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Parents' perinatal mental health

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A thesis submitted in partial fulfilment of the requirements for the degree of

Doctorate in Clinical Psychology

Coventry University, Clinical Psychology, Faculty of Health and Life Sciences

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Abbreviations

AMED	Allied and complementary medicine database
CBT	Cognitive behaviour therapy
CINAHL	Cumulative index to nursing and allied health language
DSM-5	Diagnostic and statistical manual of mental disorders
DP	Discursive psychology
EMBASE	Excerpta medica database
ICD-10	Internal statistical classification of diseases and related health problems
IPA	Interpretative phenomenological analysis
MBBRACE-UK	Mother and babies: Reducing risk through audits and confidential enquiries across the United Kingdom
MEDLINE	Medical literature analysis and retrieval system online
MESH	Medical subject headings
NCT	National childbirth trust
NICE	National institute for health and care excellence
NHS	National health service
PND	Postnatal depression
PRISMA	Preferred reporting items for systematic reviews and meta analysis
PsycINFO	Psychological information database
WDEQ	Wijma expectancy questionnaire

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Declaration

This thesis was submitted to the Universities of Coventry and Warwick. It has not been submitted to any other institution and no aspect of it has been previously published elsewhere. The work was supervised by Dr Carolyn Gordon (Clinical psychologist, Coventry University), Dr Simon Goodman (Psychologist, Coventry University) and Dr Kirstie McKenzie-McHarg (Clinical Psychologist, Warwick Hospital). The thesis was the primary author's own work.

The systematic review (chapter one) has been written in a format appropriate for the *international journal of childbirth*. The empirical paper (chapter two) is in a format appropriate for *the journal of men's studies*. It is the primary author's aim to submit these papers to these journals in the future. Participants that had indicated that they wished to receive a copy of the results will receive them.

Summary

This thesis was focused on parent's mental health during the perinatal period. Fear related to childbirth is common in mothers. Chapter one provides a meta-ethnographic synthesis of literature exploring mothers' experiences of fear related to childbirth. Three meta-themes were identified which showed what it was like for women to experience fear related to childbirth, external factors than influenced their fear (e.g. the media) and internal factors (e.g. coping strategies). This study illustrated the complexity of mothers' experiences and how fear related to childbirth can impact quality of life. The implications of these findings, and clinical recommendations, are discussed.

There is increasing recognition that fathers may experience low mood in the postnatal period. Chapter two explores how fathers talk about paternal postnatal depression (PND). Six fathers who considered themselves to have had paternal PND took part in semi-structured interviews, which were analysed using discourse analysis. The results showed that PND was constructed as something that happens to women rather than men. They highlighted the difficulties men have talking about PND and how masculine identities were used to account for this difficulty. Finally, men constructed themselves as being deficient fathers when they had paternal PND. This study has significant implications for how PND is talked about with men.

Chapter three presents a reflective account of conducting the research, which was written from the perspective of a parent. The focus was on the impact that the researcher may have had on the study and the effect that the study had on the researcher. It encompassed the whole process from developing ideas to potential areas of future study. The importance of terminology in mental health was discussed as well as what it is like conducting research on parents as a parent. The chapter ends with reflections on the researcher's epistemological position.

Overall Word count:19713 excluding abstracts, tables, figures, references and appendices

Chapter one

Mothers' experiences of fear related to childbirth: A systematic review of qualitative studies

This chapter was prepared for submission to the *International Journal of Childbirth*. Appendix 1 provides detailed author guidelines from this journal. The word count for this chapter, excluding abstract, figures, tables and references, is 7861.

Abstract

Purpose: Fear related to childbirth is common. Qualitative studies have highlighted how frightening and isolating childbirth can be for mothers. Such strong reactions to childbirth can significantly affect quality of life. The aim of this systematic review was to synthesise qualitative research findings of mothers' experiences of fear related to childbirth.

Study Design: A meta-ethnographic synthesis was conducted. A total of 10 electronic databases cataloguing relevant research (e.g. midwifery and psychology studies) were searched, which resulted in 26 studies for analysis.

Major findings: Three meta-themes were identified: 'the nature of fear related to childbirth', 'external influences on fear' and 'internal influences on fear'. Mothers' experiences of fear varied between individuals. Some described their fear as a dominating force, whilst others spoke about how their fear waxed and waned over time. Various factors that influenced mothers' experiences of fear were considered (e.g. the birthing environment and coping strategies).

Main conclusions: Whilst there were commonalities in findings across studies, there were also some important differences. This has highlighted the complexity of mothers' experiences. The impact of fear related to childbirth can be significant. It is therefore important that there are appropriate interventions designed to support mothers with fear related to childbirth.

Abstract word count: 200

1. Introduction

1.1 The risks of childbirth

Advancements in medical knowledge, practices and technology, particularly in Western nations, have been associated with a reduction in maternal complications during delivery (Chamberlain, 2006; Högberg & Joelsson, 1985). However, there are still significant risks associated with having a baby. For example, in 2011-2013 the maternal mortality rate was 2.91 per 100,000 births in the UK for deaths linked directly with pregnancy and or childbirth complications (Mother and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK [MBRRACE-UK], 2015). Moreover, although childbirth can be a joyful experience for mothers (Callister & Khalaf, 2009; Crowther, 2014; Kitzinger, 2012), it is also a process associated with significant pain (Hodnett, 2002; Jones, 2012; Lowe, 2002; Lundgren & Dahlberg, 1998; Van der Gucht & Lewis, 2015) which can be traumatic (Alder, Stadlmayr, Tschudin, & Bitzer, 2006; Beck, Driscoll, & Watson, 2013).

1.2 Fear of childbirth

1.2.1 Prevalence and range of fear

It is natural to have some anxiety about being pregnant and the prospect of giving birth (Hofberg & Ward, 2007). Indeed, childbirth represents an unpredictable event, which has been associated with anxiety in mothers

(Melender, 2002b). Philipp and Carr (2001) proposed that fears and anxieties may be expected throughout pregnancy as women adapt to physical changes and prepare for motherhood. They suggested that this may culminate in the third trimester with fear of labour.

Melender (2002a) conducted a questionnaire study with 329 pregnant women from Finland. A total of 78% of this sample reported fear related to pregnancy and or childbirth. Pallant et al. (2016) conducted a questionnaire study with 1410 pregnant women from Australia. These women were asked to complete the Wijma Expectancy Questionnaire (WDEQ), which measures fear related to childbirth. The scores on this measure range from 0 to 165 with higher scores indicating greater fear. Pallant et al. (2016) found that the scores varied from 0 to 128 (mean = 49.5). There is therefore a range in the intensity of fear related to childbirth from no or low levels up to much more significant levels of fear. Lukasse, Schei and Ryding (2014) conducted a cross sectional study of 6970 pregnant women across six European countries to establish the prevalence of severe fear of childbirth. They defined severe fear as WDEQ scores of greater than or equal to 85 (Ryding, Wijma, Wijma, & Rydhström, 1998). This study showed that approximately 11% of nulliparous and multiparous women exhibited severe fear of childbirth.

Hofberg and Brockington (2000) termed a severe fear of childbirth leading to avoidance of labour as tokophobia. This term has not been recognised by either the Diagnostic and Statistical Manual of Mental Disorders ([DSM-5] American Psychiatric Association [APA], 2013) or the International Statistical

Classification of Diseases and Related Health Problems ([ICD-10] World Health Organisation [WHO], 1992). Hofberg and Brockington (2000), in a qualitative study of 26 women with severe fear of childbirth, proposed there were three types of tokophobia. 'Primary' tokophobia referred to fear in women who had not yet had a child. 'Secondary' tokophobia was suggested to represent women who had developed a fear of childbirth after having a baby. Finally, a third type of tokophobia was identified that was described as a symptom of depression. Although some of the women in the Hofberg and Brockington (2000) study had a good birthing experience (e.g. ideal delivery and bonded well with child) despite their fear, several had difficulties with childbirth (e.g. traumatic experience), bonding with their children and experienced postnatal depression.

1.2.2 Predisposing factors

Spice, Jones, Hadjistavropoulos, Kowalyk, and Stewart (2009) explored factors related to fear of childbirth in 110 pregnant women. They found that women who were more sensitive towards the physical effects of anxiety, had increased trait anxiety and who were first-time mothers, were more likely to exhibit higher levels of fear of childbirth. In support of this, Söderquist, Wijma, and Wijma (2004) reported that trait anxiety, difficulties coping with stress and a perception of poor support from others whilst pregnant was related to fear of childbirth. Other potential risk factors include a history of sexual abuse (Heimstad, Dahloe, Laache, Skogvoll, & Schei, 2006), miscarriage (Gao, Liu, Fu, & Xie, 2015) and previous negative birthing experiences (Nilsson,

Lundgren, Karlström, & Hildingsson, 2012).

1.2.3 Impact on mother and baby

Several qualitative studies have documented mothers' experiences of fear related to childbirth (e.g. Brodrick, 2008; Eriksson, Jansson, & Hamberg, 2006; Melender & Lauri, 1999; Nilsson & Lundgren, 2009). These have highlighted how frightening and isolating labour can be, which can significantly impact on mothers' quality of life. Severe fear of childbirth may cause women to attempt to end their pregnancy (Hofberg & Ward, 2003) or seek elective caesarean section (Nieminen, Stephansson, & Ryding, 2009). Caesarean section increases the likelihood that women will require longer to recover from birth and elevates the chances of babies being admitted to intensive care due to complications (National Institute for Health and Care Excellence [NICE], 2012). Women with more a severe fear of birth exhibit an increased chance of experiencing a more painful labour (Billert, 2007) and tend to have longer deliveries (Adams, Eberhard-Gran, & Eskild, 2012). Fear related to childbirth can also impact mental health. For example, Bhatia and Jhanjee (2012) reported how a 43-year-old women with severe fear of childbirth became depressed and experienced suicidal thoughts. In addition, Rouhe, Salmela-Aro, Gissler, Halmesmäki and Saisto (2011), in a retrospective study of 2405 women with fear of childbirth and 4676 women without fear of childbirth found that mental health problems (e.g. requiring inpatient admission, mood and anxiety difficulties, etc.) were more common in the former group. However, this study did not control for previous trauma which may have affected the

results.

Talge, Neal, and Glover (2007) reported a significant relationship between elevated levels of maternal stress during pregnancy and developmental problems (e.g. emotional and cognitive problems, attentional deficit and language delay) in their offspring, which may have been due to hormonal influences (e.g. cortisol) on the foetal environment. However, there are also other potential explanations such as parents' capacity to contain and manage their distress as they were developing. Furthermore, Shahhosseini, Pourasghar, Khalilian, and Salehi (2015) conducted a review of the impact of mothers' anxiety during pregnancy on their children's health. They showed how mothers' anxiety was associated with problems with their child's physical growth (e.g. height), cognitive development (e.g. concentration), behaviour (restlessness) and illness sensitivity (e.g. asthma). Therefore, it is possible that enduring feelings of fear during pregnancy may have an impact on child development (Wenzel, 2011).

There has only been one published review specifically focused on the literature related to fear of childbirth (Rondung, Thomtén, & Sundin, 2016). This mixed-methods, narrative review, highlighted that previous negative birth experiences, a history of abuse and hearing about others' negative birthing stories caused fear in expectant mothers. Physical responses to fear included sleep difficulties, increased heart rate and stomach problems. Various causes of fear were identified such as concerns about the ability of healthcare professionals to manage labour. Rondung et al. (2016) indicated that mothers

in several studies reported trying to avoid vaginal childbirth and exhibited a preference for caesarean section. There was also evidence of cognitive avoidance of childbirth by showing a preference for not talking about it. Whilst this review provided a good descriptive summary of the literature, it did not provide any information on the nature of the lived-experience of fear related to childbirth. Indeed, there was no interpretative synthesis of the qualitative findings. Furthermore, there were several methodological problems associated with this review. First, the authors only searched two electronic databases and so are likely to have missed important studies. Second, they limited their database search so that studies conducted before 2000 were not included, but did not provide a rationale for doing this. Third, the authors did not include an explicit rating of the quality of the included research. This is important information when weighing up the contribution of findings reported in research.

1.2.4 Psychological Interventions

Rouhe et al. (2015) found that a psychoeducation group for significant fear of childbirth resulted in better maternal adjustment after birth, and enhanced childbirth experience scores, compared with a control group. Nieminen et al. (2015) explored an internet Cognitive Behaviour Therapy (CBT) course designed for people with severe fear of childbirth. After completing the course, the women reported feeling more confident and able to use adaptive coping strategies. However, more research is required to develop a robust evidence-base for such psychological interventions (Larsson, Karlström, Rubertsson, &

Hildingsson, 2015).

1.3 Aim

The aim of this systematic review, was to provide an interpretative qualitative synthesis of empirical findings relating to mothers' experiences of fear related to childbirth. A secondary aim was to explore what information qualitative studies provide about the predisposing factors associated with fear of childbirth and the impact it has on mothers. This review was therefore distinct from the previous review conducted by Rondung et al. (2016). It also sought to address the methodological problems of that review by searching multiple databases, placing no temporal limits on the search and by appraising the quality of the included research. Such a review would be useful to aid the development of interventions designed to improve mothers' quality of life. It would also provide useful information for healthcare professionals to guide their interactions with mothers.

2. Materials and methods

2.1 Search protocol

Ethical approval for this systematic review was granted by Coventry University Ethics committee (see Appendix 2). A systematic search of the literature was conducted in November 2016 for studies of mothers' experiences of fear related to childbirth. This search was updated in March 2017 to ensure that

relevant new research was included. Table 1 provides a list of the databases searched which catalogued relevant research (i.e. those relating to psychology, medicine, nursery and midwifery). The reference sections of included articles were hand-searched for additional studies. Table 2 provides specific terms, approaches to truncation and Boolean operators that were used in the systematic search. Search terms needed to be in the abstract of the studies to reduce the chance of identifying irrelevant research. Prior to conducting the search, relevant database specific thesauruses and keyword heading lists (e.g. MESH) were searched for any further relevant terms. Appendix 3 provides examples of database searches.

Table 1. Databases included in the search

Database	**Host**
AMED (Allied and complementary MedicinE Database)	Ovid
CINAHL (Cumulative Index to Nursing and Allied Health Language)	EBSCO
PsychINFO (Psychological Information Database)	ProQuest
MEDLINE (Medical Literature Analysis and Retrieval System Online)	EBSCO
PsychARTICLES	ProQuest
Nursing and Allied Health	ProQuest
Health and Medical Collection	ProQuest
Psychology	ProQuest
Web of Science	Thomson Reuters
EMBASE (Excerpta Medica dataBASE)	Ovid

Table 2. Search terms, truncation and Boolean operators

Category	Search terms
Qualitative research	Qualitative AND (research or stud* or design or data or method* or analys*) NOT Quantitative
Childbirth	(Childbirth or birth* or labor or labour or delivery or maternity) AND (experience* or complication* or pain*)
Fears, anxieties and fear of childbirth	Tocophobia or tokophobia or fear* of childbirth or paturiphobia or fear* or fear* of death or childbirth related fear* or anxi* or childbirth related anxi*

2.2 Inclusion and exclusion criteria

Original qualitative research reporting information on mothers' experiences of fear related to childbirth were included. Research that focused on animals, men or women who were not mothers were excluded. In addition, any quantitative research or non-original articles (e.g. reviews) were excluded. Women who were pregnant were considered mothers for the purposes of this review. Those with significant comorbid physical or mental health conditions that may affect their experiences of childbirth (e.g. mothers with renal transplants) were excluded. This review only included research conducted in European countries, because initiatives have been established to monitor and collate perinatal health outcomes in Europe (e.g. Euro-Peristat, 2013). Furthermore, European countries provide an opportunity to consider potential

diversity in cultural constructions of childbirth and perinatal health care practices. Studies needed to be in English to permit interpretation by the author. No date limits were applied, because such an approach would potentially exclude important research. Table 3 provides a summary of the eligibility criteria.

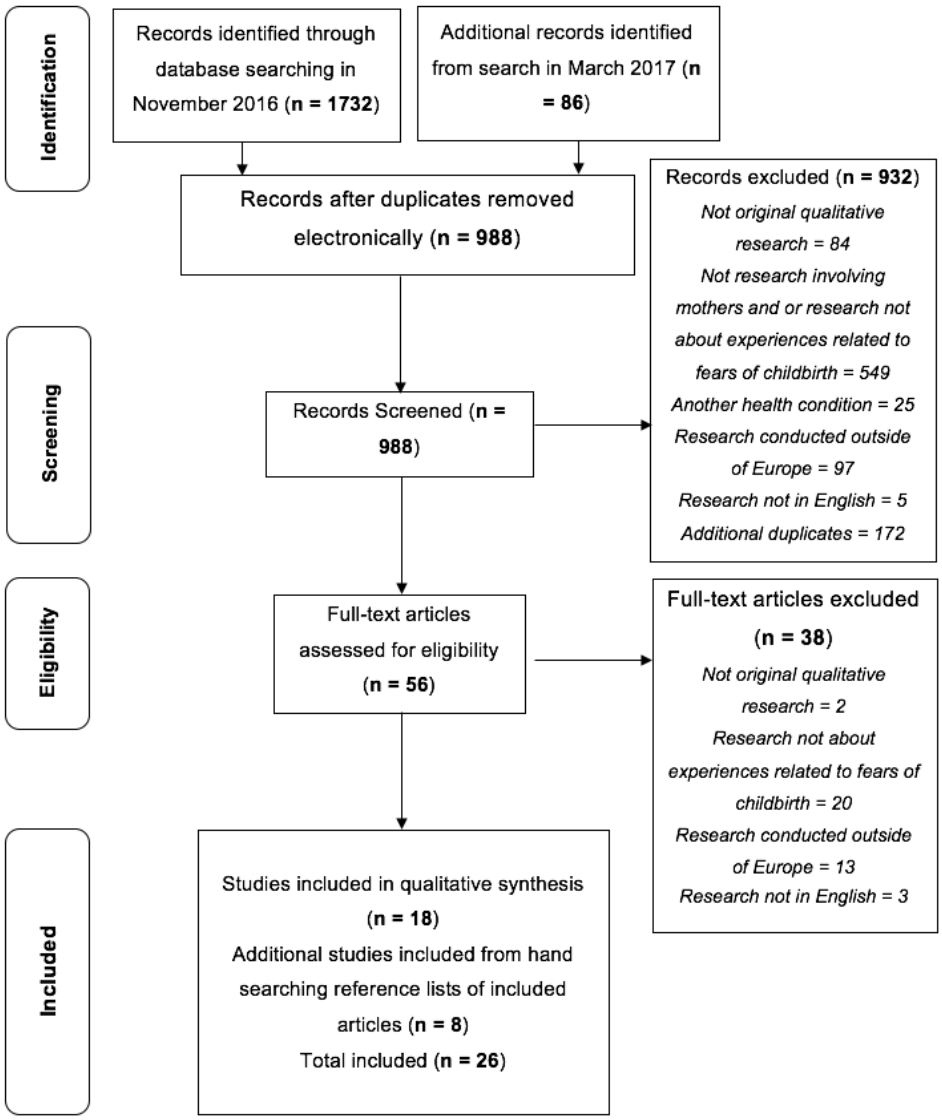
Table 3. Inclusion and exclusion criteria

Criteria	**Inclusion**	**Exclusion**
Research Design	Qualitative research	Quantitative research/non-original article (e.g. editorial)
Sample	Humans	Animals
Status	Mothers	Non-mothers
Research finding	Experiences of fear associated with childbirth	Research that does not explore experiences of fear associated with childbirth
Health	Pregnant/previously pregnant, but otherwise healthy	Another condition that may affect experience (e.g. previous renal transplant)
Area	Europe	Anywhere other than Europe
Language	English	Non-English

2.3 Study identification

A total of 1818 studies were identified from electronic databases (Appendix 4 provides totals for each database). However, 830 duplications were identified and removed by computer programs. The titles and abstract of the remaining 988 articles were examined for inclusion. A total of 932 articles were removed in line with the review criteria. The full texts of the remaining 56 articles were inspected for inclusion. An additional 38 articles were removed for failing to meet the eligibility criteria. This left 18 articles in the systematic review. An additional 8 studies were incorporated into the review after hand-searching reference lists. The search process is shown in Figure 1.

