoming depressed. The 'badness' seems to emanate from the construct that low mood should be something the father could prevent. Further, drawing on extreme reference points may serve to distance the speakers from the experience.

Of course, a drug abuser also epitomises a marginalised member of the community. This representation may also reflect the sense of being 'sidelined' as previously discussed.

4.3.2. Paternal depression as unmanageable/treatment resistant

There was also the sense that a postpartum depression in fathers would be something less tangible and more permanent than maternal depression. Siobhan explained how as the father does not experience the physical changes, low mood would be concerning:

I wouldn't say more serious, that's not what I mean, I knew I was going to get better, sit it out...my hormone levels and things...whereas for a man that's something that's not going to change, it probably needs more attention...I don't want to say serious, but, it's more concerning really...that a man would be...it's a bit more concerning because it's something emotional or in the lifestyle...you

think there's something a bit more in the head. I haven't thought about men with postnatal depression, it figures of course.

Earl's account also suggests that paternal depression would be less amenable to change. After a period of thinking he explained how it would evoke a sympathetic response in him, as it would be difficult to manage with no means of addressing it. Earl discussed how one would have to wait for it to go away on its own:

(13 seconds thinking) I suppose I'd sympathise really, not suggesting I have ever been (postnatally depressed)...but it would be sympathy tempered with the fact it's going to go away... something they'll have to work through...that sounds callous doesn't it 'just get on with it and it'll be alright.

Toby's account also alludes to the construct that a paternal depression would be something almost threatening or unmanageable. He stated:

If that were to happen to men then, woah! It's a whole new kettle of fish...is it?
Can men get it? Is that what you're saying?

There is strong suggestion of resistance of the concept in Toby's account. Further, he described how men could get low due to lack of sex, but that it could not be constitute postnatal depression. Such language may also serve to distance men from a sense that they miss intimacy; an embodiment which would not mesh with hegemonic discourses.

Holly's account suggests that a depressed postpartum father may experience guilt that he had become depressed, which the following extract indicates:

If a dad's down it's worse, they would probably carry more guilt because they should be the strong one. I mean that's a male stereotype and I'm using a lot of stereotypes I know.

Further, Maeve explained how there would be a great deal of resistance to a paternal depression:

I don't know if men want to go down that route because it (postpartum depression) was a real big erm it was a very negative thing wasn't it and it's taken a long time to get rid of that stigma.

4.3.3. Non-existent/Absent representation of paternal distress

The content and prosody of Toby's following statement suggests that paternal emotionality is something that does not sit comfortably amidst popular discourses.

You know I actually put postnatal depression down as actually (.) acutely (.) depressed. Whereas a guy who's not getting enough sex or is not getting out enough at weekends...if he's feeling left out or whatever, then I'm still not putting it down as clinically depressed...I'd put it down to other things, maybe more shallow.

Where subjects were able to draw upon sympathetic representations of paternal depression, they often contrasted supportive accounts with more popular discourses. Holly, for example, explained how paternal depression is something she feels exists, but at the same time demonstrated an awareness of others accounts of paternal experience. Thus, the speaker simultaneously gives voice to other conceptualisations of paternal distress:

I mean I do sort of think that men do get postnatally depressed, so it's not sort of a thing I'd be 'oh they can't be feeling like that', it would just be the same I suppose as, it would be with a woman, they both need help and support really.

Similarly, Milly argued for its existence, before drawing on what she felt would be a more culturally popular view. When discussing people's reactions to a father she worked with who was termed postnatally depressed, she stated vehemently that:

To me if he's depressed and it's in the postnatal period then he's postnatally depressed.

This was compared to how it could also be seen as something quite preposterous:

But when I mentioned it to some of my other colleagues they were in uproar saying that a man can't suffer from postnatal depression ...again a female friend was in uproar.

Milly's account particularly suggests that there is something quite shocking about paternal depression. Further, the fact it was discussed with her friend could suggest that it was something unusual and of interest.

5. Discussion

Findings demonstrate how competing and often polarised representations of postpartum paternity are drawn upon interchangeably. Whilst the notion of equal paternal involvement may empower marginalised fathers and women in society, parental androgyny ironically seems to threaten masculinity and maternity. Further, as drawn from Earl's and Amy's accounts, the ideal of equal involvement is unsustainable as intermittent deviations from it, such as being at work, are represented as not meeting a criteria for involved fatherhood. The endorsement and subsequent withdrawal of idealisations of active involvement fail to create a sense of the postpartum father's importance. This creates difficulty in drawing upon a realistic reference point for successful fathering.

