THE UNIVERSITY OF HULL

The Experiences of Fathers in the Perinatal Period

being a Thesis submitted in partial fulfilment of the requirements for the degree of

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Overview

This thesis portfolio is comprised of three parts: a systematic literature review, an empirical study and a set of appendices.

Part one is a systematic literature review in which existing empirical literature relating to fathers' representations of their unborn children during pregnancy is reviewed. A total of 15 studies is critically evaluated and assessed for quality. Their findings are then collated to examine the manner in which fathers represent their unborn children and the factors which influence the development of these representations. These findings are discussed in relation to clinical implications and directions for future research.

Part two is an empirical paper which explores fathers' experiences of the perinatal period in the context of maternal mental health problems. The study employed a narrative approach in the exploration of forty fathers' stories of this time. Both elicited and pre-existing online stories were included. The holistic form and content of the stories was examined in an attempt to gain insight into the factors and processes that contribute to differential outcomes for families within this period. The findings are discussed in reference to the Developmental Systems Framework of Family Resilience (Walsh, 2016) and clinical implications are presented.

Part three is a complete set of appendices of parts one and two. The supporting information for the systematic literature review and empirical study are presented, in addition to epistemological and reflective statements to provide further context for the undertaken research.

Overall word count (excluding tables, references and appendices): 18,440

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Part 1: Systematic Literature Review

This Paper is written in the format ready for submission to the *Infant Mental Health Journal.*

See Appendix B for submission guidelines.

Total word count: 8,143 (excluding abstract, tables, references and appendices)

Fathers' Representations of their Unborn Children: A Systematic Literature Review

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Abstract

Interventions targeting parent-infant attachment in the perinatal period are critical due to the potential consequences of poor attachment relationships on the parent-child relationship and family health and developmental outcomes. Cognitive skills, such as the ability to conceptualize and fantasise about the fetus, have been suggested to be linked to the development of parent-child prenatal attachment. This systematic review explores the existing empirical literature relating to fathers' representations of their unborn children during pregnancy. Electronic databases were systematically searched to identify peer-reviewed studies that described findings on fathers' representations. Fifteen studies were identified. Findings suggest that fathers perceive their children to be progressively more real as pregnancy advances, as they are presented with new forms of knowledge about the child that they can incorporate into increasingly complex representations. Perceptual experiences, and the knowledge gained from these, were suggested to be particularly influential in this process. Father-focused interventions aimed at improving the father-child relationship may be improved if future studies investigate fathers' representations of their unborn children using clear conceptualizations encompassing different types of knowledge about the child. Future longitudinal research, investigating how fathers' representations of their children relate to parent-child attachments and to family outcomes, interactions and health practices, is suggested.

Keywords: fathers; fetus; unborn child; pregnancy; representations

Introduction

Early research exploring the parent-infant relationship predominantly focused on mothers (Bowlby, 1969, 1988; Lamb, 1975; Ainsworth, 1979). It is likely this focus was influenced by dominant cultural discourses that placed the mother as the primary care giver within the home and the father as a secondary, more distant, figure (Genesoni &

Tallandini, 2009). However, the roles of mothers and fathers have become less differentiated over time (Deutsch, 2001; Draper, 2003). The past few decades have seen a significant shift in what the cultural ideals of being a 'good' father entails. There has been a movement away from the concept of the 'traditional' father (a distant, detached authority figure) towards that of the 'new' father (an attentive, nurturing figure who actively participates in childcare and domestic tasks) (Shirani, Henwood & Coltart, 2012; McGill, 2014; Henwood & Procter, 2003; Habib, 2012). With this shift, arguments for the importance of the father's role in a child's life have gained traction, and research on fathering and father-child relationships has become more prevalent.

Existing literature has provided substantial evidence that fathers' active and regular involvement with their children has a positive impact on the children's later social, behavioural, psychological and cognitive development (McWayne, Downer, Campos & Harris, 2013; Sarkadi, Kristiansson, Oberklaid & Bremberg, 2008; Leidy, Schofield & Parke, 2013). Additionally, increased father involvement has been found to improve the well-being of fathers themselves (Hwang & Lamb, 1997; Pruett, 1998). Multiple characteristics of fathers and the father-child relationship have been suggested to influence child development and wellbeing. Studies suggest children are more likely to exhibit emotional and behavioural problems when their fathers exhibit more depressive symptoms or are less responsive or sensitive in their interactions with their children (Ramchandani & Psychogiou, 2009; Lamb, 2004). In contrast, paternal warmth, nurture and closeness has been associated with positive child development (Webster, Low, Siller & Hackett, 2013; Sarkadi, Kristiansson, Oberklaid & Bremberg, 2008).

Such findings are concordant with those within literature investigating parent-child attachment. It has consistently been found that children with a secure attachment to their parents have improved outcomes (Ranson & Urichuk, 2008; Pallini, Baiocco, Schneider, Madigan & Atkinson, 2014). Notably, attachment styles have been found to be

relationship-specific as opposed to child-specific (Main & Weston, 1981), meaning children may form an insecure attachment to one parent and a secure attachment to the other. Therefore, it is possible that the potential negative impact of an insecure mother-child attachment could be reduced through a high quality, secure father-child attachment. The concept of attachment was initially developed in the context of the postnatal relationship (Bowlby, 1969; 1988). However, it has since been suggested that parent-infant attachment develops prenatally (Rubin, 1967a, 1967b; Condon, 1986; Weaver & Cranley, 1983).

Research focusing on the parent-infant relationship during pregnancy is less prevalent and, as with the postnatal literature, has predominantly focused on the experiences of mothers (Cannella, 2005; Alhusen, 2008; Yarcheski, Mahon, Yarcheski, Hanks & Cannella, 2009). During pregnancy, fathers must psychologically prepare for the child without experiencing the more direct physical changes the mother undergoes. The transition to fatherhood during pregnancy has been described as the most stressful period of a man's developmental life (Chin, Hall & Daiches, 2011; Deave & Johnson, 2008; Priel & Besser, 2002). During this period, fathers have to contend with multiple stressors, including role changes, relational conflict, and changes to their work and social life (Habib & Lancaster, 2010; Genesoni & Tallandini, 2009; Barclay & Lupton, 1999; Buist, Morse & Durking, 2002; Deave & Johnson, 2008). All of these stressors have the potential to negatively impact on the father's relationship with the unborn child. Indeed, research suggests that although fathers often report a desire to be involved in the prenatal process, and nurture a relationship with their child, they often experience ambivalent feelings during the pregnancy (Chandler & Field, 1997; Gage & Kirk, 2002; Draper, 2003). Furthermore, as the paternal-child relationship is more indirect, this may mean fathers are more easily able to distant themselves from the reality of the pregnancy and child (Miller, 2011). Increased father involvement during pregnancy has been found to

have a positive impact on the mother, with women whose partners are involved in their pregnancy being more likely to receive prenatal care, exhibit reduced health damaging behaviours, and have improved health outcomes and reduced infant mortality (Teitler, 2001; Martin, McNamara, Milot, Halle & Hair, 2007; Alhusen, Gross, Hayat, Rose & Sharps, 2012). Such findings highlight some of the potential benefits of increasing fathers' prenatal involvement.

One factor that may increase fathers' likelihood of being involved is their prenatal attachment to the unborn child. Definitions of prenatal attachment vary, but multiple studies have suggested it to be multidimensional in nature (Cranley, 1981; Condon & Corkindale, 1997; Doan & Zimerman, 2003, 2007; Shieh, Kravitz & Wang, 2001). Summaries of findings suggest it may be defined in terms of a combination of cognitive attachment (encompassing the ability to conceptualize the fetus as a distinct person), emotional attachment (an empathic affectionate bond to the fetus), attachment behaviours (such as responding and interacting with the fetus) and self-care practices (such as maintaining good health practices) (Doan & Zimerman, 2002, 2003, 2008; Zimerman & Doan, 2008).

Research on prenatal attachment has clearly demonstrated that individual differences do exist in this early relationship, varying from being highly attached during pregnancy, to demonstrating low, or no, attachment (Condon, 1986; Mikulincer & Florian, 1999). Factors that potentially relate to prenatal attachment, include, but are not limited to: social support, ultrasound use, maternal age and personality, parental mental health and attachment style, number of existing children and awareness of fetal movements (Fowles, 1996; Laxton-Kane & Slade, 2002; Lindgren, 2001; Condon & Corkindale, 1997; Yarcheski, Mahon, Yarcheski, Hanks & Cannella, 2009). Both mother and father prenatal attachment to the infant has been found to predict postnatal parent-child attachment (Siddiqui & Hägglöf, 2000; Condon & Corkindale, 1997; Müller, 1996).

Working within the framework of the above definition, it is suggested that in order for prenatal attachment to develop, certain cognitive skills may be necessary. In particular, Doan and Zimerman (2007, 2008) argued that the cognitive ability to conceptualize the fetus as a separate person is a prerequisite for prenatal attachment. Other cognitive skills that have been suggested to play an important role include the ability to mentally represent or fantasise about the fetus and/or the ability to conceptualize oneself as being attached to an imagined fetus (Doan & Zimerman; 2008). Emotional skills such as perspective taking, empathy and the ability to be sensitive to and respond to the cues of others, have also been suggested to be important factors involved in developing prenatal attachment (Zimerman & Doan; 2008). Within the motherhood literature, the way in which the unborn child is represented prenatally has been found to be related to the quality of the postnatal mother-infant relationship; with mothers who have more positive and balanced prenatal representations of their children exhibiting more positive parenting behaviours postnatally and their children showing more secure attachments (Maas, Vreeswijk, de Cock, & Van Bakel, 2012). The above literature clearly highlights the importance of the father-child relationship. Given the suggestion that the manner in which the unborn child is cognitively represented may affect the parent-child relationship, it seems pertinent to explore the topic in relation to fathers.

Despite the potential for this to have important implications, there is currently a lack of knowledge about the father-child relationship during pregnancy and the manner in which the child is perceived in this context. To the author's knowledge no review has examined the literature in relation to how fathers represent their unborn children.

The aims of the current systematic review were therefore to collate all the diverse strands of research investigating how fathers represent their unborn children, in order to explore what is known to date, how this might inform healthcare and parenting interventions, and to identify areas future research could explore.

The research questions of the review were:

- What has been examined in the literature to date in relation to how fathers represent their unborn children?
- What does the literature suggest about how fathers represent their unborn children?
- What factors impact upon the way fathers represent their unborn children?

Method

Population

Fathers present during their partners' pregnancy are the population of interest in this review. Their experiences of this time could have been investigated retrospectively or during the pregnancy itself.

Literature Search Strategy

A systematic review of literature published up to February 2016 was conducted. Four electronic databases were searched for relevant literature: PsycINFO, CINAHL Complete, MEDLINE and Web of Science Core Collection. These were chosen to facilitate the identification of literature from a number of healthcare disciplines, inclusive of social and life sciences, mental health, and medicine.

The search terms were chosen after the author examined the terminology and key words used in relevant literature. The final search terms were:

[(paternal or father* or dad*) N10 (antenatal* or prenatal* or perinatal* or pregnan* or fetal or fetus or foetal or foetus or unborn or pre-birth or "expect* father*")]*

These terms were entered into each database to retrieve articles featuring the terms in their title, abstract, subject or keywords. Where possible, search limiters were applied to

screen out articles which did not meet the inclusion criteria. The limiters used were: ‘peer-reviewed’, ‘English language’ and ‘human subjects’.

Inclusion and exclusion criteria were applied (see Table 1). Due to the broad search terms, many identified articles were not relevant for inclusion when the title and abstract were inspected. In the case of uncertainty, full articles were reviewed to assess eligibility. Reference sections of included articles were manually searched for further literature relevant to the review. Figure 1 illustrates the search procedure in full.

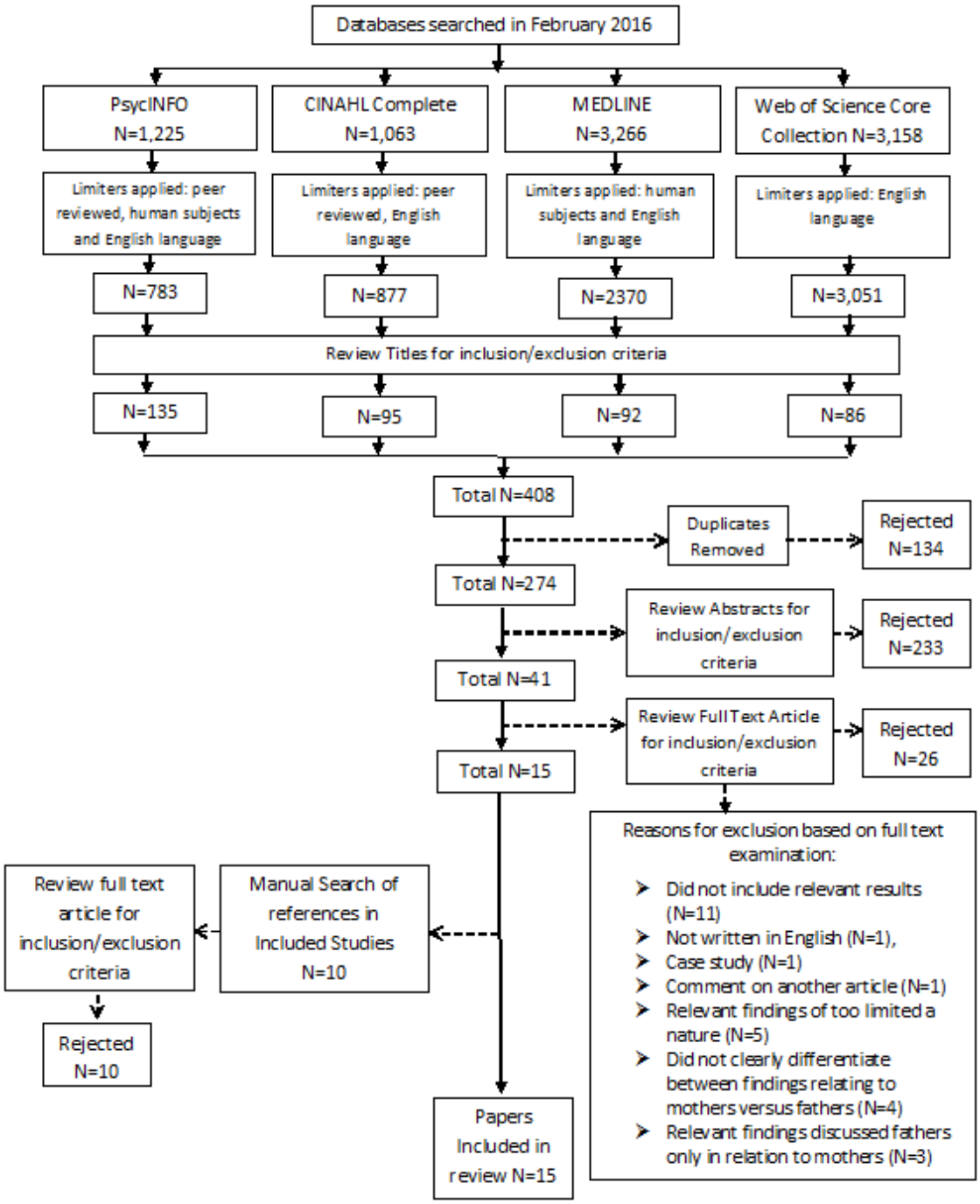

Figure 1. *Flowchart illustrating the article selection process*

Table 1. *Article inclusion and exclusion criteria*

Inclusion Criteria	Exclusion Criteria
1. Published in a peer-reviewed journal. 2. Empirical study (i.e. not a literature review or commentary article). 3. Written in the English Language. 4. Participants aged 18 and above. 5. Qualitative, quantitative or mixed methods papers. 6. Reported fathers' data separately from mothers.	1. Case studies or discussion papers. 2. Does not include findings on how fathers represent their unborn children or these findings are of such limited quantity as to not add new information to the review. 3. Discusses fathers only in comparison to mothers. 4. Fathers' representations are explored in the context of fetal abnormality, previous miscarriage, surrogacy or fertility treatment. These factors are felt to warrant separate investigation due to their likely level of impact. 5. Papers published prior to 1980. Ultrasound imagining was not common practice in pregnancy prior to 1980 (Clement, Wilson & Sikorski, 1998) and its use has been found to impact parent-child prenatal attachment (Lumley, 1990).

Quality Assessment

A quality assessment tool was employed to evaluate the quality of the included articles (Appendix C). This was an amalgamation of four published quality measures: the Mixed Methods Appraisal Tool (MMAT; Pluye, Gagnon, Griffiths & Johnson-Lafleur, 2009), STOBE checklist (Vandenbrouke et al., 2007) the Checklist for Qualitative Studies (National Institute for Health and Clinical Excellence, 2009) and the Downs & Black Checklist (Downs and Black, 1998). The adapted checklist incorporated items to assess the overall quality of the study and its methodology, results and discussion.

The overall quality score of each study was calculated in percentages with the highest possible score being 100% and the lowest possible score being 0% (see Appendix E for individual ratings). A random sample of five articles were chosen and blindly rated for quality by an independent researcher. A calculation of Cohen's Kappa showed inter-rater reliability to be good (k=0.84). Discrepancies between the two assessors' ratings were discussed until a consensus was reached.

Data Analysis

Due to the heterogeneity of included studies, a meta-analysis was not considered appropriate. Instead, a narrative synthesis methodology (Popay et al., 2006) was employed whereby data was summarised and explained through text, rather than statistics. This method allows the synthesis of findings from studies investigating different constructs, measures and methods, allowing for the integration of quantitative and qualitative evidence.

Data Extraction

A data extraction tool was developed to review the relevant articles (Appendix F). Recorded information included: the study's author(s), date, country, aims, participant numbers and characteristics, design, measures, data analysis method, main relevant findings and quality score.

Results

Characteristics of Included Studies

The initial search yielded a total of 8,712 articles. After the exclusion of articles based on the above criteria, 15 articles were identified that met selection criteria (Figure 1, Table 2). The studies were conducted across seven countries (USA, Sweden, The Netherlands, Taiwan, Thailand, Japan and England), with five using data translated from a language

other than English (Asenhed, Kilstam, Alehagen & Baggens, 2013; Finnbogadóttir, Svalenius & Persson, 2003; Iwata, 2014; Kao & Long, 2004; Sansiriphun, Kantaruksa, Klunklin, Baosuang & Jordan, 2010).

Six studies included both first-time and experienced fathers (Vreeswijk, Maas, Rijk & van Bakel, 2014a; Vreeswijk, Maas, Rijk, Braeken & van Bakel, 2014b; Vreeswijk, Rijk Vreeswijk, Maas & van Bakel, 2015; Draper, 2002; Walsh et al., 2014; Zeanah, Carr & Wolk, 1990), with the remainder including only first-time fathers. A total of 1123 fathers participated in the studies, with this falling to 562 when repeat participants were removed.

One study utilized quantitative methods and employed questionnaires (Zeanah, Carr & Wolk, 1990). This study also coded the frequency of fetal movements. Four studies utilized mixed methods, with all employing interviews, three using questionnaires (Vreeswijk et al., 2014a, 2014b; Zeanah, Keener, Stewart & Anders, 1985) and one using a checklist completed by the researcher (Vreeswijk et al., 2015). The remaining studies utilized qualitative methods, with all but one implementing interview methods. Asenhed et al. (2013) examined online blogs written outside of the research context and Draper (2002) used focus groups alongside interviews. Three studies were part of one longitudinal cohort study (Vreeswijk et al., 2014a, 2014b, 2015) and two part of another (Zeanah et al., 1985; Zeanah, Zeanah & Stewart, 1990).

Table 2. *Summary of included articles*

Article *Country*	**Aims**	***n***	**Participant characteristics** *Participant Ages (in years)*	**Methods** *Measures used*	**Design and Analysis Method** *Time-points*	**Key Relevant Findings**	**Quality Score**
Asenhed, Kilstam, Alehagen & Baggens (2013) *Sweden*	Identify and describe the process of fatherhood during the partner's pregnancy among first-time expectant fathers.	11	First-time fathers; Swedish *Of 6 known; Median Age = 28 (Range = 22-34)*	Data extracted from public blogs	Qualitative; Content Analysis *Blogs searched for at 1 Time-point. The Blogs were published during pregnancy and continued to childbirth. 3 started in the second month of pregnancy, 5 in the middle, and 3 in the eighth month.*	During pregnancy, men start to communicate and interact with their child, and this creates a developing sense of the reality of the child. Factors such as experiencing the ultrasound and fetal movements increase this sense of reality. Future representations of the child become apparent across the pregnancy.	93%
Draper (2002) *England*	Explore fathers' experiences of ultrasound scans and expose finding to a theoretical analysis	18 for interviews Unknown for Focus Groups	6 first-time fathers; 12 experienced fathers; English; Predominantly white middle class	Interviews and Focus Groups	Qualitative; Theoretical Analysis; Draws on findings from larger longitudinal ethnographic study.	All fathers engaged in body mediated moments (such as fetal movements, the ultrasound etc.) The ultrasound scan increases fathers' sense of the reality of the child and increases their awareness of it. It also brings ideas surrounding the health of the child into the foreground.	71%

			Ages not reported		*For Interviews; 3 Time-points of interviews; 2nd trimester, 3rd trimester and 8 weeks postnatally. Unknown for focus groups*	As pregnancy develops, the child moves from being seen as an abstract concept, to a 'blob' to a human being.	
Finnbogadóttir, Svalenius & Persson (2003) *Sweden*	To describe first-time, expectant fathers' experiences of pregnancy.	7	First-time expectant Fathers; Cohabiting *Age range: 28-37*	Semi-structured Interviews	Qualitative: Content Text Analysis *1 Time-point; 38-39th week of pregnancy*	The sense of the reality of the fetus increases as pregnancy progresses. In later stages of pregnancy the fetus is viewed as a human being. The focus shifts from a sense of 2 to one of 3; from "us" to "we." "Proof" of the child is identified at different stages (e.g. the ultrasound or fetal movements).	86%
Iwata (2014) *Japan*	To understand the meaning of the lived experience of Japanese men during the transition to fatherhood.	12	First time fathers of a child under 1 year old; Japanese *Mean Age = 33.8 (Range = 27-48)*	Semi-structured Interviews	Qualitative: Hermeneutic Analysis *1 Time-point: Postnatally, prior to child turning one.* *Follow up interview with 8 participants to validate findings.*	The child did not seem real at the beginning of pregnancy, but was seen as increasingly more real as the pregnancy progressed. Imagining the baby (e.g. thinking about what sex it might be) and 'working on the baby' (e.g. giving the child a nickname) were identified as themes that increased the reality of the child.	83%

Jordan (1990) *USA*	Explore the experiences of expectant and new fathers	56 28 in the longitudinal group (men were asked to be in this group if their partner was in the first half of pregnancy; all eligible agreed) 28 in the cross-sectional group At least 13 fathers were interviewed at each Time-point	First-time fathers; Cohabiting; Four raised outside country (1 European, 2 Hispanic, 1 Asian) *Mean Age = 30 (Range = 20-40 years)*	Interviews	Qualitative; Constant Comparative Analysis using Grounded Theory approach *Longitudinal; 6 Time-points: 3 prenatally (soon after conception, after the mother felt fetal movement i.e. 20-24th week of pregnancy, late pregnancy i.e. 36-40th week of pregnancy) 3 postnatally (as soon after birth as possible, 6 weeks postnatally, 1 year postnatally)* *Cross-sectional; Interviewed at one of the above Time-points.*	The reality of the child increased as pregnancy progressed. Stages of how the unborn child was represented were identified as: an idea, a diagnosis, a symptom, a potential baby and a baby. Fathers interact and play games with the unborn child.	67%

