Challenges and Experiences of First Time Fatherhood

by

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Volume I

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Experiences and Challenges of First Time Fatherhood
Academic Dossier

This section contains two essays written in year one and year two of the course. Also included in this section are three reflective accounts of the problem based learning tasks undertaken in years one, two and three. Summaries of the reflective accounts written about the case discussion groups are also included with the full accounts presented in Volume Two of this portfolio.
Can the experience of hearing voices (auditory hallucinations) be considered an ordinary part of human experience? What implications might such a conceptualisation have for the ways that clinical psychologists respond to service users that hear voices?

December 2005

Year One
"Hallucinations may be defined as a sort of perceptive experience that occurs without adequate stimulation of the relevant sensory organ, but has the compelling sense of reality of a true perception" (Perona Garcelan, 2004 pp.129). Auditory hallucinations (hearing voices) are traditionally associated with psychiatric disorders and more specifically with schizophrenia with 74% of patients experiencing this symptom (Sartorius, Shapiro & Jablensky, 1974: cited in Perona Garcelan, 2004). Auditory hallucinations are widely recognized as a distressing experience and as a result reactions to these hallucinations can range from mild irritation to self-harm or even violence especially in relation to command hallucinations (Hersch & Borum, 1998: cited in McGuire & David, 2000).

Auditory hallucinations do not occur in schizophrenia alone, they can occur in various emotional and organic states such as hearing loss and deafness, neurological conditions and psychiatric conditions (Johns, Hemsley & Kuipers, 2002). This occurrence in a variety of states indicates the diverse nature of auditory hallucinations; they do not appear to be mutually exclusive to certain disorders or behaviours and as such, the scope for who may be affected by these symptoms widens significantly. Indeed in the last 100 years there has been an increase in the number of individuals in the general population reporting to have experienced auditory hallucinations (Barrett & Etheridge, 1992). It would therefore seem that it is a more ordinary experience to hear voices than initially imagined.

In order to consider auditory hallucinations as an ordinary part of human experience many factors should be considered. The prevalence and distribution of auditory hallucinations within the general population needs to be considered to provide an overview of how many people within the population hear voices and under what circumstances. To acknowledge Britain's diverse society, an investigation into auditory hallucinations in the general public should reflect this by considering auditory hallucinations in children, in adults, and in older adults. In addition, individuals from
different cultures will also be included as our society is becoming increasingly multi-
cultural. As trainee clinical psychologists it is important that our research and work is
applicable to the population that we serve; by acknowledging the diversity of our society
we can enhance the service that we are providing and ensure that service users receive the
best quality of care.

To better understand the hallucinations that occur in the general population, we can
consider the explanations as to why such a phenomenon may transpire. By attempting to
understand the origin of symptoms it is easier to provide a treatment plan that can be
tailored to the individual as oppose to working generically with individuals that hear
voices. Many people work eclectically in clinical psychology and this way of working
lends itself to viewing each service user as an individual, with individual symptoms,
history and needs. An individualized approach such as this creates a personal approach to
our work and there is every chance that this could greatly improve the therapeutic
relationship and treatment outcome as a result.

Equally if not more important is what these hallucinations mean for the individuals that
experience them. Hallucinations are multi-faceted, that is they have many different
aspects to them and each individual may have very different experiences of them. Aspects
of hallucinations can include the content of the voices, whether the voice is in the second
or third person, do the voices have features such as sex or accent and what beliefs does
the individual hold about the voices? (Perona Garcelan, 2004). How the individual
perceives the voices can impact the way in which they react to the experience; by
understanding the meaning that the voices have for individuals, we can try to alleviate
any distress that occurs as a result. We also need to explore what factors affect distress
levels to provide a basis from which we can work; avoiding those factors which induce
distress and maintaining those which provide respite.
Finally, it is important to consider what this means for us as trainees and as clinical psychologists and how the way in which we conceptualize auditory hallucinations impacts on our response to those service users who experience them.

Auditory Hallucinations in the General Population

The prevalence of auditory hallucinations in the general population is something which has clear implications for a consideration of these hallucinations as an ordinary experience. I have decided to present and discuss the current literature regarding auditory hallucinations across different cultures, in children, adults and older adults, reflecting the different service users we will encounter throughout our placements over the next three years. This is done with the aim of gaining a comprehensive picture of auditory hallucinations taking into account age, gender and culture with an aim to recognize the contributions that these factors have towards people’s experiences.

Cultural differences

The general population in Britain consists of many different cultures. Johns et al., (2002) examined data from a national community survey to study the prevalence of hallucinations in white and ethnic minority samples across England and Wales. Interviews were carried out with 5196 ethnic minority participants and 2867 White participants. 4% of the White participants agreed with a question regarding experience of hallucinations while the percentage was 2.5 times higher for the Caribbean sample. The percentage in the South Asian sample was half that of the White sample. Across the
sample that experienced hallucinations only 25% met the criteria for psychosis. This indicates quite a high prevalence of hallucinations being present across the sample but particularly so in the Caribbean sample. This should be taken into consideration when diagnosing people from the Caribbean in order to minimize incorrect diagnoses of schizophrenia (they may simply be experiencing auditory hallucinations). It has previously been suggested that being unaware of cultural differences in hallucinations can result in patients from ethnic minority groups being wrongly diagnosed with schizophrenia (Shashidharan, 1993: cited in Johns et al., 2002).

Although the study by Johns et al., (2002) undisputedly demonstrates cultural differences between hallucinations in the general population of England and Wales, the study measured experiences of hallucinations in general; that is the study was not specific to auditory hallucinations although as these were included as a part of the description of hallucinatory experiences I felt this research was relevant.

**Children**

Auditory hallucinations in children have not received quite as much attention as adults, although studies in this area have been carried out. The frequency of auditory hallucinations in children is estimated to range from 1.1% (Garalda, 1984: cited in Mertin & Hartwig, 2004) to 5.7% (Burke et al., 1985: cited in Mertin & Hartwig, 2004).

Mertin and Hartwig (2004) investigated auditory hallucinations in 13 children referred to a community based child and family mental health service presenting with various behavioural and emotional difficulties. The study considered the basis of the initial referral to the service, the diagnosis received, the content of the hallucination and the
family history. None of the children were considered psychotic at initial presentation and all of them seemed to believe that hearing voices was not ‘normal’. All of the children did however share a common feature of mood disturbance in the form of anxiety and were all highly stressed and / or anxious at the time they were referred. The information regarding family history revealed various disruptive and dysfunctional aspects including family break-up, bereavement, domestic violence and abuse (Mertin & Hartwig, 2004).

This research suggests that there is a link between stress and auditory hallucinations; a notion already given consideration by Kotsopoulos et al. (1987) (as cited in Mertin & Hartwig, 2004) who believed that hallucinations were an indicator of high arousal levels that often accompany chronic stress. This is supported by the gradual disappearance of hallucinations once therapeutic support was provided and the levels of stress were reduced (Mertin & Hartwig, 2004). An additional explanation is that dissociative states in children often result in pretend friends that provide support and acceptance (James, 1989; Putnam, 1993: cited in Mertin & Hartwig, 2004). This is a plausible explanation; children are not as well equipped as adults to deal with times of great stress and they are likely to be unaware of support that is available to them.

The study by Mertin and Hartwig (2004) though informative, had a limited sample and therefore the results cannot be generalized. Escher et al., (2002) carried out a 3-year follow up study to investigate the experiences of child patients and non-patients over this time period. 80 children took part in this study of which approximately 50% were receiving mental health care. The results showed that over 3 years, the rate of discontinuation in the voices was 60%. Differences between patients and non-patients showed that those who were receiving mental health care were more likely to report emotional triggers to the voices and were more likely to report childhood adversity. In addition, they also reported more negative affective appraisals in relation to the voice. If we consider the findings of Mertin and Hartwig (2004) where all the subjects were
receiving mental health care, we can see that emotional triggers and childhood adversity were also present as factors. It may be that children who are not receiving mental health care are unaware of the relationship between these factors, or it could be that children who hear voices but do not experience childhood adversity have more positive hallucinatory experiences and do not feel the need for professional help. This would tie in with the finding that patients are more likely to report negative affective appraisals in relation to the voice; those who have more positive appraisals are less likely to seek help as presumably the voices cause less distress.

Adults

There have been a number of studies that have investigated the prevalence of auditory hallucinations in adults in the general population. One of the earliest studies of this kind conducted by the Society for Psychical Research involved interviewing 17,000 adults with those obviously suffering from psychiatric or physical illness being excluded. The interviews revealed that of the 17,000 individuals, nearly 8% of men and 12% of women reported at least one hallucinatory experience (Sidgewick, Johnson, Myers et al., 1984: cited in Johns & Van Os, 2001). One of the main problems with this study is that by excluding only those people who obviously have a psychiatric or physical illness, there is a risk that those individuals who suffer from psychiatric illnesses that are not easily recognizable may go unnoticed and therefore bias the results. In addition, there may be individuals who fall into the category of having a psychiatric illness but are not aware of it as they have not been formally diagnosed. At the time of the Sidgewick et al., study (1984) it is likely that there was more of a stigma surrounding mental health problems that at the present time and this may have prevented people from seeking help if they were experiencing problems. Nevertheless, this study introduced the possibility that individuals may experience hearing voices without a psychiatric diagnosis.
Earlier work by Posey and Losch (1983) (as cited in Barrett & Etheridge, 1992), involved the development of a questionnaire designed to measure experiences of hearing voices. The 14 descriptions of auditory hallucinations were derived from individuals who claimed to have had such experiences and this questionnaire was then distributed to 375 college students in order to establish how many had similar experiences. Out of the 375 students, 71% reported to have had at least one of the experiences with auditory hallucinations (Posey & Losch, 1983: cited in Barrett & Etheridge, 1992). These findings clearly indicated that there were a high proportion of students that experienced hearing voices. However, there is a risk that the students taking part in the study were simply telling the experimenters what they think they wanted to hear. An additional consideration is that students are at a time of transition; they have left school, are making new friends and as a result there may be an effect of social conformity biasing the results.

Barrett & Etheridge (1992) investigated the presence of auditory hallucinations in college students while also measuring the degree of social conformity. They also explored the possibility that those that experienced hallucinations also showed signs of psychopathology. The idea that this may be a possibility arose from the fact that when individuals report ongoing auditory hallucinations in the absence of drug use, sleep deprivation or sensory deprivation, they are often presumed to have schizophrenia (Kaplan & Sadock, 1985: cited in Barrett & Etheridge, 1992). The results showed that the number of individuals experiencing auditory hallucinations were very similar to those found by Posey and Losch (1983) (as cited in Barrett & Etheridge, 1992) with several of the descriptions having 30 or 40% of individuals indicating having had the experience. However, the measures of social conformity were not related to reports of auditory hallucinations and similarly measures of psychopathology were also found to be unrelated (Barrett & Etheridge, 1992). These findings provide support for the idea that auditory hallucinations could be a part of ordinary human experience as explanations for the
occurrence of the hallucinations are unsubstantiated. A limitation of this study does lie in its sample as by using only students a vast proportion of the population is largely ignored. In addition to this, Barrettt and Etheridge (1992) used psychology students as their participants who are likely to have a greater knowledge about auditory hallucinations, psychopathology, and social conformity than the general public. The effect that this may have is that the answers they provided may have been biased by their prior knowledge surrounding this subject.

Older adults

Cole et al., (2002) investigated the prevalence and phenomenology of auditory hallucinations among older adults. 125 individuals aged 65 years and over (men and women) that were referred to an audiology clinic were assessed for the presence of auditory hallucinations and if hallucinations had been experienced they were asked to describe the experience. The percentage of individuals that experienced hallucinations was quite high at 32.8% although this included all types of auditory hallucinations and not just hearing voices (the percentage for this kind was 2.5%). The prevalence of auditory hallucinations amongst this sample is clearly quite high but in consideration of the type of hallucinations experienced (most commonly humming or buzzing at 35.9%) and the fact that all of the subjects had hearing impairment, the findings need to be considered with some caution. It is entirely possible that hearing buzzing or humming is merely a by-product of a hearing impairment and not in fact a hallucination; of more interest is the 2.5% of the sample that actually reported hearing voices. The sample may be biased in the fact that the participants all suffered from hearing impairment and this could be argued to be a contributing factor to experiencing hearing voices. Regardless of this, the sample did not have psychiatric diagnoses and yet auditory hallucinations were still reported. As hearing impairment is relatively ‘normal’ in our society, whether or not this contributes to auditory hallucinations amongst older adults is perhaps not overly
important. What is more important is the fact that the hallucinations are present without psychiatric diagnoses. This would suggest that there are a variety of conditions in which hallucinations can be experienced ranging from non-psychiatric populations to individuals with psychiatric conditions such as schizophrenia.

Understanding Auditory Hallucinations in the General Population

There have been a variety of explanations proposed as to why individuals without psychiatric diagnosis experience auditory hallucinations. Research into this area has suggested that hallucinations may be the result of an inability to distinguish between inner ‘imagined’ speech and real external speech (Evans et al., 2000), misattribution of mental events to an external source (Baker & Morrison, 1998) and defects in auditory affective processing (Rossell & Boundy, 2005). These studies suggest similar reasons for why auditory hallucinations may be experienced but lack consideration of factors which may initiate or maintain the hallucinations. A comprehensive model of auditory hallucinations has been developed by Perona Garcelan (2004) which presents the formation and consolidation process of auditory hallucinations (Appendix A). The model does not consider hearing voices as simply a cognitive bias and it does not consider it to be a symptom that is separate from the rest of the individual’s life. The model proposes that the individual themselves has a role in the comprehension of the hallucinatory process (Perona Garcelan, 2004).

In line with the idea proposed by Perona Garcelan (2004) that the individual plays a role in the experience of auditory hallucinations, I believe it is important to consider what hearing voices means to the people that experience them, what moderates distress and the implications this has for how clinical psychologists respond to these individuals.
Beliefs regarding auditory hallucinations and their implications

The level of distress caused by auditory hallucinations differs among individuals. Cognitive behavioural models have suggested that this is related to the way that people interpret the voices that they hear (Morrison et al., 2004). It has been suggested that meta-cognitive beliefs about hallucinations will influence emotional and behavioural responses to them and in particular people who hold positive beliefs about hallucinations may try to maintain certain hallucinatory experiences (Wells & Butler, 1997: cited in Morrison et al., 2002).

Negative beliefs

The beliefs people hold about the voices they hear in relation to power, control and malevolence are important aspects of the hallucinatory experience (Chadwick & Birchwood, 1994: cited in Morrison et al., 2002). Beliefs that are metaphysical e.g. ‘They mean I am a bad person’, ‘They mean I am possessed’ have been found to be an independent predictor of distress (Morrison et al., 2002) and are likely to create feelings of distress directly. Voices interpreted as being malevolent have also been found to be linked to feelings of fear and anger and as a result are resisted by individuals that experience them (Birchwood & Chadwick, 1997: cited in Morrison et al., 2002). These findings offer a reasonable explanation of the distress caused by hearing voices; it is easy to imagine that hearing a voice that is malicious would create a great deal more distress than one that was perhaps supportive or even ambivalent.
Positive beliefs

In contrast to negative beliefs about hallucinations, positive beliefs may serve to provide companionship or comfort to people (Miller, O’Connor & DiPasquale, 1993: cited in Morrison et al., 2002). There is a body of research that suggests positive voice hearing may emerge as a result of trauma or memories of trauma and acts as a coping strategy (Romme & Escher, 1989: cited in Morrison et al., 2002). This is similar to the idea that dissociative states in children often result in imaginary friends to provide support for them (James, 1989; Putnam, 1993: cited in Mertin & Hartwig, 2004), thought it is less acceptable for adults to use coping strategies such as these and as a result they are unlikely to refer to the voices as imaginary friends.

One school of thought suggests that it is the difference between the beliefs about the thoughts that determines whether the hallucination is non-pathological or problematic (Morrison et al., 2002); people who interpret the voices as positive are less likely to see them as a problem whereas those who interpret them negatively are more likely to feel they are a problem. As a result they may want to seek help for the problem and may well receive a psychiatric diagnosis of schizophrenia or another disorder with which auditory hallucinations are associated.

Following this idea it is easy to see how support has gathered for the idea of hallucinatory experiences as being on a continuum with normality (Barrett & Etheridge, 1992; Johns & Van Os, 2001; Johns et al., 2002). If we consider this continuum as ranging from individuals with no hallucinations at one end to individuals with psychiatric diagnoses at the other we can begin to understand how the range of experiences of hallucinations can fit in between. It is likely that people with positive experiences of hallucinations that do not experience much distress will be closer to the ‘ordinary’ end of the continuum and as
experiences become more negative and more distressing, it is likely these individuals will have less control over their voices and may well seek help bringing them towards the other end of the continuum.

*Moderators of distress*

In order to provide help to those who hear voices, it is important to understand what can be done to reduce the distress that is caused by the experience. Whilst on placement I have recently visited a lady who was currently hearing voices; when asked how she felt about these voices she replied that the actual voices distressed her but that she felt better now that she had told someone what was happening. This demonstrates that although the voices may be distressing, some initial relief can be provided by confiding in someone. I visited this lady with a colleague who has built up a relationship with her over some time and I believe it is due to the relationship and trust that she had for my colleague that she was able to confess what she was experiencing. I learned that the importance of the therapeutic relationship is something which cannot be taken for granted as it is the nature of that relationship that can determine how much of the client’s distress you can alleviate.

Research regarding the interpretation of voices (Morrison *et al.*, 2004) would suggest that it is only when voices are interpreted negatively that they will cause distress. By discussing sensitively the nature of the voices and considering why they may be occurring (e.g. is it due to stress, reduced medication, use of drugs or alcohol?) the fear that the voices create may subside and the individual can regain a sense of control (Lakeman, 2000).
Investigation into what affects how individuals react to the voices they hear has suggested that there is a relationship between relating to voices and social relating (Hayward, 2003). Using Birtchnell’s theory of relating (Birtchnell, 1996, 2002: cited in Hayward, 2003) Hayward investigated the relationship between how voice hearers relate to the voice and how they relate to people socially. The study showed that there was a positive correlation between relating dominantly to the voice and dominance within social relating and a positive correlation between clinging to the voice and clinginess within social relating. A relationship between submissive relating to the voice and submissiveness within social relating was nearing significance. This study has demonstrated that there is a relationship between social relating and relating to voices and this relationship will have effects for intervention.

The Response of Clinical Psychologists

The response of clinical psychologists to service users that hear voices will be affected by their own perception of auditory hallucinations. I have learned from my training so far the importance of reflecting on my own feelings and beliefs about different situations as this can have an effect on how I react to service users and on the level of care that I provide. I consider that the way that auditory hallucinations are conceptualized would have implications for the way that clinical psychologists respond to service users in terms of assessment, formulation and intervention.

Assessment

When an individual mentions during an assessment that they are hearing voices, it is one of the main things that may spring to mind is schizophrenia. If this happens, the
assessment may be guided towards confirming or eliminating the presence of any other relevant symptoms. However, if the psychologist believes that auditory hallucinations can be present in the absence of schizophrenia and other diagnoses, the assessment has more chance to focus on occurrences prior to the hallucinations, the hallucinations content, and what effect they have. The focus is on the hallucinations themselves, the antecedents, the effects and moderators of distress. It is still important to consider psychiatric disorders but I believe that it is better to start each assessment with a clean slate rather than to begin with a preconception about the individual in question.

**Formulation**

In terms of formulation the effect of considering auditory hallucinations as part of ordinary experience is a formulation tailored to the individual. In the absence of a diagnosis, it is important that all factors are taken into consideration in order to be able to fully understand what mediates distress. In the light of previous research, it would be wise to consider the beliefs about the voices (Morrison et al., 2002), and beliefs about themselves and their relationships with others (Hayward, 2003).

**Intervention**

In his work ‘Making sense of the voices’, Richard Lakeman (2002) discusses the differences between ‘helping’ and ‘helpful roles’. “Helpful roles involve intervening on behalf of the person in care and solving immediate problems, whereas helping roles facilitate growth and development” (Barker, 1992, p.67: cited in Lakeman, 2002). In terms of auditory hallucinations, I consider helping roles to include an attempt at relieving immediate distress; in my role as a trainee the way I imagine this may happen would be to
consult with the psychiatrist in my team. This would enable any anti-psychotic medication to be prescribed as necessary in order to reduce distress caused by the hallucinations.

I feel that my position lends itself more to working in helpful roles and while working in this way beliefs about the voices can be tackled. This will have to be approached carefully and considerately with an understanding and empathy for the person’s distress. I consider that cognitive behavioural therapy may be useful in changing the individual’s beliefs about the voices they hear as this form of therapy is particularly effective when relieving immediate symptoms by challenging irrational beliefs or schemas. By providing an alternative more rational belief about the voices, distress is likely to reduce as the individual regains control over their situation. In order to tackle the relationship that is held with the voices and beliefs about the individual in relation to the voices, I would follow the suggestion of Birchwood et al., (2000) (cited in Hayward, 2003) and focus on working at the level of social relating. This would suggest that by changing an individual’s social relating, the way in which they relate to the voices may also change as a result (Hayward, 2003). Work that is carried out in this area could focus on self-esteem, assertiveness training, and perhaps family or couples therapy if appropriate.

Central to any method of intervention is the ability to create a therapeutic relationship within which the service user feels safe and able to talk about their problems. Lakeman (2001) acknowledged that any attempts at helping service users that hear voices should include understanding of their experience, sensitivity to distress, understanding coping strategies and the meaning that they attribute to the experience. Without understanding there is the risk of undermining the individuals coping strategies and their sense of self-efficacy (Lakeman, 2001). If these methods for intervention are successful then ways of coping will have improved and distress levels will reduce so that the voices no longer have a negative impact on the person’s life.
I have learned a great deal about auditory hallucinations and the impact they have throughout this piece of work. Having reviewed the literature regarding voices in non-patient populations it is clear that auditory hallucinations are indeed present in the general population and across various age groups and cultures. It is apparent that in different age groups there are various explanations as to why these hallucinations may occur including stress, anxiety, family dysfunction and hearing problems (Cole et al., 2002; Mertin & Hartwig, 2004).

There also appears to be a clear relationship between beliefs about voices (Morrison et al., 2002) and distress levels with negative beliefs creating more distress than positive beliefs. In addition, an interesting finding emerged from Hayward (2003) in that the way people relate to their voices may result from how they relate socially. All of these findings will influence my future work with service users that experience auditory hallucinations. I am more aware of the prevalence of these hallucinations in the absence of schizophrenia and this will help me to look at the service user as an individual and consider their individual circumstances in relation to their symptoms. I am more aware of the differences when working with different client groups that hear voices and aim to be mindful of this in my practice.

These conceptualizations of the way in which auditory hallucinations occur and are maintained within the general population I find both plausible and acceptable. Individuals without any symptoms of psychosis can and do experience auditory hallucinations and as a result of learning this, my way of thinking about service users that hear voices has altered. It no longer indicates only psychosis but opens the possibility that it may be one of a number of symptoms that may indicate an underlying problem but could also be the result of one.
In terms of whether hearing voices can be considered an ordinary part of human experience I think the debate centres around what can be considered ordinary. If ordinary means that a significant number of people experience the same thing then yes, I would argue that hearing voices can be considered an ordinary part of human experience. If as trainee clinical psychologists we embark on our careers with the viewpoint that experiences such as auditory hallucinations are abnormal and out of the ordinary, then it immediately puts up a barrier between ourselves and service users by seeing them in terms of their symptoms instead of looking at the whole picture. By considering auditory hallucinations as an ordinary part of human experience we are considering the service user as an individual in terms of their human experiences; ordinary experience will not mean the same for everyone therefore we should not assume that hearing voices will.
References


Appendix A

Formulation and consolidation process of hallucinations
PERSONAL ANTECEDENTS

TRIGGERS
Social conflicts
Intrusive thoughts
Images, memories, emotions etc.

STRESS

FAULTY FEEDBACK OF THE CENESTHESIC PROPERTIES OF PRIVATE EVENTS

INTERPRETATION OF THE PRIVATE EVENT AS "ALIEN"
Interpretation as "not-me"

EXTERNAL BIAS

Dimensional relationship

INTERACTION BETWEEN THE SUBJECT AND HIS VOICES
Building of "not me" identities
Autonomy of "not me" identities
Interaction between "me" and "not me"

INTERNAL BIAS

Dimensional relationship

PSEUDO-HALLUCINATION

SAFETY BEHAVIOURS
BELIEFS ABOUT VOICES
EMOTIONAL RESPONSES

Figure 1. Formation and consolidation process of hallucinations (Perona Garcelan, 2004)
Assertive outreach: Creative use of resources or therapeutic stalking?

January 2007

Year 2
Assertive outreach has been developed as a way of working with individuals who suffer from severe mental illness and do not effectively engage with mental health services. This includes working with people in their own environments which could include their home, a café they visit or even on the street. The idea is that the work is carried out wherever it is most needed and is most effective. Staff who work in assertive outreach teams are also expected to see their clients regularly and frequently and are encouraged to maintain contact with them no matter how difficult this may be (The Sainsbury Centre for Mental Health SCMH, 2001). This raises questions about consent to treatment, and contributes to the idea that assertive outreach can be seen as ‘therapeutic stalking’, a notion that will be addressed and discussed within this essay.

An alternative view of assertive outreach which will also be considered is that it is actually a creative use of resources which can be helpful in reducing the number of hospital admissions required by individuals with severe mental health problems. In order to critically discuss these two opposing views, it is essential that we understand what assertive outreach is, where it came from and what it aims to do.

Assertive outreach originated in America in the 1970’s from a model known as ‘training in community living’ (TCL) (Stein & Test, 1980). Mary Test and Leonard Stein developed this model with an emphasis on teaching clients how to cope with chronic mental illness in the community rather than trying to treat the illness (Burns & Fim, 2002). TCL was a comprehensive model that included stabilizing living circumstances, monitoring compliance with medication, being available 24 hours a day in case of crisis, and supporting all aspects of daily living. One of the key aspects of TCL was professional flexibility as all workers were expected to do all jobs necessary to keep the client well and out of hospital, even if this involved tasks not usually within the realms of their position (Burns & Fim, 2002). The result of this TCL service was that clients reported having fewer symptoms of their illness and an increase in social functioning (Stein & Test,
1980). The service did not continue once funding had run out and at follow up, Stein and Test discovered that the benefits reported by their clients faded within 14 months. This resulted in a realisation that a service aimed at simply training individuals was not sufficient and the model was renamed the ‘programme in assertive community treatment’ (PACT) to reflect the fact that ongoing support was needed (Burns & Fim, 2002).

Assertive outreach approaches in the UK have had a more mixed response than the USA where it has become accepted practice. However, assertive outreach teams have been introduced into most parts of England (Priebe et al., 2004) and it has become a central part of mental health policy (Greatley and Ford, 2002). The National Service Framework for Mental Health states that for patients needing crisis or specialist care:

“These patients should have a personalised and responsive care plan and access to 24-hour services whenever they need them:

- Assertive outreach teams are now in place to offer proactive care in communities for people with the most complex health and social care needs.
- Multi-disciplinary crisis resolution teams are operating 24-hour services and offering patients who are in crisis quicker assessment and treatment in their own homes” (National Service Framework, 1999).