Discourses around postpartum emotionality suggest that paternal difficulties are either non-existent, or unmanageable and damaging. The complex weave of popular representations around postpartum fatherhood limits the acceptability of paternal postpartum depression.

This study complements existing research addressing the positioning and experiences of the postpartum father. According to a phase model by Goodman (2005), fathers have a desire for emotional involvement and deep connection with their infant, which is

confronted with disillusionment and feelings of guilt and inadequacy. Moreover, the representation of the postpartum father as a 'helper' despite the idealisation of parental equality is supported (Woollett, 2004, Croghan, 1991).

It was argued that the very nature of an idealisation renders the construct of parental androgyny unrealistic and unsustainable. Further, polarised discourses do not permit the conceptualisation of an adequate or sufficient postpartum father. Winnicott (1953) described how for an infant's development, 'good enough parenting (mothering)' is optimal. He argued that this is in fact preferable to 'perfect' mothering for the child's development. There is evidence that the concept of 'good enough' has been applied to health practice for postpartum mothers. For example, cognitive interventions for maternal postnatal depression stress how thoughts around high personal expectations and perfectionism should be addressed (Milgrom, Martin & Negri, 2006). Further, the 'don't be superwomen' discourse is commonly used in postnatal health literature, such as patient leaflets (e.g. Royal College of Psychiatrists' Public Education Editorial Board, 2007). Accounts drawn upon by participants in this study, however, suggest the absence of a discourse for 'good enough fathering'. The introduction of this concept could have the implication of normalising the difficulties of fulfilling an idealised role, in the same way that this has been empowering for mothers.

Nicolson (1998) has argued that maternal postpartum depression is often positioned within mothers, rather than seen as a product of difficult circumstances and major life

changes. Thankfully, there is evidence of a shift in thinking with growing appreciation of contextual factors for mothers, as reflected in recent guidelines (NICE, 2007). As discussed above however, the findings from this study indicate that for men there is an absent sense of the postpartum father's presence or contribution. Without an identity as a parent, the postpartum father may be positioned as having little entitlement to a reactive depression. Prevailing discourses therefore limit the degree to which a logical causal link can be made between the psychosocial impact of parenting and paternal distress. This is suggested in constructions of paternal depression that imply negligence, permanence and that there is an element of choice to becoming distressed. This is reflective of how postnatal depression was first positioned within women.

The discourse that distressed men are uncommitted and damaging to their offspring is also echoed from a former position of the postpartum mother. Attachment theorist Bowlby (1940, 1944) argued that maternal deprivation resulted in 'affectionless psychopathy'. Such attachment discourses positioned the mother as negligent if she was not eternally present physically and emotionally. Similar constructions were demonstrated around fathers in this study.

The above discussion may explain how the clinical utility of literature on the prevalence and experience of paternal postpartum depression is currently limited. The task for clinicians is to consider the function and effect of popular 'realities' around experiences of postpartum fathers. Reflecting with health workers on the function of idealised

parental androgyny and the nature of resistance towards paternal mood difficulties may help to clinically mobilise research in this area. Further, it is recommended that the concept of 'good enough fathering' should be introduced through educational workshops. Furthermore, given that men often exhibit distress in covert ways (Brownhill, et al. 2005) there is a need to help staff identify such difficulties. In addition, it may be helpful to encourage reflection around the constraints of masculinity on help-seeking (e.g. Tudiver & Talbot, 1999).

Moreover, the accounts of fathers in this study indicate that the term postpartum/postnatal is heavily gendered. Thus, it could be expected that the embodiment of a paternal postnatal depression would be resisted. Therefore, the use of the term itself may limit clinical utility. An appreciation of the inevitable psychosocial difficulties of the postpartum period and how these may culminate in distress may be more useful for fathers than the diagnosis of a paternal postnatal depression.

It may be useful for future research to include other ethnic groups and male staff. Additionally, analysis focused heavily on the position of fathers who are cohabiting or married to their partners. There is scope for further work to address the discursive position of the separated or divorced postpartum father. There is a dearth of discursive and experiential studies concerning depressed postpartum fathers themselves. It would be clinically useful for longitudinal research to address how fathers negotiate discourses around their subjective experiences.

Discourses that may limit the utility of previous research concerning postpartum paternal distress have been discussed. Further, means of working with such resistance in antenatal and postnatal services has been suggested.