Kao & Long (2004) *Taiwan*	Explore the life experiences of Taiwanese first-time expectant fathers during their wives' pregnancy	14	First-time expectant fathers; Chinese Speaking; *Mean Age = 32 (Range = 20-43 years)*	Unstructured Interviews	Qualitative: Content Analysis using Husserlian Phenomenological approach *1 Time-point; 34-36th week of pregnancy*	In initial stages of pregnancy, the unborn child was seen as a symbol of the father's achievement, the love between the father and mother and/or the father's virility. Some fathers described finding it difficult to imagine the unborn child. Fathers wanted to build an intimate links with the child in pregnancy and believed they could communicate and interact with the child. Fetal movements were seen as a significant form of communication/proof of existence. Father imagined their future child and how they would interact with each other.	85%
Sansiriphun, Kantaruksa, Klunklin, Baosuang & Jordan (2010) *Thailand*	To understand the process of Thai men becoming a first-time father.	20	Expectant Fathers; Wife at least 37 weeks pregnant; Cohabiting *Age Range = 26-38*	Interviews	Qualitative: Grounded Theory Analysis *6 participants interviewed at 1 Time-point* *14 participants interviewed at 2 Time-points; 37th*	"Protecting the unborn baby" emerged as a key process; with the baby being seen as delicate and small. This process was divided into three phases: confirming and accepting, perceiving the unborn baby as a human being, and ensuring the health of the mother and baby.	86%

					to 40th week of pregnancy.	Fathers generally began interacting and communicating with the baby around the 5th month of pregnancy.	
Vreeswijk, Maas Rijk & van Bakel (2014a) *Netherlands*	Investigate fathers' experiences of the unborn child during pregnancy.	301 (questionnaires) 243 (interview and questionnaires)	Expectant fathers; 54.7% expecting a first child; Predominantly Dutch (80.4%) *Mean Age = 34.01 (Range = 27.29-49.60)*	Semi-structured Interviews; *Working Model of the Child Interview* Questionnaires; *PAAS; Edinburgh Depression Scale; State-Trait Anxiety Inventory (Dutch Version)*	Mixed Methods; Descriptive Analysis; Interviews coded using scheme of Zeanah et al. (1994); Chi squared analysis; Pearson product moment correlations; Multi-nomal logistic regression analysis. *1 Time-point: 26th week of pregnancy*	43.6% of fathers were classified as having balanced representations of their children, and 54.6% as having unbalanced representations. The quality of fathers' prenatal attachment and their representations of the fetus were interrelated. Fathers who reported a higher quality of prenatal attachment were more likely to have balanced representations of their unborn children.	78%
Vreeswijk, Maas, Rijk, Braeken & van Bakel (2014b)	Examine the concordance of fathers' representations of their	243 fathers; 225 fathers participated	Expectant fathers; 53.9% were expecting a first child;	Semi-structured Interviews; *Working Model*	Mixed Methods; Descriptive Analysis; Interviews coded using scheme of	43.6% of fathers were classified as having balanced representations of their children, and 54.6% as having unbalanced representations prenatally.	74%

Netherlands	children during the transition to parenthood and investigate the influences of demographic variables on the stability of these representations.	in both home visits. 217 fathers (96.4%) completed the questionnaires.	Predominantly Dutch (80.2%) *Mean Age = 34.11 years (Range = 22.31-49.60)*	*of the Child Interview* Questionnaires; *Edinburgh Depression Scale; State-Trait Anxiety Inventory (Dutch Version); Quick Big 5 Inventory*	Zeanah et al. (1994); Cohen's kappa calculations; Logistic regression analyses; Hierarchical logistic regression analysis. *2 Time-points: Questionnaires given and WCMI interview undertaken at 26th week of pregnancy; WMCI administered 6 months postnatally.*	First-time fathers more often had balanced representations of their child than fathers who already had children.	
Vreeswijk, Rijk, Maas & van Bakel (2015) *Netherlands*	Explore the association between prenatal risk factors for parenting problems and quality of mothers' and	308 Mothers and 243 Fathers	51.6% expecting a first child; Predominantly Dutch (82% mothers and 80% fathers)	Semi-structured Interviews; *Working Model of the Child Interview* Checklist;	Mixed Methods; Descriptive Analysis; Interviews coded using scheme of Zeanah et al. (1994); Independent samples t-tests;	Prenatal risk factors of parenting problems were not associated with fathers' representations of their (unborn) infants. Fathers expecting their first child have balanced representations more often than parents who already have children.	86%

	fathers' prenatal and postnatal representations of their infants.		*Fathers Mean Age = 34.09 (range = 22.3-49.6)* *Mothers Mean Age = 31.6 (range 22.3-49.6)*	*Adapted version of the Dunedin Family Services Indicator (DFSI-A).*	Chi squared analysis; Multi-nomal logistic regression analyses; *2 Time-points: 26th week of pregnancy and 6 months postnatally.*		
Walsh, Tolman, Davis, Palladino, Romero & Singh (2014) *USA*	Examine how men experience prenatal ultrasound and understand the impact of this experience on their self-perceived role as both partner and expectant father	22	11-first time fathers; 11 experienced fathers; 15 Caucasian; 16 Married *Mean Age = 31 years (Range 23-41)*	Semi-structured interviews (after researcher observed the ultrasound)	Qualitative; Thematic analysis, drawing on principles of Grounded Theory *1 Time-point: Directly after the ultrasound scan; 16th to 20th week of pregnancy*	Ultrasound attendance contributed to paternal feelings of connection to the unborn baby, created a richer perception of the reality of the child, and expanded father's thoughts on the future child. It provided reassurance that the child was healthy, leading to greater emotional engagement between father and child.	90%
Williams & Umberson (1999) *USA*	To compare expectant fathers' and mothers'	15 fathers and 15 mothers	Primarily white, middle-class;	Interviews	Qualitative; Coded via principles of Straus (1987) and	Access to the fetus via medical technology impacted on fathers' perceptions of involvement and control over pregnancy. Medical	81%

	experiences with medical technology during pregnancy and childbirth.	(one couple did not participate at Time-point 2)	Texan; married *Fathers' Mean Age = 32.5 (range 24-53)* *Mothers' Mean Age = 29.6 (range 26-36)*		Marshall & Rossman (1989) *2 Time-points: 3rd trimester of pregnancy and 2-4 months postnatally*	Technology, particularly the ultrasound, increase fathers' sense of reality of the child.	
Zeanah, Carr & Wolk (1990) *USA*	Investigate infant temperament and activity level prior to birth and assess influences on how parents imagine and perceive their unborn children, including the impact of fetal movements.	44 fathers and 44 mothers 3 couples had only single ultrasounds; 1 father did not complete the questionnaires	Couples expecting their first child; Cohabiting; Did not know sex of child *Fathers Mean Age = 28.8 years (range 21-38)*	Questionnaires; *Infant Characteristics Questionnaire (ICQ); Scale of Infant Temperament (SITA); 2 scales taken from the Parent-Infant Attachment Scale (PFAS); IPAT Anxiety Scale; Parental numerical*	Quantitative; Pearson Product Moment Correlations and paired t-tests *2 Time-points; 31st and 32nd week of pregnancy; Questionnaires at each point prior to ultrasound.*	Subjective and objective measures of fetal movements were not correlated. The more active fathers rated the child, the more likely they would rate the child as having an adverse temperament, but also that they would report a more intense attachment in the 3rd trimester of pregnancy. Father's having a higher social class and who were less anxious were less likely to rate their child as having an adverse temperament.	71%

			Mothers Mean Age = 27.1 (range 20-33)	*ratings of fetal movements; Ultrasound coding of fetal movements*		Fathers rated as having a more intense attachment to their child, were more likely to rate their child as unpredictable. Fathers who attributed more characteristics to their child were more likely to rate their child as more adaptable.	
Zeanah, Keener, Stewart & Anders (1985) *USA*	Explore how parents begin to conceptualize their developing infants as a person	35 fathers and 35 mothers	Couples expecting their first child; Sex of infant unknown; White (94%); Middle Class *Fathers' Mean Age = 30 (Range 23-38)* *Mothers' Mean Age = 38 (Range 22-35)*	Semi-structured Interviews Questionnaires; *The Revised Infant Temperament Questionnaire, modified for prenatal investigation*	Mixed Methods; Participant's interview data coded (method unclear) and descriptive statistics provided; Spearman rank correlation coefficients calculated; Mann whitney u tests *2-4 Time-points; 37th week of pregnancy (22 couples completed questionnaires again at 33rd week of pregnancy) and 4 weeks postnatally (18*	5 fathers said their unborn child did not have a personality. Most fathers gave vivid descriptions of the unborn children, using overwhelming positive descriptors, with 40% of fathers saying exclusively positive statements and another 40% making predominantly positive statements.	67%

					couples completed questionnaire again 7 weeks postnatally)		
Zeanah, Zeanah & Stewart (1990) *USA*	Explore how parents construct their representations of their infants before and after birth	35 fathers and 35 mothers	First time expecting parents *(see Zeanah, Keener, Stewart & Anders, 1985)*	Semi-structured Interviews *(The Revised Infant Temperament Questionnaire; unreported)*	Mixed Methods; Content analysis; Interview data coded, descriptive statistics calculated *2 Time-points: one month before childbirth and one month postnatally*	14% of fathers said they did not know their unborn child's personality or thought that the child did not yet have one. 88% of fathers' descriptors of their unborn child could be coded into 8 categories of personality, with activity, sociability and affect descriptors being the most common. 6% of fathers gave ideas on their child's preferences/likes/dislikes.	74%

Methodological Quality of Studies

The included articles were largely appraised as respectable in quality; quality ratings ranged from 93% (Asenhed et al., 2013) to 67% (Zeanah et al, 1985), with a mean of 79% (see Appendix E). All studies provided clear descriptions of their background and research objectives and showed high quality in their presentation of the key findings and their interpretation. As a whole, qualitative studies scored higher in quality than mixed method and quantitative studies. In determining quality, the author gave least weight to the criteria of richness of data, clinical rationale and reporting of ethics. It was hypothesised that low scores within these areas likely reflected an absence in reporting rather than a fault in the content or context of the study.

There was little evidence of reflexivity across the included studies, in relation to both the potential influence of the researcher and/or study context on results, making it difficult to evaluate the extent to which these influences may have impacted the original findings. Relatedly, studies showed lower quality in relation to a lack of rich descriptions of the study setting and the manner in which the sample was arrived at. This issue was weighted more heavily in regards to quantitative and mixed design studies due to its influence on the ability to assess the representativeness of the sample, and thus the findings' generalisability. Positively, studies showed high quality qualitative analysis, with most studies incorporating multiple researchers within this process. Only one qualitative study scored zero in this area (Williams & Umberson, 1999). Two of the studies incorporating quantitative design elements were seen to lack the desired level of description of their statistical analysis and results (Zeanah, Carr & Wolk, 1990; Zeanah, Keener, Stewart & Anders, 1985), which was weighted heavily against them.

There appeared to be limited reporting of discrepancy within studies, creating the somewhat unlikely impression that all participants shared similar perspectives. However, all papers grounded their findings within extracts of original data, therefore these

concerns were not felt to undermine the validity of findings. All but four studies failed to discuss their own limitations to a desired extent. Although a lack of reporting does not necessary correspond to how well limitations were managed, there is a possibility that important methodological limitations went unaddressed.

Study Aims and Measures

Table 3 provides descriptions of measures used across studies. Six studies had aims explicitly related to exploring fathers' representations of their unborn children; these were the only studies to include quantitative aspects within their design. Of these, three studies utilized postnatal measures that had been modified for prenatal use, asking parents to imagine their current or future child's behaviour or temperament (ICQ, SITA, Zeanah, Carr & Wolk, 1990; RITQ, Zeanah et al., 1985; Zeanah, Zeanah & Stewart, 1990). The RITQ devises scores of infant temperament based on parents' ratings of infant behaviour; there is therefore potential that the concept being measured was not necessarily parents' perceptions of personality but rather of behaviour. These studies also coded parental interview data by specific categories of infant personality descriptors, with only frequency of descriptors being reported. Similarly, Vreeswijk et al. (2014a, 2014b, 2015) reported coded data collected via the WCMI interview. This interview is designed to categorise the quality of parents' representations, and only the frequency data of each category was reported. Due to these papers reporting only the frequency data surrounding categorizations of interview content, the information available surrounding these studies' conceptualisations of the fathers' representations are restricted to the quality and style of the representation as opposed to the content of fathers' thoughts and perceptions surrounding the child itself.

Within the qualitative studies, three aimed to explore fathers' experiences of medical technology in pregnancy (Draper, 2002; Walsh et al., 2014; Williams & Umberson, 1999), with those remaining having broader aims relating to exploring fathers' experiences of

pregnancy and/or the transition to fatherhood. Therefore, findings in relation to fathers' representations of their unborn children were a by-product of fathers discussing their more general experiences.

Table 3. *Measures used within the reviewed studies*

Measures Specifically Assessing Fathers' Representations of the child	
Measure	***Description of Measure***
Infant Characteristics Questionnaire (ICQ; Bates, Freeland & Lounsbury, 1979) Modified for prenatal investigation.	Assesses parental perceptions of infant temperament; specifically in relation to difficultness. Consists of 24 items related to infant characteristics that are rated on a 7-point Likert scale. Scores are determined for four factors: fussy/difficult, unpredictable, dull and un-adaptable. The questionnaire was modified for use in the study of Zeanah, Carr & Wolk (1990), to ask about parents' *expectations* of their infants.
The Revised Infant Temperament Questionnaire (Carey & McDevitt, 1978) Modified for prenatal investigation.	A 95-item instrument that assesses parents' perceptions of their infant's temperament on 9 dimensions, such as adaptability, distractibility, and mood. Parents rate the occurrence of behaviours in their infants on a 6-point Likert scale, and these scores are transposed to the temperament dimensions. The questionnaire was modified for use in the study of Zeanah, Keener, Stewart & Anders (1985) for use prenatally, so that 58 items remained assessing 6 dimensions of infant temperament.
Scale of Infant Temperament and Activity (SITA). Developed for use in the study of Zeanah, Carr & Wolk (1990)	Consists of 2 parts. Part 1 includes parents' global ratings of 8 infant characteristics (such as activity level, irritability, sociability and soothe-ability) each arranged on a 7-point

	Likert scale. The prenatal version uses the future tense, for example, "My baby will be…" Part 2 consists of parents' rating of 13 items (on a 7-point Likert scale) derived from the Infant Behaviour Questionnaire (Rothbart, 1981), about infant activity levels during routine daily situations.
Working Model of the Child Interview (WMCI) (Zeanah et al., 1996)	A semi-structured interview that focuses on the "meaning" a child has to his or her parents. It includes questions on parents' experiences of the child, relationship with the child and expectations they have for the child, as well as questions surrounding their perceptions of the child's personality. Fathers' representations are then classified as either *balanced*, *disengaged* or *distorted* based on their answers. Balanced representations refer to those reflecting a more engaged relationship and which are open to continued adjustment. Unbalanced representations refer to those with a sense of emotional distance (disengaged) or internal inconsistency (distorted). Unbalanced representations are considered suboptimal.
Measures Assessing Other Factors ***Measure***	***Description of Measure***
Adapted version of the Dunedin Family Services Indicator (DFSI-A; Egan et al., 1990; Muir et al., 1989)	A screening inventory that assesses the risk of parenting problems and child maltreatment during pregnancy. It is comprised of a checklist of items, designed to be filled in by health professionals during pregnancy, to indicate the number of potential risk factors for parenting problems and child abuse present within a family.

	The checklist was adjusted and added to by Vreeswijk et al. (2015) in order to include more risk factors predictive of child maltreatment or suboptimal parenting.
State-Trait Anxiety Inventory (Spielberger, Gorsuch, & Lushene, 1970; Spielberger, 1983) Dutch version (van der Ploeg et al., 2000)	Assesses levels of state anxiety (anxiety at the moment of completing the questionnaire) and trait anxiety (dispositional anxiety or anxiety in general)
Edinburgh Depression Scale (EDS; Cox, Holden & Sagovsky, 1987)	Assesses the presence of depressive symptoms. 10-item self-report questionnaire.
Quick Big 5 Inventory (QBF; Vermulst & Gerris, 2005)	Assesses 5 dimensions of personality: extraversion, conscientiousness, agreeableness, emotional stability and openness. Each dimension is represented by 6 items. Each item consists of one adjective on which participants rate its applicability to themselves on a 7-point Likert scale.
IPAT Anxiety Scale (Krug et al., 1976)	Questionnaire assessing anxiety traits/level of anxiety.
2 scales taken from the Parent-Infant Attachment Scale (PFAS; Cranley, 1981)	A 24-item scale, with separate versions for mothers and fathers, which assesses the extent to which parents report affiliative feelings about and interactions with their unborn infants. Two scales were used: the 'attributing characteristics to the fetus' subscale and the total score. The total score can be used as a measure of parents' attachment to their child.
PAAS (Condon, 1993) (Dutch translation by Colpoin, De Munter, Nys & Vandemeulebroecke, 1998)	A 16-item self-report questionnaire constructed to measure father-to-fetus attachment. A global score of father-to-fetus attachment is calculated by combining scores of individual items. Additionally, subscales on quality of attachment and intensity of preoccupation can be calculated.

Synthesis

A Developing Sense of Realness

A common finding across studies was that fathers' representations of their unborn children develop and change as pregnancy progresses. This was particularly apparent in relation to how 'real' fathers perceive their children to be, with many studies finding that the fathers' sense of the reality of the child becomes more pronounced with each advancing stage of pregnancy (Asenhed et al., 2013; Draper, 2002; Finnbogadóttir et al., 2003; Iwata, 2014; Jordan, 1990; Kao & Long, 2004; Sansiriphun et al., 2010; Walsh et al., 2014; Williams & Umberson, 1999).

Different factors were suggested to influence the time-frame and manner of how the child was perceived by the father, and the heightened sense of reality these perceptions imbued. These will be discussed below. The way the child was represented appeared to differ between individuals and the suggested stages were not necessarily experienced in a directly linear manner.

Ways Fathers Represented their Unborn Children

An Abstract Idea

In early stages of pregnancy, shortly after conception, the studies indicated the child was often represented as an abstract concept, an idea or a "diagnosis" (Asenhed et al., 2013; Draper, 2002; Jordan, 1990; Finnbogadóttir et al., 2003). Fathers understood intellectually that the unborn child existed but struggled emotionally to recognise its reality. The lack of the tangible or visible made it difficult for fathers to imagine the child.

"It's more in my head. I know she's pregnant, but there's nothing to feel yet."

(Jordan, 1990, p.13)

"from the beginning it was very unreal.…..it isn't so obvious when it isn't visible so it's not there"

(Finnbogadóttir et al., 2003, p.98)

Fathers in Kao and Long's (2004) study also described how, during this initial stage of pregnancy, the child could be represented as a symbol of love between a man and woman, an achievement of the father and/or a sign of the father's virility.

A Physical Entity

As pregnancy progressed, fathers began to represent their child in a more concrete manner. The child became characterized as an entity that existed in a physical sense, with fathers using descriptors such as a "blob" or "object" to define their children (Draper, 2002; Kao & Long, 2004). The child is not necessarily depicted as a person, and yet it begins to become something beyond an idea.

"Up until then it was just sort of a vague blobby thing that was going to happen seven months away."

(Draper, 2002, p.780)

A Human Being

Later in pregnancy, some fathers were suggested to begin to depict their child as a "baby" or "human being" (Sansiriphun et al., 2010; Finnbogadóttir et al., 2003; Draper, 2002; Jordan, 1990). The child is thought of as looking like a human, with the distinct physical body parts of a typical baby.

"so…a human being is living here inside?"

(Finnbogadóttir et al., 2003, p.100)

However, other fathers were found not to identify with seeing the child as a "full human being" during pregnancy, but rather felt that this stage would not be reached until after birth (Kao & Long, 2004; Jordan, 1990).

"When the baby arrives, I'll be able to hold the baby and play with her, but right now she's not real."

(Kao & Long, 2004, p.65)

An Aware, Interactive Person

As pregnancy progresses, fathers appear to spend increasing levels of time interacting with the child (Iwata, 2014; Kao & Long, 2004; Sansiriphun et al., 2010; Jordan, 1990; Asenhed et al., 2013). This seems linked to fathers' desire to create an intimate link with their child, and their perception that the child is capable of being part of a reciprocal relationship.

Ways in which fathers were found to interact with the child included: playing games (Jordan, 1990; Sansiriphun et al., 2010), having conversations (Asenhed et al., 2013; Kao & Long, 2004; Sansiriphun et al., 2010), making requests of or mock scolding the child (Kao & Long, 2004), singing and reading to the child (Sansiriphun et al., 2010), nicknaming the child (Iwata, 2014; Kao & Long, 2004) and interacting through movement (Asenhed et al., 2013; Kao & Long, 2004; Jordan, 1990).

"I read stories, sang to the baby."

(Sansiriphun et al., 2010, p.407)

"My heart feels warm when I talk to him…I feel like it's listening to me seriously and then he looks at me with a pair of curious eyes."

(Kao & Long, 2004, p.66)

Fathers were found to describe the child responding to their touch as a form of communication. Others spoke about how the child would listen to them when they asked them to start or stop moving (Asenhed et al., 2013; Kao & Long, 2004; Jordan, 1990).

"It's nice now…actually making contact with the baby…You can push its foot and it will push back"

(Jordan, 1990, p.14)

It was suggested that many fathers felt uncomfortable talking to the baby at the start of pregnancy but became more comfortable in doing so as pregnancy advanced (Kao & Long, 2004; Sansiriphun et al., 2010).

"When he first began to move, I didn't want to talk to him at all, because he was just moving a bit. But when he begins to move vigorously, I feel like, strange, no, over-awed, and he seems to know that. So then I start talking to him."

(Kao & Long 2004, p.66)

Some fathers spoke of continually struggling to express their love for or communicate with the child. This was suggested to be particularly the case for fathers who did not perceive the child as a human being during pregnancy, with some stating they would not interact until after the birth (Kao & Long; 2004).

"my wife often complains that I don't care about my unborn girl. I won't listen to her heartbeat or look at her belly movements at home. The reason is, I don't know how to do that. It seems strange to me…I feel it isn't necessary to do that…I can't see the baby so I can't make believe all those gestures."

(Kao & Long; 2004, p.65).

A Part of the Father

Another suggested aspect of fathers' representations is the viewing of the child as a part of them or a reflection of an aspect of themselves and/or the mother. Fathers were found to differentiate characteristics of the child that they felt came from themselves and form ideas of who the child resembled in appearance and character (Williams & Umberson, 1999; Finnbogadóttir et al., 2003; Walsh et al., 2014).

"like a piece of you is just about to be here."

(Walsh et al., 2014, p.26)

"And the long legs were good because that's what I have and (my wife) doesn't so that's a little bit of me."

(Williams & Umberson, 1999, p.156)

A Family Member

Similarly, during pregnancy, fathers were suggested to begin to see and talk about the child as a member of the family (Draper, 2002; Jordan, 1990; Walsh et al., 2014). The system of the 'two' parents becomes one of 'three' people (Finnbogadóttir et al., 2003).

"seeing the baby on the screen…really made it clear that we're going to have another member of the family."

(Walsh et al., 2014, p.25).

"it's already pretty well been accepted as a member of the family."

(Jordan, 1990, p.14)

A Vulnerable Being

Fathers were found to use words such as “small”, “delicate,” “little” and “weak” to describe their unborn children, giving suggestion of them being vulnerable to harm (Finnbogadóttir et al., 2003; Sansiriphun et al, 2010). They spoke about a desire to protect and nurture the child (Sansiriphun et al. 2010).

“*I do my best to protect my baby form all dangers”*

(Sansiriphun et al., 2010, p.406)

A Future Child

Alongside conceptualising the unborn child in its current state, across the stages of pregnancy fathers appeared to represent the child as the ‘future child’ they hoped it would one day become.

Jordan (1990) found that, in early pregnancy, the father may envision an older child who is mobile, interactive and capable; a child aged four or six as opposed to a fetus or newborn. Other studies talked about the imagining of a “potential person” later in pregnancy, with some fathers describing their imaginings focusing on the immediate future of infancy, whilst others describing these extending across the child’s lifespan (Asenhed et al., 2013; Sansiriphun et al., 2010; Walsh et al., 2014; Jordan, 1990; Kao & Long, 2004; Draper, 2002).

Fathers were found to imagine how the child might impact on their own life once it was born, fantasising about who the child might be, how they might relate to each other and experiences they might share (Asenhed et al., 2013; Sansiriphun et al., 2010; Kao & Long, 2004; Draper, 2002; Walsh et al., 2014).

“there is something in there that’s going to come out and we’re going to have to cope with it”

(Draper, 2002, p.786)

"I think about the child's future most of the time. I wonder what I could add to her life."

(Kao & Long, 2004, p.66)

Finding out whether the child was a girl or boy was suggested to play a large part in father's ability to imagine their future child. This knowledge appeared to lead to the expansion of hopes and dreams for the child and the relationship they will share (Walsh et al, 2014; Kao & Long, 2004).

"As soon as we found out, she told us it was a girl, then all these thoughts started running through my head about, you know, a girl and bringing up a daughter."

(Walsh et al., 2014, p.25)

Someone with a Specific Temperament or Personality

Multiple studies found that fathers often perceive their unborn child as having a certain temperament, personality characteristics or preferences. These seem to become more common as the pregnancy advances, and the representations of the child move towards human-ness (Zeanah, Zeanah & Stewart; 1990; Zeanah et al., 1985; Zeanah, Carr & Wolk, 1990; Kao & Long, 2004). Zeanah et al. (1985) found that fathers' descriptions of their child's personality were predominantly positive, although they did not analyse what made fathers more or less positive about the child.