The Mental Health Policy Implementation Guide (2001) also places importance on assertive outreach teams and describes the aim of assertive outreach teams to be able to:

- Act as a ‘gatekeeper’ to mental health services, rapidly assessing individuals with acute mental health problems and referring them to the most appropriate service
- For individuals with acute, severe mental health problems for whom home treatment would be appropriate, provide immediate multi-disciplinary, community based treatment 24 hours a day, 7 days a week
• Ensure that individuals experiencing acute, severe mental health difficulties are treated in the least restrictive environment as close to home as clinically possible
• Remain involved with the client until the crisis has resolved and the service user is linked into on-going care
• If hospitalisation is necessary, be actively involved in discharge planning and provide intensive care at home to enable early discharge

In order to carry out these aims, an assertive outreach team must have certain characteristics. These include: being a multidisciplinary team with a range of professionals, having a low ratio of clients to workers (usually ten per caseload), having intense client contact (ideally four or more contacts per client per week), putting emphasis on engagement and developing a therapeutic relationship, liking to evidence-based interventions (if wanted), offering time unlimited services with a no drop-out policy, working with people in their own environment and providing flexible and creative support (SCMH, 2001).

It appears that in the UK, the NHS at least, believes that assertive outreach is a creative use of resources. However, in order to come to any conclusion about this we must consider the research that has been done in this area looking at the effectiveness of assertive outreach teams. I have chosen to look at effectiveness as an indicator of good use of resources as if a service is not effective, then the client group is not receiving the best care possible and time and money would be better spent on ensuring this is rectified.
The effectiveness of assertive outreach

There have been many research studies that have investigated the effectiveness of assertive outreach teams and these seem to have had mixed findings (Killapsy et al., 2006; Minghella et al., 2002; Marshall & Lockwood, 1998). The REACT study was a randomised evaluation of assertive community treatment in North London and aimed to compare outcomes of care from assertive outreach teams with care from community mental health teams (CMHT’s) for people with serious mental illness (Killaspy et al., 2006). The main outcome measure for this study was the amount of inpatient bed use 18 months after being randomly allocated to either team. The results showed that no significant differences were found in inpatient bed use or in clinical and social outcomes for the two groups. This would imply that CMHT’s are just as capable as assertive outreach teams at supporting people with severe mental illness. Similar results were found by Minghella et al., (2002) in their evaluation of two voluntary sector assertive outreach teams. In this study, the measures of outcome used were mental health, quality of life, social functioning and user satisfaction. Both clinical and social outcomes were mixed and hospital bed use (and therefore costs) actually increased.

The findings of studies such as these appear to indicate that there is little clear advantage of assertive outreach teams. In this case, it seems strange that the approach is being so widely implemented by the NHS. However, the Cochrane review by Marshall and Lockwood (1998) addressed if assertive outreach was an effective alternative to standard care and the results were very positive. They reviewed studies that were randomised controlled trials comparing assertive outreach to standard community care, hospital based rehabilitation, or case management in patients between 18 and 65 years of age suffering from severe mental illness. They reported outcomes based on number of patients remaining in contact with psychiatric services, extent of psychiatric hospital admissions, clinical and social outcomes, and costs. When assertive outreach was compared with
standard community care, clients who had received assertive outreach care were more likely to remain in contact with psychiatric services, were less likely to be admitted to hospital, spent less time in hospital, had better accommodation status, had more successful employment and reported greater satisfaction with their treatment. There were no differences between the groups for mental state, social functioning, or costs. However, when assertive outreach was compared with case management, clients in the assertive outreach group spent fewer days in hospital.

It is also worth considering that even in studies where outcome was not always improved by assertive outreach, there have been some positive responses to the approach. In the REACT study (2006), clients receiving care from the assertive outreach team appeared to be better engaged and reported being more satisfied with the service they had received. Similarly, clients from the voluntary assertive outreach teams (Minghella et al., 2002) also valued the assertive outreach teams and particularly liked the attitudes of staff and the practical help they received. It would seem then, that although assertive outreach teams may not always be more cost effective than CMHT’s, they do achieve their aims of engaging people that have previously been difficult to engage.

It is useful to consider why a model such as assertive outreach might not be making the kind of impact on hospital admissions that was expected. Many studies have considered that a lack of adherence to the model or lack of experience of working within the model may have an impact on its effectiveness (Minghella, 2002; Oliver et al., 2005; Killaspy, 2006) and this does seem a plausible explanation. If the main elements of assertive outreach treatment are not being followed then in some respects the treatment provided may well be just as it is from a CMHT and differences in outcome would therefore be unlikely. Additionally, not all studies are using the same measures for outcome. If each study measures effectiveness in a different way it is very difficult to assess if the approach is effective or not. The UK700 trial compared intensive case management with
standard case management and found that it failed to reduce the number of inpatient admissions. Weaver et al., (2003) conducted qualitative research to assess why this may have occurred. They found that for a large proportion of the study population, assertive outreach was appropriate and the traditional image of implementing the model with non-compliant and elusive clients was quite uncommon. Few differences were found between the work of standard and intensive case management and when assertiveness was required, both types of case managers practiced with the same level of effectiveness.

It would appear that when considering the effectiveness of assertive outreach, we need to be clear about what effectiveness means. Although there have been mixed findings about reducing hospital admissions, the findings regarding engagement appear to be more positive. This is a difficult situation as it raises the question of what is more important to the NHS – cost effectiveness or client satisfaction? In an ideal world client satisfaction would take priority every time but without saving money elsewhere would there even be funding for assertive outreach times? It should also be taken into consideration that perhaps the reason for engagement being improved is because the client’s have little choice in this. It has been outlined that assertive outreach staff “expect to see their clients frequently and to stay in contact, however difficult that may be” (SCMH, 2001 p.2). If engagement is measured simply by level of contact then given the above statement, it is not a true measure of client’s views of the service. The apparent persistence and no dropout policy of assertive outreach could be considered ‘therapeutic stalking’ and in order to ascertain if this is a true representation we need to consider both client and staff opinions of the approach. Staff views are important as they are the people who have to adhere to the methods used by assertive outreach and it would be useful to know how they feel about a potentially intrusive way of working. Equally if not more important are the clients as they are the receiver of these services and it is vital we hear their opinion of the treatment they receive. It will then be useful to compare these viewpoints in order to see if there is a consensus of opinion about assertive outreach.
Staff views of assertive outreach

As part of the Pan-London Assertive Outreach Study, Billings et al., (2003) researched staffs experiences and perceptions of assertive outreach teams in London. The staff included in the study were all members of assertive outreach teams and multidisciplinary staff from CMHT’s were also included to provide comparative data. The participants were asked to complete a confidential questionnaire which included measures of burn-out and job satisfaction, sources of stress and satisfaction and description of and views about training and supervision received. The results showed that staff in assertive outreach teams were moderately satisfied with their jobs and the sources of satisfaction and distress were similar for both teams. It is worth mentioning that the staff in assertive outreach teams did score slightly higher on each source of satisfaction that was mentioned in the questionnaire. In terms of sources of stress, the highest sources for the assertive outreach team were: a lack of people / resources, poor communication with other teams, and risk of clients harming self or others. Interestingly, the team approach was rated as the second lowest source of stress.

Although this research presents a fairly positive view of staff’s opinions of working in assertive outreach teams, a few points need to be considered. Firstly, as the participants were given a questionnaire to complete this meant that the topics they discussed were predetermined for them. This means that their views on how comfortable they are with the level of contact they maintain with clients may not have been addressed clearly. Also, we need to remember that generally, people who have chosen to work in assertive outreach teams will have done so because they agree with the style of working. Therefore, it would be unlikely that someone who has accepted a position in such a team would hold very negative views about the teams approach. It is also useful to consider the demographic data that was collected as part of the study. This showed that there was a fairly equal ratio of men to women (94:93) but the differences in ethnicity were more pronounced. The
majority of workers in assertive outreach teams were White UK, Irish or European (62.4%) followed by Black African, Black Caribbean or Black British (22.6%), Asian (9.1%) and mixed or other (5.9%). This may simply be representative of the make up of our society but perhaps it could be an indicator of how individuals from different cultures view the approach of assertive outreach. Some cultures may believe intensive input from mental health services is required and appropriate for treating mental health problems however, some cultures may find this approach intrusive and unnecessary and would rather keep home life separate from health services. If an individual’s culture did not support such a level of input into individual’s lives then it is unlikely that they would want to work in that kind of way.

It seems likely that the notion of assertive outreach as therapeutic stalking is referring to the persistence and creativity used by staff to engage their clients. In order to evaluate whether staff hold such a view of their methods of working we can consider their experiences of engagement when working in this way. Addis & Gamble (2004) interviewed five assertive outreach nurses with an aim to understand how they experience engagement. The research was qualitative and focused on emerging themes that constructed the nurses’ experiences. Some of the themes identified included:

*Having time*

A major part of the nurses’ experiences was having time for their clients. They were able to recognize the benefits of this by reflecting on previous roles where they had insufficient time to spend with their clients. This was useful during early attempts to engage the clients as they showed their interest in the person by having long or repeated visits. The nurses also felt that time gave them the opportunity to work at the individual’s pace, one nurse commented: “You can’t rush it along, make sure everything is happening
in two weeks. It takes time. You’ve got to be prepared to say, well, I think we can do better than this, but we can’t do that until the patient’s ready”. (Addis & Gamble, 2004, p. 455)

It is understandable that in a world where time is very precious, it is a luxury to have more time to spend with your clients. As a trainee clinical psychologist I have had clients comment to me on occasion how much they value being able to spend an hour talking to someone as oppose to being given just fifteen minutes which is often the case with medical appointments. On reflection I think it must be very difficult to have such limited time to spend with clients as sometimes even an hour can seem short when someone has very difficult and complex problems. It also seems unfair to expect people to be able to trust us enough to tell us about their difficulties when they have only met us perhaps once or twice, let alone pressurizing them further by putting a time limit on them.

*Anticipatory persistence and tired rejection*

The nurses did describe being ever hopeful they would make a connection with the client and had a strong sense of not giving up: “It’s not enough to just give up if someone pushes you away”; and “you mustn’t give up on them” (Addis & Gamble, 2004, p.455). These extracts illustrate the persistence of the nurses to engage their clients and although this may be done with the best of intentions, it raises the question of what choice the client has in this process. What if they don’t want to be engaged? Do they have to put up with someone calling on them continuously, even if they have asked to be left alone? It should be considered the effect that this could have on them as this may cause quite a stressful situation. If someone is already suffering from mental health problems, exposing them to more stress is the last thing that they need. The nurses did acknowledge times where engagement had not been successful and this was described with comments such as
"I do feel quite hopeless" and "It makes me feel pretty useless at times" (Addis & Gamble, 2004, p.455). This demonstrates how personally the failure to engage clients can be taken. In most professions it can be easy to take failure such as this personally, and it something that I have experienced while training. However, I have learned through supervision and discussion with other trainees that it is not always the fault of the professional and clients have the right not to engage with services if they do not want to. It seems there may be more pressure in an assertive outreach team to successfully engage clients as this is one of their main aims. However, what seems less clear is the client's right to refuse services.

Clients views of assertive outreach

One of the most important insights into assertive outreach can be provided by those that receive the service. This provides us with information about what works well and what doesn't and what could be changed to improve the service. Research by Graham et al., (2005) found that in an evaluation of the effectiveness of an assertive outreach team in Preston, there was a fairly high level of client satisfaction. The subcategories that were evaluated included: general satisfaction, interpersonal aspects of care, client involvement with treatment, and medication and treatment issues. The highest level of satisfaction was recorded for general satisfaction and positive comments were recorded such as "they are there when I need them" (Graham et al., 2005, p. 176). However, some negative comments were also recorded about time keeping such as "they [assertive outreach] are always watching the clock" and "I feel I am having my activity time cut down as you get more clients" (Graham et al., 2005, p. 177). It is interesting that having more time was something that assertive outreach nurses prided themselves on and felt positive about (Addis & Gamble, 2004) whereas some of the clients' views appear to be that not enough time is provided. It may be that staff and clients may have different perspectives upon how much time is enough due to their prior experiences. If staff have only ever had very
short appointment times, anything longer is likely to be viewed positively. However, if some clients are quite isolated or need more support, it is likely they will want to see someone who has more time to spend with them. However, as there may be a possibility of over-reliance on staff if too much time is spent with clients it seems that trying to strike a balance is the best option.

Interpersonal aspects of care were also rated positively and staff were predominantly viewed in a positive light. This category was assumed to relate to a good standard of therapeutic alliance (Graham et al., 2005) and therefore it seems the clients had a positive view of engagement with staff. Views of their own involvement with their treatment were more mixed although only 30% of clients felt no consideration of their opinion was taken. With regard to medication and treatment issues, the response was positive with the majority of clients feeling satisfied with their medication and the way in which their treatment was planned.

The research by Graham et al., (2005) indicates that overall, clients feel quite positive about assertive outreach and engagement with the teams. As clients of assertive outreach teams are typically those who disengaged from other services, it is interesting to consider what process led to disengagement and then re-engagement with the assertive outreach team. Priebe et al., (2005) found that factors that triggered client's disengagement from services included a desire to be independent, a poor therapeutic relationship and a loss of control due to medication. Conversely, the factors that helped clients’ with engagement were time and commitment from staff, social support, engagement without a focus on medication, and a partnership model of the therapeutic relationship. It is interesting that clients reported a desire to be independent but also wanted time and commitment from staff. Perhaps the difference lies between feeling tied to a hospital with admissions and outpatient appointments and being able to continue with your life in the community because staff will come to you. It seems that there is a sense of wanting to regain some
power in the situation and this is understandable. I would imagine that experiencing mental illness is distressing enough without having to relinquish control of many aspects of your life. It seems that assertive outreach teams may manage to avoid this by valuing individuals enough to give them the time they need and listen to their opinions.

When interpreting the findings from studies which have asked clients their views on assertive outreach, Graham et al., (2005) makes a valid point about those individuals who are not happy with the service. That is, if a client is trying to avoid contact with assertive outreach teams they are unlikely to participate in research about them as it is likely to maintain contact. This then raises the possibility that research studies in this area are potentially open to bias as it may only be those clients who wish to remain in contact with the assertive outreach team that actually participate. Therefore, when debating whether or not the approach can be seen as therapeutic stalking it is difficult as it is likely that the individuals who hold that view may not be vocal for fear of continuing to be ‘stalked’.

Comparison of client and staff perceptions of engagement with assertive outreach services

Although research has been carried out into both staff and clients’ views of engagement and assertive outreach, it is difficult to compare these views as the studies are usually measuring different things. For example, what constitutes good engagement to an assertive outreach worker may be completely different to what it means to a client. This problem was addressed by Gillespie et al., (2004) in their development of a self-report measure of engagement. The study investigated whether the measure predicted client’s engagement with assertive outreach services six months later and also compared client and staff member’s views of engagement. The results showed that staff and client ratings were correlated at time 1 but not at time 2 (approximately 6 months later). This suggests
that early on in working together both staff and clients view their engagement similarly but that this changes as time goes on. This could be due to staff having a more fixed idea of what constitutes engagement whereas client’s views of engagement could change more readily, reflecting the changes they may be experiencing in their lives at that time (Gillespie et al., 2004). This could also explain why staff ratings were correlated between time one and two whereas client ratings were not. It would seem that client’s views on engagement are not as stable as those held by staff and this may have implications for their treatment. If there is a discrepancy between what staff and clients believe constitutes good engagement then effective engagement could be very difficult to achieve.

**Assertive outreach: creative use of resources or therapeutic stalking?**

This essay has tried to debate the role of assertive outreach in an attempt to answer the above question. However, the question is not easily answered. The many research studies that have been carried out concerning assertive outreach do not seem to have led to any conclusive evidence to support one view or another. What has become clear is that perhaps the effectiveness of the service is best measured by looking at the views of those people that both provide and receive the service. To simply look at the amount of inpatient admissions and the resulting cost this has is not enough to indicate a good use of resources or not. It is important to remember that mental health problems do not disappear as soon as someone is discharged from hospital so just because someone is not on an inpatient ward is not an indicator that all is well for them. It is in some respects more important to ensure that the care they receive while in the community is sufficient to enable them to continue with their lives in the way that they would wish, and this seems to be what assertive outreach is trying to achieve.
Even in the studies which found that there was no reduction in inpatient bed use (Killaspy et al., 2006; Minghella et al., 2002), there were still positive comments made about assertive outreach including being more satisfied with the service being received and liking the attitudes of the staff. This is in line with the findings of Priebe et al., (2005) on factors that help and hinder engagement with services. Factors that helped included time and commitment from staff, social support, engagement without a focus on medication, and a partnership model of the therapeutic relationship all of which are elements of assertive outreach teams. We should also acknowledge though that some CMHT’s also try to incorporate these factors and can provide a very good service to their clients.

It is worth considering that in some assertive outreach teams that were not evaluated as being more effective than CMHT’s, it was noted that there was a lack of adherence to the model. This of course makes it very difficult to carry out a valid evaluation of the model’s effectiveness as it is not being implemented in the way it was intended. Assertive outreach is still a relatively new service to the United Kingdom and like all new services it may be some time before it achieves all the goals it sets out to. However, it does seem to be addressing some of the wants and needs of its clients which can only be a positive thing and even if money is not saved by implementing this model it has to be balanced against the level of client satisfaction. It would therefore seem that assertive outreach is a creative use of resources in that it attempts to provide what clients want – something that may have been lacking in other community services. However, it must be acknowledged that not all clients will want the same kind of service and equally will not want to be part of assertive outreach. Perhaps the way to ensure assertive outreach fulfils its aims and does not become therapeutic stalking is to continue listening to those individuals who receive the service in order that they can retain some control of their lives and the service can become as efficient and useful as possible.
References


National Service Framework, 1999


Problem Based Learning Reflective Account One

March 2005
Year one
The Original Problem and Initial Group Meeting

The original problem we were given as our problem based learning exercise was ‘The relationship to change’. I was daunted by this and unsure how to tackle it – there was little guidance on what to do and as it was only the second day I felt very unsure. I think this was related to general uncertainty at that time. This uncertainty is something that I have since observed in my clients on placement. At the first session they are often are unsure about how to approach the problems that they have. Like how I felt, they are unsure about the process that lies ahead.

The situation changed when we went into our case discussion groups and started playing around with ideas. I found it really helpful to listen to other people’s interpretations of the problem as it helped me to make sense of my own ideas and this has since helped me with working in teams. What I also found was that having someone else to give their interpretation of a problem can help to clarify the situation. I have since found that when a client has been confused about their problems and everything seems very unclear to them, by summarising it can help both of us to see the situation more clearly. It means that it is easier to see what are working with. A study by Najavits & Strupp (1994): cited in Reisner (2005) found that therapist warmth, understanding and affirmation was positively associated with therapy outcome and in our group I certainly found that having others listen and be positive about my ideas made me feel better about the situation.

My confidence in airing my ideas increased, although as a result I was concerned about talking too much. I think this reflects the relationships within the group at the time. We were all new to each other and did not know each others personalities yet so I think we were all slightly guarded in our behaviour and did not want to offend anyone.
Subsequent Meetings

The second meeting felt less positive than the first as we seemed to be going around in circles and not really making any progress. It felt as though everyone wanted to get their own point across and do things their own way. I disliked the idea that we eventually settled on but I kept quiet and tried to compromise. I think at this point we had gone past the initial politeness but had not managed to let go of the competitiveness that we needed to get onto the course. Competition for the training course is very high and only a short time ago we were competing with each other for places. It was difficult to let this go and work with each other. I have since learned that this sort of situation occurs when working in multi-disciplinary teams. Having people from different professions, backgrounds, and cultures means that there is a wide variety of opinions about how things should be done. I think it's important to be able to make a contribution but also to take on board other people's views and respect differences in opinion. If this doesn't happen, nothing is achieved and morale within the team will be low.

I felt even worse after the next meeting. I was tired and fed up of the group – no one would let go of their ideas and it seemed everyone was fighting to make sure they were included. It’s hard when no one will back down. As a result I decided to keep out of it and let the others get on with it. I think this was partly due to tiredness and partly because it had been going on for a while without progress and I had lost interest in participating. Now it occurs to me that a similar process may happen in therapy. Some clients are keener to attend in the beginning than after a few weeks and I think this may be because they reach a point where they aren’t seeing any progression and as happened with me in the PBL task, they probably doubt if it is worth still attending. By being aware of this we can tackle these feelings as they arise and hopefully reduce drop-out.
The negative feelings about the group task subsided and we started working well together, taking turns and listening to each other. We had decided to use the Tuckman stages of group development (Smith, 2005) for part of our PBL presentation and it suddenly became clear that we had been following the same process ourselves. Bruce Tuckman identified four stages of group development: forming, storming, norming and performing. Forming is characterised by a desire to be accepted by others and conflict is avoided as people want to make good impressions. This progresses to the storming stage where important issues start to be addressed and confrontations may result as people lose patience with each other. Once these conflicts have been resolved, the group enters the norming stage where people understand each other better and appreciate each others experiences. By the performing stage the people in the group know each other well and can work together easily. Morale is high as is group identity and loyalty (Tuckman, 1965: cited in Smith 2005).

It was helpful to find out the similarity to Tuckman’s Model as it normalised the experience for us and it made me feel as though our ups and downs were to be expected. This was useful to learn as it demonstrated how normalising can be useful for the clients we now see on placement. However, since starting my placement the clients have been very varied and every situation is different so although normalisation can help, I think it needs to be balanced with an appreciation of the individual’s situation.

The PBL presentation

We decided to present the relationship to change as the changes we had had experienced when starting the course. We focused on our changes as a case discussion group using Tuckman’s model (Tuckman, 1965: cited in Smith, 2005) and our individual changes using a transtheoretical model of change as described by Prochaska et al., (1992). This
transtheoretical model emphasises that there are factors that help and hinder change and by means of a questionnaire we investigated what help and hindered our colleagues when adapting to the course. Our own changes were investigated by reflecting on our journals.

I was a little bit nervous about the presentation — I think we all were, though some more than others. I was really pleased about how we all pulled together to perform the presentation and I felt very proud of what we achieved. I realised that by letting go of some of my ideas and compromising with others everyone can benefit as a result. At the time it was difficult to see beyond what I wanted to do but in hindsight, some of the other ideas were the best way to go. This is something that I try to bear in mind when working; it is easy to always want to go with your own feelings about things but it’s worth listening to what other people have to say as you can learn a lot from other people.

On the day of the presentations, it was clear how we had become close as a group. We were quite protective over our work and we all supported each other beforehand and congratulated each other afterwards. This really made it feel like a team effort and I think we all felt we had participated equally.

Interestingly, we chose to elect the only male in our group as the leader and I have since wondered if he had not been male whether his role within the group may have been different. We did look to him as the organiser and I have since thought this may have been a reflection of how we view males in our society as oppose to females. We did discuss this at one point in our group and the leader did say they were unsure of their reasons to volunteer — did they want to be leader or feel they should because they were the only male? This is the sort of unconscious views we may hold about people that I think we need to be aware of in this profession. A person’s gender may affect the way in
which we view them and even though it is important to consider gender when seeing clients we should not let it guide our expectations of them.

**Strengths and Weaknesses of the Presentation**

I think that one of the main strengths of our presentation was the acknowledgement of factors which can help and hinder change which was derived from the work of Prochaska et al., (1992). By reflecting on the sorts of things that helped and hindered our own change, it became increasingly obvious how difficult change can be and how the same and additional hindrances can affect our clients’ relationship to change. This made me realise how important it is to have an understanding of our clients and their individual circumstances in order to determine how ready they are to make any changes. In addition, we noted that adjusting to changes as a result of starting the course was quite difficult and we were lucky that we had a lot of support around us. When reflecting on our practice, we realised that this is not the case for some of the clients we work with and this emphasised how important and powerful the therapeutic relationship can be. This raises certain ethical issues as it is important to have boundaries when working with clients who are potentially quite vulnerable. If the client is relying heavily on you and they have little other support, care needs to be taken to ensure that the boundaries of the therapeutic relationship remain clear so that expectations of the relationship are realistic and achievable.

One of the main things lacking from our presentation was an acknowledgement of cultural differences on the relationship to change. One of the other groups presented people from different cultures and how they related to changes in their lives and this was very insightful. Given that the clients we come across are culturally diverse, especially for those of us that have placements in south London, it would have been useful to investigate and present the effect that culture has on change.
Also, the model of group change described by Tuckman (1965): cited in Smith (2005) does not take into account preparation for change which we found was very important to the trainees and may also be important for our clients.

Summary

The PBL task investigating the relationship to change taught me a lot about myself and my own relationship to change, change as a course group and change for the clients that I see. Keeping the reflective journal throughout the task really helped to see how my own expectations and experiences can influence how I see change and how this may influence my practice as a result. By including the course group experiences of change, it was clear that the relationship to change is different for everyone and my appreciation of the difficult nature of change increased greatly.

I feel that the task and the writing of this account have helped me to develop my reflective practice. Tony Lavender (2003) wrote that four processes are involved in reflective practice: reflection in action, reflection on action, reflection about impact on others and reflection about self. I feel that I have definitely learned skills in reflection on action, reflection about impact on others and reflection about self as a result of this task and I look forward to the subsequent PBL tasks to build on these skills and contribute towards reflecting in action.
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www.infed.org/thinkers/tuckman.htm
Problem Based Learning Reflective Account Two

March 2007

Year 2
The Original Task

The task of our third problem based learning (PBL) was centred on the Stride family. The family consisted of Mr and Mrs Stride and twin girls. Mrs Stride was a woman with learning disabilities and Mr Stride attended a school for children with special educational needs. Mrs Stride had two older children living with separate adoptive families and the twins were on the child protection register. Our task was to assist the court by conducting a full risk assessment and potentially a rehabilitation plan for the children. We were also instructed to think about whose problem this was and why.

The Group Process

Changes in group structure

Our case discussion group (CDG) experienced a couple of changes in structure at the beginning of this task. Firstly, we were assigned a new facilitator as did every other CDG. I think that we were a little anxious about who would be allocated to our group and I think this was because we all felt we had built a good relationship with our previous facilitator. In some ways it felt a bit of a shame that we had to change facilitators each year as we had become accustomed to our ways of working and we also felt comfortable with one another. However, I like to think that as a group we were fairly open minded about the prospect of welcoming someone new into our group. On writing this, it has occurred to me that this may be a process that happens a lot for the clients that we work with. I know that I have worked with a few people where either I have been the second trainee to work with them or I have handed them over to someone else when I have left. This is something that is not entirely within their control although they do have the right
not to see a trainee. However, the process of being allocated a new facilitator seems to be a good way of experiencing what it must be like to be given a new psychologist to work with. This is something that I had thought about before but I feel I now have a better understanding of what it may feel like. Our group took a while to settle down and get used to a new member and in some respects it felt a little like taking a couple of steps back before moving forward again. This is not a problem for us in a CDG however, I can imagine that this could be quite frustrating if you were progressing nicely in therapy and suddenly it is disrupted and not at your choice.