Figure 1. 'Preferred Reporting Items for Systematic Reviews and Meta-Analyses' (PRISMA) diagram (Moher, Liberati, Tetzlaff, Altman, & Group, 2009)



2.4 Quality appraisal

A twelve-item quality appraisal tool developed by Walsh and Downe (2006) was used for this review, because it was developed for qualitative studies and has been used in perinatal research (e.g. Reid, Sinclair, Barr, Dobbs, &

Crealey, 2009). Downe, Simpson, and Trafford (2007) created a scoring system for this tool that ranged from A (little to no weakness in study) to D (substantial issues with study). This system was used as a global rating of study quality. An independent researcher also scored the quality of the included studies. A second scoring system was developed to permit calculation of inter-rater reliability for individual studies and across all included studies. Each item on the appraisal tool was scored as either 1 (item either not covered or poorly covered), 2 (item partially covered) or 3 (item either completely covered to covered to a high standard). Appendix 5 provides a full outline of the quality appraisal tool and scoring systems.

2.4.1 Overview of quality assessment

The quality scores ranged from D (16) to A (35). Six articles were judged to meet the criteria for an 'A', 17 were scored 'B', two 'C' and one as a 'D'. Inter-rater reliability was calculated using Kappa coefficients (Cohen, 1960). These ranged from 0.63-1.00 for the individual studies and across all studies the coefficient was 0.81 ($p < .0001$), which indicated good inter-rater reliability.

All studies provided important information relating to the research question and none were excluded due to methodological quality (see Sandelowski, Docherty, & Emden, 1997). The 'scope and purpose' of the articles, methodological 'design' and 'interpretation' of the results were relatively well reported. Most provided information about the aims of the studies and grounded this in relevant literature. The data collection was typically well

specified and interpretation of the findings was generally clearly recorded and justified with participant quotations. However, researcher reflexivity tended to be poorly reported in the studies, which has been recognised as a common problem in qualitative research (Walsh & Downe, 2006).

2.5 Study characteristics

A summary of the 26 studies is provided in Table 4. The studies had a variety of aims, but all included findings related to mothers' fear of childbirth. Twenty-one studies collected data using face-to-face interviews, two studies included telephone interviews, one made use of open ended questionnaire responses, one used focus groups and one included data from both face-to-face interviews and focus groups. Such differences in methodologies may have affected the findings. This was considered when synthesising the studies.

Ten studies used qualitative content analysis, four used a phenomenological approach, four used a thematic analysis, three used grounded theory, one based interpretation on Antonovsky's sense of coherence theory and three studies were unclear in their specific qualitative approach. Content analysis can be a qualitative or quantitative research method (Krippendorff, 2004). All the studies using content analysis included in the current review used a qualitative approach. Hsieh and Shannon (2005) differentiated between three different types of qualitative content analysis. One type, termed a directed approach, uses pre-existing frameworks to guide coding. Such an approach would raise concerns about the comparability of findings with more data-

driven approaches such as interpretative phenomenological analysis (IPA). However, the content analysis studies included in this review were both interpretative and data-driven, which Hsieh and Shannon (2005) called convention qualitative content analysis approach.

There were variations in the quality of the reporting of participant demographics. For example, not all studies reported a mean age. However, the range of those that did was between 28 to 33. This may raise concerns over the transferability of the findings to different age groups. Approximately half of the studies were conducted in Nordic countries (54%) and half in the British Isles (42%). There was one study conducted in Spain. Additional information is provided in Table 4.

Table 4. Summary of included studies

First Author	Year	Aims of the study	Sample[1]	Pregnancy context at interview	Methods	Key themes reported in article	Quality score	Kappa
Hallgren	1995	To explore mothers' views of childbirth and childbirth education before and after delivery and education	11 Swedish primipara women and their partners were interviewed	Ante-natal and postpartum	Interpretation was based on Antonovsky's sense of coherence	Childbirth as a threatening event Perceptions of childbirth education Childbirth as a joyful but frightening event Childbirth as a normal process and a challenge Childbirth as a trustworthy life event	B (30)	0.69
Allen	1998	To explore traumatic birth and related factors	9 primipara women and 11 multipara women from UK were interviewed	Postpartum	Grounded theory	Not in control Action strategies following labour Consequences of experiencing a traumatic labour Theory of distress following traumatic childbirth	B (28)	0.71

[1] The information presented in this column was recorded in a consistent way across studies to ease comparisons. If it was not possible to extract these data, then it was considered missing.

Ryding	1998	To explore experiences of emergency caesarean section	29 primipara and 26 multipara Swedish women with a mean age of 29 were interviewed	Postpartum	Phenomenological approach	Thoughts and feelings during the course of events Thoughts about delivery/operation and about the baby Thoughts and comments about husbands Fear Derealization and amnesia Disapppointment Anger Causal attribution	B (30)	0.69
Melender	1999	To explore fear associated with pregnancy and childbirth and to establish whether they were considered warranted after birth.	10 primipara and 10 multipara Finnish women were interviewed	Postpartum	Content analysis	Object of fears Manifestation of fears associated with pregnancy and childbirth The justifiability of fears associated with pregnancy and childbirth	B (29)	0.70
Hofberg	2000	To identify and clarify tokophobia	26 women from UK were interviewed	Unclear but must be postpartum in part	Unclear form of qualitative analysis	Primary tokophobia Secondary tokophobia Tokophobia as a symptom of depression	D (16)	1.00

Gibbins	2001	To explore expectations and experiences of childbirth	8 primipara women from the UK were interviewed	Ante-natal and postpartum	Phenomenological approach	Women's childbirth expectations and experiences Women's feelings about labour How women felt after labour The impact of childbirth preparation	A (35)	1.00
Melender	2002b	Exploration of causes of fear related to pregnancy and childbirth and coping strategies	10 primipara and 10 multipara Finnish women were interviewed	Postpartum	Content analysis	Causes of fear associated with pregnancy and childbirth Dealing with fears associated with pregnancy and childbirth Seeking help Dispelling or alleviating fear associated with pregnancy and childbirth	B (32)	0.80
Nystedt	2006	To explore mothers' experiences of prolonged delivery	10 primipara Swedish women were interviewed	Postpartum	Content analysis	Being caught up in labour Being out of control Being dependent on others	B (32)	0.63
Eriksson	2006	To explore intense fear of childbirth	6 primipara and 14 multipara Swedish women with a mean age of 33 were interviewed	Postpartum	Grounded theory	Experiencing fear Dealing with fear Communicating fear	A (33)	0.80
Ayers	2006	To explore long-term	6 primipara women from the UK were interviewed	Postpartum	Thematic analysis	Effects on women	B (30)	0.69

		effects of traumatic birth				Effects on relationship with partner Effects on mother-child bond		
Weaver	2007	To explore mothers' requests for caesarean section	44 primipara and multipara women from UK were interviewed	Postpartum	Unspecified form of qualitative analysis	Women's views about caesarean section	C (27)	1.00
Barlow	2007	To explore mothers' experiences of pre-term labour	1 primipara and 7 multipara women from the UK with a mean age of 28 were interviewed	Ante-natal	Content analysis	Uncertainty and the search for meaning Communication Attribution of causality Social support Ambivalence and unintended pregnancy Prior experiences of pregnancy and childbirth Re-evaluation of lifestyle	B (28)	0.72
Ayers	2007	To explore experiences of traumatic birth	34 primipara and 16 multipara women from the UK were interviewed. 25 women had post traumatic stress symptoms and had a mean age of 30. The remaining 25 women did not have	Postpartum	Thematic analysis	Thoughts during birth Emotions during birth Postnatal cognitive processing Memories of birth	B (29)	0.85

			symptoms and had a mean age of 32					
Carlgren	2008	To explore experiences of consultation after labour and expectations of mothers that did not have a consultation	76 primipara and 74 multipara Swedish women were interviewed by telephone	Postpartum	Content analysis	To understand the course of events during labour To put into words undignified management To describe their behaviour and feelings To describe own fear	C (27)	0.85
Brodrick	2008	To explore views on childbirth of mothers prior to delivery and their views on the role of midwife	8 primipara women from UK were interviewed	Ante-natal	Thematic analysis	Maintaining internal control External control factors	A (34)	0.75
Nilsson	2009	To explore mothers' experiences of fear of childbirth	2 primipara and 6 multipara Swedish women were interviewed	Ante-natal	Phenomenological approach	The essential structure of the lived experience of fear of childbirth A feeling of danger that threatens and appeals Feeling trapped Feeling like an inferior mother-to-be On your own	A (33)	0.80

Lyberg	2010	To explore mothers' fear of childbirth and experiences of midwifery led care.	4 primipara and 9 multipara Norwegian women were interviewed	Postpartum	Content analysis	Being aware of barriers and reasons for fear Being prepared for childbirth Being confirmed and treated with dignity	A (33)	0.64
Tham	2010	To explore mothers' experiences with and without posttraumatic stress after emergency caesarean section and perceived support during birth	61 primipara and 23 multipara Swedish women were interviewed by telephone. 42 women with symptoms of post traumatic stress were recruited and 42 without symptoms were recruited	Postpartum	Content analysis	Action of midwives Content and organisation of care Women's emotions The role of the family	B (31)	0.69
Larkin	2012	To explore mothers' experiences of childbirth in Ireland.	9 primipara and 16 multipara women from the republic of Ireland took part in focus groups	Postpartum	Thematic analysis	Getting started Getting there Consequences	A (33)	0.80
Rilby	2012	To explore feelings about future childbirth in mothers that have at least one child.	908 Swedish women with at least one child who completed questionnaire	Postpartum	Content analysis	Fear Anticipation Confidence	B (30)	0.83

Lopez	2015	To explore perception of mothers with increased chance of prolongation in pregnancy.	7 primipara Spanish women with a mean age of 29 were interviewed	Ante-natal	Qualitative descriptive methodology	Representations of themselves, support individuals and future descendant Emotional wellbeing	B (30)	0.83
Iles	2015	To develop a theory of first-time mothers' experiences of postnatal posttraumatic stress.	11 primipara women from the UK with a mean age of 32. 6 with full symptoms of posttraumatic stress and 5 with partial symptoms were interviewed	Postpartum	Grounded theory	Fear and anxiety Coping and support processing Choice and control Me and my story Power of my experience	B (31)	0.84
Finlayson	2015	To explore experiences of self-hypnosis during labour and birth	16 primipara women from UK with a mean age of 30 were interviewed. They had previously taken part in a randomised controlled trial for self-hypnosis for pain relief	Postpartum	Thematic network analysis	Unexpected consequences	B (29)	0.85
Erlandsson	2015	To explore mothers' experiences of unplanned out of hospital births	10 Swedish women including an unknown mixture of primipara and multipara mothers were interviewed	Postpartum	Phenomenological approach	Balancing emotions Handling unfamiliar actions	B (31)	0.67
Ternström	2016	To explore pregnant mothers'	18 primipara and 13 multipara Swedish	Ante-natal	Content analysis	Understanding the questionnaire in terms of severity of worry and fear	B (29)	0.85

		perceptions of a fear of childbirth scale.	women were interviewed			Examples of worries and fears Worry unspecific feelings, sensations and thoughts about an unpredictable event Fear – a strong situation-specific feeling Aspects that influence worry and fear Strategies to cope with worry/fear		
Nilsson	2017	To explore views of vaginal birth after caesarean section	22 multipara women from Finland, Netherlands or Sweden took part in focus groups or were interviewed	Postpartum	Content analysis	Receiving information from supportive clinicians Receiving professional support from a calm and confident midwife or obstetrician during childbirth Knowing the advantages of VBAC Letting go of the previous childbirth in preparation for the new birth Viewing VBAC as the first alternative for all involved when no complications are present	B (32)	0.82

2.6 Synthesis of the findings

A meta-ethnographic approach was used to synthesise the findings from the studies (Atkins et al., 2008; France et al., 2014; Lang, France, Williams, Humphris, & Wells, 2013; Noblit & Hare, 1988; Purc-Stephenson & Thrasher, 2010), because it is appropriate for integrating and interpreting qualitative data and is regularly used in health research (Atkins et al., 2008). The current review was guided by the approach developed by Noblit and Hare (1988), which is detailed in Appendix 6.

Papers were read and re-read and themes, concepts and ideas were recorded. It was difficult to compare the original themes reported in the articles, because there were so many gathered from this process (see Table 5). Therefore, in line with other meta-ethnographies (e.g. Atkins et al., 2008; Purc-Stephenson & Thrasher, 2010), a thematic analysis was conducted of the themes in the articles. Each article was coded according to themes related to the research question. This was an iterative process whereby the themes were revised as new ideas were introduced by articles. To establish how the papers were related, a table was created listing the articles on the vertical axis and themes on the horizontal axis. Themes in each individual paper were then compared using an approach reported by Atkins et al. (2008). Each paper was placed in chronological order. The themes in paper 1 were then compared with paper 2. The synthesis of this process was then compared with paper 3 and so on until all articles had been considered. The final stage of the analysis

was to develop meta-themes providing an overarching framework to account for the findings of the original articles.

2.7 Reflexivity

The author was a male and so had no first-hand experience of pregnancy or giving birth. However, he was a father and had experience of his wife going through childbirth. Her experience was quite traumatic. It is acknowledged that these experiences may have an influenced his interpretation of the findings from this review.

3. Findings

Three meta-themes were identified from the 26 articles. These were ‘the nature of fear related to childbirth’, ‘external influences on fear’ and ‘internal influences on fear’. Within each of these meta-themes a series of subthemes were developed. Table 5 shows which meta-themes, and subthemes, were considered in the articles.

Table 5. Meta-themes and subthemes identified in the systematic review

Theme	**The nature of fear related to childbirth**			**External influences on fear**			**Internal influences on fear**	
Sub-themes	*The development of fear and role of uncertainty*	*Mothers' relationship with fear*	*Impact of fear*	*Social factors*	*Media*	*Environment*	*Coping strategies*	*Physical circumstances*
Hallgren, Kilgren, Norberg & Forslin (1995)	✓	✓		✓				
Allen (1998)	✓	✓	✓	✓				
Ryding et al. (1998)	✓	✓	✓	✓			✓	✓
Melender & Lauri (1999)	✓	✓	✓	✓			✓	✓
Hofberg & Brockington (2000)	✓		✓	✓			✓	
Gibbins & Thomson (2001)	✓							
Melender (2002b)	✓			✓	✓	✓	✓	✓
Nystedt, Högberg & Lundman (2006)	✓	✓		✓				
Eriksson et al. (2006)	✓	✓		✓	✓	✓	✓	
Ayers, Eagle & Waring (2006)	✓		✓					
Weaver, Statham & Richards (2007)	✓			✓			✓	

Barlow, Hainsworth & Thornton (2007)	✓						✓		
Ayers (2007)	✓	✓		✓			✓		
Carlgren & Berg (2008)	✓	✓	✓	✓					
Brodrick (2008)	✓	✓							
Nilsson & Lundgren (2009)	✓	✓	✓	✓			✓	✓	
Lyberg & Severinsson (2010)	✓	✓	✓	✓			✓		
Tham, Ryding & Christensson (2010)	✓			✓			✓		
Larkin, Begley & Devane (2012)	✓			✓		✓			
Rilby, Jansson, Lindblom & Mårtensson (2012)	✓	✓	✓	✓			✓		
Lopez, Grey, Hiller & Chen (2015)	✓			✓				✓	
Iles & Pote (2015)	✓		✓	✓			✓		
Finlayson et al. (2015)	✓			✓	✓		✓		
Erlandsson, Lustig & Lindgren (2015)	✓						✓		
Ternström, Hildingsson, Haines & Rubertsson (2016)	✓	✓		✓	✓		✓	✓	
Nilsson, van Limbeek, Vehvilainen-Julkunen & Lundgren (2017)	✓			✓		✓	✓		

3.1 The nature of fear related to childbirth

This meta-theme provided information about what it was like for mothers to be afraid of childbirth. There were three subthemes: ‘the development of fear and role of uncertainty’, ‘mothers’ relationships with fear’ and the ‘the impact of fear’.

3.1.1 The development of fear and role of uncertainty

This meta-subtheme was focused on when mothers first noticed their fear of childbirth, factors that predisposed them to it and the types of fear that they reported. Three articles discussed when mothers became aware of their fear related to childbirth (Eriksson et al., 2006; Hofberg & Brockington, 2000; Nilsson & Lundgren, 2009). Hofberg and Brockington (2000) reported that the women in their study with primary tokophobia noticed their fear of childbirth when they were teenagers. However, this paper had several methodological problems, which raises concerns about drawing firm conclusions solely from it. For example, the authors did not clearly specify their design or method of data analysis. There was also a lack of quotes from participants to provide evidence for their interpretations. However, Eriksson et al. (2006), who were much clearer in reporting their design and methods, and used participant quotations throughout their article to illustrate their findings, also found that some mothers recognised their fear as teenagers.

"*I was terrified even as a teenager*"

(Eriksson et al., 2006 pp243)

In contrast, other mothers had not become aware of their fear until much later. This included after deciding to become pregnant (Eriksson et al., 2006), after a traumatic birth (Hofberg & Brockington, 2000) or even when considering it as part of a research study.

"*When I got the questionnaire I thought 'of course I'll fill it out' and then I started to feel the anxiety*"

(Eriksson et al., 2006 pp243)

Nilsson and Lundgren (2009) wrote about how some mothers identified their fear related to childbirth much later, because they had avoided thinking about it. Their experience was therefore initially one of unawareness of fear.

"*With hindsight I can see, I skipped those chapters all the time. I didn't want to confront it, and instead I just brushed it aside. And I was totally unaware that I was perhaps afraid…*"

(Nilsson & Lundgren, 2009 ppE4)

The findings reported in the articles suggested that certain situations could predispose a mother to develop fear related to childbirth. These could be broadly categorised along two dimensions. The first was related to previous, and often brutal (e.g. invasive and painful medical procedures such as

episiotomy), experiences of childbirth (e.g., Allen, 1998; Hofberg & Brockington, 2000; Larkin et al., 2012; Melender, 2002b; Ryding et al., 1998; Weaver et al., 2007). For example, Allen (1998) described about how two mothers in their study had previously experienced their babies dying during labour and they were terrified this would happen again.