"Quiet. Generally warm. Sensitive. Given to deep, emotional feelings. More of a quiet kind of child. Reflective."

(Zeanah et al., 1985, p.208)

Studies did suggest individual differences in whether a child was perceived to have a personality, with not all fathers being found to believe their child did (Zeanah, Zeanah,

& Stewart, 1990; Zeanah et al., 1985; Zeanah, Carr & Wolk, 1990). There was also suggested to be individual differences in how balanced fathers' representations of their children were, with studies suggesting roughly half of fathers held unbalanced representations of their children (Vreeswijk et al., 2014a, 2014b, 2015).

Factors Influencing Fathers' Representations of the Unborn Child

Pregnancy Test or Doctor's Diagnosis

The ceasing of the mother's periods and changes to the mother's body was suggested to be acknowledged by fathers to be a sign of the child's existence (Jordan, 2002). However some fathers described waiting for the pregnancy test, or doctor's diagnosis, before they began to think of the child being real. 'Evidence' of the child's existence was seen to be important, with confirmation from the doctor being seen as greater evidence than that gained from a pregnancy test (Draper, 2002; Jordan, 1990).

"My experience is that there is a child that is supposedly happening. All we have is this test that is pretty reliable. ..although I was ecstatic when she showed me the test, I don't see anything happening yet. It's all for her, and I feel like I probably won't get on board…until I hear it from the doctor"

(Jordan, 1990, p.13)

Fetal Characteristics

Seeing and feeling the fetal movement was another factor that was found to influence fathers' representations, increasing their perceptions of the child's reality and fostering a sense the child could communicate and interact (Asenhed et al., 2013; Walsh et al., 2014; Williams & Umberson, 1999; Finnbogadóttir et al., 2003; Draper, 2002). Fathers' perceptions that the child would respond to their touch, or change its movements based

on request, was suggested to reinforce beliefs the child was aware and interactive (Kao & Long, 2004; Jordan, 2002).

"I say, 'baby, be nice, do not move so vigourously'"

(Kao & Long, 2004, p.66)

Kao and Long (2004) suggested that movements were taken to mean that the fetus was healthy. It was also found that some fathers considered the strength or type of the fetal movement to be indicative of their child's temperament and personality (Kao & Long, 2004; Zeanah, Carr & Wolk, 1990). Interestingly, Zeanah, Carr and Wolk (1990) found that the actual frequency of fetal movements did not impact on fathers' perceptions of their infants' temperament. However, fathers perceiving their child to be more active was associated with them perceiving their infant to have a more adverse temperament.

Hearing the fetal heartbeat (Jordan, 2002; Walsh et al., 2014; Williams & Umberson, 1999) and gaining knowledge about how the unborn baby was likely to be developing (Sansiriphun et al., 2010), such as when their limbs or sensory organs would be developed, were also factors suggested to influence how real and human-like the child was thought of as being.

Ultrasound Scans

In multiple studies, the ultrasound scan was found to be an important milestone in increasing the sense of reality of the child and changing the way the child was represented (Asenhed et al., 2013; Walsh et al., 2014; Williams & Umberson, 1999; Finnbogadóttir et al., 2003; Draper, 2002; Jordan, 2002).

"I think the scan was the point at which erm I really felt it's my child in there."

(Draper, 2002, p.782)

Ideas surrounding "evidence" and "proof" that the baby existed were again discussed. The visual aspect of scans allowed fathers to gain access to the unborn child in a way that had not been available before, and was suggested to facilitate fathers' ability to create a mental image of their child (Asenhed et al., 2013; Walsh et al., 2014; Williams & Umberson, 1999; Finnbogadóttir et al., 2003; Draper, 2002; Jordan, 1990). The reality boost of the ultrasound was found to be salient to both men expecting their first child as well as for those who were already fathers (Walsh et al., 2014).

"realizing that it was actually happening. I mean, that was proof positive. Saying, okay, you can't argue it anymore."

(Williams & Umberson, 1999, p.156)

"Obviously she's pregnant, but when you actually get to see it you're like holy cow, you know I'm going to be holding that thing in my arms in like you know six months or less… for me, to be able to like, see it…definitely makes it more tangible or real"

(Walsh et al., 2014, p.25)

This was suggested to be a time when the physical characteristics of child (such as having ten fingers and tens toes) were highlighted to fathers and incorporated into their representations (Walsh et al., 2014; Williams & Umberson, 1999; Draper, 2002).

"the most amazing thing I've ever seen in my life…the baby's foot, the baby's hand, the baby's heart, the baby's face."

(Walsh et al., 2014, p.26)

Learning the sex of the child (or even just imagining whether the baby was a boy or a girl) was also described as increasing the reality of the child and helping to create a clearer mental picture of it (Walsh et al., 2014; Iwata, 2014).

"I definitely think finding out the sex makes it feel more real. Makes it feel more like a person."

(Walsh et al., 2014, p.25)

For some fathers, the event of the ultrasound was found to bring with it the realisation that the child had the potential to be healthy or unhealthy; with the possibility that something could be wrong being brought into the forefront of consciousness (Draper, 2002; Williams & Umberson, 1999). Whilst for some this awareness was found to be present prior to this point (Kao & Long, 2004; Finnbogadóttir et al., 2003; Asenhed et al., 2013), the scan was still suggested to be a means of providing reassurance.

"Erm, because you start thinking 'shit you know, this could be a problem'. It's at this stage that we might find out there's something wrong."

(Draper, 2002, p.787)

This reassurance was suggested to allow fathers to engage more heavily in a near-tangible perception of the reality of the child and deepen their emotional connection with it (Asenhed et al., 2013; Finnbogadóttir et al., 2003; Walsh et al., 2014; Draper, 2002).

"we have a normal size kid, ten toes and ten fingers and four chambers of the heart and I can continue being happy and excited and start thinking about all those fun things about being a dad."

(Walsh et al., 2014, p.25)

Fathers' representations of their children were found to become more person-centred at this stage and it was suggested they may also be more likely to be accepting of potential developmental problems with their child. A father in Finnbogadóttir et al.'s (2003) study spoke about how:

"even if the baby isn't 100% healthy, then I will still love it 100%"

(Finnbogadóttir et al.'s, 2003, p.102)

Father Characteristics

Multiple factors relating to the fathers' own characteristics were suggested to influence their representations of their unborn children, although findings in this area were not always consistent. Some studies suggested that fathers who had a lower social class (Zeanah, Carr & Wolk, 1990) and/or had pre-existing children (Vreeswijk et al., 2014b, 2015) were more likely to rate their child's personality more adversely or have a more unbalanced representation of their child. In contrast, Vreeswijk et al. (2014a) did not find an association between fathers' representation style and the presence of existing children. However, they did find the presence of existing children impacted negatively on fathers' attachment and intensity of preoccupation with the fetus. Additionally, they found that greater attachment to the fetus was linked to higher quality representations of it; a finding also supported by Vreeswijk et al., (2015). In comparison with the suggested link between attachment and representation quality, Vreeswijk et al. (2014a) did not find a correlation between the intensity of father's preoccupation with the fetus and representation style, perhaps suggesting it is the quality of the thought that is significant rather than the amount of time spent thinking about the child.

Interestingly, the only conflicting findings between studies were within those involved in the same overarching longitudinal study, suggesting a possible methodological influence on the discrepancy. Potentially, the use of the WCMI interview, which divides fathers

into discrete categories of representations, may be less susceptible to more subtle effects of influencing factors. This may, therefore, make it more difficult to identify significant differences in relation to the impact of particular factors on fathers' representations. The prenatal attachment measure used by Vreeswijk et al. (2014a) was a self-report questionnaire which provides a continuous scale of scores of attachment, perhaps making it easier to establish significant difference between individuals.

Discussion

Examination of existing literature suggests fathers' representations of their unborn children are dynamic and evolving; with fathers seeing children as more real, human, and complex as the pregnancy progresses. The start-point of this review was centred within the argument that particular cognitive skills, such as the ability to mentally conceptualise, fantasise and see oneself as attached to the fetus, are a necessary pre-requisite to fathers developing prenatal attachment (Zimerman & Doan, 2008; Doan & Zimerman, 2008). Fathers' ability to utilise these skills during pregnancy does appear to be evident within the review's findings. However, it is suggested there are important processes and impediments fathers must navigate in order for these skills to be effectively utilized in developing their representations of their unborn children.

Specifically, the analysis suggests fathers are faced with an ontological uncertainty during pregnancy. The reality of the unborn child is presented as ambiguous, with the father viewing the child as simultaneously both present and absent, real and unreal. This position is linked to an epistemological uncertainty; through simultaneously existing and not-existing, the child becomes simultaneously knowable and unknowable. The review's findings support that these two uncertainties are intertwined; fathers' perceptions of the child as real develop as they gain increased knowledge about the child. The literature suggests a hierarchy in regards to which forms of knowledge are considered most valuable

by fathers in increasing their confidence in the child's reality and in shaping their representations of it.

This can be understood in relation to Jordan's (1997) definition of authoritative knowledge; the idea that one form of knowledge is given ascendancy over others. This concept has been used to understand the tendency for individuals to give greater weight to professionals' medical knowledge of pregnancy than to mothers' embodied knowledge of it (Duden, 1993; Sandelowski, 1994). This inequity appears to be replicated in the current findings; with fathers reporting a greater impact of a doctor's diagnosis over their partner's embodied knowledge, in regards to their developing more complex and concrete representations of their children. However, the findings also suggest that both these ways of knowing have limited impact on fathers' perceptions of their child as real in comparison to the other factors, with representations linked to these types of knowledge referencing idea and object as opposed to person or child.

Fathers' personal perceptual experiences appeared to be more highly valued. In particular, the visual knowledge imbued by the ultrasound was cited by many fathers as a major transformative factor of their representations of the child. Jenks (1995) argued that society tends to privilege visual knowledge due to perceiving it to be more objective. He suggested that seeing is often conflated with knowing and, as such, that which can be observed is often perceived as more 'factual' than that which can be alluded to. Indeed, the literature here demonstrates that fathers often used words such as "proof" and "evidence" when describing the experience of seeing the fetus on an ultrasound image. Through the advent of ultrasound technology, the image of the fetus permeated society, leading to the development of wider discourses surrounding the potentially interchangeable notions of fetus and person (Palmer, 2009; Mitchell, 2001). It is possible these associations mean that when fathers see the fetal ultrasound image they more readily

associate the presented child as having personhood. Additionally, the attribution of gender and health status is suggested to add to these human connotations.

An alternative form of perceptual knowledge, feeling the movement of the fetus, was also suggested as a key factor in fathers perceiving the child as more real. Interestingly, this form of knowledge appeared to be viewed as equally influential as the visual knowledge of the ultrasound. This finding is potentially related to perceptual knowing's relationship to the ability to imagine. Sensory information is suggested to be a prerequisite of imagination (Sartre, 2013).

Sartre (2013) suggested that imaginary objects represent an integration of not only our knowledge of objects but also what we intend them to be. Additionally, imagination permits distancing from the present (Preston, 1991). This ability to utilise imagination is suggested to be linked to the review's findings that fathers represented the child not only in the present but also as the future child they hoped it would become. As such, it is suggested that a father's imaginings of the child may enable more complex representations by permitting the child to move beyond the physical being into personhood. It can thus become positioned within the family unit and/or be seen as a part of the father, helping to move the unborn child from "fetus" to "my baby" or from "us" to "we" (Black, 1992; Weir, 1998).

Additionally, as suggested within fathers' descriptions of their experiences within the review literature, once personhood is assigned to the baby, a natural progression is to endow its action with deliberate intent or consciousness (Mitchell, 2001; Roberts, 2012; Sandelowski, 1994). As such, what at first might be a purely perceptual experience of the moving foot of a fetus, becomes a purposeful attempt of a baby to communicate with its father. This attribution of intent creates the opportunity for a relationship between beings (Büscher & Jensen, 2007; Sandelowski, 1994). It is argued that a prerequisite of a father viewing this reciprocal relationship as possible is their representing the child as real. One

of the findings of the review was that fathers' knowledge about the unborn child's physical development, such as when their sensory organs were formed, influenced how real or human the child was represented as being. It is suggested that this information may link to fathers' ability to imagine or believe that their child can sense and communicate with them. Additionally, it is suggested the combination of representations of present baby with conscious volition and future child and family member may encourage fathers to ascribe specific personality traits, temperament or emotions to the child.

The review does suggest some nuances across fathers' representations of their unborn children, with individual differences being present in both the time-scale and content of the representation. This includes findings that some fathers were found to have more negative representations than others. However, there was limited investigation into the cause of individual differences. Potential negative influences included lower social class and the presence of existing children. However, the limited nature of these results prevents any firm conclusions being drawn. Given the suggested connection between cognitive representation and attachment (Doan & Zimerman, 2007; 2008), creating a clearer picture on which factors are most influential may enable the development of more focused interventions from professionals to promote positive representations, which may in turn encourage higher quality attachment.

The findings of the review suggest that fathers do actively mentally represent and fantasise about their unborn children as distinct people. It is proposed that fathers also interact with, and show caring behaviours towards, the child, suggesting an ability to empathise with it as a theorised other. These cognitive process are in line with those suggested to be necessary for the development of prenatal attachment (Zimerman & Doan, 2008; Doan & Zimerman, 2008) and therefore provide added evidence to the ability of fathers to form prenatal attachments with their children. Whilst limited in its scope, there

was some evidence in the review's findings suggesting that fathers' attachment to the fetus was interrelated to their representations of it.

Comment on Studies

The identified studies were heterogeneous in relation to their aims, methods and measures. Fewer than half had an explicit aim of exploring how fathers represent their unborn children and these studies varied in how representation was conceptualised and measured. Interestingly, all studies that held a specific aim in relation to investigating fathers' representations of their unborn children included a quantitative element, with those also utilizing qualitative analysis methods using a reductionist form of coding and descriptors. The predominant conceptualisations of these studies focused on representation quality or how fathers viewed their children in relation to dimensions of personality.

Multiple studies used questionnaires utilizing specific concepts related to representation, potentially biasing the results. Such measures (e.g. the SITA or ICQ) assume that fathers have, for example, already formed a representation of their unborn child's personality or a mental picture of their future child. Additionally, the utilization of modified questionnaires originally designed for postnatal use creates an assumption that children are represented prenatally in a similar manner to that which they are postnatally, potentially biasing results. For the remaining studies, findings on fathers' representations were presented as a by-product to an investigation of a larger whole. Whilst this highlights the paucity of research specifically looking at fathers' representations of their unborn children, the lack of consistency and clarity of the concepts measured/studied makes comparisons difficult. Three studies had a specific aim to explore fathers' experiences in relation to medical technology (particularly ultrasound technology). There is potential that this led to inflation of this technology's significance in relation to other factors discussed with the review.

Whilst overall, included studies had good quality ratings, this review did highlight limitations in the literature. Most studies were dependent on parent volunteer sampling, with a number of studies accessing fathers through, or in conjunction with, their partners. This may have led to sample biases, as less engaged fathers may have been less likely to be invited by spouses, or available/willing to be approached by researchers. Given fathers' level of engagement may link to their representations, this may have created an absence of examination of a portion of the father population where individual differences may present.

Despite evidence that fathers' representations shifted as pregnancy progressed, there was little acknowledgement in the studies of the influence of the time-point of data collection, with these sometimes being unclear or amalgamated. It seems likely the trimester during which data is gathered would have an influential effect and needs to be considered in greater detail. Lastly, there was found to be little contrasting findings within the studies. Whilst this is possibly an accurate reflection of the data, it may be that the heterogeneity of the studies prevented direct comparison of studies investigating similar concepts or factors.

Clinical Implications and Future Directions

Involving and engaging fathers in aspects of antenatal care, especially occasions linked to access to perceptual information relating to the child, and ensuring fathers have access to knowledge about their child's development, is clearly vital for the promotion of positive representations. Healthcare professionals should encourage fathers to think about and interact with the child, facilitating them to imagine both fetus and future child. The fact that fathers' representations were found to progress across pregnancy suggests they are open to change. If fathers can be identified as having poor or limited representations of their unborn children then appropriate interventions should be put in place to assist fathers to develop these, optimizing the potential to benefit father, fetal and family

outcomes. It may be beneficial for health professionals to specifically ask fathers about their thoughts and feelings about the unborn child during antenatal appointments in order to assess if intervention may be beneficial. Although further research is needed in relation to how representations link to father-child attachment, it is suggested that fostering complex and positive representations may improve this attachment relationship.

The review highlighted a number of avenues for future research. As there is a shortage of research utilizing clear conceptualisations of fathers' representations of their unborn children, it would be suggested that exploratory qualitative research be undertaken specifically investigating this area in order to identify whether there are other aspects of these representations that current research is overlooking. As the review suggests that different forms of knowledge influence fathers' representations, it may be valuable to utilize quantitative research that compares the impact of different knowledge bases on fathers' representations, and whether there are specific features of these they affect. Additionally, research should investigate at what point in time during pregnancy access to these knowledge bases may have the most positive impact.

There is clear need for research that investigates how fathers' representations of their children relate to parent-child attachments and to family outcomes, interactions and health practices, as well as research concentrating on less engaged/accessible fathers. Longitudinal designs should be implemented to augment our understanding of the predictive value of these representations as well as precipitating factors to them (such as attachment history or mental health). Research into how fathers' representations influence, and are influenced by, systemic factors (such as the mother-father relationship) would be valuable. Additionally, studies looking at how mothers' and fathers' representations differ, and what impact any differences may have are recommended.

Strengths and Limitations

This is the first review synthesising a diverse strand of research in this area, enabling a number of important clinical implications to be identified that require further consideration. The number of papers focusing solely on fathers' representations was limited. However, the applied search identified a number of studies incorporating this element as a supplementary finding. Therefore, despite the thorough and systematic search strategy, it cannot be guaranteed that some studies containing relevant findings were not missed. The findings are constrained by a small body of literature employing a diversity of designs and measures, making it difficult to draw firm conclusions at this stage.

Conclusions

In conclusion, the review suggests that fathers perceive their children to be progressively more real as pregnancy advances and they are presented with new forms of knowledge about the child that they can incorporate into increasingly complex representations. Perceptual knowledge was suggested to be particularly influential due to its impact on fathers' ability to imagine the child, enabling the development of ideas around the child having personal volition. This is the first review to examine fathers' representations of their unborn children and identifies pertinent implications for service delivery of antenatal care.

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Part 2: Empirical Paper

This Paper is written in the format ready for submission to the *Infant Mental Health Journal.*

See Appendix B for submission guidelines.

Total word count: 9,858 (excluding abstract, tables, references and appendices)

A Narrative Exploration into Fathers' Experiences of the Perinatal Period when Maternal Mental Health Problems are Present

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Abstract

Previous research conducted on fathers' experiences of the perinatal period when maternal mental health problems are present suggests fathers can find this time to be emotionally overwhelming and frustrating. Whilst research suggests that families can experience both positive and negative outcomes in relation to these experiences, there is little research on the factors or processes contributing to differential outcomes. This research aimed to identify these factors. The study used a narrative approach to analyse forty fathers' stories of their experiences of the perinatal period when maternal mental health problems were present. Both elicited and pre-existing online stories were included. A holistic analysis of form identified three distinct Plot Themes representing fathers' experiences. 'Restorative' stories ended following a period of positive trajectory where the writers held optimistic hope for the future. 'Helpless Hoping' and 'Hopeless' stories both ended following a period of negative trajectory, when the writer's evaluation of events was considered to be negative. However, within the 'Helpless Hoping' stories the future felt uncertain and hope remained for a potential positive future. In contrast, in the 'Hopeless' stories this hope appeared lost. A holistic content analysis found that the manner in which the characters and systems of the stories interacted was a key factor in the categorisation of the stories' Plot Themes and their outcomes. Fragmentation of the system, most especially of the couple unit, was found to contribute to negative story trajectories. The research supports the use of systemic models of care in relation to providing support and preventative action surrounding perinatal mental health problems.

Keywords: fathers; perinatal; maternal mental health; narrative research; family resilience

Introduction

Becoming a first time parent is a major life transition for both mothers and fathers that brings with it profound change (Chin, Hall & Daiches, 2011; Deave & Johnson, 2008; Barclay & Lupton, 1999). Although often considered a time of happiness, this transition can bring increased stress and may cause strain to existing relationships (Cowan & Cowan, 1995; Miller, 2011; Anderson, 1996). These experiences can be further complicated by the presence of maternal mental health problems. For some, mental health problems may arise for the first time during the perinatal period, for others, there may be a recurrence of a pre-existing condition (Paschetta et al., 2014).

Perinatal Mental Health Problems (PMHPs) in Mothers

It is estimated that 15% of women will experience mental health problems during pregnancy (NHS Commissioning Board, 2013) and that the majority of women who experience severe mental illness will have at least one pregnancy (McGrath et al., 1999; Howard, Kumar & Thornicroft, 2001). Studies suggest postnatal depression affects between 10-15% of women in western countries (Dennis & Hodnett, 2007; Robertson, Grace, Wallington & Stewart, 2004), with up to 19% and 13% of women experiencing some level of depression or anxiety disorder within the perinatal period respectively (Howard et al., 2014). Puerperal psychosis is suggested to affect 1-2 women in every 1000 (Sit, Rothschild & Wisner, 2006). In the U.K., suicide is the second leading cause of maternal death and costs of PMHPs are estimated at £8.1 billion for each annual birth cohort (Mental Health Taskforce, 2016). Research suggests a mother experiencing PMHPs can have an adverse effect on her child's social, behavioural, cognitive and physical development (Cornish et al., 2005; Downey & Coyne, 1990). Identifying and supporting mothers who may need mental health support is clearly vital.

The Father's Role

Research suggests mothers who experience depression in the postnatal period are more likely to turn to, and receive support from, their partner than any other individual (Holopainen, 2002). Low levels of partner support are associated with increased risk of mothers experiencing emotional distress, anxiety and depression within the perinatal period, and a greater length of time spent within perinatal support services (Dennis & Ross, 2006; Stapleton et al., 2012; Akincigil, Munch & Niemczyk, 2010; Milgrom et al., 2008; Grube, 2005).

Importantly, some studies suggest that fathers can moderate the impact of maternal postnatal depression on children (Cabrera, Fitzgerald, Bradley & Roggman, 2007; Chang, Halpern & Kaufman, 2007; Edhborg, Lundh, Seimyr & Windstrom, 2003; Cabrera, Fitzgerald, Bradley & Roggman, 2007). However, other studies have not found this positive moderation effect, with some finding that the presence of maternal PMHPs actually negatively impacts on the father-child relationship (Goodman, 2008; Mezulis, Hyde & Clarke, 2004).

Research suggests fathers are more likely to experience PMHPs if their partner also does (Paulson & Basemore, 2010; Goodman, 2008). Additionally, existing literature suggests fathers can be reluctant to seek help from others, both in relation to their own and their partner's PMHPs (Doucet, Letourneau & Blackmore, 2012; Wyatt, Murray, Davies & Jomeen, 2015; Tammentie, Paavilainen, Åstedt ‐ Kurki & Tarkka, 2004). Furthermore, fathers often report feeling unhappy with the level or type of support that is provided and/or excluded or patronised by services (Doucet et al., 2012; Wyatt et al., 2015; Bradley, MacKenzie & Boath, 2004).

Existing Literature on Fathers' Experiences

Research in relation to fathers' experiences of the perinatal period in the presence of maternal PMHPs is scarce. Existing research focuses on the postnatal period, specifically in relation to postnatal depression and puerperal psychosis. These studies suggest fathers experience a range of heightened emotions in relation to their partner's PMHPs, including anger, fear, frustration and loneliness (Engqvist & Nilsson, 2011; Morgan, Matthey, Barnett & Richardson, 1997; Meighan, Davis, Thomas & Droppleman, 1999; Webster, 2002; Davey, Dziurawiec & O'Brien-Malone, 2006). In terms of the couple relationship, fathers have described feeling criticised, undermined and unappreciated by their partner, sometimes to the point of feeling irreparable damage has been done to the relationship (Morgan et al., 1997; Meighan et al., 1999; Webster, 2002; Davey et al., 2006). A study by Beestin, Hugh-Jones and Gough (2014) found fathers felt their manner of fathering was negatively impacted upon by their partners' postnatal depression. Despite the majority of findings citing negative changes to the partner relationship as a result of maternal PMHPs, some studies have reported positive changes to the relationship, such as feeling more strongly connected to each other (Wyatt, et al., 2015; Tammentie et al., 2004).