I remember that we were pleased with the facilitator that was allocated to us and I wonder if this was because we again had a member of the course team. Although I did not know this particular member personally, we did all know who they were and some of us knew them better than others. I think that because we had a positive experience of having a facilitator that was a member of the course team we felt positive about this again. It would probably have been a bit more uncertain having a facilitator that we knew nothing about. Research by Duck and Fielding (1999) found that members of groups that were allocated a facilitator who was a member of a different sub-group, expected them to be less fair and more biased towards the opinions and attitudes of their own sub-group. This could explain why I felt having a facilitator who was not part of our group (the clinical course) may be more daunting than someone who was. However, although our new facilitator was part of the course, they were also part of a different sub-group in that they were part of the course team rather than a trainee. According to the work of Duck and Fielding (1999) this should have made us distrustful of them but I do not think that was the case – more that we were just wary of how the dynamics of the group would change due to a new person joining.

We also had the experience of losing a member of our CDG not long after the beginning of the task. This member was someone who had to leave the course temporarily due to
failing some pieces of work. We had all become friends by this stage and I think that all of our group were sad about what happened. It seemed particularly sad because that member had a real interest and lots of experience in the area we were working on and we all felt their contribution was greatly missed. I also think that losing a group member in such circumstances also created anxiety within our group. We were not sure why the member had to leave and were not sure if they would return — it suddenly became real that trainees could be asked to leave the course and I think this made us consider our own places and how important they were to us.

It was sometimes uncomfortable when discussing this topic as I think we all felt loyal to our group member but we also knew the rules of the course had perhaps not been adhered to. In terms of group cohesiveness (Festinger, 1950) I think this event brought our group closer together as we were now one person down and were had to try and understand why together.

Motivation

Our first meeting occurred after returning to university after the summer so we had not worked together as a group for quite a long time. It felt difficult to concentrate at this point as I felt I would rather be spending time catching up with the other group members rather than working on a new presentation. This may have been a general reluctance to start working again, as the idea of starting the second year is quite daunting due to increased demands and coursework. I have also considered that even though university teaching ended for the summer, we were still working on placement and also on coursework so perhaps there was an element of feeling a bit burnt out and ready for a break.
I think that losing a group member also impacted on our motivation as we seemed to lose interest after this point. This was probably because that individual had a lot of passion and experience of working with people with learning disabilities and therefore when they left so did a lot of that enthusiasm. Also, we probably spent a fair bit of time talking about that person leaving when most other groups were probably working on their task.

Theories of motivation such as expectancy theory (Vroom, 1964) states that people are more motivated when they think that 1) their effort will result in improved performance, 2) their performance will be recognized and rewarded and 3) the rewards will be valuable and desirable. Relating this to our CDG, I think that we were not really expecting any valuable reward from the task except hoping to pass it and learning more about child protection and learning disabilities. I also think that we did not have the aim of improved performance as we were at the very beginning of our child and learning disabilities placement and I’m not sure at that time we were able to apply knowledge either to the task from placement or the other way. In terms of recognition of our work, I think the whole year group were a bit disappointed that only one member of staff came to watch our presentations and on the day of presenting motivation was not very high. Our group facilitator had given her apologies to us in advance which we appreciated as it seemed the other groups had no idea their facilitators would not be there.

On reflection of my clinical work, I feel I have an increased understanding of how difficult it can be to remain motivated. Although I am aware that I need to complete each piece of work to a good standard in order to pass each part of the course, it can still be difficult to remain motivated even though I desire the final outcome. There are many things which affect my motivation such as tiredness, relationships, moving house, or
family issues. All of these things will affect the people we work with so it is important to consider this and think about how we can support them.

_The Presentation_

For our presentation we had originally decided to present the issues in a format similar to the programme Newsnight. However, we found out that some of the other groups were also doing this so we decided to change things a bit. We decided to present the case in the future, looking back at the decisions that were made and what could have been done differently. To do this we included a panel of people who were involved in the case and also video interviews of the Stride children who were now adults.

It was interesting to discover on the day of the presentations that nearly all of the groups had used videos as a way of presenting some of the material. I think that there was a degree of competitiveness about the presentations, perhaps due to the amount of effort that we all put in last year. Also, this can be explained in terms of group bias; social identity theory (e.g. Hogg & Abrams, 1988; Tajfel & Turner, 1986; Turner, 1982), states that if individuals identify with a group, their need to maintain positive self-esteem leads them to think more favourably of their group in comparison to other groups. Therefore, it would be important to make your own presentation as good as it can be in order to preserve this preference.

I think that our presentation showed its strength in its originality. By taking a look at the case from the future, we were able to think about the long term effects that removing children from their families may have. We also managed to demonstrate the effects of diversity on this process. We chose one of the twins to have been placed into a nice foster
family, received good education and had good opportunities whereas the other twin did not receive a good education, was brought up in children’s homes and did not have much social support. The weaknesses of our presentation were that we were not able to debate the actual decision of removing the children based on what may happen today as we were debating the case retrospectively. However, we did try to emphasize what might be different had this case been happening now.

Summary

This PBL presentation has differed from the first as we are now at a different stage in training with different commitments, different priorities and different experiences. However, I do think it has contributed to understanding my development over the past year. I think I am now more relaxed on the course and more confident of my abilities on the course. The first year was a steep learning curve for me and I feel I learned a lot both personally and professionally. The PBL showed how especially when placement is busy, I have a tendency to place more emphasis on that than on university and this is something I need to be careful to balance out. I think this is probably because of my lack of clinical experience prior to the course leads me to feel I need to ‘catch up’ in some ways whereas I am more used to the university environment. I have also considered the benefits of group working which I felt was both enjoyable this year and also invaluable in terms of support. This is something that I think will be important to maintain in the future as the demands of training will no doubt increase.
References


Problem Based Learning Reflective Account Three

February 2008

Year 3
The Problem

The initial problem that we were presented with was about the Khan family. The family originates from Pakistan but migrated to Britain when Mr Khan was in his 30's. Mr and Mrs Khan have two children, one who lives in Britain and one who had returned to live in Pakistan. Mrs Kahn died 9 months ago from cancer. Mr. Khan’s youngest daughter is concerned about her father who has been suffering from short-term memory problems. He has also been neglecting himself and has lost weight. His youngest daughter is asking Social Services to do something about her father’s care.

Initial Responses

This was our final problem based learning task (PBL) and I think that as a group, we did not approach it with much enthusiasm. It has been said that PBL tasks increase motivation because students decide themselves what is relevant to their learning (Dolmans, Wolfhagen, Van der Vleuten & Wijnen, 2001). However, I think our group found this quite stressful as there were numerous directions we could take and as a result our motivation decreased.

We agreed we would try to keep the presentation simple and the work load to a minimum. As we were beginning our final year, I think we were preoccupied with our Major Research Projects (MRP) and did not want to spend all of our study time working on the PBL presentation. However, it became clear as time went on that we were all in very different places without work outside of the PBL task and this seemed to affect how much effort people wanted to make. My MRP was progressing slowly at this time and I was interested in trying to do something different with our presentation. Thinking back, I’m
sure this was the last thing some others wanted to do as they were busy collecting their data. Our responses to the task were similar in some ways and very different in others.

The Decision Making Process

Our first step was to think about the issues that we felt had been raised in the PBL and how we would present them which is where we hit our first stumbling block. There was a lot of information presented with the problem and we seemed unable to decide what the most important topics to us were. I remember feeling like these discussions ran in circles without ever coming to a conclusion and I imagine the others felt the same as the meetings felt quite pressured at times. Eventually we decided to focus on the issue of culture over and above anything else, mainly because this was the topic that we kept coming back to. I felt that we should also cover the issues around older age and dementia and I raised this with the others. However, it was decided not to include these topics. I found this frustrating, especially because it felt like there were certain group members who were very strong in their ideas and what they thought we should do. Looking back, I think I should have taken some responsibility for this as unless I voice my opinions, others cannot be expected to know what I’m thinking.

Reflecting on these processes has helped me to think about what I have learned personally from the task. I have become more aware of my own desire to have my ideas listened to and also my desire to have them accepted. My frustration when this did not happen was something of a surprise to me and I would like to be mindful of this when working in groups in the future. I also think I have learned that it is ok to have ideas rejected and not to take such things personally. I also need to bear in mind other peoples thoughts and feelings around this. I tend to come up with lots of different ideas a lot of the time, and it
may seem to other people that I am never happy with what we are doing. It may also seem as though I am criticizing their ideas even though this is not intended.

The group process and interactions is important in the PBL task as it can affect how you feel not only about the task, but the groups function and your own contributions to the task. These factors have been found to be positively related suggesting that if you feel happy with how the group functions then you will be happy to contribute and feel good about the task (Nieminen, Sauri & Lonka, 2006). Presumably, this can also work the other way so negative feelings about one part of the PBL can spread to other aspects of the task also.

The Presentation

After much discussion we decided to present our process of working on the PBL task instead of tackling the actual problem we were presented with. This meant we could share our difficulties in deciding what to present which included our reluctance to act as someone from a different culture. I think it is important to provide some context around some of the anxieties we had about these presentations. Following the meeting we all attended about bullying behaviour within our year group, a lot of us were feeling anxious, upset and angry. I think that as a group we were very anxious that we did not present anything in our PBL task which could be construed as bullying or disrespectful of another person or culture. In some ways this was useful as it certainly made us think more carefully about other people and how we consider the views of others. The meeting we had was not entirely responsible for our decision to present in the way we did but I think it was a contributory factor.
I also think that our decision to present in the format we did was reflective of our stage of training. In the first two years we very much relied upon presenting other people’s research and ideas to support what we wanted to say. Now, I feel as though we felt confident enough to present our own ideas and thoughts without having to stick rigidly to structure or use comedy or gimmicks to get our point across.

Our Reflections

One of the main things we learned through working on this PBL task was how uncomfortable we felt trying to portray someone from another culture. This was interesting for us to think about as we had not had this problem with our previous tasks. We had numerous discussions around culture and one thing that emerged was that some of the group did not feel that they had a strong sense of their own culture. As part of this, they did not feel that we were encouraged to think about our own culture very often. This was different for some members of the group and this seemed to be related to where we all grew up. We learned that although we may look as though we are from the same culture, this is not actually the case. This has taught me how important it is not to make assumptions about people and their culture based on their appearance. It is always worth checking out with people how they feel about this.

Linked to this is the notion of ‘colour blind’ racial attitudes: “Unlike more overt forms of racism, the color-blind perspective does not necessarily make explicit claims about White superiority. Rather, color-blind attitudes reflect the seemingly benign position that race should not and does not matter” (Gushue & Constantine, 2007 pp. 323). It is through thinking that race is not an issue to be considered which can result in racist views and practices that can occur unconsciously. We were conscious that we as a group of White British and Irish individuals were unable to understand what it would be like to be an
individual of Pakistani origin living in British culture. It was acknowledged that although in many ways race should not matter, it really does matter because people’s experiences, culture and identity all contribute to making people as individual as they are. If we are to offer a truly individualized approach to therapy, then all of these things need to be taken into consideration whether race and culture are obviously different to our own, or even when they are not.

I feel that the reflective nature of our presentation was its main strength. I think we worked hard to be honest and open about our feelings towards this task. This was a difficult process and resulted in some difficult meetings. One meeting in particular stands out as being particularly hard and I think a number of group members felt upset about the way the presentation was progressing. However, we did manage to reach a compromise and move forward which I think shows how we have grown as a group. The compromise was reached fairly quickly, within the same meeting and this is in contrast to previous PBL’s where disagreements have lasted a fair bit longer. By this stage we wanted our presentation to be a success and for our group to be a success. Previous research has found that when PBL groups develop team spirit, group members are encouraged to care about the group, mainly because they want it to succeed (Slavin, 1996). I think we did want our group to succeed but I would argue that we care about our group regardless of success. This may be because we are a case discussion group as well as a PBL group and we are now also friends.

The weakness of our presentation was that we decided to focus purely on process and reflections and as a result some other issues were not addressed. We did not give an answer to what we would do with the family in the scenario but this was intentional. So, although I am aware that it may seem that we did not answer a specific question, I feel that the purpose of the PBL tasks is to learn from a specific problem and then present what we learned.
I have continued to think about why this PBL was more difficult to approach than the others, especially as I have found this account the most difficult to write. I have had difficulty trying to structure what I wanted to say and also to clearly demonstrate my thoughts and feelings around the subject. I think that this reflects our unstructured approach to this year's presentation and also how huge the subject of culture is. I am also aware that I have avoided discussing the other issues mentioned in the PBL task (of ageing and dementia) just as we did in our presentation. I am not sure why this is the case. I am currently working with older adults and at times have found it challenging; not working with the client group per se, but dealing with the thoughts and anxieties it raises about your own age and mortality. I have also found it difficult coming face to face with the reality of dementia and the effects it has both on the individual and their family. I wonder if we all felt quite anxious about spending a lot of time thinking about a difficult topic and to deal with this we simply avoided it.

This PBL task seemed to be one of the more difficult tasks we were faced with. However, although we struggled with the process, I still felt happy with our presentation and with the feedback we received. The PBL has seemed to be a bit of a mystery task throughout the three years but at the end of this task I felt as though I understood a bit more about the purpose of what we have been asked to do. Our development since the first PBL task became clearer and it seemed that by working on a shared problem we were able to observe not only changes in ourselves and each other, but as professionals working together in a group.
References


Slavin, R. E. (1996). Research on cooperative learning and achievement: what we know, what we need to know. *Contemporary Educational Psychology*, 21, 43 – 69
Case Discussion Group Process Account One

Summary

September 2006

Year 1
This account reflected upon the first year of our case discussion group and my personal and professional development as a result. I recapped the problem based learning task that we worked upon as I felt this was a major part of the groups experience during the first year. The account went on to discuss how the meetings changed once the task was completed and progressed on to case discussion. The benefits of using the group to discuss placement were discussed and parallels were drawn between what was experienced in the group and what is experienced in clinical practice.

The remainder of the account discussed a shift in our meetings, towards discussing pre-planned topics. This resulted in some uncertainty in the group about certain topics but also in positive experiences of sharing personal information. I reflected upon some of the disagreements that occurred within in the group and drew upon Tuckman’s (1965) model of group development. The account discussed how the group managed such disagreements and moved on to develop into a positive, enjoyable group.

Final thoughts in the account demonstrated my enjoyment of the case discussion groups and a feeling of strength within the group. It was highlighted that it can be difficult reflecting on your own behaviour, particularly if reflections are not positive. However, it was acknowledged that this was an important part of personal and professional development.
Case Discussion Group Process Account Two

Summary

July 2007

Year 2
This process account initially described how our group had followed a very similar format to the previous year; starting with working on a problem based learning task and progressing on to case discussion.

I reflected upon our difficulties with the problem based learning task. It was felt that this might be related to the fact that we had not yet started our child or learning disability placements which left us feeling somewhat unprepared. However, it was acknowledged that we did all learn something from the experience.

A discussion followed about how we experienced moving to new placements. It was felt that this was a positive experience for most people and opportunities for increased creativity and reflexivity were discussed. Additional issues discussed included ethical dilemmas and diversity. Our new placements had given rise to new consideration of these topics and discussion extended into diversity between the members of our group.

The account concluded by reflecting that the majority of our time in our case discussion groups was spent discussing personal issues and reflecting about ourselves. It was hypothesised that this may be related to how busy we all were at this time, particularly with academic work. The group may have provided some ‘time out’ for us at a time when we felt we needed it. Finally, it was suggested that the name “case discussion group” may be somewhat misleading as by this point it was felt that it had a purpose above and beyond discussing clinical cases.
Clinical Dossier

This section contains an overview of the experiences obtained on the five placements over the three year course. Also included are summaries of the case reports written for each of the core placements. Full copies of these case reports are included in Volume Two of the portfolio.
Summary of Clinical Experience on Placement
Adult Mental Health

Client Demographics: Clients ranging in age from 18-74; direct work with five males and six females; indirect work with parents / carers and staff; psychometric assessments with three clients (two male and one female).

Presenting Problems: Anxiety, depression, health anxiety, psychosis, drug abuse, panic disorder, personality disorder.

Settings: CMHT, adult family therapy service, specialist forensic service (medium secure service).

Assessment Procedures: Clinical interviews, standardised questionnaires (including BDI, BAI, YBOC’s, AnTI), psychometric assessments (WAIS-III, WTAR, Wisconsin Card Sort, Trailmaking, Stroop Test, AMIPB, Ray Complex Figure, NART, FAS).

Interventions: Cognitive Behaviour Therapy (CBT), Narrative Therapy, Systemic approaches.

Other Experiences: Running a group on an acute inpatient ward, attending group CBT supervision, attending a reflective practice group, being part of a reflecting team in an adult family therapy service.

People with Learning Disabilities

Client Demographics: Clients ranging from age 5 – 49. Direct work with 6 clients (3 females and 3 males. Indirect work with parents and staff groups. Psychometric assessments with one male and one female.

Presenting Problems: Anger, bereavement, difficulties recognising emotions, behavioural problems, attachment difficulties, family difficulties, capacity to consent to sexual relationships.

Settings: Community learning disability team, special schools, residential homes.

**Interventions:** Cognitive behaviour therapy, life story work, systemic therapy, behavioural guidelines.

**Other experiences:** Observed a DISCO assessment being carried out, conducted a teaching session on Social Stories at a local residential home.

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**Child and Family**

**Client Demographics:** Direct work with 8 clients (4 females and 4 males) age 4-17. Indirect work with one client (1 female, parent).

**Presenting Problems:** Generalised anxiety, obsessive compulsive disorder, sleeping problems, difficulties with social interaction, eating problems, and aggressive outbursts.

**Settings:** Child and adolescent mental health service and schools.

**Assessment Procedures:** Clinical interviews, standardised questionnaires (GADS, CYBOCS, Connors, ASSQ), specific assessments (theory of mind tests, strange stories). Psychometric assessments (WISC-IV) and observations.

**Interventions:** Cognitive behavioural therapy, systemic therapy and behavioural interventions.

**Other experiences:** Attending family therapy session as part of a reflecting team, visit to a specialist adolescent service.

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**Older People**

**Client Demographics:** Direct work with 7 clients (4 male, 3 female). Psychometric assessment with 4 clients (3 females, 1 male). Group work with 8 males and 1 female.

**Presenting Problems:** Depression, anxiety, memory impairment, hallucinations, disorientation, personality changes and panic attacks.

**Settings:** Day hospital, inpatient ward, outpatient clinic and people’s homes.

**Assessment Procedures:** Clinical interviews, standardised questionnaires (AnTI, Geriatric Depression Scale, specific assessments (Graded Naming Scale, Dementia
Rating Scale) and psychometric assessment (MEAMS, FAS, Camden, WMS, WASI, Rivermead, BADS).

**Interventions:** Cognitive behaviour therapy, psycho-education, and narrative therapy.

**Other Experiences:** Attended CPA reviews and attended monthly trust wide older adult meetings.

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**Advanced Competencies**

**Client Demographics:** Children and young people aged 1-18 under the care of a consultant at the hospital.

**Presenting Problems:** Needle phobia, adjustment to illness / condition, chronic fatigue syndrome, sibling support, phobia of escalators (related to physical disability).

**Settings:** Outpatients clinic and inpatient ward.

**Assessment Procedures:** Clinical interviews, standardised questionnaires (Kovac’s, AnTI, Spence children’s anxiety scale) and psychometric assessments (WISC-IV).

**Interventions:** Cognitive behavioural therapy

**Other Experiences:** Attending regular meetings with other psychologists in the HIV service, set up and facilitated a group for adolescents with diabetes.
Adult Mental Health Case Report One

Summary

Cognitive behavioural therapy with a working age man with recurrent depressive disorder

May 2006

Year 1

In order to preserve anonymity for both services and individuals, identifying information and details have been altered throughout the report. All names used are fictitious.
Reason for Referral

Mr Jones was referred to the community mental health team for help with an episode of depression.

Presenting Problems

Mr Jones described feeling low in mood, having negative thoughts and finding it difficult to get things done. He spent most of his time sleeping and was in the process of a divorce which was also a source of difficulty for him.

Assessment

The initial assessment was a clinical interview. I followed a cognitive behavioural approach to assessment in line with NICE guidance on treatment for depression. Mr Jones described feeling as though he was having a “nervous breakdown” and often felt sad and worthless. Many of these thoughts were related to his divorce and worries about letting his children down. He described previous episodes of depression and feeling inadequate from a young age. The Beck Depression Inventory (BDI) was also administered and Mr Jones scored within the severe range.

Formulation

Mr Jones’ history of depression may have pre-disposed him to depression and his early experiences of feeling inadequate may have resulted in a belief that he is worthless. Precipitating factors appeared to be the change in family circumstances resulting from his divorce. This may have triggered feelings of worthlessness related to being a good father. Maintaining factors seem to be ruminating on negative thoughts and a lack of activity.

Intervention

Intervention followed a cognitive behavioural approach. This included goal setting, increasing activity levels, identifying negative thoughts and challenging these thoughts. Outcome was measured using the BDI which showed a slight reduction in his score.
Adult Mental Health Case Report Two

Summary

Cognitive behavioural therapy with a working age man with social anxiety

October 2007

Year 1

In order to preserve anonymity for both services and individuals, identifying information and details have been altered throughout the report. All names used are fictitious.
Reason for Referral

Mr Davies had previously been admitted to the acute ward (under section) with a diagnosis of paranoid schizophrenia. A referral was made to psychology regarding ongoing feelings of anger and anxiety a number of years on.

Presenting Problem

Mr Davies described feeling fear since being detained in hospital. He was particularly nervous about meeting new people and worried how they would respond to him.

Assessment

The assessment was a face-to-face interview following a cognitive behavioural approach (in line with NICE guidelines for anxiety). Mr Davies described the fear that he experienced when being arrested and brought to hospital. He described that he now avoiding talking to people in case they thought he was mad. The Beck Anxiety Inventory (BAI) was also administered.

Formulation

Mr Davies’ experience of being arrested and taken to hospital may have led to the belief that people are unpredictable and hard to trust. In social situations these beliefs are likely to be activated leading Mr Davies to feel self-conscious and anxious. Mr Davies responds by monitoring what he says very closely or not talking at all. The consequence of these behaviours is that he does not enter into a natural conversation with anyone and therefore his fears cannot be disconfirmed.

Intervention

Intervention followed a cognitive behavioural approach, concentrating on his thoughts and behaviours in social situations. This was followed up with some social skills training to improve Mr Davies’ confidence. Outcome was evaluated using his BAI scores which had reduced by seven points.
People with Learning Disabilities Case Report

Summary

Anger Management with a working age year woman with learning disabilities

April 2007
Year 2

In order to preserve anonymity for both services and individuals, identifying information and details have been altered throughout the report. All names used are fictitious.
Reason for Referral

Miss Williams was referred by her care manager for help with managing her anger.

Presenting Problem

Miss Williams described having problems with anger. She described an incident where she was so angry she nearly hit someone and this prompted her to seek help.

Assessment

The assessment consisted of a face-to-face interview conducted by my supervisor and observed by myself. Miss Williams described having a temper since a child and that it had got worse with age. As a child Miss Williams felt angry with everyone but could not remember why. An anger inventory by Benson & Ivins (1992) was also administered.

Formulation

Miss Williams’ early experiences may have led to a belief of ‘life is unfair’ and ‘anger is the only way people will notice me’. Other people can trigger her anger and her learning disability may impact on her understanding of situations and her impulse control. Miss Williams feels hot, angry and then ‘explodes’. She temporarily feels calm afterwards which may be maintaining her behaviour.

Intervention

Intervention included psycho-education about anger and a cognitive behavioural (CBT) approach to overcoming it. Part of the CBT included a traffic light approach which represented stopping (red), thinking (amber) and doing (green). We also worked on relaxation techniques. Post intervention, Miss Williams demonstrated keeping her temper in a number of situations although her scores on the anger inventory did not reduce.
Child and Family Case Report

Summary

A behavioural intervention with a female child with eating problems

October 2007

Year 2

In order to preserve anonymity for both services and individuals, identifying information and details have been altered throughout the report. All names used are fictitious.
Reason for Referral

Katie Jones was referred for help with fussy eating. She had been seen by a dietician but her eating had not improved.

Presenting Problem

Katie only ate food that was white and soft. She would not eat anything when she was at school. Katie was drinking a lot of milk and was still waking for a bottle in the middle of the night.

Assessment

Initial assessment was a face-to-face interview. Mrs Jones felt Katie’s eating difficulties could be linked to illnesses she experienced as a baby which would have made eating painful. Mrs Jones had tried messy play and cooking together which Katie enjoyed but did not lead to her eating more. Diary measures were used to record what Katie was eating.

Formulation

Katie’s earlier health problems may have led to her learning that eating food is painful leaving her unwilling to try new foods. Her preference for soft, white food may be due to an association with milk which would not have been painful to drink when she was younger. Her eating habits may be maintained by the amount of milk she drinks as it is likely to fill her up and reduce her appetite for other food.

Intervention

Interventions including reducing anxiety around mealtime, promoting eating as a positive experience, encouraging small changes and responding positively to any change. The intervention was initially successful however, change was not maintained. Katie was referred on to a specialist feeding team at another hospital.
Older People Case Report

Summary

A neuropsychological assessment of an older adult male with memory problems

April 2008

Year 3

In order to preserve anonymity for both services and individuals, identifying information and details have been altered throughout the report. All names used are fictitious.
Reason for Referral

Mr Thomas was referred due to his memory becoming increasingly problematic. Neuropsychological testing had been carried out 12 months earlier and a repeat assessment was requested.

Presenting Problem

Mr Thomas described needing help with his memory now and again. His wife described noticing changes in her husband over the previous year. She felt he was more muddled, had trouble concentrating and had lost interest in some of his hobbies.

Assessment

Assessment consisted of a clinical interview and the following tests: WMS-III, WASI, BADS, Camden, NART, FAS and the Rivermead. These were the tests administered 12 months previously. Of note in Mr Thomas’ history were previous episodes of depression, moderate drinking and earlier head injury. There is also a family history of dementia.