> "*I just got panicky because I thought I may end up going down the same road as I had with the first one so I was afraid that the same thing was going to happen*"
>
> (Allen, 1998 pp115)

Larkin et al. (2012) found that previous negative experiences related to mothers' fear. This study was particularly well reported and achieved an 'A' grade. It was relatively unusual compared to the other studies because it considered issues of researcher reflexivity. For example, the authors reported how they checked their interpretations with participants for validity and kept reflective diaries during their data collection. Larkin et al. (2012) described a mother who had endured an episiotomy during a previous labour and who was afraid of having another one. This mother highlighted the significance of this fear by indicating it was her worst nightmare.

> "*It was my worst nightmare when I was about four months pregnant, I said to her (consultant) 'I have horrors about an episiotomy' (whispers) and she said (brightly) 'we'll try and avoid it*'"
>
> (Larkin et al., 2012 pp102)

Nilsson and Lundgren (2009) described three types of previous negative birthing experiences that predisposed multiparous women to fear of future childbirth: those related to significant pain, those associated with poor interactions with healthcare staff and those related to feelings of a loss of identity as an individual. Of course, as previously mentioned, significant pain is to be expected during childbirth. However, a crucial factor determining the development of fear of childbirth appeared to be the women's interpretations of these experiences. Nilsson and Lundgren (2009) argued that the combination and interaction of these three factors were inconsistent with the mother's self-image, and likely their expectations, which left them with increased uncertainty over future childbirth. Other types of previous negative experiences were also linked with the development of fear related to childbirth such as sexual abuse prior to becoming pregnant (Hofberg & Brockington, 2000). In addition, negative, and often brutal, birthing experiences were not just linked to a mothers' own experiences. For example, Melender (2002b) wrote about how one mother described the impact of others' stories on her.

> "*Well, it may be the mental image that I have, as I have heard the horror stories of other women*"
>
> (Melender, 2002b pp260)

Whilst previous experiences had caused fear related to childbirth in some mothers, others linked their fear with uncertainty. Melender (2002b) described how first-time mothers associated their fear with the unknown as they had not

been through it before. Indeed, Melender (2002b) argued that uncertainty was a common issue with both nulliparous and multiparous women. Multiple sources of uncertainty were outlined in the articles such as those associated with the health of the baby, health of mother and being overdue (e.g., Brodrick, 2008; Melender & Lauri, 1999; Melender, 2002b; Nilsson & Lundgren, 2009). There appeared to be a link between mothers' fear and a failure to achieve their hoped-for birth. Such expectations and plans may have been an attempt to develop some certainty and so variations from them may have represented a loss of certitude.

> "*mothers described strong negative emotions during the labour and birth and fears of things going wrong; this was based on a mixture of actual events not fitting their expectations and increasing need for medical intervention*"
>
> (Iles & Pote, 2015 pp244)

Table 6 shows the types of fears that were reported by the mothers in the studies. Whilst these fears were differentially grouped according to similar themes, nearly all these fears could be characterised as representing some form of uncertainty about childbirth and or a loss of control. Many could be framed as a 'what if' thoughts (e.g., 'what if' I lose control, 'what if' I embarrass myself, 'what if' I am not good enough as a mother, etc.). However, some mothers continued to experience fear after their child was born and described concerns about what could have happened. Carlgren and Berg (2008) described how one mother maintained that her child had been harmed by

premature birth despite having a successful delivery. Therefore, gaining certainty over the situation did not always reduce the mothers' fear. There appeared to be a fear of being afraid during labour, feeling out of control and not coping (Allen, 1998; Hallgren et al., 1995; Nystedt et al., 2006). Several mothers exhibited a lack of confidence and questioned whether they could deliver their babies (Hofberg & Brockington, 2000; Nilsson & Lundgren, 2009).

Table 6. Types of fears reported in the studies

Fear category	Description of fear
Physical/Medical	Fear of injury, poor physical health and/or death of baby
	Fear of injury, poor physical health and/or death of mother
	Fear of medical procedures such as caesarean section
	Fear of hospitals
	Fear of incompetence of medical staff during birth
Process of birth	Fear of giving birth vaginally
	Fear of a long and/or painful birth (i.e. it may hurt)
	Fear of being overdue causing suffering for the baby
	Fear of being excluded from decisions and lacking ownership of birth
	Fear that birth progresses so rapidly that the mother does not get to hospital in time
	Fear of baby being born without staff present
	Fear of having a large baby and therefore having difficulty giving birth (e.g. particularly painful and/or causing damage).
Reactions of self and others	Fear of partner's ability to cope with seeing the mother giving birth (e.g. difficultly seeing them in pain).
	Fear that partner would not be able to be present at the birth
	Fear of embarrassing events during birth (e.g. defecating)
	Fear of losing control of oneself (i.e. physically and emotionally) and not coping with labour
	Fear of judgement from others (e.g. other mothers or health professionals) for having difficult feelings and experiences
Parenting and relationships	Fear related to not being a good enough mother
	Fear that mother lacks emotional capacity to have, and parent, another baby
	Fear of impact of birth on an insecure relationship with partner
	Fear that partner is not the child's biological father
Other types of fears	Fear of what may have happened during labour despite a medically successful birth
	Fear of unknown (i.e. unknowable process of childbirth)

3.1.2 Mothers' relationships with fear

Having defined predisposing factors and the types of fear related to childbirth reported in the articles, it is important to establish mothers' relationships with their fear. This meta-subtheme focused on the experience of fear and how mothers interpreted it. Several of the original themes in the articles were related to this meta-subtheme such as "*the loneliness"* [of fear of childbirth] (Nilsson & Lundgren, 2009 ppE4). Ternström et al. (2016) reported that mothers experienced fear as being associated with specific situations, which differentiated it from worry that was general in nature. Several studies wrote about how mothers felt overtaken or dominated by their fear (e.g., Brodrick, 2008; Eriksson et al., 2006; Nilsson & Lundgren, 2009; Nystedt et al., 2006; Ryding et al., 1998; Ternström et al., 2016). One mother described it as "*…a ghost in my mind*" (Eriksson et al., 2006 pp242). Fear was experienced as a powerful emotion that "…*just overtook the pain…*" (Ayers, 2007 pp259). The dominance of fear was such that it left some mothers' feeling trapped and unable to escape the impending reality of childbirth (Lyberg & Severinsson, 2010; Nilsson & Lundgren, 2009).

> "*When I go for an examination I may be afraid and feel anxious beforehand, but I know that it's my own choice to attend. But when I am giving birth I am trapped, I could not leave without going through with it, there was no loophole and I felt as if I was suffocating.*"
>
> (Lyberg & Severinsson, 2010 pp386)

However, not all mothers experienced fear as a constant dominating force. Others described how their relationship with fear waxed and waned over time.

> "*It wasn't a massive anxiety the whole time: I thought a lot about it sometimes, and sometimes it was hardly there: it was worst in the end*"
>
> (Eriksson et al., 2006 pp243)

Many mothers thought that it was inevitable that they would have to go through childbirth on their own. This left them with a sense of isolation (Allen, 1998; Nilsson & Lundgren, 2009). Nilsson and Lundgren (2009) was a well reported study and received high ratings on most of the 12 components of the appraisal tool, which indicates their findings can be interpreted with confidence. They reported how several mothers were quite punitive towards themselves for being afraid; it was almost as if they were unable to permit themselves to feel this way.

> "*First being scared of something and then feeling useless because you're scared of it*"
>
> (Nilsson & Lundgren, 2009 ppE5)

In contrast, other mothers appeared to embrace the fear and suggest that it is "*… an integral part of pregnancy*" (Melender & Lauri, 1999 pp180). Indeed, despite their fear, many considered labour to also be a positive or alluring experience (Hallgren et al., 1995; Rilby et al., 2012). This was often connected

with the reward of meeting their newborn baby. This feeling was captured in the study by Nilsson and Lundgren (2009), which explicitly included mothers who had significant fear related to childbirth, and so it was not just limited to those with relatively low levels of fear. One multipara woman said:

> *"It would be great to do it and feel the pain disappear as soon as the baby is out. Yes, and lift the child onto my stomach and feel that I can now cope with this and get to experience the feeling that nobody can describe"*
>
> (Nilsson & Lundgren, 2009 ppE5)

3.1.3 The impact of fear

This subtheme referred to the impact of mothers' fear. Studies discussed how mothers attempted to avoid future pregnancies and childbirth by excessive use of birth control methods (e.g. Hofberg & Brockington, 2000), avoiding sex with their partners (e.g. Ayers et al., 2006) and in some cases consideration of sterilisation (e.g. Eriksson et al., 2006).

> "*You have to sterilize me, you have to sterilize me . . . I can't get pregnant, I'm terrified of getting pregnant*"
>
> (Ayers et al., 2006 pp394)

Several mothers spoke about how they had been planning on having more children and so the choice to not have any more was akin to a grieving process (Ayers et al., 2006; Rilby et al., 2012). However, some mothers chose to try

to have another child despite their fear (e.g. see Ayers et al., 2006; Hofberg & Brockington, 2000; Rilby et al., 2012). The prospect of having another baby was a motivator for some (Rilby et al., 2012), but for others there was a need to replace their negative experience with a more positive one (Nilsson & Lundgren, 2009). Other reported consequences of being afraid of childbirth and or experiencing traumatic labour included feelings of low mood and difficulties with bonding with babies (Hofberg & Brockington, 2000; Iles & Pote, 2015).

3.2 External influences on fear

Three meta-subthemes represented external influences on mothers' fear: 'Social factors', 'media' and 'environment'.

3.2.1 Social factors

This subtheme referred to the influence that other people had on mothers' fear related to childbirth. This included support from healthcare professionals, family and friends. Several of the original themes in the articles were related to this meta-subtheme such as "*being dependent on others*" (Nystedt et al., 2006 pp61). Several studies described how primipara and multipara mothers felt an urge or a need to get support and reassurance from other people (e.g. Allen, 1998; Lopez et al., 2015; Melender, 2002b; Nilsson & Lundgren, 2009). However, Hallgren et al. (1995) wrote about how some mothers were ambivalent towards support from childbirth education classes, because they

were concerned about them exacerbating their fear. When mothers did not get the support that they wanted it made their fear worse.

> "*I would've liked to talk about when they inserted that catheter. I wanted to be under a general anesthesia...I was frightened, so afraid that it would hurt. I had no idea...I could've found out before...got some more information, that it didn't hurt, then I wouldn't have been so frightened, because it didn't hurt. I could've found out the day before*."
>
> (Carlgren & Berg, 2008 pp36)

In contrast, several of the mothers who received the support that they wanted (e.g. feeling heard by staff, supported to set goals for coping with fear and inspiring them to feel confident and calm during labour through a containing and competent manner) had positive birthing experiences, which was true of both mothers with (e.g. Eriksson et al., 2006) and without (e.g. Rilby et al., 2012) significant fear of childbirth. Communication was an important factor in moderating mothers' fear (e.g., Eriksson et al., 2006; Lyberg & Severinsson, 2010; Melender & Lauri, 1999). Although it was difficult to talk, several mothers found that sharing their fear helped reduce it (e.g. Melender, 2002b). However, for others it served to exacerbate them (e.g. Eriksson et al., 2006). This was particularly true when other people gave out misjudged advice. For example, one primipara mother said:

"*It was just like a slap on the shoulder and you know; women have been having children forever and all that*"

(Eriksson et al., 2006 pp245)

3.2.2 Media

This meta-subtheme referred to the impact that the media had on mothers' fear related to childbirth. Finlayson et al. (2015) discussed how the show 'One born Every Minute' was highlighted by several primipara mothers, which is a documentary series about childbirth. The impact was negative and it elevated their antecedent fears and anxieties about childbirth. The studies that made references to media influences were of a relatively high methodological quality (grades A and B). Areas of strength of all these articles included clearly defined data collection strategies and clear interpretation of findings. These studies considered mothers with varying levels of fear. Therefore, this finding was not limited to those with intense fear. All the articles indicated that information provided through the media served to heighten fear.

"*I kept watching that 'One Born Every Minute' programme and it makes you more frightened*"

(Finlayson et al., 2015 pp18)

3.2.3 Environment

This meta-subtheme considered the impact that the birthing environment had on the mothers' fear. It was linked with the theme "*Providing calm surroundings and continuous attentive guidance*" developed by Nilsson et al. (2017 pp330). Mothers spoke about how noisy and chaotic environments exacerbated anxieties. Larkin et al. (2012) described how some mothers felt that the buildings in which they gave birth were frightening.

> "*The building itself, you know, it is so claustrophobic and give me a weird feeling, emotions of this kind of, almost a...feeling of foreboding about the building*"
>
> (Larkin et al., 2012 pp102)

However, it is important to note that this experience of the birthing environment was not shared by others who "*defended the hospital and said staff were doing the best they could*" (Larkin et al., 2012 pp102). Multiparous mothers in the study by Nilsson et al. (2017) described their ideal birthing environment as peaceful and with as few people as possible being present.

> "*I don't need so many people there. Just my husband and the obstetrician, that's fine. . . . The ambience just has to be calm, I mean*"
>
> (Nilsson et al., 2017 pp 330)

Both Eriksson et al. (2006) and Melender (2002b) indicated that being able to visit the place that they were going to give birth helped mothers' cope with their fear.

3.3 Internal influences on fear

This meta-theme was made up of two subthemes: 'coping strategies' and 'physical circumstances'. These referred to personal coping strategies for fear of childbirth and the role of physical factors in moderating this fear.

3.3.1 Coping strategies

Several articles discussed how caesarean section was held in mind as a way of coping with fear of vaginal birth (e.g., Eriksson et al., 2006; Lyberg & Severinsson, 2010; Melender & Lauri, 1999; Nilsson & Lundgren, 2009; Ryding et al., 1998). Lyberg and Severinsson (2010) discussed how one multiparous mother felt conflicted because she wanted to have a caesarean section to help with her fear, but this was inconsistent with her ideal delivery plan.

> "*I could not feel happy about my pregnancy because I was so anxious about giving birth. I did not really know why I was so concerned, the only thing I thought was that if I can have a caesarean section I won't have to worry about it, but in my innermost mind I did not want a caesarean*"
>
> (Lyberg & Severinsson, 2010 pp386)

Weaver et al. (2007) described how some mothers considered caesarean section to be a less risky option for childbirth, which was likely a way of justifying their choice. However, this study had some methodological problems. Most notably, it was unclear what type of analysis was used for the data. It is important to note that whilst caesarean section helped some mothers cope with their fear, it caused or created fear in others (Nilsson et al., 2017). Another form of medical intervention that was considered to alleviate fear related to childbirth was to have an abortion (Hofberg & Brockington, 2000; Melender & Lauri, 1999). A less extreme way of coping that was reported by mothers was to distract oneself and avoid thinking about childbirth.

> "*I avoided looking at pictures or reading about deliveries*"
>
> (Eriksson et al., 2006 pp 244)

However, some mothers found information about childbirth reassuring (e.g. Iles & Pote, 2015). This may have been a way of seeking certainty in an uncertain situation and empowering oneself.

> "*I really wanted to read everything I could get my hands on about it – good and bad, so that I felt well-equipped*"
>
> (Iles & Pote, 2015 pp 246)

Other coping strategies that were mentioned included processing the fear by writing a letter (e.g. Eriksson et al., 2006; Melender, 2002b), acceptance of the situation (e.g. Barlow et al., 2007; Melender, 2002b), focusing on positive thoughts (e.g. Eriksson et al., 2006; Iles & Pote, 2015; Melender, 2002b), utilisation of anxiety management techniques (e.g. Eriksson et al., 2006) and self-hypnosis (Finlayson et al., 2015). However, self-hypnosis was only reported by Finlayson et al. (2015) and their study was linked to a trial on hypnosis for labour. Finally, several mothers discussed how they compared themselves to other mothers. Whilst for some it was helpful to appreciate that others had similar experiences (e.g. Melender, 2002b), others found that it lowered their confidence (Eriksson et al., 2006; Nilsson & Lundgren, 2009). Iles and Pote (2015) summed up the effectiveness of comparing oneself to others by saying "*Perceiving similar experiences to other mothers was helpful and normalising, but perceiving difference was associated with failure, low mood and shame*" (pp 249).

3.3.2 Physical circumstances

This meta-subtheme reflected the role of mothers' physical health, and physical sensations, on their fear related to childbirth. Ryding et al. (1998)

discussed how some mothers had felt disconnected from reality "*in an extremely frightening way*" (pp 249) during emergency caesarean section. It was noted that most of these mothers had difficulties with their physical health, which likely contributed towards a frightening experience. Nilsson and Lundgren (2009) and Melender and Lauri (1999) reported how some mothers experienced their fear somatically. They had such physical symptoms as stomach problems, raised heart rate, difficulties breathing and disturbed sleep.

> "*Sleeping 3 or 4 hours a night means that you become extremely tired and then I become even more scared of the birth. All these factors; concern about my job, concern about the birth, concern about what it means to feel the way I do, what it says about me*"
>
> (Nilsson & Lundgren, 2009 ppE4)

However, this subtheme also encompassed ways in which physical health, and physical sensations, could be beneficial to the mother in coping with their fear. For example, Ternström et al. (2016) described how some mothers kept themselves "*physically fit*" (ppE48) to prepare themselves for birth. Furthermore, Melender (2002b) indicated that some mothers found that the sensations of fetal movements helped reduce their fear by focusing on more positive experiences. However, Lopez et al. (2015) indicated that mothers' fears were increased in those with prolonged pregnancy when they could no longer feel their baby move.

4. Discussion

This meta-ethnographic review aimed to synthesise qualitative findings relating to mothers' fear associated with childbirth. A total of 26 articles were included, which contributed towards three meta-themes. These related to the nature of mothers' fear and external and internal factors that influenced it. There were commonalities in findings reported across the articles, which indicated that the studies formed, at least in part, a 'reciprocal translation' (Atkins et al., 2008; France et al., 2014; Lang et al., 2013; Purc-Stephenson & Thrasher, 2010). This is a termed used in meta-ethnography to represent when findings reported in different studies are comparable. However, there were also complexities present in the findings that meant that it was difficult to provide a singular account of mothers' experiences of fear related to childbirth.

4.1 Summary of findings

Some mothers were aware of their fear related to childbirth from a young age, whereas others did not become aware of them until an external factor cued them to think about it (e.g. becoming pregnant). Two broad types of predisposing factors were associated with fear of childbirth. First, a previous, and often brutal, negative experience of childbirth. Second, difficulties coping with the uncertainty of giving birth. The impact of fear related to childbirth was significant for some mothers. For example, several studies reported that mothers avoided future childbirth and in some cases considered sterilisation.

The relationship that mothers shared with their fear appeared to be deeply personal and varied between studies. Some characterised their fear as a constant dominating force and thought that childbirth left them feeling lonely and trapped. However, others described how their fear waxed and waned over time. Some mothers were quite self-critical about having fear (Nilsson & Lundgren, 2009), which contrasted with others who embraced it as part of being pregnant (Melender & Lauri, 1999).