Fathers Experiences and Online Narratives

Narratives from the internet can be seen as a form of personal communication that stand as a naturalistic form of data, unsolicited (and uninfluenced) by the researcher. The anonymity of the online context means individuals may be relatively unselfconscious about what they write. As such, online platforms may provide a safe environment for feelings and frustrations to be shared openly (Nardi, Schiano, Gumbrecht & Swartz, 2004; Hookway; 2008). Accounts can be written by the individual in a manner that is chosen by them and suits their needs, often very informally. This may permit the transmission of a depth of feeling that is less usual in formal communication or that may be harder for an

individual to articulate or feel comfortable expressing during a face-to-face interview (Robinson, 2001; Eastam, 2011).

A study by Engqvist & Nilsson (2011) used content analysis to examine eleven online narratives written by fathers in relation to their experiences of a partner's postpartum psychiatric disorder. Concurring with previous literature, they found fathers expressed fear, confusion, anger and helplessness in relation to this time. Fathers described often making sacrifices in order to hold the family together, and struggling to cope with a perceived transformation of their partner. Despite some men describing positive outcomes of their perinatal experiences (such as gaining maturity and self-esteem) others wrote about the experience ending in divorce and loneliness. What led to these different outcomes was unclear.

Overview and Rationale of the Current Study

Existing literature appears to focus solely on the postnatal period, meaning there is a gap in the literature in relation to fathers' experiences of maternal mental health problems during pregnancy. The majority of existing studies focus only on the experiences of postnatal depression or puerperal psychosis. Other types of PMHPs are currently understudied in relation to their impact on fathers. Therefore, the current study aims to explore fathers' experiences of the perinatal period when the mother of their child experiences PMHPs (of any kind) and which arise at any time before or during this period.

As previous research suggests fathers can often feel isolated, patronized and/or undermined during this period, the current study used a narrative approach in the hope that it would allow access to fathers' own stories. Such an approach attempts to exert as little influence from the researcher as possible and will allow insight into what these men themselves perceive to be of significance during this period. The author is unaware of any research in the area that has utilized narrative analysis.

The use of narrative analysis may also support investigation into the way fathers structure and story their experiences of the perinatal period, and the impact this has. There is a lack of research into reasons that some fathers report positive outcomes of their experiences of their partner's PMHPs whilst others report only negative consequences. Discovering factors that promote father and family wellbeing, and help avoid family breakdown, may inform services how they can best support families within the perinatal period, and improve understanding of a group of men who often report themselves to be disengaged or disillusioned with services (Doucet et al., 2012; Wyatt et al., 2015).

Since Engqvist & Nilsson's (2011) study, a wider data set of narratives have become available online. Therefore, the current study intends to use existing internet narratives alongside primary narratives generated within the study.

The research questions are;

1. What are the narrative experiences of fathers during the perinatal period when maternal mental health problems are present?
2. What can fathers' narratives tell us about the factors that influence men's positive or negative evaluations of this period and/or the factors that may lead to positive versus negatives outcomes for these men and their families?
3. What can these narratives tell us about the support that is needed for these men and their families during this time?

Method

Design

An exploratory qualitative narrative approach was used to investigate fathers' experiences. A combination of elicited and existing online narratives formed the data set. Both the

holistic form and content of the narratives were explored (Lieblich, Tuval-Mashiach & Zilber, 1998; Josselson, 2011). An anonymous online survey method was chosen in the hope this would increase the potential pool of participants and decrease the level of researcher influence on stories provided. This format was also hoped to be more accessible to men who may find it difficult to talk about their experiences. This study was granted full ethical approval, and no special ethical requirements were required for the use of pre-existing online stories in line with current guidelines (Ess, 2002; Robinson, 2001; Hookway, 2008; Eastham, 2011; BPS, 2013).

Participants

Participants were men whose partner had experienced PMHPs. As research suggests postnatal depression can persist beyond two years (Goodman, 2004), the parameters of the perinatal period were defined as spanning the year prior to, and two years after, the child's birth. No restrictions were placed on the type of mental health problems experienced. Specifically, it was asked that stories related to the participant's experience of having their first child. The child was required to be both parents' first child. Children were not considered to be first children if their birth was preceded by the mother experiencing miscarriage or ectopic pregnancy. The child had to currently be under ten years old. Participants were ineligible if English was not their first language, if they were under the age of 18, or if they did not class themselves to have been in a relationship with the mother of their child for at least eight weeks within the perinatal period.

Procedure

Following Ethical approval, an online survey was created and run using the Bristol Online Survey Programme (https://www.survey.bris.ac.uk/). A link to the survey was posted to a variety of social media platforms (Twitter, relevant Facebook groups, Community Forums), alongside a brief overview detailing the research (Appendix G). Additionally,

charities and non-NHS services related to perinatal mental health or support for fathers were asked to advertise the study on their websites and social media platforms, as well as via poster and word-of-mouth. A website providing details of the study was also created and advertised alongside the survey (www.dadsstoriesproject.wordpress.com; see Appendix H). The survey was advertised for a 6-month period with frequent 'boosts' from the researcher.

The survey contained the study information sheet (Appendix I) an informed consent form (Appendix J), a demographic questionnaire (Appendix K) and the study instructions.

Participants were presented with a short piece of instruction in order to guide their story production (see Appendix L). These instructions were designed to be as non-directive as possible, whilst still providing participants with some context to the task at hand. No word limit was applied to the stories. Participants were provided with the option to write (by hand or online) or audio-record their story. The story and forms could be submitted anonymously online or via post.

Despite exhaustive attempts employing a range of approaches to data collection, only two narratives were submitted via the online survey. It became clear during the course of the research that there were a number of existing narratives on online platforms. Therefore, the decision was made to utilize existing online narratives within the study.

Pre-existing Online Narratives

Procedure

To identify relevant narratives, the following search terms were inputted into the search engine Google in a variety of combinations: (story, stories, narratives or experience) and (father or dad or supporting or caring or partner) and (postpartum or postnatal or perinatal

or antenatal or pregnancy) and (mental health, depression, PND, anxiety, OCD, bipolar, anorexia, eating disorder, puerperal psychosis or schizophrenia). For each search, the first four pages of results were examined for suitable narratives. Websites and forums dedicated to supporting fathers surrounding perinatal mental health issues were also searched.

Participants

Narratives were included only if they were deemed to meet the eligibility criteria outlined above. Additionally, narratives consisting of less than 14 lines of text (or 200 words) were excluded as it was felt that shorter stories did not provide rich enough data to be informative to the study's research questions. Narratives were taken from eight sites. Of these, three were American, two Australian, two British and one Canadian. All narratives were anonymised and pseudonyms given to participants to limit the ability for quotes to be traced back to their original source.

Data Analysis

A holistic-form and holistic-content analysis was applied to the data. The dimension of *form* versus *content* refers to analysis that concentrates on either *how* it is told or *what* is told. For example, form may refer to the structure and overarching sense of the story, whilst content may refer to what happened in the story, why it occurred, and the role of different characters (Lieblich et al., 1998). Throughout analysis, narratives were read in the context of the hermeneutic circle, considering how the whole illuminates the parts, and how the parts in turn offer a deeper picture of the whole (Josselson, 2011).

The analysis method consisted of four stages. The first stage consisted of initial readings where the researcher considered tone, use of imagery, metaphor, emotive language and phrases explicitly directed to the reader, in order to generate a general impression of the text and what it appeared to wish to convey. This component is common to many methods of qualitative data analysis (see Riessman, 2008; Strauss and Corbin, 1990; Bruner, 1991).

The next two stages consisted of the holistic-form analysis (see Appendix M). This analysis initially centred on identifying narratives' Plot Phases. Following a similar model to Lieblich et al. (1998), the events, themes, characters, emotions, issues, and actions significant to the telling of the story were identified. At this stage, the story content was viewed only in so far as it guided the plot of the narrative. The plot refers to the central organising element that shapes the narrative events into a coherent whole (Ricouer, 1991). In line with methods of Gergen and Gergen (1988), the plot was viewed in relation to the story's end-point and events were identified that contributed to this end-point. Additionally, the researcher identified causal links and demarcation signs of where one event finished and another began. The researcher then wrote a brief vignette of each story outlining the basic plot and its phases in temporal order. Individual graphs were developed for each narrative based on a combination of the story's descriptions of each phase and the teller's evaluative comments, and emotion displayed, at these phases (Lieblich et al., 1998). The graphs were then compared and a prototypical graph was created that included all phases identified across stories (Lieblich et al., 1998).

The next stage centred on identifying Plot Themes. Here, the individual graphs were used to examine differences and similarities in the stories' structure relating to narrative form. Narrative forms delineate the flow of the narrative over time (Riessman, 2008). The researcher drew on methods similar to Fyre (1957), Gergen and Gergen (1988), and Frank (2013) to identify plot forms. However, the analysis did not restrict story categorisation to existing plot forms in order to retain the essence of the data. The forms were analysed in relation to the number of phases identified within each story, with particular attention given to the ending phase and outcome of the story. Alongside this process, the function of the story and intention behind it was identified (Bruner, 1991). The plot form and functions of the stories were compared and contrasted to encompass both general and individual aspects of the stories. From this analysis, Plot Themes were identified. Plot

Themes categorised the stories in relation to the overall impression of the form of the narrative in combination with the meaning of the story and what it attempted to convey.

The final section of analysis focused on a holistic-content analysis (Lieblich et al., 1998) where the essential themes and insights within the stories were identified (Beal, 2013) (see Appendix N). This incorporated identifying how characters were presented and how they interacted and performed functions within the narrative (Greimas, 1983). Colour coded highlighting was employed to identify the use of pronouns and subject-words that may represent a character of the story (Brown & Gilligan, 1993). Additionally, themes and characters were viewed in relation to the temporal framework of the narrative and its subjunctivising moments i.e. that which is described or expressed in hypothetical terms (Bruner, 1986). Specifically, there was an exploration of how the future was discussed and the use of instances which made retrospective sense of the past in view of the present position. After each individual's story was understood as well as possible, cross-narrative analysis was performed to discover patterns across, and differences between, accounts and contextual factors that may have accounted for these differences (Beal, 2013; Josselson, 2011).

Researcher Influence and Quality Assurance

The researcher was a 26-year-old, white British, female trainee clinical psychologist, who had not experienced parenthood. The psychological lens brought to the research may have shaped the research focus and her interpretation of the narratives. However, she endeavoured to maintain her awareness of her assumptions through the use of reflection and discussion with colleagues. The researcher attended a qualitative research group where she discussed the analysis process and a reflective practice group focused on processes of research. She also discussed the analysis process and findings with two supervisors and multiple colleagues who provided their own reflections. Appendix S outlines the author's reflections of her position and its influence on the research.

Results

Two narratives were submitted via the online survey. Thirty-eight pre-existing online narratives were identified that met the study criteria; one was an audio-narrative. Narratives were not felt to differ in content to an extent that would require distinct analysis, therefore the sample was treated as a whole. Stories ranged in length from 211 to 2,262 words. Available demographic data is presented in Table 1 (see Appendix O for individual participant data).

Table 1. *Available demographic data of participants*

Demographic Information	Number of Fathers
Relationship to Mother	
Together	29
Separated	11
Period in which Maternal Mental Health Problems Arose	
Prior to Pregnancy	6
During Pregnancy	2
Postnatally	32
Words Fathers Used to Describe Mother's PMHPs	

Illness/Condition/Disease/PNI	11
Depression/Postnatal Depression/Postpartum Depression/Low Mood/PPD	28
Postnatal Psychosis/Puerperal Psychosis/Hearing Voices	4
Anxiety/Worry	3
OCD	1
Eating disorder/Anorexia/Weight Issues	2
Age Range of Children	3 weeks to 9 years
Age Range of Fathers	25 to 46 years
Presence of Subsequent Children	3

The following results are divided into three sections. The first two sections describe the findings of the holistic analysis of story form. Section 1 outlines the Story Phases that were identified that represent the component parts of the overall story plot. A prototypical arc is presented to illustrate the phases that were representative of the participants' different narratives. The content of the Story Phases themselves is then outlined in Section 2. Section 3 outlines the three Plot Themes that were identified. Section 4 describes the findings of the holistic analysis of story content and characters. This is discussed in relation to how the content and characters were found to influence a narrative's Plot Theme.

Section 1: Story Phases

A prototypical arc was created that demonstrated the range of Story Phases described within fathers' narratives (Figure 1). Ten Story Phases were identified (Table 2).

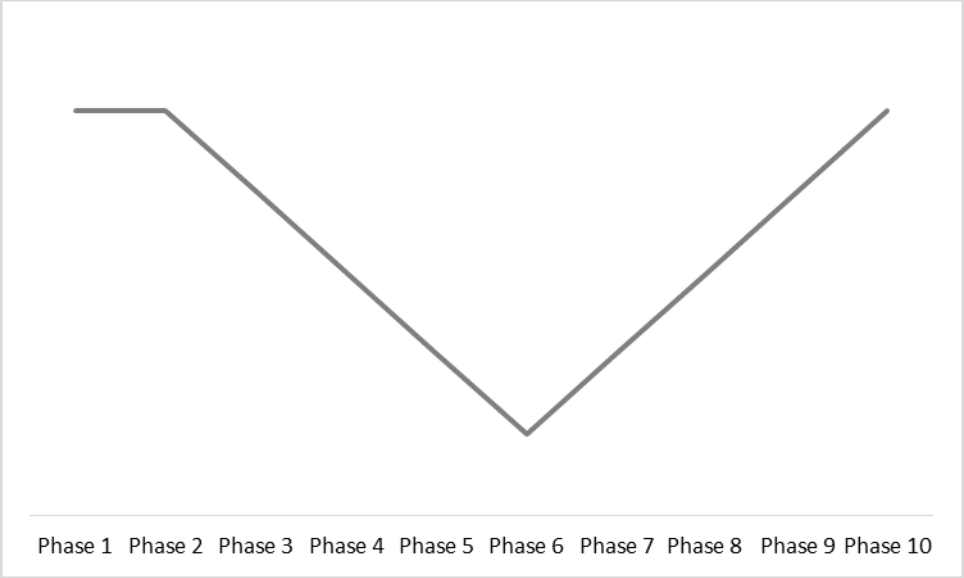


Figure 1. *The prototypical arc of story phases. The highest points of the arc represents the times at which the writer' evaluations were most positive, with the lowest points times these were most negative.*

The prototypical arc illustrates the manner in which these phases relate to each other. The creation of the prototypical arc enabled the subsequent identification of variation across individual narrative's Story Phases in comparison to the data set as a whole. The individual stories did not necessarily contain all the phases (see Appendix P for individual story phase data). The only phase contained within every narrative was Phase 6; with one story describing only this phase. However, no stories contained phases other than those presented within the prototypical arc.

The stories did not always incorporate the phases in the same temporal order and this ordering was not strictly linear, with some stories going back and forth between phases. The ending phase of the story appeared to be the main contributing factor to the story's Plot Theme categorisation (see section 3).

Table 2. *Number and name of identified story phases*

Phase Number	**Phase Name**

1	Before
2	Beginning
3	First Signs
4	Decline
5	Trying and Failing
6	Rock Bottom
7	Turning Point
8	Improvement
9	Reflection/Meaning Making
10	Restored

Section 2: Descriptions of Story Phases

Participant pseudonyms and corresponding quote line numbers are presented after each quote. Descriptions of the Story Phases within the main body of the article have been restricted due to constraints of space. Appendix Q provides richer descriptions of each phase with additional supporting quotes.

Phase 1: Before

This phase was characterised by the period of time before the core challenges of the story began. Here, fathers provided details of the background to their relationships with their partners and the love they shared, often representing this period as if a golden time. At this point, fathers were unaware what future events would bring and often described their general lack of awareness of issues surrounding PMHPs.

"Before we had our daughter, my wife loved me and cared about me." (Jack, 1)

"I had heard of the baby blues or PPD, but never really knew what it meant or what to expect." (Rory, 6-7)

Phase 2: Beginning

This phase marked the beginning of the difficulties emergence. Some fathers identified specific triggers that they felt were linked to their partner's PMHPS beginning. For some this was the pregnancy itself, for many it was the birth of their child.

"During pregnancy she was riddled with feelings of inadequacy and really stressed over whether our child would love her." (Jackson, 4-6)

Phase 3: First Signs

During this phase, it became evident to fathers that something was wrong, or that something had changed within their partner. Often this was initially attributed to challenges one would expect as a new parent, with fathers reflecting they had assumed the problems would pass quickly. A lack of knowledge of PMHPs contributed to some fathers being delayed in recognising these in their partners.

"we had lots of excuses to explain why [mother's name] wasn't feeling so well." (Cooper, 2-3)

"I didn't hear what she wanted me to hear (help, It's all going wrong), just that she lacked confidence." (Dylan, 10-12)

Phase 4: Decline

During this phase the challenges faced by the couple escalated, with multiple fathers describing the situation as getting *"worse and worse."* This was reflected both in the sense that their partners PMHPs intensified but also that the couple's relationship with each other deteriorated.

"It was during the first 4 weeks or so that [mother's name]'s postnatal depression escalated significantly" (Jonah, 26-27)

Phase 5: Trying and Failing

Fathers described making multiple and varied attempts to try and "fix" the situation, with these attempts often ending in failure. Attempts included taking on responsibilities at home and around child-care and trying to access social and service support. Some fathers described feeling their attempts failed due to their partner rejecting them or refusing to try.

"I would try to fix it. But no matter what I tried or how I tried it, it was never the correct." (Rory, 17-20)

"I have tried to offer a number of solutions, none of which she will go for." (Noah, 13-14)

For many, this pattern of trying and failing caused them to develop a belief they were not good enough, with this often being a message also given by their partners.

"I'm doubting my abilities as a father, my judgement and my general faith in humanity." (Sebastian, 3-4)

When fathers felt they had tried all they could think to do, a sense of helplessness developed. This was often the main contributing factor to their moving into the next phase of the story.

"What she went through, to me, can only be compared to what it must be like to be drowning. That is how I perceived it. This is how it was for years with no answer to the problem. She was gasping for air and I was walking in circles dumbfounded. How can you save someone when you have no idea, or the wrong idea, as to what is ailing her? To me it was just fighting." (Finn, 13-24)

Phase 6: Rock Bottom

This was the phase during which fathers' evaluations of events became the most negative. It was marked by significant distress and confusion.

"Right about the time that life was hitting the bottom and we didn't really know what to do" (Shawn, 21-22)

For some this was a period of acute crisis, where they felt loved ones were in danger.

"My girl had a bad case of post partum a few weeks ago. It was like watching someone who took a bunch of acid. Never been more scared in my life" (Theo, 7-9)

For many, this phase arose when fathers felt they were out of energy and resources, and they became unable to continue to cope.

"The fighting is at an all time worse and I'm about to go nuts. Out of energy. Not wind in my sails. Drained both physically and emotionally. Unstable." (Ralph, 57-59)

For some fathers, this period was triggered by the separation of them and their partner. Either through their partner's actions or decisions:

"I was left homeless & utterly heart broken" (Luke, 5)

Or through service input:

"They suggested she spend time in the hospital psychiatric ward and this was truly the bottom for me, and for [mother] too." (Daniel, 123-125)

Phase 7: Turning Point

In some narratives, there came a point where the direction of the story took a distinct positive shift, with fathers describing a specific experience that generated this change. Identified events included: receiving a diagnosis, the prescription of medication, input from services, finding support groups, discovering new information, and the opening up of communication between themselves and their partner.

"And then came the great relief. Absolute relief that [mother] was actually diagnosed with having an illness." (Cooper, 20-25)

Phase 8: Improvement

During this phase, the mother's PMHPs were described to be improving and/or fathers' relationship with their partner was felt to improve. Often there was a sense of coming back together.

"And things did improve, slowly. Our daughter began sleeping better. We moved house, closer to my work, closer to friends. We felt more connected again, to the outside world and to each other. The fog of helplessness was lifting and we could see the way forward." (Eddie, 46-50)

It was not always a direct process, for some there was a cycle of recovery and relapse that slowly moved towards restoration.

"every time she did too much she would use up her good health and she would get sick again from doing too much. And if she got sick then we would have to start the cycle all over again" (Cooper, 116-118)

Phase 9: Reflection & Meaning Making

With this improvement, fathers began to be able to reflect on the events of the story, what had been helpful, what hadn't, and what they had learnt. Some provided advice to others.

"I've hopefully managed to absorb some lessons from all of this too, and I discovered those worries were really a reflection of my own biases, which I'm learning to shrug off. (Kevin, 87-90)

Some identified positive effects of the experiences.

"We have become more of a team than we were when we started." (Rory, 41)

"I found new strength and confidence that has stayed with me" (Samuel, 148)

Phase 10: Restored

Within this final phase, fathers depicted the family as having overcome the challenges described within the narrative. Relationships were seen as being restored to what they once were, and their partner's PMHPs as having been dissipated or managed. Predictions of the future were positive.

"Mom, Dad and daughter are all doing extremely well, are happy, and have an amazingly close relationship." (Daniel, 6-7)

"While PPD was a hefty setback at the time, we can look back at it now as just a bump in the road." (Rory, 42-43)

Section 3: Plot Themes

Three different Plot Themes were identified; 'Restorative', 'Helpless Hoping' and 'Hopeless.' Table 3 shows the number of stories identified as belonging to each Plot Theme.

Table 3. *The number of stories belonging to each plot theme, the phase in which these stories ended and the frequency of parental separation within each group.*

	Plot Theme		
	Restorative	Helpless Hoping	Hopeless
Overall Number of Stories	13	16	11
Parental Relationship Status			
Together	12	9	8
Separated	1	7	3
Ending Phase			
6 (Crisis)	0	16	11
8 or 9 (Improvement or Reflection)	4	0	0
10 (Restoration)	9	0	0

Restorative Narratives

The arcs of these stories reflected that of the prototypical arc (Figure 2). Most specifically, these stories included the later progressive phases during which the writer's evaluations of the situation improved.

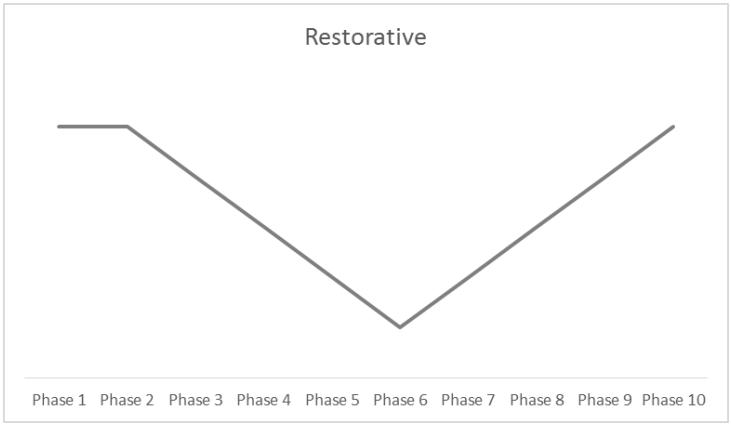


Figure 2. *Example plot phase trajectory of stories with a restorative plot theme.*

In these stories, the challenges and threats that arose within the story were overcome, or at least had begun to be so, by the end point. There was a sense of having got through or emerged victorious, and hope for a positive future was palpable.

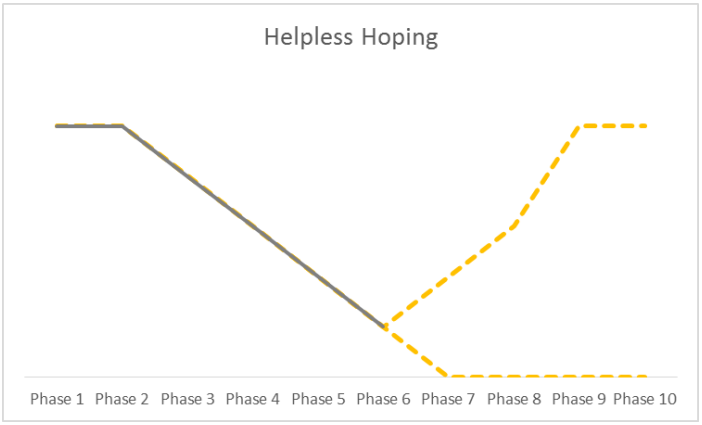
"*We're really happy. [Child's name]'s amazing. We love being parents. The days are longer, lots more to do, but we wouldn't change it for the world."* (Charlie, 37-39)

The purpose of these stories appeared to be one of reflection and meaning-making. They incorporated lessons that had been learnt or advice given to help others in a similar situation. Some had a sense of activism, a desire to inform systems and services of ways they could improve.

"*If I've learned anything, it's that your wife needs you to have the utmost strength and vigilance in order to listen and hear her clearly, infinite patience so as to not be discouraged by the lack of an immediate answer to her struggles, and pure unconditional love."* (Finn, 57-60)

Helpless Hoping Narratives

These narratives were characterised as regressive narratives, in which the phase arc showed a decline towards the 'Rock Bottom' Phase that failed to recover (Figure 3).