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Part Three: Appendices

Appendix 1: Reflective Statement

1.1 Introduction

This paper will provide an overview of the research process, and will include reflections from my research diary. It will be explained how obstacles were encountered during the design and recruitment stage and how these could be circumvented in future research. The difficulties and rewards of qualitative research in this area will also be discussed. Further, the ways in which factors such as gender may have impacted on the study will be outlined.

1.1. Formulating the Research Question & Design

It was first intended to conduct an epidemiological study with the intention of addressing what seemed to be an overlooked clinical issue. It was then surprising to discover that paternal depression had been addressed by research for over four decades and across cultures (e.g. Rees & Lutkins, 1971, Zaslów, Pedersen, Cain, Suwalsky, 1981, Aérias, Kumar, Barros & Figueirido, 1996, Madsen & Juhl, 2007). Clinical guidelines were considered and it was apparent that a relatively large body of research was lacking utility. The aim then changed: to provide a conceptualisation of how despite important research concerning the prevalence of paternal postpartum depression, the clinical phenomenon is not widely recognised. Foucauldian Discourse Analysis (FDA [Foucault, 1984]) was therefore felt the most appropriate means of addressing this aim.

In the proposal stage, it was frequently asked how such research could be useful. It has been discussed how discourse analysis can enable the identification of taken-for-granted truths around clinical issues which may limit the options of particular client groups. Further, such awareness can provide something tangible to health teams. For example, the reflection on an individual's positioning can allow health staff to reformulate a client's need, and to understand resistance to broader clinical issues. (e.g. Roy-Chowdhury, 2003, Blackman, 2001). Personally, the research has highlighted how little is known of the clinical utility of discursive research in health practice. It is felt that this was not fully appreciated in the early stages of this research. Throughout the design process it became increasingly clear that it was necessary to provide accessible explanations of the approach. Therefore, in future research endeavours the need for a clear and comprehensive elucidation of FDA will be acknowledged. This will include explanations of epistemology, the method of analysis and means of clinical application.

The focus on depression in postpartum fatherhood was met with some resistance. As the findings from the empirical paper demonstrate, a realistic representation of successful postpartum fatherhood is difficult to access. It is therefore difficult to conceive of a reactive paternal depression, as discourses shape the father as absent and his life as unaffected by the introduction of a child. These discourses are held in society and are widely accessible. A resistance towards the exploration of a clinical issue that does not sit comfortably amongst culturally popular language is therefore inevitable. Such

experiences inform that there is a need to prepare for resistance with a clear and exhaustive rationale.

It was also discussed in the introduction to the empirical paper that research that has explored fatherhood has often focused on the devastation of paternal absence. On reflection, such constructions of fatherhood were drawn upon during the design stage. In a meeting with a health professional to discuss the recruitment of staff participants, for example, I was asked ‘so are you the one looking at absent fathers?’

1.2. Recruitment, Procedure & Analysis

It was noted how health workers were keen to take part in the study and talk about such issues. It was often discussed by the staff how they felt participating would ‘be interesting’ due to services ‘thinking about dads more’. Parents were also keen to explore questions broadly, which were enriched with accounts of first-time parenthood. The semi-structured nature of the interview provided some degree of flexibility for the participants and the researcher, allowing for further exploration of rich data.

Two of the participants demonstrated some uncertainty about whether they were answering correctly. Both were postpartum fathers. At the end of an interview a father asked in disbelief ‘so was that helpful?’ and another wondered whether he had ‘buggered it up’. It is interesting that only fathers required reassurance that they were helpful contributors to the research.

It is often argued that the researcher's contribution to the interview should be taken into account in discursive work (Potter, 1998). Gender may have impacted on the research in a number of ways. Firstly, interviewees may have perceived a male interviewer as representative of the postpartum father group. This may have evoked biased responses due to effects of desirability, thus encouraging the endorsement of active involvement discourses. Second, fathers may have held back accounts of the difficulties associated with postpartum paternity for fear of unfavourable comparison.

Furthermore, it is respected that the analysis of the data may have been affected by the researcher's male gender. In addition, it is inevitable that the researcher's position as a step-father will have impacted on the research process. Assistance from female supervisors was therefore invaluable in ensuring quality control, in order to produce a balanced identification of discourses and subject positions. It is for reasons such as these that Bannister, Burman, Parker, Taylor & Tindall (1994) argue that discourse analysis is best not attempted alone.