The mothers' experiences of fear related to childbirth were influenced by social interactions (e.g. with healthcare professionals), information presented in the media and personal coping strategies. Comparisons with other mothers was most helpful when they had shared experiences (Iles & Pote, 2015). There was consensus that the way that information about childbirth was presented in the media served to increase mothers' fear.

4.2 Relation to previous literature

Studies have shown that fear related to childbirth is common (e.g. Melender, 2002a) and exists on a spectrum (e.g. Pallant et al., 2016). The current study supported this finding by reporting experiences of relatively low levels of fear (e.g. Brodrick, 2008) to much more severe levels of fear (e.g. Eriksson et al., 2006). Previous negative birthing experiences have been found to predispose a mother to fear related to childbirth (e.g. Nilsson et al., 2012), which was supported by the current review. Anxiety has also been found to predict fear

of childbirth (e.g., Söderquist et al., 2004; Spice et al., 2009). The current review highlighted how difficulties tolerating uncertainty was linked with fear related to childbirth. Intolerance of uncertainty is often a focus of psychosocial interventions designed to reduce anxieties (e.g. Boswell, Thompson-Hollands, Farchione, & Barlow, 2013). Therefore, difficulties with uncertainty may account for a proportion of the variance in the relationship between anxiety and fear of childbirth. Research has indicated that fear of childbirth may lead some mothers to seek caesarean section (e.g. Nieminen et al., 2009). Whilst this appeared to be true for some of the mothers included in this review, caesarean section was also found to cause or exacerbate fear in other mothers (e.g. Ryding et al., 1998). Rondung et al. (2016) found that previous negative experiences can lead to fear of childbirth and that avoidance is one way in which mothers cope with this fear. The current review supported these findings, but it has also added something unique to the literature. It has provided information on when mothers first became aware of their fear, the impact of their fear, the role of the birthing environment on their fear and an insight into what it was like for mothers to experience fear related to childbirth.

4.3 Limitations

This systematic review was focused on mothers' experiences of fear related to childbirth within Europe. It was anticipated that this may provide an insight into differences between countries. However, the findings reported in this review were largely comparable across countries. Most of the included studies were conducted in the British Isles or in Nordic countries. It is uncertain

whether the current findings are transferable to other European regions and non-European countries. Rondung et al. (2016), however, suggest that some European findings can be generalised cross-culturally.

Steps were taken to ensure that the current review was methodologically rigorous (e.g. consistent with other meta-ethnographies), transparent (e.g. by using appropriate quotations) and consistent with original interpretations of the data (e.g. by making references to original themes). Furthermore, the author's previous experiences with childbirth were made explicit to provide context to the analysis (Creswell & Miller, 2000; Walsh & Downe, 2006). However, it is likely that the results of the review were influenced by the way that the author interpreted the articles. This is general issue with qualitative research and not necessarily limited specifically to this systematic review (Al-Natour, 2011; Shenton, 2004). It would have been beneficial to have collaborated with co-authors during data extraction and analysis (e.g. Purc-Stephenson & Thrasher, 2010). This would add an additional layer of validity to the interpretations, because they would be based on more than one person's analysis. However, this was not possible because the review was submitted as part of a doctoral thesis and was required to be the author's own work.

4.4 Clinical implications

Several studies showed how some mothers identified that they were afraid of giving birth many years before becoming pregnant (e.g. Hofberg &

Brockington, 2000; Eriksson et al., 2006). It may therefore be useful to set up early intervention initiatives to raise awareness of this issue and provide opportunities for women to talk to professionals before becoming pregnant. There was evidence that some mothers became quite self-critical and regarded their fear related to childbirth as a weakness (e.g. see Nilsson & Lundgren, 2009). Psychological interventions that challenge unhelpful beliefs (e.g. Cognitive Behaviour Therapy), promote self-compassion (e.g. Compassion Focused Therapy) and encourage non-judgemental awareness (e.g. Mindfulness-based therapies) may be beneficial for some mothers with fear related to childbirth. There was evidence that the way childbirth is portrayed in the media served to increase some mothers' fear (e.g. Finlayson et al., 2015). There may be scope to set up national campaigns to promote accurate information about childbirth and to raise awareness of issues related to fear of childbirth.

4.5 Future research

It would be useful for both research and clinical practice to establish whether the results of this review are transferable to other countries. Therefore, future studies could seek to conduct a meta-ethnographic review of literature exploring mothers' experiences of fear related to childbirth in other geographical regions. Fear related to childbirth has also been found in fathers (e.g. Ganapathy, 2015). A systematic review of fathers', or birthing-partners', experiences of their own, or their significant others, fear related to childbirth would be important. This is because it may interact with mothers' fears. In

addition, such research would provide useful information which may stimulate the appropriate development of interventions to help with other people's fears associated with childbirth. Finally, a logical extension of this research would be to explore the literature relating to parents' fears and anxieties in the postnatal period. Such research has the potential to benefit parents in terms of providing useful information to enable the provision of appropriate support to improve their quality of life. It may also benefit their children by supporting the parents' capacity to nurture them and enable appropriate emotional and cognitive development.

4.6 Conclusions

This was the first meta-ethnography of mothers' experiences of fear related to childbirth. There were some clear commonalities in experiences across studies, but also some important differences which highlights the complexity of this phenomenon. The potential impact of this fear on mothers, their children and their wider families can be significant. It is therefore important for healthcare professionals to be mindful of mothers' fear and to take opportunities to discuss them empathetically.

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Chapter two

The discursive construction of illness identity by fathers who consider themselves to have had paternal postnatal depression

This chapter was prepared for submission to *The Journal of Men's Studies*. Appendix 7 provides detailed author guidelines from this journal. The word count for this chapter, excluding abstract, tables and references, is 8000.

Abstract

Postnatal depression (PND) is typically associated with mothers. However, there is growing evidence that fathers can also experience low mood following the birth of their children. The primary aim of this study was to explore how fathers who considered themselves to have PND constructed their illness identity with their speech. Six fathers took part in semi-structured interviews and data were analysed with discourse analysis. The results showed how men positioned PND as something that happens to women rather than men. Several fathers constructed masculine identities to account for difficulties talking about PND. The men spoke about being deficient fathers due to PND. This study has highlighted the importance of how PND is framed by healthcare professionals working with fathers.

Abstract word count: 120

Keywords: Fathers, postnatal depression, masculinity, discursive psychology

1. Introduction

The journey to becoming a parent often encompasses a change in responsibilities, routine and life course (Baxter & Evans, 2013). Adapting to these changes may be especially difficult for parents with mental health problems (Edhborg, Carlberg, Simon, & Lindberg, 2016). One of the most common mental health problems associated with having a child is depression in the postnatal period (National Institute for Health and Care Excellence [NICE], 2015). Although this tends to be associated with mothers, there is growing evidence that fathers can also experience depression following the birth of their children (Lee & Chung, 2007). The focus of this study is on fathers with depression in the postnatal period and how they talk about their condition.

1.1 Postnatal depression

Postnatal depression (PND) is a term that is frequently used in public discourse (National Health Service [NHS], 2017) and one which is recognised by the Royal College of Psychiatry (2017). However, there exists no official diagnostic criteria specifically for this condition. Instead both the Diagnostic and Statistical Manual of Mental Disorders ([DSM-5] American Psychiatric Association, 2013), and the International Statistical Classification of Diseases and Related Health Problems ([ICD-10] World Health Organisation, Organisation, 1992), use the criteria for depression and place onset restrictions of within 4 weeks and 6 weeks postpartum, respectively. These temporal restrictions are at odds with several organisations (e.g. NHS, 2017),

researchers and clinicians (e.g., Musters, McDonald, & Jones, 2008; O'Hara, 2009), who suggest that symptoms of depression can be observed anytime within the first year after birth. Given the ubiquity of the term PND in the United Kingdom (UK), it was used in the current study. However, it is acknowledged that other terminology is also used in the literature (e.g. postpartum depression).

It has been argued that PND in fathers (referred to here as paternal PND) has been established as a clinical problem (e.g. see Nazareth, 2011). Symptoms may include low mood, loss of interest, anger and social withdrawal (Tuszyńska-Bogucka & Nawra, 2014). The prevalence of paternal PND has been found to vary significantly between studies. For example, Goodman (2004) found in a literature review of 20 studies conducted between 1980 and 2002 that between 1.2% and 25.5% of fathers experienced paternal PND. However, the rates of paternal PND were between 24% and 50% in those whose partner also had PND. There are many potential risk factors for developing paternal PND including mother's PND, relationship difficulties, previous history of depressed mood, problems with infant temperament and increased stress (e.g. Goodman, 2004; Paulson & Bazemore, 2010; P. G. Ramchandani et al., 2008; Smart & Hiscock, 2007; Tuszyńska-Bogucka & Nawra, 2014). The impact of paternal PND may be significant for the whole family. For example, Ramchandani et al. (2005) found in a longitudinal study that paternal PND was associated with an increased chance of poorer emotional and behaviour outcomes in children aged 3.5 years. This effect was

present after controlling for the impact of maternal PND and father's depression in later years.

Edhborg et al. (2016) conducted semi-structured interviews with 19 Swedish fathers who scored above threshold for depression on the Edinburgh Postnatal Depression Scale (Cox, Holden, & Sagovsky, 1987) and the Gotland Male Depression Scale (Zierau, Bille, Rutz, & Bech, 2002). This study highlighted how fathers found it difficult to manage their responsibilities at work and home and how hard it was for them when their expectations of being a father were different from the reality. All the fathers noticed that their relationships were different with their partners after they had children and several thought it had worsened.

Darwin et al. (2017) conducted a thematic analysis of data from 19 fathers recruited from the Born and Bred in Yorkshire (BaBY) cohort. Fathers were purposively sampled to include a range of psychological distress. Participants felt that UK perinatal services were designed primarily for mothers and there were few specifically adapted for fathers. However, many felt that mothers should be the focus. When the men talked about psychological distress they tended to frame it as 'stress' rather than mental health problems. Fathers once again spoke about difficulties managing their responsibilities.

There is a lack of research exploring interventions specifically focused on paternal PND. This is perhaps due to poor recognition of the condition (Lee & Chung, 2007) and uncertain prevalence rates (Goodman, 2004). Wilson

(2008) showed in an interview study how fathers without paternal PND constructed those with psychological distress in the postpartum period as inadequate parents. Therefore, the poor recognition of paternal PND may be due to fathers not presenting themselves to services, because it is culturally unacceptable for fathers to experience PND. This may link with a wider issue concerning the role of masculinity in health-seeking behaviours.

1.2 Masculinity and health

Studies have indicated that men are less likely to access healthcare services (e.g. Banks & Baker, 2013). O'Brien, Hunt, and Hart (2005) showed how men in focus groups spoke about being unwilling to access healthcare unless they perceived themselves to have a 'serious' condition. Several men spoke about how sharing psychological distress was inconsistent with a masculine identity. This finding was supported in a meta-synthesis of 34 qualitative studies conducted by Krumm, Checchia, Koesters, Kilian, and Becker (2017), which highlighted how men perceived depression as a vulnerability that they attempted to hide.

Such constructions of masculinity have also been observed in the talk of healthcare professionals. For example, Seymour-Smith, Wetherell, and Phoenix (2002) interviewed professionals about men's use of general practitioners. They constructed men as '*bad'* at communicating their emotions and positioned them as *'serious users of the health service*' (pp 258-259), which meant they only used services when they had a serious issue. These

findings may be interpreted as evidence of hegemonic masculinity (Carrigan, Connell, & Lee, 1985). This refers to practices that place men in a dominant position in society. By constructing men as 'serious' healthcare users, and avoiding the possibility of male vulnerability, it puts them in a powerful position. However, it also limits their ability to seek help when they need it.

It is unknown how men with paternal PND develop their identities related to PND and accommodate them with, often stigmatising, masculine ideals of strength and stoicism. Indeed, issues of masculinity may be particularly relevant considering the strong association between PND and women (Lee & Chung, 2007). More generally, father's identities may be important in understanding PND, because research (e.g. Machin, 2015) has highlighted how some men find it difficult managing the competing demands of being an 'involved parent' and 'family provider'.

1.3 Illness identity

Yanos, Roe, and Lysaker (2010 pp74) proposed that those with mental health problems may develop an illness identity that reflects the '*roles and attitudes*' that they hold about their condition. This concept may have important implications for quality of life and the process of rehabilitation. For example, Roe (2001) conducted a longitudinal study exploring the course of recovery for people with psychosis following discharge from hospital. They found a progression in participants' identity from "*patienthood to personhood*" (pp691). However, there is increasing evidence suggesting that people with mental

health difficulties can develop self-stigmas as part of their illness identity (e.g. West, Yanos, Smith, Roe, & Lysaker, 2011). Self-stigmas may have a negative effect on a person's sense of worth (e.g., Corrigan, Watson, & Barr, 2006; Lysaker, Tsai, Yanos, & Roe, 2008), relationships (e.g. Yanos, Roe, Markus, & Lysaker, 2008) and help seeking behaviour (e.g. Vogel, Wade, & Hackler, 2007). To date, there have been no studies exploring illness identity in paternal PND.

1.4 Identity and Discursive psychology

Identity has traditionally been argued to be a cognitive construct (e.g., Berzonsky, 2008; Epstein, 1973; Kelly, 1955). However, this view has been challenged by the theory that identity may be dynamically developed within discursive communication (Abell & Stokoe, 2001; Antaki & Widdicombe, 1998; McCabe & Stokoe, 2004). Discursive psychology (DP) proposes that psychological concepts and categories can be understood as actions positioned within discourse (Edwards, 2005). Verbal communication is an interactive process with speakers taking successive turns and often aligning themselves with a social category as part of the process (Housley & Fitzgerald, 2002). It has been proposed that "*a person's identity is their display of, or ascription to, membership of some social category…*" (Antaki & Widdicombe, 1998 pp2). A DP approach therefore offers an ideal way to explore identity construction in fathers with paternal PND. Discursive analysis has been used to show how fathers construct and negotiate various identities (e.g. 'father' and 'worker') with their speech (e.g. Yarwood, 2011).

1.5 Rationale and aims

Self-stigmatising illness identities may impact quality of life (e.g. Corrigan et al., 2006) and help seeking behaviour (Vogel et al., 2007). Men typically access healthcare services less than women (e.g. Banks & Baker, 2013) and tend to experience difficulties with talking about mental health (e.g. Krumm et al., 2017), which may be linked to hegemonic masculinity (e.g. Seymour-Smith et al., 2002). An understanding of how men with paternal PND construct their illness identity, and negotiate potentially conflicting masculine identities, is therefore important. It would also be important to understand how men use and draw upon such identities when accounting for how they talk (or avoid talking) about their condition. DP provides the ideal approach to understanding how men construct their identities with speech. A better understanding of paternal PND may raise awareness of the condition and stimulate the development of appropriate interventions. This has the potential to help men with PND and potentially their families (e.g. Ramchandani et al., 2005).

1.6 Research questions

1. To explore how fathers who consider themselves to have paternal PND construct their illness identity with speech.

2. To establish how fathers negotiate and draw upon identities within their speech to account for the way that they talk about paternal PND with other people.

2. Methods

2.1 Design

The study used a DP design (Edwards, 2005; Edwards & Potter, 1992; Potter, 2012; Potter, Edwards, & Wetherell, 1993) and data were collected through semi-structured interviews. The DP approach is concerned with how psychological concepts and categories (e.g. attitudes, identities and emotions) are constructed as actions positioned within speech. It was therefore an appropriate approach to exploring how fathers with paternal PND developed their illness identity by using feature-rich psychological categories in their interviews.

2.2 Materials

An advertisement was created for the purposes of recruitment (Appendix 8), which provided a summary of the study and an email address for the researcher. A participant information sheet (Appendix 9), consent form (Appendix 10), debrief sheet (Appendix 11) and demographics questionnaire (Appendix 12) were also developed.

An interview schedule was designed to address the aims of the research (Appendix 13), which drew upon other relevant studies (e.g. Bolzan, Gale, & Dudley, 2005; Coates, Ayers, & de Visser, 2014; Wilson, 2008). The questions were developed to provide participants with space to talk about their attitudes and roles in relation to paternal PND (e.g. questions 1-5). There were also opportunities to explore their different identities (e.g. father, partner and worker) and the actions of themselves and others (questions 6-8) during the postnatal period.

2.3 Procedure

2.3.1 Ethics

Coventry University ethics committee provided approval for the study (Appendix 14) and it was conducted in line with relevant ethical guidelines (e.g. British Psychological Society, 2010). A minor amendment was made in November 2016 to permit fathers with more than one child to be recruited (Appendix 15). The study initially focused on first-time fathers, because it was considered useful to explore identity construction in those that had recently become a parent (Höfner, Schadler, & Richter, 2011). However, the amendment was required to aid with recruitment.

2.3.2 Recruitment

The study advertisement was promoted online and in physical locations by charities and other organisations. Appendix 16 provides a list of the organisations that agreed to advertise the study. Participants were required to be over 18. This was because adolescent fathers often face different challenges to their older counterparts (e.g. Clayton, 2016), which may affect identity construction (e.g. Frewin, Tuffin, & Rouch, 2007). Participants were also required to be in contact with their families (i.e. children and partner) to permit discussion of fathers' familial interactions. There exist no specific diagnostic criteria for PND and so fathers were included if they considered themselves to have had paternal PND in the last five years. The period of five years was chosen for two primary reasons. First, it was sufficiently long to maximise recruitment potential, which was anticipated to be difficult based on previous studies (e.g. Costigan & Cox, 2001). Second, by limiting to 5 years after birth it increased the chance that the children would be at similar developmental stages (Piaget, 1970) and so fathers would be likely to have similar experiences.

2.3.3 Interviews

Those who saw the advertisement and were interested in taking part initially contacted the researcher by email. The advertisement asked potential participants to provide a telephone number in their correspondence. Following receipt of their email, the researcher telephoned them to provide information

about the study and to give them an opportunity to ask questions. The researcher confirmed that they were eligible for the study (e.g. whether they were over 18) and arranged a time and date to conduct the interview. All interviews were conducted at the participants' homes. After the participants provided signed informed consent, they completed the demographics questionnaire. The interview was then conducted according to the schedule, but additional questions were added as appropriate. All interviews were audio recorded.

2.4 Participants

Six fathers participated in the study. There are no definitive guidelines for sample size requirements in discourse analysis, it is instead based on the quality of the data (Daniel, 2011). Six interviews were considered to provide sufficient data for analysis. Indeed, important discourse analysis studies have been published with fewer than six participants (e.g. Mancini & Rogers, 2007).

Table 1 provides demographic information about the participants; names have been altered to maintain anonymity. The participants were married to the mother of their child(ren), all were white and all except one was British. The non-British person was from North America. The fathers all had children under the age of four and one also had an adolescent daughter.