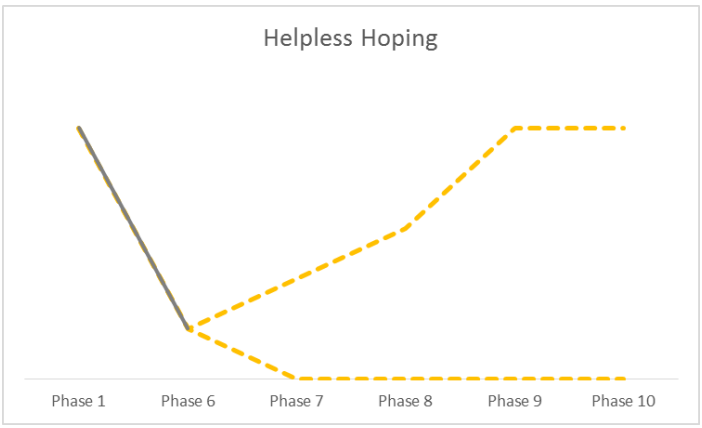


Figure 3. *Example plot phase trajectories of stories with a helpless hoping plot theme. The yellow lines indicate potential future trajectories that are simultaneously held by the writer.*

The purpose of these stories appeared to be one of searching for help and answers.

"Any advice would be treasured like you wouldn't believe!" (Rhys, 29)

Although these stories ended at a point of crisis and emitted a sense of helplessness and confusion, they contained within them a hope that the situation and the character relationships could be fixed. At the story's conclusion the future felt uncertain; the possibility of restoration and repair was held alongside the possibility that the situation would remain as it was and that suffering would continue.

"There must be a way for me to help her I just don't know how?" (Ethan, 21-22)

"It was good to see all these other stories to know there's other people going through similar things, and that some of them have happy endings. I hope mine does too." (Jack, 25-27)

Hopeless Narratives

Similarly to the 'Helpless Hoping' stories, these stories were characterised as regressive narratives, in which the phase arc showed a decline towards the 'Rock Bottom' Phase that failed to recover (Figure 4).

Figure 4. *Example plot phase trajectories of stories with a hopeless plot theme. The yellow line indicates the potential future trajectory indicated by the writer*

However, the purpose of these stories appeared to be one of venting feelings and searching for validation and connectedness to others, a pursuit to find people who understood and empathised rather than a search for help or answers.

"These posts help me so that I know that I am not alone, and it gives me a platform with which to vent my feelings." (Noah, 43-44)

They emitted a sense of hopelessness; that the writer had been defeated by the challenges of the story. In contrast to the 'Helpless Hoping' narratives, these narratives were characterised by the absence of hope that restoration and repair were possible. Rather, there was a resignation towards continued suffering.

"Gonna miss my son. Makes me wanna end my life." (Ralph, 77)

"I love her, want to be a dad but it seems like it is all over. She is the love of my life, my best friend, but there is nothing I can do" (Sebastian, 32-33)

Section 4: Holistic Content and Character Analysis

A holistic content and character analysis was conducted. Through this process, it became evident that the interactions of the story characters, in particular how characters formed alliances with and against each other, heavily influenced the story's Plot Theme. Therefore, this section will be structured in relation to how these character interactions appeared to influence stories' Plot Themes.

Alliances and Divisions that lead towards Crisis (i.e. that contribute to Helpless Hoping and Hopeless Plot Themes)

Father versus Mother

A prominent process within the narratives was the disintegration of the couple as a unit. Fathers often described becoming disconnected from their partners, with communication becoming inefficient or damaging.

"There's no communication, only tension. You're confused, lonely. You feel outcast, vulnerable and like your energy is out of tune with the one person you need right now." (Finn, 3-7)

Analysis of the pronouns used in narratives showed a pattern of fathers more commonly using the pronouns of “we” and “our” in the context of happier times (often phases 1 and 10), and those of “I/my” and “her/she” within the decline and crisis phases of the stories.

Not only was the alliance broken, but some fathers felt they and their partner moved onto opposing sides. Fathers often wrote about feeling criticised, even abused, by their partners, to the point of being deeply hurt.

“My wife says mean things to me. A lot.” (Jack, 3)

“She is actually abusive towards me now, not physically, but emotionally and psychologically.” (Mitchell, 13-14)

This treatment was seen as unfair in light of their own continued attempts to help.

“She sees only part of the whole picture so as to find fault in me where there really isn’t any.” (Aaron, 23-25)

Often fathers wrote about feeling rejected by their partners and/or no longer loved. Some felt their partners had become indifferent to them, others felt actively hated.

“My wife simply couldn’t give a damned how I felt. Its like she has no capacity for love or empathy at all & she sees me as the enemy.” (Luke, 5-7)

“I don't get the feeling that she hates me, but it’s like she just tolerates my presence” (Jackson, 38-39)

Some fathers described feeling their partner was not only rejecting them in the present but retrospectively changing happy memories to also reject their past self.

“We're everybody's perfect couple, ultra happy and she started divorce proceedings overnight a few months ago and has rewritten history” (Harry, 8-10)

The threat of separation, from partner and child, was often present, and was described as a blockade to fathers asserting their needs or opinions. For some separation had occurred and was a source of deep pain.

"if I dare to defend myself against any of her false accusations, and tells me she's going to make sure I never see my son" (Christopher, 19-23)

"She finally did take our baby boy to her parents and demanded I move out." (Luke, 4)

Couple versus Services

In some stories the couple were presented as a team fighting against unhelpful or damaging services. Often when services were described in a negative light it was in relation to a process of forced separation of the mother and father, where one or both members of the couple were not felt to be listened to or included, or where no explanation was provided for the care decisions that were made.

"Immediately afterwards was a very difficult time, made particularly bad by the policy of the hospital (name of hospital), who do not allow the partner to stay." (James, 7-8)

"There was no compassion, no reassuring words, no attempt to make it easier for us." (Samuel, 65-66)

Several fathers described hospital wards as providing inappropriate care, with one father referring to them as "*degrading."*

"The psychiatric ward of a Hospital is more of a prison for people with mental problems, not a place for help and support." (Daniel, 133-134)

For others, there was a perception of service help as being dismissive or simply absent.

"'You need to tell better jokes', said our obstetrician as I cradled our baby boy in my arms while my wife sat sobbing next to me" (Kevin, 1-2)

"I came to the realization that doctors either don't know much about this illness or they don't care enough to learn more about it." (David, 75-77)

Couple versus Family/Friends

Family and friends were at times described as adding stress and pressure to the couple at an already difficult time, or even creating the difficulties in the first place.

"As [mother's] family members starting showing up, things got even more difficult." (Daniel, 97-98)

For others the lack of support (or inappropriate support) provided by family and friends was the reason for tension.

"support from family members around us was minimal, and more often that not, left us with a strong sense of dissatisfaction." (Jonah, 15-17)

Couple versus Society

Fathers spoke about the expectations that society places on new parents being unhelpful. Words such as *"should"* and *"supposed to"* came into the story, creating pressure on the couple, and at times a sense of failure.

"When a mother (or father) doesn't feel the love that society says she should, it can be a major blow to the inner core of the person." (Daniel, 32-34)

Other people's incorrect assumptions of how they would be feeling created added stress.

"And I remember actually being in work the very first week, "how's everything going?" "bet it's the most amazing thing ever." Unless someone had been through it themselves, they didn't have a clue." (Charlie, 10-13)

Alliances and Divisions that foster or extinguish Hope (i.e. that contributed to Helping Hoping *versus* Hopeless Plot Themes)

Couple versus PMHPs

Within some narratives the couple was presented as a force fighting against the entity of the mother's PMHPs. The experience was seen as suffered by both of them, helping to hold the unit together rather than be a reason to turn against each other.

"Looking back on it, my feelings are that [mother's name]'s post-natal depression was suffered by both of us." (Shawn, 1-2).

"I knew we were in for the fight of our lives." (David, 48)

As part of their duty within this unit, fathers often described minimising or dismissing their own needs to support their partner. As such, fathers took on many responsibilities that their partners were unable to, despite this causing them stress and exhaustion.

"I felt that my own pain, and mental state, was secondary to [mother's name]'s, and my own wellbeing wasn't even on the radar" (Jonah, 44-45)

For some this involved hiding their own difficult feelings.

"So I kept a lot of it closed inside. That was my way of dealing with it. Acting as though there's not something wrong, just trying to keep going." (Charlie, 24-26)

For some this included allowing their work or financial situation to be compromised.

"I recently had to step down from my job because I could no longer fulfill my responsibilities." (Christopher, 30)

At times, this encompassed allowing their partner to act in ways that negatively affected their own wellbeing.

"I forgave her on the spot because I love her and that's it, to love is to forgive." (Theo, 28)

For some fathers, there became a point where the level of self-sacrifice felt too extreme, and their resources to sustain such action became depleted. This appeared to create a threat to the couple unit as frustration with their partner increased.

"I wish that I could take all the blame and change myself to help the situation but I have done all the changing in myself to where if I change anything more I will not know my own identity." (Joseph, 22-24)

Fathers' ability to sustain and accept the sacrificing of their own needs seemed linked to their sense that their partner appreciated their actions. The more rejected they felt by their partner, the harder it was to sustain. When fathers felt unable to continue with this path, hopelessness became apparent.

"I've sacrificed my life savings and my self esteem for this person I don't even recognize anymore. She doesn't seem to care or feel remorse about anything." (Christopher, 41-42)

Father versus Mother and Other

Some fathers described feeling side-lined for a partner's family which they felt excluded from. Others described their partner having isolated him, or both of them, from family.

"It feels that she's more connected to her family than to ours, when I'm trying as hard as I can to make our family work." (Jack, 16-17)

Some fathers described concerns that their partner was unfairly negatively representing them to others (family, friends and services) causing these characters to have an inaccurate perception of the situation that was unjustly skewed against him. There was an aspect of helplessness within these concerns due to an inability to put across their side**.**

"Basically I'm vilified and I just wish I could say "hey" you don't know the whole story, she's only telling you the parts she want's you to hear." (Aaron, 29-30)

"She turned her family against me by using me as some sort of focus to take out her frustration/anger on." (Nathan, 11-12)

Where fathers described feeling unfairly blamed or vilified, particularly when they felt unable to defend themselves against false accusations, a strong sense of injustice was apparent in their narratives. This sense of injustice was also evident when fathers felt their many attempts to help the situation were dismissed, when these attempts were felt to be inappropriately blocked by their partner, family or services, or where they felt they had been unfairly separated from their children. There appeared to be a strong association between a sense of injustice and a move towards a hopeless end point.

"I just have to sit there and take it. And if I don't and try to stand up for myself – here comes a fight." (Jack, 5-6)

"We went for marriage counseling (at my suggestion) and she lost interest as soon as the counselor did not identify me as the problem." (Logan, 7-9)

"I feel like all my efforts have been thrown back into my face." (Kieron, 24-25)

Mother versus PMHPs

Many fathers separated their partner's PMHPs from their partner themselves. This seemed especially true when the PMHPs were conceptualised as an *"illness"* or through a specific image, such as one father who talked about a *"dark cloud."* They described this separate entity as acting on or against their partner, transforming or consuming the person she was, into someone the father did not know. They spoke about the goal of getting her back to her *"old self"* as opposed to the person this entity was forcing her to be. Framing

the changes in their partner as due to an illness (that could be treated) seemed to create a greater sense of hope that things could return to how they were.

"This illness transformed her into a withdrawn, hollow person" (David, 7-8)

"I know that the person I am talking with is not my angel." (Adam, 15-16)

For some the separation of partner and 'it' made it easier for fathers to persevere in the relationship. Fathers could cope better with the actions of their partner that they found difficult if the blame for these actions was placed at the feet of an illness as opposed to their partner.

"This is what helped me through a lot with my struggles with [mother's name], that it was not [mother's name] snapping at me and biting my head off. It was the postnatal depression changing her behaviour causing her to do this to me." (Cooper, 26-29)

For some the possibility of this separation created a dilemma, particularly as time progressed. Fathers were unsure where to attribute their partner's behaviour and at what point the 'transformation' should be seen as permanent. When hope that the change could be reversed began to fail, or when culpability was transferred to their partner instead of the 'illness,' fathers seemed to move into the Hopeless Plot Theme.

"Is this the real person and the one I fell in love with was an act?" (Christopher, 39-40)

"I now feel like I am getting to the end of my tether and just want to walk away from it all. Wife is being more and more verbally abusive to me. She may have PNI but in my view it is not an excuse to be abusive, least of all to someone who is trying to help." (Owen, 12-15)

Alliances and Divisions that lead towards Restoration (i.e. that contribute to Restorative Plot Themes)

Father with Mother

The strength of coming together as a couple and the importance of this in relation to moving towards restoration was prominent. Holding on to and building love and trust was seen as vital, with the opening up of communication between the couple being a common factor in the situation beginning to improve.

"Something is wrong at this point and instead of tearing each other apart, a couple in this situation needs help and needs to come back together as one." (Finn, 54-62)

"It was important for us that we communicated our true feelings, how scared we both were, and our commitment to living a good life." (Daniel, 162-163)

Improved communication was often suggested to come about when attempts to actively fix the problems decreased.

"I quickly learned that my place was no longer to try and fix her emotional rollercoaster, but to simply be a quiet, attentive listener. Not to judge or offer advice on how to get better, just listen. Shortly thereafter, our communication as a married couple improved." (Rory, 32-38)

Being alongside their partner, and working with them, was seen as vital to recovery.

"I had to walk beside her along the way, encouraging her, helping her do what she could, when she could." (Shawn, 43-46)

Couple with Services

Professional services, such as doctors, therapy and outpatient programmes, were often described as supportive systems that aided restoration. Services were described positively when they provided explanation and understanding and listened to the couple. Additionally, allowing fathers to express their own feelings and needs, and having those

needs met alongside those of their partner (i.e. when both sides of the couple were seen as important), was described as highly valued.

*"The doctor just listened. He allowed us, mostly myself, to explain our whole ordeal. He allowed me to express a lot of the anger and frustration I had about the situation. He then patiently explained the nature of depression…He continually reassured us that [mother's name] would get better…He allowed us to ask lots of questions. He was compassionate and caring. Suddenly I felt like we had someone on our side helping us to heal [mother's name]" (*Samuel, 115-122)

"In fact, they and others made sure I looked after myself too, lest I fall in a heap just as [mother's name] began to recover." (Kevin, 40-41)

Internet support services and forums were often seen as helpful, and provided a feeling that others were on their side.

"Blogs, support groups, guest speakers, and some very strong and motivated women (including my wife) are on the frontlines making any and all information on postpartum anxiety and OCD very visible and very available to those who need help." (Finn, 50-53)

Couple with Family/Friends

Family and friends were also described as a source of support for some couples. Again, fathers talked about their support allowing space for his needs, and the needs of him and his partner as a couple to be fulfilled.

"We got tremendous support from our families and our friends, and asked for lots of support. They watched our daughter so we could get out and enjoy time together." (Daniel, 157-161)

"Having an outlet helped. You find out who your real friends are when you can just unload on them." (Eddie, 37-38)

Discussion

This study aimed to explore fathers' experiences of the perinatal period when maternal PMHPs were present and to identify factors that lead to positive versus negative outcomes within this time. Confirming the findings of previous literature, fathers described experiencing often overwhelming distress and heightened emotions, including: frustration, confusion, loneliness, fear and helplessness (Engqvist & Nilsson, 2011; Morgan et al., 1997; Meighan et al., 1999; Webster, 2002; Davey et al., 2006). The study reflects existing literature that whilst some fathers identify positive outcomes of their experiences surrounding their partners' PMHPs, others report only negative outcomes (Wyatt et al., 2015; Tammentie et al., 2004; Engqvist & Nilsson, 2011; McGrath et al., 2013). Outcomes of stories within the current study appeared to be heavily influenced by the manner in which characters and systems of the story interacted, and the alliances and divisions this created. It is suggested that the difference in trajectories, and the factors impacting on these, could be understood within the Developmental Systems Framework of Family Resilience (FFR) (Walsh, 2003a; 2003b; 2012; 2016). The underlying premise of FFR is that serious crises impact upon the whole family, and in turn, key family processes mediate adaption (or maladaption) for all members, their relationships, and the family unit. Therefore, the whole family response to crises is crucial for the resilience of all members. Family resilience can be defined as the capacity of the family to withstand and rebound from stressful life challenges (Walsh, 2012). Importantly, resilience is seen as moving beyond simply surviving an ordeal, but encompasses the potential for personal and relational transformation and positive growth to be forged out of adversity (Walsh, 2012). It is suggested this distinction between survival and resilience may differentiate narratives identified as being 'Restorative' in comparison to 'Helpless Hoping' or 'Hopeless.' The FFR outlines nine key transactional processes that facilitate family resilience. The findings of this study will be discussed in relation to these processes.

A key finding of the study was that the disintegration of the couple unit appeared to be a major factor associated with descent into, and perpetuation of, crisis. Concurring with previous literature, fathers described a breakdown of communication, a sense they no longer knew their partner and, frequently, an experience of being rejected and criticised by them (Engqvist & Nilsson, 2011; Beestin et al., 2014). Services were seen as adding to a trajectory towards crisis when they exacerbated this fragmentation, either through, sometimes forcibly, separating the couple, dismissing the needs or feelings of one or both members, or seemingly taking sides against, or blaming the father for the situation. In comparison, an ability to sustain or rekindle the unity of the couple appeared to be a protective factor that facilitated coping and a progression towards restoration. The couple learning to be alongside each other and opening up communication was cited as a major factor in restoration becoming possible. These findings could be understood in relation to FFR processes of 'connectedness', 'open emotional sharing' and 'collaborative problem solving'. In order to facilitate family resilience, members must be encouraged to seek reconnection, provide mutual support, share painful feelings, reflect on positive interactions and share decision making. These processes appear reflective of services cited as helpful by fathers.

The FFR process of 'clarity' suggests that unambiguous and consistent messages and information promote family resilience. The current findings suggest that many men felt they had insufficient knowledge about PMHPs prior to their partner experiencing them; often leading to confusion when they arose. Some fathers spoke about feeling professionals did not have good enough knowledge of these issues either; a belief also previously reported by mothers (Glover, Jomeen, Urquhart, Martin, Colin & 2014). This lack of knowledge may be an obstacle to achieving clarity within the system. Furthermore, this may extend towards society as a whole, with fathers here describing society's overly

positive expectations of new parenthood as harmful, in concurrence with findings on women's experiences (McLoughlin, 2013).

Within the narratives of fathers who remained stuck within a state of crisis, it was identified that some fathers were able to retain hope for restoration whilst for others this appeared lost. This could be related to the FFR process of 'positive outlook,' which encompasses the ability to hold hope for a positive future. The definition of hope has been greatly discussed within literature, with suggested facets including: emotional longing, uncertainty, positive future orientation, specific goal-orientation, and motivating agents (Moore, 2005; Herth, 1996; Owen, 1989; Averill et al., 1990; Sulmasy et al., 2010). Significantly, the existence of hope implies the possibility of despair (Moore, 2005; Lynch 1962). This duality seemed particularly present for men in the 'Helpless Hoping' group, with the threat of despair becoming an all too present reality for those in the 'Hopeless' trajectory.

Two factors suggested to hinder the preservation of hope include being fatigued/overwhelmed by continued losses and/or not being treated as a valued human being (Herth, 1996). The 'Trying and Failing' phase identified in the current study is suggested to reflect the process of developing fatigue as a result of continued loss and failure. In accordance with Engqvist and Nilsson's (2011) findings, fathers in this study spoke about sacrificing their own needs in attempts to support their partner. However, if this sacrifice was required to be sustained for too long, and resources became too depleted, feelings of hopelessness began. This process was seen to be exacerbated when their sacrifice went unacknowledged/unappreciated, perhaps linking to a sense of not being valued. A particularly damaging process occurred when fathers were actively blamed or vilified by their partner, services, or social network. Such attitudes may exacerbate the fragmentation of the family, reducing the ability to foster family resilience. Additionally, fathers' ability to externalise their partner's PMHPs appeared to foster hope by helping

the father to view the negative interactions with their partner as stemming from an entity separate to the couple unit. Externalisation of mental health problems is a technique suggested by systemic therapy to facilitate family cohesion and remove blame (White & Epstom, 2004; Morgan, Robinson, & Aldridge, 2002; Carr, 1998).

Only fathers within the 'Restorative' narrative group appeared to engage in the FFR processes of 'making meaning from adversity' and 'transcendence and spirituality.' These processes centre on finding meaning within experiences of adversity, learning from this and achieving positive growth as a result. The apparent absence of these processes within the 'Helpless Hoping' and 'Hopeless' narratives could suggest that, whilst these may be important for services to encourage within their work with families, the development of adaptive organisational processes, and the improvement of family communication and problem solving, may be necessary prerequisites before this work should be done.

Limitations

Men who choose to write narratives online for the purpose of imparting knowledge or seeking help may not be reflective of all fathers. The fact that recruiting men to participate via the online survey was predominantly unsuccessful suggests there is a subsection of relevant fathers who are not represented. Although the current findings may potentially be transferrable to similar men and situations, the study does not claim to make generalisations across them. It is not possible to verify the identity of the individuals who write online narratives, although the emotive and substantial information provided within the narratives would suggest they were written by the fathers themselves. However, this did obstruct the ability to obtain substantive demographic data about the participants, including their nationality, which limits identification of the populations of included/participating fathers. As differing countries likely offer different service

provisions, it is difficult to infer how country-specific structures or service provisions influence fathers' experiences.

Clinical Implications

The research proposes clear implications for clinical practice. Most significantly, the findings suggest that fragmentation of the family and the systems that surround them is damaging to the ability of the family to cope with PMHPs, foster resilience and reach restoration. Therefore, services designed around systemic models of care, such as the FFR, may be beneficial. Service assessment and interventions should encourage both mothers and fathers to express their feelings and needs and facilitate the improvement of cohesion, communication and clarity across the system. Professionals should endeavour to be aware of how they align themselves within the system and the implications this may have on the wellbeing of all family members. Alliances that promote fragmentation of the system or feed into negative patterns of family relating should be avoided.

Current findings replicate others who have found fathers to often feel alienated or excluded by services (Doucet et al., 2012; Wyatt et al., 2015). However, in contrast to these studies' findings that suggest fathers are often reluctant to seek help, many of the fathers in the current study spoke of actively longing for service help but finding this to be either unavailable, or blocked by their partner. It is unclear whether it is, as is often suggested, that fathers are disengaged or if it is, rather, that they are not wanted. During the recruitment procedure of this study it was noted that there was a paucity of organisations or services actively engaging with fathers in the perinatal period, let alone specifically designed to support them surrounding PMHPs. The difficulty in finding fathers to participate in the initial study survey could potentially reflect this lack of provision and fathers' difficulty in identifying where to turn should they desire support. Clearly changes in the ways in which services engage, respond, and make themselves available to fathers are needed.

The current study indicates that social support has the potential to be a facilitator of restoration. Services should encourage the development of positive support networks for fathers and their families. Groups for expectant or new fathers and parents could be promoted to build networks. Additionally, many of the men in the current study identified online platforms as a source of support and comfort. Directing men to relevant sites of support may therefore be beneficial. There is evidently also a need for greater provision of education about PMHPs both before and after a child's arrival. Families need to be provided with the knowledge that allows them to identify PMHPs when they occur and to know where to access support when they do.

Future Research

Following on from the findings here, future research may wish to consider how professionals within perinatal services view fathers, comparing this to fathers' own views on their relationship with services. It would be valuable to explore more deeply blockades to fathers' involvement with services and how these may be overcome. Research on employing and evaluating a systemic family approach to PMHPs may also be beneficial. As the current research mirrored existing literature in consisting of a sample where the maternal PMHPs predominantly arose postnatally, further research focusing on PMHPs during pregnancy may be beneficial. Similarly, expanding research to a variety of PMHPs, such as OCD or eating disorders is likely to provide useful insights.

Conclusions

This study aimed to explore fathers' experiences of the perinatal period when maternal PMHPs are present, and to identify factors that lead to positive versus negative outcomes within this time. The use of a narrative approach provided important additions to our understanding of men's experiences of this time. The holistic approach allowed a unique angle on the way men story their experiences and how system interactions influence the

trajectory of this story, providing important clinical implications surrounding the structure of services and the type of support they provide.

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Part 3: Appendices

Appendix A - Ethics Letter

Removed for Hard Binding

Appendix B – Guidelines for Submission to the Infant Mental Health Journal

Author Guidelines

The *Infant Mental Health Journal* (IMHJ) is the official publication of the World Association for Infant Mental Health (WAIMH) and is copyrighted by the Michigan Association for Infant Mental Health.