It is also interesting how the position of the researcher changed throughout the process. As it has been discussed, the initial intention was to address a neglected clinical issue and client group. However, such research has provided awareness of how resistance to such mental health issues also serve the subjects that this study attempts to voice. It can be

inferred from the results that fathers resist the concept of paternal depression vehemently; perhaps more than other groups. Resistance to the concept therefore has an important function as discourses of emotionality implying negligence and absence are currently too accessible for the mental health phenomenon to be acceptable. Therefore, it is appreciated that such research is more clinically useful when attempts are made to work with the resistance. A parallel can be drawn with clinical work, whereby the clinician will consider the function of a client's difficulty when considering the appropriateness of an intervention.

1.3. Selecting the Audience

The task was to select a suitable audience for the empirical and systematic review papers. Many studies concerning the emotional life of postpartum fathers have appeared either in psychiatric or nursing journals. Nursing journals would seem appropriate given the midwife's role in identifying mental health difficulties than can impact on family's wellbeing. However, the clinical issue also has implications for other health professionals involved in delivering care and policy making, including psychology, public health practitioners and those involved with health promotion and education. The Journal of Social Science & Medicine has an audience of social scientists, health professionals interested in the contribution of social sciences on health care and policy. Further, it currently boasts a reasonable impact factor of 2.453. The journal was therefore selected for both papers. This was justified by the following. As the review attempts to address the prevalence of a clinical difficulty, it would be prudent to address health professionals,

health analysts including epidemiologists and policy makers. Further, the empirical paper outlines discourses of resistance towards the acknowledgment of the difficulty, which would be important for the above to appreciate in order to implement change.

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Appendix 3: Letter of Invitation to Parents

Christopher Wilson
The Department of Clinical Psychology
The Postgraduate Medical Institute,
Hull York Medical School,
The University of Hull,
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Dear Parent,

Your Health Visitor has provided you with this letter inviting you to take part in a piece of Clinical Psychology research based at the University of Hull. I am interested in the experiences of new parents and how the arrival of a baby can present many challenges and life changes. If you are interested in taking part in this study please read the enclosed information sheet which explains what is involved.

Please do not hesitate to contact me should you have any other questions which remain unanswered by the enclosed information.

Yours Faithfully,

Christopher Wilson

Trainee Clinical Psychologist

Appendix 4: Information Sheet- Parents

Experiences of Early Fatherhood

Researcher: Christopher Wilson

Introduction

Thank you for taking an interest in this study. Please take time to read the following information carefully and discuss it with others if you wish. Feel free to ask if there is anything that is unclear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

It is widely understood that distress can occur in either parent in the period following childbirth. This study aims to gain a better understanding of these experiences so that we can try to meet needs better in the future. The study is to be conducted as part of an educational requirement.

Why have I been chosen?

You have been chosen as you have become a parent within the past year.

Do I have to take part?

No, this is entirely up to you. If you decide that you want to, you will sign to confirm that you have read this information sheet and be asked to sign a consent form. If you do decide to take part, you are still free to withdraw at any point without having to give a reason.

What will happen if I do take part?

If you do take part, you will be interviewed for around an hour. Best efforts will be made for interviews to be at a time and location that is convenient for you. You will be offered a chance to meet again with the researcher to discuss your interview, but this is optional. The study will run from July 2007 until Sept 2008.

The interviews will be audio-taped and then typed up. The tapes will be kept in a secure location and will not have your name on it. The tapes will be erased when they have been typed up. If you give consent you will also be given a sheet to fill in to give information on age, sex and occupation. You will also fill in a brief questionnaire concerning your current mood.

Risks & Benefits

All this study will involve is an interview. When you talk about your experiences, you may, however, discuss things that are upsetting. The lead researcher is a Trainee Clinical Psychologist and should any difficulties arise from your taking part, you will have the opportunity to discuss what further support you can access.

Many people find studies about their experiences to be interesting and enjoyable.

What about confidentiality?

All of your information will be kept confidential. When the interview is being typed up, all names will be removed and the tapes will be erased.

What will happen to the results of the study?

The results of this study will be produced in the form of a journal article.

The study will be completed by Sept 2008 and a copy of the journal article will be kept at the Department of Clinical Psychology, The University of Hull. Further information regarding results can be obtained by contacting the researcher closer to the time.

Who is organising this research?

Members of the Department of Clinical Psychology and the Department of Psychology at the University of Hull.

Who has approved this research?

The Research Ethics Committee for the local NHS Trusts has reviewed the study to ensure that the rights of the participants are protected and respected.