Findings

Mr Thomas’ performance remained largely consistent to 12 months previously. Areas of decline included visual recall, attention and concentration and some tasks of executive function. However, he also showed improvement on tasks of non-verbal abilities and some tasks of working memory. Due to this improvement in some areas, no diagnosis of degenerative disorder could be implied.
Research Dossier

This section contains the research I have conducted over the three year course. This includes the Research Logbook, the Service Related Research Project, an abstract from the Qualitative Research Project and the Major Research Project.
Research Log Checklist
<table>
<thead>
<tr>
<th>No.</th>
<th>Activity</th>
<th>Completed?</th>
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<tbody>
<tr>
<td>1</td>
<td>Formulating and testing hypotheses and research questions</td>
<td>✓</td>
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<tr>
<td>2</td>
<td>Carrying out a structured literature search using information technology and literature search tools</td>
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<tr>
<td>3</td>
<td>Critically reviewing relevant literature and evaluating research methods</td>
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<tr>
<td>4</td>
<td>Formulating specific research questions</td>
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<td>5</td>
<td>Writing brief research proposals</td>
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<tr>
<td>6</td>
<td>Writing detailed research proposals/protocols</td>
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<tr>
<td>7</td>
<td>Considering issues related to ethical practice in research, including issues of diversity, and structuring plans accordingly</td>
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<tr>
<td>8</td>
<td>Obtaining approval from a research ethics committee</td>
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<td>9</td>
<td>Obtaining appropriate supervision for research</td>
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<td>10</td>
<td>Obtaining appropriate collaboration for research</td>
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<td>11</td>
<td>Collecting data from research participants</td>
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<td>12</td>
<td>Choosing appropriate design for research questions</td>
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<td>13</td>
<td>Writing patient information and consent forms</td>
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<td>14</td>
<td>Devising and administering questionnaires</td>
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<td>15</td>
<td>Negotiating access to study participants in applied NHS settings</td>
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<tr>
<td>16</td>
<td>Setting up a data file</td>
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<td>17</td>
<td>Conducting statistical data analysis using SPSS</td>
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<td>Choosing appropriate statistical analyses</td>
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<td>Preparing quantitative data for analysis</td>
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<tr>
<td>20</td>
<td>Choosing appropriate quantitative data analysis</td>
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<td>21</td>
<td>Summarising results in figures and tables</td>
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<td>22</td>
<td>Conducting semi-structured interviews</td>
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<td>Transcribing and analysing interview data using qualitative methods</td>
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<td>25</td>
<td>Interpreting results from quantitative and qualitative data analysis</td>
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<td>Presenting research findings in a variety of contexts</td>
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<td>29</td>
<td>Submitting research reports for publication in peer-reviewed journals or edited book</td>
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Service Related Research Project

Evaluating the use of action points generated from a reflective practice group on an acute inpatient ward

July 2006

Year 1
Abstract

This study evaluated the use of action points generated from a reflective practice group on an acute in-patient ward. The aim was to discover whether the action points generated from the group were implemented. Clients that were discussed in the group were identified and their files checked for a record of the reflective practice group and the resulting action points. The number of action points and their content were recorded and the files examined for evidence of the action points being carried out. Data was subject to descriptive analysis in order to generate information about the number of action points that were or were not implemented. A correlation was also carried out to determine if there was any relationship between the number of action points generated and the number carried out.

A moderate percentage of clients discussed in the group did not have any record of the group in their file. Of those that did, the number of action points recorded was consistently higher than the number of action points carried out. A positive correlation was found between the number of points generated and the number carried out suggesting that the more action points are generated, the more will be carried out. The reasons why action points may or may not be implemented are discussed along with implications for the service and ideas for future research.

Acknowledgements

I would like to thank my supervisor on placement for his assistance in the development of this study and I would also like to thank the ward manager for her assistance in data collection.
Introduction

There has been a growing interest in the use of reflection in practice since Schöns (1983) conceptualisation of the ‘reflective practitioner’ established a new way of continuing professional development. The elements of reflective practice were distinguished by Schöns as comprising of reflection on action and reflection in action. Reflection on action involves thinking back on our actions and trying to understand their meaning and relevance, a notion which has been said to closely resemble peoples ‘everyday’ concept of reflection (Russell, 2005). Reflection in action is more dynamic and examples of how it may take place have been provided by Russell (2005):

1) A puzzling or surprising event during teaching might stimulate ‘reframing,’ recognizing a new way of perceiving or thinking about the professional situation of practice

2) The new perspective might stimulate a novel course of action

3) Carrying out the novel course of action might provide evidence for deciding if the new perspective and associated new actions deserved to be included in future professional practice.

The role of reflection has been highlighted by the Department of Health (2002) in their report “Mental Health Policy Implementation Guide: Adult acute inpatient care provision”. The report outlines the need for systems to be able to reflect on the effect that being in a challenging environment with complex clients has on both the clients and the staff teams. In addition, they recommend that “time should be identified within the working week for an ongoing program of structured multidisciplinary learning opportunities both on and off the ward…creating a space that allows for reflection, thinking and understanding..” (p. 21).
Although reflective practice is advocated by many professionals, it has been argued that it is not often modeled and explained to those expected to demonstrate it (Russell, 2005). One of the ways that this can be overcome is to introduce reflective practice in structured ways where people can develop skills and experience the benefits of reflective practice first hand. Lavender (2003) describes how working in groups could provide this, where a facilitator helps reflect on what has been done, what theory is relevant to make sense of events, and helps to generate a plan of action.

The reflective practice group relevant to this study was set up on an inpatient acute ward. The group was devised by the Ward Manager, two Clinical Psychologists and a Consultant Nurse and their initial aims were:

- To provide an opportunity for the inpatient team to meet with the multidisciplinary community mental health team (CMHT) to care plan together
- To get a broader understanding of the person, their problems and their context
- To finish meetings with action points

An evaluation of the group was conducted by Dr Ché Rosebert (Clinical Psychologist) and Emma Shepherd (Trainee Clinical Psychologist) (2005). This evaluation demonstrated that both members of the inpatient team and members of the multidisciplinary community team have attended the group and been involved in care planning. Within the group, time has been spent discussing the patient which has provided opportunities to increase understanding of the person and groups ended with written action points. The initial aims of the group have therefore been met.

*Research Question*

Were action points generated from the reflective practice group implemented?
Aims

This service related research project aims to discover whether action points generated from the group were implemented to ensure that reflective practice is being used to benefit both clients and team members.

Method

Participants

The participants in this study were those clients that were discussed in the reflective practice group. All were under the care of community mental health teams (CMHT's) five as inpatients and three as outpatients. For three of the participants it was unclear what their status was at the time of discussion. Seven of the participants were female and four were male. Age of the participants ranged from 20 to 66 with a mean age of 33.5.

Sample

The sample refers to “a set of individuals selected from a population and intended to represent the population under study” (Coolican, 1999 pp.351). As there was no formal record of those individuals discussed in the complex cases group, it is unclear how many people had actually been discussed. Those that attended the group were contacted and asked to provide the names of the individuals they could remember being presented to the group. Some of the participants were discussed more than once bringing the total number of cases analysed to 15. The sample was opportunistic in nature (Coolican, 1999) as these were the only participants available.
Materials

Materials needed for data collection were the files of those patients discussed in the groups.

Procedure

The initial task was to identify which individuals were discussed in the reflective practice group and this was done by liaising with members of staff that regularly attended the group and noting the clients they remember discussing. Once this list was generated their files needed to be located. This was done by checking the main computer system which holds details of each client in the service and displays their status (inpatient / outpatient) and which service they were last seen by. This meant that files were either on the ward, in the CMHT or in medical records if they were no longer in touch with services. The next step was to locate the record of the complex cases group within each file. This was a piece of green or white paper which documented the date of the group, who was present, the action points and who was responsible for implementing them and by when (see appendix A). If the information was found within the file, the action points were recorded and the file read in order to establish if there was any record of the action points being carried out. If there was clear documentation of the action point being implemented either in the multidisciplinary notes or in correspondence then the action point was deemed to have been carried out. However, if there was no mention of the action point anywhere in the file it was concluded that it had not been implemented.

Analysis

The data was subject to descriptive analysis and correlational analysis. Descriptive statistics are used to summarise the raw scores obtained from the data. This provided percentages and averages of the number of points that were generated and carried out. The purpose of carrying out a correlation was to determine if there was any systematic
relationship between two variables, in this case the number of action points generated and the number of points carried out.

Results

*Complex cases group data*

A finding which emerged from the audit was that 33.3% of the participants' did not have any record of the complex cases group in their file and therefore there was no data for these individuals (see figure 1). This clearly has implications for whether action points are implemented or not as without a record of the action points it is unclear who is responsible for implementing the points or even what the points actually are.

![Pie chart showing data recorded in the file](image)

*Figure 1. Was the data recorded in the file?*
Action points

In order to investigate whether action points were carried out it was decided that it would also be necessary to record the number of action points generated in each group. This may be useful as a potential influence on whether points are carried out or not. The number of action points recorded in each complex cases group ranged from 2 to 12. In the majority of groups (30%) 3 points were generated. Figure 2 displays the number of points generated and the percentage of groups in which they arose.

Figure 2. The number of points generated by the complex cases groups
Number of action points carried out

Once the number of action points had been recorded it was important to find out how many of these points were actually carried out. Each point was treated separately and was counted as being carried out if there was evidence to support this in the notes. A summary of these results is shown in figure 3. The maximum number of points that were carried out was 5 with the minimum being 0 and the mean 1.9. In the majority of cases (30%) either 1 or 3 points were carried out. 0 points were carried out in 20% of cases and given that every case discussed had at least 2 action points recorded this indicates that action points are not consistently carried out.

In order to discover if there was a significant relationship between the number of points generated and the number of points carried out a correlation analysis was performed.
Correlation is the measurement of the extent to which two variables change with each other. In addition it gives a measure of the extent to which values on one variable can be predicted from values on the other variable. The correlation is said to be positive if one variable increases with the other and negative if one variable decreases with the other (Coolican, 1993). A scatter plot is a useful way of demonstrating whether the correlation is positive or negative.

A significant correlation was found between the number of points generated and the number of points carried out; r (10) = .913, p < .001. This was a positive correlation as demonstrated by figure 4. This correlation is basic evidence that discussion of action points in the group appears to lead to corresponding positive action ultimately being carried out. However, the data also shows that a mean of 35.4% of action points are not carried out, which is a finding worth future consideration. What can also be seen from figure 4 is that none of the cases had all of their action points implemented. This would suggest that some of the points were deemed more important or useful than others.
Discussion

Findings and implications

One of the most important findings from this study was that in 33.3% of the cases analysed, there was no record of the complex cases reflective practice group in the file. Without this, it is virtually impossible to measure the impact that discussion in such a group has, as any action points for the future are not documented. In addition, an early discovery was that there was no formal record of who was discussed in what group. This has been addressed since the start of this study, and it is vital that this practice continues if any further evaluation of the groups impact is to be carried out.
The results also indicate that not all action points that are generated from the complex cases group are implemented. There was not one case where every action point was implemented and in 20% of cases, no action points were implemented at all. However, it is clear from the results that action points had been drawn up in each of the complex cases groups' analysed and in 80% of cases at least one was carried out.

It is worth noting that the documentation of the complex cases group was not always easily accessible in the participant’s files. There did not appear to be any particular place in which the information was filed and as a result this varied from being included in the care plan section of the file to being filed with any correspondence. If health care professionals are expected to ensure these actions points are carried out, it would be helpful if the information was in a consistent, accessible place. Time pressures are a continuous struggle for most health care professionals, especially those working on an acute ward and time spent trawling through files looking for action points may be resented. Sparrow et al., (2005) acknowledge that the workplace itself may conspire to limit the extent to which reflection is practiced and time pressures may well factor in this.

The action points sheet (appendix A) details what the action point is, those responsible for carrying it out and the date by which this is to be done by. However, in some cases this information is non-specific. An example of this is if those responsible for implementing the action point are ‘nursing staff’ and the time frame is ‘ongoing’. This may lead to individual members feeling they do not have to take responsibility as someone else will do it and as the time frame is ongoing, it may be a task people put off until tomorrow or if it was initially implemented, may be forgotten as time passes. The positive correlation between the number of action points generated and the number of action points carried out would suggest that in order to maximise the likelihood that action points are implemented, more need to be generated. However, this finding should be interpreted with some caution. It could be that those cases which require more action points are more complex and discussed in more detail; staff that attend the group may be more likely to remember these cases and refer back to the action points for future
guidance. Similarly, if these cases are more complex there is potential for greater risk and this also may influence a member of staff's decision to implement the recommended action points.

Each of these points may influence whether or not action points are carried out after the reflective practice group and the fact that in all cases there are some points that are not carried out has implications for the service itself. The service has both an obligation to its users and its providers and the development of the reflective practice group was an opportunity for health care professionals to understand the clients better, care plan with other health care professionals and develop their own skills in reflective practice. Although those attending the reflective practice group will be learning while at the group, if the action points are not carried out then the benefits of working reflectively will not be evident. It could be argued that at the moment, those that attend the group may be learning to reflect on action but the action points may provide a way to progress to reflecting in action (Russell, 2005).

The cases discussed at the reflective practice group are usually those where advice or a new way of thinking is needed in order to assist in the client's care. If the action points resulting from this are not carried out, then it can be argued that the client is not receiving the best care possible as potentially, these action points could really make a difference. Reflection can be used as a tool for directing and informing practice, for learning or transforming and reconstructing the social environment (Williamson, 1997); the action points provide a good opportunity to put some of these skills into practice.

Limitations

One of the main limitations of this study lies in its sample. Due to records not being kept of the complex cases group it was difficult to obtain a representative sample; the aim therefore, was to provide an insight into those cases which were actually recorded as being discussed in the group. For those cases which were recalled as being discussed, the
actual date of the group was only found if the information from the group was filed accordingly, therefore, in those cases where the information was missing there was no way of knowing when they were discussed. This had the implication of having an unclear time frame from which the sample was selected, although given the small number of clients actually identified, having a specific time frame may have limited the sample further.

An additional limitation was that it was not always clear how the action points specified could be recorded as being carried out. For example, if the action point specified that the nursing staff would encourage the client to participate in more group activities this would only be recognised as carried out if the staff recorded it in the file. The implication of this is that some of the action points in this sample may have been carried out, but individuals may not have recorded doing so in the file. Therefore, it was assumed the action was not implemented.

**Recommendations and future work**

This study was presented to the service in order to communicate its findings (confirmation of this is included in appendix B).

The complex cases group is clearly a beneficial practice to employ and in running such a group the service is addressing the Department of Health’s (2002) recommendation of “creating a space that allows for reflection, thinking and understanding” (p. 21). The initial aims of the group (outlined in the introduction) have also been met although it appears that the action points generated are not always carried out.

In order to facilitate the implementation of action points, it could help if someone attending the reflective practice group filed a record of the group in the client’s notes. By having an agreed part of the notes where this information should always be filed, it would
be a lot easier for staff members to refer to the action points in the future. Another option would be to have a ‘reflective practice’ file where all of the information from the groups is held as a record of who has been discussed and what the action points were. This would also have the benefit of creating a record of the groups to date. It should be acknowledged that those attending the group are now keeping records of those who are discussed (including dates of discussion) so that future evaluations could be more comprehensive.

In terms of future work it would be invaluable to understand why action points are not always implemented. Areas to consider could include: level of risk, person responsible for carrying out the action, diagnosis, length of time known to the service and patient status (inpatient / outpatient). Once the reasons why action points are not carried out become clearer, these can be addressed and the benefits of an already valuable group can be increased.
References


Appendix A

Reflective practice group record
NAME OF IN-PATIENT DISCUSSED:  

DATE:

<table>
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<tr>
<th>ACTION POINT(S)</th>
<th>WHO</th>
<th>BY WHEN</th>
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Appendix B

Letter confirming proof of feedback to the service
1st December 2006

To Whom It May Concern:

Re: Service-related research project by Sarah Burdett

This is to confirm that the CMHT received an excellent presentation to feedback on the above project, which was an audit of whether planned actions from a reflective practice group were carried out or not.

Yours truly,

[Name redacted]
Chartered Clinical Psychologist
CMHT
Qualitative Research Project Abstract

The Attitudes of Young Adults to the Change in Drinking Laws

May 2006

Year 1
Abstract

In November 2005, the Licensing Act (2003) was operationalised, which provided a new regime for the licensing of the sale and supply of alcohol, regulated entertainment and late-night refreshment. A key measure of the act was the scope for flexible opening times for licensed premises, with the potential for up to twenty-four hour opening seven days a week. The Government’s aim was to reduce alcohol related crime and disorder on the premise that binge drinking was partly responsible. However, less is known about public opinion on this issue so this study aimed to explore young people’s attitudes toward the change.

Six participants aged between 23 and 24 years old were interviewed and Interpretative phenomenological analysis (IPA) was utilised to analyse the data. Results indicated that participants felt there were a number of benefits for themselves as well as others. The extended licensing laws provided more flexibility and choice for drinkers, landlords and shift workers. Participants also perceived a reduction in both criminal behaviour and binge drinking. Finally, there was a perceived financial gain for landlords and their employees.
Major Research Project

Challenges and Experiences of First Time Fatherhood

July 2008

Year 3
Abstract

This study aimed to explore the challenges and experiences faced by first time fathers. Eight participants were given a vignette which described a first time father experiencing extreme difficulties. They were then interviewed about the vignette and the resulting transcripts were analysed using thematic networks analysis. The three global themes resulting from the data included: the experience of difficulties in fatherhood, ways of coping with difficulties and seeking support. The findings confirmed that men do experience difficulties when becoming a father for the first time and the way in which they cope with these difficulties can affect their experience of fatherhood. The difficulties discussed included the birth process, unpredictability and hard work. Ways of coping with such difficulties included getting involved, looking to others, recognising there is a problem and taking responsibility. In terms of seeking support, it seemed that the men felt there was a lack of services for fathers although they also seemed ambivalent about whether such services would be accessed. This seemed to be related to ideas the men had about 'being a man' and the stereotypes which accompany it. The findings are discussed in terms of implications for services for first time fathers, difficulties of fathers accessing these services and suggestions for future research.
1. Introduction

Becoming a parent is a time of many transitions which can bring with them times of great joy and also difficulty (Nyström & Öhrling, 2004). This study focuses on the challenges and experiences that fathers encounter when becoming a parent for the first time. The existing literature in this area is reviewed, focusing specifically on: becoming a parent for the first time, the effects of postnatal depression on children, the role of the father, challenges and difficulties of fatherhood, depression in fathers and the concept of depression in men. The objectives of the current study are then outlined along with the specific research questions.

1.1 Becoming a parent for the first time

In a review of the literature on experiences of parenthood, Nyström & Öhrling (2004) found that there were extensive changes to both men and women that were sometimes difficult to cope with. The paper identified the different ways in which men and women experience parenting and in turn the positive and negative aspects of this. Women were more likely to feel confident and satisfied in their role as a mother, if their self-esteem and health was intact. Support was identified as an important aspect of this, with partners and public health nurses being valued as sources of strength to new mothers (Nyström & Öhrling, 2004). Support was also identified as an important aspect during the antenatal period and the birth (Gibbins & Thomson, 2001). In their study of 8 pregnant women in the North of England, Gibbins & Thomson (2001) discovered that all women wanted to feel in control during childbirth and this was achieved through support from partners and midwives. However, support from partners may not always be available.

Becoming a mother resulted in a loss of self-confidence and self-esteem for some women (Mercer & Ferketich, 1995). The role of being primarily responsible for a child was experienced by new mothers as overwhelming and a strain (Nyström & Öhrling, 2004). In
addition, mothers reported feelings of restriction, guilt, loss, exhaustion, resentment, anger and ambivalence (Hall, 1992; Lupton, 2000). They also experienced reduced satisfaction in their marriage and no sexual desire (Nyström & Öhrling, 2004).

Identity theory proposes that central to identity is categorising the self as the occupant of a particular role (Stets & Burke, 2000). In addition, the meanings and expectations associated with that role are incorporated into the self. Therefore, when women become mothers for the first time, they are experiencing a new role and the meanings and expectations they have of how a mother should be will be incorporated into the self. It may take some time before women feel they match up to their expectations and therefore, it may also be some time before they feel settled in their identity and role as a mother.

Men also experience changes when becoming a father and are subject to both positive and negative experiences. Amongst the positive experiences men reported were feelings of deep attachment to the child, a desire to spend as much time as possible with the family, an increase in self-efficacy, pride in their children, feeling needed by the child and experiencing joy and fun in the father-child relationship (Olsson, Jansson & Norberg, 1998; Ahlborg & Strandmark, 2001; Nyström & Öhrling, 2004). It is worth noting the differences between men and women’s positive experiences. Women seemed to place importance on satisfaction and self-confidence in parenting whereas in addition to self-efficacy, men felt that joy and fun were also positive. However, the structure of the families interviewed may affect how they experience parenthood in terms of understanding their other roles and responsibilities. This information is not always available as is demonstrated by Nyström and Öhrling’s (2004) review study which does not contain detailed information about family structure. However, it is made clear that the studies included experienced and first time parents.

These research findings that appear to reflect traditional male and female roles of parenting can be further understood by Social Role Theory (Eagly, 1987). The theory states that gender differences, although based on actual differences, are exaggerated by
the fact that men and women occupy unequal social roles (Brehm, Kassin & Fein, 1999). These social roles have arisen out of biological, social and economic factors which led to a likelihood of men being workers and women caring for children. The theory goes on to suggest that people then behave in ways which fit the roles that they play; these behavioural differences lead to men being perceived as naturally dominant and women as naturally domestic. However, Social Role Theory argues that these differences are not down to nature, they simply reflect the roles that people play. Therefore, it may be assumed that when the roles men and women play are reversed (for example a working mother and a stay at home father), the gender stereotypes will disappear (Brehm, Kassin & Fein, 1999).

The more challenging aspects of fatherhood that have been identified are numerous and varied (Nyström & Öhrling, 2004). They include not having enough time for themselves and their partner (Hall 1992, 1994), feeling that they should change themselves or their behaviour, confusion at the lack of guidelines and role models, conflict between different aspects of their lives, feeling less confident than mothers, sadness at lack of sex since the birth, and distress at not being included in looking after the baby (Nyström & Öhrling, 2004). There are some similarities with the difficulties being faced by women but also some contrasts. The lack of guidance and role models experienced by men may reflect the changing expectations that society has of fathers. Some men may now be unable to look to their own fathers for advice as they will have had a completely different experience of fatherhood than is expected today. The importance of men’s own experiences of being fathered is demonstrated by Walters et al., (2001) study of UK fathers whose children had been referred to a Child and Family Consultation Services. They found that fathers who viewed their own fathers as ‘good’ were not only more likely to attend appointments with their partner and child but were more likely to view themselves as a better father. This research indicates that the quality of a man’s relationship with his father is an important influence on how he will experience fatherhood himself.
This may also link with the difficulty experienced in juggling the different aspects of their lives. Whereas men’s role in parenting used to be more supportive and financial, their new level of involvement means that there may be a struggle to try and combine all aspects of their lives together. Women have often been accused of ‘wanting it all’ in terms of having both a career and children (Hoffnung, 2004) and it seems that this may be what new fathers are also now experiencing.

When the difficulties of becoming a parent for the first time escalate into more serious problems, postnatal depression (PND) may be considered. Until recently, PND has been thought to affect women alone, however, more attention is now being paid to the phenomenon of PND in men which is thought to affect from 24% – 50% of men whose partners experience PND and up to 25.5% of men whose partners do not suffer from PND (Goodman, 2003). PND in women has been defined as having three forms:

1) ‘Baby blues’. This is so common that it can be considered normal. Symptoms include being weepy, irritability, and feeling low. It usually starts around the 3rd day, but usually goes by the 10th day after childbirth. It does not need any medical treatment.

2) Postnatal depression. This occurs in about 1 in 10 mothers. It usually develops within the first 4-6 weeks after childbirth. However, it can start even several months following childbirth. Treatment is advised.

3) Postnatal psychosis. This is an uncommon, but severe, form of depression. It develops in about 1 in 1000 mothers. (www.patient.co.uk)

1.2 The effects of postnatal depression on children

The link between maternal postnatal depression and the effect this has on the child has been well documented in the literature (Lyons-Ruth et al., 1986; Murray, 1992; Murray & Cooper, 1997). Lyons-Ruth et al., (1986) compared American mothers and infants who had been referred to an infant intervention service with mothers and infants from community controls. The study found that maternal depression was significantly related to poorer
infant mental and motor development at 1 year old (as assessed by the Bayley Scales of Infant Development). Similar results were found by Murray (1992) in her study of women living in Cambridge some of whom suffered from PND and some who had not. A comparison of their infants showed a significant difference between the two groups in terms of a number of indices of cognitive development.

There are three main areas where the impact of PND has been investigated: the quality of infant attachment, interpersonal development of the infant and behavioural problems (Murray & Cooper, 1997). Research into depression and attachment style has focused on both mother and infant attachment. Meredith and Noller's (2003) study of married, Australian mothers, found that depressed mothers were significantly more insecure in their attachment style than non-depressed mothers. The depressed mothers also saw themselves as more neglectful, rejecting and aggressive. Similar findings were reported by McMahon et al., in their (2006) study of mainly white Australian mothers. They reported that depressed mothers were more likely to have an insecure state of mind with respect to attachment than their non-depressed counterparts. This also led to a greater likelihood of their infant being insecurely attached, even for those mothers who had only brief depression.

In terms of behaviour problems, recent research in this area has shown an association between PND and unsettled infant behaviour (McMahon et al., 2001). Mothers suffering from PND tend to show flat affect and as a result are less stimulating with their children (Field, 1992). This leads to their children exhibiting lower signs of attentiveness, contentment and activity, and higher degrees of fussiness (Field, 1990). It has been suggested that such infants develop their own depressed mood style very early in infancy (Field, 1998) and the research would appear to support this. Murray et al., (2001) found that children who had been exposed to maternal depression were more likely to experience depressive cognitions (hopelessness, pessimism and poor self-worth) than children who had not been exposed. These findings are supported by a further study conducted with mainly European American women, which found that infants of
depressed mothers, showed more negative emotions, played less and exhibited less exploratory behaviours (Mezulis, Hyde & Clark, 2004).

With reference to interpersonal development, children rely on their parents to provide the interactions and experiences required to facilitate normal physical and psychological development (Mezulis et al., 2004). Behaviours characteristic of depression such as hostility, withdrawal and unpredictability all interfere with this process making it more likely that depressed mothers' interactions with their children are quite likely to be negative (Mezulis et al., 2004).

An association has also been found between maternal depression and adverse behaviour in children in a sample of Australian mothers and infants (Trapolini et al., 2007). Children exposed to chronic maternal depression were rated by their parents as having significantly more problematic internalising and externalising behaviours. Reports of internalising behaviours were corroborated by teachers but they did tend to report lower levels of behaviour problems (Trapolini et al., 2007). The potential adverse affects continues with the children of depressed mothers being at a higher risk of developing psychopathology not only in childhood but in adulthood also (Downey & Coyne, 1990).

The literature reviewed indicates the many ways in which maternal depression can impact upon a child's development (Lyons-Ruth et al., 1986; Murray, 1992; Murray & Cooper, 1997). However, not every child whose mother suffered from PND will experience these problems so it is likely that other factors affect children's development and can moderate or exacerbate such effects. If the father is the other main caregiver, it is possible that he could be one of these moderating factors.

1.3 The role of the father

According to Lamb (1987) the role of the father has been determined by four time periods which have shaped and influenced the modern view of the father's role. The earliest time
period was during colonial times when fathers roles were primarily disciplinarian and to provide moral guidance to their children. The Industrial Revolution was linked to the second period when there were greater demands on men to work and at times to work away from home. This led to their role within the family shifting to that of 'breadwinner'. The third period was around the 1940’s and Lamb believed that at this time men became more influential in sex-role socialisation of their children as they spent more time playing with their children than their mothers did. The fourth period is contemporary times where the father’s role is expected to be nurturing. Lamb’s (1987) conceptualisation of the changing roles of fatherhood is a useful guide to understanding some of the changing expectations that society has for fathers. It has been suggested that in order to facilitate further understanding of fathers and their roles, research should focus on directly assessing fathers’ behaviour, rather than relying on reports from mothers (Fitzgerald, Mann & Barratt, 1999).

In line with this, Draper (2003) interviewed men who were predominantly middle class and from the UK on three occasions; twice during their partner’s pregnancy and once after the birth in order to explore their experience of becoming a father. The men placed particular importance on the fact that they were changing status and this was accompanied by uncertainty about their new role and how life may change. It has also been found that through men’s attendance of antenatal classes in New South Wales, Australia, new fathers felt well prepared for childbirth but not for the changes to their lifestyle and their relationships (Fletcher, Silberberg & Galloway, 2004). These findings suggest that there are a number of areas of fatherhood that may continue to pose a challenge to men who are experiencing it for the first time.