Information for Contributors

Reflecting the interdisciplinary nature of the field, its international focus, and its commitment to clinical science, the IMHJ publishes research articles, literature reviews, program descriptions/evaluations, clinical studies, and book reviews on infant social–emotional development, caregiver–infant interactions, and contextual and cultural influences on infant and family development. The Journal is organized into three sections: Research, Clinical Perspectives, and Book Reviews. Research focuses on empirical research. Clinical Perspectives allows for more diversity in types of submissions and is designed to advance infant mental health practice and scholarship. Requests for book reviews should be sent by the author or publisher to the Editor In Chief. Please do not send a copy of the book until the request is approved.

The Journal welcomes a broad perspective and scope of inquiry in infant mental health and has an interdisciplinary and international group of associate editors, consulting editors, and reviewers who participate in the peer review process. In addition to regular submissions to the Journal, proposals for special issues or sections are also welcome. These should be discussed with the Editor In Chief prior to submission.

MANUSCRIPTS for submission to the *Infant Mental Health Journal* should be forwarded to the Editor as follows:

1. Go to your Internet browser (e.g., Netscape, Internet Explorer).

2. Go to the URL http://mc.manuscriptcentral.com/imhj

3. Register (if you have not done so already).

4. Go to the Author Center and follow the instructions to submit your paper.

5. Please upload the following as separate documents: the title page (with identifying information) and all remaining files without any identifying information, including the body of your manuscript, and each table and figure. Please note that the cover letter is uploaded directly into a field in the on-line submission platform.

6. The Title Page should include a discussion of any conflicts of interest, human subjects approvals, and funding. Acknowledgements may also appear here. The Infant Mental Health Journal complies with all relevant recommendations from the International Committee of Medical Journal Editors in these areas.

7. Your abstract should be uploaded into the appropriate field at the submission website and should also be included in the main text of the manuscript. The abstract in the manuscript must include 3-5 key words listed at the end of the text.

8. Please note that this journal's workflow is double-blinded. Authors must prepare and submit files for the body of the manuscript and any accompanying files that are anonymous for review (containing no name or institutional information that may reveal author identity).

9. All related files will be concatenated automatically into a single .PDF file by the system during upload. This is the file that will be used for review. Please scan your files for viruses before you send them, and keep a copy of what you send in a safe place in case any of the files need to be replaced.

10. Style must conform to that described by the American Psychological Association *Publication Manual* , Sixth Edition, 2009 (American Psychological Association, 750 First Street, N.E., Washington, D.C. 20002-4242). Authors are responsible for final preparation of manuscripts to conform to the APA style.

Manuscripts generally do not exceed 10,000 words and will be assigned for peer review by the Editor or Associate Editor(s) and reviewed by members of the Editorial Board and invited reviewers with special knowledge of the topic addressed in the manuscript. The Editor retains the right to reject articles that do not meet conventional clinical or scientific ethical standards. Normally, the review process is completed in 3 months. Nearly all manuscripts accepted for publication require some degree of revision. There is no charge for publication of papers in the *Infant Mental Health Journal*. The publisher may levy additional charges for changes in proofs other than correction of printer's errors. Authors have the option to participate in Wiley's OnlineOpen program which allows authors of primary research articles to make their article available to non-subscribers on publication and archive the final version of their article. With OnlineOpen, the author, the author's funding agency, or the author's institution pays a fee to ensure that the article is made available to non-subscribers upon publication via Wiley Online Library, as well as deposited in the funding agency's preferred archive. For more information, please visit the OnlineOpen page.

Proofs will be sent to the corresponding author and must be read carefully because final responsibility for accuracy rests with the author(s). Author(s) must return corrected proofs to the publisher in a timely manner. If the publisher does not receive corrected proofs from the author(s), publication will still proceed as scheduled.

Additional questions with regard to style and submission of manuscripts should be directed to the Editor: Paul Spicer, PhD, at paul.spicer@ou.edu

Appendix C – Quality Assessment Tool by Source of Question

The quality checklist is adapted from the Mixed Methods Appraisal tool, version 2011 (Puye et al., 2011), the STOBE checklist (Vandenbrouke et al, 2007) the checklist for qualitative studies designed by the National Institute for Health and Clinical Excellence (National Institute for Health and Clinical Excellence, 2009) and the Downs & Black Checklist (Downs and Black, 1998).

Topic	Item No.	Criteria	Responses				
			YES 2	Partly 1	NO 0	Unclear 0	N/A
Introduction							
Background and Rationale	1	(A) Is the scientific background and rationale of the study explained?					
		(B) Is there adequate/appropriate reference to the literature? Are the relevant/key concepts explained?					
		(C) Are the underpinning values/assumptions/ theory of the study discussed?					
Objectives	2	(A) Is the study clear in what it seeks to do? Are the hypotheses/aims/objective clearly stated?					
Context	3	(A) Does it provide a clinical rationale i.e. a real world issue that justified the study?					
Method							
Setting	4	(A) Are the settings, locations and relevant dates, including periods of recruitment and data collection, described?					
Participant Characteristics	5	(A) Is there an adequate description of the sample used in the study; are participant demographics that are critical to the					

	5	understanding of findings described (sample number, age, whether first-time father or not, relationship to the mother etc).					
		(B) Are the eligibility criteria and the sources of methods of selection of participants clearly described?					
Sample	**6**	(A) Is it explained how the study size was arrived at?					
		(B) Is the sample representative of the population under study?					
Study design	**7**	(A) Are key elements of study design presented (type of design, methods, procedure etc.)?					
		(B) Is the study design defensible/rigorous? Is the design appropriate? Is a rationale given for the design and methods used?					
		(C) Is there adequate description of the measures used in the collection of data (for example, description of questionnaire, interview schedule or description of interview topics)?					

		(D) Are the sources of qualitative data (informants, online content, documents) relevant to address the research question/objective?					
	7	(C) Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of mixed method design)?					
		(E) Are measurements appropriate (clear origin, or validity known, or standard instrument)?					
		(F) Is the mixed methods research design suitable/ relevant to address the qualitative and quantitative research questions/objectives, or the qualitative and quantitative aspects of the mixed method question/objective?					
Analysis	**8**	(A) Is the process of analysing qualitative data relevant to address the research question/objective?					
		(B) Is the data analysis sufficiently rigorous?					
	8	(C) Is the data 'rich'?					
		(D) Is appropriate consideration given to how findings relate to the researchers' influence e.g. through					

		their interactions with participant?					
		(E) Is appropriate consideration given to how findings relate to the context e.g. the setting in which the data was collected?					
		(F) Is the analysis reliable?					
		(A) Are all statistical methods described?					
		(B) Were the statistical tests used appropriate?					
		(A) Is the integration of qualitative and quantitative data (or results) relevant to address the research question/objective?					
	8	(B) Is appropriate consideration given to the limitations associated with this integration?					
Ethics	**9**	(A) Is the reporting of ethics clear and coherent? Were ethical issues adequately addressed?					
Results							
Participants	**10**	(A) Is the number of participants at each stage of the study reported?					
		(B) Is there an acceptable response rate (60% or above)?					

Main Results	**11**	(A) Are the main findings clearly described?					
		(B) Are the findings convincing?					
	11	(C) Are the findings relevant to the aims of the study?					
		(D) Have p values been provided?					
		(E) Does the study provide estimates of the random variability in the data of main outcomes?					
Discussion							
Key Results	**12**	(A) Are the key results summarised with reference to the study objectives?					
Study Limitations	**13**	(A) Are the limitations of the study discussed, taking into account sources of potential bias or imprecision?					
Interpretation of Results	**14**	(A) Is a cautious overall interpretation of results provided?					
Conclusions	**15**	(A) Are the conclusions adequate?					
Generalisability	**16**	(A) Is the generalisability (external validity) of the study results discussed?					

Appendix D – Quality Checklist Colour Coded for Questions relevant to Different Designs

White Questions = All Designs

Qualitative Elements
Quantitative Elements
Mixed Method Elements

Topic	Item No.	Criteria	Responses				
			YES 2	Partly 1	NO 0	Unclear 0	N/A
Introduction							
Background and Rationale	1	(D) Is the scientific background and rationale of the study explained?					
		(E) Is there adequate/appropriate reference to the literature? Are the relevant/key concepts explained?					
		(F) Are the underpinning values/assumptions/theory of the study discussed?					
Objectives	2	(B) Is the study clear in what it seeks to do? Are the hypotheses/aims/objective clearly stated?					
Context	3	(B) Does it provide a clinical rationale i.e. a real world issue that justified the study?					
Method							
Setting	4	(B) Are the settings, locations and relevant dates, including periods of recruitment and data collection, described?					
Participant Characteristics	5	(C) Is there an adequate description of the sample used in the study; are participant demographics that are critical to the					

	5	understanding of findings described (sample number, age, whether first-time father or not, relationship to the mother etc).					
		(D) Are the eligibility criteria and the sources of methods of selection of participants clearly described?					
Sample	**6**	(D) Is it explained how the study size was arrived at?					
		(E) Is the sample representative of the population under study?					
Study design	**7**	(G) Are key elements of study design presented (type of design, methods, procedure etc.)?					
		(H) Is the study design defensible/rigorous? Is the design appropriate? Is a rationale given for the design and methods used?					
		(I) Is there adequate description of the measures used in the collection of data (for example, description of questionnaire, interview schedule or description of interview topics)?					

		(J) Are the sources of qualitative data (informants, online content, documents) relevant to address the research question/objective?					
	7	(F) Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of mixed method design)?					
		(K) Are measurements appropriate (clear origin, or validity known, or standard instrument)?					
		(L) Is the mixed methods research design suitable/ relevant to address the qualitative and quantitative research questions/objectives, or the qualitative and quantitative aspects of the mixed method question/objective?					
Analysis	**8**	(G) Is the process of analysing qualitative data relevant to address the research question/objective?					
		(H) Is the data analysis sufficiently rigorous?					
		(I) Is the data 'rich'?					
		(J) Is appropriate consideration given to how findings relate to the researchers' influence e.g. through					

		their interactions with participant?					
		(K) Is appropriate consideration given to how findings relate to the context e.g. the setting in which the data was collected?					
		(L) Is the analysis reliable?					
		(C) Are all statistical methods described?					
		(D) Were the statistical tests used appropriate?					
		(C) Is the integration of qualitative and quantitative data (or results) relevant to address the research question/objective?					
	8	(D) Is appropriate consideration given to the limitations associated with this integration?					
Ethics	**9**	(B) Is the reporting of ethics clear and coherent? Were ethical issues adequately addressed?					
Results							
Participants	**10**	(C) Is the number of participants at each stage of the study reported?					
		(D) Is there an acceptable response rate (60% or above)?					

Main Results	**11**	(F) Are the main findings clearly described?					
		(G) Are the findings convincing?					
	11	(H) Are the findings relevant to the aims of the study?					
		(I) Have p values been provided?					
		(J) Does the study provide estimates of the random variability in the data of main outcomes?					
Discussion							
Key Results	**12**	(B) Are the key results summarised with reference to the study objectives?					
Study Limitations	**13**	(B) Are the limitations of the study discussed, taking into account sources of potential bias or imprecision?					
Interpretation of Results	**14**	(B) Is a cautious overall interpretation of results provided?					
Conclusions	**15**	(B) Are the conclusions adequate?					
Generalisability	**16**	(B) Is the generalisability (external validity) of the study results discussed?					

Appendix E – Quality Ratings

Item	Criteria	Asenhed et. al (2013)	Draper (2002)	Iwata (2014)	Williams & Umberson (1999)	Sansiriphun et al (2010)	Kao & Long (2004)	Finnbogadottir et al (2003)	Vreeswijk et al (2014, A)	Vreeswijk et al (2014, B)	Vreeswijk et al (2015)	Zeanah, Carr et al. (1990)	Zeanah et al (1985)	Walsh et al (2014)	Jordan (1990)	Zeanah, Zeanah et al (1990)	Total	Max Score
Introduction	**Background**																	
	(A) Science and rationale	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	30	30
	(B) literature	2	2	2	2	2	1	2	2	2	2	2	2	2	2	2	28	30
	(C) assumptions	1	2	2	1	1	2	1	2	2	2	1	2	1	2	2	24	30
	Objectives	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	30	30
	Clinical Context	1	1	1	2	2	2	2	2	2	2	1	1	2	0	0	21	30
Method	**Setting**	2	1	1	2	1	2	2	1	1	1	1	1	2	0	1	19	30
	Trimester	2	1	2	2	2	2	2	2	2	2	2	2	2	1	2	28	30
	Participant Characteristics																	
	(A) description	2	1	2	2	2	2	2	1	1	2	2	2	2	1	1	25	30
	(B) eligibility	2	0	2	2	2	2	2	1	1	1	2	2	2	1	2	24	30
	Sample																	
	(A) How arrived at?	2	1	1	1	1	1	1	1	1	1	0	1	1	1	1	15	30
	(B) representative								1	1	1	1	1				5	10
	Study Design																	
	(A) Key Elements	2	1	2	2	2	2	2	2	2	2	2	2	2	2	2	29	30

	(B) Defensible	2	2	2	2	2	2	2	2	2	2	1	2	2	1	2	28	30
	(C) Measures described	2	0	2	2	2	1	2	2	2	2	2	1	2	2	1	25	30
	(D) Source relevance	2	2	2	2	2	2	2	2	2	2		2	2	2	2	28	28
	(D) Sampling relevance								2	2	2	1	2				9	10
	(E) Measures appropriate								2	2	2	2	2				10	10
	(F) Mixed Method suitable?								2	2	2		2				8	8
	Analysis																	
	(A) Relevant	2	2	2	2	2	2	2	2	2	2		0	2	2	2	26	28
	(B) Rigorous	2	2	2	1	2	2	2	2	2	2		0	2	2	1	24	28
	(C) Richness	2	2	1	2	2	2	2	0	0	0		1	2	2	1	19	28
	(D) Researcher influence	0	2	2	0	1	1	0	0	0	0		0	0	1	0	7	28
	(E) Context influence	2	0	0	0	0	0	0	0	0	0		0	0	0	0	2	28
	(F) Reliable	2	2	2	0	2	1	2	2	2	2		0	2	2	2	23	28
	(A) Statistical described								2	2	2	1	1				8	10
	(B) Statistical appropriate								2	2	2	2	2				10	10
	(G) Integration relevant								2	2	2		2				8	8
	(H) Limitations considered								0	0	2		0				2	8
	Ethics	2	2	1	0	2	2	1	0	0	0	0	0	2	0	0	12	30
Results	**Participants**																	

	(A)Participants at each stage	2	0	2	2	2	2	2	2	2	2	2	2	2	1	2	27	30
	(B) Response rate								0	0	0	0	0				0	10
	Main Results																	
	(A) findings described	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	30	30
	(B) findings convincing	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	30	30
	(C) findings relevant	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	30	30
	(D) p values								2	2	2	1	1				8	10
	(E) random variability								2	2	2	0	0				6	10
	Key Results	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	30	30
	Limitations	2	0	0	2	1	0	1	1	0	1	2	1	2	0	1	14	30
Discussion	**Interpretation**	2	1	2	2	2	2	2	2	2	2	2	2	2	1	2	28	30
	Conclusions	2	2	1	2	1	2	2	2	2	2	2	2	2	1	2	27	30
	Generalisability								2	0	1	0	2				5	10
Percentage		93.1	70.7	82.8	81.0	86.2	84.5	86.2	78.0	74.4	80.5	71.0	67.1	89.7	67.2	74.1		

Appendix F – Data Extraction Tool

Title
Authors
Year
Country of Origin
Study Aims
Sample Size
Participant Characteristics (Age, ethnicity demographics etc.)
Time points of Data Collection
Study Design
Qualitative Analysis Method
Measures Used
Statistical Tests Used
Main Findings
Conclusions
Quality Score

Appendix G – Example of Study Advertisement

Are you a father whose partner and/or the mother of your child experienced mental health problems before or after child birth?

Would you like to help with research?

If the answer is yes, we would like to invite you to take part in our study.

A researcher based at the University of Hull, is conducting a study on *"Fathers' experiences of the perinatal period when maternal mental health problems are present"*.

The **perinatal period** is the period of time covering the year prior to, and the two years after, your child's birth

The study will involve telling your story of your experiences of this time. You will have the option to write (by hand or online) or audio-record your story.

If you are interested or want more information, the following link will take you to the study's website: https://dadsstoriesproject.wordpress.com

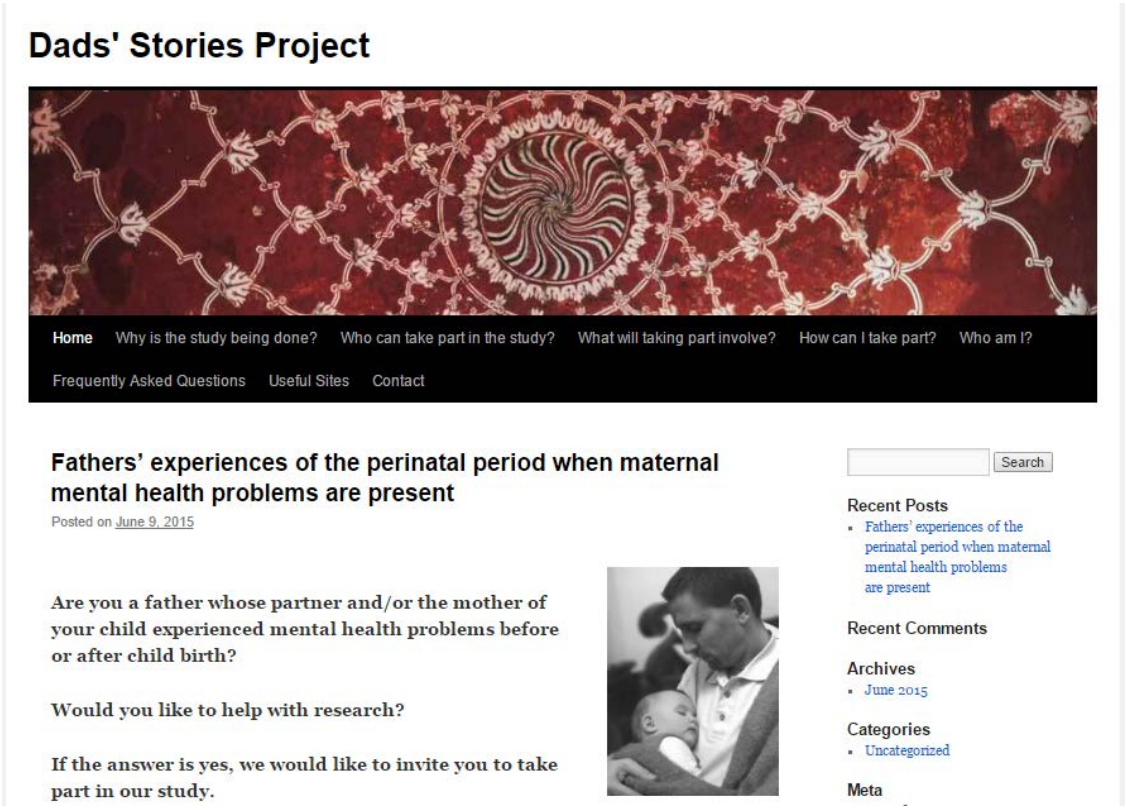
Alternatively, the link below will lead you to the study materials themselves (including information pages about the study).

https://hull.onlinesurveys.ac.uk/dads-stories-project-copy

Thank you for your interest!

Appendix H – Homepage of Study Website

https://dadsstoriesproject.wordpress.com/



Appendix I – Participant Information Sheets

Information Sheet 1

The next two pages contain information about the study and what is involved in taking part. It is recognised that there is quite a lot of information to read through, but it is seen as a requirement that this information is shared with anyone thinking about participating, in order to make sure that people are fully informed about the study and that they understand what they are agreeing to if they choose to participate. The time you take to read this information before reaching the research questions is appreciated.

What is the study about?

We know that the time before and after the birth of a child can be a particularly difficult time for new parents, and that mothers can often experience mental health problems at this time.

However, little is known about how a mother experiencing mental health problems during this time can impact on a father's experiences.

Therefore, in my research, I am particularly interested in hearing the stories of these fathers. Hopefully this knowledge will help improve services' understanding and support for this group of fathers and their families in the future.

Who can take part?

There are a number of criteria that you must match in order to be able to participate in the study. This is to ensure I am reaching the group of people I am aiming to study.

Please read the following questions carefully. If you can answer yes to all these questions then you will be eligible to take part in the study.

This study is looking specifically at experiences surrounding having your **first child**, so please answer each question in relation to the time around your first child's birth.

- **Did the mother of your first child experience mental health problems (of any kind) at any point during the three year period covering the year prior to your child's birth, up to two years after their birth?**
- **Were you in a relationship with the mother of your first child for at least an eight week period at some point during this time?**
- **Is your first child currently aged between 0 and 10 years old?**
- **Is English your first language?**
- **Are you aged over 18?**

If you have answered "yes" to all of these questions, then you are eligible to take part in the study. Please continue to the next section. If you have answered "no" to any of these questions, then, unfortunately, you are not eligible to take part in this study, but thank you for taking the time to read the information and considering taking part.

What is involved in taking part?

This study will involve asking you to write or audio record your own story relating to your experience of the period around your child's birth.

You may wish to take some time to consider whether you wish to participate in the research. If you want to take some time to decide, you can save the current questionnaire by clicking on the 'finish later' button at the bottom of the page. Alternatively, you can close this questionnaire and start a new one at a later time. If you decide you do not wish to take part, simply close the current questionnaire and take no further action. If you do decide to take part in the study, the 'Next' link at the bottom of the page will take you on to the **consent form** that you need to submit before you take part.
You will then be directed to a **screening checklist**, with questions that help to make sure that each participant fits the study criteria.
This will lead on to a **questionnaire** asking for some basic information about you; such as your age, your ethnicity, your relationship status and the age and gender of any children you have. This questionnaire is optional.

After completing these forms you will be directed to a short paragraph asking you to produce a story about your experience of the perinatal period. Below is a copy of this paragraph:

'Please write or record the story of your experiences during the period of time covering the year prior to your child's birth, through to two years after their birth. The story can be as short or as long as you want it to be. It is up to you what you include in your story. Some areas you could include might be: what happened to you, your partner and your child; what emotions you experienced; what support you received; or how you experienced fatherhood. You may wish to consider how you felt both at the time and how you feel about things now.'

There is no maximum or minimum length for how long your story can be. You will have the option to either write your story or audio-record it. This can be done electronically or by hand.

If you wish to write your story online, you will be able to do so in a space provided within the questionnaire, which you can then submit online. You will also have the option of uploading a word-file containing your story.

If you wish to audio-record your story, there will be an option within the questionnaire to upload an audio-file. You can record your story using a device of your choice (for example, a phone, tablet or computer). You will have the option to submit this online.
If you wish, you could also send your story to the researcher by freepost to the address below:
Emily Reeves,
Clinical Psychology
1st Floor, Aire Building
University of Hull
FREEPOST HU5 88
Hull
HU6 7BR
As the study is anonymous, you do not need to provide any personal information alongside your story.

It is asked that your story be submitted within 3 weeks of you reading this information sheet.

Do I have to take part?

No, you are under no obligation to take part in this study. It is up to you whether or not you would like to participate. If you decide you would like to participate,

you will be asked to submit a consent form saying that you agree to participate in the study.

You are free to stop your participation at any point up to the submission of your story, without giving a reason. As the information you give will be anonymous, you will be unable to withdraw after it has been submitted.

If you decide to send your story to the researcher by post, this will be seen as you consenting to this information being used within the study.

What are the possible disadvantages of taking part?

It is possible that some people may find the process of telling their story and thinking about their experiences around this time emotionally distressing. All participants will be given a list of servicesthat can provide further advice and support.

Participants will have to give their time to participate in the study. Completing the consent form and questionnaires should take no longer than half an hour. As you will choose how much information you wish to incorporate into your story, the amount of time you will be involved in producing this will be up to you. However, it is expected this would take at least half an hour.

What are the possible benefits of taking part?

There may not be any direct benefits from participating in this research. However, it is possible that you may find having space to think about and share your personal experiences interesting or helpful. By taking part you will help to provide valuable information that will contribute to the understanding of men's experiences surrounding the birth of their child. This may help improve support for other men and their families in the future. This information can also be used to inform further studies.

Will it cost anything?

No, there is no cost involved in taking part in this study.

If after reading the information in Part 1 you are still interested in taking part, please continue to read Part 2 for further details.

Information Sheet 2

Will my information be kept confidentially?