Contact for further information

Should you require any further information before agreeing to take part in the study, or at any time in the future, please contact:

Christopher Wilson

The Department of Clinical Psychology

The Postgraduate Medical Institute,

Hull York Medical School,

The University of Hull,

Cottingham Road,

HU6 7RX

Or Email

C.C.Wilson@psy.hull.ac.uk

What do I do if I want to take part?

Please take one week to consider whether you wish to take part or not. After this time please contact me to confirm whether or not you would care to be involved in this exploration of parenthood.

Thank you for your time in reading this information.

Appendix 5: Staff Information Sheet

Experiences of Early Fatherhood

Researcher: Christopher Wilson

Introduction

Thank you for taking an interest in this study. Please take time to read the following information carefully and discuss it with others if you wish. Feel free to ask if there is anything that is unclear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

It is widely understood that distress can occur in either parent in the period following childbirth. This study aims to gain a better understanding of these experiences so that we can try to meet needs better in the future. The study is to be conducted as part of an educational requirement.

Why have I been chosen?

You have been chosen as you are an obstetrician, a midwife or a health visitor.

Do I have to take part?

No, this is entirely up to you. If you decide that you want to, you will sign to confirm that you have read this information sheet and be asked to sign a consent form. If you do decide to take part, you are still free to withdraw at any point without having to give a reason.

What will happen if I do take part?

If you do take part, you will be interviewed for around an hour. Best efforts will be made for interviews to be at a time and location that is convenient for you. You will be offered

a chance to meet again with the researcher to discuss their interview, but this is optional. The study will run from July 2007 until Sept 2008.

The interviews will be audio-taped and then typed up. The tapes will be kept in a secure location and will not have your name on it. The tapes will be erased when they have been typed up. If you give consent you will also be given a sheet to fill in to give information on age, sex and occupation.

Risks & Benefits

All this study will involve is an interview. The lead researcher is a Trainee Clinical Psychologist and should any difficulties arise from your taking part, you will have the opportunity to discuss what further support you can access. Many people find taking part in research to be interesting and enjoyable. You also have the right to a copy of the research should you want one on completion.

What about confidentiality?

All of your information will be kept confidential. When the interview is being typed up, all names will be removed and the tapes will be erased.

What will happen to the results of the study?

The results of this study will be produced in the form of a journal article.

The study will be completed in Sept 2008 and a copy of the journal article will be kept at the Department of Clinical Psychology, The University of Hull. Further information regarding results can be obtained by contacting the researcher closer to the time. It is intended for the research to be disseminated back to you departments.

Who is organising this research?

Members of the Department of Clinical Psychology and the Department of Psychology at the University of Hull.

Who has approved this research?

The local Research Ethics Committee for the local NHS Trusts has reviewed the study to ensure that the rights of the participants are protected and respected.

Contact for further information

Should you require any further information before agreeing to take part in the study, or at any time in the future, please contact:

Christopher Wilson
The Department of Clinical Psychology
The Postgraduate Medical Institute,
Hull York Medical School,
The University of Hull,
Cottingham Road,
HU6 7RX
(01482) 464117
Or Email
C.C.Wilson@psy.hull.ac.uk

What do I do if I want to take part?

Please take one week to consider whether you wish to take part or not. After this time please contact me to confirm whether or not you would care to be involved in this exploration of parenthood.

Thank you for your time in reading this information.

Appendix 6: Semi-Structured Interview Schedule

Study: Early Experiences in Fatherhood

Researcher: Christopher Wilson

Thank you for agreeing to take part in the study.

As you will be aware from reading the information sheet that you have received, I am interested in fathers in the period following childbirth. I would like to hear your views on the role of fathers at this time.

Before we start I wonder whether you would be able to take some time to think of an image that would describe fatherhood in the first year after birth. You can draw this image or if you would prefer you can describe it to me.

What does this role entail? What do dads of babies do?

What does it take for a man to do well as a new father? How would you be able to tell?

In what way do dads struggle with this role?

How important is this role for fathers themselves?

How important is this role for the mother?

How important is this role for the baby?

Under what circumstances would parents feel low in this period?

What should the father/others be doing if the mother is low or distressed in this period?

What should the mother be doing?

How does this look in reality/ what actually happens?

What would be the impact of mothers feeling down in this period?

What should the mother/others be doing if the father is low or distressed in this period?

What should the father be doing?

How does this look in reality/ what actually happens?

What would be the impact of fathers feeling down this period?

During pregnancy, how much should a father-to-be be involved in appointments with midwives and medics and any other health professional? For what reasons should fathers attend these appointments?

You have talked a bit around what you feel should happen regarding appointments. What do you see happen in reality?