Table 1. Demographic information

Father's pseudonym	**Age range (years)**	**Employment status**	**Number of children**	**Child(ren)'s pseudonym (and gender)**	**Mother's pseudonym**
Richard	26-35	Fulltime employed	1	Harley (female)	Karen
Alan	36-45	Fulltime student	1	Jade (female)	Jessica
Tim	36-45	Fulltime employed	1	Pamela (female)	Talia
Clark	36-45	Fulltime employed	2	Kara (female) Jon (male)	Lois
Arthur	36-45	Fulltime employed	2	Lisa (female) Elsa (female)	Mera
Oliver	36-45	Fulltime employed	2	Moira (female) Thea (female)	Felicity

2.5 Method of analysis

The analysis was guided by Potter's (2012) approach to DP. Each interview was initially transcribed verbatim. These transcripts were read multiple times and preliminary notes were made to highlight the use of identities (e.g. 'father') in the participants' talk.

An important concept In DP is action-orientation (Potter et al., 1993), which relates to function of speech. It is important to understand how speakers account for action, draw upon and use rhetorical devises, position themselves, construct identities and manage dilemmas. Multiple additional readings of each transcript were undertaken to highlight the actions of the participants' speech. Excepts were identified from each interview that showed how participants drew upon social categories to construct their identities (Antaki & Widdicombe, 1998), the attitudes they conveyed about paternal PND (Yanos et al., 2010) and how they accounted for the way they spoke about paternal PND. Similar excerpts were then collated according to the discursive strategies used by the participants. A discursive strategy represents a similar way in which speech is used to achieve an action (Goodman, 2008).

Extracts that best characterised the use of a discursive strategy were included in the results. A secondary transcription process was undertaken with these extracts to provide information about how the discourse was conveyed by the speaker (e.g. speed of speech, pauses and variations in emphasis). Appendix

17 provides an outline of the symbols that were used in this process (see McKinlay & McVittie, 2008).

Several measures were taken to ensure validity of the analysis (Potter, 2012). First, the analysis included information about the context of the excerpts. Second, examples of exceptions to discursive strategies were considered. Third, extracts were provided to illustrate the analysis. Finally, relevant literature was referenced to show reliability across studies.

3. Analysis

The focus of the results is on three related discursive strategies that were identified in the father's speech. Collectively these show how fathers used their speech to construct their illness identity and how masculine identities were used to account for avoiding discussing PND.

3.1 PND happens to women

All participants stated that they had initially found it difficult to identify with paternal PND and most positioned PND as something that happens to women and not men. Several claimed that they did not initially understand or recognise paternal PND. Furthermore, despite participating in a study on paternal PND, several participants went on to reject the terminology in the interviews. Instead, they often orientated themselves as having had some other form of depression. This is illustrated in the following extract from Clark (see extract 1 below). Prior to this section, Clark had been talking about how

there is no specific treatment or recognition of paternal PND, which he said is treated as depression triggered by a natal event. He had spoken about how maternity care should consider the psychological and emotional effects of childbirth to both mothers and fathers.

Extract 1

1	Interviewer:	…how did you understand: ↓pa:ternal postnatal
2		depression?
3	Clark:	(1.0) Ermm (1.0) I-I didn't understand: that Dads could
4		suffer it at all: until I had recovered from it
5	Interviewer:	Yeah
6	Clark:	and read into it a bit more (.) I under I understood quite
7		a lot that mums can suffer PND because: it's part of the
8		stuff that is talked about (.) um particularly in the weeks
9		immediately (.) a-and it's it's the more medicalised name
10		for the baby blues
11	Interviewer:	Mm..mm
12	Clark:	(.) Ermm having read about it (.) ermm (1.5) <I-I it> (.) I-I
13		think it it it's better termed (.) err male depression
14		triggered by a birth of a child
15	Interviewer:	OK=
16	Clark:	=than than >paternal postnatal depression 'cos that
17		labels it as a specific disease relating to baby births it's
18		not< i-it's depression:

19	Interviewer:	Yeah=
20	Clark:	=>which is just been triggered by the birth of a child but
21		depression can be> <caused by> (.) moving-house,
22		death or a relative
23	Interviewer:	Yeah=
24	Clark:	=redundancy or anything else it it it's the same ill:ness
25	Interviewer:	Yeah=
26	Clark:	=and should be treated similarly it's just t-the trigger was
27		(2.0) <b-b:irth> and things relating to it (.) ermm
28	Interviewer:	So it's a context thing=
29	Clark:	=Yeah ermm <b:ut> I-I what was your question again?
30	Interviewer:	It was how did you understand
31	Clark:	[Yeah
32	Interviewer:	postnatal depression?
33	Clark:	how did I understand it] ermm (.) i-it is like any other
34		depression
35	Interviewer:	Mmm
36	Clark:	ermm it's an illness: that (.) you are you as the patient
37		are suffering from and should be treated accordingly

Clark explicitly positioned PND as something associated with women by saying '*I understood quite a lot that mums can suffer PND'* (lines 6-7). The use of the word '*medicalised*' (line 9) in relation to maternal PND served to legitimise the condition and place it as a specific disease related to baby births (see lines 16-17). This can be contrasted with how Clark talked about paternal

PND, which he rejected as a specific disease related to having a child (line 18).

The only time in the extract when Clark positioned himself as having had paternal PND was in lines 3-4 where he said, '*I didn't understand: that Dads could suffer it at all: until I had recovered from it*'. Clark constructed paternal PND as *'male depression triggered by a birth*' (lines 13-14) and built a case for this position by providing examples of depression caused by other life events (presented in a long list e.g. moving-house). He highlighted his point by slowing down his speech on line 21 (Herman, 2007). However, the act of participation in the study served to align Clark with paternal PND. This contradiction set-up an ideological dilemma (Billig et al., 1988), which was managed throughout the extract as his position shifted from initially aligned with paternal PND (lines 3-4) to rejection of the term (lines 12-18).

Having aligned PND with women, and constructed his illness identity as male depression triggered by having a child rather than paternal PND, Clark then drew upon the identity of a patient requiring treatment (lines 36-37). The function of this talk was to distinguish depression from PND, but claiming that depression in fathers is serious. Studies have shown how similar discursive strategies have been used by professionals to construct men as serious users of healthcare services (e.g. Seymour-Smith et al., 2002).

Oliver, unlike Clark, did not entirely position PND with women. However, he still emphasised that the condition is primarily associated with mothers rather

than fathers as shown in Extract 2. Before this section, Oliver had talked about how he hid paternal PND from others, which he accounted for by saying that he thought he would be judged.

Extract 2

1	Interviewer: …	how did you understand: >paternal postnatal
2		depression<?
3	Oliver:	(3.1) Err well at ↑first (1.0) <approaching> the: >sort of
4		impending birth< of our first dau:ghter you sort of you
5		you hear about it at NCT
6	Interviewer:	Mmm
7	Oliver:	Ermm I'd obviously heard about it before that but I'd not
8		really sort of <really thought> about what it meant what
9		it was and how it (.) manifested itself (.) ermm (.) and
10		you are told throughout (2.0) <those classes> that you
11		know it is something that effects mothers but fathers too
12		(.) ermm but it was always a-and sometimes fathers too

Oliver used a three-part discursive device to construct PND as something that primarily happens to women (lines 10-12). This device shared a similar structure to one reported by Antaki and Wetherell (1999). They showed how participants strengthened their positions within discourse by making a concession to their stake. This was achieved by first making a proposition that is liable to be contested. Next a concession was made that challenged the

original proposition. Finally, a reprise to the concession was made that strengthened the original proposition and reduced the effectiveness of the concession. Oliver said on lines 10-11 that classes indicated that PND is something that effects mothers, which aligned PND with women. Furthermore, by saying that it was something he was told in National Childbirth Trust (NCT) antenatal classes it reduced his accountability for this proposition. Oliver immediately makes a concession by saying that PND can also effect fathers too (line 11). However, following a short pause, he claims that it was always '*sometimes fathers'* (line 12) thereby constructing PND as something that primarily happens to women.

Tim was the only father that did not explicitly associate PND with women and so may be considered as an exception. However, he still linked paternal PND with his wife, who had maternal PND (as shown in Extract 3). Tim had been talking about how difficult his daughter's birth had been before this extract.

Extract 3

1	Interviewer:	How did you understand <u>pa</u>ternal postnatal depression?
2	Tim:	(3.0) I wouldn't say at the tim:e ermm (.) that I
3		understood it
4	Interviewer:	Yeah
5	Tim:	(laugh)
6	Interviewer:	Yeah yeah this is it [yeah
7	Tim:	Or] or or may be even recognised it and

8 Interviewer: Yeah

9 Tim: (.) It was (.) it was a lot further down the line that that (.)

10 after Talia experienced what she'd been through and

11 >you know< spoken to to Doctors and stuff

12 Interviewer: Mmm

13 Tim: that she said to me (.) that (1.5) she said >you know< I

14 think you you've (.) gone through it too I think you've

15 had it=

16 Interviewer: =Yeah=

17 Tim: =as well or have it at the

18 Interviewer: Yeah

19 Tim: at the time ermm just purely not being able to (.) deal

20 with everyday situations like I would of ermm

21 Interviewer: Mmm

22 Tim: (2.0) say I-I don't really (.) think I recognised it at the

23 time

Tim positioned himself as being unaware of paternal PND. Throughout the whole interview, he never used the term paternal PND. Tim only referred to depression twice and once it was about another person. In a similar way to Clark, Tim distanced himself from paternal PND and mental health problems more generally. Tim differentiated paternal and maternal PND by talking about his wife. He indicated that she had spoken to *'doctors*' (line 11), which constructed maternal PND as a condition meriting medical intervention. Tim claimed that his wife decided he had paternal PND (lines 13-15). This reduced

his accountability and agency in this decision. This may have been a way to protect his masculine identity from the challenge posed to it from admitting he had paternal PND; a condition that has been shown throughout this section as often associated with women. Even in this extract the decision comes from his wife who is presented in an expert position on PND.

3.2 Men do not talk about paternal PND

Here it will be shown how, despite participating in a study on paternal PND, the fathers had difficulties talking about depression at all. Several fathers presented this as having significant implications on their lives. A common discursive device to account for their difficulties with talking about depression, was to draw upon a masculine identity. Extract 4 provides an example of this (Appendix 18 provides an extended transcript). Richard had been talking about how it had been a relief when he had spoken to his wife, but that it had been hard for him to do as a man.

Extract 4

1	Interviewer:	>so do you think that there is an element< of <around>
2		the way that men are brought up?
3	Richard:	Yeah I mean like like for <u>me</u> for example on you know
4		my my parents are Latin American
5	Interviewer:	Right

6 Richard: So the Latin American culture men there's very much

7 the <ma:cho:>

8 Interviewer: Yeah

9 Richard: culture of err of the strong man and that kind of thing (.)

10 and you know I think there's > ↑part of that< I think had I

11 think there's an element of that of that you know we're

12 not err (.) you know they say look a on-online and stuff

13 they say ↑Latino's don't talk to you know to express their

14 feelings its > ↑killing< them

15 Interviewer: Yeah

16 Richard: along with men you know men well men as a

17 greater whole as well

18 Interviewer: Yeah

19 Richard: (.) So that's hard and you know I was I was I I'm a

20 >veteran< I was was in the military so there's

21 Interviewer: Right

22 Richard: that there's that aspect as well like again very ma:cho

Richard constructed Latin American culture as '*<ma:cho:>'* (line 7), which he emphasised with his speech. He claimed that they do not talk to '*express their feelings and its > ↑killing< them'* (lines 13-14). The function of this discourse was to account for his difficulties with talking about depression. Richard constructs Latin American culture as part of his identity despite it being problematic. This allowed him to account for why he found it difficult to talk about paternal PND and places blame on Latin culture. By claiming that

macho Latin culture is having a detrimental effect on people, it also served to distance Richard from this position and orientate him as in disagreement with it. Richard also talked about being a man, and in particular, a military man. Throughout this extract it can be seen how Richard constructed several masculine identities, which he himself presents as one 'macho' identity. This is then used to apportion blame onto for why he had difficulties talking about paternal PND. More generally, Richard may have also been blaming macho culture (which he constructed as including a lack of an ability to talk about feelings) for having paternal PND.

Arthur drew upon his masculine identity indirectly to account for his difficulties talking about depression. It is contextually important to note that Arthur had not told his wife that he had paternal PND. This extract followed Arthur talking about the problems he had with telling his wife. He said that she may have had maternal PND, but that they had never discussed it.

Extract 5

1	Arthur:	Probably not the best thing to tell a woman that's just
2		had a baby and you think is suffering from postnatal
3		<u>depression</u> because it's got (.) to like <with (2.0) mental
4		illness has got a stigma to it (.) <u>massively</u> (.) ermm> (.)
5		so can you imagine I would say and this is only my o:wn
6		opinion (.) and my own
7	Interviewer:	Yeah

8	Arthur:	point of view is that on the hierarchy of mental illnesses
9		let's just say for men because I know obviously women
10		aren't the same– but the hierarchy for mental illness (.)
11		postnatal depression in my opinion is probably at the
12		bottom and it's probably laughable in certain quarters
13		(1.0) and that's something that's me speaking
14	Interviewer:	Right
15	Arthur:	how I honesty feel ↑not not that I would think that from
16		the beginning not that ↑I thought Oh don't be stupid but
17		purely from t-the grounds of (2.0) <I can't imagine if you
18		(.) went to a (.) ermm (1.0) a babies club with: 10
19		women and>
20	Interviewer:	(.) Mmm
21	Arthur:	said that you were suffering from postnatal depression
22	Interviewer:	Mmm
23	Arthur:	what what response you'd get
24	Interviewer:	Mmm
25	Arthur:	maybe from the group that (.) I've seen on the internet
26		what we were talking about earlier then it's clearly
27		something and it's clearly guys out there that are
28		prepared to share it (.) I <don't know whether (.) the
29		female side> of things would ever accept that >some
30		would and some wouldn't I don't know so that's me<=
31	Interviewer:	=yeah sure=
32	Arthur:	=>speaking from an opinion point of view

33 Interviewer: Sure

34 Arthur: but with that opinion comes that (.) you keep your mouth

35 shut on this one

Arthur constructed paternal PND as a stigmatised condition by saying that it is at the '*bottom*' of the mental health hierarchy and would be *'laughable*' for some (line 12). He appeared to use a disclaimer-like structure to this statement (*'this is only my o:wn opinion…'* lines 5-6), which lessened his position on paternal PND (Wiggins, 2017). Nevertheless, this statement provided a rationale for why he avoided talking about paternal PND with his wife. Similar discursive strategies have been reported in other studies with people negotiating and aligning themselves away from mental health problems to avoid the stigma associated with them (e.g. Prior, 2012). Linking with the first discursive strategy, Arthur differentiated paternal and maternal PND by saying that '…*women aren't the same*' (lines 9-10). This also functioned to strengthen his construction of paternal PND as a stigmatised condition.

Arthur used his masculine identity indirectly by constructing a scenario of him attending a baby club consisting of women. He questioned '*… what response you'd get*' (line 23) if he had told them he had paternal PND. The implication is that it would not be a positive response. This is confirmed on lines 28-29 when he says '(.) *I <don't know whether (.) the female side> of things would ever accept that'*. The function of Arthur's talk appeared to position blame for his difficulties with communication on women. This is a controversial assertion

not least because he made it clear in the interview that he had only ever spoken to the male interviewer about paternal PND. Arthur appeared to concede this point by once again saying on lines 30-32 that it was his opinion.

Both Richard and Arthur used their male identities to account for their difficulties communicating about paternal PND and in doing this they also constructed their male identities. However, there are nuanced differences in how they used them. Richard spoke about machismo and being a strong male who therefore does not talk about paternal PND. In contrast, Arthur constructed men with paternal PND as a stigmatised group by women, which explained why he avoided talking about it. Tim was once again potentially an exception from this discursive strategy. Like all the fathers he claimed to have had difficulties talking about paternal PND, but he said he was uncertain of why this was. It is perhaps important to note that in his interview Tim constructed a joint identity with his wife who also had PND. He described how they formed a united front against their daughter at the time. Therefore, this participant may have constructed himself as more of a parent, or partner, with PND rather than specifically a father.

3.3 A deficient father

A common theme in the previous two discursive strategies was the use of masculine identities to perform linguistic actions. In this final strategy, it will be shown how the participants once again drew upon a specific-male identity, in this case that of a father, to accomplish rhetorical work. The function of this

use of a male identity was to present the problematic nature of paternal PND. Yanos et al. (2010) proposed that an important part of illness identity is a person's role. All participants constructed their role as a father as being in some way deficient when they had paternal PND (e.g. emotionally distant and not capable of coping). The following extract from Richard provides an example of this strategy. Prior to this extract Richard had spoken about difficulties that he had bonding with his daughter.

Extract 6

1	Interviewer:	…what effect if any: did (.) >paternal postnatal
2		depression< have on your role ↑as a father? Do you
3		think?
4	Richard:	OK w-well yeah you know when I was at the <u>height</u> of <u>it</u>
5		(.) you know like I said I wasn't really a father I was
6	Interviewer:	Yeah
7	Richard:	I was you know the guy (laugh)
8	Interviewer:	[Yeah
9	Richard:	that] I was here doing stuff (.) errr rather than err you
10		know actually being any type of err any type of parent
11		so (3.0) you know now looking back at it now
12	Interviewer:	Mm…mm
13	Richard:	I can see that (.) you know I I I wish that I would have
14		caught it earlier 'cos you know I could have been
15	Interviewer:	Right

16 Richard: you know I could have been there you know even

17 though new-borns

18 Interviewer: Mmm

19 Richard: don't really know but they <u>say</u> they do right

20 Interviewer: Mm..mm

21 Richard: so that's err (.) so yeah that's kind of a (.) I guess kind of

22 a regret

Richard rejected the identity of '*a father*' (line 5) and positioned himself as being '*the guy*' (line 7). He constructed his role as someone who is '*doing stuff*' rather than being a parent. This talk functioned to differentiate Richard from the concept of an 'involved' father, which is culturally important in Western societies (e.g., Henwood & Procter, 2003; Stevens, 2015). Given such importance placed on being an 'involved' father, it is self-evidently unacceptable to construct oneself as a father in this way. Indeed, Richard spent the remainder of this section building a case to account for this position and manage blame. He stated that he wished he had '*caught it earlier…*' (line 14), which placed blame for his actions on his identity as a person with paternal PND. His repeated use of the word 'I', on lines 13-14, strongly aligns Richard with this position. On lines 16-19 he claims that new-borns are not aware, which seemed to operate as a further justification for his actions. This section ends with Richard saying he had a '…*kind of a regret*' (lines 21-22). This protected him against potential criticism of his actions and constructed his new identity as someone who is different. Several of the fathers spoke about guilt and regrets about their actions when they had paternal PND. It was

therefore a common rhetorical device to manage their constructed position as a deficient father.

Oliver spoke about how being a deficient father was a threat to masculinity. This may account for why fathers in the study found it difficult to talk about paternal PND. Oliver was asked in the following extract what a father does when they have paternal PND. He had spoken how about how men have ideals that they must deal with their own emotions and that communication is difficult especially regarding depression.