Yes, your participation in the study and all information that you provide will be kept confidential. The study is anonymous, you will at no point be asked to provide your name or contact details. Individuals who agree to participate will be given a unique participant number to protect their anonymity.

Data will be held on an encrypted file. Only the researcher and her research supervisor will have access to the information. Anonymised data will be stored securely for 10 years before being destroyed.

What will happen with the results of the study?

The results will be collected and analysed by the researcher. The results will then be written up and submitted for publication in an appropriate professional journal. All of this data will be anonymous.

Direct quotes from the stories may be used in the write-up of the research and subsequent publication but you will never be personally identified. The researcher will post a summary copy of the findings of the study on the website https://dadsstoriesproject.wordpress.com/

Organising and funding

This research is being undertaken as part of a doctoral thesis in clinical psychology. The research is funded and regulated through the University of Hull. Some sections of anonymised data collected during the study may be viewed by the researchers superviosrs at the University of Hull.

Has anyone reviewed the study?

The study has been reviewed and approved by the Ethics Committee of the Health and Social Care Faculty at the University of Hull.

If you have any complaints about the study, you can contact the Programme Director of the Doctorate in Clinical Psychology in the Department of Faculty and Social Care at the University of Hull. His contact details are:

Dr Nick Hutchinson,
Department of Psychological Health and Wellbeing
Aire Building
University of Hull
Hull
HU6 7BR
email address: n.hutchinson@hull.ac.uk

If you have any further questions, comments or queries, please contact Emily Reeves (see contact details below) or go to the study's website by clicking the following link: https://dadsstoriesproject.wordpress.com/.
Thank you for taking the time to read this information.
If you would like to take part in the study, please click on the 'Next' link at the bottom of this page to be taken on to a consent form.

Contact Details:

Emily Reeves (Trainee Clinical Psychologist),
Department of Psychological Health and Wellbeing
Aire Building
University of Hull
FREEPOST HU5 88
Hull
HU6 7RX
email: e.e.reeves@2013.hull.ac.uk

Supervised by

Lesley Glover (Senior Lecturer in the Department of Health and Social Care at the University of Hull)
Julie Jomeen (Professor of Midwifery and Dean of the Faculty of Heath and Social Care at the Univeristy of Hull)

Appendix J – Consent Form

Title of study: Fathers' experiences of the perinatal period when maternal mental health problems are present.

Researcher's Name: Emily Reeves

Please read the statements below carefully and select the buttons to indicate that you agree with the following:

I confirm that I have read and understood the information for the study and I have had the opportunity to consider the information. *Required*

I agree

I understand what the project is for and what my participation involves. *Required*

I agree

I confirm that I know that direct quotes from my story may be used in future publications and I understand that they will be anonymised. *Required*

I agree

I understand that my participation is voluntary and that I am free to stop at any time without giving a reason. *Required*

I agree

I understand that once I have submitted the questionnaires and my story it is not possible for this information to be withdrawn since all the data is anonymous. *Required*

I agree

I understand that all the information I provide will be kept confidentially. *Required*

I agree

I understand that, should I submit my story by post, the sending of a story will be seen as my consenting for the information I send to be used in the study. *Required*

I agree

I have considered all of the information provided and would like to participate in the above study. *Required*

I agree

If you have agreed with all of the above statements, and wish to consent to participate in the study, please click on the 'next' button to submit this form and be taken on to the screening checklist.

Appendix K – Demographic Questions

1. What is your age? (in years)
2. What country were you living in during the year prior to, and two years after, your child's birth?
3. How would you describe your ethnic group?
4. How would you describe your relationship status?
5. What is your highest level of education?
6. What is the age of your first child? (in years)
7. What is the age of the mother of your child? (in years)
8. Do you have any other children?

Appendix L – Narrative Instructions

Please write or record the story of your experiences of the period of time covering the year prior to your first child's birth, through to two years after their birth.

The story can be as short or as long as you want it to be. It is up to you what you include in your story. Some areas you could include might be:

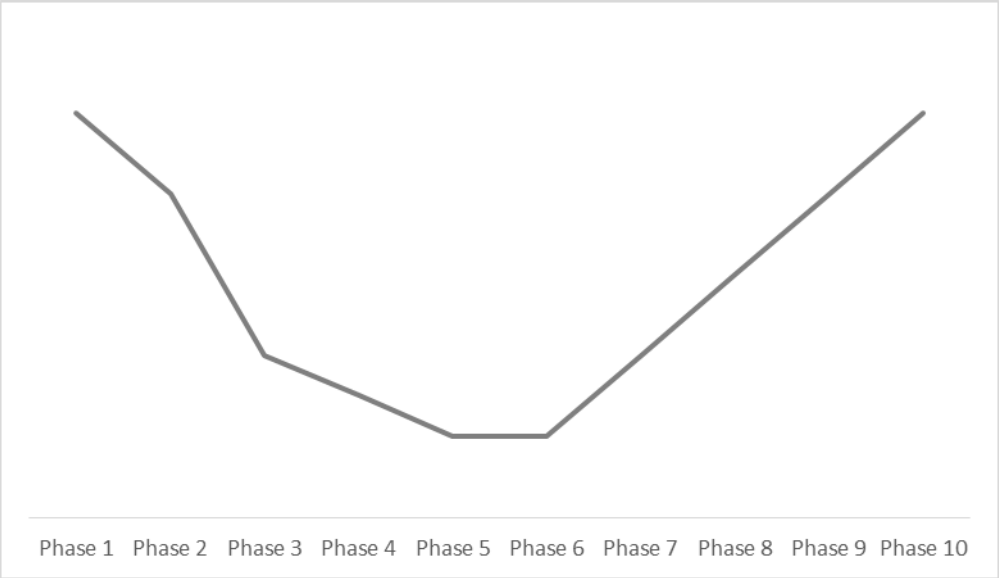
What happened to you, your partner and your child; what emotions you experienced; what support you received; or how you experienced fatherhood. You may wish to consider how you felt both at the time and how you feel about things now.

Appendix M – Example Holistic Form Analysis

Narrative Transcript	Plot Phases, Evaluations & Movement/Trajectory
She is scowling at you. Literally, she's looking to rip you to pieces. An ominous glaze has overcome her eyes. It's like she's struggling with some inner turmoil but you don't know what. There's no communication, only tension. You're confused, lonely. You feel outcast, vulnerable and like your energy is out of tune with the one person you need right now. This is not about you, though. Imagine how she must feel.	Lots of difficult feelings. Energy out. Alone. Stable Crisis
You did not exhaust every ounce of emotion and nutrient giving birth to your new bundle of joy. You did not carry the burden of pregnancy, and you're light years away from carrying the new burden she has.	Description of Triggers/Cause? - But from within more negative stage? Pregnancy as burden? Child too?
These feelings are just the tip of the iceberg. I may be lonely and confused and my wife may be fatigued beyond belief, but there is a more insurmountable challenge forthcoming. The best way for me to describe what was happening while my wife was experiencing postpartum anxiety and OCD is	Just before absolute crisis, before challenge really starts is a wealth of difficult emotions let alone inside it. PMHPs introduced.
to imagine being in the middle of the ocean, side by side, with no life jackets. As a husband and father, although I was struggling and fatigued, I still managed to tread water and stay afloat long enough for someone to come by and rescue me. My wife, on the other hand, was sinking, fast. What she went through, to me, can only be compared to what it must be like to be drowning. That is how I perceived it. This is how it was for years with no answer to the problem. She was gasping for air and I was walking in circles dumbfounded. How can you save someone when you have no idea, or the wrong idea, as to what is ailing her? To me it was just fighting.	PMHPs introduction leads to helplessness, drowning, desperation; crisis – years of it – fighting – trying to save her (trying and failing?)
It was the rumored "women just get crazy after getting pregnant" syndrome that she was going through and surely it would pass or she would just work it out on her own. Little did I know she needed me now more than ever.	Rumour, not sure what it is, thoughts it will pass – decline into? – didn't know what was to come.
What I have learned is that postpartum anxiety and postpartum OCD is a very confusing thing for both spouses even when you know it is happening. So really, what is my role in all this? Whatever it takes. Aside from the standard "love your wife and be understanding and patient" stuff (don't get me wrong those things are the foundation of helping her get through this), there also has to be many small instances of whimsical creativity coupled with the fortitude to listen to her intently at all times and actually hear what she is saying. Whether you know that it is postpartum depression or anxiety or not, it is important to engage in creative activities that promote bonding and encourage moving forward in positive ways.	What he has learnt – reflection/meaning making? Advice to reader? What makes things better, improvement, moving forward, increased positives, getting through?

Phase	Description of Events	Trajectory
1	You meet, you fall in love.	Stable, positive
2	Burden of pregnancy, arrival of child.	Things starting, slow decline
3	Abruptly and suddenly become two different people.	Abrupt decline
4	Thought that it would pass, what people say happens	Decline
5	Fallen flat on his face a lot, trying not be discouraged from immediate lack of answers	Decline
6	Wife is drowning and he is helpless, both exhausted, no communication, he is outcast.	Stable at bottom
7	Wife opened doors to support network of people, not services; blogs, support groups etc.	Turning point
8	Finding ways to get through and help things improve; Being creative, listening to his partner, coming together, promoting bonding and moving forward.	Improving slowly
9	Things he has learnt from the experience – his role and his mistakes, what he would have done in hindsight; strength, vigilance, infinite patience and pure unconditional love.	Positive knowledge gained, able to look back once out
10	Come back together as one.	Positive

Finn: Graph



Finn: Plot Theme = Restorative

Appendix N – Example Holistic Content Analysis

Narrative Transcript	Comments	Potential Themes
She is scowling at you. Literally, she's looking to **rip you to pieces**. An ominous glaze has overcome her eyes. It's like she's **struggling with some inner turmoil** but you don't know what. There's no communication, only tension. You're confused, lonely. You feel **outcast,** vulnerable and like your energy is **out of tune** with the one person you need right now. This is not about you, though. Imagine how she must feel. You did not exhaust every ounce of emotion and nutrient giving birth to your new **bundle of joy**. You did not carry the **burden** of pregnancy, and you're light years away from carrying the **new burden** she has. These feelings are just the **tip of the iceberg.** I may be lonely and confused and my wife may be fatigued beyond belief, but there is **a more insurmountable challenge forthcoming**. The best way for me to describe what was happening while my wife was experiencing postpartum anxiety and OCD is to imagine **being in the middle of the ocean, side by side, with no life jackets.** As a husband and father, although I was struggling and fatigued, **I still managed to tread water and stay afloat long enough for someone to come by and rescue me**. My wife, on the other hand, was **sinking**, fast. What she went through, to me, **can only be compared to what it must be like to be drowning**. That is how I perceived it. This is how it was for years with **no answer to the problem**. **She was gasping for air and I was walking in circles dumbfounded**.	Mother as 'she' – Anger? At him? She wants to hurt him? – She is overcome – ominous/scary *Past as Present – 'you' as 'him'?* Internal Battle within the mother – one he cannot know Lack of Communication / Confusion / Loneliness / Tension/ Outcast Dynamic changed between the couple – things not as they once were can't get support from the person you need it from –who it's supposed to be from? Not about you – him feelings secondary? Selfish to not think of her? Her sacrifice through pregnancy and childbirth. Child as burden? But also bundle of joy? Exhaustion of birth/new parenthood. – diminishing own difficulties/raising mothers? Trying to imagine her experience – still confused. All that emotion and just tip of the iceberg. PMHP's as insurmountable challenge – too big to cope with – beyond them as couple/ as people? Postpartum Anxiety and OCD – words not enough, imagery, challenge, drowning, *Switching between present and past tense.* Together but alone. Unable to help each other. No support from others. Role as father and husband –secondary struggle? He can (just about) stay afloat? Although he was struggling he could do something to help himself, find help from others – but couldn't help his wife too. *Perceived it – then or looking back now?* She was dying? Worse than his situation. Awareness of different perspectives? Question without an answer – Battle that can't be won. Confusion, helplessness, watching her drown – want to 'save' her. Wanting to be saved? Lost, doesn't have the information?	Transformation of Mother? Her inner turmoil. Separation of couple. Outcast. Lack of Communication. Confusion. Minimising own feelings/needs as secondary? Child as burden and joy. Exhaustion Intense emotions PMHPs as challenge, as both lost – but separated – unable to save her. People can rescue, but don't? Continuous struggle and helplessness.

Appendix O – Individual Participant Context Data

Father	Separated or Together	Fathers' Description of Maternal PMHPS	Period of Arising	Child Gender and Current Age	Additional demographic data (father's age, country etc)
Jonah	Together	- Postnatal Depression - Issues	Postnatally (10 weeks after birth)	Female Twins (- years)	Employed
Samuel	Together	- Postpartum Depression	Postnatal (3 months after birth)	Female (- years)	Aged 30 when child was born; married; subsequent children.
Cooper	Together	- Postnatal Depression - Illness	Postnatally	Female (- years)	Australian; college degree; employed; subsequent child.
Rory	Together	- PPD	Postnatally	Male	Married; American
Shawn	Together	- Postpartum Depression	Postnatally	Female (8 years)	Employed
Kevin	Together	- PPD	Postnatally	Male	Lived in Singapore during pregnancy and birth, moved back to Australia when child

						was 4 months old; employed
Daniel	Together	-	Post-Partum Psychosis - Post-partum Depression - Disease	Postnatally	Female	Employed
Charlie	Together	-	Postnatal depression	Postnatally	Female	Married; employed
Finn	Together	-	Postpartum Anxiety and OCD	Postnatally	Unknown	
David	Together	-	Postpartum Depression - Illness	Postnatally	Male	
Max	Separated	-	Postpartum Issues - Condition	Postnatal (3-4 months after birth)	Female	
Eddie	Together	-	Postpartum Depression	Postnatally	Female	Employed
James	Together	-	Depression - Self-esteem issues - Eating and weight issues	Pre-existing, Lowest in Pregnancy/ Traumatic Birth, Postnatal	Unknown (8 months)	Aged 31, Known wife 6 years, married 18 months; Wife Aged 30; UK; Employed; degree
Theo	Together	-	Postpartum - Hearing Voices?	Postnatally	Female (4 months)	

Joseph	Separated	-	Postpartum depression	Postnatally	Female (9 months)	25 years old; married for 2 years; employed
Luke	Separated	- Postnatal Psychosis - Paranoid - Issues		Postnatal (mentions wife having childhood issues)	Male	Married
Adam	Separated	- - ‘under’	Depressed	Postnatally	Female (- months)	With wife for 14 years; American
Jack	Together	-	Undefined	Postnatally	Female (11 months)	Married
Mason	Separated	- PPD? - PP? - Or…?		Pre-existing but reoccurring and exacerbated postnatally (not present in pregnancy)	Male (19 months)	Married for 19 years, wife 42 years old.
Logan	Separated	- PPD - Depression - Suicidal ideation, hopelessness, feelings of worthlessness		Postnatal	Female (2 years)	
Jacob	Separated	- PPD - Illness		Postnatally	Twin Males	Employed

		-	Hormonal Changes	(One month after birth)		
Dylan	Together	-	Postnatal depression	Postnatally	Male (One Year Old)	Married for 6 years; employed
		-	Mental breakdown			
Ethan	Together	-	PPD	Postnatally	Male (Months)	Met partner 4 years ago; employed
Franklin	Together	-	Anxiety attacks	Postnatally	Male (3 weeks)	Employed
		-	Uncontrollable crying			
		-	Worry			
Harry	Separated	-	Postnatal depression? Other Depression?	Postnatally	Male (21 months)	Wife aged 35 years
Jackson	Together	-	PPD	Build up in Pregnancy and then Postnatally	Male (5 and a half months)	Stay at home father; wife employed
Rhys	Together	-	PNI	Postnatally	Unknown	
		-	Anxiety			
Joe	Together	-	PPI?	Pre-existing : 'Emotional' But developed postnatally	Male (six and a half month)	Known wife 8 years.
		-	Depression?			
Mitchell	Together	-	PNI?	Postnatally	Male (1 Year and 4 months)	With mother for 12 years. Lived in London
		-	Depression?			

						England, moved back to Ireland when child was 1 year old. Previously employed but lost job during perinatal period.
Aaron	Together	- Major Depressive Disorder - PPD		Pre-existing, Exacerbated during pregnancy and postnatally	Unknown (6 month)	Married
Gabriel	Together	- PPD - Dark Thoughts		Postnatally	Female (2 years)	
Conner	Separated	- Anorexia - Eating Disorder - Postnatal Depression		Pre-existing, (continued through Pregnancy and Postnatally)	Female (9 years)	Aged 46, Mother Aged 34; UK; Degree; Subsequent children
Alex	Together	-	Condition	Pre-existing, Pregnancy, Postnatal	Male (Unknown)	Married; employed
Christopher	Together	-	Undefined	Postnatally	Male	Employed, but stopped

			(2 weeks after birth)		working during perinatal period
Noah	Together	- Undefined	Postnatally (but mentions wife struggling with insecurities from her past)	Male (3 weeks)	Employed
Ralph	Separated	- Issues - Crazy - Insane	Pre-existing, Exacerbated Postnatally	Male	Married; was stay at home dad; wife employed
Nathan	Together	PNI	Postnatally	Unknown	
Oliver	Together	Undefined Low mood	Pregnancy And Postnatally	Male (weeks)	
Owen	Together	PNI	Postnatally	Twins (2 years)	Self employed
Sebastian	Separated	PND? Depression? Unsure	Postnatally	Male (4 month)	

Appendix P – Individual Participant Phase Data

Father	Phases Described	Ending Phase	Plot Theme
Jonah	All 10 present	10	Restorative
Samuel	All 10 present	10	Restorative
Cooper	All 10 present	10	Restorative
Rory	All 10 present	10	Restorative
Shawn	All 10 present	10	Restorative
Kevin	All 10 present	10	Restorative
Daniel	All 10 present	10	Restorative
Charlie	9 present (1-2 & 4-10) 1 absent (3)	10	Restorative
Finn	8 present (1-2 & 5-10) 2 Absent (3 & 4)	10	Restorative
David	9 present (1-9) 1 Absent (10)	9	Restorative
Max	7 present (2, 3-9) 3 Absent (1, 3 & 10)	9	Restorative
Eddie	7 present (2-9) 3 absent (1-2 & 10)	9	Restorative
James	6 present (1-2, 4-6 & 8) 4 absent (3, 7, 9 & 10)	8	Restorative
Theo	3 present (1, 5 & 6) 7 absent (2-4, & 7-10)	6	Helpless Hoping

Joseph	4 present (1-2 & 5-6) 6 absent (3-4 & 7-10)	6	Helpless Hoping
Luke	4 present (1-2 & 5-6) absent (3-4 & 7-10)	6	Helpless Hoping
Adam	6 present (1-6) 4 absent (7-10)	6	Helpless Hoping
Jack	3 present (1, 5 & 6) 7 absent (2-4 & 7-10)	6	Helpless Hoping
Mason	4 present (1-2 & 5-6) 6 absent (3-4 & 7-10)	6	Helpless Hoping
Logan	6 present (2 & 4-8) 4 absent (1, 3, 9 & 10)	6 (Phase 7 & 8 described but re-verts to phase 6)	Helpless Hoping
Jacob	4 present (2-3 & 5-6) 6 absent (1,4 & 7-10)	6	Helpless Hoping
Dylan	6 present (1-6) 1 absent (7-10)	6	Helpless Hoping
Ethan	6 present (1-2, 4-6 & 8) 4 absent (3, 7, 9 & 10)	6 (phase 8 described but reverts to phase 6)	Helpless Hoping
Franklin	6 resent (1-6) 4 absent (7-10)	6	Helpless Hoping

Harry	5 present (1-2 & 4-6) 5 absent (3 & 7-10)	6	Helpless Hoping
Jackson	6 present (1-6) 4 absent (7-10)	6	Helpless Hoping
Rhys	3 present (4-6) 7 absent (1-3 & 7-10)	6	Helpless Hoping
Joe	5 present (1-2 & 4-6) 5 absent (3 & 7-10)	6	Helpless Hoping
Mitchell	4 present (1-2 & 5-6) 6 absent (3-4 & 7-10)	6	Helpless Hoping
Aaron	4 present (1-2 &5-6) 6 absent (3-4 & 7-10)	6	Hopeless
Gabriel	5 present (1, 2, 4 & 5-6) absent (3 & 7-10)	6	Hopeless
Conner	1 present (6) 9 absent (1-5 & 7-10)	6	Hopeless
Alex	4 present (2 &4-6) 6 absent (1, 3 & 7-10)	6	Hopeless
Christopher	4 present (2 &4-6) 6 absent (1, 3 & 7-10)	6	Hopeless
Noah	4 present (1-2 & 5-6) 6 absent (3-4 & 7-10)	6	Hopeless
Ralph	6 present (1-6) 4 absent (7-10)	6	Hopeless
Nathan	3 present (4-6) 7 absent (1-3 & 7-10)	6	Hopeless

Oliver	6 present (1-6) 4 absent (7-10)	6	Hopeless
Owen	4 present (2 & 4-6) 6 absent (1, 3 & 7-10)	6	Hopeless
Sebastian	6 present (2 & 4-8) 4 absent (1, 3 9 & 10)	6 (phase 7 & 8 present but reverts back to phase 6)	Hopeless

Appendix Q – Table of Supporting Quotes for Story Phases

Story Phase	Phase Content	Supporting Quotes
1: Before	The first phase was characterised by the period of time before the core challenges of the story began. During descriptions of this phase, fathers often provided details of the background to their relationships with their partners and the love that they shared with them. They particularly emphasised this being a period of time when they felt their partner loved and valued them and often depicted it as if it was a golden time in their life. This was a time when fathers did not have the knowledge of the events the future would bring. They often described their general lack of awareness of issues surrounding perinatal mental illness.	*"At the time I met a young beautiful happy go lucky girl with a real hippy like attitude. She was great. Huge hearted, beautiful, and fun. Those were the good things."* (Ralph, 3-6) *"Until 4 months ago, we were the happiest couple in the world"* (Mitchell, 22) *"My wife and I are 'high school sweethearts' I have actually known her from Junior High School and we have been together now for 14 years. To speak of the depth of our love for each other would take a very long time."* (Adam, 3-6) *"I was very proud of how quickly [mother's name] had settled into a routine of being a new mom."* (Samuel, 8-10) *"We assumed we'd get by on visits from our parents, support from our friends and had accepted the cutback to our lifestyles required to support a family."* (Kevin, 7-10*)*

		"I really didn't know what to expect when she was born. Sure, we had taken the classes. Read the books. Talked with other parents. Everything one is supposed to do as a new parent. But what happened during the first two months, nobody could have prepared us for" (Daniel, 1-4)
2: Beginning	This phase marked the beginning of the difficulties emergence, where fathers began to have a sense that something had shifted. Some fathers identified specific triggers or events that they felt were linked to their partner's mental health problems beginning. For some this was the pregnancy itself. Often this event was the birth of their child.	*"Not sure quite where to start so I may as well start at the beginning. During my wifes pregnancy she hit a really low period"* (Oliver, 1-2) *"The beginning of August her mom came to stay with us for a month… This brought great stress in the house." (Adam, 8-12)* *"My wife was diagnosed with PPD shortly after the birth of our 2 year old daughter." (Logan, 1-2)* *"Very soon after birth, it was clear that my wife's moods changed." (Gabriel, 15-16)* *"It all started out innocently enough. We were leaving the hospital when a nurse told us that this illness was out there and if we see it to get help right away."* (David, 20-24)

		It started when [daughter's name] was about three months old and [mother's name] was preparing to go back to her job as an electrical engineer. Unfortunately we had not planned out our day care arrangements very well and finding day care became very stessful. (Samuel, 15-17) *"The delivery went fast and well, but he was in ICU for eleven days prior to coming home." (Mason, 19-21)*
3: First Signs	During this phase, it became evident to fathers that something was wrong, or that something had changed within their partner. However, fathers often struggled to identify what this was. Often this was initially attributed to challenges one would expect as a new parent, with fathers reflecting they had assumed the problems would pass quickly. Changes to their partner's mood or behaviour were framed as being caused by reasons such as lack of sleep, stressful life events or difficult family.	*"When [wife's name] started to complain about always being tired, I figured it was just the extra stress and work of selling the house along with the move that was catching up with her."* (Shawn, 6-8) *"When you have a baby, there is so much sleep deprivation; we just thought what we were going through was normal."* (Daniel, 41-42) *"This was not helped by our general state of mind as new parents – it's funny how everyone seems to think that we should be ecstatic all the time, when our sleeping/eating patterns were so messed up"* (Jonah, 19-21) *"And for the most part, we figured we could handle it because "these things*