Under what circumstances should they not attend?

How important is attending these appointments for fathers themselves?

If you were to write a leaflet about what this period is like and what people should know, what sorts of things would you put in it?

What things would come into mind for you if a father was described as postnatally depressed?

If you were to interview someone about fatherhood in the first year, what sorts of questions would you ask? / Do you feel that I have missed anything that you would think is important?

Thank you for your time today. As it has been explained on the information sheet, if you have any questions/queries concerning this research a time can be arranged to do so.

Appendix 7: Ethics Form- removed for hard-bound copy

Appendix 8: Consent Form

Participant Identification Number: _____

CONSENT FORM

Name of Researcher: Mr Christopher C Wilson

Name of Supervisors: Dr Lesley Glover & Dr Anna Sandfield

1. I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions.

☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason, without my medical or legal rights being affected.

☐
3. I understand that I will be audio-taped and the content typed up. I have been assured that this information will have my personal details removed, and the tape will be destroyed as soon as it has been typed. I agree to these terms.

☐
4. I agree to take part in the above study.

☐

Name of Participant

Date

Signature

Name of person taking Consent (Researcher)

Date

Signature

Appendix 9: Demographics Questionnaire

General Information Sheet

Experiences of Early Fatherhood

Researcher: Christopher Wilson

Identification Number _____

Date of Interview _____

Personal Information

Gender: _____

Age: _____

Occupation: _____

Ethnic Group: _____

Marital Status: _____

You are entitled to a copy of the research and to arrange a time to discuss it when the project is completed.

Please tick if you **would** like to be contacted on completion of the research.

☐

Appendix 10: Transcription Notation

Table 2. Transcription Key

Symbol	Description
(.)	Pause of less than one second
(1)	Pause (with length in seconds)
...	Indicates omitted text

The above key explains the symbols used with the extracts. More symbols were used in the larger text. The Extracts were punctuated in the paper to facilitate reading.

Appendix 11: Extract of the Analysis

Figure 1. Transcription Extract

Interviewer: Okay that's great (.) thanks for that (1) erm so (.) what does this **role** entail?

(.) What do what do dads of babies do?

Milly: (1) Erm (exhales 1) initially (.) when they (.) when they (.) well if you're not talking about **birth** itself and the **preparation** for it but afterwards after the **birth** erm cos they do now (.) they are **encouraged** to go into the **delivery suites** with the partner (.) and it now seems more odd if the father doesn't (stressed) want to go in (.) so sometimes perhaps they feel a bit **pressurised** to go to go in (1) Initially obviously after the baby is born (.) It's quite an emotional time for both of them (.) and then obviously they have to then come **home** on their own (.) and leave their partner and the baby in the **hospital**.

Example of an Analysis

The quality of the following process of analysis was controlled by having two other independent transcript reviewers.

1. A systematic itemisation of the objects. These are coded in ***bold italics***.
2. The subjects are then systematically itemised to identify the categorisation of person within the text. These are coded in ***underlined bold italics***. The baby is also discussed as an object in this context.
3. The ways of speaking/categories of person are then identified.
4. Keep reading over transcripts/extracts and start to develop 'intuitive hunches'

5. Start indexing themes and discursive features. The researcher should make a conscious effort to search for counter-examples.

It is then asked ‘who is being voiced in the text?’ The father is voiced when he is considered as one with the mother: ‘It’s quite an emotional time for both of them’. He is also voiced through the use of ‘he might *feel* pressurised’, which draws on an account of an internal experience. Conversely, the father is positioned as being ‘pressurised’ suggesting that his actions/motivations are due to external influences. It is also interesting that the father ‘comes’ home rather than ‘goes’ home, as if the text locates him there and not with his partner. There is suggestion that he would not stay in the hospital, which is often a practical reality. However, it would be important to take dialect into account in this instance.

A further means of asking who is voiced is to wonder where a sense of being ‘pressurised’ and ‘encouraged’ come from. The statement ‘they are *encouraged* to go into the delivery suites’ and ‘they *have* to come home’ imply that others in the text are being voiced. Discourses voicing the value of others’ in determining postpartum paternity can be identified here, which would need to be corroborated with the remaining transcript.

It is also important to consider the context of the response. The speaker is asked ‘What does this role entail? What do dads of babies do?’ Her tangential response suggests difficulty in drawing upon an available answer. She is able to answer the ‘do’ part of the question by listing his activities from the birth. There is no account of ‘role’ in this extract.

Discourses/constructions are then compared with others identified within the transcripts as a whole.