1.4 Challenges and difficulties of fatherhood

Recently, there has been an increase in acknowledgement of such challenges and an emergence of literature on fathers experiencing symptoms of depression (Goodman, 2003; Lane et al., 1997). Currently, the research literature on paternal depression seems to
be primarily concerned with prevalence (Goodman, 2003; Lane et al., 1997), risk factors of men becoming depressed after the birth of a child (Deater-Deckard et al., 1998) and the relationship to maternal depression (Ballard et al., 1994; Harvey & McGrath, 1988). Findings from the literature have indicated that men who have previously suffered from depression are more at risk of developing paternal depression, as are those whose partners have maternal depression (Matthey et al., 2000). In addition, the more depressed the female partner is, the more the risk increases of the male becoming depressed (Harvey & McGrath, 1988).

Although rates of PND in men are available in the research literature, various methods to assess PND have been used. These have included structured interviews, the Edinburgh Postnatal Depression Scale (EPDS) (Cox, Holden & Sagovsky, 1987) the Beck Depression Inventory second edition (BDI-II) (Beck, Steer & Brown, 1996) and the General Health Questionnaire (GHQ) (Goldberg et al., 1978). It is likely that this use of a variety of measures has contributed to the wide variation in incidence rates due to the possibility that they are measuring different aspects of difficulties. Therefore, what one measure may constitute as depression may differ from another. In addition, there also appears to be a lack of consistency in the terms used, with PND, paternal depression and depression all being common. It seems that at the current time there is not a consistent and clear cut definition of what PND in men is and how it should be measured. Therefore, for the purpose of this study, the terms paternal depression and depression are used to describe symptoms of depression experienced by men associated with becoming a father. Where the term PND is used, it refers to postnatal depression in women, where its definition is somewhat clearer.

In a study conducted with first time and subsequent parents in Sydney, it has been found that there are differences between depression in fathers and mothers in the first post-natal year (Dudley et al., 2000). Whereas mothers were influenced by their own personalities, perinatal and infant related factors, fathers were more influenced by unresolved past events, the mother's personality difficulties, the mother's mental health problems and
relationship between themselves and the mother (Dudley et al., 2000). It seems that relationships may therefore play a part in men’s experience of depression.

Research into the family structure of British men who became depressed before or after the birth of a child, found that men living in step-families had significantly higher levels of depressive symptoms than men in more traditional families (Deater-Deckard et al., 1998). Additionally, it has also been found that depression in new fathers is highest in men who are not involved with the mother of the child. The lowest levels of depression were found in men who were married to the mother, followed by men who lived with the mother (Huang & Warner, 2005).

1.5 Depression in fathers

The importance of the role of the father has been highlighted by an article in Medscape Medical News (2005) “Paternal depression might hinder children’s early development”. Quoting research conducted by the ALSPAC (Avon Longitudinal Study of Parents and Children) study team, the report stated that paternal depression during the postnatal period was related to adverse behavioural and emotional problems in children aged 3.5 years and an increased risk of conduct problems in boys (Ramchandani et al., 2005). The article also reported that the effect of depression in fathers has received little attention. However, a pilot study of new fathers living in London (Dave et al., 2005) found that 1 in 12 new fathers had depressed mood and there was an association between low mood and negative infant temperament. A separate study conducted with first time fathers in Sydney also found that the rate of anxiety or depression (diagnosed) in men 6 weeks after the birth of their child was 2-5% (Matthey et al., 2003). Given that this figure only included those men who had been diagnosed with anxiety or depression it seems likely that the actual number will be somewhat higher.

With regard to longer term effects, research into depressive symptoms across adolescence in young men living in high crime areas in the USA, has found that there was a significant
interaction between maternal and paternal depressive symptoms and depressive symptoms in early adolescence (Kim et al., 2003). Interestingly, maternal depressive symptoms were only related to the son’s depressive symptoms when the father’s depressive symptoms were also high, indicating the impact that a father's depression can have on children. As the Kim et al., (2003) study only included young men, it is not clear if the same effect would occur with young women. It is possible that boys and young men identify more with their father than their mother and therefore a father’s depression will have more of an impact on sons than daughters. It has been suggested that fathers may be able to shield children from the effects of the mother’s depression but that mothers are not able to do the same (Kim et al., 2003). Similarly, Fletcher, Matthey and Marley (2006) reported that non-depressed fathers can have a ‘buffering effect’ against the detrimental effects of maternal depression on the child demonstrating the importance of their role in such a situation.

It is important to consider how the situation of having both parents’ suffering from depression will affect the child. In terms of behaviour problems, Mezulis et al., (2004) found that paternal depression exacerbated the effects of maternal depression but only if the father was spending moderate to high amounts of time with their child. Downey and Coyne’s (1990) literature review found that parent’s depressed mood may induce negative affect throughout the family and reduce both parents and children’s coping abilities.

Depression within a family is also likely to disrupt the relationships between family members, with parental depression being associated with marital hostility (Low & Stocker, 2005). In turn, marital conflict and depression have also been found to have links with children’s internalising and externalising problems. In their study of adolescents, Brennan et al., (2002) found in a community sample of Australian families, that mothers’ depression was related to children’s internalising and externalising problems whereas fathers’ depression was only related to externalising problems. These findings highlight the impact both parent’s characteristics can have on child development and the different
ways depression can manifest itself among mothers and fathers which then affects their children in different ways.

Whether it is the mother, father or both parents who are experiencing depression, the literature reviewed suggests that there will be some effect on the children. Family Systems Theory (Klein & White, 1996) proposes that anything that affects one member of the family will also affect other members of the family. This may be in a direct or indirect way and means that all family members and their relationships will in some way be affected. This theory contributes to what has already been found about the effects of parental depression on children by providing a systemic explanation for the difficulties that can result within the whole family.

Mental health literacy (Jorm et al., 1997a) is defined as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (Jorm, 2000 pp.396). It has been suggested that if individuals have poor mental health literacy this may be related to inaccurate knowledge about causes of mental health problems. This may then influence individual beliefs about mental health problems and how they are best treated. If men’s mental health literacy is poor, this could contribute to beliefs that they are not susceptible to depression and also difficulty in recognising symptoms of depression. It would also suggest that men may not know the most effective ways of accessing help for such problems and as a result may implement self-help skills as a way of coping with difficulties.

Mahalik and Kivligham (1988) investigated the success of self-help treatments for depression based on individual differences within a sample of undergraduate psychology students. They found that those individuals who were realistic were most successful at self-help treatment. In addition, those who had low superiority, high self-efficacy and an internal locus of control were also related to success. It was hypothesised that those with an external locus of control might have had difficulty in administering their own help and support. Therefore, if men decide to implement self-help skills as a way of coping with
difficulties, it seems they are more likely to be successful at this if they have an internal locus of control.

1.6 The concept of depression in men

Men's conceptualisation of depression was investigated by Brownhill et al., (2005). They investigated men’s experiences of depression by conducting focus groups with male and female students and teachers in New South Wales to discuss the experience of 'being down in the dumps'. Their aim was to try and discriminate between the subjective experience of depression, the reporting of depressive symptoms and the meaning attached to experiencing depression, suggesting a discrepancy between what men feel and how they behave. The study found that men and women experience depression in similar ways in terms of symptoms, however, the way they respond to these symptoms are very different. Whereas women may appear low in mood and be tearful when feeling depressed, it seems that men may not necessarily act how they are feeling. The study by Brownhill et al., (2005) identified the following five behaviours employed by men as a response to their feelings of depression:

1) Avoiding ‘it’ (avoidant behaviour)
2) Numbing ‘it’ (self-medication)
3) Escaping ‘it’ (escape behaviour)
4) Hating me, hurting you (aggression towards self and others)
5) Stepping over the line (deliberate self-harm)

If men are expressing their feelings of depression through such behaviours then it is understandable that depression in men may often go undetected. The behaviours listed above are not ‘classic’ symptoms of depression and many are also socially sanctioned (Brownhill et al., 2005).
These findings reinforce the notion that many men may be suffering from symptoms of depression without receiving any support and this is likely to have an impact upon themselves and those around them. It is possible that men do not recognise the symptoms of depression in themselves, they are coping adequately with fatherhood, or they are struggling but for some reason, they do not recognise or want to acknowledge this as a problem. It is thought that due to social norms, men may be reluctant to admit to emotional difficulties and as a result, many go undiagnosed every year (Robbins, 2006). Beliefs about masculinity are also thought to play a part, suggesting that many men do not believe they are susceptible to depression so they feel it is unnecessary to learn about it (Canadian Health Network, 2004).

Although the Brownhill et al., (2005) study accessed men’s experience of depression, it was not specific to the experience of fatherhood and in particular, first time fatherhood. Indeed, there is still a gap in the research around the conceptualisation and recognition of symptoms of depression that can be experienced when becoming a father for the first time. This study aimed to discover more about the conceptualisation of depression related to becoming a father and to see if it differed to depression in the broader sense. For the purpose of this study, the terms ‘experiences’ ‘challenges’ and ‘difficulties’ are used instead of ‘depression’ in order to acknowledge that the group of symptoms commonly referred to as depression may not be considered to be depression in the context of first time fatherhood. In addition, it may be unhelpful to label such difficulties as ‘depression’ as it seems men’s response to depression is to try to suppress and avoid it; possibly including talking about it. The aim of the study was to facilitate discussion around difficult aspects of fatherhood that could happen to anyone.

It was also decided to use a vignette about a fictional first time father to form the basis of discussion. This was to provide a safe way of discussing the difficulties that can be associated with fatherhood but without having to disclose personal information. However, it was hoped that through using this method, men’s own experiences of fatherhood would still contribute to their views on the situation.
1.7 Objectives

The objectives of this study were to determine how first time fathers experience and conceptualise the difficulties that can be experienced as a part of fatherhood. It is hoped that this will contribute to understanding the difficulties faced by first time fathers and also the barriers which stop them from asking for help. If we can discover more about how men think about fatherhood and the associated difficulties, this will hopefully help to make services more accessible and ‘father friendly’. Currently the sorts of services available to first time parents include private antenatal and postnatal courses which are available from local National Childcare Trusts. These include a number of courses which are specified as ‘women only’ although there are also courses which the father can attend (National Childcare Trust). In addition there are courses run in the evening and on weekends. However, course prices range from £89 - £339 which some parents may not be able to afford (National Childcare Trust). Antenatal classes are also provided free of charge by the NHS and fathers or any other birthing partners are welcome to attend (NHS Direct). When these classes are held will be dependent on individual NHS trusts and if they are held during work hours, it will be more difficult for fathers to attend.

At the moment, it seems that depression is something of a hidden phenomenon, and it appears that this may be the result of men reacting to symptoms of depression in different ways to women. By uncovering more information about men’s experience of difficulties such as depression, hopefully this can lead to increased recognition of men who are struggling by their partners, friends, families and health professionals. It may also then be possible to identify ways in which these services can change and adapt to include the father who is emerging as a significant, important and influential member of the family.

1.8 Research Questions

Identity Theory and Social Role Theory propose that men indentify with and fulfil a certain role as fathers. Their expectations of the role and the way they behave in response
to the role can be seen to contribute to their experience of fatherhood; in particular their experience of difficulties in fatherhood. The study by Brownhill et al., (2005) highlighted the ways in which men conceptualise difficulties such as depression. However, no such study has focused on how men conceptualise difficulties specific to being a first time father. Drawing on these theoretical suggestions and the research findings, the first research question of the current study is:

1) How do men experience and conceptualise the difficulties associated with first time fatherhood?

The concept of mental health literacy (Jorm et al., 1997a) raises questions about how much individuals know about mental health problems. It is hypothesised that men’s mental health literacy may be quite poor and therefore, they may resort to self-help in order to deal with difficulties. In order to address this hypothesis, this study asks the question:

2) How do men cope with difficulties experienced in fatherhood?

The work of Robbins (2006) suggests that due to social norms, men may be reluctant to admit to emotional difficulties. This coupled with the research conducted by the Canadian Health Network (2004) suggests that beliefs about masculinity may also play a part. However, these studies did not actually ask what stops men from seeking support and they were not studying first time fathers. Therefore, the final research question is:

3) What affects men’s decisions to seek support for such difficulties?
2. Method

The initial aim of the current study was to investigate first time fathers’ experiences of depression. However, my attempts to recruit fathers who were experiencing symptoms of depression received very limited success. The methods of recruitment tried initially in this study included contacting local National Childcare Trusts (NCT) and advertising the study in their newsletters which were delivered to all of their members. In addition, it was advertised on some local NCT websites. Adverts were also placed upon the Netmums website. In hindsight, many of these methods relied upon the mother passing on information to her partner and this has been found to be an ineffective method of recruitment (Sherr et al., 2006).

When reflecting upon why recruitment was so difficult, questions arose around men’s conceptualisation and recognition of depression. If men do not recognise the symptoms of depression in themselves either they are coping adequately with fatherhood, or they are struggling but for some reason, they do not recognise or want to acknowledge this as a problem. Therefore, the aim of the current study was to gain an insight into how men conceptualise and experience difficulties associated with becoming a father for the first time.

2.1 Design

The current study is a cross-sectional survey employing qualitative research methods. A qualitative research methodology was employed to address the aims and research questions of the study. Qualitative research is used with verbal rather than numerical data and has the advantage of being able to explore individual human experience rather than establish generalities across people (Lyons, 2000).
In order to answer the research questions in the most effective way, the method of data collection must allow the participants to discuss the three topics that the questions cover. This would not be possible with a quantitative approach as the answers are not likely to fit into predetermined categories. The aim of this study was not to classify participants as depressed or to assign any kind of label to the experience that they or other fathers have had. Given that previous research into depression in men (Brownhill et al., 2005) has suggested that their expression of their symptoms and feelings differs to those reported by diagnostic criteria such as DSM-IV, it seems that qualitative methods offer a wider scope to really identify how these men feel about such issues.

As this study is concerned with father’s views and opinions, an approach was required which would enable the research to follow certain lines of enquiry but also allow the participants freedom in their response. For this reason semi-structured interviews were employed. Following an extensive literature search, a number of topics were raised that would be of interest to pursue further. The semi-structured interview meant that these could be incorporated into the interview schedule while still being able to discuss any other topics that emerged.

A vignette was created to tell the story of a first time father experiencing extreme difficulties since the birth of his child (see appendix A). Vignettes can be used as a method of eliciting individuals’ perceptions and beliefs about stories which describe a certain situation. Their purposes include: interpretation of actions and occurrences that allows situational context to be explored and influential variables to be elucidated; clarification of individual judgements, often in relation to moral dilemmas, and discussion of sensitive experiences in comparison with the ‘normality’ of the vignette (Barter & Renold, 1999). Of particular relevance to this study is enabling the participants to be able to discuss a sensitive experience safely, without having to disclose their own experiences. Commenting on a story about someone else may be less threatening and therefore the vignettes can be a useful way to discuss an otherwise sensitive topic. They also give the
participants the opportunity to determine if they want to introduce their own experiences to the discussion in order to expand on their responses (Barter & Renold, 1999).

It is important that the vignette appears to be believable and real to participants (Neff 1979). In order to fulfil this requirement, the vignette used in this study was based upon real fathers’ experiences of depression after the birth of a child. A number of personal accounts can be found on the internet and based on these a fictional vignette was created. Feedback on the vignette was obtained during the interview when participants were asked about their responses to the vignette. Most responses were positive with the only negative response being that the vignette was quite long.

This vignette formed the basis of discussion during the interviews and an interview schedule was devised to elicit the fathers’ views on a number of specific topics. The broad subject areas in the interview schedule included:

1) **What it was like for them reading about John’s (the father in the vignette) experience.** This was to elicit how they felt reading about someone in distress, whether it brought back memories of their own experience and if they could relate to what they had read. Previous research has suggested avoidance is a common reaction of men to depression (Brownhill et al., 2005) so it was considered useful to ask how they felt when presented with a detailed description of a father suffering from depressive symptoms. The topic expanded to cover their opinion on what John has found difficult about being a father. This was hoped to give an insight into the actual aspects of fatherhood that men find difficult as oppose to what we expect they will find difficult.

2) **Their ideas about why John was having that particular experience of fatherhood.** This aimed to uncover their ideas about where they felt John’s difficulties originated, their ideas around responsibility and control of his problems, and what might be making things better or worse for him. It was hoped that this might give
an insight into the way men conceptualise personal difficulties and whether their locus of control is internal or external.

3) *What they thought about the way John was feeling.* This was to determine their level of understanding of what John was going through, their feelings of empathy for his situation and to get some idea of how men react to other men who are struggling with personal problems. This question was also expanded to ask if they thought many new dads would experience similar feelings to John. This was hoped to give an insight into how common feelings of depression may be after the birth of a child, even if the men do not admit to any difficulties themselves.

4) *How they thought John’s wife would react if she knew how she was feeling?* This question was designed to elicit potential barriers to men speaking about their feelings. In the vignette John has not told his wife how he feels and it was of interest to discover if the participants felt that was appropriate or not. The question was expanded to ask about reactions of extended family and friends. It was hoped this would give an insight into how the men felt fathers are viewed by those around them.

5) *How they thought John’s experience was affecting his life?* It was hoped that through asking this question, information could be obtained about how men react to difficult and stressful situations; this could then help in identifying men who may be struggling. The question was expanded to ask about any people they thought would be affected by how John was feeling. This aimed to uncover how much the participants knew about the impact a father’s behaviour can have on those around him.

6) *What they thought John should do about his situation.* This was asked to discover what the participants thought about dealing with symptoms of depression. Prompt questions included what they thought might stop John from doing what they
thought he should. This aimed to try and identify barriers which may stop men from asking for help when they are experiencing difficulties. As well as asking what they thought John should do, the participants were also asked what they thought John would do in order to highlight any discrepancy between the two.

7) *What they thought might happen to John.* It was considered important to try and discover what men thought the longer term consequences might be of the way John was feeling. Prompts included asking about his relationships and work life and what might help facilitate or prevent such things from happening. In order to think about the best way to encourage men to receive help for their difficulties, it is important to understand what they view as negative consequences.

A complete copy of the interview schedule can be found in appendix B.

2.2 Recruitment and Sample

Recruitment methods included contacting volunteers from local NCT groups who informed their members about the study, advertising on a national website for parents ([www.netmums.co.uk](http://www.netmums.co.uk)) and word of mouth. By word of mouth, emails were circulated to postgraduate students at two UK universities to ask them to consider any fathers they knew who would be willing to take part. To be eligible for this study the participants had to be first time fathers, their baby had to be a minimum of 3 months old at the time of interview and a maximum of 12 months old, in order for the findings to be comparable to previous research (Areias *et al*., 1996a; Goodman, 2003). In addition, the study was aiming to answer questions specifically around first time fatherhood and after 12 months, the experience of being a father is more familiar. Conversely, when a baby is less than 3 months old, some men may be on paternity leave or there may still be lots of visitors helping, therefore the stresses and strains of everyday life may not have resumed.
Twelve fathers were identified as possible participants. However, four were excluded as they did not meet the inclusion criteria. The remaining eight fathers were recruited through word of mouth. Demographic data was obtained and is displayed in Table 1 (in order to preserve anonymity, all names used in the study are fictitious). This included relationship status, nationality and occupation. Relationship status was included as not only would a relationship be a source of support to fathers but if the father is living with the mother of their child, time spent with their child will be greater than if they were living apart. Nationality was included due to varying beliefs in different cultures about family, relationships, children and fatherhood. Finally, occupation was included due to the influence it may have on levels of knowledge around pregnancy, childbirth and parenting.

Table 1. Demographic Data

<table>
<thead>
<tr>
<th>Participant</th>
<th>Relationship Status</th>
<th>Nationality</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dave</td>
<td>Married</td>
<td>British</td>
<td>Psychologist</td>
</tr>
<tr>
<td>Graham</td>
<td>Co-habiting</td>
<td>German</td>
<td>Graphic Designer</td>
</tr>
<tr>
<td>Henry</td>
<td>Married</td>
<td>Spanish</td>
<td>Psychologist</td>
</tr>
<tr>
<td>Nick</td>
<td>Married</td>
<td>British</td>
<td>Journalist</td>
</tr>
<tr>
<td>Gareth</td>
<td>Married</td>
<td>British</td>
<td>Chartered Surveyor</td>
</tr>
<tr>
<td>Richard</td>
<td>Not available</td>
<td>Not available</td>
<td>Doctor</td>
</tr>
<tr>
<td>Tony</td>
<td>Co-habiting</td>
<td>British</td>
<td>Windscreen fitter</td>
</tr>
<tr>
<td>Ian</td>
<td>Married</td>
<td>British</td>
<td>Works in IT</td>
</tr>
</tbody>
</table>
2.3 Ethics

Ethical approval for the study to be conducted was provided by the University of Surrey’s School of Human Sciences Ethical Committee (appendix C). Fathers that agreed to participate were assured that all information they gave during the interviews would be confidential. They remained anonymous in the research and were identifiable only by participant number or pseudonym. The participants had the option to terminate the interview at any time if they wished, without explanation or repercussion.

2.4 Materials

Materials required to conduct the study included information sheets, interview schedules, consent forms, vignettes, debrief forms, telephone and telephone recorder. In order to analyse the results a coding framework was also developed.

2.5 Procedure

Seven interviews were conducted over the telephone and one interview took part in the participant’s home. Telephone interviews were utilised due to the geographical location of the participants. All of the participants were busy working fathers and by conducting the interview over the phone they could choose a time convenient to them without having to worry about travelling to the interview or finding a suitable place in their own home. All of the interviews were conducted with the participants being in their home as being in a familiar environment is thought to be effective in facilitating discussion (Leininger, 1995).

Participants were subject to an initial telephone screening to ensure they met the inclusion criteria. They were then given an information sheet (via email) (appendix D) which detailed the exact nature of the study. Written consent was obtained by sending the consent form to the participants along with a stamped addressed envelope for them to
return it (appendix E). Once the consent forms had been received, the interviews were arranged.

At the start of the interview, demographic information was obtained. Participants were asked if they had read the vignette and reminded that they could refer to it during the interview. The interview was then conducted in accordance with the schedule and lasted between 20 minutes and 1 hour. At the end of the interview there was a verbal debrief and participants also received a written debrief (via email) with a list of organisations that could be contacted for further support should it be required. Interviews were then transcribed and subject to thematic network analysis.

2.6 Data Analysis

The method utilised for data analysis was thematic network analysis (Attride-Stirling, 2001). This method is used to conduct thematic analysis of textual data while providing illustrations (networks) to summarise the main themes emergent from the text (Attride-Stirling, 2001).

Thematic analysis is a flexible approach which is independent of theory and epistemology (Braun & Clarke, 2006). Qualitative approaches such as conversation analysis and interpretative phenomenological analysis (IPA) often stem from a certain theoretical position and this means that there is little variation in how to use such methods. For example, if this study was only concerned with men’s experiences of the difficulties of fatherhood, IPA would have been an appropriate method to employ. However, given that I decided to use a vignette to form the basis of discussion, IPA is no longer suitable.

There are a number of similarities between Thematic Analysis and other techniques such as Grounded Theory (Corbin & Strauss, 1990; Glaser & Strauss, 1967) in terms of the principles and basic steps of the techniques. However, a requirement of grounded theory is that the analysis continues until saturation is reached and then a new theory or model is put forward on the basis of the data analysis. For the current study, the sample was
difficult to recruit and as a result the sample size has remained small (n=8). Although thematic analysis does enable detailed exploration of a particular area, it does not have the requirement of saturation. The thematic networks themselves still provide a model of the data; however, with a smaller sample size the model is perhaps more of an initial model than a definitive one.

Thematic analysis can be employed as a realist method which is used to focus on the experiences and meanings of participants, or it can also be employed as a constructionist method examining the way events, experiences and the meanings placed on them are the effect of dominant discourse present in society (Braun & Clarke, 2006). The current study aimed to focus on both experiences and meanings of fatherhood as well as considering the effects of discourses in society. Therefore the thematic analysis conducted in this study was a ‘contextualist’ method lying somewhere between essentialism and constructionism (Braun & Clarke, 2006).

The particular method of thematic analysis used was based upon that outlined by Attride-Stirling, (2004). Once data had been collected and interviews were transcribed the first step was to become familiar with the data by reading and re-reading the transcripts (an example transcript is included in appendix F). The next step was to develop a coding framework in order to begin reducing the data. This involved creating codes which were based on subjects / theories from the interview questions as well as any relevant themes which emerged throughout the interviews independently. These codes were then applied to the data to group relevant pieces of information whether these were single words, paragraphs or sentences (see appendix G). These sections of data are those that were deemed worthy of further investigation and analysis. In order to validate the coding framework, discussions regarding the framework and its application were held with a Trainee Clinical Psychologist from the University of Holloway. This was to ensure that the coding framework was accurate and that resultant themes drawn from the data were appropriate and valid.
With manageable sections of data, the next step was to re-read them again, in the context of the code they had been assigned to. This was to look for any underlying patterns or structures which helped identify common or important themes that had emerged. These themes then needed to be re-read and subject to further analysis in order to reduce and refine the themes. The resulting themes needed to be specific enough to be discrete and broad enough to cover a range of ideas contained in numerous pieces of text (Attride-Stirling, 2001).

Once the themes had been refined they needed to be arranged to form similar groupings with other themes they were consistent with. This was the first step of constructing the thematic network. The groupings were based largely on commonalities in content. These groupings went on to become known as the Global Themes and within each Global Theme there were Basic Themes and Organizing Themes. As a rule, it is recommended that within each network more than 15 themes may be too many and less than 4 may not do justice to the data (Attride-Stirling, 2001). The Basic Themes are those themes that were taken from the text and used to form the Global Theme whereas Organizing themes were clusters of basic themes which were based on shared topics. In light of the Basic Themes and the Organizing themes, the Global Themes were then given a name which constituted the claim or proposition of the Organizing themes (Attride-Stirling, 2001). Once all of these steps were completed the networks were drawn out as (non-hierarchical) illustrations and re-read and refined again to ensure that they represented the data to the best of their ability.

With the thematic networks constructed, the next stage of analysis was carried out. This involved firstly describing the network and then exploring its meanings. This enabled both the contents and the meanings to be summarised into text and also to provide interpretations of the patterns in relation to the aims of the current study.
3. Results

Three thematic networks were constructed from the interview data and each will be discussed in turn with reference to the original research questions.

3.1 Global Theme: ‘The experience of difficulties in fatherhood’.

This constitutes one thematic network consisting of five organising themes and twelve basic themes (see Figure 1). The network represents discussions that the men had around both John’s problems and those they had encountered themselves since becoming a father. Initial discussions were around difficulties encountered during the birth and this led on to the men validating John’s experience. The theme of uncertainty was continuous throughout discussions and had an added element of hard work. It also seemed important to the men that even though fathers may experience difficulties, they do need to remember those people around them. The network represents how the men identified with John’s difficult situation and their ideas as to where these difficulties may come from. This network seems to confirm that fathers do actually experience difficulties when having their first child.