Extract 7

1	Oliver:	Ill thoughts towards >you know and< neglect and stuff
2		like that (.) ermm (1.0) it really (.9) ermm it goes against
3		the whole kind of (.) stereotype of the male protector (.)
4		male figure mat-paternal kind of (.) role model
5	Interviewer:	Yeah
6	Oliver:	Ermm (1.5) >so there is a reluctance I think< to (.) want
7		to even admit it let alone to kind of (1.0) just explore it or
8		talk about it

Oliver constructed the identity of *'male protector'* (line 3) as being inconsistent with actions associated with being a deficient father (i.e. neglectful, etc.). This provided a rationale for why men with paternal PND, who are constructed as being a deficient father, may be reluctant to *'admit'*, *'explore'* or *'talk'* about

their condition (lines 7-8). Specifically, it provides a means to retain a masculine paternal identity of a *'male protector'* (line 3). The talk also functioned to construct and present paternal PND as problematic; it is self-evidently unacceptable for a father, or a parent, to claim to have '*ill thoughts'* or to be neglectful (line 1).

4. Discussion

4.1 Summary of findings

Most participants positioned and constructed PND as something that happens to women and not men. Despite participating in a study on paternal PND, several fathers rejected the terminology and constructed their illness identity as having had some form of male 'depression'. The fathers reported avoiding talking about paternal PND, which made sense having constructed PND as something that happens to women. It was shown how gender featured significantly once again, as most participants accounted for their difficulty talking about paternal PND by constructing and drawing upon masculine identities. The final strategy represented another way that a specific male identity was used to accomplish discursive action. It was shown how men constructed their role as a father as being in some way deficient, which served to emphasise the problematic nature of paternal PND. Fathers positioned themselves as guilty or regretful. This was interpreted as evidence of a rhetorical device that functioned to manage their position as a deficient father and protect them against potential criticism.

4.2 Relation to previous literature

Darwin et al. (2017) reported that fathers tended to frame any difficulties that they had in the perinatal period as 'stress' rather than using words associated with mental health. Two men were included in this study who reported having had depression, but neither used the term PND to describe their condition. The current study has shown that even in a group of fathers who, by taking part in a study about paternal PND, had tacitly indicated that they had experienced it, many avoided the terminology and most associated the condition with women.

Several other studies have also found that men often have difficulties identifying with health conditions and are positioned as 'serious' users of healthcare services (e.g., Seymour-Smith, 2008; Seymour-Smith et al., 2002). Such findings may be interpreted as evidence of hegemonic masculinity (e.g. Seymour-Smith et al., 2002); by constructing men as serious healthcare users, and reducing the possibility of male vulnerability, it puts them in a dominant societal position. However, several fathers in the current study spoke about how this caused problems for men, because it limits their ability to seek help and talk about paternal PND. However, by taking part in this study the fathers were showing how they were now more open to talking about their condition.

Edhborg et al. (2016) reported how Swedish fathers with paternal PND described feeling '*not good enough, either at home or at work*' (pp 432).

Darwin et al. (2017) reported how fathers expressed guilt associated with having personal difficulties. These findings are consistent with how fathers in the current study constructed their identities as fathers with PND and the guilt and regret they expressed about it.

4.3 Limitations

Although six interviews were enough to provide an important insight into father's speech related to paternal PND, it must be acknowledged that the study had a small sample size. However, there are no definitive guidelines on sample size for discourse analysis (Daniel, 2011) and conducting additional interviews does not always contribute much more to the dataset (Jørgensen & Phillips, 2002).

It has been argued that discourse analysis should be performed on naturally occurring data rather than interviews (e.g. Potter, 1997). This is because interviews effect the course of the discourse and how participants position themselves. The interviewer was a male, and a father, which may have impacted how the participants spoke to him and it is possible his questions influenced the course of the discourse. The interviewer tended to position himself as empathetic and his use of continuers (e.g. 'yeah') indicated engagement in the discussion (Lambertz, 2011). However, interviews have been used in many DP studies (e.g. Abell & Stokoe, 2001). This potential limitation was also attended to by considering what the interviewer said during the analysis.

4.4 Clinical implications

The term paternal PND was chosen by the author as it is used in public discourse (e.g. National Childbirth Trust, 2017) and it provided a useful way of succinctly summarising the focus of the research. However, several fathers in this study did not identify with the term paternal PND. More generally, PND was closely aligned to females. It is likely that the use of the term paternal PND impacted both recruitment and discussions within the interviews; some men may have felt excluded from the study due to the use of this terminology and so did not take part. Furthermore, the use of this term in the interviews may have shifted focus of the discussions towards issues associated with terminology. If the study were conducted again, then a different term would likely be used to represent low mood in the postnatal period. This of course has significant clinical implications for how the condition is discussed with clients by healthcare professionals (e.g. midwives and health visitors) and how it is framed in public discourse. One of the clients in the current study framed it as '*male depression triggered by the birth of a child*' and framed it as '*like any other depression*'. This may be a useful way to talk about depression in fathers. Another alternative to such labels as 'paternal PND' would be to use formulation in clinical practice (e.g. see Johnstone, 2014). Formulations use psychological theories to develop a hypothesised understanding of a person's difficulties within their own personal context (Johnstone & Dallos, 2014). They eschew simplifying mental distress as disease requiring a purely medical intervention and try to make sense of a

person's difficulties given such factors as their history, current circumstances and behaviours. Formulation therefore provides a useful alternative to diagnostic approaches used with the medical model. They may be particularly useful for working with men given that the evidence suggests that many men do not readily identify with illness-related terminology. Therefore, using an approach based on formulation may help men with low mood in the postnatal period to engage with services.

There is an outstanding need for greater awareness of depression in fathers both within healthcare services (e.g. Nazareth, 2011) and the public. It is acknowledged that this may be difficult because men have been shown to have problems identifying with mental health conditions (e.g., Darwin et al., 2017; Krumm et al., 2017). This may be in part addressed by using different approaches to discussing mental health with men such as those based on formulation rather than diagnosis. Darwin et al. (2017) found that fathers were more focused on the health of their spouse. Fathers may be more receptive to discussions about their mental health if it was framed as part of looking after them so that they can look after their family.

The NICE guidelines recommend Cognitive Behaviour Therapy for women with severe depression in the postnatal period (NICE, 2015). Such approaches may be beneficial to men as well, but there is an outstanding need for further research. For example, psychoeducation about depression in fathers provided by healthcare professionals (e.g. health visitors) may help them recognise and understand their condition. Furthermore, some of the

fathers discussed how they reduced their engagement in activities whilst depressed, which would be a useful target for behavioural activation (e.g. Veale, 2008).

The study showed how many men constructed themselves as being in some way a 'deficient father' when they had low mood. Several of the participants spoke about feelings of guilt, shame and or regret over their actions when feeling low. Research has shown that feelings of shame and guilt are associated with depression (e.g. Kim, Thiubodeau & Jorgensen, 2011). With men, it has been argued that shame can be difficult to manage because displaying emotions associated with shame can in and of itself be experienced as shaming (Shepard & Rabinowitz, 2013). This has important clinical implications for the way that these difficult feelings are managed with men who have low mood in the postnatal period. Compassion Focused Therapy (CFT) posits that people with significant levels of shame and self-criticism may find it difficult to self-soothe (Gilbert, 2009). Emphasis is placed on training a person to engage in self-compassion to reduce their reliance on being critical of oneself. A crucial aspect of therapy is that clients experience their relationships with their therapists as de-shaming. Such approaches may be particularly helpful for men with low mood after having a child given the ubiquity of talk about feelings of guilt, shame and regret.

4.5 Further research

It would be beneficial for future studies to use naturally occurring data to investigate paternal PND. There are ways in which this could be achieved if appropriate permission and ethical approval were granted. For example, there exist several self-help groups for men with paternal PND. The discussions from such groups may provide potentially fruitful data for an exploration of identity construction. There have also been several television programmes on paternal PND. Similar sources of naturally occurring discourse have been used in other studies to explore identity construction (e.g. Abell & Stokoe, 2001).

The current study focused on fathers. Future work would be important to examine mothers' discourse around paternal PND. There have been a few published studies exploring men's experiences of mothers' postnatal psychiatric conditions (Boddy, Gordon, MacCullum & McGuinness, 2016; Engqvist & Nilsson, 2011) and depression (Muchena, 2007). However, there have been no studies exploring mothers' experiences of fathers' depression and certainly no research taking a discursive approach to explore identity construction. It may also be useful to explore clinicians' and others' (e.g. media) discourse around paternal PND.

4.6 Concluding remarks

This study has shown how fathers constructed PND as something that happens to women and several positioned themselves as having had some other form of depression. They constructed their role as a father as deficient, which they voiced guilt and regret about. The study showed how most of the fathers drew upon masculine identities to account for difficulties with talking about depression. This research has highlighted the need to consider how paternal PND is framed when working with fathers. Although there have been two recent qualitative studies published about father's mental health in the perinatal period (Darwin et al., 2017; Edhborg et al., 2016), there is a relative lack compared with mothers. Future research is therefore vital.

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Chapter three

Reflections on my research journey: the reciprocity between researcher and study

The word count for this chapter, excluding references, is 3852.

1. Introduction

Clinical psychologists are trained to be scientific-practitioners (British Psychological Society, 2014). An essential part of being a scientist (Holloway & Biley, 2011), and an effective practitioner (Fisher, Chew, & Leow, 2015), is a proficiency in reflecting on one's own influence on their work. Indeed, self-reflection is the bedrock of several models of learning (Gibbs, 1988; Johns, 1995; Kolb, 1984); such models typically position reflection as the precursor to behavioural change. This final chapter provides a reflective account of the effect that I may have had on the research, and in turn, the effect that it may have had on me as a person and a professional. It encompasses the whole research process from inception to thoughts about future studies. The process of reflection was guided by a diary that I have kept throughout my training on the doctorate course. In addition, where relevant, I have drawn upon therapeutic models to structure my reflections.

2. Choice of study: 'Did you have postnatal depression?'

I have often been asked why I chose to study postnatal depression (PND) in fathers. As I am a father myself, this is typically and swiftly followed by '*did you have PND?*' The answer is no, I do not think that I did. However, I do think it is important to consider the potential reasons why I chose this topic. It took me a long time to decide to focus on mental health in mothers and fathers for my systematic review and empirical study, respectively. I considered conducting research with older adults who have dementia, because I had

enjoyed my first placement working in this field. I also considered conducting research in chronic pain, which is a research area I have previously been involved in. However, I kept being drawn back to work focused on the perinatal period. Research into being a parent was, and continues to be, something I am passionate about. I believe this is fundamentally important to maintaining motivation during a long piece of work.

This of course raises the question, why am I passionate about perinatal research? The empirical paper focused on identity construction. A fundamental part of my identity on a day-to-day (and conversational) basis is being a parent, and more specifically, a father. I started training when my daughter was only three months old and so my experiences of her earlier life are closely tied to training. This experience provided me with an 'insider' perspective on being a parent, which helped with my understanding of the subject matter and stimulated the development of research ideas (e.g. Hayfield & Huxley, 2015). However, I also believe that my choice of research project helped me to feel somewhat connected to my own family as I was not able to be with them as often as I would have liked whilst completing this research. This proved to be important to keep me going throughout the difficult times such as during recruitment.

3. 'Most studies' find it hard to recruit fathers

Recruitment into the study was very difficult. I started the process in February 2016 and over the summer I had only interviewed one participant with no

interest from any other fathers. At this point I was considering altering my research idea, because I was anxious that I would not be able to recruit sufficient numbers into the study. I contacted several experts in the field many of whom I referenced in this thesis. In one personal communication, I was told that '*most studies*' find it hard to recruit fathers and that it is important to be persistent. This advice was echoed by my supervisors who were very supportive during this time. I took this advice to heart and sought to persist with the research idea. I amended my study to include fathers with more than one child and contacted numerous organisations for help with advertising the research. This persistence paid off and I recruited six fathers into the study.

On the one hand this taught me the importance of perseverance and determination when recruiting participants from a hard to reach population. However, on the other hand, it raised questions about why it was so difficult to recruit fathers with PND. In another personal communication with an expert in the field, it was suggested that part of the difficulty may have been because I required fathers to identify as '*having (had) depression*'. The reason I wanted to recruit fathers that identified with this condition was because I was specifically interested in PND. As outlined in chapter 2, the term paternal PND is recognised and used in the public domain (e.g. National Health Service, 2017) and so its use seemed justifiable. However, it is possible that my choice of terminology impacted the research in that it may have attracted some fathers to the study and caused others to avoid taking part.

As a trainee clinical psychologist, it is perhaps somewhat unsurprising that I favour the use of formulation to psychiatric diagnosis (e.g. see Johnstone, 2014 for detailed discussion on the topic). There are clear ethical and therapeutic issues associated with categorising groups of people according to a manualised definition and label, which have been recognised in the literature for many years (e.g. Shackle, 1985). One significant issue is the stigma that is attached to certain diagnoses (e.g. Wood, Birtel, Alsawy, Pyle, & Morrison, 2014). However, I also recognise that some clients may find diagnosis useful at times (see Clark, 2017). It may help them understand themselves and relate to other people in similar situations. Whilst PND does not have its own diagnostic criteria (BMJ Best Practice, 2016), the use of this term is so ubiquitous that it has taken on a kind of pseudo-diagnostic status, one that is even recognised by professional psychiatric bodies (Royal College of Psychiatrists, 2017). I initially reasoned that the term paternal PND would be a potentially useful means to recruit participants; a short-hand that, as mentioned, was used in the wider public discourse. However, my opinion has changed as a result of conducting this research. Several fathers in the empirical paper rejected the term and aligned PND with women.

I have reflected, and discussed at length in supervision, how I might frame paternal PND if I were to conduct this study again. However, I have not arrived at a definitive answer. One possibility would be to re-frame it along the lines of ‘low mood or stress following the birth of a child’ or ‘distress shortly after becoming a father’. Indeed, Darwin et al. (2017) found that men tended to show a preference for the term ‘stress’ rather than words associated with

mental health. However, this study did not explicitly recruit men that had experienced depression. Furthermore, although the fathers in the empirical study did not readily associate with the term paternal PND, several identified with depression. A number of my colleagues have suggested that it may be best to distinguish between mothers and fathers by avoiding the use of the word 'postnatal' with men. Whilst I can appreciate the importance of differentiating between mothers and fathers, I feel somewhat conflicted about this idea. Limiting a term like 'postnatal' to one gender feels restrictive. Indeed, following this line of argument to its logical conclusion one might also have feminine and masculine alternative names for such concepts as anxiety. There may also be alternative terminology between different cultures, ethnicities and perhaps between individuals. However, as described in chapter two, several of the fathers in the study did not agree with this idea.

One of the strengths of formulation is recognising individuality as part of the collaborative sense-making process and so it offers a useful alternative to such labels as paternal PND. However, it is uncertain how one might develop a formulation into a useful short-hand for the purposes of recruitment into a study. Johnston (2014) has argued that therapists often have labels for frequent difficulties (e.g. '*bereavement reaction*' pp 273), which may be useful. I wonder, however, if the use of such terms in a study may result in similar difficulties. For example, if I were to recruit fathers with a 'low mood reaction' after having a baby it might exclude those that identify with depression. In contrast, if I were to recruit fathers with a 'depressed mood reaction' after having a baby it might exclude those who feel they had low mood, and not

depression. I am not convinced there is a perfect way of phrasing paternal PND. However, a system based on formulation, rather than diagnostic-like labels, offers a promising approach. It is important however to acknowledge that whatever approach is used, it is likely to influence the findings reported in research.

It is also important to mention that it became clear during recruitment that there were fathers who identified with the term paternal PND, but were not comfortable talking about their condition in the research study. This is not surprising based on the findings of the empirical paper, which discussed how men found it difficult talking about paternal PND. I also appreciate that there are likely to be those who do not want to participate for a variety of personal reasons. However, it is also possible that their reluctance to talk about paternal PND is linked to a wider issue. The British Broadcasting Company (2017) recently published a news article on young men with paternal PND. An examination of the comments made on this article on Facebook would make for a fascinating discourse analysis study. Whilst there are clearly some people who are accepting of the possibility that men may get PND, there are others that do not accept it and outwardly reject it. One of the participants in the current study spoke about the stigma attached to paternal PND and there appears to be some evidence to support this claim in the public domain. Of course, this is not just limited to paternal PND and stigma is an issue for mental health difficulties in general. This highlights the importance of raising awareness of mental health issues and reducing stigma such as with the

recent ‘Heads Together’ (2017) campaign which was fronted by members of the royal family.

4. The interview process: ‘That must be difficult’

It is important to be aware of the potential impact that a researcher may have on the research process (Walsh & Downe, 2006). I am a clinician, a researcher, a male, a father and a partner. Such identities are likely to have influenced the conduct of the research. I wrote in chapter 1 about how my wife had experienced a traumatic birth. This was one of the reasons why I decided to explore experiences of fears related to childbirth for the systematic review. Whilst I made efforts to be objective and systematic, and followed guidelines developed for meta-ethnography, it is likely that my interpretations of the research findings were coloured by this previous experience, which was acknowledged as a limitation of the review. Furthermore, as a father, I can appreciate the difficulties associated with having a young child. I was asked by all the participants, before each interview, if I was a father. I chose to disclose that I was, which may have had an impact on how they spoke to me, what they revealed and how they felt about me as an interviewer. I chose to let the participants know that I am a father, because it felt appropriate to facilitate the interviews. The alternative would have been to not disclose, which I thought would have had a detrimental effect on our discussions given that they had asked. However, the opposite may have been true. Indeed, in clinical practice, I may have been less inclined to disclose.

I believe that my dual identities as a clinician and a father influenced the way that I conducted the interviews. Once again, this was acknowledged as a limitation in the empirical paper, but this reflective chapter provides a good opportunity to explore this issue further. I have provided an excerpt from the interview with Oliver to illustrate this issue. Oliver had been asked about what other people did when he had paternal PND, which brought him onto talking about his wife.

Excerpt 1

1	Oliver:	….I ↑feel as though my wife hasn't (.) yet forgiven me
2		e:ither
3	Interviewer:	OK
4	Oliver:	ermm (2.4) so: (3.9)
5	Interviewer:	That must be difficult

Oliver positioned himself as having done something wrong, which required forgiveness from his wife. He orientated his wife as having not forgiven him. In this moment, I truly felt sad for him and had a sense of hopelessness. As clinicians, we are taught the importance of empathy and validation (e.g. Koerner & Linehan, 2003). This section of the interview provides an example of where I was empathising with how difficult it must have been for Oliver to be in that situation by saying *'That must be difficult*' (line 4). I often positioned myself as empathic to the father's situations. This is entirely reasonable from a humanistic perspective (Rogers, 1980). However, it is very likely to have

influenced what the participants said during the interview. To take an extreme example, if I had positioned myself in line with how he constructed his wife and said something like '*I think it is right that she has not forgiven you*', then I may have derived significantly different findings. In addition, I could have framed this sentence more tentatively by saying something like '*I wonder if that feels difficult*', which may have also resulted in a different response.

This example highlights the tension that is present between academic study and clinical practice. One of the reasons why I like discourse analysis is that the researcher's speech is clearly displayed and the interviewer's position within the discourse is well defined. I feel this adds an additional layer of validity to the analysis. More generally, I feel as if this has been an important learning experience with implications for my clinical practice. What my clients say in therapy is not produced within a vacuum. It is influenced by my speech. Discursive psychology has made me more mindful of both what my clients say and what I have said that prompted their answers.