	Some spoke about having previously not believed or known that PMHPs could be something that their partner would experience, meaning they were delayed in recognising or identifying them.	*are normal" and "typically only last a week or two.""* (Rory, 7-10) *"In my mind this woman was too strong to have postpartum depression."* (David, 29-31) *"My daughter also had many ear and throat infections which meant [mother's name] had a lot of sleep deprivation and she was constantly tired so we blamed that for why she wasn't well."* (Cooper, 5-8) *"When [mother's name] started to complain about always being tired, I figured it was just the extra stress and work of selling the house along with the move that was catching up with her."* (Shawn, 6-8) *"At the time, I had no clue that my wife was in the throes of PPD."* (Eddie, 5)
4: Decline	During this phase the challenges faced by the couple escalated, with multiple fathers describing the situation as getting *"worse and worse."* This was reflected both in the sense that their partners PMHPs intensified but also that the couple's relationship with	*"Her behaviour continued to get more irrational, angry and hateful for the next 9 months after that."* (Max, 3-4) *"The arguments just kept getting worse and without stupid ability to communicate it would always turn into me leaving, and leaving her only would piss her off more."* (Ralph, 22-24)

	each other deteriorated. Conflict between the mother and father was often present. The occurrence of additional difficult life events was also seen as an exacerbating factor that caused further decline.	*"[mother's name] kept snapping at me...it didn't matter what I did, she would try to find fault with it. As time progressed this got worse and worse."* (Cooper, 10-12) *"It felt like the life that we had built together was falling apart."* (Samuel, 60-61) *"Many other things happened in her life. Her best friend divorced. Her sister was battling breast cancer. Her mother was suddenly acting strange and was diagnosed with a brain tumor. Her sister and mother were admitted to the same hospital on the same day. Her mother is now in an undetermined state of recovery. Her sister died. All of this was before [child's name] first birthday."* (Mason, 26-31)
5: Trying and Failing	Fathers described making multiple and varied attempts to try and "fix" the situation, with these attempts often ending in failure. Attempts included taking on responsibilities at home and around child-care and trying to access social and service support. Some fathers described feeling their attempts failed due to their	*"I have tried to help as much as I can"* (Owen, 4) *"I tried to remain objective. I tried to remain understanding. I tried"* (Eddie, 33) *"I felt very frustrated because it seemed like there was nothing I could do to help."* (Samuel, 23-24)

	partner rejecting them or refusing to try. For many, this pattern of trying and failing caused them to develop a belief or feeling that they were not good enough. For many, this pattern of trying and failing caused them to develop a belief they were not good enough, with this often being a message also given by their partners. When fathers felt they had tried all they could think to do, a sense of helplessness developed. This was often the main contributing factor to their moving into the next phase of the story.	*"On one occasion I contacted our local GP surgery and spoke to the doctor who offered to come out and visit her at home to see if he could help. When I told her she said that I thought she must be "mad" or "crazy" and that I don't support"* (Joe, 17-20) *"She watched me struggle, resented me anytime I tried to talk to her about it, and sat back and did nothing to help."* (Christopher, 12-14) *"I feel like I am walking on tenderhooks all the time I am at home, in fear of upsetting her."* (Kieron, 28-32) *"I tried at times to get her family to help her get help.. I brought up PNI but they didn't take it seriously! Neither did the Doctor"* (Nathan, 8-9) *"My life is centred around her and my new son. Still, I get told about what I don't do, never taking into consideration what I have done."* (Noah, 18-19) *"It's hard for me being the only one trying to make it work."* (Jack, 24) *"nothing I could do or say was ever right or good enough."* (Rory, 15-16)

		"I feel that I need all the strength in the world to just let her hurtfulness roll off my back." (Jack, 11-12) *"After I tried to correct more and more, lessening my classes and cleaning cooking dinner before she got home, taking more and more care of the baby, and still falling short, that is when I threw my hands up and didn't know what else to do."* (Joseph, 24-27)
6: Rock Bottom	This was the phase during which fathers' evaluations of the story events became the most negative. It was marked by a lot of distress and confusion. For some this was a period of intense acute crisis; often where they felt their wife or child was in danger. For many, this phase arose when fathers felt they were out of energy and resources, and they became unable to continue to cope. For some fathers, this period was triggered by the separation of them and their partner. Either through their partner's actions or	*"I'm so terribly lost."* (Dylan, 43) *"I am at the end of my rope."* (Alex, 39) *"I am really at a loss as to what to do. We can't go like this."* (Oliver, 35) *"Can anybody help? I think I was just shouting "Can anybody help?"* (Charlie, 30-31) *"I don't even understand how this happened..."* (Jackson, 60) *"I adore my kids and want what is best for them, but I just seem to have a big black cloud around me even though it is sunny outside."* (Owen, 20-23) *"I am at my wits end trying to help."* (Gabriel, 38)

	decisions, or through service input.	*"They took her to a 'care center' YA RIGHT was a week and a half of hell"* (Theo, 11)
7: Turning Point	In some narratives, there came a point where the direction of the story took a distinct positive shift, with fathers describing a specific experience that generated this change. Identified events included: receiving a diagnosis, the prescription of medication, input from services, finding support groups, discovering new information, and the opening up of communication between themselves and their partner.	*"Within about a week or two of [mother's name] attending a couple therapy sessions, I could see and sense a difference in her."* (Rory, 25-26) *"She was diagnosed with postnatal depression and prescribed anti-depressants. My sense of relief was incredible."* (Jonah, 50-52) *"The turning point was absolutely finding out it was postnatal depression"* (Charlie, 31-32) *"It wasn't until recently that my wife has been able to open doors revealing a wonderful support system full of information and experienced people who are willing to help. Things are much different now."* (Finn, 47-50) *"Being an illness it was something that they could treat. They could put a label on it and say it was postnatal depression. As a depression it could be treated and go away and finally I would be able to get my wife back."* (Cooper, 20-25)

		"Learning how common these feelings are, can be very enlightening and freeing. Knowing you are not the only one suffering." (Daniel, 34-35)
8: Improve-ment	During this phase, the mother's PMHPs were described to be improving and/or fathers' relationship with their partner was felt to improve. Often there was a sense of coming back together. This was often a slow process and not always a direct one; for some there was a cycle of recovery and relapse that slowly moved towards restoration.	*"There was a very slow process from there, and bit by bit things started to improve."* (Charlie, 34-35) *"Slowly, [mother] was becoming her old self once again."* (Daniel, 145-146) *"after a few weeks things started to improve significantly. After about a month she stopped taking Klonopin but remained on Zoloft for 6 months."* (Samuel, 130-132)
9: Reflection and Meaning Making	With this improvement, fathers began to be able to reflect on the events of the story, what had been helpful, what hadn't, and what they had learnt. Some provided advice to others. Some were able to find positive effects of the experiences and/or ways it had caused them to develop as a person.	*"Accept any offers of help. If someone comes around and says "I know you are having a bit of trouble. I'll do the vacuuming", don't be too proud. Accept any offers of help."* (Cooper, 103-105) *"an opportunity to reassess what was really important to us, and what alternative futures were possible."* (Kevin, 74-75) *"In reflection, a confidential helpline seems like a no-brainer. If only I'd known at the time."* (Eddie, 40-41)

		"As the man, you feel that you need to take all of this on yourself and keep things going. To be honest, you can't. It's not healthy or smart to just think you can cope. Never be afraid to tell anyone what you need if you think that they can help you. Never lie about how you're doing, to yourself or anyone else. If you're struggling, say so. Speak to your doctor, friends or family." (Jonah, 58-63) *"Dealing with PPD was my first real exposure to the fragility of life. Even though I was 30 when the first depression occurred, in many ways PPD forced be to grow up. Suddenly I was caring for not just myself, but also my wife and baby. My view of how my life was going to go was shaken. I had to confront my fears, my frustrations, and my disappointments and carry on."* (Samuel, 148-151)
10: Restored	Within this final phase, fathers depicted the family as having overcome the challenges described within the narrative. Relationships were seen as being restored to what they once were, and their partner's PMHPs as having been dissipated or	*"She returned to work part time as an electrical engineer and got back to being the wonderful mother that she started out being."* (Samuel, 132-134) *"Also we are thinking of having another child and maybe another after that to make our family complete. Yes we are prepared to go through postnatal*

	managed. Predictions of the future were positive, even in the event of their partner's mental health problems resurfacing.	*depression again as we have found that postnatal depression is not the end of the world"* (Cooper, 141-144) *"And we got it. Today, we have found our peace, and are working on being the parents we always knew we would be. Mom and daughter have an amazing relationship, a closeness and love that is so deep. And we live our lives, one day at a time."* (Daniel, 170-173) *"[Mother's name]'s back to her old self. I think she is even more amazing them she was before."* (Charlie, 35-37)

Appendix R – Epistemological Statement

This statement seeks to explore and make clear the ontological and epistemological assumptions underlying this thesis and the research methods chosen.

Ontology is concerned with the question of reality and what can be understood about its existence (Ormston, Spencer, Barnard & Snape, 2013). It relates to beliefs surrounding what is real or unreal, true or untrue; and whether we are able to know what in existence falls within each category. Epistemology is concerned with the nature of knowing and how we are able to come to know (Doucet, Letourneau, & Stoppard, 2010).

Positivist realism aims to ascertain definitive truth. This stems from a belief that there is a stable reality "out there" which exists whether we understand it or not. Science in this frame is held as objective, rational, neutral and true (Green & Thorogood, 2004) and there is a rejection of the value of human subjectivity (Gill & Johnson, 2002). A positive epistemological stance argues that there is an objective 'truth' that we can come to be known through robust measurement and detection (Ponterotto, 2005; Green & Thorogood, 2004; Willig, 2001). For instance, this stance would suggest there is a 'true' experience of fatherhood that could be identified through research. At the other extreme, idealism and constructionist approaches see the positivist view as unachievable and inappropriate in its approach to human behaviour (Green & Thorogood, 2004). This view assumes there is no 'truth,' only subjective meanings and interpretations that we create ourselves (Green & Thorogood, 2004). Reality is seen an idiosyncratic concept that is socially constructed and influenced through culture, relationships and use of language, and as such many forms of reality can exist (Burr, 1995; Ponterotto, 2005; Morrow, 2007).

The researcher would consider herself positioned at neither end of this spectrum. Rather, the researcher's stance lies between positivist and constructionist positions, within a subtle realism perspective (Blaikie, 2007). This position argues that there may be some

'external reality' or truth, but this cannot be measured objectively. Instead, we can reach this reality only through the distortions of human perceptions and interpretations of it, which are influenced by our social and cultural context. In line with this position, the researcher does not dispute the idea that there are some entities and events in the world that truly exist. For instance, the birth of a child is an event that is argued to exist in some form of reality. However, the researcher subscribes to the idea that the true reality of the event cannot be separated from the individual's subjective interpretations of it. Therefore, the researcher did not intend to uncover a single truth or verify the meanings exposed. A phenomenological view was taken for both the review and empirical research as they both aimed to explore the subjective experience of fathers and the meaning they give to these experiences. Phenomenologists are neither realist nor relativist. They position themselves in the centre of these ontological positions. However, this approach does intend do go beyond the text, in order to interpret meaning (Harper, 2011). Both the review and empirical research are hermeneutic in nature. As such, it is assumed meaning is brought out through interaction between participant and researcher. As a result the research cannot be fully objective, but the researcher has endeavoured to be transparent about the influences that may have shaped the meanings that the research created.

Narrative Knowing

It has been said that wherever you will find humans you will also find stories (Cobley, 2001). Telling stories allows individuals to convey what is significant in their lives and how things matter to them (Mattingly & Garro, 2000). Narrative ways of knowing are suggested to privilege the particulars of lived experiences and focuses on understanding these experiences (Bruner, 1990). Within the current research the term 'story' was viewed as synonymous with that of 'narrative' (Gilbert, 2002) and thus the terms are used interchangeably throughout.

The researcher holds the position that narratives are not to be interpreted as exact replicas of events (Gilbert, 2002; Sandelowski, 1991). The literal historical truth of an account is not the focus, but rather the concern is on a narrative truth (Spence, 1982). This research is concerned with the manner by which individuals organize the events of their lives and derive meaning from them (Ricouer, 1991; Gilbert, 2002; Riessman, 1993; Bruner, 1990). Stories are viewed to be individual, internal representations of events and experiences to which narrative gives external expression. They provide a means to explore differences between the real and wished for, the story and dream, and can encompasses contradictions (Spence, 1982). Stories can create a window to the emotional as well as the intellectual experiences of the teller and can convey points which are beyond the storyteller's ability to explain (Gilbert, 2002). The temporal nature of narratives mean they are also well suited to the study of life transition processes (Riessman, 2008).

The researcher takes the position that each facet of a story will have a different meaning at a different time and in a different social context (Elliot, 2005). Narratives continually evolve and change with each telling as they are influenced by new experiences and information; no story can ever be told the same way twice (Gilbert, 2002; Riessman, 1993; Mishler, 2004). The story relates only to what life means in the moment of telling. As such, the researcher subscribes to the idea that there can be multiple, even apparently contradictory, truths within narrative research (Josselson, 2011).

The social context is seen as important in the production of narratives, just as this dimension is seen to play a key role in the creation of knowledge and meaning. We learn about our social world through narratives, and the cultural narratives that surround us shape who we are (Gilbert, 2002). All narratives are always co-constructed, even if the audience is oneself or an imaginary other (Gilbert, 2002). As such, story-telling is seen as a social act of negotiating meaning (Gilbert, 2002). As language is the dominant

manner in which we impart stories, language is seen as a principle way in which experiences are made meaningful and create meaning (Crossley, 2000).

Stories have also be suggested to be a way for individuals to take control, and therefore can be a source of empowerment (Holloway and Freshwater, 2007; Elliott, 2005). The, participant-driven nature of narrative research helps to enable participants to have the opportunity to relate their concerns and describe themes in their experiences that are not pre-determined by the researcher; this was a major influence on the choice of using narrative in the current research.

Sandelowski (1991) posited that narratives are positioned in the "hermeneutic circle of (re)interpretation" and can change from telling to telling. The hermeneutic circle refers to the manner in which an understanding of the whole illuminate the parts, which in turn create the whole (Josselson, 2011). Therefore, all narrative research relies heavily on interpretation (Clandinin and Connelly, 2000). In narrative analysis, there is a strong emphasis on the connected knowing, where the collaborative research relationship is characterised by both researcher and participants' voices being heard (Connely & Clandinin, 1990). Within the context of the current study, the researcher has striven to be transparent about the relational nature of the research and how the researchers positioning may have influenced the interpretation of the stories (see appendix S).

There is a high level of diversity within methodological approaches to narrative inquiry (Beal, 2013) and no universal agreement of how to conduct narrative research (Josselson, 2011). The adaptation and mixing of existing methodologies and frameworks to fit the research aims is encouraged (Lieblich et al, 1998; Murray, 2003; Holloway and Freshwater, 2007). Therefore, within the current study, the researcher formulated her own narrative approach through merging methods in a pragmatic manner to fit the needs of the data.

Alternative Approaches

The researcher did consider using interpretative phenomenological analysis (IPA) as the qualitative method of choice. Both IPA and narrative approaches comprise beliefs that words and language reflect the knowledge and understanding of the teller (Wertz, 2011) and that we can gain understanding of a data through the identification of themes within it, not only through description of the data but interpretation of it. However, the researcher was particularly interested in the temporal progression of individuals' experiences and the processes and factors within these that led to differential outcomes. It was felt that IPA would less well-suited to exploring these aspects of men's experiences in comparison to narrative, therefore an IPA approach was not chosen.

The aim of this study was to explore the lived experience of a specific group of people with a particular context and to find similarities and differences between a somewhat homogenous sample. In contrast, Grounded Theory approaches use a somewhat dissimilar sample aiming to make universal claims and as such was not felt to be appropriate for the current study (McMullen, 2011). As the aim was not to generate new theory, a Grounded Theory approach was not felt to be suitable.

Discourse analysis focuses upon the social construction of words through discourse (Josselson, 2011). Discourse analysis can be used by those conducting narrative research as a strategy to analyse narrative texts, such as by focusing on the meaning of specific words or statements (McMullen, 2011). Statements were identified within the current research that held narrative significance; for instance, leading the narrative to enter a different stage or change trajectory. However, it was felt that a holistic approach that viewed the story in its entirety was most suited to the aims of the study. Therefore, as discourse analysis focuses upon the fragmentation of narratives into segments or discursive units (McMullen, 2011) it was not chosen.

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Appendix S – Reflective Statement

I had no particular area of interest the day the research fair arrived. In fact, I had been rather dreading the event due to my lack of ideas to discuss with staff. My criteria consisted of finding a topic I thought might be able to retain my interest for three years. I went around and talked to potential supervisors about their areas of speciality and chose a couple to talk to at greater length on another day. One such meeting was with my now current supervisor. We discussed general ideas surrounding research within the perinatal period. I came out of the meeting having decided to undertake research on fathers' experiences of the perinatal period in the context of maternal mental health problems.

As I write, I am aware the amount of personal thought or reflection within the story so far is limited. In essence, this mirrors the level of reflection I had at the time of choosing my research topic; I thought little more than that I had chosen a topic I had a fair level of interest in. I have since spent time reflecting on why I chose this particular topic and now feel there was perhaps a bit more to it. My research centres on men whose partners experience mental health problems. This is a dynamic mirrored by my own parents. It seems unlikely that this has not influenced my being drawn to this topic. What's more, my research is not only about partners but about mothers and fathers. One may suggest that by extension this also makes it about a child; by extension again, perhaps that I unconsciously found a way of positioning myself and my parents within my research.

Along with the subject area itself, another decision I made early on about my research was my intention to use a narrative approach. Unlike my choice of topic, the reasons behind this decision were very much within my consciousness at the time. I have always been drawn to stories; they make sense to me. In fact, I would probably say they create sense for me. I have one thing that I collect: children's books. There is a children's book on my shelf at home that I feel tells me more about the experience of sadness than all the

textbooks on psychological theory I have read combined. For me, stories convey poignancy, meaning and feeling in a way that often goes beyond that generated through other mediums of language.

I have always been fascinated by the way people story their worlds. I find it endlessly interesting that if you were to ask two people to give you a story of the same events, you could receive two seemingly unrelated stories, with neither being more or less true than the other. To me, stories are powerful; they can create worlds, our own and others. A dynamic I am aware I have struggled with in my clinical work is the practice of adhering to specific structures within clinical assessments. Fundamentally, I think I believe that people have stories about their lives and their worlds that have great meaning to them, which often they have both a desire and a need to share. I find the idea that you should attempt to constrain or over-ride a person's story, before you have taken the time to hear it as they wish to tell it, a difficult concept to swallow. So, it is no surprise that I chose to seek out people's stories within my research, nor that I attempted to choose a method which would influence the telling of these stories as little as possible.

When I started designing my recruitment strategy and data collection procedures, I sought out people within the field that might be able to provide advice on how best to go about my research. Two things stuck out during this process. Firstly, it was difficult to find the right people to ask because there was seemingly little to no organisations set up to support the fathers I was trying to reach. Secondly, those I found were very encouraging about the need for research in the area, but told me that I would have a hard time finding fathers to participate; advice that gave me both motivation and reservation. A few people also commented that they were aware that some fathers could be reluctant to participate because their partners did not want people to know about their experiencing mental health problems. An anonymous online approach therefore appeared to make the most sense as it was felt it might facilitate access to the most potential participants.

As with my decisions surrounding my choice of research topic, I have also reflected more deeply on my methodological decisions since the time that I made them and have become more aware of another potential process that may have influenced my choices. Around the time I was designing my method, a family member of mine was experiencing quite serious mental health difficulties that meant mental health services needed to be involved in their care. Access to these services was not easy to obtain (an understatement). What's more, it didn't feel that they particularly wanted or encouraged family to be involved, or even particularly recognised them. I felt angry and helpless. In my clinical work, I was aware of experiencing an internal struggle in respect of essentially being part of the very system that I felt so angry at; knowing and understanding from both sides about the reasons access can be so difficult, but not feeling particularly able to change the system. In hindsight, I think these feelings may have influenced my choice to use a method that had as little influence from me as possible; I think I felt an underlying sense that I should not dictate to a group of people who were generally ignored by the system how they should share their experiences or what they should be able to say.

As my attempts to recruit participants to the study went on, it became evident that the reservations people had given me about the difficulty this might pose were well-founded; I couldn't seem to find people to participate. During the months that followed my motivation and passion for my research ebbed and flowed. During periods where I mainly worked alone, I sometimes felt quite deflated about the study and its prospects. However, along the way I also came across a lot of people who were really passionate about the research and how much they felt it was needed; men who had had difficult experiences as well as people who were advocating for this group of fathers, trying to set up charities or inform policies. People really seemed to value it; I got asked to write blogs on the subject; someone even asked me to right a chapter of a book! In some way it made the lack of recruitment success doubly frustrating. At times I felt like I was letting people

down by not being able to get people to participate. In the end I decided that perhaps I just wasn't the right person to do that specific research at that specific time. I think an issue was my lack of having an ability to promote the research face-to-face or be present with the people who might be able to facilitate this; although people were very eager to help recruit, in reality people are very busy and just don't always have the time to do so. If I were to do things again, I think I would try to physically go and base myself in the vicinity of the people who were in the right places to help recruitment and attend more events.

In the end I had to concede that, within the bounds of the time I had on the course, I needed to change tack. Along the way I had come across a fair amount of narratives already online; this seemed like a sensible direction for the research to go. By this point, due to my difficulties in recruitment and an unexpected serious health complication, I was fairly far along into my final year. In all I had forty stories to start analysing; it was a bit overwhelming. I let myself fall into the world of narrative analysis; the most prominent theme to come out of it that there was no one way to conduct it. Initially, this was scary and frustrating. I looked at other trainees using other approaches with clearer methods and felt a bit jealous that I hadn't chosen one of them. However, after a lot of reading, I actually started to feel somewhat freed by it. Narrative analysis felt creative and, as I started actually using it on the stories, I felt that it respected the essence of the stories.

I enjoyed the process of analysis much more than I thought I would. I think this came down to the depth of emotion that I found within the stories themselves; it flowed out of the pages. I had initially been apprehensive that the existing narratives would not provide a rich enough source of data; I needn't have been! The language, metaphors and pure feeling was incredible. They were emotional to read. I had to ensure as I went along that I had breaks to keep my head straight. I had initially intended to take a more structured approach to analysis within my initial readings, but I realised that during these readings

my mind was being pulled to the emotion and trying to understand the message that the stories were trying to convey. I therefore had to do an initial side-track and just write for each one the main emotions I felt reading the story and what I thought the writer was trying to say or gain from writing it. What's more, the anonymity of the stories was difficult. Some of the men seemed so helpless and desperate for someone to do something, and some of the stories seemed to end so abruptly and so hopelessly. It was hard to know that I would never know what happened next or if the characters were okay. However, by the same token, this gave me a huge amount of passion for my research. I felt a great deal of responsibility to get it right, to convey their stories in the right way. This caused a bit of an issue in writing up – I had so much I wanted to write and not enough space to do it. Cutting some of the quotes down (or removing them completely) was painful. My results section is long; I just didn't know how to cut it further without losing the essence of the stories.

Undertaking my SLR felt quite different. Deciding on the actual question almost felt like the most difficult part. I had to go back and forth a few times and ended up reading through thousands and thousands of article titles, which was a trial of perseverance. Once I had decided on the question, it was then a challenge to feel like I personally had the expertise and knowledge to actually do the research and write it up. Supervision helped with this one, as did talking to other trainees and finding out they had similar feelings. As I did the review, it confirmed a bias in me that was also evident in my empirical: the qualitative parts of the research were my favourite parts. Reading the quotes of the fathers themselves is what gave me motivation as I went. I know that in the future if I conduct research I will want it to have a qualitative base.

Along the way I have realised the value in having people around you that can provide guidance and encouragement for your research. My supervisors were invaluable. At times when I was feeling frustrated and stuck, seeing them provided me with renewed energy

and enthusiasm, and also subdued my panic. It was also great to have people just to talk about it with, especially when it came to writing up my analysis – having people who would actually get excited about it with you was really nice. They also helped to provide a fresh perspective on things and opened up new ways of thinking that definitely made my research better – both my empirical and review paper. I know that in any future research I undertake I will endeavour to find people to fill such a role.

I have discovered that I really like narrative analysis, it fits the way my mind works. I don't think my results would have been nearly as rich if I had chosen to use another method; I would definitely use it again in any future research I undertake. I had originally thought I would find research tedious, an obstacle to overcome as opposed to a process to really get something out of. Whilst it would be untrue of me to say there weren't times it did feel this way, I was surprised at how meaningful and emotional parts of the research process felt to me and, most especially during my empirical analysis, how much I enjoyed it. It was a privilege to read and write about fathers experiences and I hope to do it more in the future.