3.1.1 Organising theme: The Birth Process

This organising theme related to both John’s experience of child birth and also the men’s own experiences. It emerged that the men felt that the birth was a major factor in how you experience fatherhood and a number of the men felt that the traumatic birth John witnessed was a factor influencing his current situation:

Dave: “certainly from his experience of the c-section, maybe that was a very disempowering experience for him”
Figure 1. Thematic network for 'The experience of difficulties in fatherhood'
Dave: "(About the c-section) he’s fairly needed in that situation, he felt a bit isolated that he couldn’t help her”

Nick: “It sounds like the birth was uh, traumatic”

The birth was also something which most of the men shared their experiences of and a number of them felt that the birth was something of a difficult experience:

Dave: “You feel a bit isolated”

Graham: “It was fairly similar with Lucy, she didn’t have a caesarean section but labour was still sort of like 18, 20 hours”

“You know you always sort of like think in worst case scenario and then it’s actually much harder than you can possibly imagine”

Tony: “I’d have to say that the labour wasn’t the same (as John’s) but the delivery that I had was traumatic”

Ian: “You’re not normally in with somebody if they’re having an operation and to see Alice go through that and to see, I mean, the sort of, she just looked out of it and there were stages I was worried that she was going to be ok and um, how our perfect little family wasn’t necessarily you know, wasn’t going to be that way”

“Whether you’re father or mother you’re quite excited about the situation but of course when you go through an awful experience of delivery then it will really change your views”
It seems that a number of the men felt surprised at the amount of time that labour can take and they felt somewhat isolated and helpless throughout the process. This raises questions about men’s knowledge and preparation for child birth as it is possible that their expectations about what is going to happen may not be completely realistic. According to this discussion, men may experience child birth more positively if they feel more involved by hospital staff and if they have realistic expectations of the process. However, a number of parents will experience traumatic labours that cannot be prepared for and as this discussion highlights both the mother and father will be affected by their experience.

3.1.2 Organising theme: Validating John’s Experience

Some of the men provided validation for John’s experience, feeling like they were able to relate to, or understand how he was feeling:

Dave: “The first bit I can relate to a little bit about the um, if you like the labour”
“Most things I can understand and relate to”

Graham: “The vignette reminded me of that feeling of helplessness”
“So yeah, it made me remember all of these things and I can actually relate to what happened”

Ian: “I suppose there’s some things that you can sort of pick up that are eh, quite sort of similar to experiences of your own”

This gave some validation not only to John’s experience to but to the validity of the vignette in general. It is important to remember that the men being interviewed did not identify to having difficulties with fatherhood yet during the interviews most could relate to some difficult aspects that John had experienced. This might suggest that some of these difficult experiences are seen simply as a part of normal fatherhood.
However, there did appear to be a point where the men distance their own experience from Johns and at this point emotional reactions were common, with feelings such as sadness and sympathy being expressed:

Nick: “Eh yeah, I felt quite sad for him”

“(The vignette was) quite, quite, depressing really”

Richard: “your sort of feel sorry for him really”

As part of the interview schedule, the men were asked if they thought many new fathers had similar experiences to John. This was important in order to get a male perspective on the frequency of such difficulties; this may differ to research studies which might have different diagnostic criteria for judging whether someone is experiencing difficulties or not. The responses to this question were consistent with nearly all of the men interviewed responding that they thought it would affect other new fathers:

Dave: “I wouldn’t say it’s rare but I wouldn’t say it’s frequent”

Graham: “It reminded me very much of a friend”

“This is probably quite normal. You know I know that it does happen”

Henry: “and I don’t think it’s kind of a, rare experience”

Nick: “Um yeah, yeah quite possibly because it is, it is literally an upheaval”

Gareth: “Yeah, I mean I know people that have you know, said similar things to me”
Richard: "I would imagine it's common to a lot of people"
"I would say there are a number of people who get affected, yes"

Tony: "I could see there being quite a few, yeah"

Ian: "Yes, I think there probably would be"

The responses of the men demonstrate that John’s experience is one that does not surprise them and nearly all of them could imagine a similar situation happening to other new fathers. This gives an indication of how difficult fatherhood can be at times and suggests there may be many new fathers who experience significant difficulties. This is an interesting finding as although there is now more research into the difficulties that fathers may experience, there does not seem to be wide recognition of such difficulties in day to day life. This raises questions about whether men keep such difficulties to themselves and whether men have always experienced difficulties. It is possible that no one has really asked men what they find easy or difficult about fatherhood as the focus is still largely on the mother and the baby.

3.1.3 Organising theme: Unpredictability

Related to John’s experience and the men’s individual experiences was uncertainty and unpredictability about how people would react to men experiencing such difficulties. This may be related to why although the men think John’s experience is common amongst first time fathers, it is not commonly discussed in society. Specifically, the men thought that John’s family should understand his situation although the word ‘should’ implies a degree of uncertainty. Linked to this was the theme that people are unpredictable; the men felt that you could guess how some people would react but their reactions could be dependent on a number of different factors:
Dave: "(About wife) I would like to think she’d be surprised"

Henry: "I’m sure his partner would be understanding"

Nick: "that’s a difficult one, it depends on the relationship"

Gareth: "I would imagine some of them (family) would probably not relate or understand what’s actually going on"

Tony: "I think they’d sympathise with him"

Ian: "I think they’d want to support him, definitely (his friends)"

"I guess in some circumstances people aren’t as helpful as others”.

The men seemed to be quite positive about there being someone in John’s friends or family that would understand or support him. It is important to note here that all of the men interviewed were in stable relationships and this may well have affected their views about support from partners. However, the element of uncertainty or unpredictability about people’s reactions remains and it is likely that this would have an impact on whether they decide to share their problems with other people or not.

The theme of unpredictability also extended to unpredictability in other aspects of fatherhood and linked with hard work this comprised the next organising theme.
3.1.4 Organising theme: Hard work and unpredictability

Unpredictability in this theme was related much more broadly to fatherhood as a whole. It emerged that the men felt that fatherhood was a constantly changing process and one that required work:

Graham: “You also have to put in the time you know, and start sort of like building a bond”

“It’s not all easy sailing and you know I have my hard moments”

Henry: “you know, if you haven’t done it before, you always have this fear of harming, hurting the baby or, but you can do this gradually which is what I have done for example, helping your partner get everything or carrying out a supportive role and gradually you take more”

It seemed that the men also felt that there was only so much you could do to prepare for becoming a father. In some respects this was seen as unavoidable whereas in other ways, it seemed as though more could have been done.

Dave: “I was rather arrogant in thinking that my child development training in psychology and experience would get me through but it really doesn’t”

Graham: “Nobody really prepares you for like once you’ve come out of hospital”

Nick: “you can only really prepare so much; it’s only after really that you can find out”

Gareth: “(I) thought wait for the arrival and see how you’re going to feel, what’s going to happen and all of that but no particular advice”
Only one man described actively preparing for becoming a father:

Henry: “I wasn’t very sure about paternity really, for many reasons. I said that I would have psychotherapy before I have the baby, so I started to have psychotherapy and I think it was quite helpful”

The majority of men did not do any real preparation for becoming a father. There seemed to be a belief that there is a limited amount you can do to prepare. It is useful to remember here that all of the fathers interviewed returned to work after their paternity leave while their partners stayed at home with their child. It is possible that if the men were to stay at home while the mother went back to work, they would have felt the need to do more preparation. There is also mention that ‘no one really prepares you for when you come out of hospital’ and this seems to indicate that it is someone else’s responsibility. This would seem to indicate that in terms of preparation, men are not likely to carry this out on their own without any input from others.

Henry, who decided it would be useful to have psychotherapy before having the baby, was an exception in terms of preparation. It is worthy to note that Henry works as a psychologist so it would be reasonable to assume that he is more aware of the types of personal support that are available. It is also likely that talking about problems or difficulties would be more common and acceptable to him than perhaps for the others.

Most men described not having many expectations and did not seem to have a clear idea of what being a father would be like. This was in contrast to their view of John who most felt had very clear expectations about fatherhood. It seemed that most of the men felt that this contributed to some of the problems John was experiencing:

Dave: “I knew what to expect, a little bit”
"He (John) seems to have very clear expectations of what a father is. Sometimes it's an anti-climax if you think 'oh everything's going to change'."

Graham: "I mean you don’t really know what to expect"

Gareth: "We were quite open minded about it (becoming parents)"

Ian: "you know certainly looking at um, you know expecting it, he’s talking about it’s not exactly how he expected"

Another area of unpredictability and hard work was related to identity, male roles and how roles of fathers are influenced by social stereotypes. The two seemed to be very intertwined and a number of the men talked about how becoming a father may or may not change identity and how they manage to juggle what society expects of men and fathers and how they really feel:

Dave: "I think he’s (John) finding it very difficult, both to identify to his new role, he believes his role should be supporting his wife"

"I think you, I think there’s a clichéd or a socially um, I don’t know, between blokes"

Henry: "you might show that you are weak or you are confused or not sure and it’s kind of difficult to fit with the idea of a man when you think of the male as a confident, strong individual, the paradox of being weak and having to pretend that you are strong”

"I think people can, other men try to be manly"
Gareth: “it’s a man’s thing to provide for his family”

“men don’t like talking about their feelings do they?”

Richard: “she (John’s wife) might be viewing it that because he is a man he is probably coping very well”

“It’s this kind of oh, expectations of stigma of not being able to cope and being a man kind of situation”

Tony: “I expect they’re probably like most men and would keep it to themselves”

Ian: “men can sometimes be scared of showing emotion”

Through these conversations, it seemed as though there was a common view of a ‘man’ and a shared understanding of what this entailed. The prevailing thoughts were that men were viewed by others as being able to cope in difficult situations, having a duty to support their family and not being able, or not wanting to talk about their emotions. However, this does contrast with the fact that the majority of the men in this study did admit to having difficulties.

3.1.5 Organising theme: Remembering those around you

The organising theme of remembering those around you was very much grounded in John’s experience. The men talked a lot about how John appeared to think about his own situation very much but seemed to neglect how his family may be feeling. This led to hypotheses that he had become isolated from his family and spent much of his time thinking about himself and judging himself negatively:

Dave: “It’s that self-judgement”
“That self-doubt about like what he should be doing”

“So it doesn’t seem to be, if you like a shared approach to the situation”

Graham: “I had the impression he was thinking, there were things, he felt a little bit left out”

“comes across as, as, feeling a little bit sorry for himself”

Henry: “He’s uh, very isolated and he, he doesn’t want to share his feelings you know”

Gareth: “perhaps he’s decided he’s not um, he’s not really being a good dad or um, isn’t supporting his wife”

Tony: “I’d probably say that he’d be quite upset and angry with himself”

Ian: “It’s all me, what about me, what about this, I didn’t feel like this, I haven’t got this, I’ve got to go to work, why you know, I’m worried about the section, I’m pleased it’s all over and it’s I, I, I, I”

“He’s maybe um, not thinking so much about his wife and the baby”

3.2 Global Theme: Ways of coping with difficulties

Whereas the first global theme confirmed that men do experience difficulties in fatherhood, the second global theme was concerned with how men cope with these difficulties. This theme although borne out of discussing John’s experiences, also drew
upon the men's own experience and what helps them in times of difficulty. The network consists of four organising themes and eight basic themes (see Figure 2).

Figure 2. Thematic network for ‘Ways of coping with difficulties’
3.2.1 Organising theme: Getting involved

This theme represented how much the men felt that taking part in looking after the baby was important. It seemed that this may almost be a preventative measure, to avoid becoming isolated and feeling left out of the process. It was recognised that this does require effort on the father’s part and also takes time but nevertheless it was felt that this was worth it:

Dave:    “even with breastfeeding you can get involved”

Graham:  “You have to invest time and effort into it you know, and you know you have to try and enjoy that time with your child”

Henry:   “helping your partner to get everything or carrying out a supportive role”
          “he (John) needs to actually behave differently to get close to the baby and spend time with the baby”

Nick:     “I think it is really important to get hands on”

Richard: “perhaps tell him (John) to take maybe a few days off and spend time with his wife”

Tony:     “try and spend a lot of time with his partner and his child as possible”

Ian:      “I think it’s a really good thing really for all men really to have enough time to be able to spend, I think the more time you spend with your family the better”
Being involved with the care of the baby was something that the men did not feel that John was part of. It seems that they felt it was his responsibility to get involved with this in order to feel less isolated and left out.

3.2.2 Organising theme: Looking to others

Another way of coping with difficulties that the men identified was looking to other people and this took two forms. Firstly there was a need to communicate to other people and a realisation that other people do not know how someone is feeling unless they are told. It seemed that the men felt that John would have benefited from being more open with those around him and letting people know that he was struggling or feeling left out:

Dave: "Certainly try and express his (John) feelings"

"He (John) should speak to somebody"

Henry: "I'm sure he (John) will feel much better if he could speak to people"

Nick: "He (John) can't talk to her (his wife) which would help"

"Speak to your wife or partner because that relationship's key really"

Gareth: "I think he needs to talk to his wife"

Tony: "to go and talk to someone (recommendation for John)"

Ian: "it would be better you know, to get it off his chest"
Again it seems that the men felt it was John’s responsibility to do something about his situation and this may reflect that the men have a more internal locus of control when dealing with their problems.

The second aspect of looking to other people involved having people around you in similar situation who you could look to for advice, support or even just to observe how they were coping. A number of the men talked about people that they knew in similar situations who had given advice to them. For others they had observed people in a similar role or for some, they drew on experiences they had themselves with other children in order to adjust to becoming a father:

Dave: “I had quite good models, you know like a lot of my close friends have had children as well”

“(I’ve) watched them grow up so I’ve kind of like had some modelling going on for me”

Graham: “I’m quite used to sort of being around kids, looking after them. I’ve got a sister who was sort of like nine years younger than me so. I used to look after her quite a lot and um, looking after my daughter now reminds me little bit actually of looking after my sister. Obviously I’ve got more responsibilities and that”

“what I will say is that if you, I think if you speak to somebody who has a kid as well, you know if you’re in the same position um, I think you get a new perspective”

Henry: “So you know, this is uh, happening now (male role models in the media) men are starting to have alternatives and I’m now thinking about Friends, and the role of Ross. Ross uh, he is kind of competitive, intellectual guy
but at the same time he’s got this son with his ex-wife and he is caring and interested and you know, we are seeing now more and more these new roles”

For one man, it was important to look to his own father to learn what he did not want to be like as a father:

Ian: “I spent probably the last, you know from 14 upwards without a father, not through anything like he passed away or that but more just that he wasn’t there and was always off you know, somewhere else and from that perspective I think that you would have, I had a determination and a grit that I wanted to make sure that I wasn’t going to do what he did”

It is interesting to note that only two men spoke about their own fathers during the interviews and both of these were in the context of their fathers not being involved. It seems that when men have experienced a lack of involvement with their own father, they recall these experiences when they have their own child. It also seems to lead to a determination to do things differently. Among the other fathers, it was more common for them to mention friends or people in the media as role models. However, as their fathers were not discussed, it is unclear why this is the case.

3.2.3 Organising theme: Responsibility

Responsibility was discussed throughout the interviews in a number of different ways. Related to coping with difficulties, the men thought that they and John had a responsibility to keep their child safe. Drawn out from John’s thoughts of harm towards his baby, a theme emerged that blame, harm and neglect should be avoided. The men pointed out that even if John did not harm his baby, harm could be caused by blaming either his son or his wife. In addition, if his feelings towards his son remained negative, there was a danger that he could end up neglecting him which again would result in harm:
Dave: “what he shouldn’t do I suppose is not to blame his partner or his son for actually hating him, but it’s not actually anything to do with them”

Henry: “perhaps the area I mentioned about the violence or to be inappropriate to his wife or exploding sometimes that could be a dodgy part. He also mentions something about harming the baby. You know, obviously I don’t think he would but that might lead to occasionally neglecting”

Nick: “I guess the worst case scenario would be, he alluded to, uh, feelings of wanting to harm his son or himself”

Tony: “Well he shouldn’t, he shouldn’t have his thoughts of harming himself or the child”

It also emerged that John had a responsibility to communicate with those around him and make time for them. It seemed that the men felt John had not been doing this so far and their experiences had taught them that this was a beneficial part of the process:

Dave: “One is you identify the problem, and then the second one is that you take responsibility for it, not necessarily that you take responsibility for it but you give that responsibility to someone else who you actually share with them the crisis”

“I don’t know, maybe in a way he could speak to his GP, he should speak to somebody”

Henry: “I’m sure he (John) will feel much better if he could speak to people”

Nick: “Speak to your wife or partner because that relationship’s key really”
Gareth: “I think he needs to talk to his wife”

Richard: “what he needs to do really is communicate”

Tony: “to go and talk to someone (recommendation)”

Ian: “it would be better you know, to get it off his chest”

3.2.4 Organising theme: Recognition

The final theme related to coping with difficulties was to do with recognising what needs to be done and when. It seemed that there were various responses that may be appropriate to different situations but the key to successfully coping was recognising that something needed to be done. The actions identified seemed to reflect different levels of seriousness of the difficulty. In more serious cases it was felt that there may be a point when a father needs to recognise that he needs professional help. However, for more day to day difficulties it seemed that it may be more beneficial to realise that sometimes you might just have to get on with things. It was also mentioned that it would be beneficial if health professionals could recognise when there is a problem:

Dave: “I suppose the biggest thing as a Dad would be to recognise there is an issue and try and resolve it in some way so talking to someone, be that a friend, partner”

Graham: “You know, get on with it, stop, stop moaning about what the situation is and try and make the best out of it”

Nick: “It might be quite good if he knew he could speak to a psychotherapist”
Richard: “I think the more people like him come out and discuss their situation more in the public domain, the more people can recognise that this is actually a problem that other people are going through”

“I think you know, various individual GP’s but all sorts of medical allied professionals if they are aware of these kind of situations therefore that will make a big difference as they will recognise there is a problem and the more it is put out there and the more that people obviously acknowledge that there is a problem they can deal with it”

Ian: “I think he should go and see his doctor”

3.3 Global Theme: Seeking support

It was an aim of the interviews to identify what things affect whether men seek support when they have difficulties and the topic emerged as a global theme being discussed throughout all of the interviews. This network consisted of four organising themes and nine basic themes (see Figure 3).

3.3.1 Organising theme: Recognising father’s needs

There was some discussion around the difficulty in recognising father’s needs. The men expressed that they sometimes had difficulty in dealing with their problems and in particular talking about them. This was not true for all of the men but for those who were able to talk, there was still mention of the notion that ‘men don’t like to talk’:

Dave: “there are very, very strong feelings and it takes guts to open up to anyone um, about those”
Figure 3. Thematic network for ‘Seeking support’
Henry: “Men don’t have time for that kind of thing”

“I think men try to cope with their problems more, not talking too much”

Nick: “I’m just thinking if that happened to me, some people um, I’d feel uncomfortable talking about really quite emotional things with”

Gareth: “Men don’t like talking about their feelings do they? I think that’s just a general male thing”

“I wouldn’t have gone to anyone anyway (in John’s situation)”

Tony: “I expect they’re (other new dads) probably like most men and would keep it to themselves”

Ian: “men can sometimes be scared of showing emotion”

The other aspect of recognising father’s needs was more linked to external difficulties. It was felt by all of the men that there is more support for mothers than for fathers. This may well be true but it was interesting to hear that men actually noticed this lack of support and had their own opinions about this:

Dave: “I think there’s kind of like within NCT’s there’s a group for women. I don’t know I suppose there’s men that join it but I don’t know”

Graham: “You know it’s one of those rare occasions of sexism towards men”

“Do you know men, they haven’t been given really the role or opportunity to do that (be there 24/7) because you know a mother gets six months maternity leave whereas men get one week”
Nick: “There’s plenty out there for women (support)”

“I would like to see something, just to sort of recognise the fact that it’s not just, it’s not just women who, who go through, the father’s role is really important as well, because the father is key in supporting his wife, or partner as well as the baby”

“I don’t think there was any kind of father specific advice”

Gareth: “The focus is all on the mother isn’t it?”

“The father is left to get on with it a little bit I think”

Richard: “Obviously for women there’s quite a good, uh, network that’s set up because obviously it’s recognised that women sometimes go through like you know, postnatal depression”

“I think for Dads’ they, there’s very little. I mean is there, I mean obviously you have to sort of do, sort of leg work to find it”

Tony: “I’m going to say there could be more because I know nothing. Nothing about any support for first time Dads”

Ian: “for men, we’ve got two weeks (paternity) and two weeks is nothing, you go on holiday for a fortnight you know”
3.3.2 Organising theme: Being a man

Also linked to barriers to seeking support was the notion of being a man and what that entails. It was very common throughout the interviews to hear talk of ‘being a man’ and each man seemed to have a set idea or assume that society held a set idea of what being a man was. One element of this theme was identifying that men need to rely on their friends and family which is perhaps in contrast to the idea that men do not need anyone:

Dave:    “With close friends you have discussions”

“I suppose it’s not just friends, it’s extended family as well, what if you’ve got someone there you can talk to”

Graham: “I could, I could speak to my parents”

Gareth: “You turn to your mum don’t you?”

Ian:    “I think most friends are supportive”

Related to preconceived ideas about men were conversations around the way society views men. It emerged that the men felt that there was a stereotypical view that men can cope with problems and they are strong individuals and this was sometimes in contrast to the way the men actually felt in certain circumstances:

Dave:    “I wonder if talking to friends he (John) would get some kind of like socially stereotypical thing about ‘oh it’s a women’s role’ or ‘don’t expect that you know, blokes should provide work and the women looks after the child’ all of that. I would imagine most blokes, even blokes down the pub they don’t believe it, it’s just a little bit of social banter”
Graham: "There's probably still a lot of like, I don't know macho-ism you know where you go, 'you've got a kid but that doesn't mean you can't go to the pub every other night to meet your friends and, you know, you can still, generally speaking you know, you can still get drunk and do whatever you want'"

Henry: "We have a very clear idea about what a man is"

"You know speaking I think to every man, have to come to terms with this paradox, the paradox of being weak and having to pretend that you are strong"

Nick: "I think that probably a, uh, uh, quite a prevalent view of society is of the modern day father who uh, uh, has a really good bond with his baby"

Richard: "I think what's lacking or the problem is because it is not recognised there's a problem because I think with all society's views that it shouldn't be a problem for a man [laughs] you know to be able to cope with your family"

Although it seemed that the men felt there was a stereotypical view of a man, it was also acknowledged that views of men were changing and this was largely considered to be a positive thing:

Henry: "we are not a society of kind, nurturing fathers and you can see that this country has evolved now, in some way and things are much better in that respect here"

Nick: "the views of fathers have really changed from generation to generation and now they're doing a lot"
Gareth: “The focus is all on the mother isn’t it? The men are um, I mean it’s better than it was”

3.3.3 Organising theme: Ups and down’s

It emerged through the interviews that becoming a father was a time which was constantly changing and one which was hard to prepare for. Similarly, the men talked about having to negotiate constant changes and the increase in responsibility and this also meant that although things were bad one day, they may be good the next. This perhaps influences men’s decisions to seek support as they may assume their problems are simply due to a ‘down day’ and things will pick up on their own.

Graham: “things change on a daily basis”

“one day is good, the other day is bad”

“I stayed home for five weeks and that was brilliant and, but to be honest, if I had a choice between working or looking after the baby for nine months and you know if I wouldn’t be working um, maybe I would find it like a chore”

Henry: “You know how can you look after a baby with all the things we have to do if we don’t negotiate that at home?”

Nick: “It’s certainly a major upheaval in your life”

Ian: “There’s you and your wife or you and your partner and suddenly you have somebody else that you’ve really, you’ve got to, you’re learning to love, you know for some people it can take time to get to know your child and get sort of used to having them around”
"Once it’s all over (the birth) and you’ve had a couple of weeks and you start to settle down, you just sort of, you’re pleased to get back to sort of normal life you know?"

3.3.4 Organising theme: Reality

Reality emerged as one of the most prominent aspects which may prevent men from seeking support. The men were asked about what they thought might happen to John in the future and also what they thought he would do. The answers were predominantly negative with many feeling that the outcome for John could well be bleak:

Dave:  "he may become depressed, um, suicidal. All those sorts of things that happen"

Graham:  "worst case scenario he might become an alcoholic, leave home. He might get deeper and deeper into a depression"

"you know, lose his job and become homeless"

Henry:  "He could be very angry and frustrated and lose control and do something stupid"

"It could make the marital life very distant"

Nick:  "It feels like he’s already started to feel negatively towards his baby uh, that could drive a real wedge between him and his wife"

"I guess the worst case scenario would be, he alluded to, uh, feelings of wanting to harm his son or himself"
Richard: “I think you know, he is to go into a spiral of depression”

Ian: “Spiral out of control, probably get more and more distant from his wife and his child”

This was where a few of the men started to talk about depression. It was felt that John may go on to be depressed in the future, if he did not do something about his problems now. However, it was a common response that in order for John to seek support and admit that he is having difficulty, things would have to get worse for him:

Dave: “It’s going to get worse before it gets better. Things have got to get worse really, he’s going to get worse. Lower mood, there’s going to be a, he may lose his job, he may, there’s going to be a crisis point”

Gareth: “He’ll just progressively get worse I expect”

Ian: “I think he would probably just keep it to himself for a while”

There were some more positive responses but these also acknowledged the fact that really, it could go either way:

Dave: “If he’s got a relationship with her (wife) then he’ll be able to confide but if not, then they’ll go their separate ways”

Graham: “by the sound of it the baby is so little so there’s, there’s plenty of time”

“It might turn into a wonderful, healthy, beautiful relationship so; it could definitely go either way”
Gareth:  “he’ll either deal with it and get his head around it, pull himself round, or he’ll just get progressively worse”

Tony:  “Hopefully his relationship with his child and his, well his whole family relationships will get better”

A summary of the main findings which emerged from the interviews were sent to all of the participants via post and email. Feedback was received from three out of the eight fathers and this was positive (Appendix H). No significant changes were suggested.
4. Discussion

This study indicated that first time fathers do experience difficulties associated with having their first child. Specific areas of difficulty discussed included the birth experience and the unpredictability and hard work of being a father. The men in the study were able to identify with a fictional father's (John) experience of difficulties and demonstrated an understanding of why such difficulties occurred. The results also gave an insight into the way men cope with difficulties in fatherhood. Ways of coping discussed included getting involved with the care of their child, looking to other fathers for support or guidance, taking responsibility for how they're feeling and recognising what needs to be done to try and improve the situation. Finally, the men discussed how they would seek support and what might prevent them from asking for help. This highlighted how the men felt that there was less support available for fathers than mothers and that they sometimes find it difficult to talk about their problems. An additional factor influencing the ways the men seek support was 'being a man' and the connotations that they felt go along with this. There was recognition that fatherhood had many ups and downs and a feeling that some difficult times were to be expected. The final theme related to support was reality which most men felt would mean problems would have to get to crisis point before someone like John would ask for help. However, there was also a feeling that things could go either way and it was possible that the problems would resolve on their own.