5. Analysis and writing-up: 'Isolation and guilt'

Transcription for the study was completed in a rather disjointed way. My first three interviews were conducted between June and October 2016. The final three interviews were completed in March 2017. As discussed, this was due to difficulties I had with recruitment into the study. However, it meant that I had to do a relatively large amount of transcribing and then analysis in a short space of time. I spent days (and evenings) shut away in my office at home

listening and reading (and re-reading) the participants' interviews. I found myself becoming increasingly frustrated, which I found difficult to fully explain. I appreciate that it is difficult to write a thesis and I have no doubts that this was part of the reason. However, I have previously written similar pieces of work, and have worked to tight deadlines, but never have I experienced so much difficulty with the process. I began to question why this might be and reflected on my feelings of anger. It has been theorised that anger can sometimes be a secondary emotion that masks or defends against conscious awareness of a more difficult underlying feeling (e.g. Greenberg & Paivio, 2003). My mind was drawn to something one of the fathers (Arthur) had mentioned repeatedly; that he felt a great sense of '*isolation and guilt*'. The mirroring of this person's experiences and my own current situation at the time was quite stark. Here I was, a father of a two and half year-old girl, isolating myself in my office and feeling incredibly guilty about it. Even as I write this reflection I can hear my daughter crying downstairs and it is hard to leave parenting responsibilities to my wife as I work.

I also felt guilty about other aspects of this work. I discussed the potential role of hegemonic masculinity in paternal PND. This refers to the practices that place men in a dominant position in society (Carrigan, Connell, & Lee, 1985). It has been argued that men fulfilling the role of the family 'breadwinner', at expense of being a present father, is consistent with hegemonic masculinity (Schmitz, 2016). My work on this thesis, and the doctorate course more generally, has typically been placed in conflict with my role as a parent; during the writing block, I feel that work was prioritised. Reading through past theses

of parents on this doctorate course, it is clear that this is an experience that is not limited to fathers. However, as a man I cannot help but also feel guilty that my wife has had to take on the role of primary care giver. She has said many times that she is happy to do this and often reassures me that I make every effort I can to spend time with them, but the guilt remains.

I previously reasoned that my choice of project helped me feel connected to my family. However, it may have also fulfilled another role. Malan (1995) developed the triangle of conflict to aid with formulation. It shows how defence mechanisms are used to manage anxiety that results from an underlying feeling. I formulated that I felt guilty about spending time away from my family to write this thesis. It is possible that my choice of thesis may have been a defence mechanism. Sublimation refers to the process of investing energy associated with difficulty feelings or impulses into something that is more prosocial (Lemma, 2003). I believe that my guilt may have been sublimated into this perinatal research to potentially benefit other families.

These experiences have highlighted the importance of family to me and self-care. It is well known that psychotherapists are relatively poor at practising self-care, but it is a vitally important part of being an effective clinician (Bailey, 2007; Bettney, 2017; Norcross, 2000). Prior to writing my thesis I worked at a service for students at a university. I spent multiple sessions with clients discussing the importance of developing a work-life balance (e.g. Greenhaus, Collins, & Shaw, 2003; Haar, Russo, Suñe, & Ollier-Malaterre, 2014), but I had difficulty applying the same principles to my own life. Reflecting on these

experiences has been incredibly helpful. Towards the end of my writing block I started to develop a better balance between work and spending time with my family, which I found had a beneficial impact on my quality of life and the quality of my work. This has proved to be an important learning experience and one which I will hold in mind throughout my life.

6. Developing as researcher: From quantitative to qualitative research

I have been fortunate to have worked on numerous research projects prior to starting training on the doctorate course. However, the clear majority of these studies were quantitative and adopted a positivist epistemological position (Barker, Pistrang, & Elliot, 2012). I was comfortable working with questionnaires and statistics, but less so within a qualitative framework. I was advised prior to training to concentrate on what I know and to avoid the '*stress*' of learning a new approach to research and analysis for my thesis. I can see the merits of this advice, because conducting this research was incredibly challenging for me. However, I have always viewed conducting a piece of research as an opportunity to learn something new; to push one's self and develop as a scientific-practitioner, which I feel I have achieved while completing this thesis.

Throughout my career, I have developed my skills at identifying underlying cognitive constructs. For example, I spent several years working as a researcher at the University of Nottingham, where I was tasked with identifying latent constructs as measured by questionnaires. More recently, in clinical

practice, I have developed my skills in formulation which often assumes that there is an unobservable cognitive construct (e.g. a core belief). This experience was put at odds with the discursive psychology approach, which was used for the empirical study. The focus of this approach is what is constructed within speech and not on some hypothetical underlying cognition (Edwards, 2005; Potter, Edwards, & Wetherell, 1993). At first this was very difficult for me to adjust to. Years of training had led me to automatically identify and interpret cognitions. However, with support from my supervisors, I learned to focus in on the action of what is said.

My experiences with discursive psychology, and qualitative synthesis, have enriched my appreciation of the role of qualitative methodologies. These approaches to research offer a significant contribution to understanding; one which cannot be replicated by adopting a purely quantitative approach. I have always thought of myself as a quantitative researcher, but as a direct result of writing this thesis, I now identify more as a mixed-methods or qualitative researcher. I believe that quantitative and qualitative approaches complement each other well and both have their place in developing an evidence base (Johnson & Onwuegbuzie, 2004).

Clinical psychologists are trained to apply their skills in research to develop an evidence-base and improve their practice (Division of Clinical Psychology, 2010). My experiences of conducting this piece of work have led me to embrace this applied academic ethos as I find myself enthusiastically considering future lines of research. As previously mentioned, I am mindful

that I am not the only parent on a doctorate course to have concentrated on fields related to the perinatal period and parenting. I believe this is a potentially fruitful area to explore in future research. In particular, what are the lived experiences of parents on doctorate courses and how does this affect their practice? It would also be important to explore how such identities as parent, and trainee, are constructed and negotiated within discourse across different settings.

7. Conclusion

The research reported in this thesis represents a significant personal journey. I started considering research ideas in my first year when I had only just recently finished working as a researcher. I look back at that person now and find it hard to recognise him. I wrote about the impact that this research has had on me as a person and a professional. I showed how this study taught me perseverance in the face of recruitment adversity, how it drew my attention to how I position myself within discourse and how it highlighted the importance of family in my life. I also discussed the potential impact that I may have had on the research process. I considered how my identity as a father contributed to the choice of study, the potential impact of how I positioned myself in the interviews on the findings and wrote about the important role of terminology in mental health. The link between researcher and research is difficult to completely differentiate; the two are not mutually exclusive. Writing this thesis, and my experiences on the doctorate course more generally, have confirmed

that reflection is vital to good practice as a researcher and clinician. I aim to take this learning forward throughout my professional life.

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Appendix 1: *International journal of childbirth instructions for authors*

International Journal of Childbirth Author Guidelines

The Official Publication of the International Confederation of Midwives

The *International Journal of Childbirth* is a quarterly, peer-reviewed publication with a global focus on childbearing. The journal invites the submission of manuscripts that address research, practice, education, and theory as well as case reports, personal narratives, and commentaries on all aspects of childbirth.

The following presentation style should be observed when submitting manuscripts:

- *Clinical and Basic Science Research* articles should include an Abstract, Introduction, Material and Methods, Case History (if applicable), Results, Discussion, Conclusion, and References.
- *Review* articles should provide a comprehensive synthesis of the available information on their chosen topic. They must include headings and reference citations.
- *Case Reports* should be brief reviews of either typical or atypical births and should include an Abstract, Introduction, Case Report data and findings, Discussion, Conclusion, and References.
- *Personal Narratives* should first-hand accounts of childbirth experiences. References are not required but may be included when needed to support data or quotations from published sources.

Manuscript Preparation

Manuscripts should be prepared in accordance with the *Publication Manual of the American Psychological Association*, which should be consulted for matters of style and formatting, including text, references, and tables.

Length. Submissions are generally expected to be 15 to 25 pages in length; however, the journal considers manuscripts that are longer or shorter.

Cover Page. A cover page separate from the main manuscript must include the article's title and the names, academic degrees, mailing addresses, and e-mail addresses of each of the contributing authors.

Abstract. Research articles, review articles, and case reports should include an abstract of between 125 and 200 words that concisely states the article's purpose, the study design, major findings, and main conclusion.

Summary. When an abstract is not appropriate for the type of article submitted, authors should include a summary of between 125 to 200 words that provides a synopsis of the article's thesis and conclusions.

Appendices. Instruments or large tables of data may be included as an appendix to the manuscript. The publication of appendices is at the discretion of the editors.

Letters to the Editor. Letters to the editor should be concise comments regarding articles published in the journal and may include references. Letters should be under 300 words. Those accepted for publication may be edited or abridged.

Photographs, Drawings, and Graphs. Illustrations should be submitted as individual, high resolution images in jpg, tiff, or eps graphics file formats (graphs created in Excel are also acceptable). Digital images should include the figure number in the file name. Additionally, a copy of each illustration should be embedded at the end of the manuscript after the reference list and tables.

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Authors should submit manuscripts electronically at **www.editorialmanager.com/ijcbirth**. If you have any trouble using the Editorial Manager system, please contact Megan Larkin at mlarkin@springerpub.com.

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Appendix 2: Certificate of ethical approval for the systematic review

Certificate of Ethical Approval

Applicant:

Bryan Moreton

Project Title:

Mothers' experiences of fears related to childbirth: A systematic review of qualitative studies

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Medium Risk

Date of approval:

08 February 2016

Project Reference Number:

P40415

Appendix 3: Search process used for CINAHL and MEDLINE

CINAHL

S1 qualitative AND (research OR stud* OR design OR data OR method* OR analys*) NOT quantitative

S2 (childbirth OR birth* OR labor OR labour OR delivery OR maternity) AND (experience* OR complication* OR pain*)

S3 tocophobia OR tokophobia OR fear* of childbirth OR parturiphobia OR fear* OR fear* of death OR childbirth related fear* OR anxi* OR childbirth related anxi*

S4 S1 AND S2 AND S3

MEDLINE

S1 qualitative AND (research OR stud* OR design OR data OR method* OR analys*) NOT quantitative

S2 (parturition OR childbirth OR birth* OR labor OR labour OR delivery OR maternity) AND (experience* OR complication* OR pain*)

S3 tocophobia OR tokophobia OR fear* of childbirth OR parturiphobia OR fear* OR fear* of death OR childbirth related fear* OR anxi* OR childbirth related anxi*

S4 S1 AND S2 AND S3

* Alternative spellings of the word searched from where asterix is placed in the word (e.g. stud* returns study, studied and studies)

OR All articles containing terms connected with 'OR' returned

AND Only articles containing all terms connected with 'AND' are returned

NOT Articles containing term connected to 'NOT' (i.e. quantitative) were not returned

Appendix 4: Search outputs for each electronic database

Database	Total
CINAHL	190
PsycINFO	164
MEDLINE	303
AMED	9
PscyARTICLES	1
Nursing and Allied Health	79
Health and Medical Collection	130
Psychology	42
Web of Science	419
EMBASE	481

Appendix 5: Quality appraisal criteria and scoring systems

Quality appraisal took developed by Walsh and Downe (2006 pp 114-115)

Table 4 Summary criteria for appraising qualitative research studies.

Stages	Essential criteria	Specific prompts
Scope and purpose	Clear statement of, and rationale for, research question/aims/purposes	• Clarity of focus demonstrated • Explicit purpose given, such as descriptive/explanatory intent, theory building, hypothesis testing • Link between research and existing knowledge demonstrated
	Study thoroughly contextualised by existing literature	• Evidence of systematic approach to literature review, location of literature to contextualise the findings, or both
Design	Method/design apparent, and consistent with research intent	• Rationale given for use of qualitative design • Discussion of epistemological/ontological grounding • Rationale explored for specific qualitative method (e.g. ethnography, grounded theory, phenomenology) • Discussion of why particular method chosen is most appropriate/sensitive/relevant for research question/aims • Setting appropriate
	Data collection strategy apparent and appropriate	• Were data collection methods appropriate for type of data required and for specific qualitative method? • Were they likely to capture the complexity/diversity of experience and illuminate context in sufficient detail? • Was triangulation of data sources used if appropriate?
Sampling strategy	Sample and sampling method appropriate	• Selection criteria detailed, and description of how sampling was undertaken • Justification for sampling strategy given • Thickness of description likely to be achieved from sampling • Any disparity between planned and actual sample explained
Analysis	Analytic approach appropriate	• Approach made explicit (e.g. Thematic distillation, constant comparative method, grounded theory) • Was it appropriate for the qualitative method chosen? • Was data managed by software package or by hand and why? • Discussion of how coding systems/conceptual frameworks evolved • How was context of data retained during analysis • Evidence that the subjective meanings of participants were portrayed • Evidence of more than one researcher involved in stages if appropriate to epistemological/theoretical stance • Did research participants have any involvement in analysis (e.g. member checking) • Evidence provided that data reached saturation or discussion/rationale if it did not • Evidence that deviant data was sought, or discussion/ rationale if it was not
Interpretation	Context described and taken account of in interpretation	• Description of social/physical and interpersonal contexts of data collection • Evidence that researcher spent time 'dwelling with the data', interrogating it for competing/alternative explanations of phenomena
	Clear audit trail given	• Sufficient discussion of research processes such that others can follow 'decision trail'

Table 4 (*continued*)

Stages	Essential criteria	Specific prompts
	Data used to support interpretation	• Extensive use of field notes entries/verbatim interview quotes in discussion of findings • Clear exposition of how interpretation led to conclusions
Reflexivity	Researcher reflexivity demonstrated	• Discussion of relationship between researcher and participants during fieldwork • Demonstration of researcher's influence on stages of research process • Evidence of self-awareness/insight • Documentation of effects of the research on researcher • Evidence of how problems/complications met were dealt with
Ethical dimensions	Demonstration of sensitivity to ethical concerns	• Ethical committee approval granted • Clear commitment to integrity, honesty, transparency, equality and mutual respect in relationships with participants • Evidence of fair dealing with all research participants • Recording of dilemmas met and how resolved in relation to ethical issues • Documentation of how autonomy, consent, confidentiality, anonymity were managed
Relevance and transferability	Relevance and transferability evident	• Sufficient evidence for typicality specificity to be assessed • Analysis interwoven with existing theories and other relevant explanatory literature drawn from similar settings and studies • Discussion of how explanatory propositions/emergent theory may fit other contexts • Limitations/weaknesses of study clearly outlined • Clearly resonates with other knowledge and experience • Results/conclusions obviously supported by evidence • Interpretation plausible and 'makes sense' • Provides new insights and increases understanding • Significance for current policy and practice outlined • Assessment of value/empowerment for participants • Outlines further directions for investigation • Comment on whether aims/purposes of research were achieved

Scoring system developed by Downe et al. (2007 pp 132)

Grade	Interpretation
A	No or few flaws, the study credibility, transferability and confirmability is high
B	Some flaws, unlikely to affect the credibility, transferability, dependability and/or confirmability of the study
C	Some flaws, which may affect the credibility, transferability, dependability and confirmability of the study
D	Significant flaws, which are likely to affect the credibility, transferability, dependability and/or confirmability of the study

*This system was used to provide a global assessment of study quality

Scoring system developed for inter-rater reliability

Score	Interpretation
1	Not covered or poorly covered
2	Partially covered
3	Completely covered or covered to a high standard

*This system was applied to each of the 12 essential criteria to provide a numeric score representing quality.

Appendix 6: Meta-ethnographic method

The steps identified by Noblit and Hare (1988) as summarised by France et al. (2014 pp 121)

Table 1 The seven phases of Noblit and Hare's meta-ethnography approach

Phase	Noblit and Hare's description
Phase 1: Getting started	'Identifying an intellectual interest that qualitative research might inform' ([15], p.26). The focus of the synthesis may be revised through reading interpretive qualitative studies.
Phase 2: Deciding what is relevant to the initial interest	Study selection should be 'driven by some substantive interest derived from comparison of any given set of studies' ([15], p.28). Searches for studies need not be exhaustive: 'unless there is a substantive reason for an exhaustive search, generalizing from all studies of a particular setting yields trite conclusions' ([15], p.28).
Phase 3: Reading the studies	The repeated reading of studies and noting of metaphors with close attention to details in the studies and what they tell you about your area of interest ([15], p.28).
Phase 4: Determining how the studies are related	Noblit and Hare recommended that reviewers create 'a list of key metaphors, phrases, ideas and/or concepts (and their relations) used in each account, and [to] juxtapose them' ([15], p.28) in order to make an initial assumption about how the studies relate to one another. This informs the type of synthesis that will be carried out – a reciprocal or refutational translation or line of argument synthesis.
Phase 5: Translating the studies into one another	The metaphors and/or concepts in each account and their interactions are compared or 'translated' within and across accounts while retaining the structure of relationships between central metaphors/concepts within accounts. The translations taken together are 'one level of meta-ethnographic synthesis' ([15], p.28). These are systematic comparisons and reciprocal translation is key to a meta-ethnography.
Phase 6: Synthesising translations	If there are many translations from phase 5 these can be compared with one another to see if there are common types of translations or if some translations or concepts can encompass those from other studies. 'In these cases, a second level of synthesis is possible, analyzing types of competing interpretations and translating them into each other' ([15], p.28) to reach new interpretations/conceptual understandings.
Phase 7: Expressing the synthesis	Tailoring the communication of the synthesis to the intended audience's culture and language so that it is intelligible and meaningful to them - 'the written synthesis is only one possible form' ([15], p.29).

Appendix 7: *The Journal of Men's Studies*

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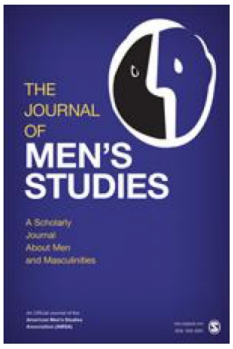

The Journal of Men's Studies

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A Scholarly Journal About Men and Masculinities

Editor-in-Chief

James Doyle, PhD Roane State Community College

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- Description
- Aims and Scope
- Editorial Board
- Abstracting / Indexing
- Submission Guidelines

Submissions must be sent electronically to https://mc.manuscriptcentral.com/men.

Manuscript preparation.

The Journal of Men's Studies publishes regular articles (7,500 to 8,500 words) and brief reports (2,500 to 3,000 words). Authors should prepare manuscripts according to the Publication Manual of the American Psychological Association (6th ed., 2009). Formatting instructions and instructions on the preparation of abstracts, text with designated headers (A-level through C-level), references, tables, and figures appear in the Manual. All copy must be double-spaced.

Abstract and keywords.

All manuscripts must include an abstract containing a maximum of 120 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References.

References should be listed in alphabetic order (also double-spaced). Each listed reference should be cited in the text, and each text citation should be listed in the References. Basic formats are as follows:

Journal article:

Chua, P., & Fujino, D. C. (1999). Negotiating new Asian-American masculinities: Attitudes and gender expectations. The Journal of Men's Studies, 7, 391-413.

Article in an Internet-only journal:

Gordon, R. (2004, June 15). The men among us. Library Journal.com. Retrieved October 15, 2006, from http://www.libraryjournal.com/article/CA423789.html

Book:

Lee, T. (2007). A new path at midlife: Transformative relationship & story for men. Harriman, TN: Men's Studies Press.

Chapter in a book:

Pleck, J. H. (1995). The gender role strain paradigm: An update. In R. F. Levant & W. S. Pollack (Eds.), A new psychology of men (pp. 11-32). New York: Basic Books.

Dissertation:

Davis, F. (1987). Antecedents and consequents of gender role conflict: An empirical test of sex role strain analysis (Doctoral dissertation, Ohio State University, 1987). Dissertation Abstracts International, 48(11), 3443.

Figures.

Graphic files are accepted if supplied as Tiff files (.tiff). High-quality printouts are needed for all figures. The minimum line weight for line art is 0.5 point for optimal printing.

Review Procedure.

The Journal of Men's Studies uses a masked review process. Authors are asked to include all identifying information in the cover letter, including the manuscript title, the authors' names, institutional affiliations, and e-mail addresses. The first page of the manuscript should include only the article's title, abstract, and keywords. Footnotes containing information that would reveal the authors' identity and/or affiliation should be removed. Every effort should be made to see that the manuscript itself contains no clues to the author's identity.

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Appendix 8: Advertisement for study

Participants needed for a study of postnatal depression in fathers

The focus of the study is on the way that people describe themselves as fathers with depression and how this effects their relationships with other people in their life. We are looking for first time fathers over the age of 18 who think they either currently have postnatal depression or have had it within the last five years. Participants will be asked to take part in a face-to-face interview, which will take place in their homes. The interview will include questions about postnatal depression, fathering and relationships with other people. It is estimated they will take approximately one hour and information will be treated confidentially in accordance with the Data Protection Act (1998).

If you are interested in receiving further information about this study please contact:

Bryan Moreton
Clinical Psychology Doctorate Programme
Universities of Coventry and Warwick
Coventry University
James Starley Building
Priory Street
Coventry
CV1 5FB
Email: moretonb@uni.coventry.ac.uk

Please provide your name and telephone number so that the researcher can speak to you

[For internet adverts – Please do not provide your personal details to/on this post/forum]

Version 1

Appendix 9: Participant information sheet

Participant Information Sheet

Research title: The discursive construction of illness identity by fathers who consider themselves to have paternal postnatal depression

Primary investigator: Bryan Moreton
Supervisors: Dr Carolyn Gordon, Dr Simon Goodman and Dr Kirstie McKenzie-McHarg

I would like to invite you to take part in this research study. Before you decide I would like you to understand why I am doing this research, how your information will be used, what the study will involve and the potential benefits and risks. Take your time to read the following information and feel free to talk to others about the study if you wish. Please ask if there is anything that is not clear.

Purpose of the project
I am conducting this study because I am interested in fathers who consider themselves to have postnatal depression. The focus of the study is on the way that people describe themselves as fathers with depression and how this effects their relationships with other people in their life. This will involve discussing how postnatal depression effects their role as a father and the attitudes that people hold about their condition.

I am a Trainee Clinical Psychologist at the Universities of Coventry and Warwick. This research will form part of my training program.

Why have I been chosen?
You have been chosen because you have indicated your interest in taking part in the study. The study aims to recruit 6-10 fathers who consider themselves to either have or had postnatal depression in the recent past.

Do I have to take part?
No participation is entirely voluntary. It is up to you to decide whether to join the study. You do not have to be involved in this research if you do not want to. If you decide you do not want to take part, you do not have to give a reason for this.

What do I have to do?
If you take part, then I will invite you to participate in a face-to-face interview, which will take place in your home. The interview will include questions about postnatal depression, fathering and relationships with other people (e.g. your partner and child). It is estimated that the interviews will last for approximately one hour, but the exact time will vary depending on how much you have to say. The interview will be audio tape recorded so that the information can be typed up and analysed. Prior to the interview, you will be asked to complete a short questionnaire about demographic information (e.g. your age and

ethnicity). If there is anything that you do not wish to talk about, then you will be able to tell the researcher. You can also decide at any point if you do not wish to continue with the interview.

What are the risks associated with this project?
Taking part in this study will use your time and therefore may be inconvenient. Some of the questions in the interview may cover topics that are sensitive or embarrassing, but all information will be anonymised and treated as confidential. Your involvement in the study can stop at any time during the interview if you do not wish to continue. Furthermore, you will be able to withdraw yourself from the study up to one month after completing the interview by contacting the researcher. Some people may find that talking about their postnatal depression lowers their mood. However, you will be able to talk to the researcher if you experience this and he will be able to provide information about services that can offer additional support.

What are the benefits of taking part?
Taking part in the study will provide useful information about postnatal depression in fathers. This may be used to develop psychological interventions to improve quality of life. Although there will be no payment for participation, some people may find it useful to talk about postnatal depression.

What will happen if I want to withdraw from the study?
Your participation is voluntary and so you can withdraw yourself, without providing a reason, by informing the researcher up to one month after the interview. There is a time limit because your information will eventually be aggregated with other participants and the findings will be written up in a report. However, all of your data will be completely anonymous. Withdrawing yourself from the study will have no impact on your legal rights.

Data protection and confidentiality
Audio recordings of the interview will be written-up onto a computer file and the demographics questionnaire will be transferred to an electronic database. In accordance with the Data Protection Act (1998), all identifying details will be removed from the files and false names will be used instead. Only the researcher conducting the interviews will have access to information that links the false names to the original person. Other people involved in the study will only be able to look at anonymised records of the interviews. Physical data will be kept in locked draws and electronic data will be stored on password protected data storage devices. The information that you provide will be analysed in accordance with the aims of the study. Excerpts and quotes from the interviews may be used in reports and publications but it will not be possible to identify you.

The primary investigator and his supervisor (Dr Carolyn Gordon) will be the only members of the research team that will have access to your personal details. They will not be provided to anyone else or used for any purpose other than for the research. Your personal information will be destroyed after it is no

longer necessary to contact you. All personal information will be stored separately from interview data.

What if things go wrong? How can I complain?
If you have any concerns about the way you have been treated during the course of the study, please discuss them with the researcher conducting the interview. If you wish to raise your concerns to someone who is unconnected to the research team, then please contact Professor Ian Marshall who is chair of Coventry University Ethics committee. He can be contacted using the following email address: i.marshall@coventry.ac.uk.

What will happen with the results of the study?
The results of the study will form part of a report that will be submitted for a university course. In addition, the results of the study may also be presented to other researchers and clinicians at meetings and through publications in scientific journals. However, as previously mentioned, your data will remain anonymous. If you wish to have a copy of the final results, then please inform the researcher conducting the interview (contact details also provided below) who will be happy to send you a copy when they are available.

Who has reviewed this study?
The study has been reviewed by university lecturers and clinical psychologists to ensure it meets sufficient scientific standards. The study has also been reviewed and been given favourable ethical opinion by Coventry University Ethics Committee.

Key contacts
The primary investigator is Bryan Moreton who is a Trainee Clinical Psychologist. Dr Carolyn Gordon is his academic supervisor. Both people can be contacted at:
Clinical Psychology Doctorate Programme
Universities of Coventry and Warwick
Coventry University
James Starley Building
Priory Street
Coventry
CV1 5FB
Email: moretonb@uni.coventry.ac.uk
Carolyn.gordon@coventry.ac.uk
Telephone: 02477657806

Thank you for taking the time to read this information sheet.

Version 1

Appendix 10: Consent form

Informed Consent Form

Research title: The discursive construction of illness identity by fathers who consider themselves to have paternal postnatal depression

Brief summary of research: The focus of the study is on the way that people describe themselves as fathers with depression and how this effects their relationships with other people in their life.

	Please initial
1. I confirm that I have read and understood the participant information sheet version 1 for the above study	☐
2. I have had the opportunity to ask questions and have understood the answers provided	☐
3. I understand that my participation is voluntary and that I am free to withdraw from the interview at any time without given a reason and without, if relevant, the support I am receiving being affected. I am aware that I have the right to change my mind about participating in the study for a period of one month after the interview has concluded. After this period my anonymised data will be included in the analysis	☐
4. I consent to being interviewed for this study	☐
5. I understand that all information I provide will be treated in confidence	☐
6. I understand that my interview data will be anonymised and all identifying details will be removed	☐
7. I agree to be audio recorded and for anonymised quotes to be used in the final report and any potential future publications or presentations	☐
8. I agree to take part in the research project	☐
9. I wish to receive a copy of the final results when they are available **(optional)**	☐

Name of participant: .....
Signature of participant: .....
Date: .....
Name of researcher:.....
Signature of researcher: .....
Date:.....
Version 1

Appendix 11: Debrief sheet

Debrief Sheet

Research title: The discursive construction of illness identity by fathers who consider themselves to have paternal postnatal depression

Aims and summary of research
This study aims to understand the way that people describe themselves as fathers with depression and how this effects their relationships with other people in their life. Audio recordings of the interview will be typed up and the data will be anonymised so that it will not be possible to identify you. You will be able to withdraw your data up to one month after the interview by contacting the researcher (details provided below). The results of this study will be written up and submitted as part of a university course. It may also be submitted to scientific journals and presented at meetings. However, it will not be possible to identify you from the results.

Contact details
If you would like to receive a copy of the results, then please ask the researcher conducting the interview. If you are unhappy with the way you have been treated during the study, then please discuss them with the researcher conducting the interview. However, if you would like to talk to someone unconnected to the research team then please contact Professor Ian Marshall who is chair of Coventry University Ethics Committee (i.marshall@coventry.ac.uk). Both Bryan Moreton (principle investigator) and Dr Carolyn Gordon (academic supervisor) can be contacted at:
Clinical Psychology Doctorate Programme, Universities of Coventry and Warwick, Coventry University, James Starley Building, Priory Street, Coventry, CV1 5FB
Email: moretonb@uni.coventry.ac.uk Carolyn.gordon@coventry.ac.uk
Telephone: 02477657806

Addition support
You may have found talking about your experiences of postnatal depression difficult or would like to talk about it further with someone else. Your GP will be able to put you into contact with services that can provide additional support. Contact details have also been provided for the Samaritans and SANEline who may be able to help. They are not connected with the study and anything you tell them will be kept confidential.
Samaritans telephone: 116 123 (24 hours a day)
SANEline telephone: 0300 304 7000 (6pm-11pm daily)

The researcher who conducted the interview may also be able to provide details of local support services.

Version 1

Appendix 12: Demographics questionnaire

Demographics Questionnaire

Date: ……..

Participant: ……..

Participant's age: ……..

Participant's ethnicity (please circle):

White British	Black British	Asian British	Mixed White/Black Caribbean
White Irish	Black African	Asian Indian	Mixed White/Black African
White other	Black Caribbean	Asian Pakistani	Mixed White/Asian
Not known	Black other	Asian Chinese	Other Mixed ethnicities
Not stated		Asian other	

Other (please specify)……..

Participant's employment status (please circle):

Not known	Unemployed
Student – part time	Student – full time
Work – full time	Work – part time
Homemaker	Other (please specify) ……..

Child's age: ……..

Child's gender (please circle): Male Female

Child's ethnicity (please circle):

White British	Black British	Asian British	Mixed White/Black Caribbean
White Irish	Black African	Asian Indian	Mixed White/Black African

White other	Black Caribbean	Asian Pakistani	Mixed White/Asian
Not known	Black other	Asian Chinese	Other Mixed ethnicities
Not stated		Asian other	

Other (please specify)……..

Mother's age: ……..

Mother's ethnicity (please circle):

White British Caribbean	Black British	Asian British	Mixed White/Black
White Irish African	Black African	Asian Indian	Mixed White/Black
White other	Black Caribbean	Asian Pakistani	Mixed White/Asian
Not known	Black other	Asian Chinese	Other Mixed ethnicities
Not stated		Asian other	

Other (please specify)……..

Mother's employment status (please circle):

Not known	Unemployed
Student – part time	Student – full time
Work – full time	Work – part time
Homemaker	Other (please specify) ……..

Version 1

Appendix 13: Interview schedule

1. What is your experience of paternal postnatal depression? When did you start to experience paternal postnatal depression? How would you describe paternal postnatal depression?
2. What do you think might have caused you to develop paternal postnatal depression? What made your paternal postnatal depression better or worse? What effected your experiences of postnatal depression? How did you understand paternal postnatal depression? What impact did it have on you?
3. What effect if any did paternal postnatal depression have on your role as a father? If it did have an effect, how do you think your role would have been different if you did not have paternal postnatal depression? What impact if any did paternal postnatal depression have on your relationship with your child?
4. What effect if any did paternal postnatal depression have on your role as a partner to the mother? If it did have an effect, how do you think your role would have been different if you did not have paternal postnatal depression? What impact if any did paternal postnatal depression have on your relationship with the mother?
5. **[if relevant]** What effect if did any paternal postnatal depression have on your occupation? If it did have an effect, how do you think your role as a worker would have been different if you did not have paternal postnatal depression? What impact if any did paternal postnatal depression have on your relationship with work?
6. What do you feel a father does when they have paternal postnatal depression? What did you do when you had paternal postnatal depression?
7. In your view, what could a mother do when a father has paternal postnatal depression? What did your child's mother do when you had paternal postnatal depression?
8. What could other people do when a father has paternal postnatal depression? What did other people in your life do when you had paternal postnatal depression?

Appendix 14: Ethical approval for study

Certificate of Ethical Approval

Applicant:

Bryan Moreton

Project Title:

The discursive construction of illness identity by fathers who consider themselves to have paternal postnatal depression

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Medium Risk

Date of approval:

08 January 2016

Project Reference Number:

P37727

Appendix 15: Approval of amendment

Project [P37727]

The discursive construction of illness identity by fathers who consider themselves to have paternal postnatal depression

Project Details | Comments (3) | Downloads | Approval Steps

Evaluation of the ethics of the proposal:
This is a very thorough proposal which specifies an appropriate research methodology and method of analysis. The applicant has considered possible ethical issues in great detail. A very well written application.

Anonymous - 08 Jan 2016 12:15 PM

Evaluation of the participant information sheet and consent form:
As with the rest of the proposal, these are very well written and presented - with an appropriate level of information. I see no issues.

Anonymous - 08 Jan 2016 12:15 PM

Amendment to widen sample, inclusion criteria to include all fathers (i.e. including those with more than one child), applicant has confirmed project aims and methods will remain the same. Interview Schedule will be altered slightly to include 'child(ren)' rather than referring to 'child', as appropriate.
The Chair has approved this amendment.

Sophie Krumins - 23 Sep 2016 08:26 AM

3 Comments

Appendix 16: Recruitment sources

Charity / Organisation
Netmums
Dad Info
Fatherhood institute
PANDAS Dads
Mind
Father's reaching out
Who let the Dad's out
Babycentre
Family action
House of light
PNI ORG UK
APNI
Smile group
Warwick University Counselling Service
Home link family support
Mengage
EVOC
Bluebell care
Men Tell Health
PMH Cymru
Oxford PIP
Dad's rock

Appendix 17: Transcription symbols

From McKinley and McVittie (2008) pp 19-20

TRANSCRIPTION NOTATION

[ ]	Overlapping talk is shown by square brackets, with "[" indicating where the overlap begins and "]" indicating where the overlapped utterance (or part of an utterance) stops.
=	An "equal to" sign "=" at the end of one line and another at the end of the succeeding line indicates that there is no gap between the two lines.
(.) (dot)	A dot in parentheses "(.)" indicates a very slight gap.
: (colon)	A colon ":" indicates that the sound immediately preceding the colon has been elongated, with the lengthening of the sound indicated by the number of colons.
↑	An upwards pointing arrow "↑" indicates that the speaker is raising pitch.
↓	A downwards pointing arrow "↓" indicates the speaker is lowering pitch.
Numbers	Numbers in parentheses, e.g. (0.3) indicate time elapsed in tenths of a second.
Underlining	Underlining of letters or words (e.g. "Doh") indicates that the speaker is stressing that part of the speech by increasing volume or raising or lowering pitch.

20 INTRODUCTION

Upper case	Upper case indicates that the speaker's utterance is produced with a particularly high volume (e.g., "DOH").
Punctuation	Punctuation markers indicate the speaker's intonation. For example, the question mark "?" indicates a "questioning" intonation.
° (degree sign)	The superscripted degree sign "°" indicates unvoiced production.
< (left caret)	Placed before a word, a left caret "<" indicates a hurried start. Placed after a word it indicates that the word stopped suddenly.
> < (right/left carets)	Right/left carets "> <" surrounding an utterance (or part of an utterance) indicate the speech is speeding up.
< > (left/right carets)	Left/right carets < > surrounding an utterance (or part of an utterance) indicate the speech is slowing down.
– (dash)	A dash "–" indicates that an utterance is "cut off."
hhh	A row of instances of the letter "h" "hhh" indicates an out-breath.
.hhh	A row of instances of the letter "h" prefixed by a dot, ".hhh" indicates an in-breath.
( )	Empty parentheses ( ) indicate that the transcriber could not make out what was said or, alternatively, who was speaking.
(Doh) (word in parenthesis)	Placing parentheses around a word indicates that the transcription is uncertain.
(( ))	Doubled parentheses contain transcriber's descriptions.

Appendix 18: Extended extract

1	Interviewer:	>so do you think that there is an element< of <around>
2		the way that men are brought up?
3	Richard:	Yeah I mean like like for <u>me</u> for example on you know
4		my my parents are Latin American
5	Interviewer:	Right
6	Richard:	So the Latin American culture men there's very much
7		the <ma:cho:>
8	Interviewer:	Yeah
9	Richard:	culture of err of the strong man and that kind of thing (.)
10		and you know I think there's > ↑part of that< I think had I
11		think there's an element of that of that you know we're
12		not err (.) you know they say look a on-online and stuff
13		they say ↑Latino's don't talk to you know to express their
14		feelings its > ↑<u>killing</u>< them
15	Interviewer:	Yeah
16	Richard:	along with men you know men well men as a
17		greater whole as well
18	Interviewer:	Yeah
19	Richard:	(.) So that's hard and you know I was I was I I'm a
20		>veteran< I was was in the military so there's
21	Interviewer:	Right
22	Richard:	that there's <u>that</u> aspect as well like again very ma:cho
23	Interviewer:	Yeah

24 Richard: err kind of culture where you err (.) you know expecting
25 kind of be self-sufficient and you know
26 Interviewer: Yeah
27 Richard: Only you know only only only pussies get mental health
28 problems and you know
29 Interviewer: Yeah
30 Richard: Cheer the fuck up and that kind of thing
31 Interviewer: Yeah
32 Richard: So there's you know I I had kind of a double whammy or
33 ↑triple whammy of being a man:
34 Interviewer: Yeah
35 Richard: being a you know a Latino man and then having been
36 in the >↑military< you know that that it's you know=
37 Interviewer: =So all these [experiences
38 Richard: It's all] these all these kind of pressures to be
39 Interviewer: Mmm
40 Richard: be a strong ma:cho man when
41 Interviewer: Yeah
42 Richard: in reality it you know it could've it ↑could've literally you
43 know
44 Interviewer: Yeah
45 Richard: you know ruined my ↑life...