The study aimed to answer three particular questions. The first of these was:

4.1 How do men experience and conceptualise the difficulties associated with first time fatherhood?

The men were fairly open in admitting that they do experience some of the difficulties that were mentioned in the vignette albeit in with less severity than in John’s experience. The birth seemed to be something that nearly all men found difficult to some extent and it
appears that this may be related to their expectations about what would happen. It also seemed that at times, men felt isolated during the birth experience and unable to help their partner. The men commented on their surprise at how long labour took and also how traumatic it can be if things do not go smoothly. It may be that men could benefit from more preparation for child birth to increase the knowledge about what may happen before hand. This is supported by the work of Johnson, (2002) who found that the negative aspects of men attending the birth of their child were related to being under-prepared. These findings indicate that men may require higher levels of support and involvement during and after the birth process. However, there are likely to be difficulties in achieving this due to pressures on staff and limited resources.

Most men felt that John’s experience would be fairly common among new fathers and most of them knew someone who had had a similar experience. This implies that there are many new fathers who experience difficulties and could benefit from support at this time. The men interviewed were not surprised or shocked by John’s experience and felt it could be a common experience. However, current healthcare provisions for parents do not seem to reflect this as there are very few support groups or provisions aimed specifically at fathers. In addition, it does not seem to be commonly acknowledged in society that men experience such difficulties after the birth of a child.

The men could not be sure of other people’s responses to the fact that some fathers have difficulties and this is likely to impact who they decide to share their difficulties with. This might be related to the way society views fathers and their roles. A predominant view appears to be that men are strong and don’t have difficulties, therefore it may be uncomfortable for people to think about fathers struggling with their new role. Social Role Theory (Eagly, 1987) suggests that people behave in ways which fit the roles that they play and on this premise, it may be that society holds the view that men can cope due to the fact that they do not talk openly about their difficulties.
The men's conceptualisation of experiencing difficulties seemed to be that fatherhood is hard work and also unpredictable which therefore can bring difficult times. Part of this was that your identity may or may not change and most men felt there was only a limited amount of preparation that you could do. It seemed as though the men had a passive approach to fatherhood and only one participant had done any kind of formal preparation for becoming a parent. It is interesting to note that this participant worked as a psychologist and had decided that psychotherapy would be useful for him before becoming a father. It seems reasonable to assume that his career had an influence in his ability to reflect upon what he needed in order to become a good father. However, it is also interesting to compare this with the other father who was also a psychologist; Dave had thought that his background would help him prepare for fatherhood but on reflection felt that it did not. This does indicate how for some men, their occupation can affect how they view becoming a father although the same occupation can affect people in different ways. Noticeably, the only fathers who mentioned their occupation in terms of preparing for fatherhood were the two psychologists and it seems reasonable to assume that this is linked to the emphasis placed upon people, relationships and in particular early relationships during most psychology training.

When it came to adjusting to fatherhood, most men felt that it was very important to remember those around you. It was considered that John was not thinking about his family in his situation and by focusing entirely on himself, this was making his problems worse. The men seemed to advocate a family approach to the hard work of being parents and this was felt to be beneficial. It should be noted that all of the men interviewed were in stable relationships and this is likely to have influenced their views on this subject. It would be interesting to compare discussions on this topic with fathers who are not in a relationship with their child's mother.

It seemed as though the men felt that John and themselves occupy a role as a father. Identity theory suggests that that central to identity is categorising the self as the occupant of a particular role (Stets & Burke, 2000). However, there appeared to be a discrepancy
with incorporating the meanings and expectations associated with that role into the self. The men spoke about not having many expectations of being a father and that this was in contrast to John. It is possible that this is a protective factor; if the men have few expectations of themselves they are less likely to feel pressure to live up to them. This theory would also account for why John experienced such a difficult time. The men felt that part of the problem was that he had very clear expectations of what a father should be. If this was true, he would have difficulty in identifying himself as a father because he would not have felt able to live up to the expectations that such a role creates.

The identity and role of a man however, seemed to be separate to that of a father. Whereas the men identified fathers as experiencing difficulties and needing support at times, they also acknowledged that this does not fit with the most common view of a man. This difference could reflect social stereotypes that are present in society as it seemed that the men did not necessarily feel that society’s views of men were accurate. This disparity between the view of a man and the view of a father may also reflect the changing status of father’s and men in society. As previously mentioned, social role theory states that individuals act in ways accordant with their role. However, more and more mothers and fathers are now fulfilling different roles, such as the working mum and stay at home dad. This means that the social stereotypes around the roles of mothers, fathers, men and women are forced to adapt in order to acknowledge this.

The second question asked by this study was:

4.2 How do men cope with difficulties experienced in fatherhood?

The men identified a number of different ways they coped with difficulties. Firstly, they felt that it was important to be involved in looking after the baby even though this takes time and effort. This involved working around their work commitments and helping with the baby both before and after they had gone to work. The men talked about different ways they were able to get involved, including carrying out a supportive role in tasks like
breastfeeding. In terms of involvement, it would be important for the mother to be open to sharing these tasks and willing to let the father be involved. This is more likely to happen when both parents are in a stable relationship and might be more difficult if the relationship is difficult or if the parents are no longer together. Additionally, as with John’s story it could also prove difficult if there are other extended family members around who are also eager to take part in caring for the baby. It seems that although new parents benefit from the help of friends and family members, it is also important that they have the space to get used to looking after the baby themselves, particularly for the father who may run the risk of feeling isolated by the female family members.

The men did recognise the importance of other people, and identified communicating with others and having role models as ways of coping. In particular, communicating with their partner was a major way of coping with difficulties. All the men seemed surprised that John was not talking to his wife about how he was feeling and this is likely to reflect their own relationship status. The men felt that it was useful to be able to look to other fathers as role models and these included both friends and characters from films and television. It is interesting that only two men referred to their own fathers throughout the interviews and in both these cases it was with reference to them not being around very much. It has been suggested that men are less likely to want to emulate their own fathers when it comes to their relationship with their own child and therefore they may lack a role model (Condon, 2006). This study seems to support this hypothesis as the only mention of the men’s own fathers was in the context of not wanting to be like them. This may also explain why men talked more about looking to friends or characters on television. As the role of fathers appears to be changing so much, it is likely that men will look to fathers of a similar age to themselves in order to facilitate their own adjustment to a new identity.

The men felt very strongly that it was important to take responsibility for communicating to others if help is needed. This was related to their beliefs that harm and neglect to the child should be avoided at all costs as it was felt that not talking to others would make coping very hard. Again, this is a way of coping that assumes individual responsibility
and control over the situation. It is important to remember that the fathers interviewed were not currently struggling with fatherhood and they may have answered differently had they been experiencing a very difficult time.

The majority of these coping strategies were self-directed and involved the men taking responsibility of the situation to try and make it better. This may indicate that their locus of control is more internal than external although as this was not directly measured it is merely a hypothesis. If the men do have an internal locus of control, this may explain why they have been able to cope with the difficulties they have experienced so far. If the men’s locus of control was external, it is likely that they might feel less able to deal with difficult situations as they might be relying on other people or external factors to change the situation. The work of Mahalik and Kivligham (1988) supports this as they found that individuals with an internal locus of control were more successful at implementing self-help treatments for depression.

Recognition was also an important factor and this involved being able to identify when it was appropriate to just get on with the situation and when it was time to ask for professional help. Although it was acknowledged that there may be times when professional help is required, only a few of the fathers mentioned that professional help would be required for John in his current situation. This was interesting as the symptoms he was experiencing were quite indicative of depression and he was also expressing thoughts of harm to himself or to his baby. Most men felt that there were things that John could do himself to help his situation. This provides support for the hypothesis that men’s mental health literacy is quite poor and as a result they are more likely to implement self-help strategies to deal with difficulties (Jorm, 2000).
The final question asked by the study was:

**4.3 What affects men’s decisions to seek support for such difficulties?**

In terms of seeking support, a number of factors were believed to influence men’s decisions. Firstly, there were issues around the recognition of father’s needs. Men felt that it was sometimes hard for them to talk about their problems and this was not helped by the fact that there is less support available to fathers than mothers. It is interesting that the men had discussed communication as a necessity for coping with difficulties and yet they also acknowledge that this can be hard for them to do. It appears that although they have ideas about would be helpful in this situation, they may find it harder to put into practice. This may explain why hearing of fathers experiencing difficulties is not very common but all of the men felt that it was a common experience. It may be that it is common knowledge amongst fathers that it can be very difficult but because it is not openly discussed, the rest of society assumes that they are coping well.

The majority of the men admitted that they would not know where to go for help if they were struggling with fatherhood. A common response was that there’s plenty of support for mothers but nothing for fathers and as a result, most men said they felt more could be done to support new fathers. It was also identified that men were not given enough time for paternity leave. Nearly all men felt that it took time to bond with their child and to learn how to love them; however, most of them felt that having only one or two weeks in which to do this was not sufficient. It was suggested that it might be more helpful to have a longer time period but spaced out over a few months rather than taking all of the time in just one block.

This leads on to the next theme identified of ‘being a man’. The men felt that they were viewed as being strong and able to cope, whereas being a father sometimes led to situations where they did not feel that way. However, it was acknowledged that society’s views of fathers were now changing with more of an emphasis being placed upon the
father who goes to work and gets involved with looking after their child. It seems that to some extent, the process of change that men go through when they become a father, is not acknowledged in the same way as it is for mothers. When a woman becomes a mother she has the clear physical markers to signal the changes that are going on for her. In addition, the effects of hormonal changes on new mothers are also well documented. There are no such markers for men becoming fathers and they rely on feedback from the mother throughout the pregnancy. Because there is not such a clear set of changes for the father, it may be that society considers there to be little distinction between the role of a man and the role of a father. However, it seems that the men interviewed felt that the two roles can be quite different and that they can occupy both roles in different situations. This implies that it is possible that fathers do need support and cannot always cope with difficulties but as men, they can find it difficult to communicate this to others. This teaches us that because fathers might not complain of how difficult they are finding things, it does not necessarily mean everything is ok.

It was common for the men to rely on their family and friends in time of need and asking for professional help was rarely mentioned. Fatherhood was also considered to be a time of up's and down's and through understanding this, support was not always necessary. This seemed to be because if there was a down day then there was the hope that there would be a good day to come. Finally, the reality of the situation also had an influence on what support, if any, would be sought. The majority of men felt that John would not do anything about his situation and this would mean things have to get worse before they get better. They felt that the outcome for him could be bleak but also could go either way. Perhaps it is this uncertainty about what would happen that led them to believe John would not do anything about his problems at the current time. There seemed to be a combination of thinking his difficulties would resolve of their own accord, in their own time and thinking that they would spiral out of control until he reaches a crisis point, where he has no choice but to acknowledge the situation. Again this highlights that although the men were aware of ways that these difficulties could be tackled, they did not actually think someone like John would do anything until he had to. This suggests that
either they see themselves differently to John and therefore they would behave differently in that situation or that this reflects a more common trend; men may know what it is that they should do but this does not always mean that they are going to do it.

4.4 Limitations

This study has a number of limitations which may limit the extent to which the findings can be generalised to other first time fathers. Firstly and as previously mentioned, the men who took part in the study were all in settled relationships with the mother of their child and this is likely to have affected how they felt about John’s difficulties and what he should do in his situation. It has been found that men living in step-families had significantly higher levels of depressive symptoms than those men living in more traditional families (Deater-Deckard et al., 1998) which indicates that the men in this study are less likely to have experienced depressive symptoms. If they have not experienced such difficulties themselves, they may find it more difficult to think about how they would respond in a similar situation.

Similarly, all the fathers in this study were employed with the majority in jobs which require academic qualification. This has implies that most of the fathers finished school and are paid a reasonable salary. Socio-economic status is likely to have an impact upon views towards fatherhood for a number of reasons. Firstly, having a good job and earning sufficient money eliminates a degree of stress about providing for the family. Secondly, the views and expectations of fathers may well differ across social classes. In more manual jobs there may be more pressure to live up to the image of a stereotypical man. Although the men in this study were aware of that stereotype, most seemed able to view it as that, a stereotype.

Although there was cultural variation within the sample, the participants were all still European. Given that the UK has a large Asian and Afro-Caribbean population it would have been interesting to interview fathers from these cultures to see how their views may
differ. It is likely that these cultures hold different attitudes towards mental health, gender and parenting and it would be interesting to see how men combine these with the attitudes held in the UK.

Another limitation lies again with the sample. Through interviewing first time fathers who are not experiencing difficulties themselves, their views about difficult experiences and how to cope with them may not accurately reflect what it is like for the fathers who are going through a difficult time. However, what came out of these interviews is that all the fathers experienced difficulties at one time or another and they seemed to feel that this was a normal part of fatherhood. This gives us an insight into the way they think about such difficulties and it seems that John’s experience, although considered unfortunate, was not a surprise to the men in this study. This may be because they see it as a part of fatherhood but what can make the difference between men coping or not, is how new fathers respond to these difficulties.

However, although the men interviewed were not surprised at John’s experience and had many ideas for what might be helpful for him, it is not clear what these men would do if they were actually in John’s situation. This limitation lies with the method. Although the use of vignettes provided a safe opportunity to talk about a difficult topic, the result was that the men shared their opinions on John’s experience and offered extracts of their own experience. Without the men actually being in the same situation as John or being asked to imagine they were in his position, it is only possible to hypothesise about how they would actually respond.

4.5 Future directions

It would be interesting to replicate this study with fathers that are not in stable relationships and if possible, fathers that identify themselves as experiencing difficulties. This would give the opportunity to ascertain further the ways in which new fathers experience and cope with difficulties associated with becoming a parent. This study
indicated that men with an internal locus of control are more likely to implement self-help techniques in order to cope with difficulties. As it has been found that men with an internal locus of control are more likely to be successful at using self-help techniques (Mahalik & Kivligham, 1988) a future study could measure new father’s locus of control, their ways of coping with difficulties and their effectiveness of coping with difficulties. This would test the hypothesis that locus of control is a factor in determining whether men require external help to cope with their difficulties.

This study confirmed that men feel there is a lack of support services for first time fathers after the birth of their child. Men are now routinely invited to participate in antenatal classes and previous research has shown that although men find they help them to prepare for the birth, they did not help prepare them for changes in their lifestyle and relationship afterwards (Fletcher, Silberg, & Galloway, 2004). The majority of the men in this study did not seem to be well prepared for the child birth process, but it was not clear how many of them attended antenatal classes. A hypothesis from the results of this study is that men may experience more difficulties in adjusting to fatherhood if they are unprepared for the birth and / or experience a traumatic birth. A future study addressing the relationship between preparedness for childbirth, experience of childbirth and later difficulties could provide further clarity.

The results of this study indicated that the men did not feel there was a lot of preparation that could be done for becoming a father and this is reflected in the fact that only one of them discussed any kind of formal preparation. Therefore, it may be more appropriate to focus on including fathers in postnatal care. Once the baby has been born, the father is faced with the day to day responsibilities and difficulties and may be more open to accepting support at this time. However, in order for this to be a viable option, fathers need to be made more aware of what support is available. Currently, fathers can attend private NCT courses, NHS classes and self-help support such as books and the internet. However, Fletcher et al., (2004) found that fathers were less familiar than mothers with the family related services that were available after the birth of a child. This study also
found that the men were very unsure about where they could go to access help if it was needed. Part of the reason that men may not be aware of where to access help could be due to their lack of contact with health professionals. If men have limited paternity leave or do not have paternity leave at all, they are unlikely to accompany mothers to new baby clinics or to be at home if the midwife or health visitor comes around. In addition, services are often aimed at mother and baby presumably due to the fact that in the majority of cases, it is the mother who stays at home to look after the baby. If postnatal services were more family focused and the father was encouraged to be part of follow up appointments, they may feel more included and involved in their baby’s care rather than having to work hard to be involved. Fathers may also feel more supported and be more aware of where to go for further help or advice if it was needed. In addition, this study has demonstrated that men can be quite passive and find it difficult when it comes to talking about difficulties. Therefore, it could be beneficial for health visitors, midwives and GP’s to routinely ask about the father and how he is coping in the same way that they routinely ask the mother in order to promote a family focused approach.

The fathers in this study all experienced difficulties to some degree but were able to cope with these difficulties more effectively that John. The factors that seemed to influence the men’s ability to cope were being involved, looking to others and recognising when there is a problem. These factors could be promoted by existing services in order to increase all fathers’ abilities to cope with the difficult times. Antenatal and postnatal classes could encourage women to include their partner in the care of the baby and give men ideas on how they can take part. Discussion of positive role models and education about difficulties associated with fatherhood could also be beneficial.

However, it must be acknowledged that even if more services were made available and were tailored more towards fathers, they may still be reluctant to attend. Perhaps a focus of supporting fathers could be to facilitate self-confidence and self-efficacy in their role as a father. If men feel their role as a father is important, they may be more likely to ensure that they receive the support necessary to fulfil this role. The research by Walters
et al., (2001) has highlighted the relationship between men’s experiences of being fathered, perceptions of their own role as a father and attendance at family appointments. Men who had positive views of their relationship with their own father were more likely to view themselves positively and attend appointments; this suggests that increasing self-esteem among fathers who did not experience a good relationship may be beneficial and may also result in greater attendance at services. If building self-esteem was incorporated into antenatal classes attended by men and women, future attendance at postnatal services may also increase.

In terms of improving men’s experience of first time fatherhood, another important topic was paternity leave. The majority of men felt that two weeks was not enough, some fathers interviewed had only one week and one father had no paternity leave at all. The men felt that they needed time to adjust to being a father and time to create a bond with their child; going back to work limited the amount of time they had to do this. It is unclear how practical a solution increasing paternity leave would be and individual employers are likely to have different guidelines regarding this. However, possible solutions such as spreading paternity leave over a few months may mean that fathers get to spend more time with their family on a regular basis and still attend work regularly.

4.6 Self-reflection

My position conducting this study was as a researcher, a trainee clinical psychologist and a daughter. My own experiences of being fathered will certainly have influenced my opinions on fatherhood and what this role should entail. This may also have influenced my interpretation of the results although perhaps unconsciously. As I am not a parent and I am a woman, I am unable to fully understand the fathers’ positions. However, I felt that this gave me the advantage of being able to have a genuine curiosity as they have experienced something I will never be able to. Being a woman did have implications for how I viewed the fathers and how I viewed their opinions. I found that at times I was thinking of the mother’s view and how the experience must have been for her,
particularly when discussing child birth. I feel perhaps I empathised more for her situation during child birth than I did with the father and I think this is likely to be because I am a woman. It was important when such issues arose, that I was aware of my position and be able to monitor my responses in order to remain as unbiased and un-leading during the interview as possible.

Although conducting interviews over the telephone was convenient for the fathers and myself, it did pose some challenges in terms of engagement and observation. Some of the fathers were more talkative than others and I recall feeling as though I was experiencing the fact that ‘men don’t really like to talk’ quite directly at times. This was difficult as my honest reaction was to feel somewhat offended even though rationally I knew that they were likely to be tired after working all day and it is not easy to talk to a stranger on the telephone. However, it did make me think about how easily assumptions are made in everyday situations and how important it is to take time to consider the situation in its entirety.

On the whole, I thoroughly enjoyed conducting this study and found that the father’s opinions and experiences were interesting and engaging. It has made me more aware that there are two people going through the entire experience of having children and although they experience it in different ways, both are equally valid.

4.7 Summary and conclusions

Recent developments in the research literature have led to the acknowledgement that men can also experience difficulties similar to postnatal depression (Goodman, 2003; Lane et al., 1997). We also know that there are certain risk factors that may pre-dispose men to experiencing difficulties (Deater-Deckard et al., 1998) and that there are differences between depression in fathers and mothers in the first post-natal year. Following on from research which showed that men may conceptualise and respond to depression differently to women (Brownhill et al., 2005), this study aimed to move away from the use of the
term ‘depression’ in order to gain a view of difficulties associated with fatherhood that were not influenced by a particular label. What this study has added to the research literature on difficulties in fatherhood is an understanding of how first time fathers think about such difficulties, how they cope with such difficulties and what influences their decisions to access support. It seems that men are now adjusting to changing roles and expectations of fathers and are happy and willing to take up these new roles. However, it seems the provision of services and employers attitudes around having children are still somewhat mother focused. If men are to adjust to becoming a father and continue providing support to their partner and child it is imperative that they are in turn given the time and support they need in order to effectively carry out and enjoy this important role.

However, it appears that men do not always wish to access services that provide support for first time parents. This poses a difficult question in terms of how to effectively support fathers. It may be that focusing on changes to service provision may be somewhat premature and the first step to making a difference is increasing knowledge and awareness that fathers can experience difficulty. That way, stigma may be reduced and men may become more open to discussing the difficulties that they do experience and the help they would like to receive. When this has happened services will be better able to try and ensure they meet new fathers needs.
References


http://www.medicalnewstoday.com/articles/9475.php


Postnatal depression. [http://www.patient.co.uk/showdoc/23069110/](http://www.patient.co.uk/showdoc/23069110/)


Appendix A: Vignette
Vignette – John’s Story

The birth of my child was not exactly how I expected. It was a traumatic birth, and after 20 hours of labour it culminated in an emergency c-section. I thought I would cry tears of joy and happiness at the arrival of my son – instead I cried tears of relief that it was all over. I don’t think I was prepared for what happened, and also not prepared to see my wife in so much pain and feel completely helpless. I didn’t know what to do to help her, to try and make it better.

Since the birth, things have been pretty difficult. My wife Jo took a while to recover from the c-section although she seems to be getting better now. What has started to worry me now is that as things appear to be getting back to normal, I’m not sure how well I am coping. I always thought that Jo and I were close but since having our son things have changed so much. Jo has taken so naturally to being a mum and has grown very close to the baby. In contrast I feel more and more useless. Jo’s mum has helped us out a lot and at times I don’t know what we would do without her but with her and Jo taking care of the baby, there doesn’t seem to be much for me to do. I actually looked forward to going back to work as by providing for my family I would be helping in some way.

However, work isn’t helping like I thought it might. I constantly feel stressed and exhausted. I can’t remember the last time I slept through the night and I get irritated so easily. When I do manage to get some sleep, it’s not long before I’m woken up by my son crying. I don’t feel like seeing my mates because they all coped so well when their children were born and I know I should be happy. I feel so guilty for feeling this way. I knew that having a baby wouldn’t be easy. I just didn’t think it would be this hard.

Worse of all is how much I have struggled to get close to our son. I always thought it would come naturally to me, I was really looking forward to being a dad but it seems that whenever I’m with him he just cries until Jo takes him. It’s like she is the only one who is good enough. At times it feels like he hates me, and I am ashamed to admit that I have had thoughts of harming him or myself.

I’ve thought about talking to Jo about how I feel but how can I explain it? She’s been through so much, the pregnancy was difficult as was the birth and she’s doing practically everything for our son. She doesn’t need me to look after as well. I just feel like I have let her and everyone down. As the father I am supposed to be supporting my wife, not the other way around.
Appendix B: Interview Schedule
Interview Schedule

1) What was it like reading about John’s experience?

Prompts:
- How did it make you feel, reading about his experience?
- How do you think he is experiencing fatherhood at the moment?
- What things you think John is enjoying about being a Dad?
- What things do you think John is finding difficult about being a Dad?
- How do you think John feels about the way he is feeling right now?

2) What ideas do you have about why John is having this experience of fatherhood?

Prompts:
- What do you think may be making things worse for John?
- What do you think may be making things better for John?
- Is there anything else that you think may be influencing how John is feeling right now?

3) What do you think about the way that John is feeling at the moment?

Prompts:
- Do you think he is justified in how he is feeling?
- Do you think there are many new Dads who have a similar experience to John?

4) How do you think John’s wife would react if she knew how he was feeling?

Prompts:
- How do you think his (extended) family would react?
- How do you think his friends would react?
5) How do you think that John's experience may be affecting his life?

Prompts:
- How may it affect his work life, social life, relationships, and family life?
- Are there any people in particular that you think would be affected by how he is feeling?
- In what ways do you think they will be affected?

6) What do you think John should do about his situation?

Prompts:
- Is there anyone in particular that you think he should talk to / or would understand how he is feeling?
- Is there anything you think he should not do?
- [in response to their answer about what he should do] Do you think there might be anything that would prevent John from doing this (whatever they feel he should do)
- What do you think is the most likely thing that John would do?

7) What do you think might happen to John?

Prompts:
- What might happen to his relationship with his wife / son / friends
- What might happen in other areas of his life? Work / social life.
- What will facilitate / prevent these things from happening?

This is the end of the interview, thank you very much for taking part.
Appendix C: Ethical Approval
7th November 2007

Dear Sarah

Reference: 134 - PSY - 07
Title of Project: Experiences of symptoms of depression in first time fathers

Thank you for your re-submission of the above proposal.

The Faculty of Arts and Human Sciences Ethics Committee has given favourable ethical opinion.

If there are any significant changes to this proposal you may need to consider requesting scrutiny by the Faculty Ethics Committee.

Yours sincerely

[Signature]

Dr Mark Cropley
Appendix D: Information Sheet
Information Sheet

Study Title

Challenges and Experiences of First Time Fatherhood

What is the study about and who is involved?
Becoming a parent for the first time can be both a joyous and difficult experience. Much has been written about the difficulties that mothers can face after childbirth; however, more attention is now being paid to fathers' experiences also. This study is aiming to learn how fathers think about the difficulties that some people experience after the birth of a first child. It is hoped that by learning more about this the way in which fathers think about becoming a father for the first time, more can be done to support them, their partners and their children.

This study is being conducted as part of the PsychD in Clinical Psychology at the University of Surrey. I am Sarah Burdett and I will be working directly with the people taking part in the study. The study is being supervised by Dr Susan Howard and Dr Laura Simmonds from the University of Surrey.

Benefits and Risks of taking part

Becoming a parent for the first time can be filled with many different emotions, both positive and negative. It can be difficult to talk about some of these emotions that may be experienced but it can also be beneficial to share these feelings with somebody. It can be helpful to have a space where you are able to discuss experiences of becoming a father in a non-judgemental environment. We will be able to provide you with names and contact details that might be helpful to you if you wish to seek further support.

It is also hoped that by increasing the amount of research that is undertaken in this area, more recognition will be given to the experience of new fathers. In the long term this may contribute to increasing understanding of what is needed to ensure that becoming a father is as positive an experience as possible.

Do I have to take part?

It's up to you whether you take part or not. If you do agree to take part you will be given a consent form to read and sign. If you consent you are still free to withdraw from the study at any time and without giving a reason.

Before you decide to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read this information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if
you would like more information. Take time to decide whether or not you wish to take part.

What will happen if I take part?

If you agree to take part in the project, you will first be contacted by telephone for an initial screening. This is to ensure you are suitable for taking part in the study, to give you an opportunity to ask questions and to arrange a convenient time and place for the interview to take place. If you are suitable and would like to take part, you will be given a short vignette to read. You will then be interviewed about your views on the vignette. You will not have to answer any questions you would rather not. There are not any right or wrong answers to the questions; we are interested in your views and opinions. The interview will be audio taped and transcribed so that we are able to analyse the results.

This interview will take place either at the University of Surrey (daytime only) or at your home depending on which is more convenient. For interviews to take place in the home there must be somewhere available for the interview to take place without any interruption or distraction.

What happens to the information collected?

All information collected will be kept confidential. The results of the study may be published at some time in the future, but you will not be identified in any way. Nothing we report could be traced back to you. If you want information about the results of the study you can request these from the researcher. You are able to withdraw from the study at any time.

Contact details

Sarah Burdett: s.e.burdett@surrey.ac.uk
Appendix E: Consent Form
Consent Form

- I the undersigned voluntarily agree to take part in the study on 'Challenges and Experiences of First Time Fatherhood'

- I have read and understood the Information Sheet provided. I have been given a full explanation by the investigator of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been advised about any discomfort and possible ill-effects on my health and well-being which may result. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

- I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998). I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity is preserved.

- I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

- I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Name of volunteer (BLOCK CAPITALS) ............................................................

Signed ..............................................................................................................

Date ..................................................................................................................

Name of researcher taking consent (BLOCK CAPITALS) .................................

Signed ..............................................................................................................

Date ..................................................................................................................
Appendix F: Transcript
Participant 2

R: What was it like for you reading about John’s experience?
P2: Um (pause), I read through it and um, and actually, funnily enough there’s probably like a couple of friends who’ve just had had babies, well actually two and
R: [overlaps] yeah
P2: um, and personally, I’m lucky enough that I can’t actually relate to it that much but I’ve you know, spoken to other first time dads and it reminded me very much of a friend who sort of like went through a very similar scenario (speaking slowly here)
R: Oh I see
P2: that’s been described sort of like, in John’s story
R: yeah I see
P2: Not all points, but you know
R: No
P2: But a few, a few points um, to make me think ah, maybe I’m actually quite lucky. Um, sort of like, my initial reaction was just like, this is probably quite normal but sort of like it’s a little bit sad
R: yeah
P2: I think at certain points
R:[overlapping] yeah
P2: and actually to most points I can understand them but personally I can’t relate to them
R: No, no I see Ok. And so how do you think he is experiencing fatherhood at the moment?
P2: Um, who my friends or myself?
R:Um no, John, in the vignette
P2: Um, um well he comes across as finding it sort of like quite hard um I think and um I’ll just go through the text do you know he mentions do you know that at the beginning it was sort of like quite a traumatic birth and sort of like there were complications. Um, it was fairly similar with S, um she didn’t have a caesarean section but labour was still sort of like 18, 20 hours
R: Wow
P2: and she needed to have like an epidural and then there was like problems with the epidural so she had to stay in hospital for another 4/5 days just to make sure that everything was alright
R: Oh so that was more complicated than perhaps you were expecting
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35  P2: Uh, a little bit
36  R: Yes
37  P2: A little bit. I mean you don't really know what to expect because
38  R: I see
39  P2: It's the first time and uh, you know you always sort of like think in worst case scenario
40  and then it's actually always much harder than you can possible imagine
41  R: yes
42  P2: but then on the other hand um do you know, there's quite a few moments which make it
43  worthwhile and do you know once everything's over you tend to forget things quite, quite
44  quickly and
45  R: [overlapping] I see
46  P2: and sort of just concentrate on the good points and I've, I guess that's what's stayed with
47  me
48  R: Yes
49  P2: my memory
50  R: OK
51  P2: Um, but to reflect, certain things do you know where he was going on about that he felt
52  sort of like a little bit useless and you know that the mother and the baby sort of like had a
53  very strong bond and sort of like, I had the impression he was thinking, there were things, he
54  felt a little bit left out
55  R: Yes
56  P2: Um, as I had I haven't really experienced that so, you know I know that it does happen
57  and
58  R: [overlapping] mm hmm
59  P2: as I said an actually very similar situation happened to my friend um
60  R: So it's something you're aware of but haven't experienced directly
61  P2: Exactly
62  R: Yeah, ok. I was just wondering, you said earlier about um how, you were able to even you
63  know, even throughout the times where things were quite difficult you were able to forget
64  quite quickly and like concentrate on the good things. What do you think might be going on
65  with John in the vignette that's stopping him from being able to focus on the good things?
66  P2: Um
67  R: What do you think might be different?
68  P2: (pause) I think you know things change on a daily basis
P2: So in relation to me, one day is good the other day is bad but I think sort of like the overwhelming feeling with me is that most of the time it’s good.

R: Yes

P2: and I think with John it probably um you know I’m sure he also has his good moments but

R: yeah

P2: sort of like being outweighed by the you know, the bad moments and

R: I see

P2: I think it probably, it sort of like seems to me sort of like a classical you know sort of like not necessarily stereotypical but more conditioned sort of like what is expected from mum and dad

R: I see, ok

P2: you know today like you know, the mum is the one who’s very close to the baby

R: [overlapping] yeah

P2: and they have that bond and the men sort of like are feeling a little bit left out and

R: I see

P2: you know before you have a baby your girlfriend or your wife is concentrating on you primarily and now there’s sort of like this new person coming in and that means sort of like for, for the man or John in this case you, you’re not getting the whole attention

R: No, no that’s true

P2: You know there is like, apart from how he describes feeling a bit useless there might be maybe, a little bit of jealousy in there eh,

R: Do you mean jealousy of the baby, of their relationship?

P2: Yeah, the baby maybe or I mean, I don’t know it sounds awful to me, do you know how you always talk about do you know women getting into postnatal depression

R: Yes

P2: Um, this to me sounds a little bit like you know, actually the bloke gets into a little bit of some kind of postnatal depression

R: Yes, yeah

P2: and

R: And is that something you were surprised at? Or have you you know, thought that that could be something that happens to men before?
P2: Um, (pauses) maybe, we used to go to classes, NCT classes
R: mm hmm
P2: and anyway, everything sort of like concentrates or focuses on do you know, how do you
got through pregnancy and um do you know sort of like for the mother to give birth but
nobody really prepares you for like once you come out of hospital
R: I see
P2: There's two of you and like now you have to get on and that's sort of like part of it
R: Yeah
P2: and um, had I been expecting that? To be honest yes and, I didn't have an idea.
R: No, ok
P2: I didn't really expect anything
R: Yeah
P2: um, I think maybe what might have helped me a little bit is sort of like I've only got one
sister but I've got, I come from like a fairly bit family and I'm the oldest because my mum
and dad had like five brothers and sisters and they've all got two or three kids and stuff
R: mm hmm
P2: I'm quite used to sort of being around kids, looking after them. I've got a sister who was
sort of like nine years younger than me so
R: Ok
P2: I used to look after he quite a lot and um, looking after my daughter now reminds me
little bit actually of looking after my sister. Obviously I've got more responsibilities and that
R: But it's not entirely new in a sense
P2: Not entirely new um and definitely not scary
R: I see, I see
P2: I think maybe for someone like John, or say it might be a new situation you might have
someone who was, you might act a little bit apprehensive at the beginning
R: mm hmm
P2: Um, I mean I, I know, do you know this mate of mine I'll come back to, I've had a lot of
chats with and he said do you know, I think my baby doesn't, doesn't love me
R: Ok
P2: you know and I've seen in this text it goes on as well he's
R: Yes
P2: you know see's mum and baby getting on and he sort of like feels left out
R: Yes
P2: and I didn’t have that um, and I don’t have that. I feel like it’s a baby, babies don’t really
know you, what love is you know
R: yeah, and yeah of course
P2: on you, there’s no such thing as your baby doesn’t love you. You also have to obviously
put in the time you know, and start sort of like building a bond
R: mm hmm
P2: and um, I mean I was lucky enough that S gave birth and I stayed home for five weeks
R: Ok
P2: I managed to you know take 3 weeks holiday and I got one week special leave
R: I see and do you think that was helpful in helping you to get to know your daughter and
P2: Maybe, maybe um I think it certainly helped um, You know I wouldn’t say that that was
the main reason for it, but um to have the now, I don’t really see her that often that is you
know I’ll feed her in the morning so I then go to work sort of 9 and normally she wakes up
around 7 so I spend 2 hours with her in the morning
R: I see
P2: Then I go to work, S stays home with her all day and then I get home around half 6
normally, and then I bath her and I will feed her again and then fingers crossed hopefully she
goes to bed
R: Yes, [some overlap] so it sounds like you’ve managed to find a way to still spend time
with her
P2: yeah
R: even though you’re working which sounds really positive.
P2: Yeah, but it’s like I wouldn’t, I don’t see it as a chore or
R: No
P2: or, something that you know I have to do. I mean originally, I’ve said that I’m German, I
was born and brought up in Germany but both my parents are Croatia
R: Ok
P2: so that, I don’t know, sort of like a little bit the Italians, you know southern Europe where
families sort of like means alot
R: I see
P2: You have, very often you have two, three generations living together, Grandpa, Mum and
the kids and stuff so um, you know I think that maybe there’s like a cultural aspect
R: Yes, possibly
P2: Um, I don't know but it definitely contributes.

R: Yeah

P2: Um so, I would say it's not as bad as I thought it might be

R: I see, I see. And what do you think, just going back to John for a second, what do you think that he thinks about himself at the moment?

P2: Um, well he comes across as having sort of like you know fairly, fairly low esteem or do you know, feels a little bit useless so he doesn’t know how to handle those situations do you know, and most things I can understand and relate to and I’ve certainly felt that at times um, I don’t know what's maybe sort of like a little bit disturbing is, do you know what does he say (quotes) “at times it feels like he hates me”

R: mm hmm

P2: feels like he doesn’t love his dad because, and then (quotes) “I'm ashamed to admit that I've thought of harming him or myself” um do you know, that strikes to me I think of like uh, quite, quite harsh reaction

R: Yeah, yes. And do you think he has good reason to feel like that, based on the other information that was in the vignette?

P2: Um, I can understand that, I wouldn't, I wouldn't judge anybody and you know with, that’s not something particularly I've heard amongst my friends

R: No,

P2: and I've never felt like that. I can sort of try and understand where he comes from

R: Yes

P2: Um, but you know the reasons for that I don’t know. Probably just very low esteem or you know he feels like do you know because the birth basically, is such a big thing you know, he also says um, do you know normally there’s sort of, when the mother’s sort of, when the baby comes, giving birth, you know such a sort of, Hollywood experience you know, you sort of like expect to cry and you know, and be the best moment of your life you know and he says "I cried cause of, uh" what does he say, you know he didn’t cry because of happiness he cried because of something else, I can’t remember now but um, I mean to be honest, what happened sort of like to me was do you know I was, do you know I was there, I was present during the birth but um, do you know when, when, she came out, to be completely honest I didn't really feel very much at all

R: mm hmm

P2: Um, there wasn’t sort of like this, like, oh this was amazing

R: I see

P2: do you know, I think S was very exhausted and so she didn’t really have that she was just glad it was all over and

R: Yeah I'm sure
P2: I was exhausted and all that and uh, I felt a little bit guilty because there was this baby and you’re supposed to like to love it, unconditionally and it was a bit strange and probably took me, probably took us both probably a week or two you know

R: Yes

P2: till you actually sort of like get used to that new little person and know, I think you have to start building a bond first,

R: Yes,

P2: to you know,

R: I see

P2: till you can love somebody. There certainly wasn’t this moment that, that, neither me or her burst into tears of complete joy so you know, in that way, oh here it goes (quotes) “instead I cried tears of relief that it was all over”

R: Yes

P2: I didn’t cry but you know my, my first thing was that I was quite glad that it was over, rather than saying like, oh, this is the best thing that’s ever happened in my life

R: Yes, I understand, yep, ok. Um, I’m just thinking um, about what you said earlier about um, you obviously have a friend who had some similar experiences to John

P2: mm hmm, mm hmm

R: I was wondering, do you think there are many new dads that have a similar experience to, to John or to your friend?

P2: Umm, to be honest it’s hard for me to tell because actually, well we were almost the first ones to

R: I see, ok [overlapping]

P2: out of our friends. Sort of, certainly within my family like uncles and aunts and all that um, if they did, it’s never been spoken about. Maybe I was too young as well

R: yeah, so not that you’ve been aware of

P2: I wouldn’t really know, um so I can only go, I can only go by personal experience and sort of like these one or two friends I have. Anything else would be really pure speculation.

R: Yeah, that’s fine. And how do you think that John’s wife would react if she knew how he was feeling?

P2: Um, (pause) um, I don’t know. I think she would be maybe quite surprised

R: yes

P2: of course it sort of like depends on you know on the relationship and lets say that the baby is not, not an accident or mistake you sort of plan it and you’re either married or not but you know you’re like living together but um, do you know. I mean very often you sort of like
you know think 'oh if I'd known that I would have done something about it' um, you know I
think it's sort of like (pause) I don't know it depends on the relationship
R: Of course, of course
P2: You know, how good you know them, sometimes you don't have to say anything and
people tend to
R: Yes, that's true
P2: other times you know, you can say it over and over again and people still ignore you and
stuff
R: Yeah
P2: Um,
R: And what about extended family or friends, if he was to talk to them, how do you think
they would react to hearing how he is feeling?
P2: Um, I mean I, again, I think this is speculation but what I will say is that if you, I think if
you speak to somebody who has a kid as well
R: Yes
P2: you know, if you're in the same position um, I think you get a new perspective.
R: I see
P2: I think you are, you know, I wouldn't judge my friend and I wouldn't say he's a bad dad
R: mm hmm
P2: um, do you know or, or, a brilliant dad or something you know I'd sort of like, when I
hear stories like that you know, there are moments when sometimes I think yeah I can relate
to that, sometimes I think I didn't have that or things are better I think I'm lucky that I didn't
have that and understand that because it's certainly hard at times, you know. It's not all easy
sailing and you know I have my hard moments and you know there is sort of you know, I
stayed home for five weeks and that was brilliant and but to be honest, if I had a choice
between working or looking after the baby for nine months
R: Yes
P2: you know, if I'm really honest, I don't mind going back to work
R: Yes, I see, yes
P2: Do you know. I can see, I think it is very, very hard
R: Yes, I'm sure, I'm sure
P2: Um, I remember you know, breastfeeding and all that which men never experience you
know, and you know, I have her for 2 hours in the morning and I have her for 2 hours in the
evening which might be (pause) not very much compared to, compared to what you know the
mother can do
R: Yes

P2: or what is expected from her so, uh, I would never do you know judge somebody or say like you know, I would never react badly or if somebody tells me, this story

R: I see

P2: or

R: I see. So thinking more generally how do you think society as a whole would view dads with these sorts of problems? Do you think that it's acknowledging that fathers have difficulties or do you think it's not really spoken about?

P2: Uh, probably, I think everything's, you know the mother-child relationship is much, much stronger I think than the father child relationship

R: yeah

P2: You've got that sort of generally, isn't there that core movement at the moment, is it father's for justice or something?

R: yeah I've heard of them

P2: they, they stand for quite a lot of things, you know it's one of those rare occasions of sexism towards men

R: I see

P2: and in a way, surely if a mother was going to say like, you know I don't get on with my baby

R: mm hmm,

P2: that might be maybe frowned up a little bit more because it is sort of like expected from the mother really to be there 24/7 you know um. Do you know men, they haven't really been given really, the role or opportunity to do that because you know, a mother gets six months maternity leave whereas men get one week

R: that's true

P2: If you looked, do you know, at how society is structured, the man doesn't really have the chance or the possibility to access the same

R: So it's not like on an equal um, on an equal footing really

P2: No, I don't think so you know and there's obviously all this sort of like, among men, there's probably still a lot of like, I don't know, macho-ism you know where you go, you've got a kid but that doesn't mean you can't go to the pub every other night

R: I see, yeah

P2: to meet your friends and, you know you can still, generally speaking you know, you can still get drunk and do whatever you want

R: mm hmm
P2: more or less
R: So some of those stereotypes are still around
P2: I think so,
R: Yeah
P2: I think so, very, very much
R: Ok. And thinking about um, the rest of John's life, how do you think that the experience
he's having at the moment, in what ways do you think his life, you know would you expect it
to be affected?
P2: Um, (pause) uh, I suppose you know, looking back, if you have, do you know, low
esteem
R: uh huh
P2: He's not feeling very comfortable or you know, or confident um, so that might then, you
know, that might have an influence on your professional life, your private life is not really
good I expect. You know it might affect your work, it might affect sort of like also your
friends you might get you know, I don't know, if you're not happy, whatever the reason is
um, you might be frustrated, you may get uh, you know it might maybe become some kind of
, sort of like self fulfilling prophecy
R: I see, yes
P2: where you're feeling like well you know, I'm not good at this, this is not going well in
my life, and do you know you might become quite sensitive to little things that knock you
back where normally you wouldn't even think twice about it. You might start building, sort
of like a world view or like a picture of yourself and then your life where everything
suddenly becomes bad.
R: I see, that would make sense. And, what do you think that John should do about his
situation, what's your view?
P2: Um, (pause), that's quite hard. Do you know, it's, I could, I could speak to my parents,
sort of like older people are always quite pragmatic
R: yes, yes [overlaps]
P2: ... you know, get on with it, stop, stop moaning about what the situation is and try and
make the best out of it
R: Yes,
P2: And,
R: Do you think there might be anything that might prevent John from doing something like
that?
P2: Yeah, yeah of course you know, sort of like the character and stuff
R: yeah
P2: um uh, you know at the same time that might make it maybe actually worse because do you know going and saying to somebody who obviously is having difficulties just to say 'oh get on with it'

R: mm hmm

P2: might uh, not be the right approach you know and there's do you know, there's probably what he needs, somebody you know who he can talk to and you know where he feels at ease and someone who is taking him serious and

R: yes

P2: and you know feels like, 'wow, yeah I can relate to that' or 'I can understand you' or 'you're not alone' or 'you know I've been through that' or 'I know people who have been through that' and it's not do you know, you're not like a, a freak or, you're not abnormal, it happens to lots of people and lots of people have been through that and you know a few years later they've got an amazing you know, relationship with their kid

R: yeah I see. So it's important who, who he chooses to speak to really

P2: Yeah, I mean it's very hard but there is still um, to bring back again to my friend um, I think maybe it was because the mum is like, taking over quite a lot so he doesn't really have to do very much if he doesn't want to

R: yes

P2: you know. I think, (pause) you know, you know you have to build a bond with your child.

R: Yes

P2: You have to invest time and effort into it, you know and you know you have to try and enjoy that time with your child and, and you know as I said when you're, to be honest, I feel very close to my daughter but if I'm completely honest I don't spend that much time, I spend as much time as possible with her

R: yes, yes

P2: and you know if I wouldn't be working um, maybe I would find it like a chore, if I would have to look after her every day for three or four hours, but because I only see her you know 2 hours in the morning, 2 hours in the evening for me it's like a special occasion

R: I see

P2: and so I think what I hope, do you know, I make an effort and that I think it works at the moment, it works quite good between us. Um,

R: Yeah that's good

P2: You know, other, other people, you know if I wouldn't do that or if the mum were to take completely over, you don't have that bond and then you know, it's the same thing as I said when, you know when she was first born I didn't really feel that much of a bond you know, you have to work for that you know and that, that develops and you know can say like well John stop feeling sorry for yourself and you know if anybody you've got yourself to blame
R: mm hmmm

P2: um, but you know he might find that maybe offensive so another approach would be like, right, you know you me and both our daughters, let's all go out and try, try make a, rather than things be chores try and make a you know, a day of fun out of things and I think what's probably quite hard is that you can do that once but to do that on a regular basis

R: But is sounds like there are you know, a few different things that he can try and there's not necessarily just one answer

P2: Yeah

R: For this. Is there anything in particular you think he really shouldn't do?

P2: Um, (pause) let me think, um, um, (pause) well he shouldn't, (his partner comes into the conversation at this point) she asks do you want to interview the mother?

R: (laughs) I'm afraid I don't need mothers at the moment but thank you,

P2: (to partner) ok, well if she needs you, she'll let you know

R: That's very kind,

P2: Um, he comes across as, as, feeling a little bit sorry for himself um, as I said earlier so I would say you know, stop doing that. Having said that, you know I've personally found it very easy to get on with my daughter but there other areas where I have difficulty and stuff.

R: Once you feel you get stuck, it's, it's not easy to get out of it. However, if you're going to do something by yourself, it's, it's not just going to come along

R: I see

P2: you know, he sort of may be a little bit proactive, try and change the situation yourself rather than sort of like waiting for some kind of miracle to happen

R: I see, ok. And final question, what do you think might happen to John?

P2: Um, (pause) Um, hard to say, there's too little information about that

R: Yeah, that's fair enough

P2: the relationship he's having with the mother um, you know you could say worse case scenario he might become an alcoholic, leave home. [phone line goes dead]

R re-calls the participant

R: Hello,

P2: Sorry, I think my battery just ran out

R: Ok, that's absolutely fine, no problem

P2: Um, um, what was I saying, oh, how he might end up

R: Yes
P2: Um, yeah, so you know worse case scenario may be uh, that he might get deeper and
deeper into a depression uh, or he might turn alcoholic

R: yes

P2: uh, you know, lose his job and become homeless

R: ok

P2: which I'm sure that probably has happened. Um, you know but at the same time his, by
the sound of it the baby is so little, so there's, there's, plenty of time and you know in, I think
personally I'm fairly good with little kids but that doesn't say that maybe once my daughter's
four or five years old that our relationship will maybe change somewhat and you know, I'll
find it hard and you know the same way for John. You know, once the baby can talk, and do
stuff with him you can go out and you can go to the zoo and they don't rely on being fed
every 2 minutes it might turn into a wonderful, healthy beautiful relationship so,

R: So it could really go either way

P2: I think you know, at this point, you can't say at all how their relationship is going to, you
just don't know, it could definitely go either way

R: Ok. Well that's the end of the interview so I'm just going to turn the tape off now ok?

P2: Ok.
Appendix G: Moving from Codes to Themes
## From Codes to Themes

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<td>- Limited</td>
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<td>- Preparation for fatherhood</td>
<td>- Clear (John)</td>
<td>5) John needs to think about others</td>
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<tr>
<td>- Expectations of fatherhood</td>
<td>- Not met</td>
<td>6) John’s isolation and negative self-judgement makes things worse</td>
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<td></td>
<td>- Anti-climax</td>
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<td>- Identity and roles</td>
<td>- Change</td>
<td>7) Fatherhood brings increased responsibility and changes</td>
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<td>- What helps</td>
<td>- Involved</td>
<td>8) The birth is a major part of the experience</td>
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<td>- Effort</td>
<td>9) Fatherhood takes work</td>
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<td>- Communication</td>
<td>10) There’s only so much you can do to prepare</td>
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<td>- Aware</td>
<td>11) If you have clear expectations you may be let down</td>
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<td>- Role models</td>
<td>12) Identity may or may not change</td>
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<td>- Time</td>
<td>13) Roles are influenced by society</td>
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<td>14) It helps to take part in looking after the baby</td>
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<td>16) Need to</td>
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<td>- What doesn’t help</td>
<td>- Keeping quiet</td>
<td>17) Having role models helps</td>
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<td>- Being pushed out</td>
<td>18) Not communicating and not having time makes it very hard</td>
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<td>- Minimising</td>
<td>19) Sometimes you need to ask for professional help</td>
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<td>- No time</td>
<td>20) Sometimes you need to ‘get on with it’</td>
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<td>- Communication</td>
<td>21) Blame, harm and neglect should be avoided</td>
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| - Advice should not                    | - Hard            | 22) It’s hard to deal with difficulties and talk about them |
|                                         | - Avoid           | 23) There is less support for men than women |
|                                         | - Talk            | 24) Men need to rely on friends and family |
|                                         | - Close friends   | 25) Society views men as strong, able to cope, being involved |
|                                         | - Extended family |                               |
|                                         | - Comparisons     |                               |
| - Dealing with difficulties            | - Stereotypes     | 26) Views of men are changing |
|                                         | - Change          |                               |
|                                         | - Strong          |                               |
|                                         | - Doing           |                               |
|                                         | - Cope            |                               |
| - Social support                      |                   |                               |
|                                         |                   |                               |
| - Societies views                     |                   |                               |
|                                         |                   |                               |
| - Impact on life                      | - Responsibility  |                               |
|                                         | - Change          |                               |
|                                         | - Others          |                               |
|                                         | - Affairs         |                               |
|                                         | - Depression      |                               |
|                                         | - Suicidal thoughts |                               |
|                                         | - Alcoholism      |                               |
|                                         | - Relationship    |                               |
|                                         | - breakdown       |                               |
|                                         | - Homeless        |                               |
|                                         | - Improve         |                               |
|                                         | - Crisis point    |                               |
| - Anticipated outcomes                |                   |                               |

27) Negotiating changes and increased responsibility
28) The outcome could be bleak
29) Things could go either way
30) Things have to get worse before they get better
From Basic to Organising to Global Themes

<table>
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<tr>
<th>Basic Themes</th>
<th>Organising Themes</th>
<th>Global Themes</th>
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<td>1) John’s story is sad but easy to relate to</td>
<td>Validating John’s experience</td>
<td>The experience of difficulties in fatherhood</td>
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<td>2) Family should understand</td>
<td>Unpredictability</td>
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<td>3) People’s reactions are unpredictable</td>
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<td>4) John’s experience is not uncommon</td>
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<td>5) John needs to think about others</td>
<td>Remembering those around you</td>
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<td>6) John’s isolation and negative self-judgement makes things worse</td>
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<td>7) The birth is a major part of the experience</td>
<td>The birth process</td>
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<td>8) Fatherhood takes work</td>
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<td>9) There’s only so much you can do to prepare</td>
<td>Hard work and unpredictability</td>
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<td>Ways of coping with difficulties</td>
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<td>14) Need to put effort in which takes time</td>
<td>Looking to others</td>
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<td>15) Need to communicate</td>
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<td>16) Having role models helps</td>
<td>Recognition</td>
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| Responsibility |

| 21) It's hard to deal with difficulties and talk about them |
| 22) There is less support for men than women |
| 23) Men need to rely on friends and family |
| 24) Society views men as strong, able to cope, being involved |
| 25) Views of men are changing |

| Recognising fathers’ needs | Seeking support |

| 26) Negotiating changes and increased responsibility |
| 27) The outcome could be bleak |
| 28) Things could go either way |
| 29) Things have to get worse before they get better |

| Ups and downs | Reality |
Appendix H: Email Feedback Received
Hi Sarah,

Thanks for this, and thanks for asking me to take part - it was really interesting to participate and got me thinking about a few issues relating to fathers, particularly first-time ones. I hope you've been able to get out of the study what you wanted.

Best Wishes,

Sarah Burdett <sarahburdett@hotmail.com> wrote:

Dear

Thanks very much for taking part in my study about first-time fathers. I have now completed the analysis of the interviews and have attached both a list of themes identified and a diagrammatic representation of those themes. The interviews were very interesting to conduct and to analyse and I hope that I have done them justice.

If you have any feedback about the interviews or the themes identified please feel free to contact me on this email address. Many thanks once again for your participation,

Sarah.
Dear Sarah,

The themes and thematic networks are easy to follow and make sense (although it may have taken ages to do I guess!!!), I could not have done it better. However, I think there is something in my head that I am not sure if its necessary to put because it may be implicit in the network. Its the issue of society and how things are constructed by it. Fathers might have difficulties because of society's views and expectations more than for any biological reason. Society is reluctant to accept changes. Although the social circumstances are different society sticks to old values and beliefs (culture is always conservative).

B/W
This seems like an excellent piece of work, I will look out for the write-up.
Well done

Thanks very much for taking part in my study about first time fathers. I have now completed the analysis of the interviews and have attached both a list of themes identified and a diagrammatic representation of those themes. The interviews were very interesting to conduct and to analyse and I hope that I have done them justice.

If you have any feedback about the interviews or the themes identified please feel free to contact me on this email address.

Many thanks once again for your participation,
Sarah.